Safeguarding Early Adopters programme

Learning example – Developing and implementing a Black Country Child Death Review Panel

Early Adopter: Dudley, Sandwell, Walsall, Wolverhampton

Learning theme: Increasing the child death review footprint of the local area involving multiple local authority areas and NHS organisations

Introduction

This learning example describes the work and learning that has been undertaken to join up Dudley, Sandwell, Walsall and Wolverhampton's Child Death Overview Panels (CDOP) into a strategic Black Country CDOP.

Background, aims and objectives

What inspired or drove the work? What were the drivers for change?

- Local authorities and CCGs have a new statutory responsibility to review child deaths;
- There were different practices between partners across the Black Country when a child dies;
- There was a lack of consistency, clear leadership capacity, clear governance arrangements, joint protocols and no sharing of resources in an efficient way;
- Each area had separate rapid response processes;
- Each area had a different team structure and variation in administration, coordination, support and leadership
- There are no clear links between hospital mortality review processes and CDOP reviews in each area;
- Small number of deaths in each area does not support thematic analysis and effective learning;

Purpose: what were we trying to achieve?

To develop a Black Country Strategic Child Death Review Panel in order to:

- Undertake robust thematic analyses due to handling larger numbers of cases;
- Provide good quality data on causes of death and modifiable factors in domains related to the child and the wider system;
- Develop novel approaches to linking hospital mortality review processes to CDOP reviews;
- Improve the ability to conduct thematic reviews and identify trends;
- Develop an opportunity to influence the prevention and quality assurance agenda on a wider geographical footprint;
- Create effective links with regional and national networks;
- Enable better links between CDOP and the Black Country Maternity Network;

- Instill a more resilient approach and better use of resources;
- Ability to review around 120 deaths per year and more readily identify patterns and shared learning;

A description of the expected long and short-term goals:

Short term:

- Establishing of a Strategic CDOP to oversee the CDR processes and policies in the Black Country;
- Developing consistent processes and accountability;
- Adopting a system wide and proactive approach to the prevention of child death agenda;

Long term:

- Developing solutions to address challenges and threats, such as agreeing local and regional accountability structures;
- Agreeing protocols around learning disability death reviews;
- Strengthening links between local and national serious case review processes;
- Improving health and wellbeing of children in the Black Country
- Contributing to assessing the health and social care needs of children in the Black Country;
- Contributing to the quality assurance and patient safety agendas across the health and social care systems and how it will measure its impact on reducing children mortality in the short and long term;
- Reducing child deaths
- Developing robust Black Country training arrangements to share learning from Child Death reviews.

Approach

Description of planning process

- Developing an action plan;
- Identifying stakeholders and key decision-makers;
- Establishing a Steering group;
- Developing an options appraisal;
- Making recommendations

Brief details of project scope and timescale

- The project involved all CDR partners within the four existing Local Children's Safeguarding arrangements. This includes the CCGs, hospital trusts, local authorities, and WM Police;
- The project was intended to start in September 2018 and finish at the end of March 2019. Some work has been rolled over into the new financial year to ensure that momentum is not lost, a coordinator appointed, and a shared budget established;

Details about the approach taken to deliver the project

i. Who are the key people involved on both a strategic and operational level:
- DsPH and PH Consultants in Local Authorities
- CDOP Chairs
- Designated professionals
- CDOP administration
- Police
- CDOP members
- CCG Quality and Nursing Leads
- Safeguarding professionals

ii. How was the project monitored
- Steering group oversaw the action plan and progress
- Day to day progress was monitored by a small project delivery group

iii. What activity has taken place to engage key stakeholders
- Initial stakeholder survey to gauge current position and thoughts
- Steering group established made up of professional/ geographical/ organisational stakeholder representation;
- Exploratory stakeholder workshops organised to consider the future direction, options, risks,
- Presentation to the Stakeholders following the West Midland CDOP Network
- Presentations and engagement with North and South CDOPs
- Link established with Local Maternity System and Neonatal network
- Communication plan established

Challenges

The problems we encountered

- At the time that the project was to commence, the person responsible for putting the bid together and project lead, started a secondment in another country;
- Lack of clarity in the first instance as to who the new strategic lead for the work should be;
- A general apathy from key decision-makers on the importance of agreeing new CDR processes;
- Historic different ways of working;
- Various perspectives;
- Inconsistent approaches to the child death review processes;
- The four areas were at varying stages regarding future Multi-Agency Safeguarding Arrangements (MASA) and Governance arrangements.

How we overcame/dealt with them

- Organising a series of engagement/co-design events;

- Developing a series of discussion/briefing papers with recommendations
- Provided opportunities to influence the final model;
- Be flexible and empathetic to others perspectives;
- Map existing practices and resources;

What we would do differently next time

- Map out the stakeholders, key decision-makers and decision-making groups and when decisions need to be made;
- Clarify the dates of all relevant strategic meetings in advance;

Successes

Specific challenges to the work/project that we overcame:

- Initial skepticism from some professionals and organisations due to a lack of initial engagement in pulling the bid together;
- A wide range of organisational and professional perspectives;
- Competing work priorities;
- A resistance to change;
- Identifying the key decision-makers in the local economy;
- The CDR processes involve passionate professionals from both strategic and operational perspectives, and can have very different perspectives and strongly held views;
- Inadvertently the proposed model put at least one person at risk of redundancy. It is important to seek HR advice at an early stage;
- Maintaining the momentum for the change;

The biggest contributors to these successes were:

- Recruiting an independent senior child death review consultant;
- Designating project support time across the two operational areas;
- Ensuring that stakeholders had the opportunity to co-design the new arrangements and provide input;
- Establishing a Steering Group with respective partners made up of both strategic and operational staff;
- Providing regular updates through a Steering group and producing a series of papers with recommendations for the decision-makers.
- Establishing a set of clear working principles that can help as a guide through difficult times. The agreed principles for the black Country were:
    - Ensure that the review of every child death "is grounded in deep respect for the rights of children and their families" (CDR Guidance 2018)
    - Be child, family and outcome focused to make a difference
    - Maximise the use of limited resources, to maximise effectiveness and efficiency
    - Learn from areas that already have regional child death arrangements

        - Optimise the opportunity for review and learning on a sub-regional/STP footprint
        - Nurture collaboration between partners and inform the development of local systems
        - Strengthen links between child death review process and other mortality reviews
    - Clarifying options for stakeholders to consider, and considering the risks / benefits of each;
    - Clarifying and agreeing the common "strategic" roles/functions amongst the various Black Country CDOP options including:
        - Analysing data on a BC Footprint
        - Producing an annual report for the BC
        - Providing oversight and quality assurance of the CDR processes for partners
        - Considering Adverse Childhood Experiences relating to the dead child/family
        - Providing peer review opportunities
        - Providing constructive challenge to system partners and networks
    - Developing a clear set of terms of reference for the steering group;

Benefits of the project:

- A coordinated approach across the wider health and social care economy and one that is now co-terminous with the NHS organisational boundaries;
- An established joint budget based on fair proportionate contributions;
- A transparent and firm foundation on which to build;
- Providing clarity about the expectations of the Strategic CDOP and the statutory partners through an MOU;

Feedback from key stakeholders (key partners, other agencies, young people, parent/carers):

- The model has been co-produced using active engagement and feedback from stakeholder partners, both strategic leads, professionals and administrative staff.
- There has been no engagement with young people or parents/carers on this project.

Conclusion

What we achieved:

- Establishment of a strategic CDOP for the Black Country;
- Creation of a joint budget for Coordination/ Administration; eCDOP; training and development; and appointment of an Independent Chair;
- Developing consistency in notification and information sharing;
- Agreed protocol for how cases involving a learning disability will be addressed;
- Establishment of the eCDOP software with consistent notification processes;

- Appointment of a single CDOP Coordinator for the Black Country with a clear job description and person specification;

Benefits that have already been realised:

- A coordinated approach across the wider health and social care economy;
- Opportunities to discuss child death review issues across the Black Country;
- Consensus around a preferred model and the need for a Black Country perspective;
- A governance structure in place to guide the new CDR processes, which will need to be reviewed in the light of the new strategic CDOP;
- A senior strategic lead has been identified as the Chair of the new Strategic CDOP;
- A Black Country Database for recording data;
- Standardised Learning Disability Death review (LeDeR) processes

Future potential benefits:

- A Black Country learning and education programme
- A Black Country Sudden Unexpected Death in Childhood (SUDC)
- A Black Country Memorandum of Understanding with the coroner
- Child Death Review protocols/ policies local standard and operating procedures for the Black Country
- A joint annual report 2018/19 to meet the requirements of the new guidance
- Protocols to link local hospital mortality reviews, regional networks with CDOPs
- Data collection procedures and data sharing agreements including the results of hospital mortality review processes
- Standardising mechanisms and protocols of sharing the learning from Black Country CDOPs and the Local Maternity System
- A reduction in risks for young people;
- Improved intelligence to inform future policy;
- Black Country SUDC protocol;
- Consistency in terms of notification and information sharing;
- Coordinated administrative function across the footprint;
- Influence of various strategic partnerships including Multi-Agency Safeguarding Arrangements; Health and Wellbeing Boards and; Community Safety Partnerships

Lessons learnt (particularly those relevant to a wider audience):

- Recognise that there is no right way;
- Listen to all perspectives;
- Provide opportunities for active discussion and co-develop new models;
- Establish a set of no more than six clear working principles at the beginning that can help guide the change processes. These effectively act as a compass through tricky periods;
- Clarify who and what the key decision-making people and bodies are;

- Undertake an initial stakeholder survey helped identify consensus or antagonism, to inform the first discussions;
- Design a Memorandum of Understanding which clarifies the expectations and responsibilities of CDOP and the statutory partners. This should include the strategic partnerships that CDOP will report to e.g. Multi-agency Safeguarding Arrangements, Health and Wellbeing Boards, Community Safety Partnerships etc

Interim outline of future CDOP arrangements for NHSE (awaiting a formal template from NHSE):

Geographical footprint

- The Black Country Strategic CDOP will cover the resident population of Dudley, Sandwell, Walsall and Wolverhampton local authority areas and have oversight of the Child Death Review Processes across the patch.
- Deaths will be reviewed at two child death review panels in both the North (Wolverhampton and Walsall) and the South (Sandwell and Dudley).
- Notification and information sharing will be done on a Black Country footprint, using eCDOP.

Who are the statutory partners

- City of Wolverhampton Council
- Dudley CCG
- Dudley Metropolitan Borough Council
- Sandwell and West Birmingham CCG
- Sandwell Metropolitan Borough Council
- Walsall CCG
- Walsall Metropolitan Borough Council
- Wolverhampton CCG

What are the reporting links to Strategic partnerships - MASA, HWB, CSP

- The BCCDOP will provide Quarterly reports to each local authority multi-agency safeguarding system, the Health and Wellbeing Boards and any other relevant strategic partnership.
- Some rationalisation is still required

Expected number of annual reviews

- Approximately 120 deaths per year

Outstanding issues

- Local decisions are required about which strategic partnership group should take the lead for Child death reviews