Papworth Hospital NHS
NHS Foundation Trust

Document title: **Children & Young Adults Management Policy**

Document number: **DN270**

Staff involved in Development (job titles):	Director of Nursing / Assistant Director of Nursing Lead Nurse for Child Protection Social Work Team
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Key points of this document

- To enable safe care delivery for children and young adults at Papworth Hospital NHS Foundation Trust.
- To safeguard children and young adults against deliberate harm or abuse.
- To outline the process to be followed should deliberate harm or abuse be suspected.

Contents

1.0 Introduction

The core purpose of the Trust is to provide a comprehensive range of cardiothoracic services for adult patients. However in 1994 the Trust Board endorsed the development of an adolescent service for patients with Cystic Fibrosis (CF) and, in 1995, endorsed the admission of young patients requiring the unique services of the Respiratory Support and Sleep Centre (RSSC). Furthermore, in 2010 the Board of Directors extended this to cover admission to any side room, on exceptional occasions, children or young adults that may require access to the full range of specialist services offered by the Trust following discussion with and approval of the named nurse or appropriate other in her absence. It was also acknowledged that these children will require the services of our out-patient departments.

This document provides information on the Trust's approach to managing paediatrics within an adult environment, with reference to the necessary national child protection guidelines and procedures for paediatric admission and paediatric cardio pulmonary resuscitation.

2.0 Background

The Laming report, also known as the Victoria Climbié Inquiry report, (HMSO, 2003) and the Baby P enquiry emphasised the need for public service organisations to review and improve the arrangements for children, particularly in respect of safeguarding. As a result, the then Commission for Health Improvement (CHI) designed a self-assessment approach for health care organisations to address key issues in child protection and to promote action to improve safeguarding services and practice. In addition to this the Care Quality Commission (2009) following a review of the NHS safeguarding children arrangements called for a review of all provision working towards a new registration scheme to be announced and in place in 2010.

Each year the Trust is required to submit a self assessment against standard 11 (Appendix A) of the Childrens Act (2004) to the Local Safeguarding Children Board.

Specific to Papworth Hospital is that paediatric admissions form 1.60% of the total inpatient activity and 1.61% of the total out-patient activity (2012/13).

Care Quality Commission Outcome 7: Safeguarding people who use services from abuse

People using the service:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld. This is because providers who comply with the regulations will:
- Take action to identify and prevent abuse from happening in a service.

- Respond appropriately when it is suspected that abuse has occurred or is at risk of occurring.
- Ensure that Government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice.
- Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.
- Only use de-escalation or restraint in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services.
- Understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns.
- Protect others from the negative effect of any behaviour by people who use services.
- Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.

3.0 Aims

- To ensure that Papworth Hospital NHS Foundation Trust has an environment that is safe for children, irrespective of whether the child is a patient (Appendix P) or a visitor.

- To ensure that Papworth Hospital staff can safeguard children, promote their welfare and reach decisions about the appropriate course of action for the children about whom there are concerns (Appendices H and P).

- To ensure there are agreed standards to monitor compliance (Appendix A).

- To ensure that transitional arrangements are explicit within each specialty when a child moves from a paediatric to adult environment at the age of 16 (Appendix B).

- To provide safe recruitment processes as per DN121 Recruitment & Selection Procedure.

4.0 Scope

To consider the recommendations of Every Child Matters (DoH, 2003), this obliges all public institutions to promote the well being of children and young people. To deliver on the standards set by the Children's NSF (2004) Standard 7 (Appendix C). Under the Children's Act 1989, the term "children and young people" extends to just before the 19th birthday if the person is disabled or chronically ill but, for the purposes of child protection procedures, a person is only regarded as a child up to but not including his/her 18th birthday.

All healthcare staff have a vital contribution to child protection through their:

- Recognition of children in need of support (Appendices D, H and I).
- Participation in enquires about the needs of an individual child (Appendix H).
- Assessment of a child's needs and her/his parents' capacity to meet them.
- Planning and provision of support to a child in need.
- Planning and participation in protection plans to support a child at risk.
- Provision of therapeutic help to a family via child and adolescent mental health services.

4.1 Child Protection Requirements

As a provider Trust Papworth is responsible for identifying 'named' doctor/s and nurse/s for child protection and Safeguarding Champions who are responsible within our organisation for ensuring:

- Provision of expert health advice on child protection to staff and other agencies, as appropriate, regarding individual cases and contribute to the planning of services.
- Provision of inputs to the Local Safeguarding Children's Board (LSCB) agencies in the ongoing development of policies, procedures and guidance.
- Identification of training needs of all staff including the training needs of medical personnel.
- Multidisciplinary training.
- The review of child protection standards in the Trust.
- Systems between different parts of the health services for the transfer of children's records and other relevant information.
- Service level agreements that incorporate child protection requirements including a clear monitoring process.
- Effective systems of child protection audit to monitor the application of agreed child protection standards.
- Appropriate doctors/nurses denomination to undertake the Trust's responsibility for case reviews (DoH 2010 Working Together to Safeguard Children Chapter 8 pg 233-255).
- Dissemination of recommendations and implications of case reviews in conjunction with the chief executives concerned.
- Identification and reporting of unmet needs in service provision to senior managers and the consequences of the situation.
- Coordination and liaison with other professionals with child protection responsibilities within health services and other partner agencies.
- Adherence to the Trust's operational procedure for child protection (Appendix H), when a non-accidental injury or child maltreatment is suspected or considered as identified by NICE (2009). Refer to NICE Quick Reference Guide When to Suspect Child Maltreatment (July 2009).

This is monitored internally by the Board of Directors on an annual basis, by commissioners on a quarterly basis, and through submission of self assessment against Section 11 Standards of the Children's Act 2004 to the Local Safeguarding Children's Board.

5.0 Protocols

- The Trust is guided by the Local Safeguarding Children's Board (LSCB) procedures (July 2010), and Working Together to Safeguard Children, H M Government March 2010.

- The Trust risk management process also supports the above. For example, should a child be admitted and it was "missed" that the child was on either the Child Protection Register, In Need or A Cause for Concern, a clinical incident form would be raised and a review undertaken.

6.0 Safeguarding Children Training

It is expected that all public service employees receive the appropriate level of training. The level of training is dependant on the autonomy of the employee, the level of supervision that they work within and the amount of contact that they have with children and young people. This training is provided by either the LSCB or the Trust. Training levels are identified in Appendix L.

The Trust holds the child safeguarding training records on OLM and this will be reviewed biannually by the Safeguarding Vulnerable People Committee.

Training is about raising the awareness of key staff about what factors correlate with children and young people and how presenting circumstances should be managed. Training aims to develop competencies and skill-sets so that staff can fulfill key roles.

Please refer to the Training Needs Analysis (DN302) for levels of training needed for each staff group.

6.1 Non Attendance at Training

It is the responsibility of managers to identify the training required by all substantive staff, on recruitment, relevant to their job role and responsibility and as procedures are developed or amended. It is the responsibility of staff to access and attend training relevant to their role. The annual appraisal/individual performance review process should also be used to confirm that staff have undertaken the required training and identify any future training needs. Managers should ensure that staff are booked on to the relevant training for their job role via Human Resources Learning & Development Department who will ensure that records of attendance are maintained via a central database.

The Learning & Development team will notify managers of staff non-attendance at training courses. It is the manager's responsibility to re-book staff and ensure attendance at the next available training session. Where this is not achievable, managers must assess the associated risks and report through the relevant directorate group.

7.0 Child Safeguarding Audit

Each year the Trust is required to return a Section 11 self assessment to the Cambridgeshire LSCB. In addition to this 10% of cases involving child protection or safeguarding will be reviewed using the methodology set out in Appendix M. If we have nil cases a minimum of 10 % of child or young adult case notes from the previous 12 months admissions shall be reviewed to enable us to assure the board that we are not missing such cases or any other safeguarding issues.

8.0 Accountability for the Reporting of Child Safeguarding

8.1 Within the Trust (Appendix E)

- Each member of staff has responsibility for reporting a concern to their line manager and documenting this through Datix.
- Advice of child safeguarding issues can be sought through the Named Nurse or Safeguarding Champion. Outside normal office hours, this can be done through the Bronze on call manager.
- An annual agenda item at the Clinical Governance Management Group.
- Then to the Quality and Risk Committee.
- Then to the Board of Directors.

8.2 Regionally

See accountability map (Appendix F).

8.3 Reporting Child Death

Childhood deaths whether they are expected as part of a natural part of a long term condition or unexpected need to be reported to the LSCB using the form in Appendix O. The Named Nurse for Safeguarding Children must be informed and the completed forms forwarded to her once completed. If assistance is required when filling in the forms please refer to the Named Nurse for Safeguarding Children detailed in section 12.1.

9.0 Following up a missed appointment

If a child or young adult misses an appointment an attempt to contact the child / young adult or their parent or guardian, must be made to ascertain the reason for the appointment being missed. If there is reason for concern about the child's / young

adult's well being, the Social Worker must be informed and flow chart in Appendix H followed. This should then be followed up with a letter to the GP (suggested template Appendix N) stating that the appointment was missed, whether you have contacted the child, young adult, parent or guardian, the reason given and any further action taken.

10.0 Records for Children

Responsibility for this is via the Medical Records Committee via the Clinical Governance Management Group. In the event of a child safeguarding issue, these records may need to be shared with other agencies. Advice should be sought from the Named Nurse or Doctor.

11.0 Staff Disclosure and Barring Service (DBS) Checks

DBS checks are mandatory for every new Trust employee. There are two levels of DBS checks, standard and enhanced as well as an additional pre employment check that is completed by all staff working at Papworth. Further details pertaining to DBS checks can be found in the Staff Disclosure and Barring Service Policy.

12.0 Child Safeguarding Governance at Papworth Hospital

12.1 Responsible Officers

Name	Title	Duties & responsibilities
Non-Executive Trust Board Officer		
Executive Trust Board Officer	Director of Nursing	• Reports to Board of Directors • Oversees the implementation of the strategy • Coordinates CP Clinical Governance within the trust • A member of the Clinical Governance Management Group and Chair of the Risk Management Group.
Named Nurse reporting to LP	Karen Graham Modern Matron Thoracic Services	• Coordinates CP through the NAC and their role profiles • Attends appropriate external CP forums, PCT CP Meeting • Attends county wide - Child Health Advisory Group • A member of the CP Named Nurse forum Peterborough & Cambridgeshire
Link Doctor	Dr Helen Baxendale Consultant Immunologist	• In the event of suspected neglect or abuse, maintains dialogue with paediatric colleagues and named doctor.

Name	Title	Duties & responsibilities
Designated Doctor Designated Nurse	Dr Emily Wawrzkowicz Paula South NHS Cambridgeshire	• To take a strategic lead and support and advise the Trust on safeguarding issues
Safeguarding Champions	Lead Social Worker	• Attend LSCB business meetings • Investigate and support any considered, suspected or actual child maltreatment concerns. • Liaise with all agencies • Keep contemporaneous records • Training of staff
	Assistant Director of Nursing	• Chair Safeguarding Vulnerable People Committee • Deputise for Director of Nursing • Coordinates policy review and implementation. • Leads on audit and monitoring

13.0 When to Use a Chaperone

The safety, privacy and dignity of the patient are paramount. The process of chaperoning allows medical and other health staff to safeguard themselves from any accusation by patients of improper conduct. It can be expected that parents will be present with the child or young adult, but this does not substitute the need for a chaperone.

Refer to Chaperone Guidelines DN168.

13.1 Visitors

Visitors other than patient carers, relatives, personal friends, including VIP visitors, are to be escorted whilst on site in patient areas at all times. Professional visitors will be managed as per HR policy.

14.0 Dealing with Allegations Against a Member of Staff

Any suspicion, allegation or actual abuse by a member of staff must be reported to the line manager and Director of Nursing (or deputy) as named designated officer immediately, and recorded on Datix.

Refer to the Disciplinary Procedure DN117. All staff fall within the scope of this policy. Careful consideration of the need for suspending the member of staff from duty during an investigation must be discussed with the Director of Nursing and will be based on a formal inter-agency risk assessment

Any complaints that involve children and young adults must be reported to the Director of Nursing, who will report these on to the Local Authority Named Officer. All allegations will be reported to the Local Authority Named Officer by the Director of

Nursing or Assistant Director of Nursing within one working day, at which point the Trust will act on their advice.

15.0 Support Arrangements for Staff

If a member of staff is involved in reporting/recognising or investigating a child protection issue, please refer to support arrangements for staff DN288.

Particular supervision can be arranged by contacting any of the responsible officers in Section 12.1.

External supervision is accessed by the Named Nurse and Safeguarding Champions, and is provided by the Designated Nurse at NHS Cambridgeshire.

16.0 Key Legislation

Working Together to Safeguard Children – HM Gov (updated March 2010)

Children's Act – DoH 2004
http://www.opsi.gov.uk/acts/acts2004/40031--c.htm

Every Child Matters (Government Green Paper) – DoH 2003
http://www.everychildmatters.gov.uk/_files/EBE7EEAC90382663E0D5BBF24C99A7AC.pdf

Safeguarding Children in whom illness is fabricated or induced – DoH 2002
http://www.dh.gov.uk/assetRoot/04/05/66/46/04056646.pdf

Data Protection Act 1998
http://www.opsi.gov.uk/acts/acts1998/19980029.htm

Human Rights Act 1998
http://www.opsi.gov.uk/acts/acts1998/19980042.htm

United Nations Convention on the Rights of the Child 1990
http://www.dh.gov.uk/assetRoot/04/05/11/05/04051105.pdf

Keeping Children Safe: Government's response to the Victoria Climbie Report and Joint Chief inspectors Report Safeguarding Children – DoH/HMSO 2003
http://www.dh.gov.uk/assetRoot/04/07/19/80/04071980.pdf

Lord Laming's Report of the Inquiry Into the Death of Victoria Climbie – DoH 2003
http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm

The Protection of Children in England: action plan (2009)

A review of arrangements in the NHS for safeguarding Children – Care Quality Commission (2009)
www.cqc.org.uk/getinvolved/consultations.cfm

When to suspect child maltreatment – NICE 2009
www.nice.org.uk/CG89

17.0 Audit & Governance

- Any child safeguarding incident will be discussed at the Safeguarding Vulnerable People Committee and any actions identified monitored for completion. The learning is then used to plan future changes in staff training.

- Monitoring of staff knowledge about procedures if an incident or issue is suspected will be carried out through an annual audit and the training programme adjusted accordingly.

- As part of our Global Trigger Tool review of patient episodes, we will highlight any case notes randomly selected and, once reviewed, bring forward for discussion at the Safeguarding Vulnerable People Committee to identify actions and monitor for completion.

- Monitoring of actions identified from the annual Section 11 self assessment will be through the Safeguarding Vulnerable People Committee.

Key References:

ROYAL COLLEGE OF NURSING - CHILD PROTECTION

Department of Health (2004) National Service Framework for Children, Young People & Maternity Services.
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en

Department of Health (2003) What to do if you're worried a child is being abused. London: Department of Health www.doh.gov.uk/safeguardingchildren/index.htm

HMSO (2002) The Victoria Climbié inquiry: report of an inquiry by Lord Laming. London: The Stationery Office.
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Cawson, P. (2000) Child maltreatment in the United Kingdom - a study of the prevalence of child abuse and neglect.
London: NSPCC.

National Commission of Inquiry into the Prevention of Child Abuse (1996)

Childhood matters: report of the National Commission of Inquiry into the prevention of child abuse.
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Department of Health (1999) Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children.
London: The Stationery Office.

The Scottish Office (1998) Protecting children, a shared responsibility: guidance on inter-agency co-operation. Edinburgh: The Stationery Office.

Department of Health (2000) Framework for assessment.
London: The Stationery Office.

Department of Health (2002) Safeguarding children in whom illness is fabricated or induced.
London: The Stationery Office.

Department of Health (2000) Safeguarding children involved in prostitution: supplementary guidance to 'Working together to safeguard children'.
London: Department of Health.

Royal College of Nursing (1996) Female genital mutilation. London: RCN.

Cleaver, H., Unell, I., Aldgate, J. (1999) Children's needs - parenting capacity: the impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development.
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Scottish Society for the Prevention of Cruelty to Animals (2001) Animal cruelty: family violence.
Edinburgh: SPCA.

Her Majesty's Inspectorate of Prison's for England and Wales (2002) Inspections of young offender institutions 2000 to 2002.
London: Home Office.

Nursing and Midwifery Council (2002) Code of conduct.
London: NMC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) Guidelines for professional practice.
London: UKCC.

Department of Health (1995) Child protection: clarification of arrangements between the NHS and other agencies.
London: Department of Health.

NHS Executive (1997) The Caldicott Committee: report on the review of patient-identifiable information.
London: NHS Executive.

Thomas, T. (2001) Preventing unsuitable people from working with children – the criminal justice and court services bill.
Child Abuse Review, 10 60–69.

Department of Health (2000) The protection of children act 1999: a practical guide to the act for all organisations working with children.
London: Department of Health.

National Health Service Executive (1998) Children's safeguard review: choosing with care, Health Service Circular 1998/212.
London: Department of Health.

Appendix A – Section 11 Children's Act

EASTERN REGION SAFEGUARDING CHILDREN BOARDS

FOR MEMBER AGENCIES AND ORGANISATIONS IN RELATION TO S11 CHILDREN ACT (2004)

Part One - Background, Context and Overview

Part Two - The Eight Standards for All Partners

1. Senior management commitment to the importance of safeguarding and promoting children's welfare.
2. A clear statement of the agency's responsibility towards children is available to all staff.
3. A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children.
4. Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families.
5. Staff training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children and families.
6. Recruitment, vetting procedures and allegations against staff.
7. Inter-agency working.
8. Information sharing.

PART ONE

1. INTRODUCTION

1.1 'Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends upon effective joint working between agencies and professionals that have different roles and expertise.' *Working Together to Safeguard Children 2006*.

1.2 The Benchmarking toolkit seeks to enable agencies, professionals and volunteers to understand their vital role in supporting children and young people to be safe, participate, enjoy, achieve and grow.

1.3 The Cambridgeshire Safeguarding Children Board will support and challenge agencies, professionals and volunteers with significant access to children so that they can exercise their roles and responsibilities and discharge their functions with regard to safeguarding and promoting the welfare of children and young people

2. PARTNERS

2.1 Partner agencies and organisations will be all those working with children and young people in Cambridgeshire including agencies with significant access to children and young people.

2.2 There will be three categories of Partner agency

- Statutory members of the Cambridgeshire Safeguarding Children Board
- Other board members
- There are a number of voluntary, community and business agencies that are not directly represented on the Cambridgeshire Safeguarding Children Board, yet do have an interest in achieving good outcomes for children in relation to safeguarding

3. SELF-ASSESSMENT

3.1 Self assessment is an ongoing and integral feature of the planning, review and improvement cycle for LSCB partner organisations. A self assessment tool has been produced in order to help organisations monitor the effectiveness of the arrangements in place within their organisation, and their contracted service provider organisations, in relation to meeting their duties under Section 11 of the Children Act (2004), and provides a common set of performance indicators. It offers a user friendly framework for quality assurance that can contribute to:

- Encourage the implementation across the wider children's workforce of guidance contained within Making Arrangements to Safeguard and Promote the Welfare of Children under s11 Children Act (2004).

- Identify both strengths and areas for improvement in local practice.

- Inform future planning and training to encourage continuous improvement.

- It should be noted that any reference to 'staff' or 'people who work with children' includes both paid and voluntary workers.

Appendix B – Paediatric Transitional Arrangements

Standards for the transition of young people with long term conditions from paediatric to adult care

Each specialist area within the Trust may have their own particular transition process, therefore the aim of this document is to set out the minimum standard that can be expected by the young person and their carers during the transition from paediatric services in other hospitals to adult services within Papworth Hospital. A six monthly or yearly transition clinic (depending on need) will be organised in each speciality. A medical consultant and specialist nurse will attend each transition clinic, and it should generate a feeling of the trust between the two teams, which will help give the young people and their carers a feeling of safety on moving up to the adult service.

At the clinic it is important that young people and their carers are:

- Introduced to the adult team.
- Given booklets about the adult inpatient and outpatient service which includes names of all the team.
- Given the chance to ask questions about the adult service.
- Offered an informal visit to look around the unit/wards and outpatient facilities.

When the young person comes to have a look around it should be discussed with them when is the most appropriate time for them to transition to adult services. Once the time of transition has been agreed with the young person and their carers the referring physician will write a formal letter to the adult service physician asking them to take over the care.

On receiving the letter the following should take place:

- The referral letter should be given to the secretaries of the specialist team to be distributed to: consultant physicians, specialist nurses, database manager and directorate business manager.
- The secretary should send out a standard letter to the referring physician requesting the case notes or a copy of each annual review.
- The secretary will arrange patient registration at Papworth Hospital and request that patient notes are compiled.
- The secretary will transfer transition data from transition files into the patient notes.
- The specialist nurse will liaise with the consultants to discuss referred patients and set dates for new patient visits.
- Patients will then be telephoned and offered an informal visit if they haven't had one or a new patient visit or both.
- A summary of any discussion with the young person or their carers will be recorded in the patient notes.
- A letter will be sent out from the specialist nurse confirming the date for the new patient visit.

AL, SH, DB,CSH, June 2007 updated by JR August 2009. © Papworth Hospital NHS Foundation Trust 2007

Appendix C – Standards Set by Children's NSF

The Children's National Service Framework sets national standards for children's health and social care, which promote high quality, women and child-centred services and personalised care that meets the needs of parents, children and their families.

Part I

Standard 1:
Promoting Health and Well-Being, Identifying Needs and Intervening Early
The health and well-being of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS in partnership with local authorities.

Standard 2:
Supporting Parenting
Parents or carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.

Standard 3:
Child, Young Person and Family-Centred Services
Children and young people and families receive high quality services which are co-ordinated around their individual and family needs and take account of their views.

Standard 4:
Growing Up into Adulthood
All young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood.

Standard 5:
Safeguarding and Promoting the Welfare of Children and Young People
All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

Part II

Standard 6:
Children and Young People who are ill
All children and young people who are ill, or thought to be ill, or injured will have timely access to appropriate advice and to effective services which address their health, social, educational and emotional needs throughout the period of their illness.

Standard 7:
Children and Young People in Hospital
Children and young people receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings.

Standard 8:
Disabled Children and Young People and those with Complex Health Needs
Children and young people who are disabled or who have complex health needs receive co-ordinated, high quality child and family-centred services which are based on assessed needs,

which promote social inclusion and, where possible, which enable them and their families to live ordinary lives.

Standard 9:
The Mental Health and Psychological Well-Being of Children and Young People
All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multidisciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.

Standard 10:
Medicines for Children and Young People
Children, young people, their parents or carers, and health care professionals in all settings make decisions about medicines based on sound information about risk and benefit. They have access to safe and effective medicines that are prescribed on the basis of the best available service.

Part III

Standard 11:
Maternity Services
Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

Appendix D – Terms of Reference Safeguarding Vulnerable People Committee

Membership

Assistant Director of Nursing (Chair)
Human Resources Representative
Learning & Development Representative
Modern Matron – Cardiac (or representative)
Modern Matron – Critical Care (or representative)
Modern Matron – Thoracic (or representative)
Modern Matron – Transplant (or representative)
Named Doctor(s) for Safeguarding
Named Nurse(s) for Safeguarding
PALS Manager
Social Worker
Ward Sister RSSC

Co-opted:
Designated Nurse for Safeguarding Children & Looked After Children

A member of the Trust's staff will act as Secretary to the Committee.

Duties

As a provider Trust Papworth is responsible for identifying "named" doctor(s) and nurse(s) for child protection who are responsible within their organisations for ensuring:

- Provision of expert health advice on child protection to staff and other agencies, as appropriate, regarding individual cases and contribute to the planning of services.
- Provision of inputs to the Local Safeguarding Children's Board (LSCB) agencies in the ongoing development of policies, procedures and guidance.
- Identification of training needs of all staff including the training needs of medical personnel.
- Multidisciplinary training.
- The review of child protection standards in the Trust.
- Systems between different parts of the heath services for the transfer of children's records and other relevant information.
- Service level agreements that incorporate child protection requirements including a clear monitoring process.
- Effective systems of child protection audit to monitor the application of agreed child protection standards.
- Appropriate doctors/nurses denomination to undertake the trusts responsibility for case reviews (DoH 2003 Working Together to Safeguard Children Chapter 8 pg 87-95).
- Dissemination of recommendations and implications of case reviews in conjunction with the chief executives concerned.
- Identification and reporting of unmet needs in service provision to senior managers and the consequences of the situation.
- Coordination and liaison with other professionals with child protection responsibilities within health services and other partner agencies.
- Adherence to the Trust's operational procedure for child protection (Appendix 10), when a non-accidental injury or child abuse is suspected.

Frequency of Meetings

Meetings will be held twice per annum, with further ad hoc meetings called as and when appropriate.

Quorum

The Committee will be considered quorate if the following are present:

- Assistant Director of Nursing.
- Lead Nurse for Safeguarding Child.
- Directorate Representative.
- One other.

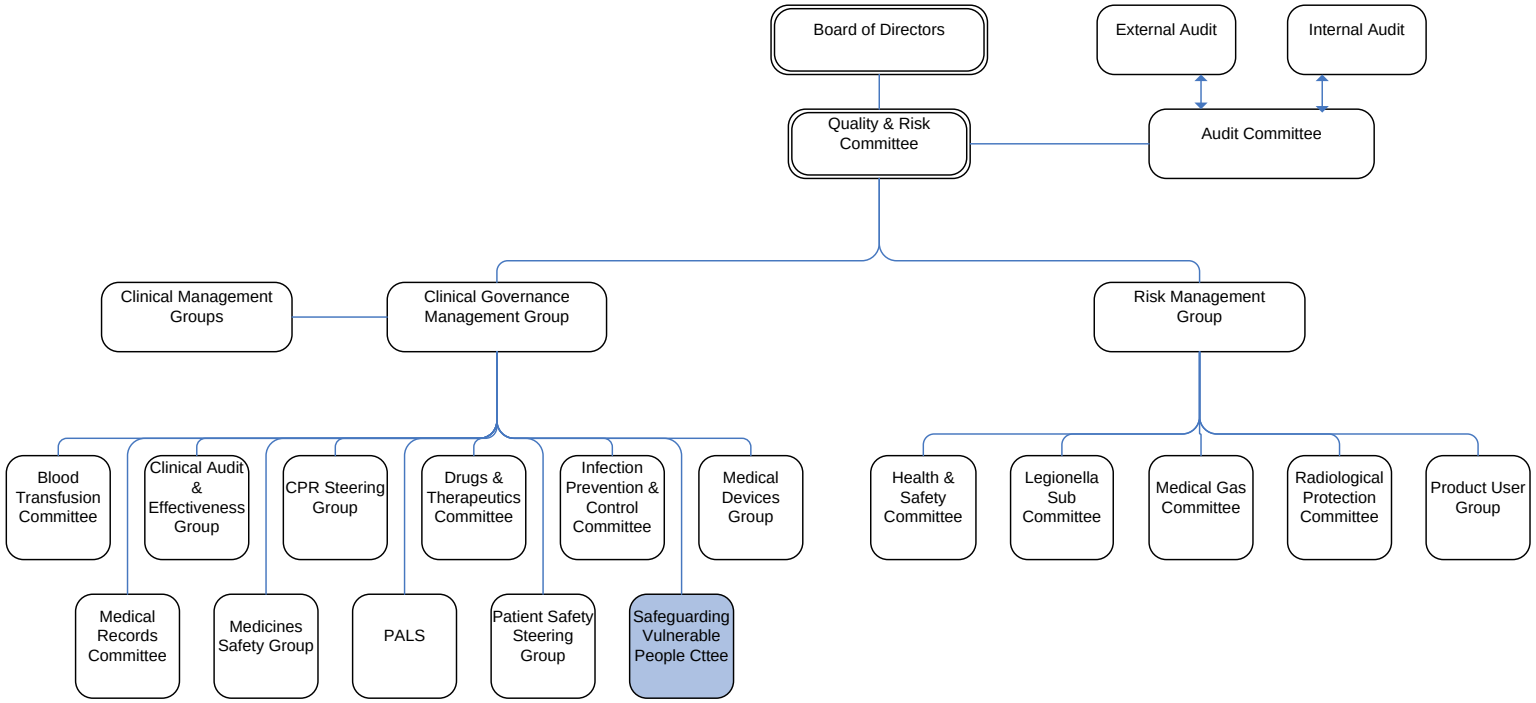
Reporting

Board of Directors
↓
Quality & Risk Committee
↓
Clinical Governance Management Group
↓
Safeguarding Vulnerable People Committee

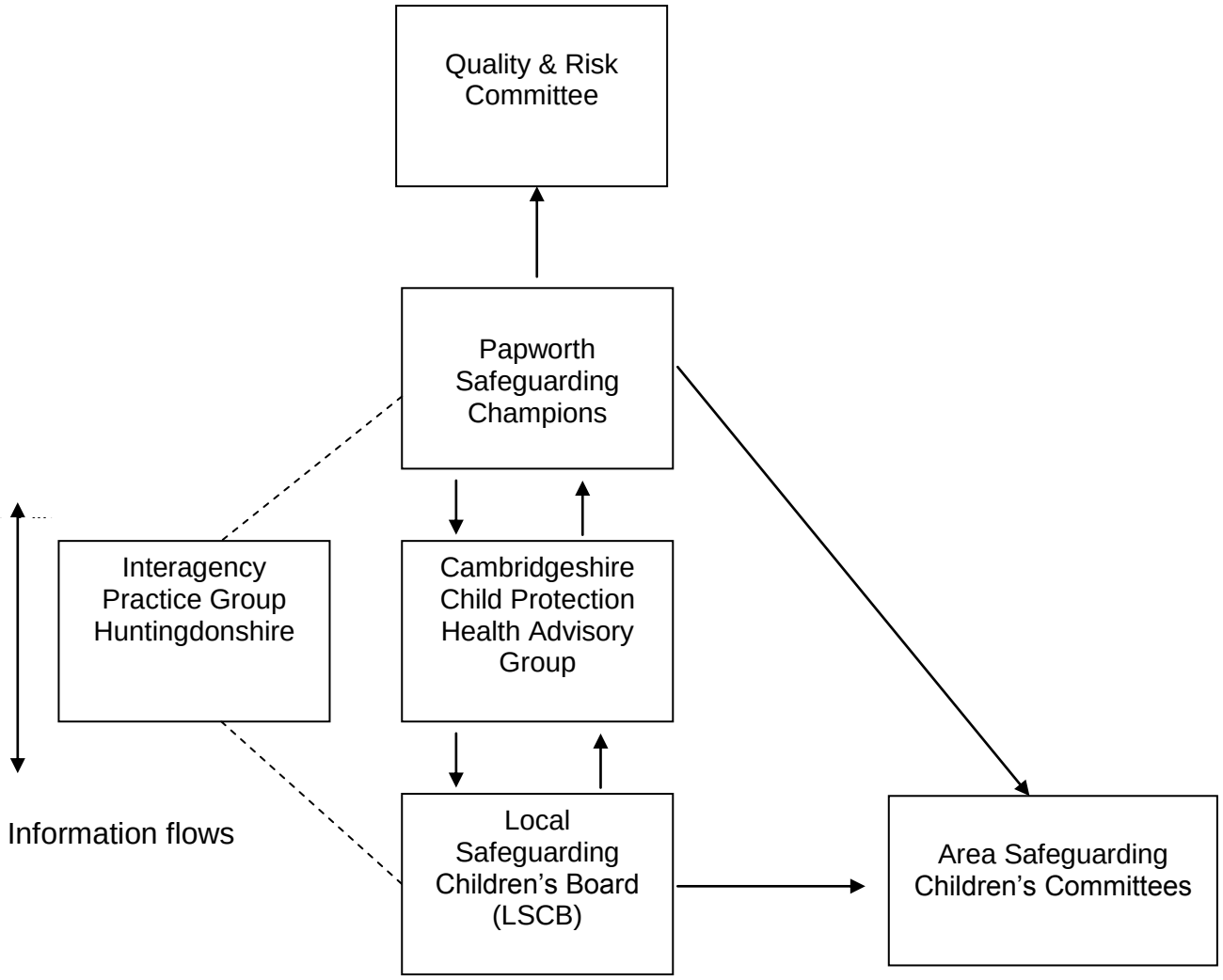
May 2010

Appendix E – Papworth Clinical Governance Map

Clinical Governance & Risk Management Committee Structure – July 2010



Appendix F – Regional Accountability Map



Appendix G – RCN Definitions of Child Abuse & NICE Guidance on When to Suspect Child Maltreatment

CHILD PROTECTION

The Nursing and Midwifery Council (NMC) Code of Conduct states that all nurses have a duty and personal responsibility to act in the best interests of a child or young person, and to inform and alert appropriate personnel if they suspect a child is at risk or has been abused. This role is not limited to nurses, but extends to all staff working at Papworth.

This means that you must first know how to identify the children who are at risk, and then know where to seek expert advice and support.

What are maltreatment, abuse and neglect?

- **Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. This includes fabricating the symptoms of, or deliberately causing, ill health to a child.

- **Emotional abuse** is the persistent emotional ill-treatment of a child that causes severe and persistent adverse effects on the child's emotional development. This may involve:
  - Conveying to a child that she/he is worthless, unloved, inadequate, valued only insofar as they meet the needs of another person.
  - Imposing inappropriate age or developmental-related expectations on children.
  - Frequently causing children to feel frightened.
  - Exploiting or corrupting children.

- **Sexual abuse** involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve:
  - Physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts.
  - Children looking at, or being involved in the production of, pornographic material.
  - Encouraging children to behave in sexually inappropriate ways.

- **Neglect** is the persistent failure to meet a child's basic physical and/or psychological needs that is likely to result in the serious impairment of the child's health or development. This includes:
  - Failing to provide adequate food, shelter and clothing.
  - Neglecting or unresponsiveness to a child's basic emotional needs.

The signs of Child Abuse

All nurses need to be aware of the potential signs of child abuse.

Common indicators of abuse and neglect include:

- Physical signs such as hand-slap marks, bruising in unusual areas, bruised eyes, bite marks.
- Poor physical care and inadequate hygiene, inappropriate dress or failure to seek appropriate health care.
- Unrealistic parental expectations and over protection of a child.
- A child's behaviour may also indicate that they have been abused. For example, the child may show fear of adults or a fear of certain adults when they approach them,

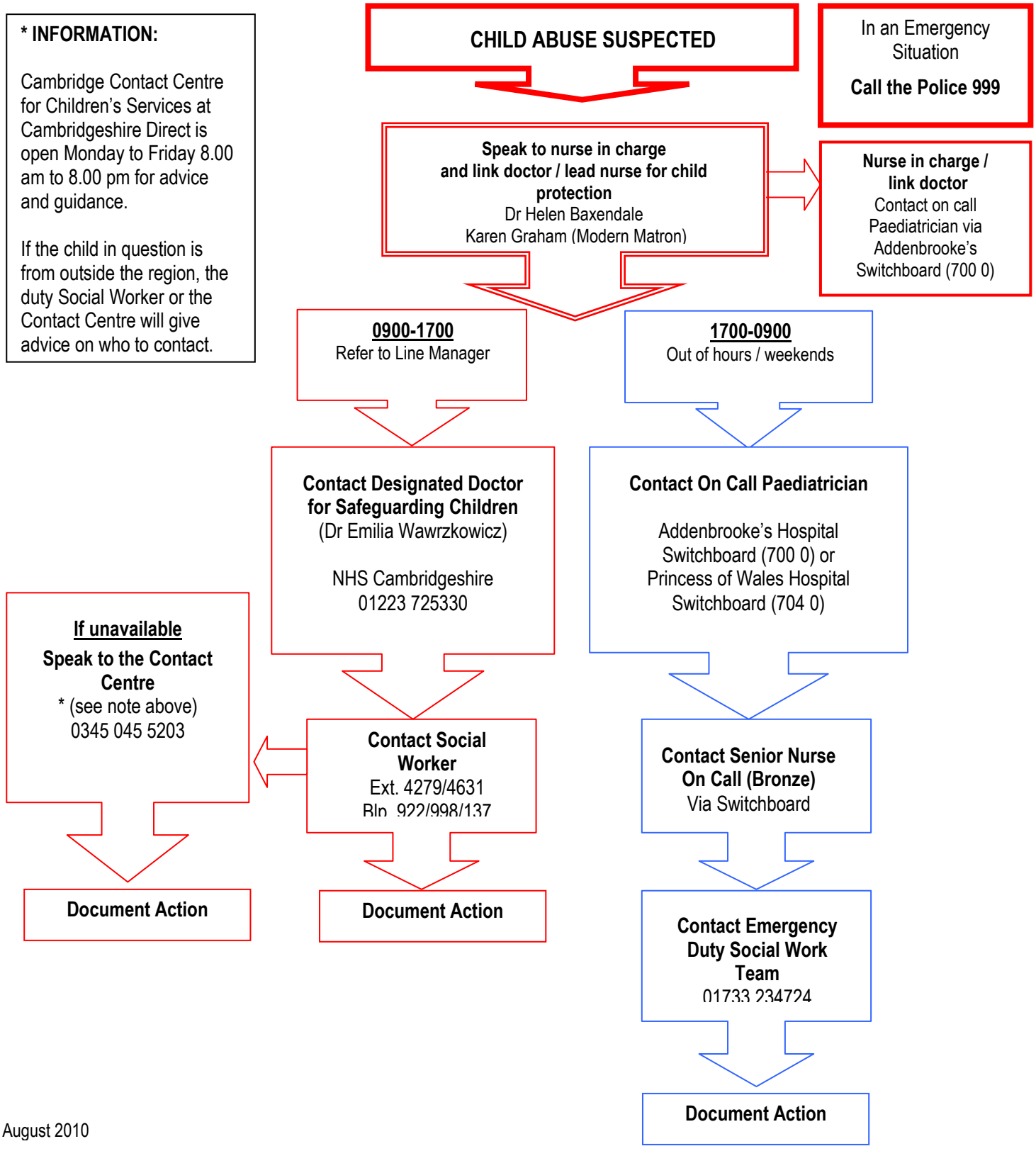
display aggressive behaviour or deliberate self-harm and substance abuse. The story provided by the adult might be inconsistent with any injuries.

Definitions of Consider & Suspect Using NICE guidance.
RCN – June 2003, Updated June 2005.

Appendix H – Suspected Child Maltreatment Action Flow Chart

Action to take when there is a suspected case of child abuse, either a patient or a visitor

Suspected cases of child abuse must be dealt with immediately - **never ignore or leave until the next day**



August 2010

IF YOU HAVE ANY QUERIES – CONTACT THE NAMED NURSE FOR CHILD PROTECTION - Karen Graham Ext. 4705 / Blp 077

Appendix I – Child Protection Operational Flow Chart

Do you suspect non-accidental injury (NAI) or child abuse?

- Refer to paediatrics.
- Refer to the Office of Children & Young People (OCYPS) via switchboard.

Checking the Child Protection Register

- Ring Social Services through switchboard Monday to Friday (9.00 am to 5.00 pm).
- Out of hours/bank holiday/weekends ask switchboard to contact Emergency Social Worker.

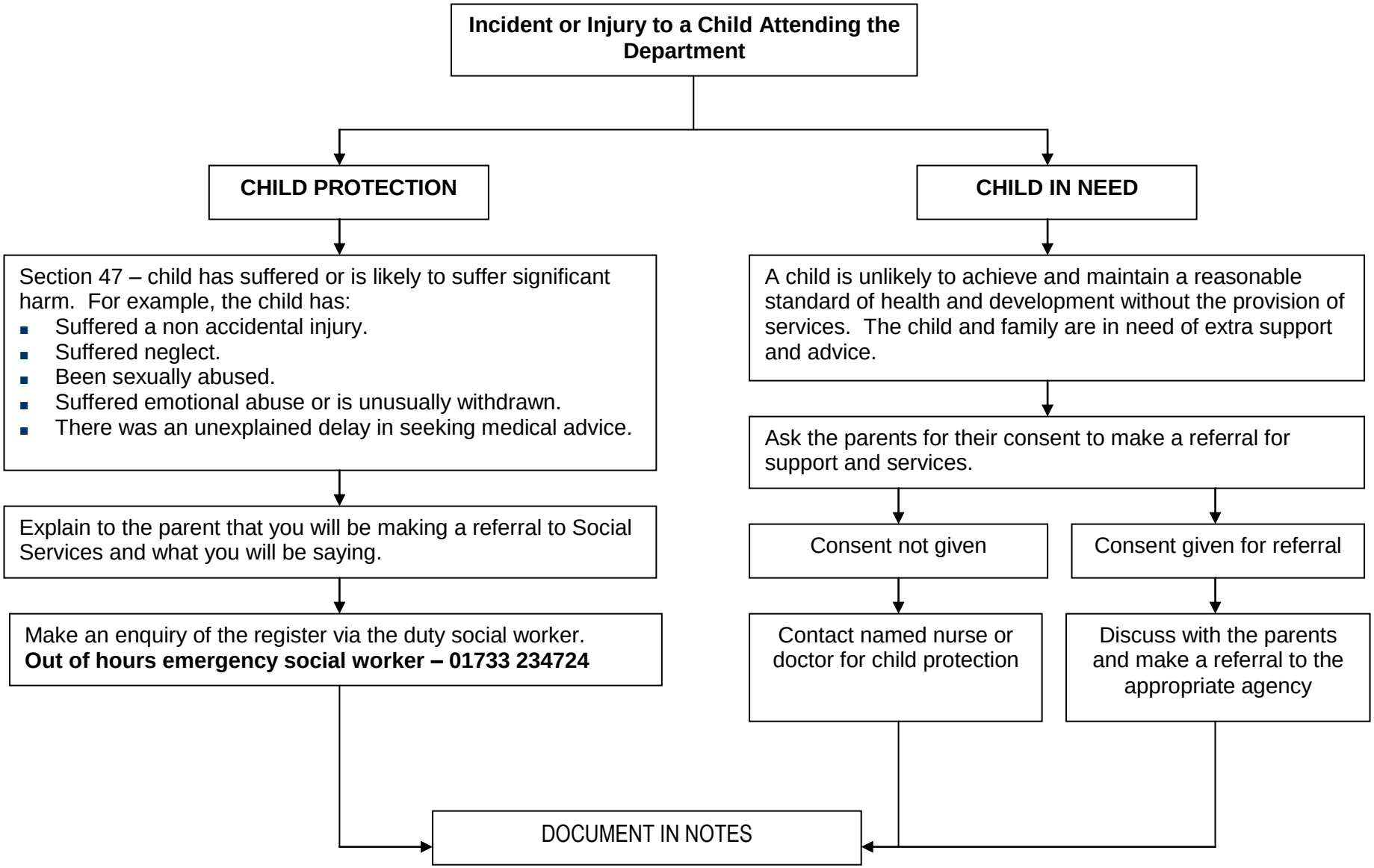
Ensure that you have available the following information

- Child's name
- Date of birth
- Current address
- Brief reason for your concerns

NB: Ask Social Services to whom the faxed interagency form is to be sent. Attach original form to child's notes

Revised November 2004
CG/KM

Appendix J – Reporting Flow Chart



Appendix K – Equality Impact Assessment Form

Name of Policy/ Project/ Service: **Paediatric Management Policy**
Name of person / team completing the assessment: **Claire Tripp**
Date initial Assessment completed: **13 June 2007**
Date Full Equality Impact Assessment started: **13 June 2007**
Date completed: **June 2009**

Stage 1

Aims and objectives of Policy/ Project/ Service	To ensure safe effective management of paediatrics in an adult environment.
Strategic objectives	
Which group(s) will it benefit	Those under 19 years of age.
Legislation	The Children's Act (2004). Working to Safeguard Children DoH 2006

Stage 2

Which group has been consulted with?	Child Protection Committee (CPC)
How did this consultation take place?	Via regular CPC meetings.
Are there any identified gaps?	
Do you need further information from another party?	

Stage 3 – will this have a negative / positive impact and on which group?

Groups effected	Positive impact	Negative impact	Reasons
RACE			
DISABILITY			
GENDER			
AGE	✓		Ensures compliance with required legislation and standards relating to children
SEXUAL ORIENTATION			
RELIGIOUS & BELIEF			
OTHER e.g. rural			

Does it meet the specific and general duties of each legislation and the Trust's Equality & Diversity Policy?

Groups effected	Yes	No	Reasons
RACE	✓		
DISABILITY	✓		
GENDER	✓		
AGE	✓		
SEXUAL ORIENTATION	✓		
RELIGIOUS & BELIEF	✓		

TRUST EQUALITY Policy	✓		

Can any negative impacts be minimised or improved? If yes, how?

Groups effected	Yes	No	How
RACE			
DISABILITY			
GENDER			
AGE			
SEXUAL ORIENTATION			
RELIGIOUS & BELIEF			

Stage 4 – consider alternatives
Examine available data, research, studies, guidance, reports, recommendations, and surveys, audits that may be relevant to this policy/service and list what they are and how they relate.

Stage 5 – consultation
Ensure that ALL groups are able to participate and individual needs are met

Groups consulted on issues of	Service users	Family Carers	Staff
RACE			
DISABILITY			
GENDER			
AGE			
SEXUAL ORIENTATION			
RELIGIOUS & BELIEF			
Other – general policies & services			

Stage 6 – decide whether to adopt the policy/ service

Stage 7 – monitoring arrangements

Stage 8
Date report sent to Human Resources Manager _____
Date report sent to Trust Board for approval and agreement _____
Date report approved for publication by Trust Board? _____
Date report published _____
Where has the report been published? _____
Has the report been distributed to participants? _____

Appendix L – Safeguarding Children Training and Practice Development Standard

1.0 Purpose

1.1 This training and development policy will outline the organisation's approach and commitment to safeguarding children training.

1.2 All training and development is part of a continued personal and professional development programme.

1.3 The overall aim is to ensure that all training in this area is child centred, by promoting children's rights and needs, and ensuring child welfare is paramount.

1.4 Working together to Safeguard Children 2006 is clear that individual agencies are responsible for ensuring that their staff are competent and confident in the area of safeguarding children.

1.5 Training for NHS staff and Independent Contractors will be linked to national competency frameworks.

2.0 Expectations

"Child protection training is essential for health professionals engaged in services for children. It is not an optional extra" (Mr Barry Capon, chair of independent inquiry into the death of Lauren Wright, 2002.)

Section 11 of the Children Act 2004 and section 175 of the Education Act 2002 place duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children.

This paper takes into consideration the NSF, Working Together 2006, Skills for Health, Children Act 2004, Every Child Matters: Change for Children and Agenda for Change.

Health professionals and organisation have a key role to play in safeguarding and promoting the welfare of children.

2.1 **The NHS Trust has a responsibility to:**

- Provide and allow staff to access training and development opportunities.
- Ensure that staff have access to specialist nursing and clinical safeguarding children support and advice.
- The NHS Trust will facilitate/offer appropriate training and skills.

2.2 **Line managers have a responsibility to:**

- Use the safeguarding children induction checklist as guidance for introducing procedures within Cambridgeshire with new members of staff.
- Ensure that new members of staff attend introductory training within 4 weeks of commencing their contract.
- Ensure safeguarding children training is part of the annual appraisal process for their team members.
- Ensure that their staff have participated in mandatory safeguarding children training in line with their individual responsibilities.

- Pass on any gaps in staff member's performance and for knowledge that is not being met by training and development activities to the Safeguarding Vulnerable People Committee.

2.3 **Individual NHS staff members and Independent Contractors are responsible for promoting their own training and development and have a responsibility to:**

- Book and attend mandatory safeguarding children training.
- Identify gaps in their own skills and knowledge, possible ways that these can be met, and discuss these with their line manager.
- Actively participate in safeguarding children Supervision, if relevant to their role.

3.0 **Training and Development Benefits:**

- Increasing awareness of safeguarding children.
- Reducing risks and improving outcomes for Children.
- Providing higher levels of service to the clients/patients.
- Utilising a workforce that is aware of individual's roles and responsibilities in the field of safeguarding children.
- Increasing awareness of child welfare principles and safeguarding children.
- Updating knowledge on current/new safeguarding children legislation and procedures.
- Learning from historical case studies highlighting good and poor practice issues.
- Working in a multidisciplinary environment where ideas and expectations can be shared.

4.0 **Training and development Competences**

4.1 Under the Children Act 2004 all health care organisations have a duty to make arrangements to safeguard and promote the welfare of children and young people and Chief Executives will ensure that all their staff are able to meet this requirement.

4.2 It is recognised that the numerous staff groups within NHS Trusts will have different training needs depending on their level of contact with children. This training policy will use national guidance to formulate the training strategy and advise on training levels across a continuum.

4.3 Working Together, pg 113 (2010) describes training to equip people to work effectively in the safeguarding arena. It recognises that training will take place in two ways, single-agency and inter-agency.

5.0 Training Levels

5.1 All staff are expected to attend *Trust induction* days to inform delegates that safeguarding children is everyone's responsibility (Level 1).

5.2 *Basic level* training is for staff members who do not assess the health needs of children and is aimed at all staff working in healthcare settings. Other staff members that work specifically with children and families would use this training as a stepping-stone to the next level. This may be single agency training, which can be undertaken in a group or using the e-learning package. Staff will need to repeat this level of training once every three years for where they are not participating in the advanced level programme (Level 2).

Key Outcomes:

- Explain what individual actions may be needed to safeguard children.
- Describe how staff should respond to concerns about children in need.
- Communicate and act appropriately, within national and local guidance to safeguard children.
- Explain the local arrangements, services and sources of advice for supporting families and safeguarding children that are available to Trust staff.

5.3 *Advanced level training* for all Trust staff and independent contractors who have frequent contact with children, young people and families and undertake assessment as part of their role. This will be both single and inter-agency training and staff will need to update by choosing an appropriate training opportunity from those on offer from the Trust, LSCB or outside agency (Level 3).

Key Outcomes:

- Complete core tasks for safeguarding and promoting children's welfare in line with Working together to Safeguard Children 2010.
- Explain principles and process for effective collaboration.
- Communicate and develop working relationships in the interests of children.
- Describe the contribution made by others to safeguarding children and the impact of own decisions and actions on others.
- Increase, maintain and update knowledge on specific health topics/issues relating to safeguarding children and young people.

5.4 *Specialist level training* for designated and named doctors and nurses and others who act in an advisory capacity for staff and the Trust on safeguarding issues.

6.0 Training Methods and Approaches

6.1 Training and development activities will utilise a range of methods and styles that should encourage group discussion and appeal to differing learning styles.

6.2 These include:

- Utilising case studies to learn lessons to improve practice.
- Role play practice scenarios.
- Fictitious case studies where a variety of 'safe' decision and work practice can be discussed.
- Facilitated discussion.
- Supervision.
- E-learning.
- Shadowing.
- Self directed study.

7.0 Evaluation

All single agency training will be evaluated at the end of each training session by use of evaluation forms, audits and feedback from trainers.

References:

Children Act 2004
Education Act 2002
Intercollegiate Document
Working Together to Safeguard Children 2006

Appendix M – Methodology for Case File Audit

Context

As part of the Local Safeguarding Children's Board's (LSCB) strategic approach to the safeguarding review required by the Government in response to the Baby P case, the LSCB has requested that Cambridgeshire County Council's OCYPS (covering social work and education files), all Cambridgeshire NHS Trusts and Cambridgeshire Police all undertake a small audit of case files. The outcome of each audit will be used to inform the LSCB's action and improvement plan and the work programme for the following year.

This will also provide important evidence for national government and each relevant regulatory body of the action taken by Cambridgeshire LSCB to assure itself of the current position in the area.

Methodology

1. Identify the cohort of cases involving a section 47 investigation and/or child protection processed in your agency over a one year period (December to December)

2. Take a random sample of 10% of the cohort for audit (record your sampling methodology).

3. Undertake a desk based audit of the selected files against the following standards:

    a. Compliance with LSCB and single agency procedures.

    b. Quality of professional practice benchmarked against the profession's code of conduct and standards of practice.

    c. Timeliness.

    d. Evidence and effectiveness of supervisory oversight.

4. Identify actions required to improve practice.

5. Identify examples of good practice suitably anonymised.

6. Prepared an anonymised report with recommendations for action for your agency with a copy to go to the Cambridgeshire LSCB Business Unit by the end of February.

Appendix N – Letter Template for Follow up of Missed Appointment

Date

Dear

(Insert details of child/young person)

The above named failed to attend an out-patient appointment on **insert date**.

* We contacted this * child's / young person's * parent / guardian **(give brief description of conversation).**

***** We attempted to contact this * child's / young person's * parent / guardian and got no response.

We * are / are not concerned about the safety of the above named * child / young person.

We * have / have not contacted our Social Work team.

* delete as appropriate

Yours sincerely

Place file copy in patient notes.

Appendix O – Notification of Child Death

Form A - Notification of Child Death

Notification to be reported to CDOP Manager at e-mail Helen.cornwell@nhs.net or Helen.cornwell@cambridgeshire.gov.uk.

Tel: 01480 376722
Fax: 01480 371010

The security of any system for transferring the information on these forms must be clarified and agreed with the Caldicott guardian. If there are a number of agencies involved, liaison should take place to agree which agency will submit the Notification.

Date of referral	
Name of referrer	
Agency	
Address	
Tel Number	
Email	

Details of Agency Contacts

Agency	Name, Address & Tel No.	Agency Report	
		Requested (date)	Received (date)
GP			
Midwife/ Health Visitor/ School nurse			
Paediatrician			
Police			
Children's Social Care			
School/ nursery etc			
Others (list all agencies known to be involved)			

Child's Details

Full Name of Child		
Any aliases		
DOB		NHS No.
Address		
Postcode		

School/nursery etc	
Date & time of death	

Other Significant Family & Household Members

Full Name	DOB	Relationship	Full Address

N.B. Pages 1 and 2 can be removed for the purposes of anonymising the case. Pages 3-5 should be made available with Form B to the child death overview panel.

Child's Details

Sex	☐	Male		
	☐	Female		
Age (yy/mm/dd)			Indicate if estimated	☐ Estimated ☐ Confirmed
Ethnic group	☐	White	☐	British
			☐	Irish
			☐	Any Other White background
			☐	Traveller of Irish Heritage
			☐	Gypsy/Roma
	☐	Mixed	☐	White & Black Caribbean
			☐	White & Black African
			☐	White & Asian
			☐	Any other mixed
	☐	Asian or Asian British	☐	Indian
			☐	Pakistani
			☐	Bangladeshi
			☐	Any other Asian
	☐	Black or Black British	☐	Caribbean
			☐	African
			☐	Any other black background
	☐	Chinese or other ethnic group	☐	Chinese
			☐	Any other, specify
	☐	Not known/ not stated		
Immigration Status	☐	Asylum seeker		
	☐	Refugee status		
	☐	Exceptional leave to remain		

Details of the death:

Location of death or fatal event *				
Death certificate issued?	☐	Yes	☐	No
For neonatal deaths Any known cause of death as specified on the death certificate?	a. Main diseases or conditions in infant b. Other diseases or conditions in infant c. Main maternal diseases or conditions affecting infant d. Other maternal diseases or conditions affecting infant e. Other relevant conditions			
For deaths of children aged over 28 days Any known cause of death as specified on the death certificate?	Ia Ib Ic II			
Death expected?	☐	Expected	☐	Unexpected
Reported to Coroner	☐	Yes	Date:	
	☐	No	Name:	
Reported to Registrar	☐	Yes	Date:	
	☐	No	Name:	
Post mortem examination:	☐	Yes	Date:	
	☐	No	Venue:	

* place where the child is believed to have died, or where the event directly leading to death occurred. For example, if a child is involved in a road traffic accident, and is resuscitated but subsequently dies, the location of death should be recorded as the site of the collision, rather than the hospital where the child's death was confirmed

Notification Details:

Please outline circumstances leading to notification. Also include if any other review is being undertaken e.g. internal agency review; any action being taken as a result of this death.

Level of review	☐	Notification only
	☐	General review
	☐	In depth review
	☐	Serious Case Review
	☐	Perinatal Review
	☐	Other
Date of local case discussion		
Date discussed at panel		

Appendix P – Papworth Paediatric Admission & Resuscitation Procedure

PAEDIATRIC ADMISSION & RESUSCITATION PROCEDURE

Staff involved in development: *Job titles only*	Director of Nursing / Assistant Director of Nursing Modern Matron – Thoracic Services Ward Sister – RSSC
Directorate:	Nursing
Department:	Nursing
For use by:	All Staff

Purpose:	To support paediatric/young persons admissions and inform the resuscitation requirements.
This document supports: *Standards and legislation*	NSF
Key related documents:	

Approved by: *Management/Clinical Directorate Group*	Safeguarding Vulnerable People Committee
Approval date:	August 2009
Ratified by Board of Directors/ Committee of the Board of Directors	N/A

1. INTRODUCTION

The core purpose of the Trust is to provide a comprehensive range of cardio-thoracic services for adult patients. In 1994 the Trust Board endorsed the development of an adolescent service for Cystic Fibrosis patients and in 1995 endorsed the admission of young patients requiring the unique services of the Respiratory Support and Sleep Centre (RSSC).

It is evident that, on occasion, children may require access to the full range of specialist services offered by the Trust. Therefore, Varrier Jones ward will be used for cardiac admissions. Children below the age of 10 years will not be admitted, except within the RSSC.

2. PRINCIPLES

The safety and well being of children admitted to Papworth is of paramount importance and, therefore, services will be provided in accordance with relevant Department of Health directives and national guidelines.

The following principles have been approved by the Board of Directors:

a) Only children aged 10 years or over will be admitted, except for the small number of children below this age who may require the unique and specialist services of the RSSC.
b) A consultant wishing to consider the admission of a child is responsible for ensuring that comprehensive arrangements are in place **before** the admission of a paediatric case, and this will be achieved by informing the relevant Directorate Manager or Modern Matron.
c) The lead nurse for child protection and the Director of Nursing should be informed of the admission.
d) The child/adolescent will be admitted to the appropriate clinical area for the specialty, and relevant equipment will be provided to meet routine and emergency requirements.
e) Medical, nursing and other staff will receive appropriate training **in child protection issues** (Appendix L of Paediatric Management Policy) to ensure the safe care of the child/adolescent.
f) A child will not be admitted without a named paediatrician being identified to provide relevant support. **This will be clearly stated within the medical notes.**
g) The parent or guardian will be advised by the consultant that the child is to be admitted to an adult hospital in an adult ward, and will be involved in decisions pertinent to the child. This discussion must be documented in the case notes.
h) All paediatric admissions will be accommodated in single rooms and will not be admitted to a bay where there are adult patients. The child's parent or guardian will be expected to stay with the child during their admission.
i) If a child has to be admitted to the Critical Care area every effort must be made to segregate the child from adult patients.

These principles reflect the requirement of services as dictated by the Health Care Commission and Standards for Children's Services within the NSF (2004) (Appendix C of Paediatric Management Policy).

3. PAEDIATRIC CPR PROCEDURE FOR RSSC AND VARRIER JONES WARD

Cardio-pulmonary resuscitation for paediatric patients aged 10 years or over (above the weight of 25 kg) will be provided by the Cardiac Arrest team.

For RSSC and Varrier Jones Ward paediatric patients below the age of 10 years (or under 25 kg) resuscitation will be led by a doctor qualified in Paediatric Advanced Life Support in addition to the Cardiac Arrest team.

4. QUALIFICATIONS

4.1 The policy states the principles to be followed for the elective admission of paediatric cases, however, it is recognised that in exceptional circumstances the need to admit a child as an emergency may override some of the principles set out above.

4.2 The Paediatric Admissions & Resuscitation Procedure for RSSC admissions will be audited annually.

4.3 Staff caring for children and young adults on a regular basis will have competence in sick children's care planning and care delivery. Other areas of the hospital where this is a rare occurrence will have access to those who are competent to guide and support the care delivery.

Paediatric CPR - RSSC

On occasion the RSSC admits paediatric patients known to weigh less than 25 kg (irrespective of age) or be under the age of 10 years of age.

Paediatric patients admitted to the RSSC are those that will benefit from the specialist skills available at Papworth, which are not available within Paediatric Units elsewhere.

Papworth Hospital NHS Trust believes that the following policy will ensure a well-ordered response in the event of a paediatric admission and subsequent resuscitation attempt.

1. Equipment and environment for an elective paediatric admission

i. There must be a resuscitation trolley equipped for paediatric patients on the ward for any paediatric admission.

ii. Patients must be accommodated in a single room.

iii. Parents/guardians must be accommodated with their child.

iv. Flexible visiting arrangements will be available to siblings during the patient's admission.

v. A cot must be made available for small children.

vi. Arrangements must be made to meet the dietary requirements of the child during their admission – this will be coordinated with the Cystic Fibrosis Ward where individual meals can be requested and prepared.

2. Arrangements for an Elective Paediatric Admission

i. The organisational arrangements outlined on within this document will be initiated for all elective admissions to the RSSC and as outlined in section 2 above for the remainder of the hospital.

ii. Provision of a medical locum, competent in paediatric advanced life support will be provided within the Thoracic Directorate for the duration of the child's admission, if the paediatric advanced life support trained SpR is not available.

iii. (a) In the event that a paediatric advanced life support locum is employed, a Cardiac Arrest bleep will be made available by switchboard, and the locum will take lead responsibility in the event of a paediatric arrest on RSSC.

(b) The paediatric advanced life support locum will be briefed on arrival in the Thoracic Directorate.

3. In the Event of a Paediatric Cardiopulmonary Arrest

i. Cardiopulmonary resuscitation will be initiated and the paediatric advanced life support SpR or locum will be summoned to the cardiac arrest by switchboard, and take lead responsibility of the cardiac arrest team.

ii. It will be the responsibility of the paediatric advanced life support SpR or locum to document the events of the resuscitation in the patient's clinical notes, to complete the hospital CPR audit form and to inform the patient's Consultant of the outcome of the resuscitation.

4. Equipment and Drugs

i. The ward sister on RSSC will be responsible for ensuring that appropriate equipment and drugs are accessible and in good working order/within expiry dates as recommended by the CPR steering group. Two paediatric emergency resus kits must be obtained from the Pharmacy Department before the child is admitted. As the kits contain Midazolam, they must be ordered using the Controlled Drug order book on the ward (each kit contains 1 amp Midazolam 10 mg in 2 ml).

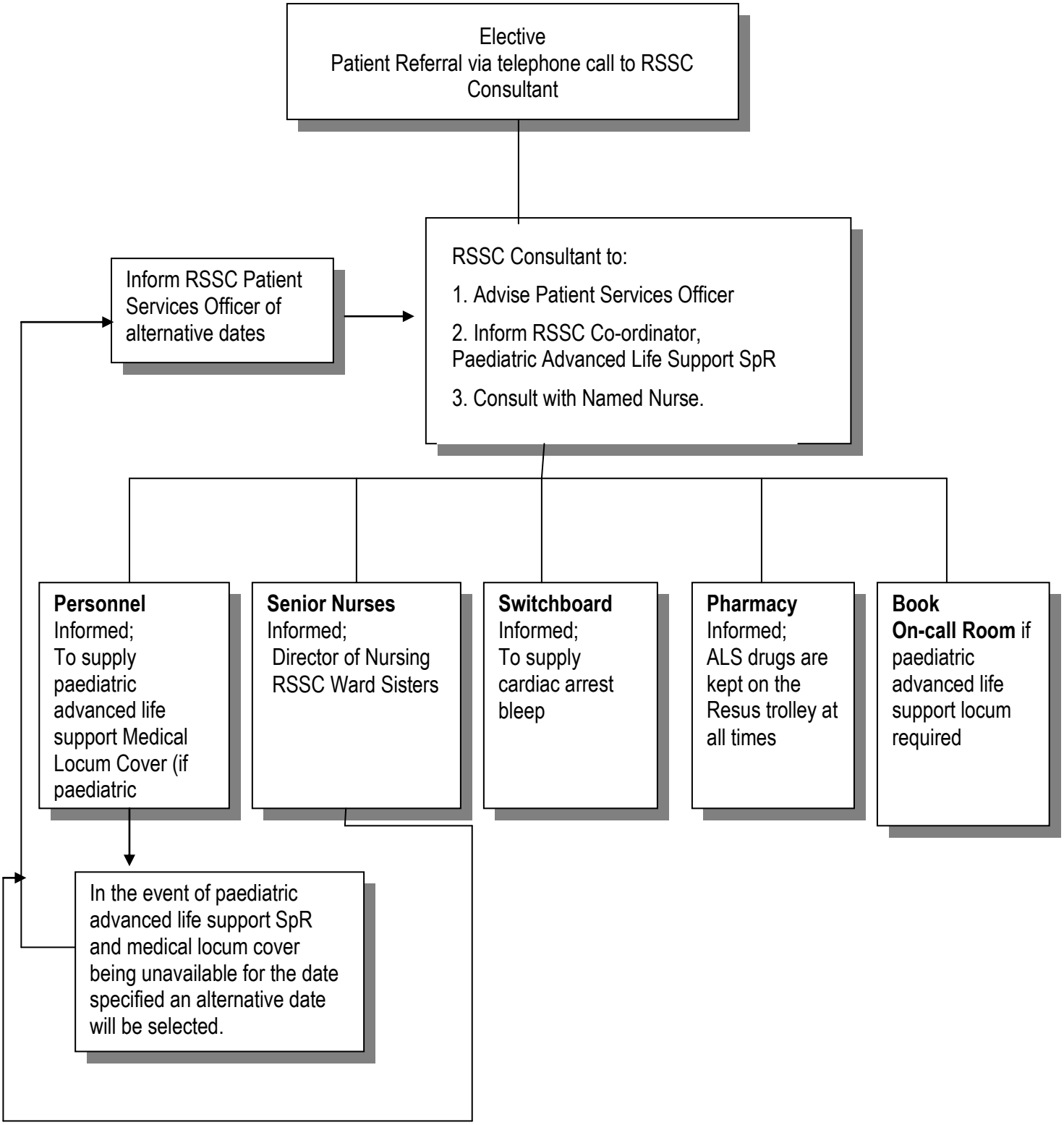
ii. All CPR equipment will be audited annually for its appropriateness by a member of the steering group, and a report made available for the directorate manager

iii. All equipment will be standardised and purchased in accordance with recommendations from the CPR steering group.

5. Do Not Resuscitate Instructions

i. Cardiopulmonary Resuscitation will be initiated unless there is a documented Do Not Resuscitate (DNR) instruction as per the Trust's DNR guidelines.

Paediatric Resuscitation - Organisational Arrangements Flow Chart



Briefing Sheet for Paediatric Advanced Life Support Locum for RSSC

Day 1

On arrival at Papworth:

- Report to the Human Resources Department to have qualifications and identification confirmed and to be issued with a visitor's badge.
- Go to switchboard to collect the cardiac arrest bleep and be informed how to use the bleep system.

RSSC

- Report to the nurse in charge of RSSC who will:
  - Orientate you to the ward environment.
  - Inform you of the fire exits and procedure to follow in the event of an emergency.
  - Demonstrate the paediatric resuscitation equipment available in the ward.

The doctor on call for chest medicine will:

- Introduce you to the paediatric admission(s) and their next of kin, and show you to the hospital restaurant and on-call accommodation.

Your responsibilities will be to:

- Admit the patient(s) and take arterial blood gas samples (if required).
- Inform the nurse in charge and the doctor on-call of the patient's condition.
- Remain within the Thoracic Directorate throughout the patient's admission period, using the on-call room overnight.
- In the event of a cardiopulmonary arrest act as lead doctor for the arrest team and ensure that the record of events is documented in the patient's health records, and on the hospital CPR audit form.
- Complete an ALS drug prescription form, which should then be kept with the patient's medical notes.

Day 2 0830 hours

Provide handover of the patient's clinical condition to the Consultant who will review the patient's sleep study and blood gas data.

If discharge of the patient is delayed, then extension of the locum cover will need to be negotiated.

Appendix Q - Management of the deteriorating patient (children and young adult< 18)

All hospitals that admit children as an inpatient must have a policy for the identification and management of the seriously ill child. This should include Track & Trigger and a process for escalating care to senior clinicians. Early detection and optimal care in the critically ill adult is associated with improved outcomes (DoH 2000), an association that may apply to children. Appropriate intervention is therefore equally important in children, and may prevent the need for admission to intensive care.

Papworth Hospital NHS Foundation Trust provides a limited range of cardiothoracic services for children and young adults. The Trust Board approved the development of an adolescence service for patients with cystic fibrosis (CF) in 1994, and agreed on the admission of young patients requiring the services of the Respiratory Support and Sleep Centre (RSSC) in 1995.

On occasion, children or young adults may require access to the full range of specialist services offered by the Trust. This was approved by the Board of Directors in 2010 and it was decided that Varrier Jones Ward will be used exclusively for any cardiothoracic surgical admissions. These will be children over 12 years of age and above the weight of 40 kg.

191 children under the age of 18 years were admitted to Papworth Hospital as an inpatient in 2011/12, this figure has decreased slightly in 2012/13 where the number of paediatric admissions was 140. The breakdown across departments of paediatric admissions in 2012/13 is; 46 to RSSC, 2 Transplant, 55 Respiratory Medicine, 6 across Cardiothoracic surgery and 30 in Cardiology. Out of the above there were only 23 under the age of 16 years and only 1 under the age of 9 years. The majority of paediatric admissions, and all of those under 13 years of age, are admitted to RSSC and are classed as being ‘well’.

It is has been agreed that there will be a Senior CMT/CST - SpR level medical practitioner competent in Resuscitation Council (UK) accredited paediatric advanced life support with current experience in the field of paediatric medicine on duty at all times during a child’s admission who fits the criteria of 12 years and under and less than 40Kg in weight. If there is no-one working within the trust with those qualifications a medical locum competent in Resuscitation Council (UK) paediatric advanced life support will be provided for the duration of the child’s admission. The medical locum or Senior Trainee will take lead responsibility and co-ordinate the management in response to deterioration or in the event of a cardiac arrest.

The Alert Team can be called to assist in the event of a child’s deterioration and will work alongside the paediatric medical team to manage the patient. Each child or young adult will be managed following the management of the deteriorating patient procedure (DN538) and therefore the deteriorating patient algorithm will be used in order to escalate concern. Urgent medical assistance can also be requested by either the nursing or medical team for any child giving serious cause for new concern. The Alert Team have all attended a Resuscitation Council (UK) PILS course and this is updated on a biannual basis. The Alert Team will also help to facilitate the transfer to a different department if necessary for the child’s safety. Please also refer to Appendix P for guidance on admissions and paediatric resuscitation procedures for further information.

The paediatric observation ranges, included in the paediatric immediate life support course by the Resuscitation Council, will be used for guidance.

Paediatric Observation Ranges

Age	Mean Heart Rate	Respiratory Rate	Systolic BP	Weight	Urine Output
Newborn (0-1m)	140	30-40	>60	3.5 kg	2ml/kg
Infant (1 -12m)	130	30-40	80	7-10.5 kg (6-12 m)	
1-2 Years	130	26-34	90 + 2x age (mean) 70 +2x age (lower limit)	Age +4 x2	1ml/kg
2-5 Years	80	24-30			
5-10 Years	80	20-24			
>10 Years	75	12-20	120		

Department of Health (2000) Comprehensive Critical Care – A Review of Adult Critical Care Services. London, DoH.
Paediatric immediate life support (2012). Resuscitation Council, UK
DN538, Management of the deteriorating patient.
DN270, Children and young adults management policy.

Further document information

Approved by Executive Director/local committee**:**	Safeguarding Vulnerable People Committee Quality and Safety Management Group
Approval date:	October 2013
Approved by Board of Directors or Committee of the Board **(required for Strategies and Policies only):**	Quality and Risk Committee
Date:	December 2013
This document supports: *standards and legislation – include exact details of any CQC & NHSLA standards supported*	▪ Care Quality Commission Outcome (7) Leg (11) ▪ Care Quality Commission Review – Safeguarding children (2009) ▪ NICE guidance, when to suspect child maltreatment (2009) ▪ Working Together to Safeguard Children (2006) ▪ The Children's Act (2004) ▪ Local Safeguarding Children's Board Policies & Procedures
Key related documents:	▪ Papworth Admission & Resuscitation Procedure (Appendix P) ▪ Criminal Records Bureau & Employment Checks Policy ▪ Chaperone Guidelines DN168 ▪ Disciplinary Procedure DN117 ▪ Support Arrangements for Staff DN288 ▪ Training Needs Analysis DN302 ▪ NICE Quick Reference Guide When to Suspect Child Maltreatment (July 2009)

Equality Impact Assessment: Does this document impact on any of the following groups? If YES, state positive or negative, complete Equality Impact Assessment form from DN507 Single Equality Scheme, and attach.

Groups:	Disability	Race	Gender	Age	Sexual orientation	Religious & belief	Other
Yes/No:	No	No	No	Yes	No	No	No
Positive/ Negative:				Positive			

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