Waltham Forest, East London and the City Child Death Review Transformation Plan

Barts Health NHS Trust, Homerton University Hospital NHS Foundation Trust, NHS City and Hackney CCG, NHS Newham CCG, North East London Foundation Trust, NHS Tower Hamlets CCG, NHS Waltham Forest CCG

Waltham Forest, East London and the City (WELC) Child Death Review System Development

Transition Project: Child Death Review System Plan

1. Introduction

1.1 National context

The *Children and Social Work Act (2017)*, *Working Together: transitional guidance (2018)* and the subsequent *Child Death Review Statutory and Operational Guidance (updated January 2019)*[1] (the national Guidance)set out how local authorities and clinical commissioning groups (CCGs) are required to come together as Child Death Review (CDR) Partners. Under the new legislation they must make arrangements for the review of every death of a child normally resident in the local authority area. The purpose of child death reviews is to identify and act on learning at local and national level that could prevent future deaths.

The national Guidance aims to standardise outputs from child death reviews as much as possible by setting out key features of a robust child death review process. This includes formal collaboration between CDR Partners to ensure that child death reviews will be undertaken at greater scale. The CDR systems are required to encompass operational footprints with a minimum case review level of 60 cases per annum. The Guidance sets out standardised approaches to key elements in the CDR process, such as:

- immediate decision making and notifications
- investigating and information gathering
- the child death review meeting (CDRM)
- the child death overview panel (CDOP)
- family engagement and bereavement support.

The nationally set timelines for transition to the new arrangements are:

- all CDR Partners are required to publish details of their new arrangements by 29 June 2019; and
- the new CDR arrangements must be in place by 29 September 2019.

1.2 Local context

Under the old arrangements there were seven CDOPs in North East London delivering CDR functions and none of these had the required level of cases or footprint required by the new legislation. Accordingly Barking and Dagenham, Havering and Redbridge (BHR) are proceeding to one CDR System; and formal agreement was reached earlier this year for a single CDR System across the Waltham Forest, East London and the City (WELC) footprint. This move to working at scale has been broadly welcomed because, in addition to improving themed learning to prevent child deaths, a CDR System across the WELC footprint offers an opportunity to achieve greater consistency, peer learning, streamlining of processes and better ways of working for all staff involved in these processes

A WELC CDR System Transition Group comprising CCG and local authority representatives (see appendix A for membership) has been charged with seeking views from their respective organisations on how we should develop new CDR arrangements. The Group has been working closely with an independent consultant, Christine Christie, from Chanon Consulting, to develop this CDR System

[1] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

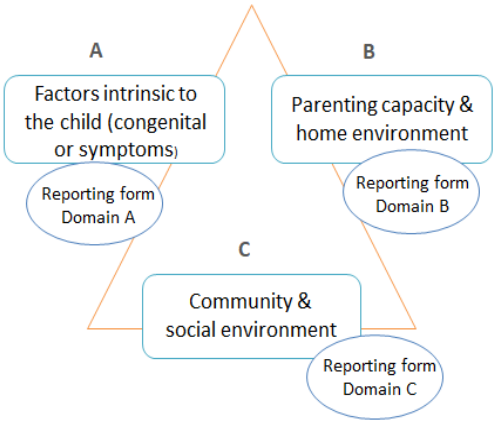
Plan. The Plan outlines an agreed approach to be confirmed by each CCG Board and LSCB to enable Partners to publish their arrangements by the required deadline.

2. Project aims and principles

2.1 Project aims

The death of a child is a devastating event for the child's parents/carers, siblings, friends and peer group. It is important that we have robust support and review systems in place to understand why a child death has occurred and provide appropriate support to the bereaved. Equally, as a public health initiative, the national CDR programme seeks to protect and improve the nation's health and wellbeing and reduce inequalities, by drawing learning from individual cases to prevent child deaths where possible. This means collecting data on the 'whole' child, as described in Diagram 1:

Diagram 1



How we do this matters – standardisation makes the process most efficient; and quality assurance gives the process value and demonstrates respect for the child and their family. There is a recognition too, that families need real time information and some need longer term bereavement support. The Plan proposed in this paper sets out how we:

- support bereaved families
- collect and analyse data on all three domains, at every step
- standardise our data collection, analysis and output
- contribute to local, regional and national initiatives to improve learning from CDRs
- within timelines, efficiently and effectively.

2.2 Project principles

The principles followed in developing the Plan included, that it:

a) Complies with all the requirements outlined in *Working Together* and *Child Death Review; Statutory and Operational Guidance (England) (Updated January 2019).* And with children's safeguarding procedures flowing from *Working Together*[2] and the *London Child Protection Procedures*[3].

[2] *Working Together to Safeguard Children: Statutory guidance on inter-agency working to safeguard and promote the welfare of children (2018)*, DfE; https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[3] *London Child Protection Procedures* (2017), London Councils; https://www.londoncp.co.uk/

b) Links appropriately with relevant national processes e.g. NCMD[4]; the SUDI/C Guidelines[5] and the Learning Disabilities Mortality Review (LeDeR) Programme[6].

c) Facilitates working with other agencies such as the London Ambulance Service, The Police, Trauma systems, Hospices and voluntary sector child bereavement services.

d) Commits to embedding collaborative working with NHS Service providers.

e) Is cost neutral in relation to existing child death review arrangements.

f) Promotes a Public health focus on reducing health inequalities.

g) Provides resilience and staff wellbeing in light of the fact that they will be dealing with child death all day every day.

h) Facilitates the delivery of individualised child death output information to each WELC CDR Partner.

3. Proposed Model

3.1 Process

Following agreement on the structure of the WELC CDR System, a Standard Operating Procedure will be developed in discussion with a WELC CDR Practice Reference Group. The Procedure will combine compliance with the Child Death Review; Statutory and Operational Guidance (England), and tailoring to complement the structure and take into account any local needs.

The WELC CDR System outlined in this document is designed to manage the process from the moment of a child's death to the completion of the review by the child death overview panel (CDOP). This includes the key elements highlighted in the Guidance: immediate actions after a death; local review by those who interacted with the child during life, and were involved in the post-death investigation; the CDOP and activity related to sharing learning and reporting progress in implementing improvements.

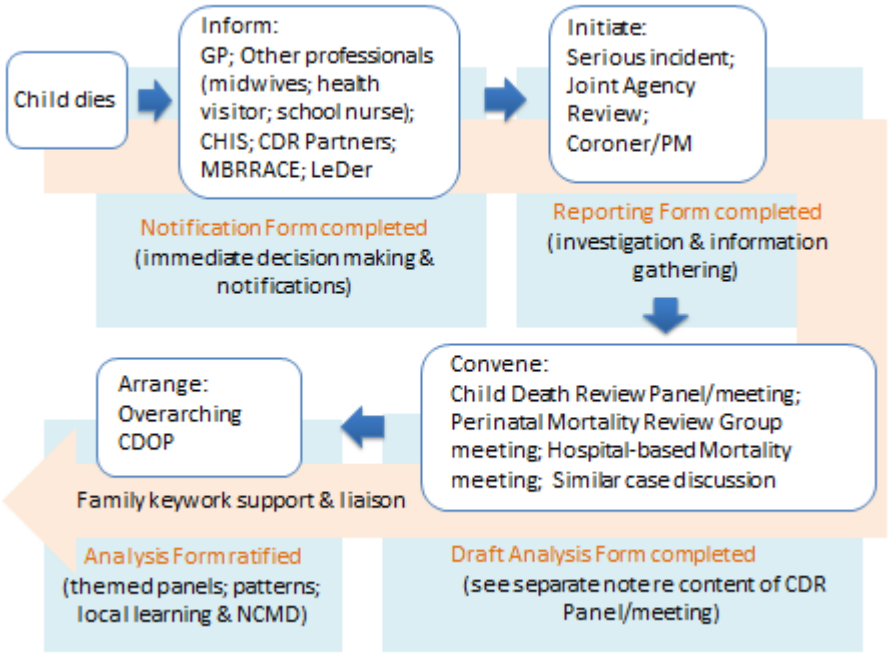
Diagram 2 presents an overview of the CDR System process:

[4] The National Child Mortality Database: https://www.hqip.org.uk/clinical-outcome-review-programmes/national-child-mortality-database/#.XQt66EpFz4g

[5] *Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation:* https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/sudden-unexpected-death-in-infancy-and-childhood-2e.pdf

[6] *Guidance for the conduct of local reviews of the deaths of people with learning disabilities: https://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance%20for%20the%20conduct%20of%20reviews%20%20FINALv2.2.pdf*

Diagram 2



CHIS– Child Health Information System

MBRRACE – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

PM – post mortem

CDOP – child death overview panel

Child Death Review Panel/meeting

Multi-agency discussion of the child's death by professionals directly involved with the child's life and death.

Key worker presents parents queries and views and reports back to them.

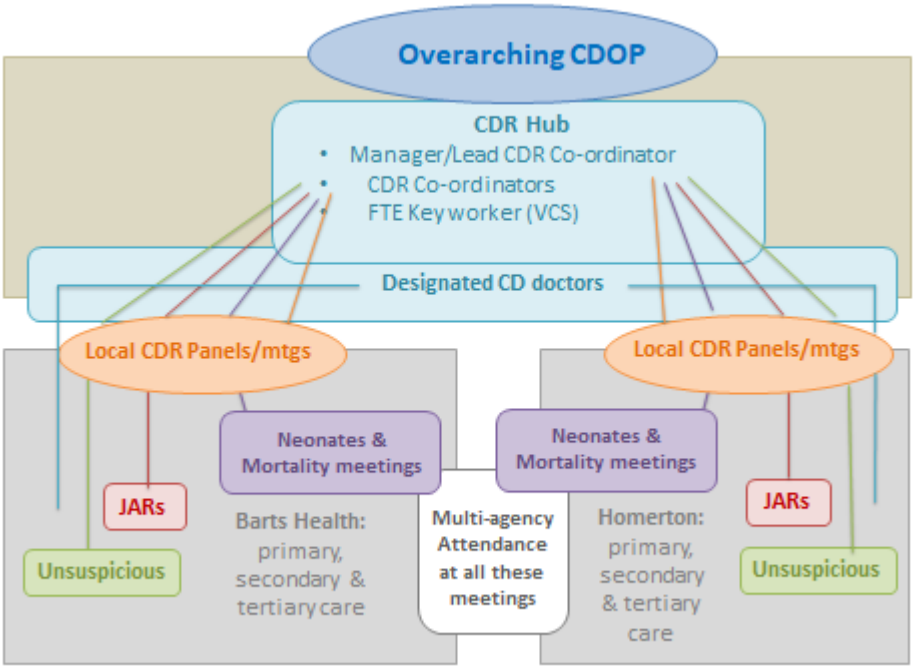
Aims to:

- review history, investigations, treatment, cause of death
- ascertain any contributory or modifiable factors in the child, the environment or service delivery
- describe learning and identify actions to improve child safety & welfare
- review support for family and staff
- inform the coroner
- complete draft Analysis Form to go to Overarching CDOP.

3.2 Structure

The WELC CDR System Model is underpinned by an exercise in which the consultant met with the relevant partners and staff involved in the CDR process across the footprint; to map existing systems, resources and assets, understand critical points of contact, information sharing and reporting/learning; to scope bereavement offers in place; and to consult on a sustainable model for the delivery of the keyworker function. Options generated from this have been subject to analysis of the strengths, internal challenges, opportunities and external challenges related to each option (SCOC Analysis); and considered by the Transition Group. Diagram 3 presents the WELC CDR System structure:

Diagram 3



KEY

Lead responsibility for action shown by:

CDR Hub team supporting Designated Dr for Child Deaths

CDOP – Child Death Overview Panel

CDR Panels/mtgs – Child Death Review Panels/meetings

JAR – Joint Agency Review

Unsuspicious –the death of a child which was anticipated

Organisational positioning

The Model is rooted in the need for multi-agency working to achieve good quality data gathering and analysis for all three domains in Diagram 1. The Model recognises that the immediate response and review of child deaths is largely located within the NHS Service providers (the grey areas in Diagram 2) – both within and outside of the WELC footprint; and in primary, secondary and tertiary care settings. In general terms, this brings an important health focus (Domain A, in Diagram 1), which will be most effectively balanced by contextual information (Domains B & C, in Diagram 1) from the local authorities and other partners (the brown area in Diagram 3). Notwithstanding this, the CDR Hub staff are likely to spend a significant amount of time in the Acute providers working closely with families and clinicians.

Overarching CDOP

The purpose of a CDOP is to enable effective thematic learning from reviews. The multi-agency Overarching CDOP would receive anonymised cases from the CDR panels/meetings and analyse common themes and trends across the Local Areas. In accordance with the Guidance the CDOP will be chaired by someone independent of the key providers in the footprint. Attendance would be delegated from each of the Local Areas, to include: Designated Doctor for Child Death and Designated Doctor or Nurse for Safeguarding, Acute Paediatrician or Safeguarding Lead, JAR/Neonates Lead, Bereavement Lead, Public Health Lead, Police Lead, Coroner Lead, Social Care Lead, Patient and Lay Representatives. Panel membership will include representatives from the London Ambulance Service, Hospice Primary Care and Housing where relevant.

As part of the process, the Overarching CDOP will examine, potentially adjust, and ratify the Analysis for each case. The cases and the learning will then be fed into the National Child Mortality Database (NCMD) by the CDR Hub team as part of its administrative support to the CDOP.

CDR Hub Co-ordinators

The CDR Hub is critical to the effectiveness and efficiency of the Model. The intention is to employ staff with practice knowledge (to understand the cases and what is needed); relationship skills (to ensure information flow); and strong administrative abilities (to make the system work). In summary, the Hub staff will receive notification of the death, record the case on eCDOP, arrange and attend the CDR panels/meetings, and and track each case till closure after the Overarching CDOP; co-ordinating keyworking for the family and LeDeR and other processes, in parallel.

In addition to tracking and chasing the cases to ensure no drift and good quality information; the Hub Co-ordinators (Lead Co-ordinator and other three) will, together with the Designated Doctors, arrange the JARs (Joint Agency Response) and neonates & mortality meetings CDR panels/meetings, attend them and follow up the outputs i.e. do all the CDR administration.

The Hub Co-ordinators will work as a team across the whole WELC footprint. Within that, each will be allocated a local area in relation to ensuring that the Domain B & C information (from Diagram 1) comes into the various child review meetings. This will involve developing a network of contacts in the local authority and local area to access information about a child when needed (all reporting forms to be complete before the CDR panels/meetings).

The Hub team will have responsibility to ensure that the voice of the bereaved is captured and fed into the CDR process. The team will also ensure that families are kept updated in a timely way throughout the CDR process and are informed about the outcome from the Overarching CDOP. This will include linking with complaints/litigation as appropriate. The LeDeR process will be completed alongside the CDR process. Keywork activity will need to be tailored to individual families, the Hub Co-ordinators will oversee this in each Local Area.

This is all support to the NHS Service providers, as well as the local authority and CCG commissioners. It also integrates the local authority and health partners in the CDR System, so that there is no part which is not engaged with another – improving efficiency and ensuring transparency. The integration will need to include the different local authority departments and tiers in Health (i.e. primary, secondary and tertiary care), as well as contracted services.

As well as providing Trust-specific information to the Health Trusts, each CDR Hub Co-ordinator will provide their allocated Local Area with Area-specific information when needed e.g. for HWBB, CQRM function, Safeguarding Partnerships. The CDR System will be linked to local Safeguarding Partnerships and will work collaboratively with them to ensure that children's safeguarding procedures flowing from *Working Together*[7] and the *London Child Protection Procedures*[8] are adhered to. The CDR Hub team will provide full administrative support to the overarching CDOP. They will negotiate with eCDOP for improvements, draft the annual WELC CDR report and feed the NCMD.

Finally a team of four allows the CDR Hub Co-ordinators to attend the CDR panels/meetings and other child death related meetings; and it provides resilience and staff wellbeing in light of the fact that they will be dealing with child death all day every day.

CDR Hub keyworker

The Model includes a voluntary sector services keyworker in the CDR Hub. This is in line with Local Government Association[9] and NHS England thinking[10] that collaboration between the voluntary

[7] *Working Together to Safeguard Children: Statutory guidance on inter-agency working to safeguard and promote the welfare of children (2018)*, DfE; https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[8] *London Child Protection Procedures* (2017), London Councils; https://www.londoncp.co.uk/

[9] https://www.local.gov.uk/search/all/voluntary%2Bsector

[10] https://www.england.nhs.uk/integratedcare/resources/voluntary-sector-partnerships/

sector, local government and the NHS is crucial to improving care for people and communities. The keyworker would be seconded by a child bereavement voluntary sector organisation to work alongside the Health service staff and the Hub Co-ordinators to provide a seamless liaison service and transfer of families to longer term bereavement support. From a service user perspective this will avoid being sign-posted to another agency, because the transfer would be to the keyworker's colleagues within the voluntary sector child bereavement organisation.

CDR Panels/meetings, JARs (Joint Agency Response) and Neonates & Mortality meetings

The CDR panels will review a number of children at a time, with the practitioners relevant to each child attending for the child they were involved with. A Hub Co-ordinator will assist the relevant Designated Doctor for Child Deaths to plan and manage all the child death panels/review meetings. As with all the CDR meetings, the panels will be flexible and proportionate, and focused on local learning[11]. The four key benefits of managing child death review meetings in this way are that the:

a) Local Area and Trust staff are able to see potential local themes (which would otherwise only be visible at footprint level by the Overarching CDOP

b) Hub Co-ordinator will be in a position to:

- be able to support the Designated Doctor for Child Deaths
- support quality assurance at the CDR level
- improve Area-Hub networking through face-to-face contact and counterbalance a tendency for centralised teams to become detached from practice on the ground
- gather and retain the essence of the child's experience, which can easily be lost in the process of anonymisation for the Overarching CDOP.

The CDR panel/meeting will 'note', rather than review the deaths which are reviewed in the form of a final case discussion following a JAR, a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, a hospital-based mortality meeting following the death of a child in a paediatric intensive care unit (respectively, 'neonates and mortality meetings') or similar case discussion[12]. These child death review meetings will be held in the location where the child died or received most treatment. However, the CDR panels/meetings (which are likely largely to be reviewing deaths of children which were anticipated or which happened outside of the WELC footprint) will need to be held at carefully chosen local venues.

Whole or staged approach

The Model is a starting point in that it illustrates at cautious approach of merging the CDR activity only at the level of the Overarching CDOP and the CDR Hub. Merging services at the level of CDR panels/meetings and Neonates and Mortality meetings, where possible, would be good. Currently two Areas do this.

4. Model elements still for consideration

There remain several areas within this CDR System Model for which the detail still needs to be worked up and agreed between the CDR Partners and the NHS provider services. These include:

a) Funding, in terms of agreed overall cost, contributions and which agency will manage the budget

[11] CDR Statutory & Operational Guidance (England), DHSC, 2018. Para 4.1.3.
[12] CDR Statutory & Operational Guidance (England), DHSC, 2019. Para 4.1.2.

b) Related to budget-holding will be which agency will employ the CDR Hub team. Staff affected by this change will need to go through an HR consultation process

c) Location of the Hub team; preferably centrally as the team will be travelling regularly across the footprint

d) Setting up a collaborative arrangement with a voluntary sector child bereavement organisation in relation to the Keyworker

e) Development of a WELC CDR Practice Reference Group to develop the WELC CDR System Standard Operating Procedure; and a set of outcomes and KPIs to support delivery of the agreed outcomes

f) Managing the eCDOP contract on behalf of the WELC CDR System.

The consultant will support implementation by drafting the WELC CDR System Standard Operating Procedures; and developing the underpinning Governance, Memorandums of Understanding, and Data Sharing Agreements.

5. Project risk assessment

There are risks related to the very tight timescales for this Project, both in terms of initial sign of – by 29 June 2019; and in relation to implementation – by 29 September 2019. These are set out in Table 2 Risk assessment:

Risk	Impact	Likelihood	Counter-measures
Decision-making on the Model (on the Hub location) is not timely	high	medium	a) senior management is sighted on the requirements for initial sign-off and implementation. b) for initial sign-off – there is enough information to make a good overarching decision. c) for implementation the Model is clear and detailed. d) the need for refinement post-implementation is recognised.
Incomplete 'buy-in' from staff	high	low	a) visible strong leadership across WELC; and clear messaging that collaboration is a priority, can make the difference to whether implementation is successful.
Financial risk - no additional funding from central govt; but increased activity (keyworking/bereavement offer) & cost (eCDOP)	high	medium	a) this is an 'invest-to-save', prevention service. An effective CDR System should result in fewer unexpected deaths and the related costs. b) up front commitment to embed a high quality service is most likely to produce efficiencies which allow for cost reduction in the future without losing quality in the new CDR System

6. Conclusion

Development of the WELC CDR System Model involved many meetings with CDR Partners and much discussion amongst staff at all levels. The expertise, goodwill and willingness to collaborate between Partners underpins confidence that successful implementation of a high quality WELC CDR System to timescale is eminently achievable.

Appendix 1

WELC CDR System Transition Group

Membership

Chetan Vyas, NHS Newham CCG (Chair)
Reagender Kang, NHS Newham CCG
Jason Strelitz, LB Newham
Sandra Moore, NHS Tower Hamlets CCG
Daniel Devitt, Tower Hamlets GP Care Group CIC
Katie Cole, LB Tower Hamlets
Lynn Torpey, NHS Tower Hamlets CCG
Susan Liebeschuetz, Barts Health NHS Trust
Nicola Needham, LB Newham
Clare Hughes, Barts Health NHS Trust
Bella Lowen, LB Waltham Forest
Korkor Ceasar, NHS Waltham Forest CCG
Suzanne Elwick, LB Waltham Forest
Carla Stephen, Homerton University Hospital NHS Foundation Trust
Mary Lee, NHS City and Hackney CCG
George Howard, LB Hackney
Sue Milner, LB Hackney
Yeba Forbang, LB Hackney

Christine Christie, Consultant, 20 June 2019