Norfolk Safeguarding Children Partnership

Norfolk Child Safeguarding Practice Review Processes

REVISED MARCH 2022

Date ratified by Three Statutory Partners:	7 April 2022
Date for Guidance Review:	31 March 2023

Table of Contents

1. Background and Context 3
2. Referral to SPRG Flowchart 5
3. Record of Serious Incident Notification 6
4. SPRG Referral Form (non SIN) 8
5. Rapid Review Template 14
6. Record of Decision-Making Template 20
7. Lead Reviewer Commissioning 24
8. Involving Parents and Children in CSPRs 25
9. Roles and Responsibilities of CSPR Panel Members 27
10. Sign off and Publication 28
11. Dissemination of Learning Options 30
12. Menu of Learning Options 31

Appendices

Appendix 1: Norfolk's Thematic Learning Framework 33

Appendix 2: CSPR Report – QA Tool for Panel 40

1. Background and Context

From June 2019 the responsibility for local safeguarding arrangements in Norfolk sits with the Local Authority, the Police and Health (led by Norfolk & Waveney Clinical Commissioning Group, CCG lead for children and host of Norfolk's NHS Designated Child Safeguarding Team). Collectively, they replace the former Local Safeguarding Children Board and are known as the Norfolk Safeguarding Children Partnership (NSCP). This arrangement is made statutory under s16E of the Children and Social Work Act 2017, and Working Together 2018 and is supported by Norfolk's plan for Multi-Agency Safeguarding Arrangement (MASA).

The partners are responsible for ensuring that cases which meet the criteria for child safeguarding practice reviews have robust processes that meet the standards expected by the National Child Safeguarding Review Panel (hereafter referred to as the National Panel). They have delegated the responsibility for the final decision to the Independent Chair of the NSCP. NB The partnership has appointed an independent chair to guide the functions of the panel and ensure the responsibility is exercised equally and take the lead on any issues that arise between the partners. While the functions have been delegated the statutory partners are still accountable for the decisions made; the statutory bodies are represented on the multi-agency Safeguarding Practice Review Group and all processes are subject to scrutiny.

This document sets out the local processes for conducting Rapid Reviews , including actions for cases that do not meet the criteria. The processes are informed by the National Panel's Practice Guidance, published April 2019 and draws from examples of best practice nationally.

The process guidance has been ratified by the three statutory agencies named in Working Together 2018, i.e.:

- The Local Authority – Norfolk County Council, represented by Sara Tough, Norfolk County Council Executive Director Children's Services
- A clinical commissioning group – Norfolk and Waveney CCG, represented by Rebecca Hulme, Joint Associate Director – CYP & Maternity for the CCG and Norfolk Children's Services
- The chief officer of Norfolk Constabulary, represented by Nick Davison, Assistant Chief Constable

The named statutory partners take decisions on behalf of their organisation / agency and have power to commit resourcing , making policy, and holding their organisation to account, effecting and implementing local changes

Governance for these arrangements sit with the NSCP's Safeguarding Practice Review Group (SPRG), which is made up of senior representatives from Children's Services, Police and Health, with additional members from Education and Cafcass. The group also has legal advice provided by Norfolk County Council's internal team. The SPRG has an independent

chair who provides challenge and guidance to the partners. The chair is also responsible for ensuring that learning and key messages are reported to the NSCP and the partners are alert to thematic issues as well as examples of best practice.

The SPRG is supported by the NSCP's Business Unit. In addition to providing administrative support, the Head of NSCP Business Delivery is responsible for co-ordinating the review process, communicating with the National Panel and partners on any cases referred to SPRG and leading on the dissemination of learning from child safeguarding practice reviews in the multi-agency arena.

Future developments for SPRG will be to consider the development of reviews of cases that went well. This work will be developed with the input of the NSCP's Workforce Development Group.

The guidance will be reviewed annually or on publication from any further direction from the National Panel or relevant regulation or guidance in statute by the Secretary of State as stated in s22 of the Children and Social Work Act 2017.

March 2021
Abigail McGarry
Head of NSCP Business Delivery

Norfolk County Council

Sara Tough
Executive Director, Children's Services

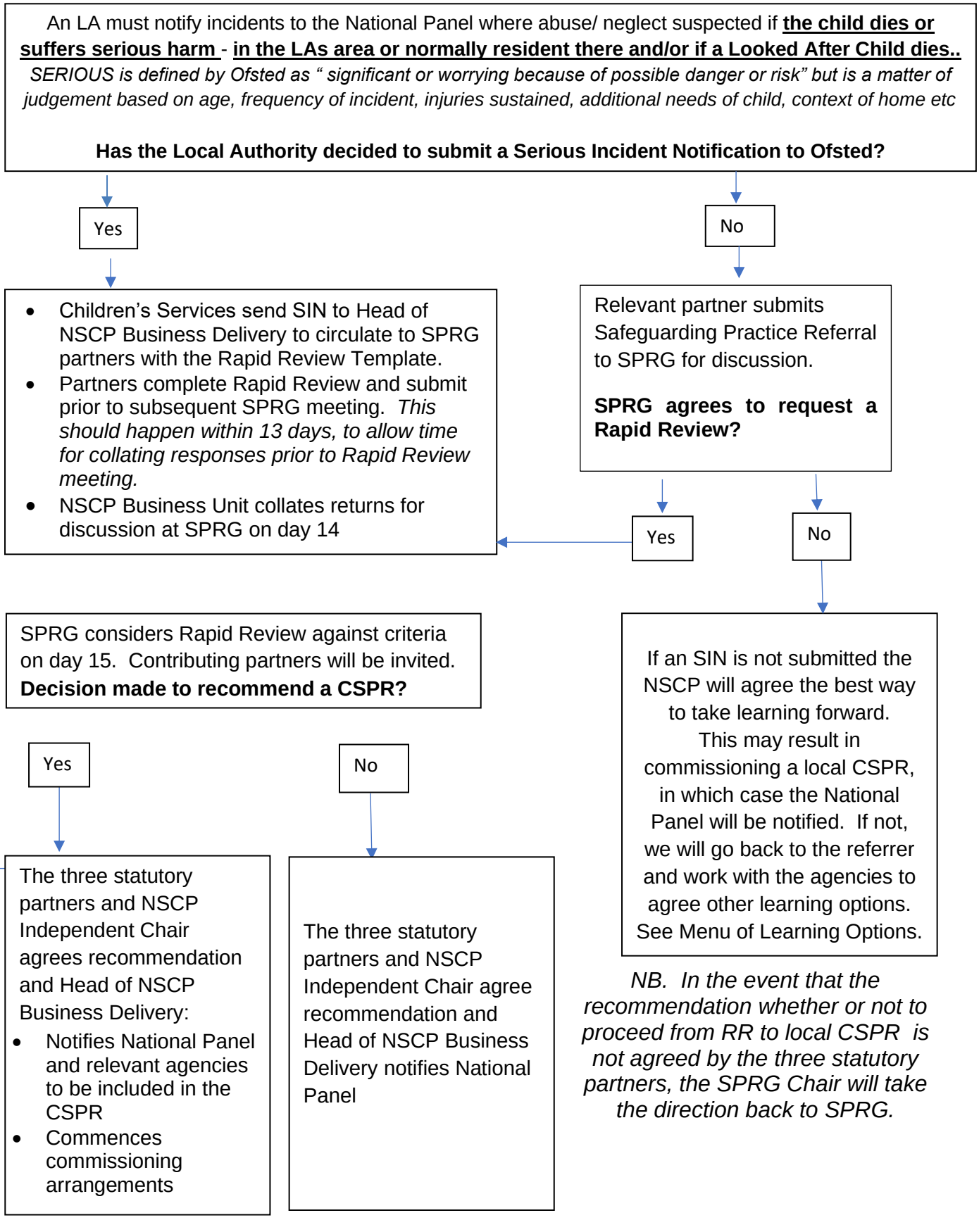
NORFOLK CONSTABULARY
Our Priority is You

Nick Davison
Assistant Chief Constable

NHS

Rebecca Hulme
Director of Children, Young People and Maternity,
Norfolk and Waveney CCG

2 Flowchart for Referrals to SPRG



3. Record of Serious Incident Notification

The decision to submit a Serious Incident Notification (SIN) to the National Panel sits with the Local Authority. It is the responsibility of the Local Authority to submit when:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred, i.e. meets the criteria set out under Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), which states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if – (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England. The LA also must notify secretary of state and Ofsted if a LAC child dies (reg 40 Children's Homes (England) Regs 2015.

This definition must be interpreted in a way which allows for the most serious incidents of abuse and neglect in all categories of harm to be identified and referred for consideration (this will include sexual abuse (which includes child sexual exploitation), neglect, physical and emotional abuse). Interpretation of the criteria must not exclude children or young people because of their age and the definition does not apply solely to children who have suffered severe physical injuries who have self-evidently suffered severe physical harm that is likely to affect their global development. [1]

A referral must be made when a child has died or is seriously injured in a children's home (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

The Children's Homes Regulations 2015, including quality standards guide provides examples of incidents that are likely to be considered serious. These include:

- a child being the victim or perpetrator of a serious assault
- a serious illness or accident
- a serious incident of self-harm
- serious concerns over a child's missing behaviour

[1] Alleged child perpetrators may also be the subject of a review, if the definition of 'serious child safeguarding case' is met.

Serious illness or accident would include matters such as broken bones, when a child loses consciousness or situations that require admittance to hospital for more than 24 hours. Notification should consider and include cases:

- about the death of a child
- about the referral of someone working in the home to your Local Safeguarding Children Board [now Partnership]
- if you know or suspect that a child has been involved in or subject to sexual exploitation (you should be able to provide evidence)
- about a serious incident with a child that required police involvement
- about an abuse allegation against the home or someone working there
- if a child protection enquiry has begun or finished

If an SIN is submitted, Children's Services will immediately notify the NSCP Business Unit in order that a Rapid Review is triggered.

4. NORFOLK SAFEGUARDING CHILDREN PARTNERSHIP
Safeguarding Practice Review Referral Form

Referral to the Norfolk Children's Safeguarding Partnership as a possible Serious Child Safeguarding Incident

Guidance note – It is the responsibility of the Local Authority to submit a Serious Incident Notification (SIN) to Ofsted when:

- *abuse or neglect of a child is known or suspected and*
- *the child has died or been seriously harmed*

In some cases the Local Authority may not be required to submit an SIN, for example:

- *complex medical needs cases*
- *children who are not known to/not active cases within Children's Services*
- *chronic neglect*

In those cases, partners may still have legitimate concerns and there is learning for the multi-agency safeguarding partnership. If the senior manager or professional in a specialist safeguarding role believes that the circumstances of the child constitute a serious child safeguarding case she/he must refer the circumstances to the NSCP Business Unit using the Safeguarding Practice Review Referral Form.

It is good practice for agencies working with the child or family to jointly complete the referral to SPRG.

The Head of NSCP Business Delivery will ensure that the referral is put to the NSCP's Safeguarding Practice Review Group for consideration on whether Children's Services need to submit an SIN to Ofsted and/or to proceed to a Rapid Review.

Safeguarding Practice Review Referral Form

Background Information

Name of Child:

Date of Referral:

Agency Referral

Name of senior officer / named or designated officer	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number & e-mail

Child and family composition

Child's Details

Name of Child		Date of Birth	
Ethnicity		Date of Death (if applicable)	
Brief details of any confirmed disability		Gender	
Currently looked after child?		Formerly looked after child?	
If yes give details			
Currently CP plan?		Former CP plan?	
If yes, give details			
Currently child in need ?		Formerly CIN?	
If yes, give details			
Name(s) of Siblings		Sibling's(s')' dates of birth	
Should the entire sibling group be considered in the scope of this review? Please provide detail here			
Home address			
Housing provider (if applicable/known)			
School or Early Years Provider			

Date of serious Incident or incidents being reported	
Location of serious incident if not the child's usual home address	
Is the incident the subject of a criminal investigation and, if so, who is the Senior Investigating Officer?	
If there has been a Rapid Response meeting who was the coordinator?	

Details of Parents/Carers, Significant Family Members and other significant adult or children linked to the case

Name and Address	Date of Birth	Relationship to Child	Any significant information known at this point

Other agencies known to be involved

Agency	Name of key individuals	Phone and email if known

Category of Abuse

The Categories listed below are used to support the National Panel collate data. Please select any that are relevant.

Abuse					
Domestic Abuse		Physical		HSB: extra-familial	
Alcohol		Physical: Self-Harm		HSB: intra-familial	
Drugs/Solvents		Physical: FGM		Faith-Based	
Neglect: Long standing		Sexual: inter-familial		Online	
Neglect: Recent		Peer on Peer		Bullying	
Exploitation					
Countylines		Trafficking		Sexual Exploitation	
Modern Slavery		Extremism		Forced Marriage	
Criminal acts/Potentially Criminal					
Filicide (parent kills child)		Risk-taking behaviour by child		Road traffic accident	
Gang violence		Child perpetrator		Other (see below)	
Knife crime					
Health/Medical Issues					
Injury		Self-harm		Shaken baby syndrome	
Life-limiting illness (natural causes)		Suicide		Sudden infant death syndrome	
Serious illness		Fabricated illness		Other (see below)	
Other: if you have responded other to any areas above/if the issue is not categorised, provide details					

Case Background

This information will be used to determine whether to trigger a multi-agency Rapid Review. ***This is a significant step that commits substantial professional time and has capacity and resource implications and should have senior management sign off at submission****. Please ensure that the information you provide is accurate and does not omit significant details. If you are uncertain of details, please highlight this.*

Provide brief details of the child and the family background, including previous serious incidents and services provided

Provide brief details of the incident that triggered this referral and why it constitutes a consideration by the Safeguarding Practice Review Group.

Use the chronology table below to highlight key events known to your agency leading up to and immediately following the incident.

Date	**Time (if significant)**	**Event**

What action if any has been taken to safeguard the child or other children and adults affected? Do you have concerns about the current safety of this child or other family members?

Have you taken any steps to escalate these concerns outside of the Safeguarding Practice Review Group? Have any other investigations into the incident been triggered? If so, please provide details and outcomes.

Advice and Submission of this Form

To submit the form, or seek advice on its completion, contact:

Abigail McGarry
Norfolk Safeguarding Children Partnership Business Manager
abigail.mcgarry@norfolk.gov.uk
Tel: 01603 223335

You may also wish to refer to the
National Child Safeguarding Review Panel's Practice Guidance

For completion by NSCP Business Unit only

Details of decision as to whether to convene a Rapid Review, including:

- date of the SPRG meeting
- details of the discussion, including any disagreement noted
- decision reached and reasons for decision.
- actions agreed

Once completed the form should be returned to the referrer and shared with the NSCP.

Date of SPRG meeting		**Name & Role of officer recording decision**	
Points to note: • debates • outcomes • decision & actions			

5. NORFOLK SAFEGUARDING CHILDREN PARTNERSHIP
Rapid Review Template

Purpose of the Rapid Review

In line with *Working Together 2018*, the aim of this Rapid Review is to enable safeguarding partners to:

- gather the facts about the case, as far as can be readily established;
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately;
- consider the potential for identifying improvements to safeguard & promote the welfare of children;
- decide what steps to take next, including whether or not to undertake a child safeguarding practice review.

Decision about whether to conduct a Local Child Safeguarding Practice Review

Guidance: Norfolk Safeguarding Children Partnership (NSCP) is holding a Rapid Review of the circumstances surrounding a serious child safeguarding incident. The responsible officer is required to return a response in 15 days. The NSCP recognises the resource and capacity issues this involves, and this template is issued on the grounds that either (a) the case has met the criteria for the Local Authority to submit a Serious Incident Notification to Ofsted; or (b):a partner has submitted compelling evidence that the case meets the criteria for a child safeguarding practice review using the Safeguarding Practice Review Referral.

Details of the child, family and the incident are set out below.

*The partnership is required to decide whether it will conduct a local safeguarding practice review or what other action to take and report its decision to the National Child Safeguarding Practice Review Panel by ****. The Rapid Review will be considered by the NSCP's Safeguarding Practice Review Group (SPRG) on ****.*

The SPRG requires information from member agencies to inform this decision. We attach the Serious Incident Notification for your reference; this document provides a summary of the information received to date.
[2]
*This Rapid Review template must be submitted in to the Head of NSCP Business Delivery, abigail.mcgarry@norfolk.gov.uk by **** on ****. NB All boxes will expand. Delay in providing relevant information may seriously impair the ability of the partnership to reach the best decision. The NSCP Business Unit will collate all single agency Rapid Reviews into one coherent document for decision-making at SPRG*

Details of the individual and agency completing this form

Name **Agency &** **Designation/Title**	**CONTACT DETAILS** **including direct line, telephone number & email**	**Date** **Completed**

[2] In the event that the RR is triggered without a Serious Incident, this template will be adapted to reflect the referral source and timelines for completion.

Background Information *(This should be completed before this form is sent out)*

For completion by NSCP Business Unit: **Reasons for completing the Rapid Review**
For completion by NSCP Business Unit: **Time period to be covered by agency submission** ***(NB additional earlier background information should be submitted if it will inform the decision making)***

Family details

NB All agencies are asked to check whether the details below match information held on their systems. Please note any significant anomalies.

For completion by NSCP Business Unit:

Name of Subject Child		Ethnicity	
Also Known as		NHS Number	
Date of Birth		Date of Death (if applicable)	
Brief details of any confirmed disability		Gender	
Currently looked after child?		Formerly looked after child?	
If yes give details			
Currently CP plan?		Former CP plan?	
If yes, give details			
Currently child in need ?		Formerly CIN?	
If yes, give details			
Name(s) of Siblings		Sibling's(s')' dates of birth	
Should the entire sibling group be considered in the scope of this review? Please provide detail here			

Home address	
Housing provider (if applicable/known)	
School or Early Years Provider	
Date of serious Incident or incidents being reported	
Location of serious incident if not the child's usual home address	
Is the incident the subject of a criminal investigation and, if so, who is the Senior Investigating Officer?	
If there has been a Rapid Response meeting who was the coordinator?	

Category of Abuse

The Categories listed below are used to support the National Panel collate data. Please select any that are relevant based on the information held by your agency.

Abuse					
Domestic Abuse		Physical		HSB: extra-familial	
Alcohol		Physical: Self-Harm		HSB: intra-familial	
Drugs/Solvents		Physical: FGM		Faith-Based	
Neglect: Long standing		Sexual: inter-familial		Online	
Neglect: Recent		Peer on Peer		Bullying	
Exploitation					
Countylines		Trafficking		Sexual Exploitation	
Modern Slavery		Extremism		Forced Marriage	
Criminal acts/Potentially Criminal					
Filicide (parent kills child)		Risk-taking behaviour by child		Road traffic accident	
Gang violence		Child perpetrator		Other (see below)	
Knife crime					
Health/Medical Issues					
Injury		Self-harm		Shaken baby syndrome	
Life-limiting illness (natural causes)		Suicide		Sudden infant death syndrome	
Serious illness		Fabricated illness		Other (see below)	
Other: if you have responded other to any areas above/if the issue is not categorised, provide details					

Details of Family Members and other significant adult or child (including carers at the time of the incident if known

For completion by NSCP Business Unit: ***NB if the Rapid Review Author has any additional information please add it here***			
Name and Address	**Date of Birth**	**Relationship to Child**	**Any significant information known at this point**

Agency Information and Involvement

<u>SUMMARY:</u> Provide a *<u>brief</u>* summary of your agency's involvement with children and adults listed above. <u>The National Panel requires a concise summary of the facts</u>, so far as they can be ascertained, about the serious incident and relevant context; this should give sufficient detail to underpin the analysis against the Working Together criteria, but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts; *Give details of key events in chronological order including periods when your agency was involved and gaps in contact. NB if the involvement was extended over a period of time, use the date column to state start and end date.*	
Date(s)	**Details of involvement/Event/Key Practice Episode**

*Guidance note before proceeding to **Analysis** below: the NSCP/SPRG will use your analysis to report back to the National Panel on:*

- *decision-making in terms of whether the criteria for a CSPR has been met and on what grounds, and if not, why not. Clear reasons are required;*
- *a recommendation on whether or not a national review would be considered necessary, and if so, why. Clear reasons are required;*
- *if the decision is taken not to proceed with a CSPR, a summary of why it is thought there is no further learning to be gained;*

ANALYSIS: Based on the summary, does your agency's involvement in this case highlight any of the following areas? These are relevant to the decision to conduct a local safeguarding practice review?

- The need for improvement in services to safeguard and promote the welfare of children in your own agency or sector
- Concerns about the way in which two or more agencies have worked together to safeguard a child (including agencies working primarily with adults)
- Gaps in service provision or the lack of involvement of an agency with safeguarding responsibilities
- Concerns about the way in which agencies have worked across local authority or health trust borders
- The safeguarding of children and young people by or in an institutional setting
- *Good individual practice or service provision*
- Other areas not listed above
- Do the themes of this case merit a national thematic review? Y/N. If yes, please stipulate why

Please provide further details below, or record N/A (not applicable). *Where appropriate, cross reference Analysis to the key practice episodes noted in summary above.*

Need for Improvement	
Multi-Agency Working	
Gaps in provision	
Cross boundary working	
Institutional settings	
Good practice identified	
Other	
National Thematic Review?	

Views on learning to be gained?	
To what extent has the current Covid-19 crisis impacted either on the circumstances of the child or family or on the capacity of the services to respond to their needs?	

IMMEDIATE LEARNING: Please use space below to summarise your agency's response to this case in terms of: • *immediate safeguarding arrangements of any children involved;* • *any immediate learning already* • *plans for the dissemination of immediate learning;* • *potential for additional learning within your agency*

Advice on Submission of Rapid Reviews

Contact details for advice on the completion of this form and where the completed form should be submitted to:

Abigail McGarry - Tel: 01603 223335
Head of NSCP Business Delivery
abigail.mcgarry@norfolk.gov.uk

You may also wish to refer to the National Child Safeguarding Review Panel's Practice Guidance

6. Template for recording Rapid Review Decision-Making

NB This section will be cut and pasted to the Rapid Review report for submission to the National Panel

Date:

List of Participants in Rapid Review:

Name	Job Role/Title	Agency/Organisation

Immediate Action

If further action is required to ensure that the child (ren) and any adult who may be at risk and who are affected by **this review provide details of who will be responsible and how this will be communicated**		
Action Required	**Responsible Officer**	**Deadline for action**

Identifying Improvements to Safeguard and Promote the Welfare of Children

SPRG has considered whether the referral constituted a serious safeguarding incident and have considered how best to learn from the case using the determinants listed in the table below. NB There is space in the subsequent boxes to provide further comment on your scaling.

The Rapid Review determined that based on the information available the referral	**Notes**
1 Highlights improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified	
2 Highlights recurrent themes in the safeguarding and promotion of the welfare of children	
3 Highlights concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children	
4 Is one in which safeguarding partners have cause for concern about the actions of a single agency	
5 Is one where there have been gaps in agency involvement (or no involvement) and this gives the safeguarding partners cause for concern	
6 Is more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around	
7 May raise issues relating to safeguarding or promoting the welfare of children in custody or institutional settings	
8 Highlights good individual practice or agency service provision	
9 Highlights other significant factors that may lead to learning or service improvement	
If there was significant disagreement on any of the above provide details	

Rapid Review Discussions

Record of the Rapid Review decisions to include details of **1 the nature and extent of the harm suffered by the child** **2 strengths in practice or service provision identified** **3 any concerns about single or multi-agency practice identified** **4 the potential for learning and improvements in practice and service delivery identified**

Rapid Review Decision

Give details of the action the partnership take as a result of the Rapid Review. • **This may include commissioning a local child safeguarding practice review or another form of audit or review.** • **Explain the reasons for the decisions made: <u>clearly state whether or not the case has met the criteria for a child safeguarding practice review</u>** • **Provide details of any specialist advice provided, including legal advice.** • **Include a record of any disagreement with the approach adopted if any agency wishes that to be recorded.** • **SPRG may also ask the partnership or a member agency to take specific action.**

Does this episode require review under other statutory guidance/NHS procedure? If so explain how the reviews will be combined or co-ordinated.

If proceeding to a child safeguarding practice review, please note any areas SPRG wishes to be included in the Terms of Reference for that review

Provide details of further consideration given to this decision by the NSCP Independent Chair, if any:

If an SPR is not being commissioned detail any other learning options and log the name of the officer responsible for taking learning forward and date of completion in the action log below

ACTION LOG		
Further action	**Who is responsible**	**Date of completion**
Share information with NSCP Chair and Executive Partners for any further discussion		
Provide feedback to referring agency		
Submit Rapid Review Report and record of decision-making to the National Panel		
Notify agencies involved of decision to proceed to CSPR, if applicable.		
Commission Lead Reviewer, if applicable.		

7. Commissioning an Independent Lead Reviewer

When a child safeguarding practice review has been commissioned, the NSCP will appoint one or more suitable individuals as Lead Reviewers. The Lead Reviewers should be independent of the organisations involved in the case

Prior to commission, the Lead Reviewer must demonstrate that they are qualified to conduct reviews. The NSCP has developed commissioning tools to support selection. At vetting, all Lead Reviewers are required to provide:

- contact details of two referees
- up-to-date CV, including previous experience of undertaking reviews
- details of any recent reviews conducted – ideally with links to published reports to review writing standards
- confirmation of public liability and professional indemnity insurance
- confirmation of registration with the Information Commissioner

Only high level information on cases will be shared with the Lead Reviewer at initial discussion. Detailed information will not be provided until the above has been provided and a contract agreed.

The NSCP offers clear guidance to reviewers, including the provision of background information on Norfolk's Thematic Learning Framework (Appendix 1) as well as a summary of local strategies or initiatives which are relevant to the case. The Lead Reviewers are also encouraged to visit the NSCP website to view the resources and learning tools available in Norfolk.

8. Involving Parents and Children in CSPRs

Family members are an important source of information about how services were experienced in an individual case and may provide information about service delivery in general. In this context, the definition of family can be broadened to include wider family and networks where this is judged to be necessary and proportionate to the likely learning. Publication of CSPRs places a greater onus on the Norfolk Safeguarding Children Partnership (NSCP) to ensure that personal data placed in the public domain is accurate and involving family members may facilitate this. However, it can be entirely appropriate for family members to decide not to take part.

Families will be notified in writing and by telephone when a CSPR is commissioned with a clear explanation of the process, i.e. it is about learning not apportioning blame and is an opportunity to better understand and improve safeguarding systems.

Family members will be offered the opportunity to speak directly with the independent Lead Reviewer as early in the process as possible, recognising potential constraints around any criminal investigations. Any evidence the family may wish to submit in terms of correspondence or other written records they hold of service interventions should be treated with equal weight as the evidence provided by agencies.

Children and/or siblings will be communicated to via their support networks and/or through their allocated social worker. The Lead Reviewer will ensure that:

- The conversation is managed sensitively and in language that the child can understand and respond to
- Follow up care is arranged in the event that the meeting causes additional distress.

The Lead Reviewer will be accompanied by a note taker, usually the Head of NSCP Business Delivery, in order to record the meeting. Notes will be shared with the family member to check for factual accuracy. Should there be a criminal investigation any such notes will be subject to review by the police disclosure officer to ensure compliance with the Criminal Procedure & Investigations Act 1996

One or more meetings may need to be arranged to ensure that the family is recognized as a key stakeholder in drawing out the learning.

Prior to the meeting(s) consideration will be given to:

- Identifying the support needed to enable child involvement
- Additional support needed where there are issues of domestic abuse
- Clarity about confidentiality especially if there is fear re repercussions from wider family/ network
- Addressing any contradictory views between family members - especially if there are expectations about a definitive account
- Engaging with the senior investigating officer so they get the focus and scope of the review in order to allow informed discussion about how and when families can be involved

The published reports will note:

- The purpose of family involvement, including which family members are involved and why
- How the analysis is informed by family members' knowledge and experiences relevant to the period under review
- Are there mechanisms to allow the family to feedback on the report before it is completed?

The family will be advised of the publication date in advance and sent a hard copy of the final report for their records.

If family members are not involved, the reasons for non-involvement will be noted in the report, e.g. they declined and/or were prohibited by parallel proceedings.

9. Roles and Responsibilities of CSPR Panel Members

The Norfolk partnership should be proud of its approach to learning and the culture of openness and transparency that has been evident in its Serious Case Reviews and, since September 2019, its Safeguarding Practice Reviews. This is in large part down to the senior officers selected to sit on review panels and the clarity they have about their roles and responsibilities.

It is expected that officers will continue to contribute to creating safe learning environments for both the Panel as well as the professionals directly involved in the cases. The CSPR Panel members will:

- have sufficient seniority to be able to work at and represent all levels within their agency
- have had no significant involvement in the case under review
- be familiar with current child protection practice
- provide all information requested by the Lead Reviewer within prescribed timescales and in accordance with national guidance
- have unrestricted rights of enquiry and access to staff within their agency, including relevant records and files
- ensure that all files relating to the child/the review are secured to ensure information is not lost
- ensure that the relevant staff in their agency are informed of the purpose of the child safeguarding practice review, and exercise their duty of care to staff involved, including communicating with them regarding expectations and their role in the process, the methodology agreed and the opportunities available for them to contribute to the learning
- participate in 1-2-1 meetings with any professional involved in the case, subject to methodology
- be fair in the way that the views of staff are represented
- advise the professionals involved, their agency and the Panel if any competency issues emerge as a result of the review and deal with this outside of the review process
- facilitate meetings with children and families, if appropriate to their role
- contribute to the analysis of practice and learning
- quality assure the draft reports prior to them being finalised for sign off

Additional guidance for Panel members in relation to their quality assurance role is included as Appendix 2.

10. Sign off and Publication

Child Safeguarding Practice Review (CSPR) Report Sign Off

The process for signing off CSPRs prior to publication involves three steps:

1. CSPR Panel agrees report is complete and reflects Panel discussions, prior to going to SPRG

2. SPRG agrees final report for sign off by NSCP

3. NSCP Partnership Group signs off the report at its bi-monthly meeting

NB The NSCP is led by the three statutory partners, i.e. the Local Authority, the Police and Health, but the bi-monthly meetings will also include strategic leaders from other areas of the partnership. When a CSPR is scheduled for sign off the head of any agency involved in the review will be invited to attend that meeting and agree the report prior to publication.

CSPR Report Publication

Child Safeguarding Practice Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond. *Working Together 2018* requires local safeguarding partners to publish the final reports, unless they consider it inappropriate to do so. In such a circumstance, the partnership must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

When compiling and preparing to publish the report, the safeguarding partners will consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners will ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

The Head of NSCP Business Delivery is responsible for sending a copy of the full report to the Panel and to the Secretary of State no later than five working days before the date of publication. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, the Head of NSCP Business Delivery will also provide a copy of that information to the National Panel, the Secretary of State and Ofsted within the same timescale.

Norfolk County Council is the lead partner managing press statements, collaborating with relevant partner agencies. A separate briefing for Children's Services Lead Member is also prepared and issued by the Head of NSCP Business Delivery prior to publication.

A template 12-step publication plan is included below to ensure that communication systems are in place throughout the publication process.

PUBLICATION PLAN – TEMPLATE

ACTION		DATE	Who
1	Final QA of report: • check watermarks • include NSCP logo on front page • check whether judicial agreement is required from Family Court		
2	Summary learning PowerPoint developed and agreed at SPRG		
3	Meeting with NCC comms & press statement/strategy drafted		
4	NSCP Chair to brief partners re publication date & draft press statement shared with: • NCC Managing Director & DCS • Norfolk Constabulary, Chief Constable • Health Leads: CCG/provider CEX • Heads of Other Agencies involved • Children's Services Lead member		
5	NSCP Press statement shared with comms partners from all agencies involved in the case		
6	Advise family of report publication date and meeting arranged pre-publication		
7	Advise Lead Reviewer and Panel of publication date		
8	Send report only to National Panel/Ofsted with proposed publication date allowing at least five working days before publication		
9	Forward final report and PowerPoint to: • SPRG & NSCP • CSPR Panel & Lead Reviewer Advise that the report is embargoed until publication date and to let professionals involved in CSPR know of publication date Ensure that any SWs or other professionals currently working with the families are aware		
10	Write to parents/children and send them a copy of the published report		
11	Post report and summary PowerPoint on website to meet publication date		
	Write to relevant LSCPs about report for their learning (if applicable – may include earlier depending on involvement)		
12	Send link to report and notice of publication to: • The NSCP wider partnership • SPRG • CSPR Panel & Lead Reviewers • Case Groups/professionals who participated in review • Safer trainers • In-Trac (NSCP Multi-Agency training provider) • Other interested parties, e.g. CDOP, Trading Standards etc		

11. Dissemination of Learning Options

The NSCP will build on current processes to support the dissemination process. Options that have been used or could be developed in the future are included below:

Options for Disseminating Learning	Rationale
Summary learning PowerPoint, published alongside full reports	Feedback from frontline indicates that this format is useful, particularly in team meetings
CSPR roadshows	Reach into frontline and evidence of positive feedback from evaluation and raises profile of NSCP
Best Practice Events	Ability to hone in on specific safeguarding issues
Conferences	Supports strategy development on specific issues, e.g. CSA, and raises awareness
Used in training – shared with: • NSCP Workforce Development Group, • single & multi-agency training providers and • Safer trainers	Ensures training material is local and focusing on improving practice linked to learning
Films	Enables voice of children, families and frontline to be heard in different format
Webinars – discussion with Lead Reviewer and NSCP Partners on specific cases	Wider reach and interactive format
Leadership Learning Events	SCR methodology demonstrated this is a powerful way to ensure strategic leaders are included in learning/review process
Incorporated into NSCP Business Plan and relevant strategies	Specific and/or thematic recommendations tracked through to business delivery and strategy implementation

12. Menu of Learning Options

This menu is intended to provide a framework for learning options in relation to cases considered by the Safeguarding Children Practice Review Group. This is not intended to be restrictive or definitive in terms of possible methodologies and may be added to or reviewed with time and experience. The methodology and type of learning model should be adopted to meet the specific learning potential for an individual case. NB any Rapid Reviews triggered by a Serious Incident must result in a CSPR if case specific learning is progressed.

Type of learning	Rationale	Lead Officer	Timescale for completion	Methodology	Governance oversight
Local Child Safeguarding Practice Review	Meets statutory criteria	Independent Lead Reviewer Head of NSCP Business Delivery (supporting)	Six months	As required within Working Together 2018. Proportionate and using Systems approach to include: • Professionals • Families & children	SPRG & NSCP Board
Multi-agency learning event	Learning for multi-agency partnership but does not meet CSPR criteria	To be agreed. Either: • Senior manager in partnership • LSCG Chair • Independent facilitator	Three months	One day event with TOR and lines of enquiry set by SPRG, with Summary of Learning report produced at completion.	SPRG & NSCP
Focussed Multi-Agency Case Meeting	Learning for multi-agency partnership but does not meet CSPR criteria. Where a need is identified for a greater degree of case analysis than is possible	To be agreed. Either: • Senior manager in partnership • Independent facilitator • LSCG Chair	3 – 6 months	As above: One day event and Summary of Learning Report, but with some limited/defined additional material/inquiries e.g: • Issue/event specific Chronology	SPRG & NSCP

Type of learning	Rationale	Lead Officer	Timescale for completion	Methodology	Governance oversight
	within a stand alone Multi-agency learning event.			• Document review • Meetings with staff • Meetings with families **Scope and focus to be clearly defined by SPRG**	
Joint Agency Group Supervision (JAGS)	Key issue for consideration is way agencies are working together for cases that did not meet CSPR criteria	Independent supervisor identified in line with JAGS procedure	4 – 6 weeks	One session Reference joint supervision policy and supporting docs	SPRG
Single agency review or audit	Learning identified for single agency only.	As identified by relevant agency.	To be identified by agency	In line with agency policy and practice	Governance is with Single Agency Lead.
Priority Subgroup Lead	Learning is linked to a priority subgroup or workstream and they consider how this is being addressed in existing strategies and/or plug any gaps	Head of NSCP Business Delivery and/or SPRG Chair summarises case for relevant subgroup	2 – 3 months	Strategy and action plan check	Subgroup with feedback to SPRG

Appendix 1: Supporting information provided to Lead Reviewer

Norfolk Safeguarding Children Board: Lead Reviewer Brief on Learning from Serious Case Reviews & Key themes and 'Practice Standards'

Background and context

Norfolk has commissioned a number of SCRs under the statutory guidance set out in *Working Together* 2013 and 2015. It is crucial that the Board makes sense of the learning so we can plan, action and evidence improvement within a clear structure.

The SCR process, now moved over to the Safeguarding Practice Review process, includes regular review and analysis of the recommendations from the reports. Over the years, we have pulled together a Thematic Learning Framework, to enable us to think about the recurring issues and barriers to effective working together. This has moved us from a position where we are looking at over 100 individual and sometimes repetitive recommendations to a point where we can think about SMART actions to move us forward on a continuous journey of learning and improvement.

This framework has been presented to the NSCP's SPR subgroup and Norfolk's Public Protection Forum (PPF). Through PPF, the Thematic Learning Framework has been adopted by the Adult Safeguarding Board and the Countywide Community Safety Partnership in their work on safeguarding adult reviews and Domestic Homicide Reviews.

Thematic Learning Framework

At the heart of all learning is the child or young person, understanding their experience, what they expect from the adults in their lives and how this aligns with the Norfolk vision, i.e. that all children are loved, valued and respected, happy, healthy and safe and have high aspirations for their future. The central focus is that all learning is child centred and we need to be anchored to the premise that we are working to get the best outcomes for children: remembering what it is like to be a child in Norfolk and asking ourselves what can and should they expect from the adults in their lives who should be keeping them safe.

The thematic learning framework, focuses on four key learning areas:

1. **Professional curiosity** – how can the NSCP encourage and support appropriate curiosity with families, and between professionals?

2. **Information Sharing and Fora for discussion** – how can the NSCP ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?

3. **Collaborative Working, Decision making and Planning** – how can the NSCP improve timely and collaborative planning and get strong and shared decisions?

4. **Leadership: Ownership, Accountability and Management Grip** – how does the NSCP give effective leadership and champion better safeguarding, locating clear accountability?

Sitting underneath everything we do is the recognition that safeguarding requires people at all levels to manage risk and uncertainty.

Following a thematic Serious Case Review, published in January 2020 (Case AF), Norfolk has committed to a cultural shift be developing trauma informed leadership and practice. The framework should therefore be looked at through a trauma informed lens, recognising that safeguarding is a human business and these cases deal in human suffering therefore having a profound emotional impact on everyone involved.

> *It is important to be clear about the context within which safeguarding work takes place. It is a context that features high volume, restricted resources, the sadness of the human condition and the impact that this has on children's lives. It is work that is saturated with a plethora of legislation, policy, targets, performance indicators, inspection and criticism. It is an imperfect system that requires politicians, policy makers, leaders and the media to share the responsibilities for what gets side lined or truncated. There are hard choices to make but the consequences belong to all.*

The themes identified in the learning framework need to consider the reasons why learning may be inhibited in terms of: professional curiosity; where and how we share information; the

ways we work together to make decisions, plan, intervene and share responsibility; and the role our strategic leaders play in containing the workforce.

While this framework attempts to distil the recurring challenges around effective safeguarding, we recognise that the themes will cross over and interlink, for example effective communication and information sharing is intrinsic to collaborative working and the ability to be professionally curious and reflective is dependent on management support and organisational culture.

More specifically, under each of the four quadrants we have started developing headline outcomes that we need to work towards to assure ourselves that Norfolk safeguarding arrangements are co-ordinated and effective. We use this framework to review our approach to practice standards, with reference to our Threshold Guide and multi-agency commitment to working within the Signs of Safety framework. The detail of these headline outcomes is included below.

KEY THEMES:

Analysis of the recommendations show additional themes linked to specific and recurring safeguarding issues and/or areas of practice.

Recurring safeguarding issues:

- Domestic Abuse
- Working with men and fathers
- Challenge and Escalation (use of the Resolving Professional Disagreements Policy)
- Communication between agencies
- Engaging fathers
- Neglect

Recurring areas of practice

- Information-sharing
- Returning children home
- Disseminating learning from SCRs
- Quality of engagement with children and young people
- Quality of referrals to CSC and feedback mechanisms
- Early Help practice
- Practitioner confidence re Child Sexual Abuse
- Core standards for supervision
- Use of historical information in assessments and professional curiosity

Learning in Practice

The NSCP Safeguarding, Intelligence and Performance Co-ordinator works with members of the SPRG to:

- Gather evidence that any agency specific recommendation has been implemented and if not, what establish any barriers to improvement

- Shape the high level actions that will help Norfolk to achieve SMART outcomes against each quadrant of learning, including identifying owners

The Head of NSCP Business Delivery ensures that at the point of commission all Lead Reviewers are aware of this framework and can contribute to supporting its development by:

- Acknowledging any current work being undertaken to improve practice

- Alerting the NSCP/statutory partners to any case/child specific learning and/or the need to review the framework as learning from SCRs and CSPRs emerge

The NSCP Chair also sits on the PPF and is working with Chairs of other partnership boards, including Adults, Community Safety Partnership (responsible for DHRs) and MAPPA to ensure that our combined learning is managed strategically.

More specifically, all partners need to consider the learning from SCRs/SPRs and how that is fed into the domestic abuse change programme: domestic abuse-related themes have emerged from a number of different reviews in Norfolk with specific recommendations on this theme featuring in specific cases. The key points emerging from child reviews in Norfolk have ranged from the overarching need to ensure professionals recognise and respond to concerns in relation to domestic abuse, to more specific recommendations regarding: information-sharing between the Police and other agencies; use of specific risk assessment tools; and the importance of professionals offering to speak to women alone where domestic abuse issues are suspected.

Recommendations and the Composite Action Plan

Historically, we published an action plan and summary PowerPoint alongside the report as part of a comprehensive publication plan, including press statements from the NSCP Chair. With the revised approach to learning, the NSCP has agreed that the benefit of having a more coherent approach to learning outweighs the risks of not addressing each individual recommendation. In order to ensure learning translates to actions and improvement, we:

- Ensure the summary learning PowerPoints links back to the thematic learning framework and addresses any case specific recommendations

- Include specific recommendations in relevant strategies, e.g. Neglect and Protecting Babies, and ensure that all recommendations have a 'home' where actions can be taken forward

- Follow up single agency recommendations and the way they disseminate learning to their staff through the Section 11 self assessment process.

- Maintain a Composite Action Plan where all recommendations are logged against the themes for monitoring purposes

We are committed to honouring the child/ren subject to review as individuals, and we use these cases as windows on the safeguarding system to narrate how we can improve. Our approach to publication ensures that the press statement recognises the children's unique experiences and how the system has learned from them.

Dissemination of Learning

SPRG has also suggested that we consider ways to promote the thematic learning, both as a coherent framework as well as focusing on specific areas of concern. The NSCP Business Unit organises CSPR roadshows across the county whenever a review is published to take the learning directly to the frontline and middle management. Local CSPRs are also shared with all training providers through its workforce development subgroup.

Practice Standards: Outcomes & Evidence Expected

1. PROFESSIONAL CURIOSITY AND PRACTICE

1.1 Practice is child centred and recognises the children and young people we work with as unique individuals

1.2 Multi-agency assessments are analytical, of a high quality, and make full use of all the child/family's history

1.3 Parents and carers, including less visible parents, are fully involved with safeguarding and child protection processes, and issues of PR and consent are routinely explored

1.4 The workforce is highly skilled and trained to recognise, address and challenge disguised compliance

1.5 Practice takes account of the impact of different types of abuse, both emotional and physical, and addresses the needs of the child

2. INFORMATION-SHARING AND FORA FOR DISCUSSION

2.1 Engagement with children and young people is effective and professionals build positive relationships with children and young people, helping them to feel safe

2.2 Norfolk has effective systems in place to track concerns within agencies, records include all relevant information and all relevant information is shared between agencies, with a particular focus on Domestic Abuse

2.3 Appropriate professionals are engaged in decision-making within the Multi-Agency Safeguarding Hub and other multi-agency discussions, in particular health partners

2.4 Information recorded in assessments and agency records is high quality and shared with children, family and the multi-agency partnership in a timely manner

2.5 Practitioners from all agencies understand the difference between consultations and referrals, and feel confident in making referrals to the MASH. Feedback on referrals is provided in a timely way

3. COLLABORATIVE WORKING AND DECISION-MAKING

3.1 Professionals are confident to challenge one another and be challenged within the multi-agency arena in order to achieve the best outcomes for the child

3.2 Norfolk applies consistent thresholds and there is a clear rationale in each case for why decisions have been made, leading to appropriate and timely referrals for intervention

3.3 Significant case decisions in respect of safeguarding are made jointly across agencies and supported by multi-agency planning to best meet the needs of the child

3.4 Norfolk's Early Help offer is well established and includes robust mechanisms for proactive review and challenge to ensure cases do not drift

4. OWNERSHIP AND ACCOUNTABILITY: POLICY, PROCEDURE AND GUIDANCE

4.1 All agencies understand and follow national guidance in relation to information sharing when working with children and families

4.2 Practice standards for Early Help are in place and QA systems are used routinely to ensure the quality of the FSP process

4.3 Staff supervision is of a high quality and provided to all frontline staff working with children and families

4.4 Practitioners and managers are able to confidently exercise sound professional judgement in order to safeguard vulnerable children and young people

4.5 Policies and procedures are in place to support all staff in achieving positive outcomes for children, specifically in relation to Domestic Abuse and Neglect

5. Ownership and accountability: commissioning and gaps

5.1 Practitioners and managers have access to specialist advice and services when working with complex cases (including CSA)

Ownership and accountability: NSCP monitoring and scrutiny

6.1 All agencies are aware of, promote and follow NSCB policies, with a specific focus on Professional Disagreements, Disclosure Protocol and Working with Reluctant and Hostile families

6.2 Practitioners are confident when working with cases where neglect, sexual abuse and/or domestic abuse are present, including at the Early Help stage

6.3 Robust processes and arrangements are in place to ensure that the actions from CSPRs are completed and that learning is shared and embedded across the children's workforce

Appendix 2 – CSPR Reports: QA tool for Panel

QUALITY ASSURING CSPR REPORTS GUIDANCE NOTES AND QA TOOL

Background and Context

Historically, Norfolk has published a significant number of SCRs of varying quality. While the Head of NSCP Business Delivery does assess proposed Lead Reviewers on commission, the Review process itself can sometimes highlight issues about quality for example relating to report writing style or analysis. In some cases, the Panel members may have provided feedback or expressed concerns but in others they may be too close to the process themselves to identify issues. Sometimes the Lead Reviewer may not have received all the information they need to complete the report successfully. In all these cases, it can mean that the issues are not properly drawn out until an SCR report which is not considered to meet the standard required is presented to the Board's subgroup. This is very late in the process and often the report is already scheduled to go to Board so there is limited time to make the amendments requested.

As Panel member, part of your role is to quality assure the report prior to submission for sign off.

Commissioning Lead Reviewers

On commission, Lead Reviewers are asked to provide references, examples of published reports and other relevant documentation. The Head of NSCP Business Delivery issues background information on Norfolk in relation to services, inter-agency working and the Thematic Learning Framework (TLF), derived from the bank of local SCRs. There is an expectation that the Lead Reviewer will make reference to the TLF in their reports. This QA document has also been added to the information sent out at the point of commissioning to support with managing expectations.

Purpose of the QA Guidance and Tool

The QA tool developed should help both the Panel and Lead Reviewer (author) to deliver a high quality report by the time it gets to SPRG for sign off. The purpose of this guidance is three fold:

1. To be used alongside draft reports so Panel members have an aide memoire to critically appraise and comment on the expected quality of CSPR reports
2. To have a mechanism of recording feedback and concerns raised
3. To support the Lead Reviewer in delivering a high quality final report

Reports should succinctly summarise what happened and then focus on ***why*** things happened as they did (analysis), before drawing out conclusions as to what this tells us about previous and current practice in Norfolk, which should lead directly to recommendations. There is also an expectation for getting the basics right in terms of grammar, structure, formatting and reference notes.

NB We are ***not*** taking a prescriptive stance on how the reports are formatted but we would expect all reports to follow roughly the headlines noted below.

How the tool will be used

Panel members will receive the draft of report at least five working days ahead of the Panel meeting where it will be discussed. They should complete the tool as part of their preparation for that meeting and use it as a reference during the meeting. They should also provide either the hard copies or electronic copies of their feedback to the Head of NSCP Business Delivery for her/his records. The Business Manager will collate the feedback and provide an overall summary for the Lead Reviewer to consider before revising the draft; this will be done within three working days of the Panel meeting. Individual feedback records will not be shared directly with the Lead Reviewer.

Feedback is welcomed on all aspects of the case review process, including the Panel's QA function and this tool.

CSPR Report QA Tool

CSPR Case Reference:	
Name of Panel Member:	
Date:	

HEADLINES: Introduction, Background, Methodology & TOR		
Generic notes	**CONTENT TO EXPECT/QUESTIONS TO ASK**	**Y/N**
This section is essentially factual and does not require analysis or particularly sophisticated writing.	Is there clear reference to the criteria for conducting a CSPR?	
	Has the case been summarised effectively and include all relevant information?	
	Is the case appropriately anonymous so the child/ren and their family cannot be identified?	
	Is there explicit reference to the Terms of Reference and any key lines of enquiry/research questions to be explored in the report?	
If relevant, please provide a summary of how the report can be improved in the box below (It will expand).		
Please use the space below to provide any positive feedback or further comment		

HEADLINE: Narrative		
Generic Notes	**CONTENT TO EXPECT/QUESTIONS TO ASK**	**Y/N**
*This section tells the story of **what happened** in more detail*	Is the narrative clear, with a proportionate level of detail? Does it make sense chronologically?	
	Does the story effectively capture the key practice episodes agreed at Panel?	
	Are there any gaps or important details missing?	
	Are the headlines within this section effective? Do they lead the reader through the story?	
	Is the text sufficiently anonymised?	
If relevant, please provide a summary of how the report can be improved in the box below (It will expand).		
Please use the space below to provide any positive feedback or further comment		

HEADLINE: Analysis		
Generic Notes	**CONTENT TO EXPECT/QUESTIONS TO ASK**	**Y/N**
*This section should assess the quality of practice, identify **why** practice was of poor, or good quality, and draw out what this tells us about practice systemically, i.e. beyond this individual case.*	Does the writer clearly state views on analysis of practice?	
	Are the narrative facts of the case used effectively to illustrate how the writer drew his/her conclusions?	
	Has the author analysed the case without unnecessary repetition of the narrative?	
	Where relevant, are any known contributory factors identified? If so, has the report addressed the systemic *'why?'* question?	
	Is the analysis founded on a good evidence base with evident professional expertise?	
	Are the headlines within this section effective? Do they relate back to the key lines of enquiry/research questions from the TOR?	
	Are there any gaps or details missing?	
If relevant, please provide a summary of how the report can be improved in the box below (It will expand).		
Please use the space below to provide any positive feedback or further comment		

HEADLINE: Conclusions (or Learning)		
Generic Notes	**CONTENT TO EXPECT/QUESTIONS TO ASK**	**Y/N**
*This section summarises the **key learning points** making reference to the analysis*	Does the writer summarise the key learning points effectively?	
	Can you trace the learning points back to the analysis?	
	Has the author successfully drawn on evidence from the system (such as local QA/SCRs/research) to triangulate the findings?	
	Are the headlines within this section effective? Do they provide answers to the key lines of enquiry/research questions from the TOR?	
	Are there any gaps or details missing?	
If relevant, please provide a summary of how the report can be improved in the box below (It will expand).		
Please use the space below to provide any positive feedback or further comment		

HEADLINE: Recommendations (or Findings)		
Generic Notes	**CONTENT TO EXPECT/QUESTIONS TO ASK**	**Y/N**
*This section should direct the Board on either **<u>what actions they need to take</u>** (recommendations) or the **<u>areas they need to consider taking action</u>** (findings)*	Are the recommendations/findings logical and link back to the learning?	
	Are the recommendations/findings relevant and/or manageable?	
	Are the recommendations/findings relevant SMART? If not, do they need to be?	
	Has the Lead Reviewer made reference to Norfolk's Thematic Learning Framework?	
	Do the recommendations reflect the discussions at Panel meetings? Are there any gaps or details missing?	
If relevant, please provide a summary of how the report can be improved in the box below (It will expand).		
Please use the space below to provide any positive feedback or further comment		

GETTING THE BASICS RIGHT		
Generic Notes	**BASIC EXPECTATIONS**	**Y/N**
Please confirm that you have considered the aspects listed to the right and agree that they meet expected standards	Grammar/writing style	
	Structure, including use of headlines	
	Formatting, including section and paragraph numbering	
	References	
	Appendices	
If relevant, please provide a summary of how the report can be improved in the box below (It will expand).		
Please use the space below to provide any positive feedback or further comment		