



END OF LIFE CARE POLICY CARE OF THE DYING CHILD

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‘During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups’

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
29/11/17	0.1		Clinical Director	New policy written and out for consultation	Dr Sian Butterworth – Clinical Lead Jackie Harry NICU Sister Samantha Matthias – Acting Sister Children's Ward
26/01/18	0.1		Clinical Director	For ratification	Clinical Standards Group
13/03/18	1.0	13 Mar 18	Director of Nursing	Approved at	Policy Management Sub-Committee
29/01/21	1.0	13 Mar 18	Chief Operating Officer Acute & Ambulance	12 month blanket policy extension due to covid 19 applied with author review date set 180 days prior to Valid to Date.	Quality & Performance Committee
07/05/21	1.0	13 Mar 18	Chief Operating Officer Acute & Ambulance	Extended policy uploaded and linked back	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1. Executive Summary

This policy covers children aged 0-18 years of age. This policy outlines the values, principles and practices that underpin the Isle of Wight NHS Trusts approach to the delivery of high quality end of life care for children.

It has been developed in line with the Together for Short Lives: Standards framework for children's palliative care (2015) and the NICE guidance for End of Life care for Children 2017. It uses the Together for Short Live Care Pathway for children as it's basis.

This policy is aimed at all professionals who work with children, in the Isle of Wight NHS Trust, and clearly outlines staff roles and responsibilities in assessing, recording, supporting and responding to all children who are considered to be end of life.

Its main focus is based on, and tailored to the needs wishes and preferences of the dying child and, their family, carers and those identified as important to them.

Compliance of the policy will be monitored both at paediatric department level and monthly auditing, and also against defined key performance indicators which are reported on, on a quarterly basis.

2. Introduction

Caring for children at the end of life and providing support to families and friends at this time is of profound importance. There is only "*one chance to get it right*" for the individual patient and the impact of that death will live on in the memories of those close to them.

End of life care is an emotive and important area of care that will affect us all. The Department of Health Strategy (2008) states, 'How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole, and it is a litmus test for health and social care services.'

Together for Short Lives is a nationally and internationally renowned charity that advocates for palliative care for children. They promote a care pathway approach to children's palliative care, and have produced three care pathways which relate to different age groups, and a further one specifically focused on making choices surrounding the withdrawal of life-sustaining treatment.

Giving families real choice is key to the care pathway approach: a choice of place of care, a choice of place of death, a choice of emotional and bereavement support, and putting the child and family at the centre of decision making to produce a care plan that is right for them.

Since the publication of the first care pathway in 2004, ACT (now Together for Short Lives) has been nationally and internationally recognised as setting the standards for

the care received by life-limited babies, children and young people. A number of other resources have been developed based on the standards' including *The Quality Standards for Children and Young People's Palliative Care* produced by the West Midlands Paediatric Palliative Care Network supported by West Midlands Quality Review Service. The group of children and young people covered by this document are described in detail within the relevant care pathway, but generally cover children of all ages – babies, children and young people – with any kind of life-threatening or life-limiting condition, receiving palliative care from health, social care and education services within the statutory and voluntary sector.

The NICE End of life care for infants, children and young people Quality standard [QS160] Published date: September 2017 offers very clear standards that we must adhere by.

[Statement 1](#) Infants, children and young people with a life-limiting condition and their parents or carers are involved in developing an advance care plan.

[Statement 2](#) Infants, children and young people with a life-limiting condition have a named medical specialist who leads and coordinates their care.

[Statement 3](#) Infants, children and young people with a life-limiting condition and their parents or carers are given information about emotional and psychological support, including how to access it.

[Statement 4](#) Infants, children and young people with a life-limiting condition are cared for by a multidisciplinary team that includes members of the specialist paediatric palliative care team.

[Statement 5](#) Parents or carers of infants, children and young people approaching the end of life are offered support for grief and loss when their child is nearing the end of their life and after their death.

[Statement 6](#) Infants, children and young people approaching the end of life and being cared for at home have 24-hour access to both children's nursing care and advice from a consultant in paediatric palliative care.

3. Definition

Patients are considered to be 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients:-

- Whose Death is imminent (expected within a few hours or days).
- Who have advanced progressive, incurable conditions where death is expected within the year.
- Who are frail and have co-existing conditions that mean they are expected to die within 12 months
- Who have existing conditions that they are at risk of dying from in the event of a sudden acute crisis

This policy is primarily focused on the identification and care of those people who are identified in the last weeks, days and hours of life.

4. Scope

This policy applies to all healthcare professionals who work within the Isle of Wight NHS Trust, and care for children who are deemed to be in the last weeks, days and hours of life.

End of Life Care is everyone's responsibility and applies to all healthcare settings within the organisation. The Neonatal Unit follow regional guidelines, so babies cared for within the NICU will be cared for in accordance with those guidelines.

5. Purpose

In line with local and national End of Life guidelines the purpose of this policy is to ensure that care given to patients in the last days and hours of life: -

- 5.1.** Is compassionate.
- 5.2.** Is based and tailored to the needs, wishes and preferences of the dying child and, their family and those identified as important to them.
- 5.3.** Includes regular and effective communication between the child and family, health care staff, and those identified as important to them.
- 5.4.** Includes regular assessment of the child's condition, with timely and appropriate response to changes where identified.
- 5.5.** Ensure care is led by a senior responsible doctor, and a lead responsible nurse who can access support from specialist end of life/palliative care services when needed.
- 5.6.** Ensure care is delivered by doctors, nurses, carers and others who have a high professional standard, skills, knowledge and experience that is needed to care for dying children and their families.
- 5.7.** Meets the standards highlighted by the NICE guidance (2017).

6. Roles and Responsibilities

6.1. Executive Medical Director and Executive Director of Nursing

- Will ensure the Trust has an evidence based policy in place to support early recognition and responses to all end of life patients.

6.2. Clinical Directors and Head of Nursing and Quality of Paediatric areas.

- Will ensure the policy is fully implemented within their business units.

6.3. Lead Clinician (medical and non-medical)

- Will ensure all their clinical team and members have read the policy and understand their role, actions, and responsibilities they have for children at end of life.
- Will champion this policy in practice.
- Will undertake and or delegate audits of the appropriate section of the policy and feed this into the overall data analysis of care of the dying.

6.4. Paediatric Matrons Department Leaders

- Will ensure all staff have read this policy and understand their role, actions and responsibilities when caring for children at end of life and those identified as important to them.
- Will ensure that all staff are compliant with the actions within the policy that relate to their service.
- Will undertake regular audits to ensure the clinical area is compliant with the policy.
- Will performance manage staff as per the Capability and Disciplinary policy should they not comply with the frame work of the End of Life policy.

6.5. Registered Practitioners (i.e registered nurse)

- Must be aware of the End of Life Care Policy and ensure that the process is followed correctly within the practice setting for all children who are deemed to be end of life.
- Must ensure, where appropriate, the correct referrals are completed, i.e. Children's Community Nursing Team, and the Regional Palliative care team from University Hospital Southampton.
- Must complete all relevant documentation to ensure that the delivery of care and decisions made are well evidenced.

- Must ensure that the Together for Short Lives care pathway is followed.
- Must ensure they are competent and confident to deliver end of life care, and to seek advice where needed.

6.6. Health Care/Nursing Assistants

- Must be aware of the End of Life Care Policy and ensure that the process is followed correctly within the practice setting for all children who are deemed to be end of life.
- Must ensure the registered practitioners are informed if there are any concerns i.e. change in symptoms.

6.7. Medical Staff (All Grades)

- Must be aware of the End of Life Care Policy and ensure that the process is followed correctly within the practice setting for all children at end of life and those identified as important to them.
- Must complete all relevant documentation to ensure that the delivery of care and decisions made are well evidenced.
- Must ensure they are competent and confident in making end of life decisions.

7. Policy detail/Course of Action

This policy applies to all clinical staff who work within the Isle of Wight NHS Trust and who are responsible for providing care for the dying child and those identified as important to them.

As detailed in the Together for Short Lives Care Pathway (2014), there are standards that should be applied to ensure that families experience a co-ordinated approach to family centred care throughout their child's life, regardless of their child's diagnosis, with clear and open communication and support to enable the family to build up and maintain access to an appropriate network of support, regardless of where they are cared for, whether that is in hospital, in their home, or in a hospice.

This policy will focus on care for the end of life, clearly making the dying child themselves the focus of care in the last few days and hours of life and exemplify the high-level outcomes that must be delivered for every dying child. The way in which the Standards for Care are achieved will vary, to reflect the needs and preferences of the dying child and their family, and the setting in which they are being cared for.

7.1. Recognition of end of life phase

The possibility that a child may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.

- 7.1.1.** When a child's condition deteriorates unexpectedly, and it is thought they may die soon, i.e. within a few hours or very few days, they must be assessed by a doctor who is competent to judge whether the change is potentially reversible or the child is likely to die.
- 7.1.2.** If the condition is deemed as potentially reversible, prompt action must be taken to attempt this, provided that is in accordance with the child and family's wishes. If it is established that the child lacks capacity to make the decision about treatment at that time, the decision can be made by the child's parents.
- 7.1.3.** If the child is likely to be dying, unless otherwise indicated by the child's age and level of understanding, and taking into account the views of the parents, this must be clearly and sensitively explained to the child, their family and those deemed as important to them in a way that is sensitive to their circumstances.
- 7.1.4.** The child's views and preferences must be taken into account, and those important to them must be involved in decisions in accordance with the child's wishes.
- 7.1.5.** A plan of care must be developed, documented, and the child must be regularly reviewed to check that the plan of care remains appropriate.
- 7.1.6.** Care for children who are potentially in the last few days and hours of life should be a continuum of assessment, with the focus on their condition, needs and wishes and where appropriate responses should be made in response to the child's needs and preferences.

7.2. Communication

Sensitive communication takes place between staff and the dying child, and those identified as important to them.

- 7.2.1.** Open and honest communication between staff and the child who is dying, their parents, and those identified as important to them, including carers, is critically important to good care.
- 7.2.2.** Clear, understandable and plain language must be used verbally and in all other forms of communication with the dying child and those important to them.

- 7.2.3. If the dying child or their parents, need additional support to understand information, communicate their wishes or make decisions, these needs must be met.
- 7.2.4. Communication must be regular and pro-active, i.e. staff must actively seek to communicate, not simply wait for the child, their parents, or those important to them to ask questions.
- 7.2.5. Communication must be two-way, i.e. staff must listen to the views of the child, their parents and those important to them, not simply provide information.
- 7.2.6. Communication should be conducted in a way that maximises privacy.
- 7.2.7. Communication must be sensitive, respectful in pace and tone and take account of what the dying child, their parents, and those important to them want and feel able to discuss at any particular point in time.
- 7.2.8. Staff must check the other person understands of the information that is being communicated, and document this.

7.3. Decisions

The dying child, and those identified as important to them, are involved in decisions about treatment and care.

- 7.3.1. The NHS Constitution pledges the right for all individuals to be involved in discussions and decisions about their health and care which includes end of life care. "Where appropriate this right includes their family and carers."
- 7.3.2. Sensitive and honest communication with the dying child, their parents and those identified as important to them must be undertaken to assess to what extent they wish to be involved in the decisions about the treatment and the way it is delivered.
- 7.3.3. Sensitive communication is needed to ascertain the wishes of the dying child, their parents and their wishes must be respected.
- 7.3.4. The child, their parents and those important to them, must be told who is the senior doctor in the team who has responsibility for their treatment and care, whether in hospital or in the community, and the nurse leading their care.
- 7.3.5. Where it is established that the dying child lacks capacity to make a particular decision, the decision made or action taken on their behalf

must be in their best interests, and they should still be involved as far as possible in that decision.

7.3.6. An Advanced Care Plan should have been explored and completed with the family and distributed as per policy. This should aid difficult decisions relating to life prolonging treatments.

If an ACP is not in place, and decisions need to be made regarding life prolonging treatments, the care team should discuss with parents and the child, if appropriate, and together must decide which decisions need to be made on the spot to ensure the child's comfort and safety, and which can and must wait for a review of the person's condition by the senior doctor or the delegated on-call clinician.

7.3.7. Where the dying child and parents are assessed as lacking in capacity the multi-disciplinary team must comply with the legal requirements in relation to representation or advocacy and Best Interest decisions.

7.3.8. The Resuscitation status of the dying child should be agreed and recorded in line with the Isle of Wight Trust Paediatric Advanced Care Plan Policy.

7.3.9. Professionals must also ensure they respect advance decisions that are valid and applicable to the circumstances.

7.3.10. When there are fundamental disagreements between clinicians and parents/child around the care to be given, these will be explored fully using alternative clinicians in the first instance, and mediation. If this is then unresolved, legal advice should be sought.

7.4. Wishes and Choices

The needs of families and others identified as important to the dying child are actively explored, respected and met as far as possible.

7.4.1. Families and those identified as important to the dying person are likely to have needs during such a time of distress and therefore these must not be overlooked. It is not always possible to meet the needs of all family members however staff must ensure opportunities are available for sensitive and open conversation in quiet surroundings to provide updates on care provided and to offer support.

7.4.2. If a lack of capacity is assessed in the dying child and in the parents, the decision-making process should be explained to those people who are supporting the family and they should be involved as much as possible.

7.4.3. Choices around place of death will be offered and discussed with the family and should be documented within the Advanced Care Plan. Families can choose the specialist children's provision at Earl Mountbatten Hospice, to be at Home or on the Children's Ward. The

Community Children's Nursing Team will support care wherever the family chooses and offer 24hr on call cover, (as well as 24hr sitting service if EMH is the chosen place of death as per the Memorandum of Understanding).

7.4.4. Access to the Isle of Wight NHS Trust chaplaincy service should be considered.

7.5. Care needs

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

7.5.1. A plan for care and treatment must be developed to meet the dying child's needs and wishes in relation to how their care should be managed and any treatment preferences they and their parents may want to express.

7.5.2. This plan must include attention to symptom control developed with the Regional Paediatric Palliative Care Team at University Southampton Hospital Trust (e.g. relief of pain and other discomforts) and the child's physical, emotional, psychological, social, spiritual, cultural and religious needs.

7.5.3. This plan of care must be clearly documented so that consistent information about the child and family's needs and wishes is shared with those involved in the person's care and available at the time this information is needed.

7.5.4. The care plan should be reviewed as circumstances, including the dying child's preferences, change.

7.5.5. The care plan should be immediately available to health and care staff who are or might become involved in caring for the dying child, (including ambulance services, social care services and 'out-of-hours' general practitioners), so that the child and family's preferences are known and can be taken into account across the range of services they receive.

7.5.6. There must be prompt referral to, and input from, the Children's Community Nursing Team or for more complex, specialist palliative care needs, a prompt and timely referral should be made to the Regional Paediatric Palliative Care Team at University Southampton Hospital Trust Hospital.

8. Symptom Control

All medications, including anticipatory medicines, must be targeted at specific symptoms, have a clinical rationale for the starting dose, be regularly reviewed, and adjusted as needed for effect.

Referrals to specialist palliative care teams must be undertaken if adequate pain relief is not being achieved.

8.1. Nutrition and Hydration

The child must be supported to eat and drink as long as they wish to do so, and their comfort and dignity prioritised.

If there is concern that there may be serious risks associated with food and drink consumption specialist advice must be sought e.g. choking assessment and alternative methods of hydration considered.

If the dying child and family makes an informed choice to eat or drink, even if they are deemed to be at risk of aspiration, this must be respected.

8.2. Comfort and Dignity

Assessment of the dying child's comfort and dignity must be documented in the care plan and include the use of relevant assessment tools, the frequency of reviews and how personal and mouth care are delivered.

Specialist equipment used for comfort and dignity must be sought if deemed necessary e.g. specialist mattresses and bedrails.

If care is being delivered within the Children's Ward, this should be within a side room.

8.3. Spiritual and religious care

The dying child's religious/spiritual needs must be assessed and access to the chaplaincy service must be considered.

Staff, must seek to establish from the dying child, their family and those important to them, details of any relevant cultural or religious-specific requirements, including what constitutes respectful treatment of the body after death.

8.4. Transfer of a dying patient

If a child is expected to die within 24 hours of the documented assessment, and place of death is in an alternate environment, hospital transfers must be deemed as a priority and done within 4 hours.

The family may choose to transfer the child within their own car. This should be done in close liaison with the Children's Community Nursing Team.

If there is a concern the child may die on transfer, then the child **MUST NOT** be moved

The risks of person dying on route must be explained to the family and the family must be in full support of the non-clinical transfer.

All conversation must be documented.

8.5. Care after death

Parents should be offered the choice of using the facility at Earl Mountbatten Hospice for after death care. The body of the child can be transferred to EMH after death and cared for using a cooling mattress and a cool environment.

Parents can choose to transfer the child in their own cars or by funeral directors.

8.5. Inclusion/Exclusion criteria for use of the End of Life Care Plan.

Inclusion:-

All children that are recognised as dying, including children that attend ED, must have an end of life care document commenced.

Exclusion:-

Unexpected deaths, i.e. cardiac arrests, trauma.

Deaths within the Neonatal Unit will be managed utilising the Thames valley and Wessex Neonatal Operational Delivery Network Guideline.

Children who die unexpectedly whilst receiving active treatment.

9. Consultation

This policy has been developed in accordance with National and Local Guidelines. The Leadership Alliance for the Care of Dying People and the One Chance to Get It Right (2014) was utilised as a platform, with the main focus on the principle use of the Five Priorities for Care.

Both Medical and Nursing professionals have been consulted and the policy has been shared via the end of life working group.

It has been out for consultation to the relevant Medical Directors and Heads of Nursing and has been shared with relevant professionals within the business unit.

10. Training

The implementation of this policy will be supported through awareness sessions with all relevant Business Units and Corporate Teams

This end of life Policy has a mandatory e learning requirement for groups of clinical staff.

This is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis.

The following non-mandatory training is also recommended: -

Monthly End of Life Champions training sessions.

Advanced Communication skills

The Children's Community Nursing Team and Regional Paediatric Palliative Care Team will deliver informal education to staff as requested.

11. Monitoring Compliance and Effectiveness

The compliance for this policy will be conducted by the clinical leads responsible for End of Life Care.

All reports and findings from audits will be presented at the Monthly End of Life Care operational group meeting and will be fed back to the IOW NHS Trust and Earl Mountbatten Hospice Partnership Board.

- Data is collected via PIDS, and the compliancy with the use of the 'Priorities for Care' care plan is audited monthly.
- Monthly audits will be undertaken by the End of Life Care Facilitator and the Earl Mountbatten Discharge coordinator to monitor discharge to preferred place of care.
- Quarterly audit to monitor the overall quality of end of life care.

- A weekly Mortality and Morbidity review is held.
- Data is collected in relation to non-clinical end of life transfers.
- Any cases of failure to comply with this policy will be investigated.

12. Links to other Organisational Documents

Paediatric Observation/PEWS Policy.

Children and Young People Advanced Care Planning Policy.

Mandatory Training Policy.

Resuscitation Policy.

13. References

Department of Constitutional Affairs (2005) Mental Capacity Act. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf [Accessed 30th October 2017].

Department of Health (2008) *End of life Care Strategy: promoting high quality care for all adults at the end of life*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf [Accessed 30th October 2017].

Isle of Wight NHS Trust (2015-2020) *End of Life Care Strategy*. Available at: <http://www.iow.nhs.uk/Downloads/Consultation%20Engagement/End%20of%20Life%20Care%20Draft%20Strategy%20APPENDICES%20for%20Public%20Consultation%20-%20PRINT.pdf> [Accessed 30th October 2017].

NHS England Leadership for the Alliance (2014) *One Chance to get it Right*. Available at: <https://www.england.nhs.uk/ourwork/qual-clin-lead/lac/> [Accessed 7th November 2017]

National Palliative and End of Life Care Partnership (2015-2020). *Ambitions for Palliative and End of life Care: A National Framework for Local Action*. Available at: <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf> [Accessed 30th October 2017].

Nice Guidelines (2017). *End of life care for infants, children and young people Quality standard [QS160]*
Available at <https://www.nice.org.uk/guidance/qs160/chapter/Quality-statements>

Together for Short Lives February 2013 *A Core Care Pathway for Children with Life-limiting and Life-threatening Condition 3rd Edition*, Available at http://www.togetherforshortlives.org.uk/assets/0000/4121/TfSL_A_Core_Care_Pathway_ONLINE.pdf

Together for Short Lives (2015) *Standards framework for Children's Palliative Care* Available at http://www.togetherforshortlives.org.uk/professionals/resources/3687_standards_framework_for_children_s_palliative_care_2015_free

14. Appendices

Appendix A **Checklist for all children who are deemed to be End of Life.**
Appendix B **Financial and Resourcing Impact Assessment**
Appendix C **Equality Impact Assessment (EIA) Screening Tool**

Checklist for all children who are deemed to be End of Life.

- Ensure open discussions have occurred with families and the child if appropriate, and recorded within the Children and Young person's Advanced Care Plan is in place that clearly shows the child is for optimal supportive care.
- Sign off PEWS chart if in place, and stop observations.
- Inform the Children's Community Nursing Team, so that the option of place of death can be fully supported.
- Contact the Tertiary Paediatric Palliative care team for support in writing a symptom management plan
- Commence the Individually written, End of Life Care Plan. Ensure that all relevant conversations with family are documented.
- Ensure Just in case medications are prescribed and all unnecessary medications are suspended.
- Consider any spiritual needs and contact chaplaincy via switch.
- Ensure that the child and family are moved into a side room.
- Consider preferred place of care, discuss this with the family.
- Liaise with the management team at Earl Mountbatten Hospice if the children's facility is expected to be required for EoL care or for after death care.
- Photocopy the Children and Young Persons Advanced Care Plan on purple paper, sending original document with the child on discharge, and retain the photocopy within the child's main hospital notes.
- Ensure that an Ambulance Anticipatory Care Plan is completed, a Triage Bypass Card is given to the family, and a copy of the CYPACP is attached.

Financial and Resourcing Impact Assessment

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore, this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	End of Life Care Policy: Care of the dying child
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Totals	WTE	Recurring £	Non-Recurring £
Manpower Costs	Time to allocate staff to complete mandatory training		
Training Staff Mandatory E learning for appropriate clinical groups	Completion of mandatory training module		Equates to approximately 40mins of time per person
End of Life Champions Monthly Teaching Sessions	Wards to release champions to attend meetings		1.5Hrs per month
Paediatric Palliative Care Networking meetings	Staff to be released to attend quarterly meetings at Naomi House Children's Hopsice	Quarterly Travel costs to attend meeting	

Summary of Impact: Training of staff in the use of this policy will occur through local induction to clinical areas and will be disseminated through the Champions meetings. The training is supported by the End of Life Nurse Facilitator and the Hospital Palliative Care Team. Specific Paediatric Palliative Care training is disseminated from the quarterly networking meetings at Naomi House.

Risk Management Issues: This policy document is designed to support effective risk management across the Trust by decreasing the risk of patient harm by failure to provide high quality care of the dying person.

Benefits / Savings to the organisation:

- Dying child will receive high quality individualised end of life care
- Family and those deemed as important to the dying child will be communicated with and included in decision made.
- Children who are dying will have increased opportunity to die in their preferred place of care.
- Children who are assessed as dying will not be transferred inappropriately.
- Reduced hospital stays.
- Contribute to following both National and Local quality guidelines.

Equality Impact Assessment

- | | |
|--|-----|
| ▪ Has this been appropriately carried out? | YES |
| ▪ Are there any reported equality issues? | NO |

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	WTE	Recurring £	Non-Recurring £
Operational running costs	N/A		
Totals:			

Staff Training Impact	Recurring £	Non-Recurring £
End of Life Champions Monthly Teaching Sessions	1.5hrs per month	
Mandatory On Line Training	40 mins per year	
Totals:		

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed	NA	
Building alterations (extensions/new)	NA	
IT Hardware / software / licences	NA	

Medical equipment	NA	
Stationery / publicity	NA	
Travel costs	Quarterly travel to attend networking meeting Redjet and train to Winchester approx. £32.00 x 4 = £128 per year	
Utilities e.g. telephones	NA	
Process change	NA	
Rolling replacement of equipment	NA	
Equipment maintenance	NA	
Marketing – booklets/posters/handouts, etc	NA	
Totals:	£128.00	

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Equality Impact Assessment (EIA) Screening Tool

Document Title:	End of Life Care Policy: Care of the dying child.
Purpose of document	Care of the dying child.
Target Audience	All areas and clinical staff who care for the dying child
Person or Committee undertaken the Equality Impact Assessment	Children's Community Nurse Team Leader

1. To be completed and attached to all procedural/policy documents created within individual services.
2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?
3. If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	N	N	
	Women	N	N	
Race	Asian or Asian British People	N	N	
	Black or Black British People	N	N	
	Chinese people	N	N	
	People of Mixed Race	N	N	

	White people (including Irish people)	N	N	
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	N	N	
Sexual Orientation	Transgender	N	N	
	Lesbian, Gay men and bisexual	N	N	
Age	Children	N	N	
	Older People (60+)	N	N	
	Younger People (17 to 25 yrs)	N	N	
Faith Group		N	N	
Pregnancy & Maternity		N	N	
Equal Opportunities and/or improved relations		N	N	

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

Appendix D - Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	NO
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	

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