NHS NAViGO

NAViGO HEALTH AND SOCIAL CARE CIC

LEARNING FROM DEATHS

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Target Audience:	All staff and bereaved families/carers

Any locally held old paper copies must be destroyed.

All staff are responsible to checking that they are using the most recent version of this document by checking the intranet before each use

Policy Amendments
Please provide a brief summary of amendments made to this policy
Care review tools process added (appendix B)
Changed terminology from ***Case record review*** *to* ***care review tool***
Changed detail of the team that the PALS coordinator works under (from ***quality team*** *to* ***corporate affairs****)*
Removed details of ***L&D service****, page 8*
Changed Appendix A to the ***new version of care review tool***

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NAViGO HEALTH AND SOCIAL CARE CIC

Learning from Deaths

1. INTRODUCTION / STATEMENT OF INTENT

The failings at Mid Staffordshire NHS Foundation Trust highlighted that essential improvements were needed to increase quality of care. A public enquiry lead to Robert Frances QC's detailed report highlighting a culture of secrecy and defensiveness, causing horrendous suffering to many patients. This enquiry identified a whole system failure and made 290 recommendations for improvement.

Sir Bruce Keogh undertook a review of 14 other failing NHS Trusts as indicated by high patient mortality. The report highlighted that practical steps were not being made to reduce avoidable deaths in NHS hospitals (Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, 2013).

A further report, Learning Candour and Accountability, Care Quality Commission, CQC (2016) supported these findings and showed that priority was not being given to learning lessons from deaths and therefore essential learning was being missed. A particular concern raised within this report was the poor and inconsistent engagement with bereaved families and carers during the investigation process.

The first attempt to standardise practice in regard to identifying, investigating and learning from deaths across NHS organisations was the Learning from Deaths report by the National Quality Board (NQB, 2017).

NAViGO is following the approach taken by the Northern Mental Health trusts in regard to interpreting the Learning from Deaths report in order to standardise practice.

This policy has been written to provide a clear and concise account for families and carers to enable them to understand NAViGO's process and principles for learning from deaths and how we will implement that learning, support them through the investigation process and how we will keep them informed. A more detailed policy in regard to the management of all serious incidents is available and should be read in conjunction with this policy where necessary.

Staff, Service users, families and others can raise concerns about this policy through the Quality team via email:

navigo.qualityteam@nhs.net

Alternatively please contact us by phone on:

01472 583040

2. SCOPE

This document applies to all staff within NAViGO whether they are employed permanently, temporarily, through an agency or bank arrangement, are students on placement are party to joint working arrangements or are contractors delivering services on NAViGO's behalf.

3. DEFINITIONS

Care Review Tools and Structured Judgement Reviews

A structured desktop review of a case record carried out by a clinician to determine whether there were any problems in the care provided to a service user. Care review tools are undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help to find problems where there is no initial suggestion anything has gone wrong. It can also be used where concerns exist, such as when bereaved families or staff raise concerns about care.

Death due to a Problem in Care
A death that has been clinically assessed using a recognised method of case record review where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision.

Investigation
A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why these problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by and follow case record review or may be initiated without a case record review happening first.

Mortality Review
A systematic exercise to review a series of individual case records using a structured or semi-structured methodology, to identify any problems in care. To draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of service users.

Quality Improvement
A systematic approach to achieving better service user outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Spine
System that supports the IT infrastructure for health and social care in England

4. Main Content

4.1 Objectives

NAViGO will implement the requirements outlined in the Learning from Deaths framework as part of its existing procedures to learn and continually improve the quality of care provided to all its service users.

The main objective is on learning from deaths and supporting families, carers and staff through this difficult process by:

- Prioritising and providing consistent, effective and meaningful supportive engagement with families, carers and staff that enables them to raise questions about the care provided.
- Identifying what improvements can be made to reduce the inequality in the life of people with a serious and enduring mental illness.
- Having a standard approach to assessing, reviewing and learning from deaths.
- Ensuring that NAViGO work cohesively with other stakeholders (acute trusts, primary care, public health, safeguarding and health and well-being boards) to maximise our learning from deaths.

This policy details how we respond to the deaths of individuals receiving care from NAViGO, how we work with partner agencies and how we promote learning from deaths.

The policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of NAViGO.

4.2 Culture

NAViGO promotes a culture of learning from deaths through its open and transparent involvement of both families/carers and staff in the investigation process. Working alongside families and carers within the investigation process provides an invaluable source of insight to improve our services.

NAViGO has identified a Freedom to Speak Up Guardian to assist staff in highlighting any safety concerns which is fed into the Chief Executive and the Assistant Director of Nursing and Quality.

Our Patient Advice and Liaison Service (PALS) team work within our corporate affairs team and supports individuals raising concerns about the care that we provide.

4.3 Family and Carer Involvement and Support

If you are reading this as a family member or carer of someone who has died and who received services from NAViGO and you have any questions or concerns to raise then please contact the Quality team via email at:

navigo.qualityteam@nhs.net

alternatively please contact us by phone on :

01472 583040

Once alerted about a death that may fall under the serious incident framework for investigation we will make initial contact with the family/carer. A decision will be made in conjunction with the Quality team, the service area manager concerned and the lead clinician as to who is the best person within NAViGO to make that initial contact.

Where it is undecided if the serious incident will fall under the serious incident framework for investigation we will make contact with the family/carer to gain an initial insight into their views in regard to the care that was provided to assist NAViGO in making the decision to investigate or not.

The initial contact with family is to ensure that we offer our condolences in regards to their loss, that we offer support where required and to explain the serious incident process and ask for their invaluable involvement within this.

Family and carers will also be sent a letter as per the Duty of Candour requirement, explaining all of the above in writing.

Family and carers will be offered an appointment with the appointed family liaison officer who may be the Associate Director of Nursing and Quality or the Quality Manager. We will gain the consent of the family/carer for the service manager of the affected service area to also attend this meeting as we feel that their involvement at this stage offers them invaluable insight into how their service area performed from the family perspective. We will respect the families/carers decision should they not want the involvement of the service manager at this point.

Families and carers will be invited to review meetings but we will respect their decision should they not want to be involved in these and will offer 1:1 meetings with them to gain their views.

At the initial meeting we will further explain the investigation process, we will explain what the terms of reference for the investigation are and we will invite the family to give their account of

events and record what terms of reference they wish to be addressed within the investigation. We will establish if the bereaved family/carer is receiving any support and will offer further support where needed, this may involve us providing support from a neighbouring organisation. We will explain timeframes and set a realistic timeframe that the family/carer will receive the report should they wish to have this.

The family liaison officer will make contact with the family/carer as agreed within the initial meeting, however, we will provide families/carers with the contact details to contact the family liaison officer where needed.

NAViGO has compiled a fact sheet in regard to serious incident investigations that we send out to family/carers with our initial letter.

Once the report is assured by our commissioners we will make this available to the family/carer. We prefer to do this in a face to face meeting so that we are available to answer any concerns raised at the time but will respect the family/carer wishes should they wish to receive this in the post. In these cases we will assure the family/carer that we are available to answer any questions they have and will arrange to do this either over the phone or in a face to face meeting (whichever they prefer).

4.4 Staff Involvement and Support

NAViGO start any investigation with the understanding that none of our staff come to work to do a bad job, this steers us in the right direction for identifying system or process errors rather than apportioning blame on individual clinicians. Should there be evidence that any member of staff has engaged in poor practice or malpractice then this will be looked into under a different framework.

Staff affected by the death of a service user will be notified in person by their line manager of the death where we are informed of this and they will be reassured of the level of investigation that will be taking place and their involvement in this.

They will be offered the opportunity to reflect on the incident informally with their line manager outside the formal investigation process.

A debrief will be held for all staff involved and on-going support provided by the line manager or a member of the quality team. Further information on debrief sessions can be found within NAViGO's serious incident policy.

Staff will also be offered the confidential care helpline should they require independent support.

Staff will be involved in the investigation process and in most cases will be interviewed as part of any investigation. They will be informed of the outcome of the investigation and will be kept up to date with progress during the investigation by their line manager.

4.5 Identifying and Reporting Deaths

The NAViGO performance team send a list weekly to the Demographic Batch Service (DBS) which processes information held against the spine who then flag which of our records have a date of death recorded. Following clarifying the cause of death with the registrar or coroner this information is fed back to the performance team who then record the death in our electronic record. A decision is then made as to whether or not the death falls under the Serious Incident Framework for investigation.

Any unexpected death reported or known to NAViGO staff must be reported to their line manager and through the DATIX incident reporting system within 24 hours of them being alerted to the death. The datix will be reviewed by the quality team and they will support the clinician and the service manager in regard to the next steps.

Once alerted to a death we will inform other organisations involved in care including the GP and the coroner within 72 hours.

Where we are alerted to an unexpected death from another organisation the individual clinician taking this information is responsible for completing a DATIX immediately.

An update on all reported deaths is provided to the executive team and to the CIC Board within the Safer Services report quarterly.

The Chief Executive and Director of Operations is informed of all deaths that fall under the Serious Incident Framework immediately.

4.6 The Decision to Investigate or Review

Our process involves the use of an amended Structured Judgement Review (Appendix A) along with the guidance provided by the Serious Incident Framework (2015), the National Quality Boards (NQB), Learning from Deaths (2017) recommendations and the LeDeR framework and the Child Death Review (2017). The process for structured judgement reviews is described in Appendix B.

The NQB, Learning from Deaths provides guidance on ‘must do’s as follows:

- Investigate all deaths where bereaved families/carers or staff have raised concerns about the care that NAViGO provided
- Investigate all inpatient and community deaths of those with a diagnosed Learning Disability
- Investigate all deaths in services where a previous significant concern has been raised with NAViGO through whatever means
- Investigate all deaths where individuals were not expected to die, for example in elective procedures such as ECT
- Investigate all deaths related to any quality improvement work that is ongoing to inform improvement projects
- Investigate a proportion of all other deaths that do not fit the identified categories, we will do this through a 10% random sample

For individuals with a diagnosed Learning Disability NAViGO will follow the LeDeR program. NAViGO’s LeDeR lead is the Safeguarding Nurse.

For all deaths of service users subject to the Mental Health Act we will notify the CQC immediately.

NAViGO will investigate all deaths of people diagnosed with a severe mental illness as defined by Psychosis including Schizophrenia, Bipolar Disorder, Unipolar Depressive Psychosis, Delusional Disorder and Schizoaffective Disorder until further clarification on this is made.

NAVIGO is following the Northern Mental Health trusts approach to supporting staff in the decision making and in managing deaths as follows:

NAViGO has the responsibility to report and investigate deaths as follows:

1. ***Where NAViGO is the main provider if at the time of death the service user was subject to:***
    - An episode of inpatient care in our services
    - An episode of community mental health care under the Care Programme Approach
    - An episode of community care due to identified mental health, learning disability or substance misuse needs
    - A Community Treatment Order (CTO)

- A Conditional Discharge
- A Guardianship
- An inpatient episode or a treatment package within the six months prior to their death
- Where an episode of care occurred longer than six months ago we will review the case on an individual basis or if requested by the family/carer, staff or external agencies such as our commissioners or the CQC

2. *Service users who meet the above criteria but are inpatients within another health care provider or custodial establishment at the time of their death*

In these cases the death will be reported by the organisation under whose direct care the patient was at the time of their death. That organisation will also exercise the responsibilities under the Duty of Candour. A joint investigation may be completed where it is felt that this will produce greater learning.

3. *Services provided by NAViGO where we are not classed as the main provider:*

Such as care home liaison where we will assist in the investigation process

4. *Exceptions*

Where we are not the main provider of care but where any act or omission by NAViGO staff or service is felt to have contributed to the death of a service user NAViGO will conduct an investigation.

NAViGO will make other trusts/organisation aware if they identify any problems within their services so that they may complete an investigation or review.

Where it is felt that a joint review will produce necessary learning NAViGO will work with other organisations in a coordinated way ensuring that quality improvement is prioritised, that care is reviewed from the family/carer perspective and that learning is demonstrated.

In addition to this the Northern mental health trusts have identified other potential triggers for review/investigation to which NAViGO will adhere:

- Where family/carer or staff raise any concerns with the care provided by NAViGO
- Where medication with known risks such as Denzapine was a significant part of the care package
- From causes or in clinical areas where concerns had already been flagged (e.g. at CIC or Membership Board or via complaints)
- In the use of rapid tranquillisation
- Where there had been previous safeguarding and public protection concerns
- Known delays to treatment from NAViGO or where there was any gap in service from NAViGO
- Associated with known risk factors/correlations
- Particular causes of death such as Epilepsy

- Random Sampling

4.7 Governance Process

Improving services for our service users is the primary focus of this policy.

NAViGO is committed to involving bereaved families, carers and staff in all investigations in order that we gain the richest learning that will promote quality improvement.

We will measure the implementation of this policy through the Safer Services report presented to our CIC Board where we will identify themes for thematic review.

We will measure the impact of this policy through feedback from families, carers and staff and through national guidance as it emerges.

We will assess learning through completing a review of each investigation that will identify:

- If improvements have been identified
- Are the actions SMART (Specific, Measurable, Achievable, Realistic, Timely)
- What the expected outcome of the actions are
- Quality improvement
- Improvement in patient experience
- Where improvements have led to safer services
- How the learning will be shared across NAViGO and other organisations where appropriate
- Where cultural changes are needed and any actions to ensure this have been made

If this policy is successful there should not be a repeat of the same lessons to learn, where this is identified NAViGO will complete a review with the services affected to ascertain why this issue has come up again and to put in robust actions to ensure any changes are embedded in the culture of the service area.

Where any themes are identified a thematic review will be completed by the quality team, the performance team and the service areas affected to see if there are any further actions required.

4.8 Data Reporting

We will disseminate the learning from deaths across all relevant clinical services by sharing the safer services report through the CIC Board.

We will present updates on progress for each investigation through the Quality Governance Committee.

NAViGO's Learning from Deaths policy and the Safer Services report is uploaded to our internet under Board Papers.

4.9 Death of a Child Under 18 Years of Age

NAViGO provides services for adolescents from 14 years old in our Early Intervention Service and young adults 16.5 years plus in our eating disorder service. As such we will follow the

guidance as set out in the Child Death Review Statutory Guidance (October 2017). The guidance supports that of Learning from Deaths and much of the process is the same.

All reviews of a child's death must enable us to understand why a particular child dies, of a particular cause, at a particular time through 4 areas

- Factors intrinsic to the child
- The social environment
- The physical environment
- The quality of care provided

Where the child is subject to a death in custody, under the Mental Health Act, Deprivation of Liberty Safeguards (DoLS), if the death is sudden and/or unexpected or where there is no apparent cause the death meets the criteria for a Joint Agency Response.

We will complete the form in Appendix B to ensure our procedure is being followed, this will be completed by the quality team or the on-call manager and forwarded to the quality team inbox immediately.

5. DUTIES

The Learning from Deaths framework places an increased emphasis on boards to ensure that a culture of learning is embedded across their organisation.

Role	Responsibility
Chief Executive, NAViGO CIC Board and Non-Executive Directors	To ensure compliance with the NQB guidance on learning from Deaths 2017 and working towards achieving excellence in mortality governance. Ensure quality improvement, patient safety and experience is a priority through effective actions and learning from investigations. The Medical Director has been appointed as the Board level safety director with responsibility for learning from deaths. NAViGO has also identified a named Non-Executive Director to take responsibility for oversight of NAViGO's progress and approach to learning from deaths.
Associate Director of Nursing and Quality	Accountable for the application of the serious incident policy and framework Produces a quarterly Safer Services report detailing that: • Robust systems are in place for identifying, reporting and investigating deaths • That bereaved families/carers are supported and engaged in the process • That learning from deaths is a priority and promotes quality improvement • That processes focus on learning and can withstand external scrutiny. Acts as family liaison officer where required

	Leads on highly complex investigations where required Attend Coroners Court for highly complex cases as the NAViGO representative Ensure all staff completing investigations have the necessary skills to do so in a competent and highly skilled manner Promote learning from deaths and ensure learning is acted upon to improve the quality of care Ensure that sufficient time is allocated within quality governance to manage learning lessons
Associate and Assistant Directors	Assist family liaison officer in meetings with family/carer where appropriate in highly complex investigations Complete highly complex investigations with the Associate Director of Nursing and Quality including homicide investigations Attend Coroners Court for highly complex cases as the NAViGO representative Ensure all actions pertaining to their services are embedded into practice
Clinical Managers and Service Leads	Assist family liaison officer in meetings with family/carer where appropriate. Complete investigations with the Quality Manager Attend Coroners Court as the NAViGO representative In conjunction with the quality team support staff to review and investigate deaths by giving them time to complete these to a high standard
Clinical Quality Manager	Act as family liaison officer Complete investigations Lead the quality team in regard to this policy and the serious incident policy
The Quality team	Has the responsibility to ensure: • All data on deaths is recorded and published to monitor trends • Compliance with this policy in relation to identifying deaths under the Serious Incident Framework, reviewing 10% of all deaths reported not initially subject to the Serious Incident Framework using the amended Structured Judgement Review to ensure consistency.
All Staff	To make themselves familiar with this policy and fully understand the process for learning from deaths.

	Report any quality or service user experience issues to their line manager, gaining advice from the Freedom to Speak Up Guardian where required.

6. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This policy has been presented at the Membership Board and to Quality Governance for approval.

A carer and NAViGO's community Non-Executive Director have approved the policy along with the Medical Director and the Quality Manager.

7. TRAINING NEEDS

All staff undertaking investigations are trained in root cause analysis.

As further clarification on the specific case record review method for mental health is identified we will ensure staff receive training on this method.

8. MONITORING AND AUDIT

The adherence to this policy will be reported through the NAViGO CIC Board via the Safer Services report.

9. REFERENCES

CQC (2016) Learning, Candour and Accountability A review of the way NHS trusts review and investigate the deaths of patients in England

Keogh B. (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

National Quality Board (2017) National Guidance on Learning from Deaths

10. APPENDICES

Appendix A – Care Review Tool

Appendix B – Process for Care Review Tools/Structured Judgement Reviews

Appendix C - Decision-making pro-forma for children up to the age of 18 years

Appendix D - Equality Impact Assessment

Appendix A

Care review tool for mortality reviews

Section 1

This section should be completed as soon as is possible.
If it is deemed appropriate to complete Section 2, it should be completed within 60 days of selected patients' deaths.

Patient identification number:		**Gender:**	
Date of birth (dd/mm/yyyy)		**Age:**	
Social deprivation index (first 3–4 letters of postcode)		**Ethnicity:**	
Date of death		**Time of death:**	
Location of death			
Was the patient identified as being within the last 12 months of life?			
Cause of death (if known)			
Primary diagnosis, including ICD-10 code			
Co-morbidities			
Learning disability (if present, this death should be reviewed through the LeDeR process)			
Healthcare teams involved in the patient's care at the time of death			
Dates of last admission to a psychiatric hospital (where relevant)			
Patient summary (can be completed by the clinical team)			
Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns)			
Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns)			
Red flags indicating further review where the death is not being investigated by other means (please indicate):			
Family, carers or staff have raised concerns about the care provided			☐
Diagnosis of psychosis or eating disorders during the last episode of care			☐
Psychiatric inpatient at time of death, or discharged from inpatient care within the last month			☐
Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death			☐
Other locally determined criteria for review (please state): ……………………			☐
Case selected at random			☐

If a red flag is identified, or it has been agreed this death is for a review of care, please proceed to completion of Section 2.

Trusts may add additional red flags and should choose an additional random sample of other cases to review.

Time taken to complete Section 1 of this form (minutes): ……………………

Date of completion: ……………………

Name of person completing Section 1: ……………………

Job title of person completing Section 1 ……………………

To be completed by Quality Team:

No further review required	
Full SJR (section 2 to be completed)	
SI investigation	

Section 2

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Allocation and initial assessment or review (where relevant) Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.2. Phase of care: Ongoing care (where relevant)

- **Was mental health monitored adequately?**
- **Was physical health monitored adequately?**
- **Please list medication if known and relevant, and comment on medication monitoring where appropriate**

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.3. Phase of care: Psychiatric Inpatients – comment on care during admission (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.4. Phase of care: End of life care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

2.5. Phase of care: Discharge plan of care (where relevant)
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.6. Other area of care (please specify)
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.7. Overall care Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice. Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation. Please also include any other information that you think is important or relevant.
Please rate the care received by the patient during this phase as: 5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐ Section not applicable ☐

2.8. If care was below an acceptable standard, did it lead to harm? If yes, please provide details and state an action plan (consider whether a serious incident investigation or another Trust process is required).

2.9. Was the patient's death considered more likely than not to have resulted from problems in care delivery or service provision? If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.10. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required. If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.11. Were the patient records adequate for the purpose of the review?	Yes ☐ No ☐
Please outline any difficulties in accessing appropriate information:	

Time taken to complete Section 2 of this form (minutes): ……………………

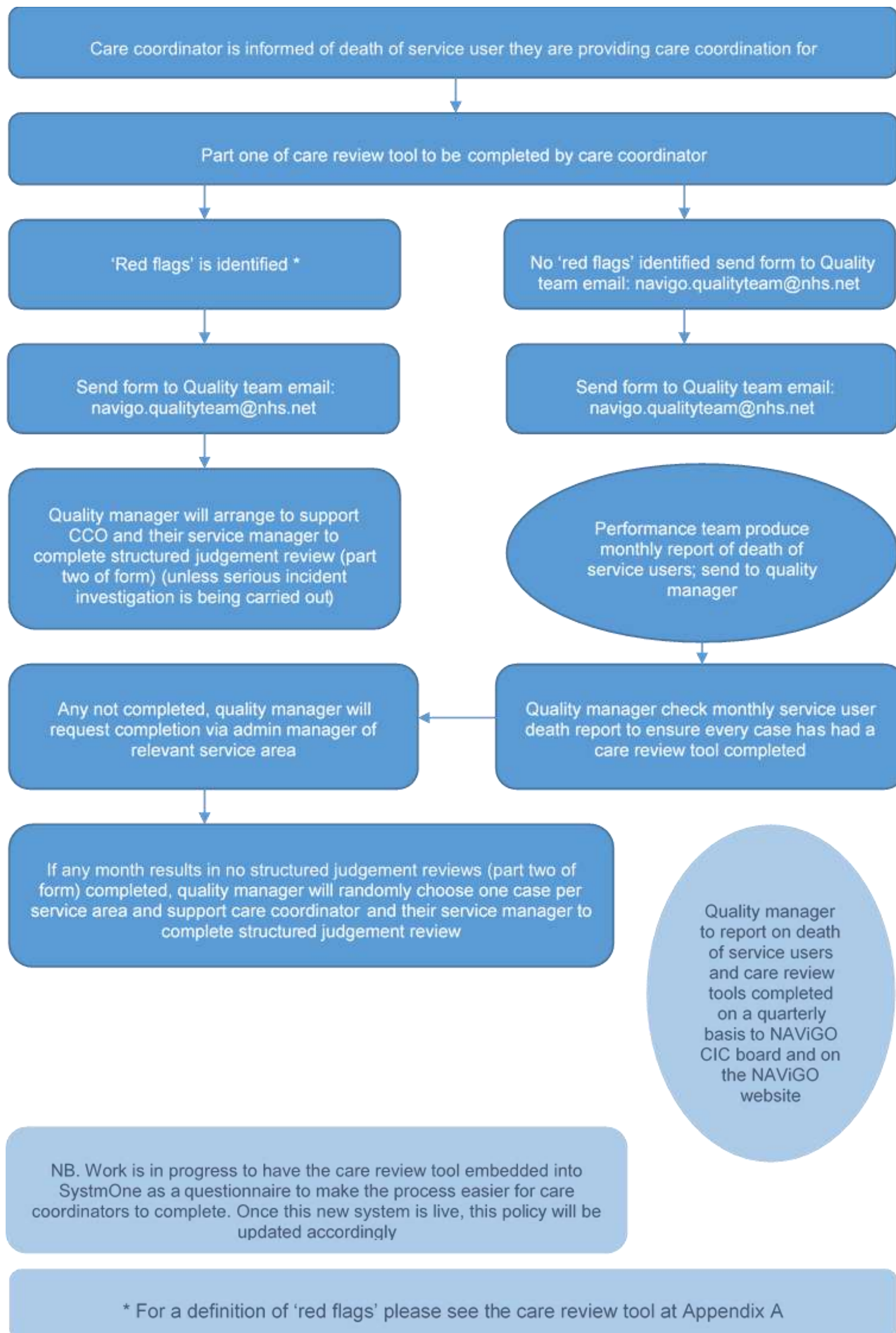
Date of completion: ……………………

Name of person completing Section 2: ……………………

Job title of person completing Section 2: ……………………

Appendix B

Care Review Tool and Structured Judgement Review Process



Appendix C

Decision Making Pro-forma for Children up to the age of 18 years

Child's name:	
Address:	
NHS or hospital number:	

Actions to be completed with 1-2 hours of death being declared (within 24hrs of death identification)				
	Decision?	Highlight with a cross	Action	Action completed?
1	Does death meet criteria for a Joint Agency Response? (death due to external causes, death sudden with no apparent cause (e.g. SUDI), death in custody or when child detained under MHA)	Yes No	If Yes, ensure that an initial meeting has taken place if not contact police, duty social worker and request they attend an initial meeting with the lead investigator and Consultant Psychiatrist in charge of the patients care.	Yes No Explain
2	Can a Death Certificate be issued?	Yes No	If No contact the coroner's office	Yes
3	Has a care or service delivery issue occurred?	Yes No	If Yes contact the Quality team	
3a	In relation to 3: Are there any immediate actions necessary to ensure safety of other patients?	Yes No N/A	If Yes describe here	
3b	In relation to 3: Has a Datix form been completed?	Yes No N/A		
3c	In relation to 3: Have obligations under the Duty of Candour been fulfilled?	Yes No N/A		
4	Describe the approach to supporting the family (key worker, end of life medical lead, family liaison officer):			
5	Describe the incident surrounding the death of the child/young person			
6	Is there a suspected care or service delivery problem identified			
7	Views of family/carer			

8	Views of Staff

Name of person completing this form	
Job title	
Date	

Appendix D

EQUALITY IMPACT ASSESSMENT

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

Name of Policy/Procedure/Service/Function being assessed: **Learning from Deaths**
Function or Department: Quality Improvement
List the main stakeholders – the recipients of the Policy/Procedure/Service/Function or the individual(s) or groups who are expected to benefit from, or to whom it applies: *All navigo staff, other organisations providing care for service users of NAViGO, service users, families and carers*
How relevant is the Policy/Procedure/Service/Function to each of the groups below? Does the policy have, or have the potential for differential outcomes for any of the listed groups? Does the policy affect or have the potential to affect any of the listed groups in an adverse way?

Category:	Relevant?	High Medium Low	Reasons for differential impact and why:
Ethnicity (Race)	NO		
Disability	NO		
Gender	NO		
Age	NO		

Sexual Orientation	NO		
Religion/Belief/Non-belief	NO		
Other (please state)	NO		

Overall rating:	*low*
Priority rating:	*low*

What other information do you need to complete this assessment, and before determining whether to proceed to a full Impact Assessment?
Other comments/observations for action:

Scheduled for Full Impact Assessment:	YES ☐ NO ☐

Name of person completing screening: Amanda Simpson

Designation: Associate Director of Nursing and Quality	Date Completed:	13.08.19