June 2012

Health and Social Care Scrutiny Sub-Committee

Scrutiny Review of Children's Safeguarding – Interim Report

Members of the Review Group

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INTRODUCTION

This report outlines the interim findings of the review into children's safeguarding. The need to urgently consider whether children's safeguarding arrangements in the borough was sufficiently robust with all the appropriate services, procedures and individuals in place was brought to the attention of the Scrutiny Leadership Group by the Chair of the Health and Social Care Scrutiny Sub-Committee.

The Chair of the Health and Social Care Scrutiny Sub-Committee had in turn been alerted by the Corporate Director for Children and Families regarding some outstanding concerns (at the time) related to progress on some of the recommendations that came out of the NHS London Safeguarding Children Improvement Team (SIT) visit to the Harrow health community in October 2010. (Appendix A).

Given that the main focus of the NHS London SIT team visit was on the health provision in the borough relevant to children's safeguarding, this has been the main focus of the review group to date. However, as Members began to consider evidence on the health aspects of children's safeguarding in greater detail it also became evident that in order to fully assess the children's safeguarding arrangements in the borough (although not part of the SIT team visits focus) it was necessary to also look at the councils arrangements as well.

Following the first two meetings of the review group, Members also decided that it would be sensible to await the conclusions of the recent Ofsted inspection of safeguarding and looked after children arrangements due to be published in June 2012. The reviews scope will be re-considered in the light of the inspection outcomes and also to consider the social care element.

BACKGROUND

Over the past few years a number of high profile tragic cases have brought children's safeguarding to the forefront. The statutory inquiry into the death of Victoria Climbie led to the publication on the Green paper *'Every Child Matters* and the provisions of the 2004 Children's Act. The key outcomes from this included:

- the creation of Children's Trusts
- the need to establish Local Safeguarding Children's Boards (LSCB) in all local authorities
- the duty for all agencies to safeguard and promote the welfare of children

More recently the Baby Peter case in 2008 led to Lord Laming's review of social care which resulted in *'The Protection of Children in England: A progress report' ,* March 2009 of which all the 58 recommendations that were made were accepted by the Government. The recommendations focussed on:

- leadership and accountability

- support for children
- inter-agency working
- children's workforce
- improvement and challenge
- organisation, finance and legal framework

Following Lord Laming's report *'Working Together to Safeguard Children'* March 2010, a procedural guidance on safeguarding and promoting the welfare of children and families was published. *'Working Together to Safeguard Children'* providing a guideline for how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004.

The recent Munro Review also concluded that an emphasis on imposing and meeting performance targets has led to less of a focus on the children in need of help and protection and an over standardised system. The key findings of the Munro review are as follows:

- local authorities should be given greater freedom to develop their own approaches to handling case work, rather than being bound by statutory guidance.
- Councils should develop ways of keeping experienced senior social workers in front line work so they can better supervise junior practitioners.
- the excessive burden of inspection on child protection departments should be lifted, and the inspectorate, Ofsted, should not evaluate serious case reviews into child deaths.

It was also recommended that the social work profession be more open and transparent in talking about the pressures and dilemmas they face, particularly during times of crisis, such as during the Baby Peter case.

Children's safeguarding has always been a key priority for the borough along with other authorities nationwide but these events have meant that assurances, examination and monitoring of safeguarding arrangements has been given even greater prominence over the past few years.

Safeguarding encompasses a varied range of activity applying to all children and young people. The statutory definition of safeguarding and promoting the welfare of children is:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- undertaking that role so as to enable those children to have optimum life chances and enter adulthood successfully.

Safeguarding Children Scrutiny Guide, Centre for Public Scrutiny and Local Government Improvement and Development Agency, 2009

SCOPE OF THE REVIEW

The main focus of the NHS London SIT team visit in October 2010 was on the health provision in the borough relevant to children's safeguarding and so this was the initial focus of the review group, as detailed in the scope (Appendix B). The review group wanted to address whether health partners had made progress against the recommendations and follow up actions that were suggested. The review group also wanted to consider whether arrangements were in place to provide reasonable assurance and confidence that children at risk of significant harm in Harrow were suitably safeguarded.

Current developments and progress underway and where any gaps needed to be met amongst the various health organisations involved in safeguarding children's services in the borough was another area that was considered. The review group also wanted to understand the role of key individuals in delivering and monitoring robust and effective safeguarding arrangements.

The review was initially planned to be a one day challenge panel/ light touch review but as Members began to consider written evidence in greater detail and following on from their initial meeting more questions arose along with a need for further clarity and it became apparent that the scope of the review would need to be revisited.

METHODOLOGY

The review group began by considering the some background information including:

- NHS London Safeguarding Children Improvement Team (SIT) visit to the Harrow health community in October 2010 report. (Appendix A)
- NHS Harrow Review of Paediatric Contracts (Appendicx C)
- NHS Harrow response to Harrow LSCB report on Safeguarding Children.

The paperwork members considered provided an update on progress, developments underway and addressed what policies, procedures and people were currently in place.

The review group met with partners on 11April and 28 May and met alone to consider evidence in greater detail on 26 April.

At the meeting on 26 April members went through the evidence that had been submitted by colleagues and a number of additional questions and gaps in evidence was then requested by the review group. It was at this point that the review group felt that besides talking to commissioners, it would also be helpful to speak to key providers and so it was decided that a further meeting should take place. The review group decided that they would meet with the key

providers from North West London Hospitals Trust and the Integrated Care Organisation.

SUMMARY OF NHS LONDON SAFEGUARDING IMPROVEMENT TEAM (SIT) VISIT, OCTOBER 26-27 2010

The review group considered the report of the NHS London 'Safeguarding Children Improvement Team (SIT) visit to the Harrow Health Community, October 26-27 2010' (Appendix A) as a starting point for the review.

The key points arising from the visit are summarised below:

1. Northwick Park (NP) A&E/ Urgent Care Centre (UCC) /Paediatrics

Procedure and Policy

- There is a lack of clarity with regards to procedure and policy as when staff were asked about procedures, different answers were given and at times they did not match policy.
- There is a lack of clarity about who does what. At the UCC and A&E, staff couldn't identify which doctor would see children in which situation.

Recommendation - Trigger questions should be built into the assessment paperwork to guide when a referral to paediatrics should be made.

Training

- Training of adult A&E staff was said to be at level 2 training level. However, having met an adult A&E nurse working in the paediatric area, the nurse reported they had not had safeguarding training in 5 years since arrival.
- There were not enough paediatric nurses in post to have one in the children's A&E 24/7.

Recommendation – Assurances should be made that staff working in that area are appropriately trained, and level 3 would be the best.
Commissioners should also determine how satisfied they are with the number of paediatric nurses in A&E.

Liaison Health Visitor (LHV) role

- There is a part-time LHV role where all attendees records are checked. LHV seem to work best when full time.
- Northwick Park A&E does not have a weekly psychosocial/ case review meeting that looks at all risky cases. In most places this is a key meeting point between social work and health.
- A&E say that they get insufficient feedback from social services after cases have been referred to them.

Recommendation - NWL should review how robust is the post attendance checking and that multidisciplinary review are sufficient.

Paediatric Department

- There is a weekly psychosocial meeting with good attendance other than from social work.
- Paediatric staff thought they got a good initial response from social services but, like A&E, did not receive feedback later.
- Staff were not clear on appropriate levels of training and few were clear on compliance levels.
- There was also uncertainty about just how mandatory training was for doctors.

Recommendation - The use of the word mandatory would be better as would sanctions. In some trusts, for example, doctors cannot get excellence awards, or get through annual appraisal, unless mandatory training is up to date.

Northwick Park Community Paediatrics

- Attendance at case conferences is rare but reports are sent.

Recommendation – It is suggested that its is made sure that doctors, especially junior or hard pressed staff, do not make decisions about not going to conferences alone as with some cases this could be a very significant decision.

- The NWL named doctor has 1.5 sessions. It was explained there were plans to increase it as two hospitals and community paediatrics is a significant area to cover.
- All named doctors are required under Working Together 2010 to be supervised professionally by a designated doctor, and this may not be happening.

Northwick Park Maternity

- The midwives are trained to level 2.

Recommendation - midwives who work alone, such as community midwives should have level 3.

- Supervision is currently by election.

Recommendation - midwives working with families on their own should have mandatory 1-2-1 supervision.

2. Ealing and Harrow Community Health Services School Nursing (SN)

- There are 3 (maybe 3.2) working time equivalent school nurses (SNs) at present. In October 2010 the SNs wrote formally to the Designated Nurse expressing that they were 'stressed and vulnerable'.
- There are two vacancies, frozen along with other Ealing and Harrow Community Health Services posts. The manager responsible for the service has an adult rather than children's background and needs support to judge how to weigh up concerns raised on community nursing capacity. There was no indication that the issues with SN had been discussed at board level.
- In the NHS Harrow policy, child protection supervision of SN is on a group basis twice termly. This did not appear to be happening to that Level.

Recommendation - 1-2-1 supervision, especially as individuals are so stretched should be considered.

Health Visiting (HV)

- The average caseload for HV was said to be 709. The caseloads were amongst the highest NHS London had seen. There was recognition it may become an issue once the Integrated Care Organisation is formed.
- Under the organisations policy, HV should receive two 1-2-1 child protection and two group sessions a year. This is probably not happening as specified. It is common practice elsewhere to have 3 monthly 1-2-1 supervision.

Link Health Visitor (LHV)

- There is LHV for GP practices, but there is clearly variation in how this role is fulfilled.

Recommendation - You should specify what you expect of the link role and work with GPs on their part of the arrangement.

Mental Health

- CAMHS reported generally good relations with social work but they did feel that some important cases were accepted by social work.

Recommendation - It would be worth checking how much of an issue this is and whether escalation is used.

General Practice

- GPs would like whole practice training and GPs were unclear if safeguarding was or was not in their appraisal.

Thoughts of the review group on organisational issues

- Compared to most places
- Staff were less fluent on levels required and eligibility
- Were less au fait with training compliance levels
- Were less clear on 'mandatory-ness'

3. Commissioning:

NHS London felt that acute commissioners at sector level had little to no knowledge of safeguarding performance in their acute trusts and the safeguarding did not seem to be something monitored by them.

Designated and Named Professionals (DPs and NP)

Recommendations - Support and develop DPs in their role as their position may change from PCT to GP Consortia or local authority based in Public Health.

- Ensure NPs have time to do their job and are robust as they are likely to need to be more independent of DP support as the DPs face change.

- Chart out the supervision arrangements between DPs and all NPs to ensure there is a comprehensive system in place, including for example expectations of frequency of formal meetings.

Governance

- Board reports across the health community are good in terms of narrative but they contain very little measurement of success
- All NHS boards should have specific training on safeguarding so they can knowledgably interrogate the increasing reporting on safeguarding as assurance processes develop.
- Boards need to decide on the minimum assurance detail they need to see at the Board, to demonstrate that they are being positively assured about service quality.

Recommendations - All organisations should have a safeguarding audit schedule to ensure you get the right information to feed the assurance process.
- Agreeing a shared package of measures that gets as close to quality as possible would be helpful to measure the quality of, rather than the existence of, safeguarding activity.
- It is important that governance committees and boards receiving assurance material are provided with a narrative on its meaning, so that results are put in context
- The following areas should be prominent in board assurance (as adapted for particular organisations):

- vacancy rates in key clinical groups
- caseload numbers for midwives and health visitors
- attendance at case conferences by key health staff
- invitations to case conferences, and % attendance
- achievement of level 1-3 training—as % of target
- supervision arrangements in place and compliance SCR updates
- % completion of the child screen in adult mental health cases

Key overall areas for thought/action

- There is a need for assurance around compliance with policies
- An external review around staffing and risk in community nursing should be considered. NHS Harrow and EHT to work together on a board view.
- Supervision and training: following policy, more 1-2-1 and mandatory, greater clarity on training levels and auditing is needed

AREAS CONSIDERED BY THE REVIEW GROUP

The review group have held two evidence gathering sessions to date on 11 April and 28 May.

In attendance at the meeting on 11 April were the following:

- Sue Dixon, Designated Nurse
- Catherine Doran, Corporate Director for Children and Families
- Javina Sehgal, Borough Director, NHS Harrow
- Genevieve Small, Lead GP for Safeguarding Children
- Rebecca Wellburn, Deputy Borough Director, NHS Harrow

At the 11 April meeting, NHS Harrow colleagues provided an update report which detailed progress that had been made since the NHS London SIT team visit to Harrow in October 2010 (Appendix A), that was due to be presented to the LSCB meeting.

In attendance at meeting on 28 May were the following key providers:

- Carole Flowers, Director of Nursing, North West London Hospitals NHS Trust (NWLH)
- Paulette Lewis, Interim Assistant Director Community Nursing Services, Harrow Community Services, Integrated Care Organisation (ICO)
- Sue Westbury - Named Nurse, Harrow Community Services, Integrated Care Organisation (ICO)

In advance of the meeting with the ICO and NWLH the review group sent a number of questions.

Detailed below is a summary of some of the discussions and deliberations from the two meetings.

1. Key Roles and positions across the health sector

Members were keen to get clarity on some of the key roles in the health sector that are directly related to children's safeguarding issues. They addressed what particular positions entailed, whether people were actually in post and lines of supervision. Issues with lines and levels of supervision in particular had been highlighted by the NHS London SIT visit.

Named Professionals

There is a core job description for all named professionals and all NHS trusts, NHS foundation trusts, and if the public and third sector, independent section, social enterprise and PCT providing services for children are required to have a named doctor, named nurse and a named midwife.

Named professionals are responsible for promoting good professional practice, ensuring policies are in place, provide advice to fellow professionals and have

specific expertise in children's health and development and safeguarding and promote the welfare of children.

Harrow has the named GP as an elected lead member of the Clinical Commissioning Group (CCG) and so safeguarding is high on the agenda and the Safeguarding Working Group meets every two weeks as a sub-committee of the CGG. This is a forum where safeguarding issues are discussed and every two months provider leads are invited to attend and update on arrangements, share service developments and to address any outstanding issues. The review group also learnt that the Quality Innovation Productivity and Prevention Programme (QIPP) also has safeguarding as the common thread throughout so when transition comes, the preparatory work will already have been done.

Designated Professionals
Designated professionals supervise and also performances manage. The designated role is statutorily set out in national guidance. Designated professionals hold a strategic role dealing with standards and provide expert advice. The interim designated doctor currently in post will continue until September 2012. The review group are keen to get some clarity over what will happen to this role after September 2012 and have sight of the implementation plan.

The designated doctor currently leads the rapid response team but other options for the rapid response team (who look at the circumstance in which any child dies in the borough) are currently under consideration including the possibility for the development of a nurse led team across the Outer North West London (ONWL) boroughs.

Looked After Children (LAC) Doctor
The review group had some concerns over the LAC doctor post, which they learnt had been difficult to recruit to due to the details of the position not being clearly specified in the past. This role is currently commissioned under the NWLH contract and the members learnt that LAC protocol was put in place at the beginning of 2012 to clearly define the role and the joint working arrangements with partner organisations. The current designated doctor is covering the role on an interim basis and will be implementing an action plan to further strengthen the arrangements for monitoring the health needs of LAC.

Paediatric Nurses
Paediatric Nurses transferring from Central Middlesex Hospital; has been reported to have resolved the previous problems in terms of capacity at Northwick Park A&E that was highlighted in the SIT visit report. The Director of Nursing, NWLH explained that there is someone appropriately trained in paediatrics at all times in the A&E department. The trust is also currently embarking on a development programme to improve services and this has been commissioned through Bucks University.

Health Visitors (HV)
The SIT review in 2010 highlighted that HV had very heavy workloads. However, following an NHS London benchmarking exercise against other authorities it was found that that the workloads were not so high in comparison to other boroughs and so work is being carried out to look at how services are structured to better manage work loads. Work is being carried out to look at skills mix, implement the Healthy Child Programme and address ways of working to improve productivity. The HV group is also looking at reviewing structures, succession planning, case loads and staffing levels. The number of HV is based on dependency in terms of caseload. In the central part of the borough there is a high level of vulnerability and so consideration is being given to how to try and re-align and support the HV in the central team. The HV groups are split into three areas in Harrow which includes central, west and east (this mirrors the split for district nursing and GP clusters).

School Nurses (SN)
SN was highlighted as another challenging area during the SIT team visits. There are currently 7.6 SNs and ideally more would be helpful but a tri-borough service specification with KPIs has been developed with a clearly set out safeguarding requirement. Work is ongoing and being managed with the resources available and a review of the service will take place shortly in this municipal year. The SN are able to deliver but it was reported that it is a challenge and as with a lot of health services they tend to work on good will a lot of the time.

2. Training

The review group spent some time considering the issues of GP training where they learnt that the main challenge with regards to this was monitoring. Training was reported to have been consistent in the last 5 years but there has only been a clear structure in the last six months to check on the training. The Royal College of General Practitioners toolkit is being distributed to all GPs in the borough and commissioners are asking that all practitioners complete the assessment tool for their own development and allow the designated and named professionals to provide support which relates to practice specific action plans.

Practice teams and nurses are also trained and although training at all levels is delivered by the Harrow designated doctor and designated nurse it was explained that there is a need for practices to acquire training from other sources in order to meet ongoing demand. In future all GP's will be registered with the CQC so this will add further assurance in terms of safeguarding compliance and training.

Across the board in the health sector training is required at level 1 for people who don't work on a ward level, whilst staff engaged in a clinical setting should be at level 2 and level 3 training is required for those who work directly with children

and young people. Besides the regular training, when new findings are unveiled good practice briefings and case conferences are also rolled out to disseminate knowledge. One of the key challenges for training is maintaining and keeping the database live on what training has taken place.

3. Health Visitors location in Children's Centres

The review group were keen know whether the location of HV in children's centres was having an impact on working arrangements and interaction with GPs. The review group learnt that 1/3 of HV still go to GP surgeries whist the others were based at children's centres. As there are a limited number of HV, it means that it isn't feasible to have one at each GP surgery and so HV are now locality based. The Communications Plan is discussed with GP's to look at vulnerable children on a monthly basis and this is part of the CQUIN. The review group will be keen to look at the Communications Plan.

The HV CQUIN developed by Harrow commissioners is focussed on strengthening the working relationship between HV and GPs. The CQUIN scheme is a financial incentive worth an overall 2.5% of the community contract sum. Around £120k of this will be paid to the ICO dependent on named HV meeting at least monthly with GPs to identify vulnerable children and ensure that appropriate health visiting support and onward referral is in place where appropriate.

Colleagues explained that the location of HV at children's centre's could mean that some of the softer intelligence through face to face interaction may be lost but at the same time opportunities are bound to arise especially as children's centres are available for wider use. It was further explained that some GPs have found the move to children's centres somewhat of a challenge but appropriate systems and processes in place should help to alleviate some of the challenges.

4. Working relations

The review group spent some time considering working relations amongst partners. NWLH generally had a positive working relationship with commissioners through both formal and informal mechanisms. The Safer Child Strategy and work plan helps to provide guidance for this but there is still a need for some improvement in terms of partnership relations.

In respect of the working relationship with social care, colleagues from NWLH reported that there are areas that could be improved in respect of communication and responsiveness.

The working relationship between the ICO and the commissioners is generally good and positive relations are also being formed with the Clinical Commissioning Group (CCG). Colleagues from the ICO regularly meet with

commissioners to address whether they are achieving standards and KPIs and these meetings are always followed with key actions. In respect of partnership relations, the Interim Assistant Director Community Nursing Services, ICO attends the LSCB meetings whilst the Named Nurse attends the LSCB working group meetings.

The ICO also carry out a great deal of work with colleagues in the police through a range of different settings such as the Inter Agency Group, Integrated Offenders Panel and the Joint Agency Group. There is also attendance at Domestic Violence meetings.

In terms of the relationship with social care, the ICO also reported that there could be some room for improvement in terms of the provision of timely information about where children are placed out of borough being made available to relevant practitioners as there is sometimes a delay. In order to improve partnership working, better information in relation to when health assessments and investigations being carried out and when section 47 are enforced would also help. It was explained that this has been raised with the JAG.

Informal liaison and relationship building would also be beneficial for example new HV could meet with social workers and vice-versa to garner an idea of what the other person does and what challenges and tensions they have to deal with. There is a willingness from all parties to have the dialogue in particular with front line staff through the Joint Operational Group.

5. The structure of the Integrated Care Organisation (ICO)

The review group required clarity in terms of the structures in which the ICO operated in view of the fact that it was meant to a merged organisation, but there were still very separate policies and procedures for Ealing, Brent and Harrow. It was reported that as new policies are coming up for renewal there will be a further move towards integration and the three named nurses across Ealing, Brent and Harrow are looking at how they can join up services and they regularly meet to discuss training and agree various standards.

Three separate policies are being kept for all three authorities as merging too soon could also cause some problems. At some point the teams will be more integrated but all authorities will always have one named nurse. It was explained that partly why separation is also maintained is that the ICO colleagues in turn interface with different services in different authorities, e.g. Harrow children's service and Ealing children's service have different care pathways. Ealing also have Family Practitioners that neither Brent nor Harrow have. Each authority also has very different demographics to which services have to be tailored. A Safeguarding Advisor had now been appointed who will be responsible for supervision and training across the board. The review group learnt that the ICO have finalised the contract negotiation for a tri-borough HV service and a Health

Visitor Link role will be established. Work is also currently underway to try and amalgamate the Annual Safeguarding report of the three authorities

The Named Nurse from the ICO also attends Adult Safeguarding Board meeting to feed back and ensure things are joined up in order to help translate policy into practice and it was stressed that It is key to their work that children's and adults aren't seen in silo and the Named Nurse is working hard to raise the profile of safeguarding children and ensure there is a crossover.

6. Engagement with private providers

The review group learnt that there is a lack of capacity to provide a high level of engagement with all private providers which is a nationwide challenge but the CQC registration scheme is designed to address. The Corporate Director of Children and Families and the Named GP for Safeguarding Children will also be exploring how to address this challenge in the future.

7. Potential Merger of Ealing Hospital Trust (EHT) and North West London Hospitals (NWLH)

The review group were keen to know the views on the potential merger of EHT and NWLH. ICO colleagues expressed that the potential merger of EHT and NWLH is positive as it will help to align working relationships and avoid things falling though the net. The Director of Nursing, NWLH explained that the merger would mean a bigger team, greater expertise and a more extensive role in the community setting and this will help to better align services and progress is already being made in respect of working closer together already. NHS Harrow have highlighted that the merger poses both challenges and opportunities and governance and assurance systems are key to ensuring quality services are provided during the transitional stage.

POTENTIAL AREAS FOR FURTHER CONSIDERATION

At this stage of the review, Members are not in a position to make specific recommendations; rather they have drawn up some areas they may wish to consider further going forward, dependant on the outcomes of the Ofsted inspection.

Key areas and questions that could be considered includes:

- The outcomes and all the recommendations arising from the Ofsted inspection in detail. As part of this review group could meet with the portfolio holder to look at the plans going forward in the light of the inspection.

- The review group did not take a general look at the local picture in respect of children's social care and children's safeguarding as their main focus had been on the Harrow SIT visit report. Perhaps taking time to consider the New Operating Model and local information in respect of performance and benchmarking data related to children's social care will also be useful for the review group. Considering the councils children's safeguarding policy may also help with the review groups deliberations.

- Aside from looking at the results of inspections, evidence provided by partners and officers in the council, are there another methods around quality assurance scrutiny and in particular the Children and Young People lead scrutiny members may want to use to substantiate evidence from professionals in the future?

- Besides the council and health partners, there are a number of other key relationships and partners involved in children's safeguarding. This includes the police and the voluntary and community sector, are the relationships and procedures for sharing information with these partners and the council robust and working well through the current groups and bodies available?

- What will be the implications of all the ongoing and imminent changes in the health environment in terms of children's safeguarding? Including Public Health coming into the council CCG's taking over the commissioning role from the PCT. During this time of change it will be vital that effective safeguarding is maintained.

- The review group could address the link with Adults services and the crucial transition stage from children's safeguarding to adults.

- The review group were also keen to know what is happening with the Multi Agency Safeguarding Hub as this wasn't mentioned during discussions around partnership relations.

- The review group also wanted to know what is happening with the golden number.

CONCLUSION

The first stage of the review has shown there is a clear commitment by all the organisations and officers the review group met with to safeguard children at risk in Harrow. One thing that is clear from what the review group has considered thus far is that children's safeguarding is not just the responsibility of one agency alone but for everyone, from Councillors as Corporate Parents to officers working in seemingly unrelated roles throughout the council.

There can never really be complete assurance that an unfortunate children's safeguarding incident will not take place in any given authority nationwide but knowing that the right policies, procedures and people are in place with thorough implementation and robust and regular monitoring systems in place will go some way to provide a level of re-assurance.

In order to form a comprehensive view on how things stand in Harrow, as mentioned in the introduction, the review group will be addressing the outcomes of the Ofsted inspection and in particular will be looking at the important social services aspect of children's safeguarding.

APPENDIX A

Safeguarding Children Improvement Team visit to the Harrow Health Community October 26-27th, 2010

1. Introduction: This report confirms the feedback given by the Safeguarding Children Improvement Team (SIT) at its visit to Harrow. This was the 26th 2-day visit undertaken by the SIT. This was not a regulatory inspection, but a peer review process aimed at supporting and improving safeguarding children in the NHS. The visit was hosted by NHS Harrow (NHSH) and included North West London Hospitals NHS Trust (NWL) --focussing on Northwick Park Hospital (NP)—Central NW London NHSFT (CNWL) which provides MH services in Harrow and other boroughs, and Ealing and Harrow Provider Services (E&HCHS) which provides community health. The London Borough of Harrow (LBH) participated, as did the LSCB.

2. We were most grateful to CNWL, and E&HCHS for their continued participation in this programme as we move round the boroughs they serve. We will focus on NWL as an organisation and visit Central Middlesex Hospital during our visit to Brent.

3. The focus was specifically on the NHS performance, in terms of improved services for children and improved assurance of good practice. Interface issues were, of course, discussed and we took soundings from social work and the LSCB. The programme began with a very well attended briefing meeting with senior managers from the four NHS bodies, and safeguarding colleagues, which helpfully set the scene. Interviews followed with managers from the health organisations, named and designated professionals, other clinical leads, the LSCB, and the Borough, including the Director of Children's Services. On the second day, visits were made to, or discussions held with NP A&E, paediatrics, community paediatrics and therapists, and midwifery; health visitors and school nurses; mental health; the hospital social care team; and GPs. The visit ended with a very well attended feedback meeting with managerial and clinical staff from the organisations.

4. The SIT is listed at the end of this report, and consisted of expert staff from five NHS organisations who have been nominated by their Trusts to provide peer review, plus the SIT chair (an LSCB chair and ex NHS CEO) and the SIT Project Manager. The team members' views are given in a professional capacity rather than for their employing organisations. Our team members found the visit informative and will take back issues to consider in their own organisations.

5. This was a short visit, and so our feedback to you was in terms of our impressions and issues for discussion, rather than thoroughly evidenced findings or black and white conclusions. It focused on themes more than a detailed feedback by each separate organisation. The style was mainly to identify things for you to consider, rather than providing a menu of recommendations. This allows you to consider what is important (or even accurate) for you in light of our feedback. We hope that this report is written in a way that enables you to share its contents widely with appropriate health staff, and others if you find that helpful. This report mirrors the feedback on day 2, and therefore reflects the position you agreed to be a fair comment as to where you are on safeguarding. We hope that the process of the visit itself and the dialogue and reflection was as important as the formal feedback. It may also have been a useful rehearsal for any subsequent regulatory inspections had you not had your announced inspection first!

6. Our report is for you. The SHA will not send it to regulators such as the CQC, but you can do that if you wish.

7. We were very grateful for all the effort you put in to make our complex visit go smoothly. Please thank all the staff concerned.

8. Summary: Overall we found staff to be keen and committed to safeguarding, but we shared with you our view of risks around community nursing, and also some lack of clarity about how things happen in practice which needs exploring.

9. Plaudits: This list is just a flavour of some of the things we particularly liked. It is not meant to be a complete list. * means there is a rider in the report

   - Electronic flagging in the NP A&E and UCC
   - Work between mental health and social work on deliberate self harm
   - CNWL safeguarding strategy
   - NWL Safeguarding Policy*
   - A growing focus on safeguarding in NHSH
   - Professionalism of front line community nurses in the face of high workloads*
   - Some strong specialist nursing posts (eg LAC, Homeless Families, DV HV)
   - NHSH having an influential named GP (many PCTs find it hard to recruit one)
   - CNWL going beyond ‘think family’ to children associated with adult patients

10. How do things work in practice?: In the time available these were our impressions. We met many staff in nine separate meetings/visits on the morning of day 2. In overall terms we formed a positive view of your services.

11. North West London: We are focussing on the Trust overall at our Bent visit, and looked at NP this time.

12. *NP A&E/UCC/Paediatrics:* At the feedback we said that we found some examples of staff giving us differing answers when asked about procedure, or answers which did not always match policy. We leave this issue with you to consider, as in the time available we could not conclude if it reflected any actual uncertainties, or our questions being unclear, or staff needing to be a bit more fluent about the way things are done when faced with external looks. Our comments reflect no lack of interest in safeguarding. The UCC is E&HCHS led, and the A&E incorporates a separate children's area, the combined department being run by A&E

13. We were impressed by the electronic flagging in the UCC and A&E. Names from six local authority CP lists are included. A code is printed onto the cascard indicating which borough. Coverage by paediatric doctors in A&E is good. The UCC uses GPs. We were told GPs are asked about safeguarding training, and that most can produce some certificate of training, but not all.

14. At the UCC and A&E we asked about the rules about which doctor would see children in which situation, and neither could identify any formal rules, although paediatrics later told us they see all under ones. An A&E consultant said that A&E doctors would be OK to see safeguarding cases, but paediatrics said they are always called for such cases. This may have been a misunderstanding, but check you are satisfied all is clear. We were told there were no decision making trees, but the pack you gave us contained one. (That said a registrar should see a safeguarding case without specifying if an A&E or paediatric SpR. It should be the latter).

15. We also thought some trigger questions could be built into your assessment paperwork, to guide when a referral to paediatrics should be made

16. Training of paediatric staff seemed to be appropriate, and we were told adult A&E staff had L2 training. However we met an adult A&E nurse working in the paediatric area who said he/she had not had any safeguarding training in 5 years since arrival. There are not enough paediatric nurses in post to have even one in the children's A&E 24/7. You must be sure that staff working in that area are appropriately trained, and L3 would be the best. NWL (with commissioners) should determine how satisfied they are with the number of paediatric nurses in A&E.

17. There is a p/t liaison health visitor (LHV) role, and all attendees' records are checked. However this cannot be done daily due to the p/t nature of the role. Also this A&E, unlike any we can recall from other visits) does not have a weekly psychosocial/ case review meeting that looks at all risky cases. In most places this is also a key meeting point between social work and health. (A&E say that they get insufficient feedback from social services after cases have been referred to them). NWL should review how robust is the post attendance checking, and

that multidisciplinary review is sufficient. LHV are commonly, and seem to work best when, full time.

18. A&E have been doing two good audits. One on cases that do not attend after booking in, and a second on referrals to fracture clinic. The next grand round will look at patterns of skeletal fracture in child abuse.

19. Staff said that GPs sometimes refer children for child protection medicals to A&E when there is no immediate need for A&E service, when community paediatric would be appropriate.

20. At the Paediatric Department, we met doctors and nurses. The nursing team came over strongly and the junior nurses were confident and fluent in discussing safeguarding work. The SpR has recently gained an acting named doctor post elsewhere, and one consultant we met is the named doctor in another Trust, so there is good knowledge within the department.

21. There is a weekly psychosocial meeting with good attendance other than social work, who are core attendees elsewhere. The senior social worker we met (in post only 2 months) said he was unaware of it and had not been asked, even though he attends the maternity and neonatal meetings. He seemed willing to see how this could be addressed. Paediatric staff thought they got a good initial response from social services but, like A&E, did not receive feedback later.

22. We asked about flagging in OPD and there was no clear picture, and the doctors had not had a case so flagged. Inquiries by NWL staff, after the meeting, showed that there *is* electronic flagging, but there has been no process to alert doctors. They will address this, and when completed you will have as good a flagging system as anywhere we go.

23. Training was an area where there seemed to be quite a lot of activity but it was hard for us to get a clear picture. Staff did not seem to be too clear on appropriate levels, and few were clear on compliance levels. One of our team said at feedback that at her trust there is a central system that logs everyone who needs safeguarding training and that all those who need it soon or are overdue are flagged to her (executive lead) level and monitored for completion. There was also uncertainty about just how mandatory training was for doctors. The NWL London training strategy we were shown says " the Trust expects staff to complete the appropriate level.. and that .. it should be included in appraisal processes. However the use of the word mandatory would be better as would sanctions. In some trusts, for example, doctors cannot get excellence awards, or get through annual appraisal, unless mandatory training is up to date.

24. *NP Community Paediatrics:* There were clear pathways for elective child protection medicals, and there is a rota (shared partially with inpatient

paediatricians) to ensure availability for those medicals. There is good senior availability to support staff and a useful child protection coordinator role.

25. Attendance at case conferences is rare but reports are sent. We suggest you make sure that doctors, especially junior or hard pressed staff, do not make decisions about not going to conferences alone as with some cases this could be a very significant decision.

26. They reported good relations with Harrow Social Services.

27. We met a number of therapists, and they came over well on child protection.

28. *Named Doctor:* The NWL named doctor has 1.5 sessions. We heard there are plans to increase this which is good, as two hospitals and community paediatrics is a significant area to cover. All named doctors are required under Working Together 2010 to be supervised professionally by a designated doctor, and this may not be happening

29. *NP Maternity:* The midwives are trained to L2. We think those who work alone, such as community midwives should have L3.

30. There are regular multiagency maternity and neonatal psychosocial meetings, well supported by Harrow social work but not Brent. We heard that Brent staff have raised confidentiality issues about cases not theirs or vice versa but our team did not think that should be an issue. Some places anyway divide meetings into borough segments.

31. There is a good plan for a band 7 mental health midwife. Pre birth processes are in place (although GP's we met said they would like to hear more between referral and birth).

32. With the increase in self bookings, it should be standard to ask mothers' permission to seek background health information form GPs, as having such information is vital to risk assessment.

33. Supervision is by election. We think that midwives working with families on their own should have mandatory 1-2-1 supervision, as they carry similar sometimes more risk that social workers/health visitors/school nurses who do almost everywhere.

34. Our visitors suggested you check staff are clear on and use escalation processes when not getting what they need from partners.

35. Ealing and Harrow Community Health Services: Our feedback on the two nursing services below was a major part of our feedback, and we are asking that the relevant boards ensure they that they are fully briefed, assess the risks involved,

are satisfied that these are being managed now, and any necessary longer term action is taken. Any decisions not to change the status quo should be clearly recorded with reasons.

36. *School Nursing:* You have three (maybe 3.2) wte school nurses (SNs) at present. We were told during the visit there are now over 160 school age children with CP Plans. If correct, that is over 50 per school nurse. Earlier this month the SNs wrote formally to the designated nurse expressing extreme concern about the position. It was not clear to us how much the PCT or EHT board knows about this letter. We think the boards should see it. The risks here are high as the nurses can only do the most critical of work, and although they seemed to us a robust group, the pressure they are under must get to them .Their letter describes themselves as 'stressed and vulnerable'. It describes all the things they cannot do, and there must be long term and immediate risks in this. Delays eg in being able to check MERLINs (or A&E summaries) do not sit well alongside the MERLIN SUI.

37. There are two vacancies, frozen along with other E&HCHS posts. The manager responsible for the service has an adult rather than children's background and needs support to judge how to weigh up concerns raised on community nursing capacity , and how that relates to corporate decisions about financial rigour. We saw no indication that the crisis in school nursing had been discussed at board level.

38. In the NHS Harrow policy, child protection supervision of SNs on a group basis is to be twice termly. This does not appear to be happening to that level. You should also consider 1-2-1 supervision, especially as individuals are so stretched.

39. *Health Visiting:* You told us that the average caseload for HVs is 709. We heard that some HVs might have over 1000. Whilst HVs seemed to be a strong group despite workloads, caseloads are towards the highest we have seen, but there was no indication in our advance briefing material, of health visiting being considered a special issue. There was reference to capacity issues but no recognition of this being of any special note. Indeed when asked in advance what we should focus on the statement agreed for our team preparation was that 'there were no current capacity issues in health visiting', although there might be after the merger. This may suggest a lack of realisation of how risky is the situation.

40. While you do have a schedule of priority to guide HVs when stretched, and we were told you had identified a 25% shortfall through the use of a particular tool, there does not seem to be ' a plan' to improve capacity, or a formal board level decision not to. Other places we have been to at least have a plan in place.

41. As with SNs we could not see that HV capacity has been an issue for boards.

42. Under your policy HVs should receive two 2 1-2-1 child protection and two group sessions a year. This is probably not happening as specified. Most areas we have visited have 3 monthly 1-2-1 supervision.

43. There is link health visitor for GP practices, but it is clear that how they fulfil this role varies considerably. You should specify what you expect of the link role, and work with GPs on their part of the arrangement.

44. *Our thoughts:* We were asked by a director at the feedback session about the level of risk/danger. All we can say is that staff concern is high, workloads are high, work not being done must be building risks, and the pressures on staff will take a toll. It is for your board/s to determine how big the concern should be and whether all appropriate steps are in place to manage the situation. We did recommend that you had an external look at the risks and how they might be handled, and you can consult the SHA's Strategic Safeguarding Adviser Briony Ladbury.

45. The impression we picked up was that there have been concerns about community nursing capacity for some time, and that staff have frustration about the level of response. We were not with you long enough to form a view on this, but the SN letter must indicate something about this. Secondly, there needs to be a process so that (if agreed) there can be exceptions to savings rules where safety is an issue.

46. We think there is a risk of there being some lack of clarity on where ultimate decisions are made. The PCT is commissioner and also legally responsible for Harrow Community Health, whilst EHT will take the Ealing and Harrow services formally next year and currently host them. Line management of Harrow community nurses runs up through EHT. There is then the potential for the concerns about community nursing to fall between two boards, one of which is also commissioner.

47. Our recommendations are in para 34 above.

48. *Mental Health:* We have commented on CNWL on previous visits, so make few comments this time. There are three mentions in 'plaudits' above. We say again that the practice of the named nurse meeting with the CEO is one we would like others to follow. The Trust safeguarding strategy is good. We could not see training percentage compliance in board papers.

49. At our first briefing an issue arose about the CNWL role in the perinatal service. The Trust asst director of operations told the feedback meeting this would be sorted.

50. Whilst the CAMHS staff we met reported generally good relations with social work, they did feel that some important cases were not accepted by social work. It would be worth checking how much of an issue this is and whether escalation processes were used.

51. CAMHS also said they were surprised to get no referrals from HVs/SNs, although at feedback community nurse managers were surprised to hear that.

52. *General Practice:* We met one practice and the named GP (who was well thought of by GPs and others). This practice had good flagging in place. It is likely that this is far from universal. Some PCTs (eg Lewisham) have a GP Safeguarding Policy which sets out expectations and has been agreed with GPs.

53. This would include setting out the role of lead GP in practices. Even in the good practice we visited, the ownership of the role was far from clear. The practice relationship with community nurses (see 43 above) should also be set out.

54. GPs would like whole practice training, ands this has been achieved by some other PCTs. The GPs were unclear if safeguarding was or was not in their appraisal.

55. Organisational Issues:

56. *Supervision:* At the feedback we left you with some key messages, as we thought practice could be improved

- Be sure CP cases are supervised not just the worker
- Child protection supervisors must be properly trained
- Make sure it happens
- Report compliance levels to boards

57. *Training:* Compared to most places we have been:

- Staff were less fluent on levels required and eligibility
- Were less au fait with training compliance levels
- Were less clear on 'mandatory-ness'

58. *Commissioning:* You have a safeguarding commissioning committee. Some places have provider leaders too, so it can be used both to determine what is commissioned but also to close the loop on performance against requirements.

59. In this ever changing commissioning world it is important to be sure safeguarding duties do not get lost. We have seen here and elsewhere for example that acute commissioners at sector level have little to no knowledge of safeguarding performance in their acute trusts, nor does safeguarding seem to be something monitored by them.

60. Some places (Lewisham , and K&C/Westminster) have a safeguarding commissioning policy

61. *Designated and Named Professionals (DPs and NPs)*: We have three key messages.

- Support and develop DPs in their role as their 'home' might change from PCT to sector to maybe GP consortia or local authority based public health
- Ensure NPs have enough time to do the job and are robust as they are likely to need to be more independent of DP support as the DPs face much change
- Chart out the supervision arrangements between DPs and all NPs to ensure there is a comprehensive system in place, including for example expectations of frequency of formal meetings.

62. *Mergers:* For the PCT our thoughts were in 59 above. For the CHS and EHT our suggestion is that the new enlarged trust should have one named nurse and doctor so there is a clear focus of advice and consistent processes, but with supporting safeguarding experts to cover borough based issues.

63. *Culture:* Our feedback expressed concern about some staffing issues, although that level of concern did not appear corporately in our briefings, even though there is a lot of front line concern. Is there anything that can be learned from this about local processes?

64. Governance: This section looks at the collection and use of evidence, and covers how boards can be assured of good safeguarding. NHS London has issued guidance on this: ("Guidance for PCT Commissioners to strengthen assurance framework for safeguarding children") which is being revised. Your board reports across the health community are good narratively but they contain very little measurement of success. This section discusses this, and make some suggestions.

65. *Boards and Assurance*: All NHS boards should have specific training on safeguarding so they can knowledgably interrogate the increasing reporting on safeguarding as assurance processes develop. (NWL trained their board to L2 this year). We discussed with you how, over recent years, boards have found ways to be assured on infection control. This has been by moving away from exception reporting to receiving comprehensive detail that can assure them that the service is good in practice (eg cleaning reports, compliance with antibiotic policies and high impact interventions etc). Thinking of how well this has worked across the NHS will help your thinking on safeguarding assurance. Boards need to be able to answer the question, "How do we know things are OK". LSCBs play a part in this but they need to be sure that local organisations have their own assurance arrangements.

66. There are decisions to be made about the degree of detail that goes to Boards and that which is seen at committee level. Our view is that Boards need to decide on the minimum assurance detail they need to see at the Board, to demonstrate that they are indeed being positively assured about service quality. There also needs to be coordination of key report areas to boards so both Trusts and the commissioning PCT (or successor body) get what they need to be assured.

67. Each of your organisations should have a safeguarding audit schedule, setting out what you require to be audited, by whom, at what frequency, who sees the results and who is responsible for remedial action. This will ensure you get the right information to feed the assurance process. Epsom St Helier has a good one.

68. The following areas should be prominent in board assurance (as adapted for your particular organisation)
    - Vacancy rates in key clinical groups.
    - Caseload numbers for midwives and health visitors.
    - Attendance at case conferences by key health staff.
    - Invitations to case conferences, and % attendance
    - Achievement of L1-3 training—as % of target.
    - Supervision arrangements in place and compliance
    - SCR updates
    - % completion of the child screen in adult mental health cases

69. The Haringey pilot on safeguarding metrics aimed at increasingly measuring quality is, inter alia, measuring
    - % compliance with case notes standards by discipline
    - % compliance with quality required in case conference reports;
    - % all flagged health visitor and school nurse cases being subject to supervision in required timescales;
    - % health visitor cases being seen at required frequencies
    - % new birth visits achieved within target

70. Haringey may have had special challenges, but we expect there to be a raised expectation on board assurance everywhere. Agreeing a shared package of measures that gets as close to quality as possible would be helpful. In other words measuring the quality of, rather than the existence of, safeguarding activity.

71. It is also important that governance committees and boards receiving assurance material such as this are provided with a narrative on its meaning, so that results are put in context and boards can see easily what is really important.

72. <u>Key areas for thought/action:</u> (in no order)

- The need for assurance around compliance with policies
- Consider an external review around staffing and risk in community nursing. NHSH and EHT to work together on a board view.
- Safeguarding safeguarding through white paper and provider changes
- Supervision and training: following policy, more 1-2-1 and mandatory, greater clarity on training levels---and auditing it

40. What Now?: We would be grateful if NHSH on behalf of the Harrow Health Community sends a joint response to this report to vicky.scott@london.nhs.uk , with a copy to alan.bedford@london.nhs.uk , identifying any actions you have decided to take. This is essentially a development programme but your NHS London performance link will monitor progress in a light touch way, as the SIT moves on to other areas. Please send the note within 4 weeks of receipt. (An update on the nursing issue in advance of the collective response would be helpful). Thank you again for your enthusiastic involvement with the visit.

Alan Bedford, SIT Chair. Director, Safeguarding Improvement, NHS London, and Brighton and Hove LSCB Chair
Dr David Elliman, Designated doctor, NHS Haringey
Pauline Fonteriz, Head of Nursing, Women's and Children's Directorate Epsom St Helier University Hospitals NHS Trust
Shan Jones, Director of Quality Improvement/ Director Lead for Safeguarding Children and Adults, West Middlesex University Hospital NHS Trust
Mary Mason, Designated Nurse NHS Southwark
Alison Rogers, Joint Commissioner, CYP Services, NHS Bexley/LB Bexley
Maggie Rogers, Assistant to Chief Nurse (safeguarding) and ex Trust chief nurse

29.10.10 v2

APPENDIX B

HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE

APRIL 2012

SAFEGUARDING CHILDREN - SCOPE

1	**SUBJECT**	Safeguarding Children Review
2	**COMMITTEE**	Health and Social Care Scrutiny Sub-Committee
3	**REVIEW GROUP**	**Councillors:** Councillor Christine Bednell (Chairman) Councillor Ann Gate Councillor Krishna James Councillor Vina Mithani Councillor Paul Osborn
4	**AIMS/ OBJECTIVES/ OUTCOMES**	▪ To assess how much progress has been in the borough in terms of ensuring robust safeguarding children arrangements since the NHS London Safeguarding Children Improvement Team (SIT) visit in 2010. ▪ To review and assess progress against action plans developed to address some of the recommendations arising from the review. ▪ To ensure some of the key issues highlighted by NHS London's review that has a major impact on practice such as clarity on organisational policies and procedures, staffing and workforce issues, training and development, supervision are being adequately addressed. ▪ To gain an understanding of the role of key individuals and organisations involved in monitoring and ensuring robust and effective safeguarding arrangements in the borough. ▪ To ensure organisations in the borough are working effectively in partnership to safeguard children in Harrow. ▪ To identify and address any gaps in services provision that may hinder the effectiveness of children's safeguarding arrangements. ▪ To consider what else could be done to ensure that the safeguarding needs of children in Harrow are met through the identification of good practice.

5	**MEASURES OF SUCCESS OF REVIEW**	▪ To gain clarity and understanding of the various organisations, individuals, policies and arrangements in place to support safeguarding children arrangements as highlighted in the SIT team visit ▪ To identify any obstacles to effective safeguarding, and to make recommendations for action as appropriate ▪ To engage successfully and openly with internal colleagues and partner organisations ▪ To reach an overall conclusion on whether the Council and its partners are doing/ have plans in place to ensure everything they reasonably can do to prevent any serious incidents in the borough is being done. ▪ Development of realistic and constructive recommendations to support successful multi-agency partnership working to deliver robust, safe and effective services. ▪ That any outstanding issues are closed and resolved to mutual satisfaction
6	**SCOPE**	The scope of the review will focus on the progress of the recommendations and the follow up and developments since the NHS London Safeguarding Improvement Team visit to the Harrow Health Community in October 2010. The overall objective is to review whether partners arrangements in place provide reasonable assurance and confidence that children at risk of significant harm in Harrow are suitably safeguarded. The exact focus of the review will be refined following the first meeting/ correspondence with partners and consultation and discussion amongst the review group.
7	**SERVICE PRIORITIES (Corporate/Dept)**	This review relates to the following Corporate Priorities 2011/12: ▪ United and involved communities: a council that listens and leads ▪ Supporting and protecting people who are most in need

8	**REVIEW SPONSOR**	Catherine Doran, Corporate Director Children's Services
9	**ACCOUNTABLE MANAGER**	Lynne Margetts, Service Manager Scrutiny
10	**SUPPORT OFFICER**	Fola Irikefe, Scrutiny Officer
11	**ADMINISTRATIVE SUPPORT**	Scrutiny Team
12	**EXTERNAL INPUT**	The input of the following may be gauged through the course of the review: **Stakeholders:** ▪ Staff involved in the delivery of safeguarding children's services in the health sector and also the local authority ▪ Relevant corporate director(s) ▪ Relevant portfolio holder(s) ▪ Harrow Local Children's Safeguarding Board ▪ Residents and members of the public ▪ Staff within other children's settings e.g. children's centres, youth centres **Partner agencies:** ▪ NHS Harrow ▪ North West London Hospitals Trust ▪ Central North West London Mental Heath Trust ▪ Integrated Care Organisation ▪ Clinical Commissioning Group ▪ GP's ▪ Compass ▪ Schools and Academies ▪ Harrow Police ▪ Interest groups (including residents groups, disability groups, business groups etc) **Experts/advisers:** ▪ Representative interest groups ▪ Care Quality Commission ▪ Centre for Public Scrutiny ▪ Academic experts ▪ Public policy think tanks
13	**METHODOLOGY**	The review could gather evidence using a range of methods including written evidence, oral evidence,

		research, focus groups, presentations, evidence from key officers and managers (both internal and external), inspections, site visits, expert witnesses, public meetings etc. The review will be a light touch review taking evidence at a few meetings. Suggested stages for the review are: ▪ Identify current policies/practices through initial briefings ▪ Identify current position in terms of the implementation of policies and practices and action plans arising from NHS London's review. ▪ Examine how performance and implementation matches policies ▪ Identify issues arising and what gaps need to be met ▪ Determine how to support the development of constructive policies and procedures.
14	**EQUALITY IMPLICATIONS**	The review will consider during the course of its work, how equality implications have been taken into account in current policy and practice and consider the possible implications of any changes it recommends. In carrying out the review, the review group will also need to consider its own practices and how it can facilitate relevant stakeholders in the borough to have their voices heard.
15	**ASSUMPTIONS/ CONSTRAINTS**	Success will depend upon the ability and willingness of officers, partners and stakeholders (as relevant) to participate and contribute fully in this review.
16	**SECTION 17 IMPLICATIONS**	The review will have regard to the possible community safety implications of any recommended changes to policy or practice.
17	**TIMESCALE**	▪ Scoping – February 2012 ▪ Initial desktop research – February/ March 2012 ▪ Evidence gathering and review group meeting/s – March 2012 onwards ▪ Final report to O&S for onward transfer to Cabinet – to be confirmed

18	**RESOURCE COMMITMENTS**	To be met from existing scrutiny budget. No significant additional expenditure is anticipated.
19	**REPORT AUTHOR**	Fola Irikefe, as advised by the review group.
20	**REPORTING ARRANGEMENTS**	Outline of formal reporting process: To Corporate Director [✔] throughout the course of the review and when developing recommendations To Portfolio Holder [✔] as a witness in the review and when developing recommendations To CSB [✔] to be confirmed To O&S [✔] May/ June 2012 To Cabinet [✔] to be confirmed
21	**FOLLOW UP ARRANGEMENTS (proposals)**	6 month review by the Performance and Finance Scrutiny sub-committee.

Contact: Fola Irikefe, Scrutiny Officer, fola.irikefe@harrow.gov.uk, 020 8420 9389.

APPENDIX C

NHS Harrow Review of Paediatric Contracts