



CARDIFF AND VALE SAFEGUARDING BOARD

LEARNING AND IMPROVEMENT FRAMEWORK

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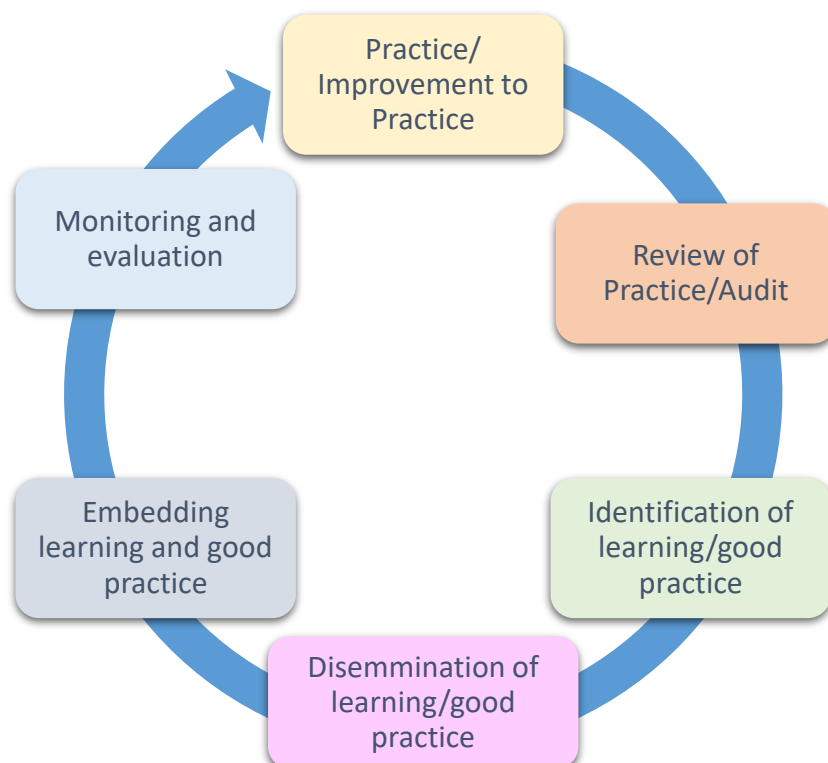
INTRODUCTION

The Cardiff and Vale Safeguarding Board (CVSB) are committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working.

This document provides an overview of the CVSB Learning and Improvement framework (LIF). It demonstrates how learning will be identified, disseminated and implemented in practice within a multi-agency context in order to improve outcomes for children and adults at risk within Cardiff and Vale of Glamorgan. The LIF is central to multi-agency safeguarding arrangements. It enables, not only a rigorous assessment of the quality of multi-agency safeguarding arrangements, but also how we learn from this to drive forward improvements to safeguarding and in turn, outcomes for children and adults at risk.

The LIF recognises that CVSB agencies and organisations have their own internal governance and learning structures. This framework, therefore, seeks to complement and build on current single agency arrangements by adding a multi-agency approach to support partner agencies to learn lessons from a range of reviews and to use this learning to improve joint working in order to secure improved outcomes.

It is important that organisational learning resulting from this framework is dynamic, cyclical and a multi-layered process that informs the CVSB wider strategic planning framework and determines current and future priorities as per the continuous review model outlined below.



CORE PRINCIPLES

The principles underpinning the learning and improvement framework are:

- There should be a **culture** of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children and adults at risk, identifying opportunities to draw on what works and promote good practice.
- Reviews should be delivered in line with the relevant **guidance**
- Professionals should feel confident in contributing to reviews **without fear** of being blamed.
- **Families**, including children or adults at risk, should be invited to contribute to reviews, ensuring that the child or adult at risk remains at the centre of the process.
- Improvement must be **sustained** through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children and adults at risk.



LEARNING MODEL

Reviews are not an end in themselves, but a method to identify improvements needed and to consolidate good practice.

Learning can be identified in a variety of ways, ensuring we continuously capture, and review learning generated from the streams outlined in the diagram below will ensure a robust learning model is in place.



STATUTORY LEARNING

SINGLE UNIFIED SAFEGUARDING REVIEW

The output of a Review is to generate professional and organisational learning and promote improvement in future inter agency practice to keep people safe.

The Single Unified Safeguarding Review (SUSR) is a single review process incorporating all reviews in Wales. This ensures affected families can expect a swift and rigorous *single* review process. This will reduce the trauma and time in awaiting an outcome and learning.

The criteria for SUSR needs to meet one or more of the following:

- Adult Practice Review
- Child Practice Review
- Domestic Homicide Review
- Mental Health Homicide Review
- Offensive Weapons Homicide Review

The SUSR brings agencies and individuals connected to the incident into a safe learning environment to:

- build a greater understanding of what happened during an incident and why
- improves the understanding of the impact of organisations' actions
- looks into whether different actions may have resulted in different outcomes for the child or adult at risk
- identify any learning opportunities for the future
- provides a clear action plan on how to improve service

As stated in the SUSR Statutory Guidance “the Review process will be completed as soon as possible, but not normally longer than twelve months from the date of referral to the Regional Safeguarding Board’s Case Review Group.”

The first panel meeting should be initiated within 2 months where possible.

Multi Agency Professional Forum (MAPF)

A MAPF can be conducted when a case does not meet the criteria for a SUSR. As with SUSR they will utilise case information, findings from safeguarding audits, inspections, reviews, and other learning to develop and disseminate learning to improve future child or adult protection policy and practice and to inform the Regional Safeguarding Board’s future audit and training priorities.

The forums have two main purposes;

- a) **Case learning**: facilitated discussion, consultation and reflection by practitioners, managers, or core groups, using a systems approach to examining and analysing cases.
- b) to provide other important opportunities for **local multi-agency practitioner and manager learning** Dissemination of new knowledge and findings: from multi-agency safeguarding audits and from SUSR's, inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

For the Cardiff and Vale region MAPFS will be conducted to ensure quick, relevant and significant learning is captured and shared. They will be conducted within the following parameters;

- One day multi-agency practitioner sessions, facilitated by nominated facilitator *or*
- Desktop review and extraction of learning
- Key findings will be summarised along with a set of SMART actions (good practice indicates a maximum of 3 is preferred) and shared with professionals via the MAPF learning template.
- The actions will be embedded into the tracker and will be visible on the dashboard for agency oversight.
- Timelines will not be expected in order to complete a MAPF – emphasis will be placed on multi agency discussion and sharing of learning.

MAPFS will be completed within 3 months of initiation

Case Review Group

Case Review Group provides multi-agency representation to promote, receive, discuss, and make decisions on safeguarding review referrals in respect of approval, review type, progression and any identified learning, and the required level of immediacy for implementation. CRG Monitors the progression of safeguarding reviews and provides advice, support, and challenge as appropriate, in order to ensure that they are fit for purpose and delivered in an effective and timely way.

The Case Review Group will consider all referrals submitted to ascertain if it meets the criteria for a SUSR. If not, the case may be considered for a Multi-Agency Practice Forum (MAPF)

All decisions are subject to RSB chair sign off and Welsh government notification.

IMPROVEMENT

Recommendations / Actions

For an SUSR a report is published which will outline the key learning captured from the review process and will outline the recommendations to board partners. In addition, these recommendations are considered by Case Review Group members and are translated into an **action plan** that will be circulated to board partners and the actions generated will be added to the tracker / dashboard.

To be effective the actions generated need to be;

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Time Specific**

It is key that clear leads are assigned to the actions to allow for effective progression and follow up of actions generated.

Dissemination of Learning

Each agency is responsible for disseminating the report and the learning within their agency.

CVSB will utilise a variety of methods to disseminate the learning on a multi-agency basis to include one or more of the following:

- Case Study
- Thematic 7-minute briefing
- Lunch and learns / Learning workshops
- Multi-media resources
- Training

Agency Ownership

When developing recommendations and actions via an SUSR process or a MAPF, the single agency responsible, including the area to which it applies needs to be clearly identified. In some cases, multiple agencies and / or multiple areas (i.e. Cardiff and Vale Social Services) will be responsible for progressing the recommendations, however there is not an expectation for both areas to progress actions to completion prior to sign off if it is not relevant.

It will however be the responsibility of all partners to review the recommendations and actions generated from reviews to ensure they are taking cognisance of and learning from these even if they are not responsible for progressing the action to completion. Notes specifying this can be included when developing the action plan if required.

Recommendations – Complete / Stepped Down

The Review Manager will have central oversight of the progress against SUSR reviews and recommendations, they will follow up with individual partners to obtain status updates and evidence in order to progress actions to completion. Actions that require completion sign off will be presented to Delivery Group by the Review Manager for ratification. Regional Safeguarding Board will be provided with regular data and analysis which outlines the current position in terms of progress and any barriers or risks to completion will be escalated to board for review.

Annual Progress report

Once SUSR is implemented, each SUSR completed will be subject to a brief Progress report 12 months after the recommendations and actions have been published. This will outline the progress against the actions and highlight any barriers to progressing the improvements.

Dashboard / access

The RSB Data Dashboard allows for live access for partners to review and progress the actions that are assigned to their organisation, as well as having live oversight of the overall progress of reviews, recommendations and actions.

The dashboard can be accessed by Board Members, Delivery Group Members and Case Review Group members only and can be accessed via this link once permissions have been granted.

ROLES AND RESPONSIBILITIES

Professionals and organisations protecting children and adults at risk need to reflect upon the quality of their services and ensure that they learn from their practice, and that of others, in order to improve regional safeguarding practice.

Partner agencies and all local organisations that work with children and families are expected to endorse this framework and embed it into workforce learning and development policies.

Partner agencies and local organisations are responsible for contributing and responding to learning and improvement activity in a timely manner by:

- Allocating **staff resource** / representatives to relevant meetings and training opportunities where required
- Ensuring findings of self-assessment / audit / reviews / inspections etc are fed into delivery group for consideration / **continuous learning and improvement** as per the continuous review model.
- Ensure learning is **shared and communicated** effectively within organisations
- Ensure actions relevant to their agency are progressed to **completion within timescales**
- Utilise audit / evaluation and data to **evidence the impact** of leaning on practice
- Providing a high level of **mutual support**, setting ambitious expectations and enabling effective, constructive challenge

