Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	26 June 2019
Executive Member / Reporting Officer:	Dr Ashwin Ramachandra (Chair) – NHS Tameside and Glossop CCG Councillor Eleanor Wills – Executive Member (Adult Social Care and Population Health) Gill Gibson, Director of Quality and Safeguarding
Subject:	**REQUIREMENTS FOR REVIEW OF CHILD DEATHS IN GREATER MANCHESTER**
Report Summary:	In October 2018 recommendations were made by the Department for Education that the responsibility for the statutory reviews of child deaths moves away from Local Safeguarding Children's Board's to become a statutory responsibility of Clinical Commissioning Groups and Local Authorities. The purpose of this paper is to outline the arrangements required for Tameside Local Authority and Tameside & Glossop Clinical Commissioning Group to meet the statutory requirement for reviews of deaths of all children 0-18 years. The report outlines suggested reporting structures for the child death review process to GM Health and Wellbeing Boards The paper was produced and agreed on behalf of the Greater Manchester Directors of Children's services and Directors of Nursing CCGs and Directors of Population Health to scope the current arrangements; and to make recommendations as to changes required to meet the statutory guidance for the review of child deaths. Tameside's Director of Children's Services and Director of Population Health are fully sighted and supportive of this arrangement. The report outlines the suggested reporting structures for child death review process transfers from local safeguarding boards to report into Tameside Health and Wellbeing Board. The Director of Quality and Safeguarding (CCG), The Director of Children's Services (TMBC) and Director of Population Health (TMBC) as statutory partners with responsibility for the oversight of learning from child deaths will receive on a quarterly basis the learning from child death reviews. An annual report on the learning from child death reviews will be received by the Health and wellbeing Board. The report also describes that the current operating model for Child Death Overview Panels (CDOP) across GM should be unaffected however makes recommendations for local tripartite arrangements with Stockport and Trafford to continue but to be revised in order for this statutory function to be carried out effectively.

Recommendations: That the Strategic Commissioning Board note the following and agree:

(a) Health Commissioners and Providers across Greater Manchester to understand and implement systems to ensure mortality reviews of all children who have died within their services are carried out using a multi-agency model of review. This includes commissioners and providers of public health services.

(b) Partners other than health services to understand the requirement of practitioners in their agencies to participate in all mortality reviews as necessary.

(c) Review of procedures and services within acute trusts by health providers and commissioners to ensure that services to meet the needs of families where the death of the a child has occurred are effective.

(d) Agreed information sharing between health providers and CDOP to ensure that all reviews of deaths of children are shared with Child Death Overview Panels.

(e) Revision of current SUDC policy and mortality review policies to ensure that information sharing and involvement in reviews of deaths of children include the SUDC paediatric staff as necessary.

(f) Agreement across CCG areas of whether there is a perceived need for a discrete role of designated doctor for child deaths including funding arrangements if this is necessary.

(g) Agreement of continuation of current funding arrangements for SUDC by all 10 CCG areas.

(h) Agreement reached between SUDC service and acute trusts about the management and review of some cases of unexpected deaths which may occur within the acute trust setting.

(i) Responsibility for Governance arrangements for CDOP to be transferred to Health and Wellbeing Boards.

(j) Continued agreement for the funding of CDOP administrators.

(k) Agreement that current arrangements for funding of the CDOP administrator role are reviewed across Greater Manchester to ensure that there is capacity to carry out revised role and to ensure that databases can be maintained.

(l) Joint decision making as to the most appropriate holder for the transfer of budgets for CDOP from LSCBs to alternative arrangements for CDOP. This includes budgets for maintaining databases.

(m) Continued support for the current Greater Manchester CDOP arrangements from commissioners of health services and their partners.

(n) Role of public health partners in leading CDOPs roles needs to be established.

Corporate Plan:	The Corporate Plan sets out the strategic direction of Tameside and Glossop Strategic Commission and aligns with the Commissioning Strategy through a focus on the life course – Starting Well, Living Well and Ageing Well.
Financial Implications: (authorised by Section 151 Officer)	There are no direct financial implications arising from this report.
Legal Implications: (authorised by Borough Solicitor)	The proposed governance structure and operating model are set out in the Statutory and Operational Guidance at **Appendix 5**, and so procedures will need to be in place, which follow this guidance, as the coroner will expect to see it demonstrated by the CCG and the Council through its Children's Services, with a holistic approach to child deaths.
Risk Management:	None applicable

Access to Information :

Appendix 1	Child death review process 2018 overview
Appendix 2	7 minute briefing
Appendix 3	Annual reporting for Child Death Review Process
Appendix 4	Child Death Review Statutory and Operational Guidance (England)
Appendix 5	Organisational And Operational Information Including Information-Sharing Protocol

The background papers relating to this report can be inspected by contacting Gill Gibson or Victoria Leonard.

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1. BACKGROUND

1.1 Since 2008 there has been a statutory requirement for Local Safeguarding Children's Boards to ensure that the deaths of all children under the age of 18 years are reviewed. This work has been carried out by Child Death Overview Panels (CDOP). The panels are currently sub groups of the local safeguarding children's boards' arrangements. The Wood Review (2016) identified the need for change in the way that child deaths investigations were completed. The review recommended the transfer of the responsibility to review deaths of children to local authorities and Clinical Commissioning Groups (CCGs).

1.2 In 2018 further statutory guidance has been published. This sets out requirement for review of deaths of children by local health providers in the area in which the child dies. Although most acute trusts already carry out reviews of death as per mortality steering group processes, there is a need for this work to be more formalised for the deaths of children. In addition there is a requirement that these reviews will be shared with CDOP panels as a matter of routine.

1.3 CDOPs will no longer be part of the revised safeguarding partnership arrangements within local authority areas. It is envisaged that in Greater Manchester the health and wellbeing boards within each local authority areas will be required to scrutinise the learning from reviews of child deaths locally with the Greater Manchester Health and Wellbeing Board receiving Information about child deaths across the region.

1.4 The Director of Quality and Safeguarding (CCG), The Director of Children's Services (TMBC) and Director of Population Health (TMBC) as statutory partners with responsibility for the oversight of learning from child deaths will receive on a quarterly basis the learning from child death reviews. An annual report on the learning from child death reviews will be received by the Health and wellbeing Board.

2. PURPOSE OF REPORT

2.1 The Designated Health Professionals for safeguarding children were requested by the Directors of Children's services and the Greater Manchester Directors of Nursing to scope the revised guidance issued in October 2018 and to make recommendations as to changes required to meet the statutory guidance for the review of child deaths.

2.2 The purpose of this paper is to ensure that commissioners and providers of health and social care services within Greater Manchester are clear of the statutory requirement for reviews of deaths of all children 0-18 years to be carried out, to ensure that there are clear reporting structures of the findings of deaths of children and young people, to have clear procedures in place to use data gathered, through various review arrangements, to use information gathered to prevent further deaths and ensure that effective services are commissioned and provided to families who have suffered bereavement through the death of a child.

3. CURRENT ARRANGEMENTS FOR THE REVIEW OF CHILD DEATHS IN GREATER MANCHESTER

3.1 There is requirement that the deaths of all children (0-18 years) receive review (Children Act 2004).

3.2 Children may die either expectedly or unexpectedly. As per Greater Manchester Sudden Unexplained Deaths of Children (SUDC) policy, the usual place of verification of death of a child is within an acute trust setting - the exception to this maybe children who are receiving end of life/palliative care and there is a request for the child to die at home. Invariably,

however, even children in this category are likely to be receiving care from health services which are based within an acute trust setting.

4. MORTALITY REVIEWS

4.1 As part of the Learning from Deaths (2017) guidance there is a requirement for acute trusts to undertake reviews of all persons who may die within the acute trust setting. To date a significant amount of this work is undertaken through hospital mortality steering group arrangements. These tend to be medically led and focus on the clinical care which was delivered to the patient, usually in the latter part of their life. It is rarely multi agency in nature so the information gained does not include wider information for example, the impact which possible adverse living conditions may have had on the patient's health including compliance with treatments.

4.2 In the case of deaths of children, some acute trusts may have separate arrangements for reviewing causes of deaths of children who die in specific situations. For example large neonatal departments may have arrangements for the review of babies who die. To date information gathered at internal reviews are not always collated to review learning across the organisation or further afield. For example sharing of information between secondary and tertiary acute hospital settings where children may have died. The information collated within internal reviews of child deaths is then not always shared with the CDOP for the area in which the child dies or in the area where the child would normally have been resident.

4.3 The revised statutory guidance require that all deaths of children are reviewed by the health provider and that the review includes all multi agency professionals who may have knowledge of the family and been involved in the family's care. In addition there is a need for all reviews to be subsequently submitted to the CDOP for that area so that further analysis of data can be made.

5. SUDDEN AND UNEXPECTED DEATHS IN CHILDHOOD (SUDC)

5.1 In Greater Manchester each CCG jointly commissions the role of the SUDC paediatrician. The SUDC rota is covered by a team of paediatricians, provided by Manchester University Hospitals NHS Foundation Trust whose role is to work across the Greater Manchester area and respond to all sudden and unexpected deaths of children and young people. The paediatricians form part of a multi-agency review of sudden and unexpected deaths of children and young people throughout Greater Manchester, a recommendation as stipulated in the Kennedy Report (2016). They work closely with Greater Manchester Police and Children's social care, pathology and the Coroner. They jointly undertake rapid review of deaths. This arrangement is undertaken on a seven day per week basis for fifty two weeks of the year. The model for sudden and unexpected deaths of children, as used in Greater Manchester, has received national recognition and is seen as the gold standard for the review of these deaths.

5.2 Currently there is some sharing of information and joint investigation of circumstances in which a child may have died unexpectedly with acute trusts. All information collated during the SUDC process taking place is shared with the current CDOP arrangements. Some confusion is evident when a child dies unexpectedly whilst an inpatient or if the death is unexpected but does not occur in the immediate time of admission to hospital. E.g. children with conditions such as meningitis, injuries which subsequently result in the death of the child but death has not occurred within 24 hours of the injury occurring. The current SUDC procedures will need to be updated so that there is agreement between the SUDC arrangements and the acute provider to ensure that a full review is carried out with input from all professionals who have been involved in the care of the child. This will also need to

include the family GP. The revised statutory guidance supports that this model of review of sudden and unexpected deaths of children continues.

5.3 Some paediatricians who undertake the SUDC rota will also be a member of the CDOP of the area. There is requirement in the revised guidance that there is recognition of the role of Designated Doctor for child deaths. Currently within Greater Manchester the SUDC paediatrician is not always represented at the CDOP. There has been some local agreement in some of the tripartite arrangements for CDOP that the designated doctor for safeguarding also presents the information provided by the SUDC Paediatrician. However, and discussion needs to occur as to whether stand-alone roles for the review of child deaths at CDOP needs to be considered given that CDOP will review both expected and unexpected deaths.

6. CDOP ARRANGEMENTS

6.1 Previous versions of the Working Together statutory requirements placed the responsibility for the reviews of child deaths on the local authority from where the child was resident. As trends in child deaths are based on child population figures, the mortality rates arrangements were made for the ten local authorities across Greater Manchester to come together using a tri partite arrangement. In line with the 2008 DfE recommendation that CDOPs should cover a population of 500,000 of children or higher, three of the CDOPs are made up of multiple LSCBs which also fall under the same geographical areas as the Coroner's Office jurisdiction:

- Tameside, Trafford and Stockport CDOP
- Bolton, Salford and Wigan CDOP
- Bury, Rochdale and Oldham CDOP
- Manchester City CDOP

6.2 The current CDOP arrangements remain in line with the revised Working Together Guidance which states that the geographical and population 'footprint' of Child Death Review Partners should be locally agreed, but must extend to at least one local authority area. These may overlap with more than one local authority area or clinical commissioning group and should cover a child population such that they typically review at least 60 child deaths per year.

6.3 Professionals from Public Health currently chair the Manchester CDOP and Bury, Rochdale and Oldham CDOP. The Tameside, Trafford and Stockport CDOP and Bolton, Salford and Wigan CDOP have appointed an Independent Chair. The Independent Chair, as well as the CDOP Co-ordinator/Manager for each CDOP, is funded through the current LSCB arrangements. Future funding arrangements of an independent chair will need to be negotiated locally between each tripartite CDOP.

6.4 The CDOP Coordinator role is vital to ensuring that there is a single point for providers to make notification about the death of a child and to ensure that information is coordinated. Discussion needs to occur between local authorities and their safeguarding partners to ensure that monies which are currently held by the LSCBs to fund this area of CDOP work is transferred to a central point and that review is undertaken to ensure that any increased workload, which may be brought about as additional information from internal mortality reviews are shared, is recognised.

6.5 CDOP Chairs, CDOP Co-ordinators/Managers and previously the GM Safeguarding Partnership Co-ordinator come together to form the GM CDOP Network. This Network meets on a quarterly basis to ensure that the approach to the collation of data, the application of modifiable factors and interpretation of data is consistent across Greater Manchester. The GM CDOP Network also highlight any emerging themes in child deaths

across GM, share good practice and work together to support the GM CDOP Annual Report. It is envisaged that this network will need to report to the Greater Manchester Health and Wellbeing Board.

7. LOCAL AND REGIONAL REPORTING OF CHILD DEATHS

7.1 In line with Working Together Guidance, each CDOP prepares a local annual report of relevant information for their LSCB(s). This information is used to inform the LSCB(s) of local emerging trends and themes within each local authority to identify lessons on the prevention of future child deaths.

7.2 Each CDOP Coordinator/Manager provides annual statistics to the designated Public Health representative who takes the lead undertaking the analysis and producing the GM CDOP Annual Report.

7.3 Both the local CDOP Annual Report and the GM CDOP Annual Report are presented to each of the ten LSCBs. The GM CDOP Annual Report and the Rapid Response Service Annual Report are presented to the GM Children's Safeguarding Partnership as well as to the local safeguarding children's boards.

7.4 As part of the revised Greater Manchester Children's safeguarding partnership arrangements the Greater Manchester Safeguarding Partnership Board is no longer in place. As per the Wood Review (2016), there has also been a review of the effectiveness of local safeguarding children's boards and from September 2019 all local authority areas will be responsible for ensuring that there are clear arrangements in place within the local authority, a responsibility shared with clinical commissioning groups and the Police. There will be no requirement, however, for safeguarding children boards in their current form to exist and the work of CDOP will no longer be overseen by safeguarding arrangements. This requires, therefore, a review of reporting arrangements and scrutiny of CDOPs. It is proposed in this paper that the findings and scrutiny of CDOPs should be transferred to local and Greater Manchester Health and Wellbeing Boards.

7.5 CDOP Coordinators/Managers submit annual data to the DfE who review national trends in child deaths and produce the national Child Death Reviews Report. This database is no longer available and from 2020 the requirement is for this information to be submitted to the National Mortality Database.

7.6 There is multi agency representation on each of the CDOPs. This consists of Police, Health and Children's Social Care representation. Health services are normally represented by designated nurse and/or doctor. Public health is also represented at each CDOP. The additional requirement in the revised guidance is that there is a designated doctor for child deaths present. There is a need to decide whether this will be a discrete role or whether the role can be met between the designated doctor for Safeguarding and the SUDC paediatrician.

7.7 Each CDOP operates its own individual in-house Microsoft Access Database which is currently cost free. Bolton, Salford and Wigan CDOP and Tameside, Trafford and Stockport also operate the AGMA SharePoint system to securely share and exchange case information with CDOP members. There is a license fee for each user (£100 per user) which is funded by their LSCBs. Review of funding arrangements needs to occur.

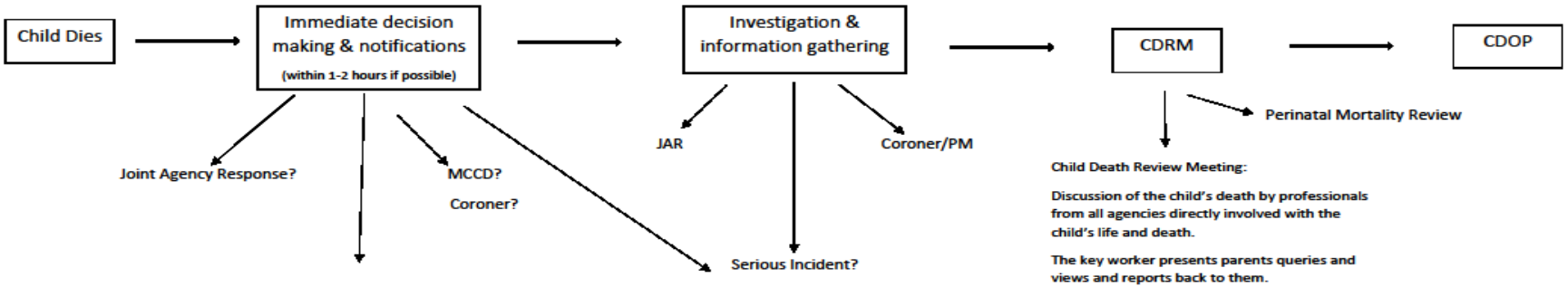
8. RECOMMENDATIONS FOR CHANGE

8.1 As set out at the front of the report.

APPENDIX 1

Child Death Review Process 2018

Overview:



Inform:

GP

Other professionals (midwives; health visitor; school nurse; etc)

CHIS

CDR Partners

MBRRACE

LeDer

Child Death Review Meeting:

Discussion of the child's death by professionals from all agencies directly involved with the child's life and death.

The key worker presents parents queries and views and reports back to them.

Aims are:

- **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 and welfare**
- **Review support for family and staff**
- **Inform the coroner and CDOP**

The meeting will complete as far as possible the draft analysis form to go to CDOP and should be chaired by lead professional for child death process within the Trust, generally in the location where the death occurred.

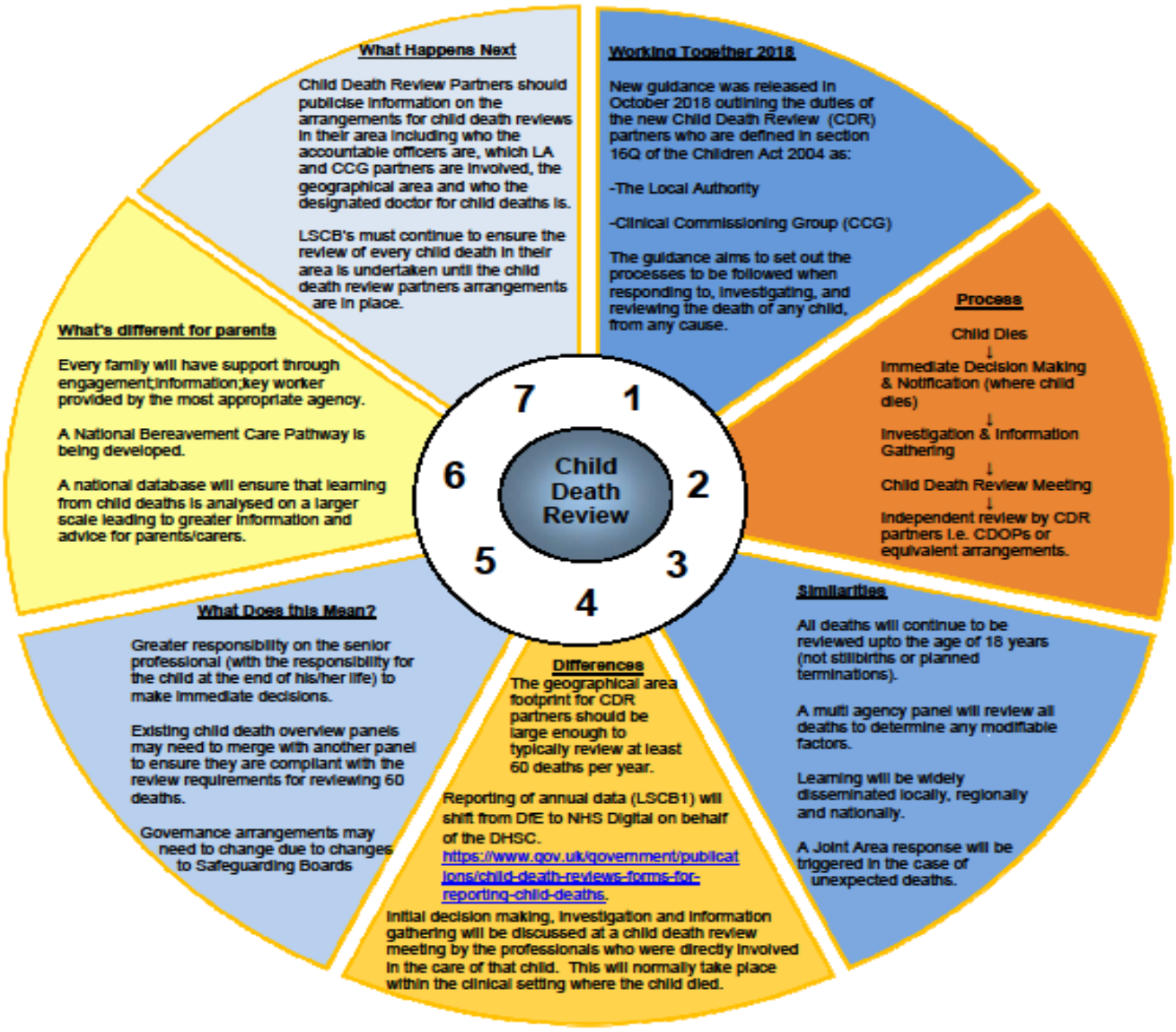
Support for the family:

- **Engagement – with the review and investigation process**
- **Information – from and to all relevant agencies**
- **Key worker – named, single point of contact. It is the responsibility of the organisation where the child was certified dead to identify a key worker for the family.**

APPENDIX 2

7 MINUTE BRIEFING

Child Death Review Statutory and Operational Guidance (England) 2018



Appendix 3

Annual reporting for Child Death Review Process