**Child Death Review and Rapid Response: Examples of options considered by EA Sites**

**Option 1: Overarching Strategic All-Area Panel**

Overarching All-Area Child Death Overview Panel. 12 meetings per year; on a themed basis. Individual Child Death Review Meetings (CDRMs) to take place as required for each child death.

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| **Overview**  | **Information**  |
| Frequency of Strategic CDOP  | Monthly (12 per year)  |
| Average number of deaths to be reviewed per meeting  | TBC |
| Themes | Unexpected: 2 per year Expected: 2 per year Neonates: 8 per year  |
| Purpose of the Meeting  | Child Death Review (CDRMs) would provide recommendations to the local strategic meetings for the a) cause of death b) recommendations specific to death and c) any learning to be disseminated. The meeting would furthermore identify themes and any specific learning points for a) boroughs b) specific to hospital trusts/systems c) specific to public education and learning and d) specific to commissioning  |
| Strategic CDOP Members  | The strategic CDOP would require delegated attendance from each of the eight Local Areas including:

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| Member  | Total  |
| CDOP Chair (e,g. STP Safeguarding lead) | 1 |
| Designated Safeguarding Doctor or Nurse from each borough | 8 |
| Paediatrician or safeguarding lead from each hospital | 5 |
| Rapid Response Lead | 1-3 (dependent on RR model) |
| Public Health Lead  | 8  |
| Police Lead  | 3 |
| Coroner Lead  | 3 |
| Social Care Lead  | 8  |
| Patient Representative  | 1-2  |
| Total  | 38 (minimum) -41 (maximum) members per group |

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| Benefits  | Strategic CDOP would provide function of analysing common themes and trends across the Local Areas Increases shared learning; particularly system learning (related to hospitals which are shared amongst Local Areas) and learning related to public health. Governance and CDOP attendance list to be agreed.  |
| Challenges  | Tight coordination and management of CDOP required; implementation of E-cdop across the Local Areas to ensure consistency and coordinated approach to joining the areas together.  |
| Cost Impact  | Reduction from 26 to 12 CDOP meetings per year would provide a cost saving; this saving, however, would mostly be a time resource saving (actual and time cost saving to be calculated)  |

**Option 2: Strategic All-Area Panel & Local Child Death Review Hospital Clusters**

All-Area Strategic Child Death Overview Panel (CDOP) to join together 5-6 local CDOPs clustered around hospital trust ‘localities.’

Individual Child Death Review meetings would support the local CDOPs.

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| **Overview**  |  |
| Frequency of CDOP meetings  | Strategic – Twice per year Local – Every 2 months per CDOP cluster area  |
| Average number of deaths to be reviewed per meeting  |  TBC |
| Themes  | Local and strategic meetings would not be themed; though themes and learning would be identified.  |
| Purpose of the Meeting  | **Local CDOP**CDRMs would provided recommendations for the CDOP meeting for form c in summary form.Local meeting will review succinct information on form c’s and confirm cause of death, modifiable factors, recommendations and key learning points. **Strategic CDOP** Strategic CDOP would reflect on overarching All-Area themes, trends and key learning points and further disseminate in relation to the following areas a) Local Areas b) specific to hospital trusts/systems c) specific to public education and learning and d) specific to commissioning.  |
| Strategic and Local CDOP Members  | **Strategic CDOP**

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| **Member**  | **Total**  |
| CDOP Chair - STP CCG Safeguarding Lead  | 1 |
| Designated Safeguarding Doctor/Nurse  | 3(1 from each cluster area)  |
| Paediatrician/Safeguarding Lead  | 3 (from each cluster area) or 5 (from each hospital trust) |
| Social Care  | 3 (1 from each cluster area) |
| Rapid Response  | 1-3 (Dependent on agreed model) |
| Police  | 3 (1 from each BCU) |
| Coroner | 3 (1 from each BCU)  |
| Patient Voice  | 1 |
| Total  | Approximately 18 (minimum) – 22 (maximum  |

**Local CDOP Members – In each cluster**

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| **Member**  | **Total**  |
| CDOP Chair | 1 |
| Rapid Response Lead  | 1 |
| Designated Safeguarding Doctor or Nurse  | Either 1 (delegated) or 2/3 (from each Local Area) |
| Paediatrician/Safeguarding Lead  | 1-3 dependent on no. of hospitals within a cluster  |
| Social Care | 2-3 dependent on how many Local Areas in a cluster |
| Patient Voice  | 1 |
| Police  | 1 |
| Coroner  | 1-2 dependent on how many coroner offices within a cluster |
| Total | Approximately 9 (minimum) – 15 (maximum)  |

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| Frequency of Local CDOP  | Every 3 months; 4 per local hospital cluster area. |
| Benefits  | Strategic CDOP would provide function of analysing common themes and trends across All-Areas. Local CDOP increases shared learning; particularly system learning (related to hospitals which are shared amongst Local Areas) and learning related to public health. Governance and CDOP attendance list would need to be agreed. |
| Challenges  | Would require current existing time resource to manage and coordinate strategic and local CDOPs.  |
| Cost Impact  | Potentially no impact cost savings (both financial and time); calculations to be undertaken but similar resource likely required.  |

**Rapid Response Options**

**Option 1: All-inclusive Chid Death Response Team**

All inclusive Rapid Response team covering all 8 Areas. The team would provide coordination and response to rapid response. They will also coordinate child death review meetings for all out of hospital child deaths with support from hospitals for deaths whereby a child dies at hospital.

The team would have the added benefit of being able to provide a holistic keyworking function to support families through the child death process.

The team will also coordinate child death overview panels in liaison with the CDOP chair. The team would also be responsible for identifying trends, themes, undertaking research and providing training to key stakeholders across All-Areas.

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| **Title**  | **Information**  |
| **Overview** | One Full time Rapid Response team covering All-Areas; Rapid Response, CDRM support, CDOP coordination and Keyworking function |
| **Staffing Capacity Required (based on data; approximate)** | 4 Nurses; Band 8a lead, 2 Band 7s, 1 Band 6 and Band 5 Admin Business support (further capacity modelling required). |
| **Consultant Paediatrician Input**  | 1-2 specialist Designated doctors or doctors for child death provide support OR each Designated Doctor in each Local Area continues to provide CDOP support and advice.  |
| **Child Death Review meetings**  | Lead for unexpected deaths. Coordinator for expected deaths  |
| **Link with CDOP**  | Organise and provide both business management and admin support for CDOPs.  |
| **Keyworking** | Team would provide a team working function  |
| **Contractual elements**  | Team would need to be hosted by a hospital, commissioned by 8 CCGs with a lead commissioner for contractual oversight  |
| **Benefits**  | Holistic and all inclusive response; joined up link between CDOP and Rapid Response. Team can coordinate and support CDRM meetings. Keyworking element maintained.Integrity of model/consistent approach; equitable service across All-Areas regardless of postcode/borough. Can build on professional links in community with ease. Strong learning and development function. Training and research element. Psychological support for staff - resilience |
| **Key Challenges**  | Additional cost of this model.  |
| **Cost Impact**  | Current staffing re-configuration and negotiations would be required (thus some costs can be retrieved), however, an all inclusive staff team would be at an additional cost to current Area models. Cost to be calculated.  |

**Option 2: On-Call Rota Team**

On-call Rapid Response team supported by each individual Local Area. Designated Doctors or/and nurses (CCG based) or/and Named Nurses (Acute Hospitals) join a yearly rolling rota. Professionals on-call would respond to all child deaths across All-Areas within their designated on-call week. This includes hospital visits, report writing for coroners/pathologists/CDOP, production of annual reports. Management function and handover process would be required to support this model. On-call system also allows for annual leave and sickness cover.

A coordinator role would be required to support JAR meetings and coordination of the CDOP.

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| **Item**  | **Information**  |
| **Overview** | Named nurses at hospitals or Designated professionals (nurses or doctors) assigned to each Local Area. Assigned individual responds to Rapid Response cases across All-Areas. Each individual will provide cover for 7 weeks per year.  |
| **Staffing Capacity Required**  | One assigned individual per Local Area. Minimum of 8 staff across All-Areas |
| **Consultant Paediatrician Input**  | Designated professional (doctor/nurse) in each Local Area provides CDOP support and advice. Managerial post required.  |
| **Child Death Review meetings**  | Lead for unexpected deaths. Coordinator for expected deaths  |
| **Link with CDOP**  | Professionals will not be expected to organise CDOP; but will be required to liaise with CDOP lead and attend CDOP meetings.  |
| **Keyworking** | Due to capacity it may be challenging to provide holistic keyworking. Team to primarily sign-post to relevant agencies.  |
| **Contractual elements**  | Each individual will be hosted by their respective hospitals/CCGs. Job plan negotiations would be required. Lead CCG in collaboration with CCGS.  |
| **Benefits**  | Lower cost than an all-inclusive model. Designated professionals would continue to cover Rapid Response; this would be a joint nurse and doctor led model (dependent on borough).  |
| **Key Challenges**  | Potentially inconsistent response to child deaths.Designated professionals, on an on-call basis, would be required to respond to all deaths across Local Areas; to discuss; capacity and feasibility to attend to all Local Areas (time, information etc). Limited engagement with parents and potential difficulties coordinating and matching bereavement support across multiple trusts. Challenges in building consistent relationships with key partner agencies (e.g. police, coroners and stakeholders)Increased challenge in time resource to provide coordinated training to key stakeholders, as well as, undertaking local research |
| **Cost Impact**  | Minimal additional cost required (compared to an all- inclusive team). On-call costs and any additional job requirement costs would need to be factored in.  |

**Option 3: On-Call Rota Around Local Area Clusters**

Shared On-Call Rapid Response clusters partially based on current configurations and shared hospital clusters. Professionals on-call would join a rota within their individual clusters with an overarching All-Area system process and procedure guidance. This would provide further equity of quality of provision across All-Areas whilst utilizing current resource (with addition of on-call costs).

On-call role includes hospital visits, report writing for coroners/pathologists/CDOP, production of annual reports. Management function and handover process would be required to support this model. On-call system also allows for annual leave and sickness cover.

A coordinator role would be required to support JAR meetings and coordination of the CDOP

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| **Item**  | **Information**  |
| **Overview** | Named nurses at hospitals or Designated professionals (nurses or doctors) assigned to each Local Area cluster. Assigned individual responds to Rapid Response cases across All-Areas. 2-Local Area clusters – individuals would provide cover for 27 weeks within a year. 3-Local Area clusters – individuals would provide cover for 18 weeks within a year.  |
| **Staffing Capacity Required**  | One assigned individual per Local Area  |
| **Consultant Paediatrician Input**  | This will mirror current provision.  |
| **Child Death Review meetings**  | Lead for unexpected deaths. Support to coordinate for expected deaths; with more ownership on hospitals for coordination.  |
| **Link with CDOP**  | Professionals will not be expected to organise CDOP; but will be required to liaise with CDOP lead and attend CDOP meetings.  |
| **Keyworking** | Due to capacity it may be challenging to provide holistic keyworking. Team to primarily sign-post to relevant agencies.  |
| **Contractual elements**  | Each individual will be hosted by their respective hospitals/CCGs. Job plan negotiations would be required. Lead CCG in collaboration with individual clusters.  |
| **Benefits**  | Lower cost than an all-inclusive model or All-Area on-call model. Designated professionals would continue to cover Rapid Response; this would be a joint nurse and doctor led model (dependent on Local Area). Minimal implementation resource required. Resilience within system; shared coverage. Increased equity of provision across All-Areas with shared guidance.  |
| **Key Challenges**  | Potential inconsistencies in child death processes between each cluster. Designated professionals, on an on-call basis, would respond to all deaths across their clusters; to discuss; capacity and feasibility of accessing clustered Local Areas (time, information etc). Limited engagement with parents and potential difficulties coordinating and matching bereavement support across multiple trusts due to limited resource. Some challenges in building consistent relationships with key partner agencies (e.g. police, coroners and stakeholders) (but not as much as option 2). Less time resource to provide coordinated training to key stakeholders, as well as, undertaking local research. |
| **Cost Impact**  | Minimal additional cost required (compared to an all- inclusive team). On-call costs and any additional job requirement costs would need to be factored in. Managerial costs required and CDOP coordination post required.  |