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Review of the implementation of the Child Practice Review Framework

REVIEW OF THE IMPLEMENTATION OF THE CHILD PRACTICE REVIEW FRAMEWORK

Cordis Bright

For further information please contact:
Chris Roberts
Knowledge and Analytical Services
Welsh Government
Cathays Park
Cardiff
CF10 3NQ
Tel: 029 2082 6543
Email: chris.roberts@wales.gsi.gov.uk

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EXECUTIVE SUMMARY

1. REMIT

The Welsh Government commissioned Cordis Bright to complete this review in order to assess the implementation of the Child Practice Review (CPR) framework. Its main aim is to assess the extent to which the intended improvements on the previous system of completing Serious Case Reviews (SCRs) can be seen two years after the implementation of CPRs. The new CPR process stemmed from the Care and Social Services Inspectorate Wales report published in October 2009: *Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews*. This work concluded that action was required to replace the SCR process which had become ineffective in improving practice and inter-agency working.

The review was not designed to evaluate the quality or impact of CPRs undertaken to date due to the limited numbers completed. The assessment of the wider impact of CPRs will follow at the appropriate time.

2. METHODS

The review of the implementation of CPRs took the following approach:

- a review of Welsh Government monitoring data on CPRs;
- a review of 44 notifications to the Welsh Government of the intention to undertake either a concise or extended review or a Multi-Agency Professional Forum (MAPF);
- a review of 10 published CPR reports in order to gain an understanding of the application of the guidance for this part of the process;
- semi-structured interviews with 32 stakeholders involved in the CPR process, groups and panels.

3. FINDINGS

Level of awareness of CPRs

Awareness varied according to professionals' level of involvement within the CPR process. Most stakeholders believed the more senior a professional was within an agency, the more likely they were to have a greater understanding and awareness of the process due to their Local Safeguarding Children Board (LSCB) involvement or involvement on Child Practice Review Groups (CPRGs) and Review Panels. In contrast, front-line practitioner awareness was considered to be based on whether they had been involved in a Learning Event. Most stakeholders held the view that as more CPRs are completed, the greater the awareness will be across agencies of the process. An important finding was the universal support for the CPR process over that which had been in place previously, although stakeholders still felt there was a need for raising awareness of the CPR process amongst all staff groups in all agencies.

How are decisions made about whether to proceed to a CPR?

A concern expressed by some stakeholders related to the use of certain terms set within the guidance and how it appeared to be interpreted differently across some regions. An unintended consequence of this was perceived by a number of stakeholders to be that some CPRGs might agree to complete a CPR based upon the local interpretation of the guidance while in other regions they would not proceed to a CPR. Stakeholders who sat on more than one regional CPRG said they had seen variations in how the guidance is interpreted. That said, a general view held by stakeholders was that decision making within their region was robust and consistent amongst their CPRG members.

What time and resources are required to undertake a CPR?

A general view held by stakeholders was that CPRs are time consuming and have a significant impact on those who are involved and on their capacity to fulfil not only the requirement of the CPR but also their substantive roles. A further challenge to

the process was being able to coordinate diaries of a number of staff, with the consequence that the CPR process can take longer than the six months originally envisaged in the guidance. At the time of undertaking this review, we understand that the average length to complete a CPR is twelve months. The delay was considered to have a negative impact upon the quality of the final CPR report. Also, stakeholders reported that possible opportunities for learning were lost as key professionals were, on occasion, unable to attend Learning Events leading to key information not being available. Finally, stakeholders reported that there appeared to be little difference in both time and effort in completing either a concise or extended review.

Who is involved in CPRs?

It was acknowledged that there was good involvement and commitment by all stakeholders at all levels to the CPR process. The Learning Event was described as a positive aspect of the process and drove reflective learning. The involvement of families was seen to add considerable value to the process. Some stakeholders believed some parallel investigations such as criminal proceedings, disciplinary processes or Coroner's Inquests, impeded the completion of CPRs within desired timescales. Stakeholders also reported that the guidance needed to offer more clarity than it currently does for the CPR process in circumstances where external investigations remain on-going as these cases tended, by their very nature, to be more complex.

How effective is dissemination?

Most stakeholders believed that there was considerable room for improvement in the dissemination of learning from CPRs, especially around wider national learning and how different regions could learn from each other.

4. CONCLUSION

There was universal support for the new CPR process and stakeholders demonstrated a high degree of commitment to make the process work, albeit differently, across regions. Although there was widespread acknowledgement among stakeholders that the process adds a considerable amount of additional work to professionals' capacity, this is tempered by a genuine recognition of the need to get the process right, to support frontline practitioners and managers and to engage families in a more positive way. There was recognition of the differing levels of quality in some aspects of the process and how delay has, on occasion, impacted upon quality, but it was felt that as more CPRs are completed the quality of the process would improve and awareness would increase. This would, in turn, have a positive impact on the wider level of practice learning across Wales. Finally, stakeholders were keen to be part of the development of national dissemination of the findings.

1. INTRODUCTION

1.1 REMIT

The Welsh Government commissioned Cordis Bright to undertake this review of the implementation of Child Practice Reviews (CPRs). The focus of the review was to assess the extent to which the new system of CPRs (in operation for two years since the implementation of the guidance and as per the then Deputy Minister's commitment to review the process) has achieved the intended improvements compared to the previous regime of Serious Case Reviews (SCRs). The review considered:

- implementation of the CPR framework;
- appropriateness and effectiveness of the CPR framework; and
- the extent to which the guidance on completing CPRs supports the process of completing CPRs.

This review was not designed to evaluate the quality or impact of the CPRs that have been produced to date due to the limited numbers completed. The assessment of the wider impact of CPRs will follow at the appropriate time.

This review has been completed at a time of significant changes within Wales in relation to the safeguarding of children as locally based Local Safeguarding Children Boards (LSCBs) have been reconfigured into six regional Boards. The development of new regional Boards has brought challenges in its own right over and above the development and additional challenges of the CPR process.

1.2 CONTEXT

Child Practice Reviews (CPRs) are the product of formal, multi-agency review processes which take place following a significant incident where abuse or neglect of a child is known or suspected.

CPRs stem from a report published by the Care and Social Services Inspectorate Wales in October 2009[1] which examined the Serious Case Review (SCR) process in place at the time and concluded that it was hindering inter-agency working and failing to improve practice.

CPRs are intended to differ from SCRs by being more streamlined and flexible, allowing for a more efficient and effective use of time and resources, whilst focusing on multi-agency learning and practice improvements. In addition, by involving multi-agency teams throughout the process, the CPR framework intends to make collaborative learning from practice a part of the day-to-day activity of practitioners and managers.

As part of this, the CPR system aims to promote a positive culture of multi-agency child protection learning and reviewing in local areas, for which LSCBs and partner agencies hold responsibility. The aim is to set in place a foundation for reflective learning by professionals from different agencies which can support continuous improvement in inter-agency child protection practice. The role of the Welsh Government within the process is to receive notifications and final reports prior to publication. The Welsh Government's role in relation to local processes is not a quality assurance, monitoring or directive role. This is the responsibility of LSCBs.

[1] Care and Social Services Inspectorate Wales (2009*). Improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews*.
http://cssiw.org.uk/docs/cssiw/publications/091019seriousen.pdf

1.3 STRUCTURE OF CPRs

This section summarises the main elements of the guidance on completing CPRs[2]. When abuse or neglect of a child is known or suspected and the child has died, sustained a life threatening injury or sustained serious and permanent impairment of health or development, the relevant LSCB is required under this framework to undertake a concise CPR. A concise CPR is appropriate for cases in which the child was not on the child protection register within the six months preceding the trigger event.

If the child has been on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the six months preceding the date of the event referred to above or the date which a local authority or partner identifies that a child has sustained serious and permanent impairment of health and development, then the relevant LSCB is required to undertake an extended CPR.

A decision to proceed to a CPR is made by the Child Practice Review Group (CPRG), which is a standing sub-group of the regional LSCB. This Group then establishes a Review Panel for that particular CPR and is responsible for appointing a trained reviewer (or reviewers) to facilitate the exercise. For a concise CPR, one reviewer is appointed, and for an extended CPR two reviewers are appointed. In both instances, they are independent of the case concerned. Children and families are directly engaged with the review process where appropriate and when they wish to be involved. There is an expectation that the practitioners and managers who have been working with the child and family will engage in the process. The main exception is where a professional might be subject to disciplinary processes or on-going criminal issues within the case, especially relating to the police. In this case,

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[2] Welsh Government (2013). *Protecting Children in Wales. Guidance for Arrangements for Multi-Agency Child Practice Reviews*. http://gov.wales/docs/dhss/publications/121221guidanceen.pdf

Welsh Government (2013). *Protecting Children in Wales. Child Practice Reviews: Guide for Organising and Facilitating Learning Events*. http://gov.wales/docs/dhss/publications/121221learningen.pdf

professionals might be withdrawn from the process as advised by their agency or their external support not to participate. Equally, if a professional has been adversely affected by a child's injury or death they are not required to participate in the CPR.

A critical stage of the review is the Multi-Agency Learning Event[3] where relevant practitioners come together to share their understandings of what happened and to identify key learning points to inform future practice. This is intended to foster a culture of learning – both from an individual's practice and across professions/agencies.

The purpose of the review is to produce a draft report and an outline action plan which is presented by the Chair of the Review Panel (and in some instances also the reviewer/s) to the LSCB, taking the Board through the practice and organisational learning. When the report is finalised it is then passed to the Safeguarding Team of the Welsh Government to consider whether further action is necessary before its publication. The action plan is drawn up by the Review Panel reflecting any comments made by the LSCB with the intention to lead improvements in child protection practice. It is the responsibility of the CPRG to monitor the take-up and effectiveness of this action plan.

If a case does not meet the criteria of either a concise or extended CPR but learning is felt to be identified then the guidance recommends that a multi-agency professional forum (MAPF) is held. This has two purposes: case learning; and dissemination of new knowledge and findings. The guidance envisages MAPFs as a continuous LSCB programme for learning together via multi-agency facilitated events for practitioners and managers. They are primarily designed to examine case practice and provide an opportunity for consultation, supervision and reflection to

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[3] Welsh Government (2013). *Protecting Children in Wales. Child Practice Reviews: Guide for Organising and Facilitating Learning Events*.
http://gov.wales/docs/dhss/publications/121221learningen.pdf

improve local knowledge and practice and to inform LSCBs' future audit and training priorities.

1.4 CPRs TO DATE

Across Wales, LSCBs have been re-arranged into six regional Boards. They are:

- Cardiff and Vale: Cardiff and the Vale of Glamorgan;
- Cwm Taf: Merthyr Tydfil and Rhondda Cynon Taff;
- South East Wales: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen;
- Mid and West Wales: Carmarthenshire, Ceredigion, Pembrokeshire and Powys;
- North Wales: Conwy, Denbighshire, Flintshire, Gwynedd, Anglesey and Wrexham;
- Western Bay: Bridgend, Neath Port Talbot and Swansea.

At the time of our document review, Welsh Government monitoring data showed that 44 notifications had been received from the regional Boards noting their intention to complete either a concise or extended review or a MAPF. Of these notifications, 21 had resulted in CPRs being undertaken with 10 completed, in progress or overdue (13 concise and eight extended CPRs). Ten notifications indicated a MAPF was being held and the remaining 13 notifications indicated no concise or extended CPR or MAPF being completed.

Further information by region is provided in the charts below:

Figure 1: Notifications from Regions to the Welsh Government as of January 2015

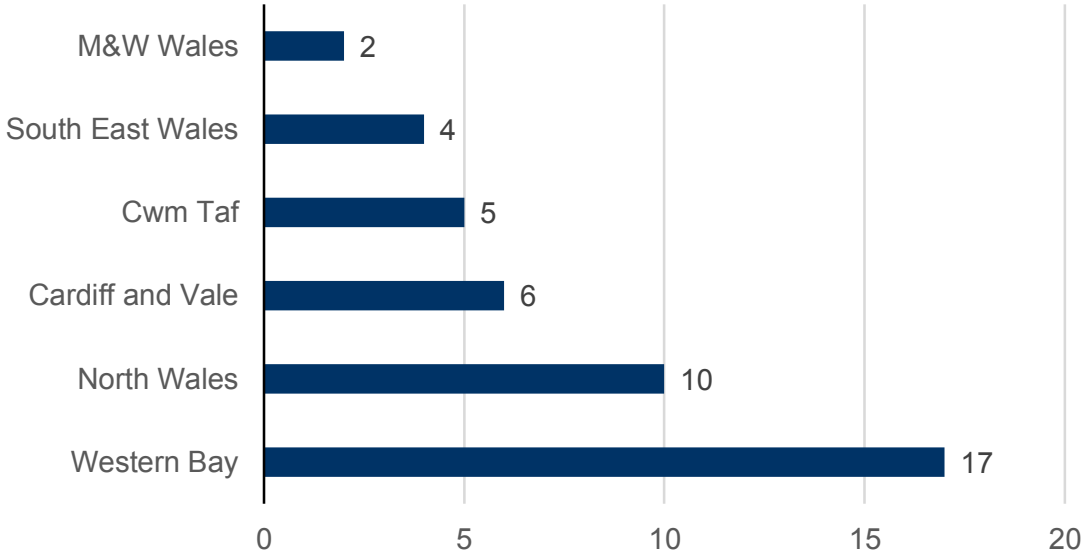
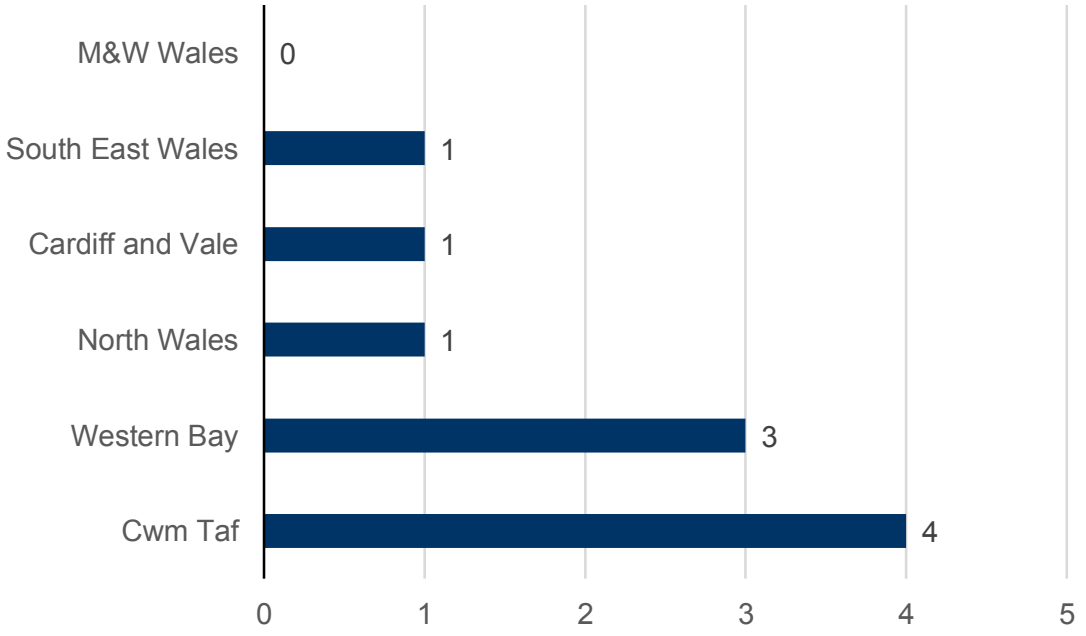


Figure 2: Number of concise and extended CPRs completed and published as of January 2015



A note about variations in the number of notifications between regions

While the remit of this review was not to explore regional variations, a brief note is necessary to put findings into context.

The table below seeks to explore whether the differences in the distribution of notifications is connected to the total population of 0-15 year olds in the region or to the number of children in need. This suggests that there is not a strong link with the total number of children aged 0-15 in the region. For instance, Western Bay makes up 39% of notifications (ranked highest) but has 16% of the 0-15 population (ranked joint third). Mid and West Wales contributes 5% of notifications (ranked lowest) but also has 16% of the 0-15 population (ranked joint third).

However, the data do suggest a potential link with the number of children in need. For five out of the six regions (the exception being the South East Wales region) there is a relatively strong overlap between the rank of number of notifications and the rank of children in need. For example, Western Bay has the highest number of notifications and also has the highest number of children in need; Mid and West Wales has the lowest number of notifications and the lowest number of children in need. That said, the overall distribution of notifications and children in need (in terms of percentages) do not align, e.g. you might expect that as Western Bay has 21% of all children in need across Wales it would contribute a similar proportion of notifications. However, this would appear not to be the case, although further analysis may prove helpful.

Section 2.2 below highlights some findings from interviews with stakeholders that could provide further insight into the reasons for this variability between regions.

Figure 3: Notifications compared to 0-15 population and number of children in need

Region	Notifications % (and rank)	0-15 population % (and rank)	Children in need % (and rank)
Mid and West Wales	5% (6)	16% (=3)	13% (6)
South East Wales	9% (5)	20% (2)	21% (=1)
Cardiff and Vale	14% (3)	16% (=3)	14% (=4)
North Wales	23% (2)	22% (1)	17% (3)
Western Bay	39% (1)	16% (=3)	21% (=1)
Cwm Taf	11% (4)	10% (6)	14% (=4)

1.5 METHODS USED FOR THE REVIEW

Governance and ethics

A working group was established to oversee and monitor the review. This consisted of:

- Senior Policy Officer Safeguarding and Advocacy, Welsh Government; and
- Senior Researcher, Welsh Government.

The group provided input into various aspects of the project including the approach to document review, sampling, the interview schedule and feedback on drafts of the reports.

Given the nature of the review, ethical approval was not necessary. However, informed consent to participate in the research was secured from all respondents in advance of fieldwork being undertaken. The research complied with the Government Social Research (GSR) ethics guidance[4].

[4] For further information please see Government Social Research Unit (2006) GSR Professional Guidance: Ethical Assurance for Social Research in Government. http://resources.civilservice.gov.uk/wp-content/uploads/2011/09/ethics_guidance_tcm6-5782.pdf

Review Framework

A document review was undertaken which reviewed all 44 notifications, ten published CPRs and five action plans, as well as the *Protecting Children in Wales Guidance*. There were no LSCB Annual Reviews available to establish regionally how the impact of CPRs had affected agencies to date. An analysis of the Welsh Government monitoring data record was also completed.

The results from this review helped to inform the approach to sampling for the semi-structured interviews, as well as the content of the interview schedule.

LSCB Chairs were approached by the Welsh Government to nominate interviewees, who then gave formal consent to be approached by Cordis Bright for interview. At the beginning of the interview we asked for informed consent from participants and made clear the purpose of the research and why it was important. Thirty two stakeholders across Wales, with various responsibilities, participated in an interview. These were as follows:

- LSCB chairs (2)
- CPRG chairs (6)
- CPRG members (13)
- Independent reviewers (5)
- Directors of Children's Services (2)
- Guidance author (1)
- CPR national trainer (1)
- Welsh Government policy officer (1)
- Children's Commissioner for Wales' office (1)

The sample can also be broken down by agency within which these individuals worked:

- Children's Social Care (10)
- Education Services (4)
- Police Services (2)
- Probation Services (1)
- Health Board members/Primary Health Care members (9)
- Housing Services (1)
- Independent and Voluntary Sector (2)
- Welsh Government (2)
- Other (1)

A copy of the interview schedule is included as an appendix (see page 31). Interviews were conducted by telephone or were face-to-face and lasted between 45 minutes and one hour. Notes were taken using the interview schedule as a template for recording[5]. A matrix based approach was used to draw out key findings from the interviews. This explored key themes, commonalities and differences in responses, with these findings then drawn out of the matrix. The findings were then triangulated with those from other analyses conducted as part of the research. Examples are provided throughout to illustrate emerging themes.

Those interviewed as part of the review have been referred to as 'stakeholders' throughout the main body of the report.

[5]Given the nature of the review and time available, comprehensive notes were taken rather than recording and transcribing the interviews.

2. FINDINGS

This section explores emerging themes from analysis of the following sources of data:

- Welsh Government monitoring data record;
- stakeholder interviews;
- published concise and extended CPRs, action plans and notifications provided to the Welsh Government.

The findings are presented under five key themes emerging from the analysis: awareness of CPRs; decisions about proceeding to a CPR; time and resources required to undertake a CPR; level of involvement of different stakeholders; and effectiveness of dissemination.

2.1 AWARENESS OF CPRs

The review tested the level of awareness of CPRs across Wales to ascertain how embedded the process was within agencies, especially compared with what went before. The review also explored the relative success of moving the ethos of reviews from a blame culture (a view held by all stakeholders when asked about the previous SCR process), to one of learning.

The consistent response from stakeholders with regard to level of awareness and understanding of CPRs was that it was heavily influenced by a professional's level of involvement in them.

There was a general sense amongst stakeholders that CPRs are very different from what went before. Some examples provided by stakeholders were they were more succinct and focused and gave a voice back to practitioners rather than being an activity primarily for senior management. Stakeholders also held the view that the CPR process, in particular the Learning Event, offered a form of therapeutic support and reflection for practitioners. However, it was clear that stakeholders felt the more senior a professional was in an agency, the greater their understanding. It was also

suggested that CPRs are about agencies taking responsibility for the emerging learning and a recognition that the process is also about challenging and holding agencies to account.

The general view of stakeholders in relation to practitioners' understanding of the CPR process was that if they had been involved in a Learning Event they were more likely to understand their aims and purpose. If they had not, then the level of awareness and understanding tended to be relatively low. There was a sense that the relatively low number of CPRs completed to date had inhibited the overall level of awareness around CPRs across agencies and regions. As part of this, a small number of stakeholders reported that the level of engagement from other agencies (e.g. in relation to responsiveness to requests for documentation) was, on some occasions, lower than it had been under the previous SCR framework. Some of these stakeholders suggested that this was a result of other agencies perceiving CPRs to have less gravitas or importance than SCRs. There was a hope that this would change as the number of completed CPRs and awareness of them increased.

Overall, however, the majority of stakeholders felt the CPR process was a good experience and had a positive impact due, for example, to the learning that took place and the ethos of giving a voice back to practitioners.

Stakeholders were clear that they preferred CPRs to SCRs, as the process was considered to be easily understood on the whole. The exception to this was when the case referred to CPR was especially complex and/or if the case was subject to parallel investigations (e.g. criminal proceedings, Domestic Homicide Reviews or Mental Health Reviews). In these circumstances, stakeholders felt that CPR processes were not closely aligned with other protocols or processes.

As part of the research, some stakeholders put forward suggestions for how to improve awareness and understanding of CPRs. These included:

- ensuring that CPR processes were part of Safeguarding Children Boards' wider safeguarding training programmes.
- Welsh Government to facilitate a one-off awareness-raising event.
- developing all-Wales or regional communication groups to look at wider learning and awareness raising.
- development of on-line resources, good practice and improved report structure.
- sub-group chairs to share learning across Wales to assist each other and improve practice.
- The Procedural Response to Unexpected Deaths in Childhood (PRUDiC) process should be referenced within the guidance as stakeholders felt PRUDiC should always consider the need for a CPR and raise awareness of the process.

2.2 DECISIONS ABOUT PROCEEDING TO A CPR

This section explores: (1) stakeholders' views on the clarity of criteria included in the CPR guidance[6]; and (2) how local areas have interpreted that guidance.

Criteria

Stakeholders had mixed views about the clarity of criteria used. The majority felt that the criteria for proceeding to a CPR were clear and easy to understand. Some raised concerns about language, specificity and clarity. For instance, in many interviews the use of some terminology within the guidance caused stakeholders concern. One example related to the term 'permanent impairment' as one of the criteria to decide whether to proceed to CPR. A consistent view held amongst stakeholders was that 'permanent impairment' was difficult to define at the time of a case being referred into CPRGs, where members may not be in a position to determine if the 'harm' was 'permanent'. As a result, this could lead to uncertainty or delay about whether to proceed and/or inconsistencies of application of this criterion between regions. In response to this, some stakeholders suggested that 'permanent' be removed from the guidance.

[6] See section 1.3 for further information.

A further use of terminology raising concerns among stakeholders was reference to where 'abuse or neglect of a child is known or suspected'. There was a general view that if a child was not known to services then a CPR is unlikely to be completed, especially in circumstances where a child had died. Again this was felt to be unhelpful terminology within the CPR process due to some regions possibly interpreting the term 'known' literally. In our review of documentation, we identified three notifications where a child had died and was not known, and no CPR was undertaken.

A further issue expressed by stakeholders was the more complex the case the more difficult the criteria were to apply, especially where parallel investigations such as Domestic Homicide Reviews, disciplinary issues, criminal proceedings or Coroners Inquests were on-going. The main concern expressed was the impact these parallel processes might have for the CPR process and implications for professionals involved in other external investigations. For instance, in some cases practitioners might not be able to take part in the Learning Event due to one process impacting detrimentally on another. It was also felt these external processes could have implications for families not being able to be part of the CPR process, especially in relation to criminal proceedings. In some cases, reviewers had been specifically requested not to speak to family members. Stakeholders reported that the guidance offers some direction, but that it could, and possibly should, offer greater clarity around cases subject to these multiple processes. One suggestion to assist in offering some clarity was to reference, within the CPR guidance, the Domestic Homicide Guidance and how this deals with the issue.

Interpretation of the criteria

During the review, some stakeholders – in particular those sitting on more than one regional Board – highlighted variation in the application of the CPR criteria between regions. They reported that this was resulting in some cases proceeding to CPRs in some regions, but not in others. That said, there was a high degree of consistency among those involved at a more senior level of how decisions are made and formalised within regional CPRGs and Review Panels. This group noted that there

was an agreement on when to proceed to CPR. Most stated there was a high degree of healthy robust challenge when deciding on whether to proceed with a CPR and that they arrived at the correct decision based on information they had before them. There was agreement among these stakeholders regarding the regional processes to report cases to CPRGs for a decision to go forward with a CPR or MAPF. These stakeholders recognised that on occasion, professionals who were reporting incidents provided insufficient information within the referral process in order to make an informed decision about whether to proceed with the CPR. This was thought by most stakeholders involved in the CPRGs to be linked to professionals (across agencies) not having sufficient awareness or understanding of the CPR process (rather than inconsistencies in the application of criteria).

As part of the document review, we examined the 44 notifications received by the Welsh Government to explore whether there was any evidence of differences in the interpretation of the criteria. We identified variability in both the quality and content of information contained within these notifications. For instance, some notifications offered an extensive outline of issues as to why a CPR would be completed, whereas others offered only a few sentences. In a small number of notifications, the type of review and/or whether it was a unanimous or majority decision were omitted. We also noted that in half of the notifications the rationale for the decision was not clear and it did not follow the requirements of the CPR template notification form included in the guidance. As a result of this variability it was difficult for our analysis to identify whether there was evidence of differences in the interpretation of criteria.

One other variation highlighted by some stakeholders was in the number of reviewers deployed to undertake a CPR. Stakeholders noted that for some regional Boards it was deemed best practice for two reviewers to be involved in all reviews. As a result, some regions had moved away in this regard from the guidance (which states that one reviewer is sufficient for a concise review but must be independent of case management).

These comments from some stakeholders raised questions about how directive the guidance should be. For example, some stakeholders reported that it was not

directive enough, risking the possibility of inconsistent decision-making across Wales. It was suggested by these respondents that the guidance should be more specific and directive about whether to proceed to a CPR. Conversely, others were of the view that local interpretation was a good thing (as it could respond to local need) and the guidance should not be prescriptive.

In addition to the points above, most stakeholders considered there was scope for improvements within the decision making process to proceed or not to a CPR, with two main issues identified:

- development of regional communication groups to support consistent development of CPRGs;
- improving the dialogue between Welsh Government and LSCBs to inform policy development of CPRs through a national conference or facilitated forums to share experiences, held once or twice per year.

2.3 TIME AND RESOURCES REQUIRED TO UNDERTAKE A CPR

As stated earlier, stakeholders supported the CPR process and viewed it as positively different from the previous SCR methodology. In particular, it was reported that the CPR promoted an active, practice-focused review (rather than a desktop review) that sought to promote learning (rather than allocate blame). As part of this, there was consistent support for the Learning Event which was felt to be a quality product, supporting the emphasis of a learning culture for practitioners and managers across agencies. The Learning Event was universally accepted as a good thing.

However, some concerns were expressed about the capacity of staff, at all levels, to allocate the time and resources required to undertake or participate in a good quality CPR. This resulted in CPRs taking significantly longer than the guidance expects. For instance, difficulties in coordinating diaries could result in a Review Panel's first meeting being delayed. This was further exacerbated when the availability of the independent reviewer/s to undertake the CPR was also taken into

account. Most stakeholders felt that once a decision to proceed to a CPR had been agreed there could be 'in-built' delays of up to two months before the first Review Panel meeting could take place. The guidance anticipates that the CPR as a whole should take six months in total so this represents a significant delay to this timescale. A consequence of the delay in completing the CPR, on occasion, was the immediacy of learning was lost or that the rationale for proposed changes in practice was unclear. However, wider learning from the Learning Event was being put into place prior to the final report being published.

This was further supported by the document review of published CPR reports which identified a mean average of 12 months for completion. It was not possible to establish from the document review why CPRs were taking this length of time but stakeholders reported a number of reasons in addition to those noted above, such as:

- the length of time between Review Panel meetings;
- number of Review Panel meetings required;
- time available to professionals involved in CPRG/Review Panels (especially as CPRG and Review Panel members were often the same professionals);
- reviewers' and professionals' availability to attend the Learning Event;
- the impact of parallel processes (such as criminal proceedings, Domestic Homicide Reviews) which have led some agencies to request a suspension of the CPR process;
- the length of time some Boards take to sign off final CPR reports.

A majority of stakeholders felt that whilst the guidance clearly defines the difference between a concise and extended CPR or undertaking a MAPF, there was little difference in the resources required to complete whichever process was chosen. In addition, chairs of MAPFs reported the process was like completing a mini concise CPR. The document review of published CPR reports would concur with this view as there were no distinguishable differences in the CPR final reports except in concise CPRs where some had one reviewer and others had two reviewers. The

finished products for concise and extended reviews were similar in terms of length, content and recommendations.

Most stakeholders suggested improvements with regard to the use of time and resources to undertake a CPR, such as:

- agencies across all sectors need to consider how to support professionals involved in the CPR process and to consider how capacity could be in-built into the process by learning from other regional Boards;
- having a national team of pooled trained reviewers who could offer a coordinated and consistent response to CPRs;
- ensuring the administration of the CPR process is secured from the outset, for example working backwards from the completion date;
- wider dissemination of the Learning Event should take place among agencies in order to create more opportunities to support practice improvement at all levels;
- gaining a clearer understanding of the local interpretation of the guidance and 'what works' for them and why. This includes locally devised protocols on what threshold criteria apply and why, in agreeing to a concise or extended CPR or the completion of the MAPF process.

There were mixed views amongst stakeholders regarding the quality of the CPR process and the resulting report. Some specific comments included that the CPR reports were too brief and/or did not sufficiently reflect the learning that takes place within the Learning Event. These stakeholders suggested this risks the learning only being retained by those involved directly in the CPR process and wider learning for those not participating in the CPR directly becoming lost. As a direct consequence of this view, a number of trained reviewers, in agreement with Review Panels, have significantly extended this section of the CPR report template and expanded the section outlining the circumstances of harm by offering more context as to why the review was undertaken. On the other hand, some suggested that the brevity of the report was positive, with learning being identified and presented succinctly.

Another area for improvement highlighted by some stakeholders related to the quality of CPRs which had taken a long time to complete. Some stakeholders felt that, in these circumstances, the quality of the CPR report became 'stretched' the longer the process took due to the report being repeatedly edited over a longer period of time.

Finally, some stakeholders highlighted that although CPR reports were generally of a high quality, their relevance and insightfulness would further improve as the number of CPR reports completed increased and as Boards become more confident about levels of expectation and quality in relation to CPRs.

2.4 LEVEL OF INVOLVEMENT OF DIFFERENT STAKEHOLDERS

During the interviews it was reported that there was good involvement by all stakeholders at all levels and a commitment to the CPR process by all agencies. There was a general sense of motivation by agencies to change to a learning culture. In addition, a number of stakeholders reported that the change to the CPR process had exceeded their expectations, especially in relation to the level of commitment to the process shown by organisations at all levels and their drive to improve multi-agency practice.

The involvement of practitioners at the Learning Event was universally felt to be good and supported a process of reflective practice from a multi-agency perspective. Whilst some practitioners were anxious prior to the Learning Event, as reported by a number of reviewers who had facilitated them, this was thought to be down to practitioners not being aware of what the Learning Event was or not being prepared sufficiently by their agency. Some noted that they thought it was training, rather than a reflective process. Stakeholders stated that during and after the Learning Event, as reported to them by practitioners (as practitioner views were not sought as part of this review), there was an emphasis on learning and not blame. This approach was felt to support individual changes to practice.

Stakeholders believed that whilst some children and families did not wish to be part of the process, those who were involved added significant value to the Learning

Event as their views were central to the planning and learning outcomes. Stakeholders reported that those families who did participate valued being listened to, receiving feedback and outcomes, and understanding what had been learnt from the process.

When asked if the guidance supported the CPR process and an understanding of what was required in order to complete a review, the general view was that it did. Stakeholders reported that the guidance offered a framework and enabled learning in a 'managed way', meaning information was shared from a multi-agency perspective at the Learning Event in a reflective manner. This enabled practitioners to think about aspects of their practice they would wish to take away and do differently.

The vast majority of stakeholders felt the process was broadly proportionate to an injury or death of a child as it identifies the ways in which agencies can improve multi-agency practice. That said, the length of time the process takes remained an issue as, on occasions, a significant length of time had passed before the learning was disseminated, with a sense that learning may get lost.

Most interviewees felt there could be further improvements to the level of involvement of wider stakeholders to the CPR process. Suggestions included:

- a single point of access for completed CPRs, such as a website for published CPR reports to help raise the level of awareness of CPR learning and widen engagement, understanding, involvement and learning of all practitioners and agencies within Wales;
- learning could be expanded upon within CPR reports to support more multi-agency changes in practice, rather than a focus on the role of individual practitioners.

2.5 EFFECTIVENESS OF DISSEMINATION

A number of examples were shared by stakeholders relating to the effectiveness of regional dissemination of learning. Various methods were shared, including: local learning groups; arranging multi-agency workshops; LSCB events; newsletters; and regional communication groups. In some instances stakeholders advised it was their role to ensure learning points for their agency were shared with colleagues within their own organisation. However, in a small number of instances stakeholders were unclear of what processes were in place, or were not aware of any methods deployed to disseminate learning.

A view held by the majority of stakeholders was the need for improvement with dissemination and an overall requirement for establishing a process which enables national learning. Many stakeholders reported they were unclear whether other regional learning was available and how others' learning might have an impact within their region. Similarly, it was reported that there was no proper 'loop' or feedback in order to understand what was taking place within Wales generally.

When stakeholders were asked how the learning from the CPR process was changing multi-agency practice, there were mixed views. Some felt within their region it was too soon to tell as so few CPRs had been completed, whereas others argued that whilst practice has not changed overall, it has for individual practitioners who engaged with the Learning Events. However, it was recognised that there were real opportunities for excellence within the process and there should be more shared learning. When asked how learning from MAPFs was disseminated, no stakeholder was able to clearly articulate what processes, if any, were in place.

Various improvements to increase the effectiveness of dissemination from CPRs within Wales were noted, including:

- the development of a national approach by LSCBs to the dissemination of CPR reports on completion of the process;

- a seminar for those involved in CPR processes to be held once or twice per year, possibly supported or facilitated by the Welsh Government;
- national dissemination of completed CPR reports, such that each regional Board should disseminate CPRs to all other Boards to support national learning.

3. CONCLUSION

There is a clear commitment from all stakeholders to the CPR process even if there is some evidence that guidance has been interpreted differently across regions. Our review suggests that the CPR process has resulted in a palpable move away from a 'blame culture' to one that supports a 'learning culture'. There is universal support for the voice of the practitioner to be heard and listened to without a loss of focus on outcomes for children and to improve practice. However, the impact of how wider learning is disseminated (regionally and nationally) and how much this results in changes to practice at a local level remains an area for further development. As part of this, there is a clear desire from stakeholders to put in place a mechanism by which learning from CPRs can be effectively disseminated nationally.

There is good evidence to suggest that while the criteria guidance has been interpreted differently across regions, there is consistency in the processes they use to make decisions in relation to CPRs, such as how cases are referred into CRPGs, how the decision is made to proceed with a CPR or MAPF and how decisions are formalised and sanctioned by the LSCB Chair. There is also consistency in how the Review Panels are managed regionally and Learning Events are universally welcomed as a quality product and a significant improvement on what went before.

There is a general view that CPRs (concise or extended) are time consuming and take a mean average of 12 months to complete (against an original expectation in the guidance of six months). This is placing considerable capacity issues on those involved and can result in learning becoming lost as a result of the delay. It is unclear how long a MAPF takes or how learning is disseminated as there is no record of them being completed within the context of this review.

The general view held by stakeholders is one of good commitment and engagement across agencies, with a desire to see the CPR process work for them in order to learn and develop practice. A significant number of stakeholders felt the guidance available supported the CPR process but some language was unhelpful and

possibly led to inconsistent decision making across Wales due to local interpretation.

It would appear from this review that the aim of reforming the review system to promote a positive culture of multi-agency child protection learning has seen a successful transformation in this way of working, even if transformation has occurred at a different pace across Wales. Stakeholders see CPRs as a positive change, giving a voice back to practitioners to enable multi-agency practice improvements.

4. RECOMMENDATIONS

Based on the outcome of this review the following recommendations are suggested to support the development of the CPR process both nationally and regionally.

1. Now that the CPR process has been in place for two years consideration may need to be given as to the role and function the Welsh Government has within the CPR process. As there is currently no independent quality assurance or oversight of the process, some thought may need to be given as to where this role might be best placed if not completed by Safeguarding Children Boards.

2. As part of this, the Welsh Government may wish to consider commissioning or undertaking on a regular basis (potentially annually) an ongoing review or stock-take of the number, timeliness, quality and impact of CPRs undertaken across Wales. This will help to ensure that the guidance is fit-for-purpose, is being followed by local authorities and their partners, and is having the expected impact on practice.

3. The Welsh Government may wish to give some consideration towards a facilitated workshop to look at the national progress to date and to give some consideration as to future planning around the development of the CPR process.

4. The Welsh Government may wish to reconsider how data on CPRs are collated by them for monitoring purposes. This includes mechanisms to ensure that the data are accurate, up-to-date, enable analysis at regional and national levels and facilitate monitoring of whether CPRs have been completed on time and with an accompanying action plan.

5. Safeguarding Children's Boards or sub-group Chairs need to give consideration as to how best to disseminate local, regional and national learning by the development of communication groups to support consistent development of CPRGs and sharing of outcomes of completed CPRs.

6. Safeguarding Children Boards may wish to consider how to disseminate all completed CPRs to other regions or, if a single access point needs to be developed across regions, how they can support this.

APPENDIX: INTERVIEW QUESTIONS

Q1. How would you rate the level of awareness of CPRs?

- Purpose. How would you rate from before - impact?
- Awareness across sectors?
- Awareness across levels of practice e.g. practitioners, managers, reviewers, LSCB members?
- Is the process easily understood?
- How user friendly is it?
- Improvement suggestions

Q2. How are decisions made about whether to proceed to a CPR?

- Criteria used?
- Are these formalised?
- Who is involved in the decision making?
- Who makes the decision?
- Is there equity in decision making between agencies?
- What is the process to report incidents to CPR review process
- Improvement suggestions?

Q3. What time and resources are required to undertake a CPR?

- What are those resources and how much time is required?
- How does the CPR compare with previous regimes?
- Views on quality of CPRs undertaken to date?
- Lessons Learnt?
- Improvement suggestions?

Q4. Who is involved in CPRs?

- What is the level of involvement of different stakeholders in CPRs?
- What is the extent of involvement with?: a) practitioners b) family members
- Does the guidance support process regarding CPRs?
- Is the process proportionate?
- CPR learning process v Blame culture?
- Lessons learnt?
- Improvement suggestions?

Q5. How effective is dissemination?

- What mechanisms are used to disseminate findings and, in particular, MAPFs?
- Effectiveness of raising awareness?
- Effectiveness in changing practice, including specific examples of changing practice, systems and management?
- Specific views on changing effectiveness of changing multi-agency practice?
- Improvement suggestions?