Appendix A

DELIVERING the NEW CHILD DEATH REVIEW PROCESS ACROSS BEXLEY, LEWISHAM AND GREENWICH

Underpinning principles that shape the changes:

"To improve the experience of bereaved families, as well as professionals, after the death of a child

To ensure that information from the child death review process is systematically captured to enable local learning and, through the National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice"

Child Death Review Statutory and Operation Guidance (England), October 2018

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Child Death Review Process Partners

Commitment of Six Partners Across Three London Boroughs to Deliver Child Death Review Arrangements

Signature

Michael Boyce
Deputy Managing Director and Director of Quality

NHS Bexley Clinical Commissioning Group

Signature

Martin Wilkinson
Managing Director

NHS Lewisham Clinical Commissioning Group

Signature

Yvonne Leese
Deputy Managing Director and Director of Quality

NHS Greenwich Clinical Commissioning Group

Signature

Anjan Ghosh
Director of Public Health

LONDON BOROUGH OF BEXLEY

Signature

Catherine Mbema
Interim Director of Public Health

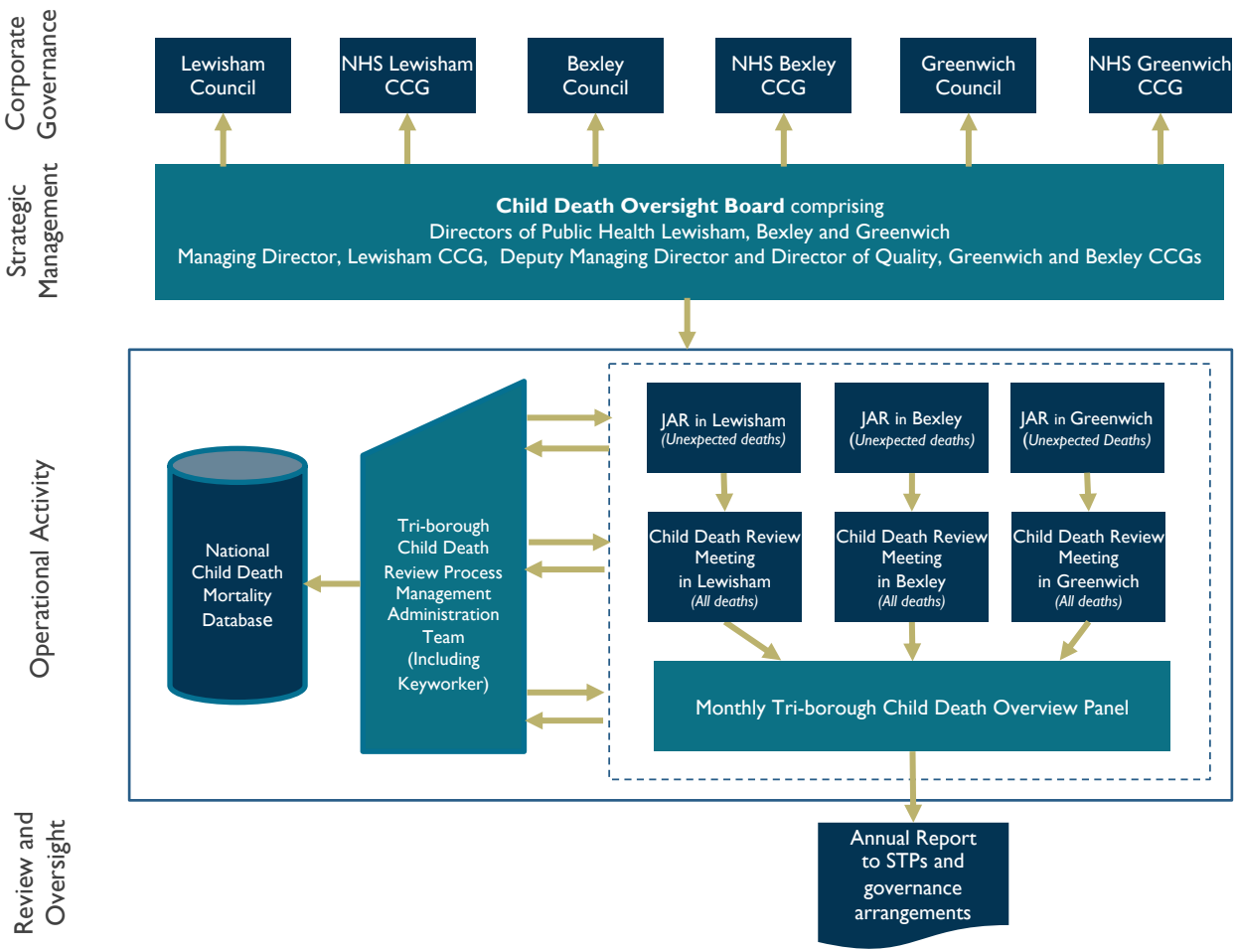
Lewisham

Signature

Steve Whiteman
Director of Public Health

ROYAL borough of GREENWICH

Governance of New Arrangements



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Child Death Review Process Arrangements

Partners and Funding

Bexley, Lewisham and Greenwich have agreed to combine and be treated as a single area for the purposes of Child Death Reviews. The six Child Death Review Partners shown on the previous page have committed to contribute shared and equitable funding to support a single central 'team' to support all aspects of the management and administration of the Child Death Review Process from notification of the child's death and assignments of a of keyworker through to review at the monthly Child Death Overview Panel (CDOP) including future costs of eCDOP.

Administration and Management

The Central Team will consist of a

- 1.0 Full Time Equivalent Process Manager
- 0.5 Full Time Equivalent Keyworker
- 1.0 FTE Administrator

Lewisham will act as the host for all posts within the Central Team.

Keyworker Role

Bereavement midwives and hospice workers, who currently undertake many aspects of the keyworker role for neonatal deaths and children who die in hospice (approximately 60% of child deaths) will continue to undertake this function.

A dedicated part time key worker will be based in the central team and will act as keyworker for all families that do not have a bereavement midwife or a hospice worker. Absence cover will be provided by the Process Manager to ensure that all families receive timely and consistent support.

When a child dies and an NHS Serious Incident Investigation is instigated, a 'case manager' will be appointed who will support the keyworker in having oversight of the various processes, tracking timelines and ensuring commitments to the family are met

Joint Agency Response

The acute trust will take the lead and liaise with the police, social care, education and other agencies (potentially by phone) and determine what information needs to be collected, who needs to be contacted and if investigations need to be triggered.

Any meetings, virtual or otherwise, will be chaired by the Designated Paediatrician.

Child Death Review Meetings

The Designated Pediatrician in each of the three hospitals (Lewisham, Queen Elizabeth and Darent Valley) is responsible for organising, and in most cases chairing, Child Death Review Meetings in their respective areas. In Lewisham and Greenwich the Designated Pediatrician has been allocated 2 pa sessions per week; in Bexley the Designated Pediatrician has been allocated 1 pa session per week to undertake this task. The allocation of time will be reviewed before the start of the next fiscal year.

Child Death Overview Panel (CDOP)

There will be a single monthly themed CDOP for the triborough where approximately 6 – 7 cases will be discussed. Three chairs will each chair four meetings a year in rotation and agree holiday and absence cover among themselves. Scheduling of cases to be reviewed and all organisation and administration will be undertaken by the Central Team.

A protocol for the Child Death Review Process for Bexley, Lewisham and Greenwich children who die in other areas has been developed.

Use of eCDOP

The eCDOP system is used in the Triborough and across London to ensure that information can be shared securely and that the National Child Mortality database receives the required information for each child death.

Annual Report

The three Chairs of CDOP will be responsible for producing an annual report on local patterns and trends in child deaths, lessons learned and actions taken as well as the effectiveness of the wider child death review process.

This report will be taken to the Triborough Oversight Group, which includes representatives from the local authorities, CCGs and police in the triborough. In addition, it will be taken to the appropriate Governance committee within the SE London STP.

The Annual Report will be published on the three local authority and three Clinical Commissioning Group websites.