**Rapid Response Service Specification**

The Rapid Response Paediatric Service be provided in line with

* + Working Together to Safeguard Children 2015
  + NHS Safeguarding Assurance Framework 2013
  + Sudden unexpected death in infancy: A multi-agency protocol for care and investigation, the report of a working group convened by The Royal college of Pathologists and The Royal College of Paediatrics and Child Health, September 2004; and
  + The Greater Manchester Proposal for the Providing a Rapid Response

(insert name) Clinical Commissioning Group (CCG) CCG will commission Central Manchester Foundation Trust (CMFT) to provide the following components on behalf of the Greater Manchester CCGs

* + - * 1. **Host the Greater Manchester Rapid Response Service (SUDC paediatric service). The duties of the host include the following:**
  1. Organise the rota of paediatricians giving cover for 24 hours per day, 365 days per year
  2. Lead the development and review of protocols
  3. Define Continuing Professional Development (CPD) requirements of staff and provide or signpost to appropriate CPD opportunities including completion of the Warwick training course for new doctors to the rota and provide training updates as required via doctors meetings and study days
  4. Provide both managerial and clinical leadership to the Consultants on the Greater Manchester rota
  5. Provide a central administrative function
  6. Provide the SUDC function for any child death that occurs in the Greater Manchester CCG’s footprint irrespective of where the child is resident or registered
  7. Comply with NHS England Serious Untoward Incident and StEIS reporting requirements including the completion of Root Cause Analyses (RCAs) and feed back of lessons learned
  8. To provide an annual report of the activity of the Rapid Response Team for consideration by the local Child Death Overview Panels (CDOP).
     + - 1. **The CCG Commissioned Paediatric services will provide pro-rata Consultant Paediatric cover contributing to the Greater Manchester rota or make payments to CMFT to cover this requirement. It will financially contribute to the function of the host i.e. CMFT. The functions being to:**
  9. Provide the first point of contact for sudden or unexpected deaths
  10. Respond to notifications of SUDC when on call. To provide immediate telephone advice and promptly attending Emergency Departments, and other necessary locations, when appropriate. To share information with healthcare staff, police and other staff directly involved.
  11. Take the lead:
  + In the medical investigation and running of the multi-agency protocol for care and investigation after SUDC
  + In the communication with other healthcare professionals
  + In the communication with other agencies, notably the police, the coroner’s office and the social services department
  + Ensuring all necessary multi-agency strategy discussions take place.
  1. Arrange to attend the Emergency Department, or other location where the relevant child is located, as soon as possible after the death to talk with the family, examine the child, and to examine the environment in which the child collapsed or died (which may not be in the family home) in accordance with the GM SUDC Protocol.
  2. Collate all relevant medical records (in collaboration with the local on-call consultant paediatrician).
  3. Prepare a report for the pathologist prior to the post-mortem examination.
  4. Ensure the family are fully informed and given appropriate support at all stages in close working with the Police Coroner’s Officer.
  5. Coordinate, organise and chair the local case discussion meeting as soon as the full results of the post-mortem investigations are available, usually several months after the death, and usually held in the primary care setting.
  6. Prepare a written summary of the local case discussion meeting and ensure it is distributed to all relevant professionals, including Her Majesty’s Coroner (“the Coroner”).
  7. Offer to meet the family to explain the outcome of the local case discussion meeting, including the cause of the child’s death, and send the family a letter, in accessible language and format summarising the meeting.
  8. Provide support to the Coroner whenever necessary in the organisation and conduct of the inquest.

1. **Work within CCG footprint and across Greater Manchester to develop high standards which are in line with Royal College guidance**
   1. Agree the division of responsibility between the on-call paediatrician at local provider Trust and the SUDC paediatrician in the event of an unexpected child death.
2. **Ensure the development and implementation of a local agreement between the coroners, police and NHS on the principles of how unexpected deaths in Childhood should be managed (the GM SUDC protocol)**
   1. Advise the CCG and NHS England Area Team on the commissioning of services relevant to care and investigation after SUDC.

**Information Governance**

Each individual provider Trust who provides Consultant Paediatrician on call cover for the SUDC rota will ensure that the correct Information Technology (IT) equipment (which complies with the requirements of the Data Protection Act 1998) is available to the doctor on call, and that the doctor has completed their employing Trust’s Information Governance (IG) mandatory training. The provider Trust will also ensure the Consultant Paediatricians who are covering the GM will have this duty reflected in the job description/plan.

**Governance**

On behalf of the GM CCGs, Tameside and Glossop CCG will be the lead commissioner for the Rapid Response Service. It will seek assurance for the performance and quality of the service provided.

**Performance Management Matrix**

Performance requirements may change as dictated by changes in national standards or at the request of the Lead Commissioner. Failure to meet a Key Performance Indication will trigger an Exception Report.

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| --- | --- | --- | --- |
| **Activity** | **Evidence** | **Key Performance Indicator** | **Exception Report Level** |
| **Activity Indicators** | | | |
| SUDC paediatrician attends all child deaths which are sudden and unexpected, unless directed not to by the police. | Annual report (AR) provides number of childhood deaths within GM within financial year. AR provides percentage of child deaths attended. | 100% of sudden, unexpected childhood deaths attended by SUDC paediatricians if agreed following initial telephone case discussion. | 95% |
| SUDC paediatrician should complete SUDC audit of case after completion. | Audit forms are available and completed. | 85% of all completed child death cases are audited | 80% |
| **Quality Indicators** | | | |
| Multi agency meetings are convened by SUDC paediatrician for child deaths with appropriate involved professionals in area child resided | Audit evidence is available within annual report | 90% of cases are followed by a multi agency meeting | 85% |
| **Outcome Indicators** | | | |
| Attempts are made to inform the family of the final case discussion/PM examination report findings when deemed appropriate. | Audit evidence is available within annual report |  |  |