## Trust Board

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Date: 31 July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Report</td>
<td>Safeguarding Children / Vulnerable Adult reports</td>
</tr>
<tr>
<td>Purpose of the report and the key issues for consideration/decision</td>
<td>To provide the Trust Board with the annual report for safeguarding of children and vulnerable adults.</td>
</tr>
<tr>
<td>Prepared by: Name &amp; Title</td>
<td>Various</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Pauline Jones, Director of Nursing Umesh Prabhu, Medical Director</td>
</tr>
<tr>
<td>Action Required (please X)</td>
<td>Approve</td>
</tr>
<tr>
<td>Strategic/Corporate Objective(s) supported by this paper</td>
<td>Governance</td>
</tr>
<tr>
<td>Is this on the Trust’s risk register?</td>
<td>No</td>
</tr>
<tr>
<td>Which Standards apply to this report?</td>
<td>CQC</td>
</tr>
<tr>
<td></td>
<td>NHSLA</td>
</tr>
<tr>
<td></td>
<td>BAF Objectives 13/14</td>
</tr>
<tr>
<td></td>
<td>WWL wheel strategic priority</td>
</tr>
<tr>
<td>Have all implications related to this report been considered?</td>
<td>Finance Revenue &amp; Capital</td>
</tr>
<tr>
<td></td>
<td>National Policy/Legislation</td>
</tr>
<tr>
<td></td>
<td>NHS Contract</td>
</tr>
<tr>
<td></td>
<td>Human Resources</td>
</tr>
<tr>
<td></td>
<td>Consultation/Communication</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
</tr>
</tbody>
</table>

### Previous Meetings

Please insert the date the paper was presented next to the relevant group

<table>
<thead>
<tr>
<th>Meeting Point</th>
<th>Audit Committee</th>
<th>Quality &amp; Safety Committee</th>
<th>Finance &amp; Investment Committee</th>
<th>HR Committee</th>
<th>IM&amp;T Strategy Committee</th>
<th>Management Board</th>
<th>NED</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Na</td>
<td>Na 10.07.13</td>
<td>Na</td>
<td>Na Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
</tr>
</tbody>
</table>
Safeguarding Vulnerable Adults & Children
Annual Reports
2012 - 2013

Authors: Margaret Jolley, Head of Adult Safeguarding & Vulnerable Adults

Dr E Abbas
Consultant Community Paediatrician
Designated Doctor for Safeguarding Children
Debbie Spruce
Named Nurse Child Protection Safeguarding Children
Executive Summary

Safeguarding Vulnerable Adults Annual Report 2012/13

The purpose of this report is to provide assurance to the Board that there are robust arrangements in place to ensure Adult Safeguarding is fully integrated into the Trust’s systems and meets the required regulations and standard.

The information contained within this report comprises the period from 1 April 2012 to 31 March 2013 in respect of the following:

- Adult Safeguarding concerns raised
- An analysis of the data during the 2012/2013, using comparative data from previous years.
- The key achievements throughout the year and future developments.

The report also provides an update to the Board on the progress and developments made in addressing the needs of Vulnerable Adults within Wrightington Wigan & Leigh NHS Foundation Trust with specific reference to:

- Responsibilities
- Reporting
- Wigan Adult Safeguarding Board (WASB)
- Safeguarding Referrals
- Mental Capacity / Deprivation of Liberty Safeguards (MCA/DOLS)
- Learning Disabilities
- Dementia
- Training

Safeguarding Vulnerable Children/Child Protection Annual Report 2012/13

The purpose of this report is to:

- Inform the Trust Board about their responsibilities for safeguarding children and to promote children’s wellbeing to prevent them from suffering harm.
- To discuss future plans, strategy and developments in safeguarding children.
- To report the key achievements over the last 12 months.
- To share information from the Integrated Health Group, Heath Commissioning Group Safeguarding Subgroup and Wigan Safeguarding Children’s Board (WSCB).
- Provide information on the future needs of the service

Recommendation

The Board is asked to receive and approve the attached reports for the period 2012/13.
SAFEGUARDING VULNERABLE ADULTS ANNUAL REPORT 2012/13

Responsibilities

Safeguarding Vulnerable Adults is the responsibility of all healthcare staff and the Trust is responsible for ensuring all staff are familiar with the Trust Safeguarding Adults policy and joint local procedures that must be implemented if staff suspect a vulnerable adult is at risk.

Safeguarding is wider than 'adult protection' which predominately focuses on reacting to incidences of harm. WWL’s approach to safeguarding is about addressing inequalities, creating an environment where patients feel safe and where their dignity is respected and whatever their circumstances are free from discrimination.

The following Trust wide policies have been developed to support / guide staff working with Vulnerable Adults:

- Missing Persons Policy- ratified June 2013
- Therapeutic Management of Vulnerable Adults with Challenging Behavior (including Control & Restraint Management) – ratified June 2013
- Mental Capacity (2005) including Deprivation of Liberty Safeguards – awaiting ratification

Reporting

The Director of Nursing is the identified Executive lead for Safeguarding Vulnerable Adults and is therefore responsible for reporting to the Trust Board. The Trust Safeguarding Committee addresses both the adult and child/young person’s safeguarding agenda.

Bi-monthly Adult Safeguarding reports are presented to the Safeguarding Committee by the Head of Adult Safeguarding. These reports indentify the number and type of adult safeguarding concerns raised by staff across the organisation, highlighting any trends identified. Wigan Adult Safeguarding Board updates are also presented together with updates on training figures and new training initiatives.

The Safeguarding Committee chair reports on a bi-monthly basis to the Quality & Safety Committee, which, in turn reports quarterly to the Trust Board.

The Head of Adult Safeguarding provides a detailed annual update on Safeguarding & Vulnerable Adults to Trust Board.

Wigan Adult Safeguarding Board (WASB)

The Director of Nursing, with support from the Head of Adult Safeguarding, represents the Trust on the Wigan Adult Safeguarding Board, reporting back to the Trust Safeguarding Committee.

Professor Paul Kingston has been appointed as independent chair of WASB, all organisations within the board welcome this appointment. Professor Kingston’s expertise is in ageing, mental health, safeguarding vulnerable adults and measuring quality of life. This is a positive step within Adult Safeguarding, WWL, together with other agencies within the borough, have contributed from a financial perspective in support of this appointment.
There have been 3 local case reviews of vulnerable adults who have died, one currently undergoing murder investigation, all cases were community based.

WWL Head of Adult Safeguarding attends and contributes to the North West Safeguarding Network, chaired by the Assistant Director of Patient Safety and Clinical Quality. This network provides peer support for the Adult Safeguarding Leads across the North West and ensures the sharing of innovations and good practice across the region.

**Safeguarding Referrals**

During 2012/13 there has been a further increase of acute Trust referrals in relation to Adult Safeguarding (Graph 1). 141 potential safeguarding referrals were made from the period April 2012 through to 31 March 2013. In the same period 2011/12 there were 81 referrals and in 2010/11 57 referrals.

![Graph 1 – Referrals to Adult Safeguarding by Year](image)

The increase in referrals within Wrightington, Wigan and Leigh NHS Foundation Trust continues to be consistent with an increase in safeguarding referrals across all agencies within the Wigan Borough.
Referrals received in regard of concern for welfare continue to increase, in light of the changes to Welfare reform, this will continue to be monitored and discussed at the WASB and Learning Disability partnership board.

**Mental Capacity / Deprivation of Liberty Safeguards (MCA/DOLS)**

The Mental Capacity Act, 2005, provides a statutory framework for acting and making decisions on behalf of people who lack capacity to make those decisions for themselves.

The Deprivation of Liberty Safeguards (DOLS) was added to the act by the government in 2008. The safeguards focus on the most vulnerable people in society, who, for their own safety and in their own best interests need to be 'accommodated' under care and treatment regimes. These regimes may have the effect of depriving them of their liberty. Within the hospital, application must be made to the supervisory body (Wigan Borough Clinical Commissioning Group), to request authorisation to deprive a patient of their liberty.

The Trust has continued to develop in relation to MCA/DOLS and there has been an increase in engagement and requests for authorizations. However, there were no referrals for Independent Mental Capacity Advocate support (IMCA) in the last quarter. The Trust Head of Adult Safeguarding is working with the IMCA service to promote the service and raise awareness across the Trust with particular attention to the Trust Assessment Units and pre – op clinics.

Wigan Borough Clinical Commissioning group, since April 2013, have the responsibility in monitoring the Trust implementation of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.
Learning Disabilities

Winterbourne View Hospital – Panorama (2011)

Following the BBC Panorama exposure in 2001 of staff at Winterbourne View hospital staff mistreating and assaulting adults with learning disabilities and autism, a serious case review was commissioned by South Gloucester’s local Adult Safeguarding Board and a report with key findings published in July 2012.

Although in the main the recommendations of this enquiry relate to commissioning bodies, there is some learning in relation to whistle blowing process and the need for the Trust to continue to promote the physical and mental health of adult patients who are vulnerable. The Head of Adult Safeguarding, working in collaboration with Partner Organisations to ensure learning actions from Winterbourne view are coordinated and shared.

The Trust continues to be work collaboratively with its partner organisations via the following:
- Wigan Learning Disability Partnership Board
- Wigan Borough Clinical Commissioning Group
- Mental Health Implementation Board
- 5 BP Mental Health Law Forum

The Trust is committed to integrated working with the hospital liaison team for learning disabilities and together have successfully delivered a 12 month training program to front line staff, in particular reception and outpatient staff across all sites.

Tours of A&E and the Surgical Admissions Lounge for individuals with a learning disability continue, with tour dates set for the forthcoming 12 months. The main aim of the tours is to show the individual with a learning disability, what they can expect should they ever have to attend hospital either in an emergency (A&E) or planned surgery (SAU). It is planned that the tours are extended in the coming 12 months to include outpatient departments across all three hospital sites.

The Head of Adult Safeguarding continues to work in collaboration with catering, I.T. and the Trust nutritional group, in the development of ‘electronic’ pictorial menus. This initiative will not only address the communication difficulties of individuals with a learning disability, but for all vulnerable adult groups with communication difficulties.

The Trust will continue, via the Head of Adult Safeguarding, contribute to the Annual Joint Health and Social Care assessment (Learning Disabilities). The outcome/ action plan from this self assessment, when published, will be included in the Trust Safeguarding Committee bi annual report.

Dementia

The Trust is committed to improve the care and experience of patient’s with Dementia and their family and carers. Dementia continues to be a significant challenge and a key priority for the Trust with an estimated 25% of acute beds occupied by people with dementia.

The NHS institute and Dementia Action Alliance launched the ‘Right Care’ creating dementia friendly hospitals in October 2012. The Trust signed up to this call following in November 2012.

In signing up to this the Trust agrees to improve the following 5 key areas:
The environment in which care is given
The knowledge skills and attitudes of the workforce
The ability to identify and assess cognitive impairment
The ability to support people with dementia to be discharged back home
The use of a person centred care plan which involves families and carers.

Key achievements to date:

- 50 Vulnerable Adult/ Dementia Champions across the organisation
- Successful delivery of the 2nd, 2 day intensive training course on dementia completed July 2012 for Champions.
- The Clinical Lead, Senior Nurse and Head of Adult Safeguarding represent the Trust, and are actively involved in the multi agency Dementia Steering Group led by Wigan Clinical Commissioning Group.
- Information and reports from this group are delivered at the Trust Safeguarding Committee.
- The Trust Lead Clinician for Dementia provides an integrated elderly cognitive assessment clinic, which is currently being piloted with a senior nurse practitioner from 5 Boroughs Partnership Mental Health Trust. Following evaluation of the pilot, 5 Boroughs Partnership NHS FT have submitted a business case to extend this.
- The Trust Lead Clinician for Dementia provides training for junior doctors, feedback from this training is attached with this report. (Appendix 1).
- 5 Dementia champions attended a 2 day seminar delivered by the Kings fund, ‘Healing the environment’
- A WWL ‘dementia friendly group has been established, membership includes Director of nursing and key stakeholders from estates and facilities and the dementia champions. Minutes from this group will be sent to the Trust Safeguarding Committee.
- The Trust Lead Clinician has been successful in the following:
  - The community collaboration work published (AQuA)
  - NT Award for collaborative clinic service with 5BP(attached.)
  - presented to national BGS meeting, Belfast and well received as best practice-
  - Produced an action plan following the outcome from the recent National Dementia Audit.

Training

Training and awareness raising continues in all vulnerable adult fields, and dates for the coming year have been advertised with requests for nominations to attend.

Safeguarding adult’s basic awareness is delivered via a module on the Trust e-compulsory training site, and at the Trust monthly induction sessions.

There continues to a month on month slight increase in e-compulsory safeguarding vulnerable adults training, the compliance figure for May 2013 91.4% (75% compliance May 2012) against a Trust target of 95% set by the NHSLA.

Divisional Heads of Nursing have produced action plans to ensure this continued improvement of compliance, this is monitored at the Trust Heads of Nursing meetings by the Director of Nursing.
The continued provision of multi professional training, provided by Wigan Council, is currently under discussion with Wigan Adult Safeguarding Board. The Head of Adult Safeguarding will inform the Trust of the outcome via the Safeguarding Committee.

Bespoke training for senior clinicians and practitioners on the Mental Capacity Act / Deprivation of Liberty Safeguards and the Law was carried out in September 2012 and again in February 2013.

**Key Priorities/ work streams 13/14**

- Continued development of vulnerable adult senior nursing team.
- Vulnerable Adult / Dementia -12 month training plan, training will be delivered in house by the vulnerable adult team for all groups of Trust staff.
- Continue in the development of the delivery of specialist service provision for frail elderly patients, including the environment
- Engage with the newly formed Wigan Health watch group

**Summary**

- In line with national and local trends, there has been an increase in adult safeguarding referrals.
- E–mandatory training compliance, although currently below the Trust target, has increased almost 20% in the last year. Compliance is expected to continue to increase.
- There is a robust reporting structure in place to give assurance to the Trust Board with regards adult safeguarding.
- Wigan Borough Clinical Commissioning group, since April 2013, have the responsibility in monitoring the Trust implementation.
- The Safeguarding of Vulnerable adults is now a key agenda item on the WWL Quality Safety & Safeguarding Group (CCG).
Dementia Training – 15 May 2013 at 13:00 with Arvind Kumar

Educational outcomes

Good session on dementia which is such a common problem for us in hospital and common differential increasingly.

You cannot diagnose dementia in an inpatient setting.

Approach to management of dementia patients in hospital

Case presentation on dementia - diagnosis and management

Difference and definition of delirium and dementia

Excellent insight into memory service and its role in treating patient with Dementia. Interesting insight into dementia with lewy bodies and its treatment.

Really good overview of dementia and delirium, the key differences and how to deal with both

Teaching feedback

Great interactive, funny and memorable session. Thank you.

Good sessions, informative.

Very informative session. Useful for updating clinical practice.

Good interactions with crowd, questions were very well answered.

Good session, well presented, relevant topic.
Appendix 2

The Prevention, Diagnosis and Management of Delirium in Older People

Delirium is common in the older medical patients (up to 30% medical and up to 50% in post op elderly inpatients) and is often unrecognized by medical and allied health professionals. It can result in

- Higher mortality and morbidity
- Increased length of inpatient stay
- Hospital acquired complications like falls, infection, pressure sores
- Premature institutionalisation and
- Three times likelihood of developing dementia.

The main focus of this guideline (adapted from NICE 2010) is to

- Identify those at risk of delirium
- Implement strategies to prevent delirium in those identified to be at risk
- Diagnose delirium
- Manage delirium using multicomponent, non-pharmacological interventions as a first choice to address modifiable clinical factors, and
- Guide re pharmacological options for delirium

Risks and Prevention

Delirium is common, but serious and complex with poor outcomes. Thus every patient should be assessed, on admission, for risk of developing delirium.

The main risk factors for developing delirium are

- Age>65 years (frailty, comorbidities)
- Dementia or previous delirium (5 times more common in people with dementia)
- Current hip fracture
- Severe Illness (surgery, infection, constipation)

Those at risk should be assessed for features of delirium, and prevention strategies incorporated into their care plan to prevent delirium. Preventative measures include:

- Orientate patient to surroundings and people
- Ensure call bell in reach, and patient made aware of its use
- Treat hypoxia if present
- Maintain hydration and nutrition
- Ensuring hearing aids and spectacles are available, within reach and in good working order
- Minimise pain, constipation
- Encourage visits by family/friends
- Avoid moves between and within wards, esp. during nights unless absolutely necessary
- Encourage mobilization and ensure walking aids are accessible
- Review medications- withdrawal/poly-pharmacy, assess for signs of withdrawal and reduce medications where appropriate.
- Consider treating electrolyte imbalance if present
• Ensure good sleep pattern (avoid nursing or medical interventions during sleep hours, if possible and reduce noise to a minimum during sleep).

Continue to assess regularly for development of any new symptoms, which could potentially lead to delirium and treat as appropriate.

DIAGNOSIS

At presentation, as well as regularly throughout their hospital stay, those at risk should be assessed for acute changes or fluctuations in:

• Cognition,
• Perception,
• Level of activity (hyperactivity or agitation/ hypo activity or lethargy/ mixed), and
• Behavior (restlessness, agitation).

A careful history from patient, relative or carer about the onset and course of the confusion will help distinguish between delirium and dementia and may help identify the cause of delirium as well.

An AMTS should be performed in all the at risk patients. If AMTS shows a score of 7 or less out of 10, or indicators of delirium (as mentioned above) are identified, carry out clinical assessment based on short Confusion Assessment Method (CAM) to diagnose delirium.

ABBREVIATED MENTAL TEST SCORE (AMTS)

1  - Age
2  - DOB
3  - Year
4  - Place(Name of hospital)
5  - Name of Monarch
6  - Count backwards from 20
7  - Dates of WW2
8  - Recognition of 2 people
9  - Address to recall (42 West Street)
10 - Time (to the nearest hour).

CAM

<table>
<thead>
<tr>
<th>1-Acute Onset &amp; Fluctuating Course</th>
<th>Is there an evidence of an acute change in mental status from patient’s baseline?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Come and go</td>
</tr>
<tr>
<td></td>
<td>• Fluctuate during the day</td>
</tr>
<tr>
<td></td>
<td>• Increase/ decrease in severity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2-Inattention</th>
<th>Does the patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Have difficulty focusing attention</td>
</tr>
<tr>
<td></td>
<td>• Become easily distracted</td>
</tr>
<tr>
<td></td>
<td>• Have difficulty keeping track of what is said</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3-Disorganized Thinking</th>
<th>Is the patient’s thinking disorganized or incoherent? E.g. does the patient have</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Rumbling/irrelevant conversations?</td>
</tr>
<tr>
<td></td>
<td>• Unpredictable switching of subjects?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4-Altered Level of consciousness</th>
<th>Overall, what is the patient’s level of consciousness?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Alert</td>
</tr>
</tbody>
</table>
Vigilant (hyper alert)  
Unclear or illogical flow of ideas  
Lethargic (drowsy but easily roused)  
Stuporous (difficulty to rouse)  
Comatose  (unrousable)

Formal scoring of CAM requires 1+2+ either 3 or 4 to diagnose delirium. High index of suspicion is suggested to consider delirium if there is a positive response to any of the 4 parts of CAM. In postoperative patients or those on ITU, CAM-ITU should be used.

If there is difficulty distinguishing between delirium and delirium with dementia, treat as delirium first and arrange a follow up appointment to review.

MANAGEMENT OF DELIRIUM

Initial Management

a-Find and treat the underlying cause: -

There is often more than one cause, commonly, drugs or drug withdrawal, infection, electrolyte disturbances, dehydration, pain or constipation.

It is important to take a good history of onset and course of confusion, symptoms suggesting infection, drugs and recent changes, bladder and bowel function, dietary and fluid intake and baseline cognition/functional status. The clinical assessment should include conscious level, AMTS, CAM, looking for signs of infection, neurological examination, signs of alcohol abuse or withdrawal, ruling out urinary retention or faecal impaction and nutritional status. Routine investigations like CRP, FBC, U&Es, Bone profile, LFTS, glucose, ECG, CXR, urinalysis (+/-culture) are almost always indicated to help identify the cause. Other investigations like ABG, blood Culture, CT Head, B12, folate, TSH (if pre-existing dementia suspected) and LP should also be considered depending on history and clinical examination findings.

b-Non pharmacological strategies

- Provide personal and environmental orientation
- Explain what is being done and why
- Reduce medications but ensure adequate analgesia
  - Ensure hearing and visual aids are available and in working order
  - Encourage mobility
- Maintain good fluid intake
- Maintain nutrition
- Avoid constipation
- Maintain good sleep pattern
- Familiar objects form home
  - Ensure continuity of care
- Involve relatives and carers and provide with information
  - Avoid complications (immobility, malnutrition, pressure sores, over sedation, incontinence and falls)
- If wander some behavior exhibited-provide close observation within safe and closed environment, ask relatives to help to provide meaningful distractions. Act in patient’s best interest to keep them safe and use drug treatment only as a final option.
Do Not

Use restraint
Catheterize
Sedate routinely
Argue with the patient
Inter ward transfers especially during nighttime

c-Pharmacological Management

In patients who are distressed or considered a risk to themselves or others, use verbal and non-verbal techniques to de-escalate the situation where possible. Medications should be used as a last resort and may be necessary in the following circumstances.

- To carry out essential investigations or treatment
- To prevent patients endangering themselves or others
- To relieve distress in a highly agitated or hallucinating patient.

If sedation is to be used

- Only one drug (not a cocktail of drugs) should be used, starting with the lowest possible dose taking age, BMI, sex and degree of agitation into consideration.
- The dose may be increased in increments if necessary after regular assessments and the effective dose should be maintained for a few days and then tapered off and stopped (ideally within a week’s time) while monitoring for signs of recurrence.
- Aim to reduce and stop/taper psychotropic drugs as quickly as possible ~48 hrs. If treatment for symptoms of delirium is required for more than 72 hours, seek PLN review/ specialist advice.

The use and indication for antipsychotics must be reviewed regularly in patients with delirium (2 hourly is recommended and at least every 24 hrs). Antipsychotics have significant adverse effects. They can result in over sedation, increased risk of falls, stroke and extrapyramidal side effects (EPSE). They can be lethal in dementia with lewy bodies (DLB). ECG monitoring is advised due to risk of QTc prolongation and Torsades de pointes. The IV use is associated with higher risk than oral, hence use oral formulation where possible, otherwise IM.
### Drugs options, dose, SE, maximum dose and frequency

<table>
<thead>
<tr>
<th>Drug</th>
<th>Oral dose</th>
<th>IM (use in emergency)</th>
<th>Side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>-0.5-1mg bd</td>
<td>In emergency, when oral route is not possible</td>
<td>- Avoid in DLB&lt;br&gt;- ECG monitoring recommended&lt;br&gt;- EPSE common &amp; increased if &gt;3mg in 24 hours&lt;br&gt;If &gt;2mg in 24 hours required consider referral to PLN</td>
</tr>
<tr>
<td>OR</td>
<td>-Maximum frequency- 2 hourly</td>
<td>-1-2 mg IM&lt;br&gt;-Max dose in a 24 hrs- 5mg, -maximum frequency-2 hourly</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>-Maximum dose - 5mg/24 hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>-0.5 mg, oral</td>
<td>-Use in emergency, when oral route is not possible&lt;br&gt;-0.5-1mg IM&lt;br&gt;-Max dose 3mg in 24 hrs</td>
<td>- Safe in DLB/PD/arrhythmias&lt;br&gt;- May cause respiratory suppression reversible with flumazenil.&lt;br&gt;- Lorazepam tablets can be given sublingually.&lt;br&gt;- Can be given IV in hospital setting in cases of emergency&lt;br&gt;- Due to ongoing supply issues with lorazepam injection (resulting in reduced availability) midazolam may be used as an alternative</td>
</tr>
<tr>
<td></td>
<td>-maximum frequency- 2 hourly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- maximum dose in a 24 hrs- 3 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midazolam</td>
<td>-1.2-2.5mg IM</td>
<td>-May cause respiratory suppression reversible with flumazenil.</td>
<td>- Note that flumazenil has a shorter half-life &amp; duration of action than midazolam so patients may become re-sedated.</td>
</tr>
<tr>
<td></td>
<td>-max frequency 2hrly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Max dose-7.5 mg in 24 hrs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Those prescribing sedation MUST be familiar with the Mental Capacity Act 2005 and Deprivation of Liberty legislation.
### Key stages in assessment and management of Delirium

**Step 1**
Assess all patients on admission for risk factors for delirium and continue to monitor those at risk for changes/fluctuations in behaviour regularly throughout hospital admission. When cognitive impairment is suspected use the AMTS on the first encounter to help assess cognitive function.

**Step 2**
Consider delirium in all patients with cognitive impairment and at high risk (severe illness, dementia or previous delirium, current fractured neck of femur, age >65). Use the CAM screening instrument to diagnose delirium. A history from a relative or carer of the onset and the course of the confusion is essential to distinguish between delirium and dementia.

**Step 3**
Identify the cause of delirium if present from the history obtained from relatives/carers, examination and investigations. **Treat underlying cause or causes** – commonly drugs or drug withdrawal, infection, electrolyte disturbance, dehydration or constipation.

**Step 4**
In patients with delirium and patients at high risk of delirium: **Do:**
- Provide environmental and personal orientation
- Ensure clear communication
- Ensure continuity of care
- Encourage mobility
- Reduce medication but ensure adequate analgesia
- Ensure hearing aids and spectacles are available and in good working order
- Avoid constipation
- Maintain a good sleep pattern
- Maintain good fluid intake maintain nutrition
- Involve relatives and carers
- Avoid complications (immobility, malnutrition, pressure sores, over-sedation, incontinence and falls)
- Liaise with old age psychiatry service / refer to “Rapid Assessment Interface Discharge” (RAID Team) where necessary

**Do NOT:**
- Use restraint
- Catheterize
- Sedate routinely
- Argue with the patient

**Step 5**
If sedation has to be used, use one drug only starting at the lowest possible dose and increasing in increments if necessary after an interval of two hours. **Haloperidol** 0.5mg (repeated max every 2 hrs up to a total dose of 5mg in 24 hrs in hospital and maximum of 3mg in primary care orally is the recommended drug choice. For patients with Parkinson's Disease/ Dementia with Lewy Bodies/benzodiazepine withdrawal use lorazepam 0.5mg to 1mg orally which can be given up to 2hourly as required (max 3mg in 24 hrs)

**Step 6**
GP to consider follow-up with Medicine for the Elderly/ collaborative memory clinic or old age psychiatry team (check if already arranged by PLN).
Our purpose is to work together to improve life chances

Our Vision is that all children, young people and families are safe, healthy and happy within our Community

We are proud with our safeguarding team achievement in 2012 as we scored outstandingly in the latest joint care quality commission (CQC) and Ofsted inspection in May 2012.

Introduction:

- This report aims to inform the Trust Board about their responsibilities for safeguarding children and to promote children's wellbeing to prevent them from suffering harm.

- To discuss future plans, strategy and developments in safeguarding children.

- To report the key achievements over the last 12 months.

- To share information from the Integrated Health Group, Heath Commissioning Group Safeguarding Subgroup and Wigan Safeguarding Children's Board (WSCB).

1. Statutory requirements:

- The safety and health of a child are mutually dependent aspects of their wellbeing. Many health interventions also equip a child to stay safe.

- UN Convention on the Rights of the child, ratified by UK Government 1991 takes into account the European Convention of Human Rights, also it takes account of the requirements of the Children Act 1989, Children Act 2004 and Education Act. It requires that a range of organisations including NHS Trusts make arrangements for ensuring that the functions and services provided on their behalf, are discharged to safeguard and promote the welfare of children.

- In March 2012 the Health and Social Care Act was introduced by the Government for Health Reform. The aim of the Act is to devolve power to clinicians through clinical commissioning groups (CCGs) which formed in April 2013. The commissioning of public health services is being devolved to local authorities’ social care.

Primary Care Trusts and Strategic Health Authorities have now been abolished.

The responsibility of safeguarding children lies now within the CCG.
• All organisations commissioning or providing health care whether in the NHS, independent healthcare sector or social enterprises should ensure there is Board level focus on the needs of children and that safeguarding children is an integral part of their governance systems.

1.1 Responsibility at Trust Board Level

All health services have a duty to protect children, and the Trust is responsible for ensuring that all staff are familiar with the local procedures that they must apply when it is recognised that a child is at risk of harm.

All healthcare staff involved in working with children should attend training at an appropriate level in safeguarding and promoting the welfare of children, and have regular updates as part of their continuing professional development.

The Medical Director is the Board member responsible for reporting safeguarding matters in children and adults to the Trust Board.

1.2 Named and Designated Professionals

All NHS Trusts must identify Named Professionals (Doctor, Nurse, Midwife) who have a key role in promoting good professional practice within the Trust and who can provide advice and expertise for other staff and assist with the management of child protection cases when the need arises.

All staff should also have access to the Designated Professionals (Doctor and Nurse).

To fulfil these responsibilities the Trust has a Named Doctor, Named Nurse, Named Midwife and also employs a Designated Doctor.

Each professional has their responsibility defined within their job description which should be in line with Guidance “Children and Young People: Rules and Competencies for Health Care Staff 2010”; an intercollegiate document supported by the Royal College of Paediatrics and Department of Health.

- Designated Doctor for Safeguarding Children Dr E Abbas
- Named Doctor for Safeguarding Children Dr M. Mukherjee (the role will be fulfilled by Dr S Castille from July 2013)
- Named Nurse for Safeguarding Children Mrs Debbie Spruce
- Named Midwife for Safeguarding Children Caroline Ashton
- Lead A&E Consultant for Safeguarding Dr S Khan (Dr Khan will be taking the Designated Doctors responsibility from October 2013)
- Lead Nurse for A&E Claire Birchall

Strategy for Safeguarding Children

1. The National Service Framework for Children, Young People and Maternity Services 2004 stipulates that all agencies should develop their own strategy to ensure that systems are in place to safeguard children.
2. WWL’s Policy for Safeguarding Children was originally produced in 2004. This has been updated twice with the latest one in 2011. The policy is due to be reviewed in August 2013.

3. The Trust’s Safeguarding Guideline developed in 2004 has been updated three times; most recently in 2012. There are various policies and procedures available for all the staff via the Child Health/Safeguarding page on the Intranet.

4. The Trust’s Child Protection, Safeguarding Children and Young People’s Strategy has recently been updated in June 2013 and is in line with the Wigan Safeguarding Children’s Board Plan and Wigan Council Children and Young Peoples Plan.

Referral to the Independent Safeguarding Authority

All organisations have a legal duty to inform the Independent Safeguarding Authority (ISA) if they dismiss a member of staff because they have harmed a child or vulnerable adult.

The Trust has also a duty to refer such staff to the local authority Designated Officer (LADO).

John Lenney, Director of Human Resources for the Trust, is the nominated officer for the Trust to investigate such allegations and work with WSCB.

Children’s Safeguarding Virtual Team Development Programme

A review of children’s safeguarding was conducted in 2010 by Organisational Development Services (ODS).

ODS consultancy outlined a number of recommendations; one of these was to develop a Virtual Integrated Health Safeguarding Team across the health economy to include the Acute Trust. It was hoped this would reduce duplications and help to develop a seamless system-wide service.

The team development programme started in September 2011 and completed in December 2012.

A virtual integrated health safeguarding team across the health economy including WWL was formed in January 2013 on the basis of the organisational development service programme (18 month programme). The aim of the team is to work together within the health setting to reduce duplications and develop the seamless system-wide service. The team meets every three months.

One of the team’s achievements is an electronic communication newsletter via WSCB which is distributed to all health as well as WSCB members.
Training

Training is a vital and energising way of improving our skills, professional confidence and strengthening our practice to work collaboratively to protect children and young people.

Employers are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting children’s and young people’s welfare.

Different levels of training are required in safeguarding according to the staff members’ exposure to children and families.

Level 1 – All clinical staff (fulfilled by completion of mandatory e-training module).

Level 2 – Clinical staff who in their work have some contact with children and families.

Level 3 – Clinical staff working directly with children and young people and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Plan

1. All new staff will have a brief safeguarding awareness training in their induction.

2. All Paediatric staff have an additional safeguarding induction with the Named Nurse for Child Protection once they have commenced their post on Rainbow ward.

3. A safeguarding e-Learning module was developed for WWLFT and has been in place since 2010. This is considered as mandatory Level 1 training for all clinical staff.

4. From October 2010 the WWL Training strategy has mirrored the Wigan Safeguarding Children’s Board training module to ensure all agencies within the Borough can provide a consistent approach to safeguarding children.

5. Level 2/3 in line with other agencies provided within the WSCB training programme.

   Level 2 training is an e-learning module hosted by WSCB.

   Level 3 consists of two parts; part 1 is similar to level 2 e learning module and part 2 is a half day face to face inter agency training.

   However with the Acute Trust, the Named Doctor, Nurse and Designated doctor have delivered the same package of inter agency level 3 face to face training, organised by the Trust’s Training Department and facilitated by Mrs Helen Moreton - we delivered 12 to 15 half day sessions achieving the targets for the Trust.

The latest training figures for May 2013 overall safeguarding children training compliance within the Acute Trust is 84%

- The total number of non compliant users for May 2013 is 667 Employees
- Annual Training - 406
- 2 yearly Training – 207
### Table

<table>
<thead>
<tr>
<th>Total No of Users</th>
<th>Compliant Users</th>
<th>Non compliant Users</th>
<th>May 2013</th>
<th>April 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>4165</td>
<td>3498</td>
<td>667</td>
<td>84%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>

### No of users for

<table>
<thead>
<tr>
<th>Annual Training</th>
<th>2396</th>
<th>460</th>
<th>80.8%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 yearly Training</td>
<td>1769</td>
<td>207</td>
<td>88.3%</td>
</tr>
</tbody>
</table>

6. The Designated and Named Doctor deliver ½ day training to all new medical staff in A&E, Paediatrics (FY1 and FY2s) and Paediatric middle grades twice per year.

7. The Designated and Named Doctor organised half day awareness sessions regarding Domestic Violence and Sexual Exploitation from a specialised team in Wigan (28.6.13).

8. Staff working closely with children and families suffering from domestic violence are offered access to multi agency training packages via a WSCB training programme.

9. The Designated Doctor has delivered 1x4 Fabricated and Inducted Illness Training sessions for WWL staff; the most recent one in May 2013, and has also delivered other services for WSCB staff.

10. The Named Doctor and Named Nurse deliver a multi agency one day Training session on physical injuries via the WSCB four times a year.

11. WWL staff also have free access to various courses as part of the interagency training programme via WSCB.

12. The Designated Doctor also contributes to other inter agency training. There is also updated training for Child Health staff on various topics; the most recent was regarding Abusive Burn Patterns in Children.

### Audit

1. The Designated Doctor undertakes an annual child protection audit. An Audit regarding the child protection cases for 2012 is due to be completed in September 2013. This will be the 8th annual audit in the past nine years. The audit is looking at the Trust’s compliance with the Laming Health recommendations and NICE guidelines for Child Protection. Over these years there has been vast amounts of information gathered by various action plans being implemented to improve our safeguarding system and compliance with the recommendations.

2. Dr Downes (the Named Doctor for Sudden Unexpected Child Death) undertakes an annual Child Death Audit. Total number of deaths in 2012 was 18 which was higher than the previous year, with 1 suicide (17 years old), 1 fall from cliff top (16 years), 11 deaths were preterm or neonatal death, 1 hypoxic ischaemic encephalopathy (13 years), 1 acute obstructive hydrocephalus (6 years), severe intractable epilepsy (3 months), downs
syndrome (15 years), pontine giloma (7 years). The 2011 audit shows 16 deaths but has not yet been presented.

3. A Bruising in Infants audit was completed in February 2013 under the supervision of the Designated and Named Doctor. Various recommendations came out of that audit which indicated an improvement in our practice. The audit was also presented by the Designated Doctor to the A&E staff to raise their awareness about the staff compliance needing their support.

4. A safeguarding children internal audit was completed by the Independent North West Audit Group. The Named Nurse and Designated Doctor contributed various recommendations to the audit which were implemented except the training of locums which is outstanding.

5. The Trust takes part in case file audit as part of WSCB audit three times a year.

6. The Trust contributes to the Section 11 audit as part of an inter agency group on behalf of WSCB in inline with the Ofsted grading system, to provide assurance to the WSCB that agencies comply with all Section 11 safeguarding standards. The majority of the outcomes were green with a couple which were amber rated.

7. The Designated Doctor is re-auditing the Trust’s DNA rate looking at the reasons behind the DNA within our paediatric services. This audit is being carried on behalf of the Acute Trust at the request of a Lesson Learned Sub Group of WSCB. This audit will improve our overall health DNA policy.

Work has been undertaken to address the recommendation of the serious case review and local case review action plan recommended by the WSCB.

**Serious Case Review (SCR), Local Case Review (LCR) and Lesson Learned**

When a child dies and there may be safeguarding issues it is looked at by the WSCB. If the death is suspicious, a serious case review should be conducted by the Authority. This would be chaired by an independent person.

From March 2013 – April 2014 the WSCB is conducting two parallel SCRs regarding Child C and Child D. Both children have attended WWL services and were known to the Acute Trust.

We contributed to three multi agency LCRs via the Designated Doctor and Lesson Learned Sub Group under the WSCB.

**Messages from research**

(Gateway reference number: 16899)
The Safeguarding Children Research Initiative is an important element in the Government’s response to the inquiry following the death of Victoria Climbie. Its purpose is to provide a stronger evidence base for the development of policy and practice to improve the protection of children in England. Eleven studies were commissioned and this overview focuses on the findings and also refers extensively to a further four important research studies that were also reported at the same time.
Link: https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RB164

**Action:** NHS and local authority Chief Executives will wish to study this research which provides an overview of the key messages, distilled to meet the need of those professionals who seek to utilise such research findings to shape their day-to-day work.

**Key achievement 2011 -2012**

1. We are proud of our safeguarding team achievement in 2012 as we scored outstandingly in the latest joint care quality commission (CQC) and Ofsted inspection in **May 2012**.

2. The Trust’s Safeguarding Committee holds regular joint Children and Adult Safeguarding meetings to promote the welfare and safety of vulnerable children and adults. The committee is chaired by the Medical Director.

3. Within the Trust we continue to provide a rapid access Child Protection Service. Between the hours of 9am and 5pm there is a Consultant Paediatrician dedicated to Child Protection with opportunities for training of the middle grade doctors. There is also an Out of Hours On-Call Paediatric Team who provide assessment, support and advice.

4. For 2012 January – December our NAI numbers were 132. We filed 132 cases of Child Protection medical reports. We discussed over 130 cases at our weekly peer review supervision meeting. There have been more than 300 referrals to our Named Nurse via the Safeguarding proforma completed by staff concerned about a case in their area. The proforms are from the Adult, Paediatric and Accident & Emergency (both Adult and Paediatric) areas.

5. There is a clear line of accountability. The staff are advised to follow an Escalation Policy to address any conflicting views and opinions.

6. Managing bruises in young babies was one of the messages that came from one of the local case reviews. Since this the Trust has adopted a policy for Bruises in Young Babies, and all babies with injuries will be seen by Paediatric staff in A&E.

7. Maintaining electronic in-house and paper databases of all Safeguarding Proformas faxed to the Named Nurse Child Protection office. Referrals are made from both Adult and Paediatric areas within the Acute Trust. All of the cases are assessed, and any queries/concerns are followed up prior to the proformas being sent out to Bridgewater Safeguarding Unit. The Named Nurses in Bridgewater disseminate to the relevant health professionals in the community. A report is completed every six weeks and is discussed at our Acute Trust Internal Safeguarding meeting and at the Clinical commissioning safeguarding health group.

8. We are very proud that we achieved implementation of the Flagging System (new policy) to flag up children at risk who are on a child protection plan. We have a system now where children are flagged on the electronic patient record as well as the child’s file, and this has been implemented across the child health system and A&E system.
9. The Trust is also taking part in a national child protection information sharing project. The Trust is part of six authorities being piloted in England, and we will be in the first wave having access to the electronic information held centrally of any children on a child protection plan and known to social services. Our A&E and midwifery system will be taking advantage of the project to start with, and our child health system will follow. This project will be completed by April 2014, and the Designated Doctor has taken the lead in liaising with the Department of Health. IT training of A&E staff has been organised to address this need.

10. All policies and procedures have been updated in 2012 as part of the preparation for the CQC inspection.

11. We continue to link with Adult Safeguarding Team via the Named Nurse for Safeguarding Adults.

12. A&E has a nominated Lead Consultant Dr S Khan who is available to staff for supervision and advice. There is a nominated Nurse in A&E who acts as Safeguarding Champion.

13. The Named Nurse has been working closely with the Paediatric Nurses on Rainbow Ward and has initiated a development post for one day a week under the supervision of the Named Nurse to assist with safeguarding duties, communicating with external agencies and developing their skills in dealing with child protection/safeguarding processes. Two Nurses have successfully completed a six month secondment and a third is due to commence the role. It has been well evaluated by the nursing staff and many of the nurses are keen to undertake the post.

14. Continue to provide weekly peer review safeguarding supervision for child health staff, chaired by Named Doctor, minuted and monitored.

15. Named and designated professional access supervision via Greater Manchester Safeguarding network every three months. The Named Doctor will be supervised by Designated Doctor, and the Named Nurse will be supervised by the Designated Nurse; who will supervise the Named Midwife also.

16. We continue to contribute to Greater Manchester Rapid Response Team to assist with the investigation of sudden unexpected child deaths. Also, we are contributing to the overarching Child Death Overview Panel (CDOP) via Designated and Named Professionals.

17. We contribute to various WSCB subgroups eg Health Agencies Subgroup, Training, Lessons Learned, WSCB and Greater Manchester Designated Professionals Group, as well as the CCG clinical commissioning safeguarding health group meetings.

18. Implementations of various recommendations of SCR of Child C and Child D. Further support from the Executive Team will be required for the Named Professionals as well as the newly appointed Designated Doctor in due course.
**Conclusion**

WWL has many positive qualities which were reflected in the integral North West audit as well as last year’s CQC and Ofsted inspections.

As there are various reforms within the health system as a result of Health and Social Care Act 2012, various changes may be introduced in the near future regarding roles and responsibilities especially within the Designated and Named Professionals.

It is important to ensure that compulsory training targets are achieved, as well as targeted training and staff supervision so that the Trust can be proud of its service for vulnerable children.

**Future needs include:**

- Domestic violence training for A&E staff, midwifery and child health staff needs addressing.

- Supervision of midwives and nursing staff via named Professionals needs addressing.

- Continue to build up and strengthen our communication with other agencies to address child safety and welfare eg flagging of children and young people’s records where there are social concerns.

- Continue to train the front line staff on levels 1-3.

Dr E Abbas  
**Consultant Community Paediatrician**  
**Designated Doctor for Safeguarding Children**

Debbie Spruce  
**Named Nurse Child Protection Safeguarding Children**