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# Review of the implementation of the Child Practice Review Framework

## Executive Summary

# REVIEW OF THE IMPLEMENTATION OF THE CHILD PRACTICE REVIEW FRAMEWORK

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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.