NHS
North West London
Collaboration of
Clinical Commissioning Groups

Brent

Ealing
www.ealing.gov.uk

Harrow COUNCIL
LONDON

h&f
hammersmith & fulham

HILLINGDON
LONDON

London Borough
of Hounslow

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

City of Westminster

Please note this is subject to final partner endorsement.

North West London (NWL) Child Death Review Plans

Statement of Transition
June 2019

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1. Our Commitment

New Child Death Review (CDR) statutory guidance[1] was released in October 2018 outlining a set of requirements of The CDR Partners[2]. A North West London[3] (NWL) CDR project established in September 2018 by the 16 NWL CDR Partners has worked internally and with the Metropolitan Police, the Hospital Trusts who provide services in NWL and the three coroners' courts who have responsibility for investigating child deaths in NWL to agree a model that meets the requirements of the CDR guidance.

The NWL CDR partners accept that, although there are some good CDR working practices across NWL, CDR functions cannot continue as they are currently commissioned because they do not meet the requirements of the new CDR guidance.

The NWL partners are committed to meeting the requirements of the new guidance to ensure the following:

- Every child death will be subject to a Child Death Review Meeting (CDRM), a multi-agency meeting attended by professionals involved with the child's care during their life and other professionals responsible for investigating the child's death.
- All child deaths meeting the Joint Agency Response (JAR) criteria in NWL will have a prompt and coordinated response.
- All child deaths will be reviewed at a local CDOP meeting as a result of which organisational learning will be extracted and shared either locally or more widely.
- The collective analysis and review of NWL child deaths will lead to better understanding of trends and themes associated with child deaths across NWL.
- The 16 NWL partners will ensure that at least 60 deaths are reviewed each year.
- NWL partners will work with key stakeholders including hospital trusts, the Police, the Ambulance Service and the Coroner's Service to ensure an effective response to child deaths.
- Every family will be provided with a named keyworker who can support bereaved families throughout the CDR process.

The 16 NWL partners intend to deliver an operational and collaborative NWL approach to child deaths by 29th September 2019.

2. NWL Child Death Review Partners

The 16 CDR Partners comprise eight NWL Local Authorities (LA) and the eight NWL Clinical Commissioning Groups (CCG) that operate in the corresponding LA footprint (Figure 1). On average there are 154 deaths each year in this footprint. The majority of these cases will be

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

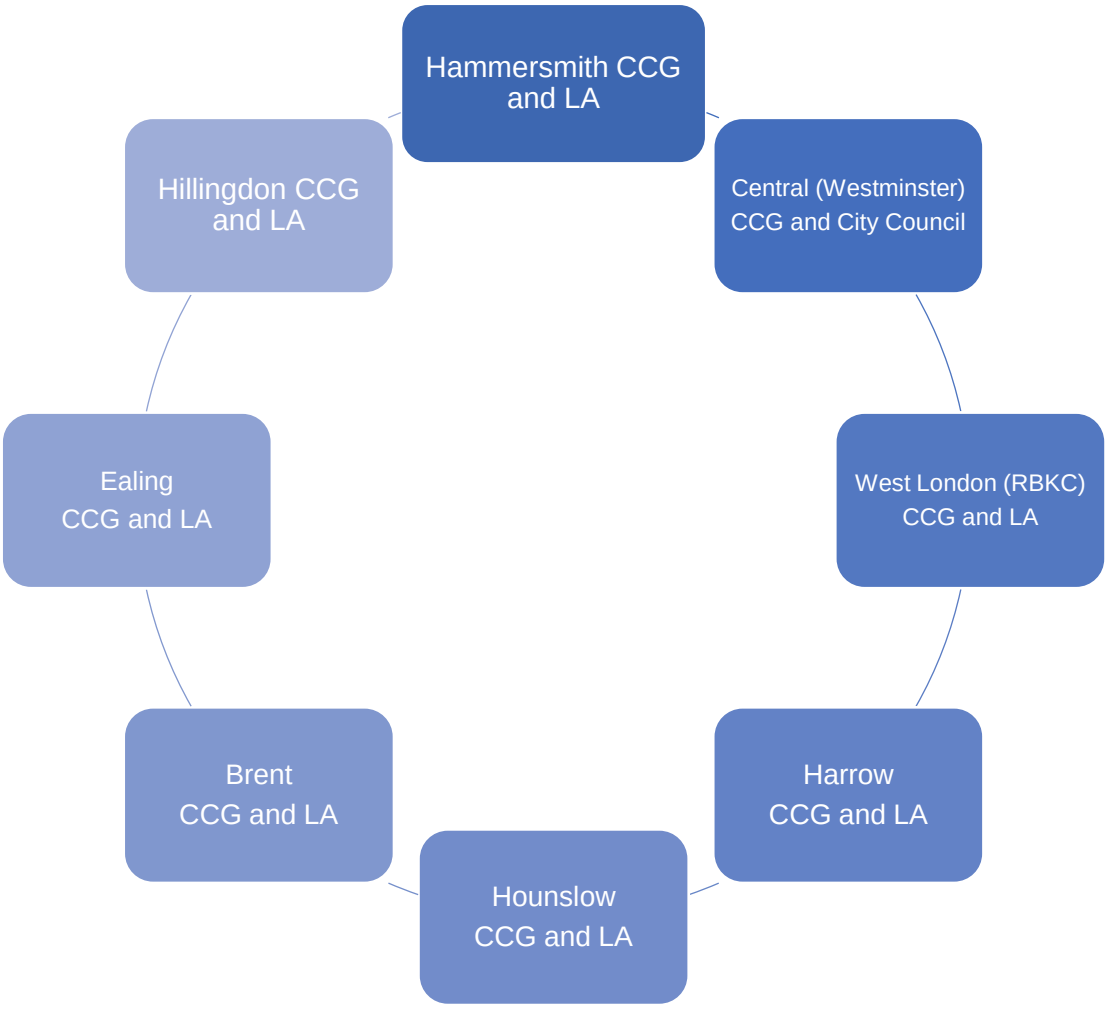
[2] The two CDR partners are the Clinical Commissioning Group(s) (CCGs) and Local Authority (ies) (LAs) who now have responsibility for meeting a series of requirements outlined in the guidance.

[3] NWL is that section of London that comprises the London Boroughs of Brent, City of Westminster, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow and the Royal Borough of Kensington and Chelsea.

reviewed within a year ensuring that the NWL plan meets the requirement that an annual 60 minimum deaths are reviewed.

Borough	Cases Reviewed 2018/2019
Brent	22
Ealing	37
Harrow	21
Hillingdon	21
Hounslow	12
Tri-Borough [Hammersmith & Fulham, Kensington & Chelsea and Westminster]	46
Total	159

Figure 1: Child Death Review Partners

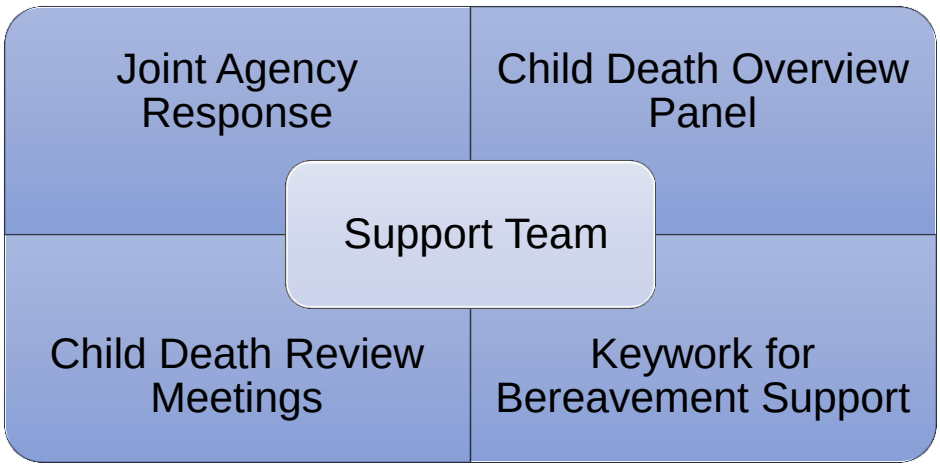


The CDR process is jointly owned by the 16 NWL partners and will be hosted on their behalf by the NWL Collaboration of CCGs. The new CDR model will cost about £351,000 and will be funded with equal contributions from each partner. The Chief Nurse and Director of NWL for the NWL CCG Collaboration will oversee the operational effectiveness of the NWL CDR Process.

3 The NWL Child Death Review Model: The Four Elements

The CDR model is comprised of four main elements each of which is supported by one dedicated support team as shown in Figure 2.

Figure 2: The NWL Child Death Review Model



4 The Support Team

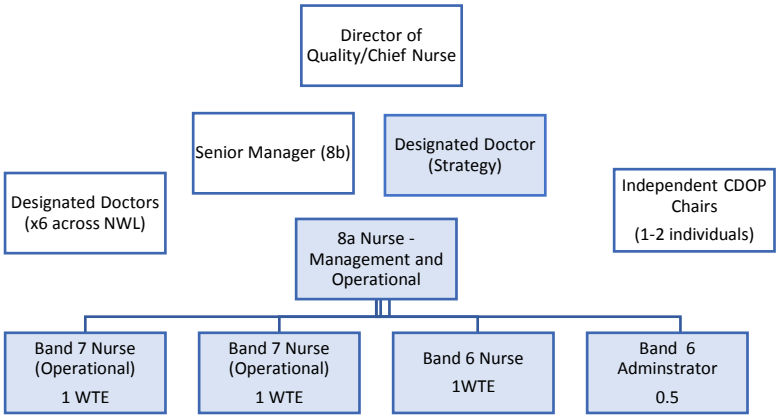
The NWL model employs a dedicated staff team to oversee all four elements of the CDR process. We have based this on current national good practice and the team comprises nursing professionals dedicated to the CDR process supported as required by designated doctors and other paediatric specialists.

This team will;

- respond to all deaths across NWL,
- coordinate the joint agency response when required,
- ensure that all deaths are subject to a child death review meeting,
- work collaboratively with LA social services, Primary Care, other health providers in particular hospital trusts, the Police and the Coroner's Service,
- coordinate CDOP meetings and
- offer key work support to all bereaved families.

The team will maintain strong local links with each borough and ensure close working relationships with the CCGs, LAs including Public Health and all other key stakeholders. This includes the provision of training and local/clustered learning.

Figure 3: Child Death Review Team Structure



The team's structure is depicted in Figure 3 and the various roles and responsibilities are outlined in Table 1. Capacity and demand modelling has helped us to determine the size and shape of the team.

Table 1: Child Death Review Team Roles and Responsibilities

Staff Type	Roles and Responsibilities
Director of Quality (NWL Collaboration of CCGs)	Chairs strategic CDOP and oversees the NWL CDR processes
Independent Chair(s)	Chairs CDOP clusters and supports the strategic CDOP.

CDR Senior Management	Line manages the CDR Nurses – management and operational support at strategic board meetings, strategic stakeholder relationships and oversight of data analysis and trend identification.
CDR Nurse – Management and Operational	Management 50%: Management and coordination of staff team (band 6 and 7 nurses and administrator). Leading on strategic board meetings, management input at strategic CDOPs, build strategic stakeholder relationships, oversight of data analysis and trend identification, oversight of annual report and returns to Child Mortality database. Support provision of sector training and dissemination of sector wide learning. Operational 50%: Support JAR processes including home visits, CDRMs and keyworking.
Designated Doctor - strategic (Senior Consultant Paediatrician)	Provision of consultant paediatrician support into development of CDR processes including clinical oversight of CDOP and taking ownership of the dissemination of learning (working alongside Public Health). Attendance at strategic CDOP. Sharing in the oversight of data analysis and trend identification. Support provision of sector training and dissemination of sector wide learning.
Designated Doctors across NWL boroughs	Consultancy and advice to JAR team. Support with home visits, JAR and CDRMs where required. Attendance at local CDOP as required. Support provision of local training and dissemination of local learning.
Specialist Nurses	Undertake JAR (including home visits); Chair CDR meetings for all child deaths. Undertake key work function. Support at CDOP meetings.
Nurse (with administration focus)	Facilitate CDOP for both cluster areas/interface with JAR team/ attend CDRMs and support to navigate eCDOP. Support analysis of trends and themes. Development element includes supporting the Specialist Nurses to undertake JAR and keyworking responsibilities.
Administrator	Organise and provide administrative support to all CDOPs, CDRM and JAR meetings. Support in organising learning events. Facilitate the collection of child death reporting forms via eCDOP. Support in analysis of trends and themes and report writing.

5 Child Death Review Meetings

5.1 The overarching process:

The CDR team will lead on all elements of the CDR response. In the event of a death the following course of actions will be undertaken:

i. Anybody will be able to report a death via eCDOP (a link will be circulated to key partners across NWL and will be published on CDR webpages of all partners). A

generic nhs.net team email will be available for a notification to be sent should there be a failure of the eCDOP system.

ii. Contact details for the CDR team will be available to all key stakeholders and on the CDR partner webpages outlining the criteria for a JAR and the contact details working hours of the JAR team. It is expected that the CDR team will be notified of any death meeting the criteria for a JAR within 1 hour of death (within working hours) or at 8am the following morning.

iii. For all cases, an alert will be sent to the CDR team via eCDOP. The appointed Designated Doctor for the respective borough will be notified by the CDR team.

iv. The CDR team, supported by the Designated Doctor will review the death and decide whether a JAR (including home visit/site of death) is required. This includes liaison with police, hospital, children's social care and professionals involved within the child's life.

v. In the event where a JAR is required the CDR team will also arrange a JAR meeting with professionals involved in the child's life.

vi. The family will also be contacted with an offer of support. This will include explaining the CDR process, providing a listening ear, linking families to bereavement support and ensuring that the family is updated through the CDR stages. In some cases, a home visit may be required.

vii. Approximately three months after the child's death a CDR Meeting will take place. The CDR team will work to a CDRM protocol with professionals involved in the child's life. The professionals expected to attend the CDRM include hospital trusts, community services, children's social care and from time to time the police. Some deaths may not be reviewed within this time frame because of, among other things, a delay in the availability of a post mortem report or the concurrence of other investigations (e.g. HSIB).

Following the CDRM the child's death will be reviewed at a NWL CDOP meeting. Data from the death will also be collected and used to support the local analysis of child deaths and wider dissemination across NWL, London as a whole and nationally as appropriate.

5.2 <u>Deaths that occur outside NWL or where a child not normally resident in NWL dies in NWL</u>

Some children not normally resident in NWL will die or, after death, will be taken to a hospital in NWL. Similarly, some children resident in NWL will die or will be taken to a hospital outside of NWL

In either event, similar "mirror image "processes will take place. The CDR processes applicable to the hospital where the child dies/is taken will be initiated and at an early stage the CDR team/process that relates to the home address of the child will be contacted to provide support. The best placed team should then take the case forward.

NWL has a number of tertiary services, including a paediatric major trauma unit and paediatric intensive care unit. For the majority of cases, where the child is not resident in NWL, the NWL CDR team will provide an initial immediate response (including key worker role) and CDRM. Then at an agreed point hand over to the local CDR team for key working and CDOP review.

6. The Joint Agency Response: out of hours service

The CDR team will be a Mon-Fri 8-8pm and Sat/Sun 8-1pm service. This may not be fully available till early 2020.

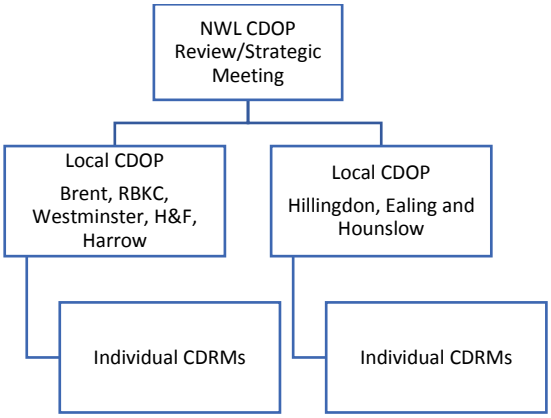
In hours, the CDR nurses will attend the hospital for all cases which require a JAR, undertake any joint home visits with police as required (including interview of parents/carers) and act as the key worker for families.

Out of hours, hospital staff and police family liaison officers will provide early support to the family. Where a joint home visit is required, police will assess the home as a crime scene, and will gather appropriate information and evidence. If necessary the police will retain the home as a crime scene until the joint home visit can be undertaken.

7 Child Death Overview Panel

We have opted for a two tier CDOP model for NWL. This involves a NWL strategic CDOP and two CDOPs clustered around local hospitals.

Figure 4: CDOP Cluster Model



The strategic CDOP and the local CDOP serve different purposes. The strategic CDOP will oversee the local CDOP clusters and their processes and will focus on broader trends and themes. It will also audit how learning was disseminated and data used to improve practice. The strategic CDOP, meeting 3 to 4 times per year, will be chaired by the Director of Quality for the NWL Collaboration of CCGs who is the Senior Responsible Officer (SRO) for this service.

The locally clustered CDOPs will meet six times a year and will focus on the sign-off and review of individual deaths (formerly known as form c) following the CDR meetings. These two CDOP clusters will be themed so as to maximise learning from deaths that are similar. Both will be chaired by an Independent Chair.

The representation of professionals for the strategic and CDOP clusters are outlined below:

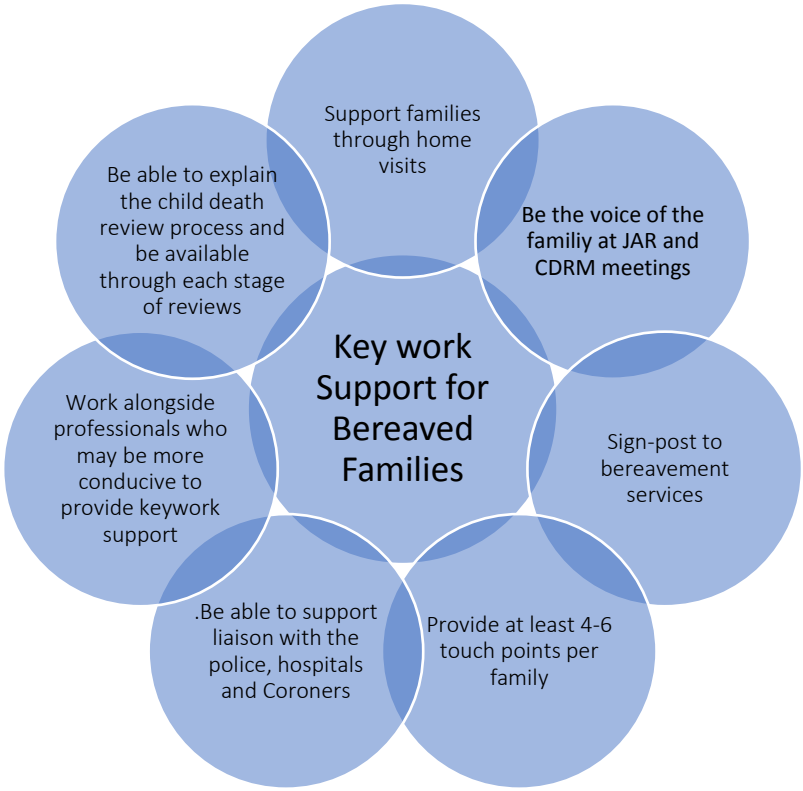
Table 2: Professional Attendance and Local and Strategic CDOP Meetings

Representation	Clustered Local CDOP	Strategic CDOP
Required Professionals	• Chair – Independent • Designated Doctor for Child Death (Acute Paediatrician and Community Paediatrician) • Senior representative of Children's Social Care • Named GP or Named Nurse for Safeguarding Children • Lay member • CDR Manager and Specialist nurses	• Chair - Chief Nurse • CDOP Manager (Nurse) • Strategic Designated Doctor for Child Death • Senior Police Officer • Head of Children's Social Care • Education Safeguarding Lead • Lay representative • Designated Doctor or Nurse for Safeguarding Children • Senior Public Health Representative
Co-opted Professionals as Required	Neonatologist Midwife Obstetrician Education Safeguarding Lead Police Trauma Lead LeDeR reviewer Senior representative of CAMHs Cardiologist	Senior representative of Ambulance Service Senior representative of Fire Brigade Trauma Lead LeDeR reviewer Senior representative of CAMHs

8 Key Work Support

The CDR team will ensure that all families can readily access a named worker to support them through the CDR process. In many instances this will be a NWL CDR team worker. Each family as well as having a single named worker will be able to access approximately 4-6 touch points of support.

Figure 5: Role of the CDR Team in the Provision of Key Work Support for Families



The keyworker will explain the CDR process to families and keep them informed about issues arising from and progress of any coroner's or police enquiry. The keyworker will also signpost families to relevant bereavement support.

Where another professional could act as the keyworker because they already know the family, (e.g. family liaison or palliative care nurse), the keyworker role can be undertaken by them with close support and liaison from the CDR team.

The CDR team will oversee the development of Child Death Communication packs outlining the CDR process with reference to bereavement support for families who wish to access them.

9 Engagement with Stakeholders

To ensure strong communication and engagement; the CDR project team, joined by the CDR manager and nurses once appointed, will oversee the following training and awareness sessions:

All key stakeholders who are involved in the CDR process will have training and awareness events provided to them. This includes:

- The CDR team
- Designated Doctors and Designated Nurses across NWL
- Senior staff and selected staff members at the hospital trusts across NWL (including specialist tertiary hospital, mental health trust and private healthcare organisations)
- Senior staff and selected staff in the three NWL Police Basic Command Units
- Senior and other selected staff in London Ambulance Service
- Local Coroners' officers

The training events will cover:

- The Child Death Review Meeting
- The JAR process for NWL
- The CDOP process
- The keyworker programme.
- Joint Home Visits and parent/carer interviews
- eCDOP

The training programme to support the roll out of the NWL CDR Process will comprise:

- Workshops
- Training and awareness events

9.1 Working with Hospitals

A series of workshops with individual hospital trusts will be held to agree joint working protocols. This will lead to agreement on how hospitals will engage with the CDR, JAR and CDOP processes.

The CDR team will ensure that key individuals in the various health provider Trusts are fully aware of the new CDR service and particularly how and when to contact it. This includes but is not limited to staff members from midwifery, neonatology, paediatrics, palliative care and emergency care. There are a number of tertiary services in adult settings offering care to children 16 and 17 years. We will be liaising closely with individual Trusts regarding children in adult care settings.

Notification, reporting and supplementary reporting forms will be collated using eCDOP. The CDR team will offer bespoke training to key individuals within each Trust who will act as CDR champions for that Trust.

The CDR team will support each Trust with the organisation and facilitation of non-JAR CDRMs.

Each case is likely to have a medical lead who will liaise with the CDR team to arrange the CDRM. The CDR team or Designated Doctor will be present at the CDRM to support local learning and to provide independent scrutiny.

9.2 Deaths of children known or suspected to have learning disabilities: Learning Disability Mortality Review Programme (LeDeR)

Where a child known or suspected to have learning disabilities dies or is taken to a hospital after death, the Hospital Trust where the body of the child rests will notify LeDeR. The CDR team will ensure that the medical lead for the case completes this notification and will provide suitable support with the online process.

Under current LeDeR guidance for children aged 4-17 years, following completion of the CDR process the CDOP Form C will be shared with the LeDeR programme with the identified learning and recommendations. This enables the LeDeR programme to complete their database and close their review without them undertaking a separate review of the case.

10 Reporting Mechanisms

The 16 NWL CDR partners strive to ensure that all child deaths are appropriately reviewed, families are adequately supported and learning across local areas, and NWL footprint as a whole, has improved practice.

To ensure that the CDR model and impact is reviewed NWL will publish an annual report. It will be published on the CDR webpage across the CDR partners' websites.

The report will include the following:

- Number of child deaths for
    - Local Authority areas
    - CDOP clusters
    - NWL footprint and
    - will also identify the number of deaths per hospital
- Analysis of any trends
- The core themes identified
- Key learning considerations
- An understanding of how learning was disseminated and whether it was effective.
- The effectiveness of the CDR arrangements.

Analysis will be undertaken by the CDR team and Designated Doctors for Child Death, supported by local Public Health colleagues across NWL. As eCDOP will be used throughout the child death review process, the data will be captured and integrated for theme and trend analysis. The captured data will also be systematically sent to National Child Mortality Database (NCMD).