RCPCH Audits

Pilot Report

RCPCH Child Protection Service Delivery Standards Audit

Contents

Background

About the audit

In 2020, the Royal College of Paediatrics and Child Health (RCPCH) and the Child Protection Special Interest Group (CPSIG) published the 'Good practice service delivery standards for the management of children referred for child protection medical assessments' with the aim of reducing unwanted variation in care across the United Kingdom.

The RCPCH will be conducting a nationwide audit of these standards to:

- Understand current service arrangements, and how closely they follow the standards
- Understand how well current service delivery infrastructure supports teams to meet the standards

We will also use the audit as an opportunity to:

- Understand the map of services providing child protection medical assessments across the UK
- Learn about current models of service delivery – for example, information on capacity, accepted age ranges, and venue arrangements.

About the pilot

Before rolling out the audit full-scale, we undertook a pilot phase to identify any areas for improvements to the audit processes, with a focus on making the submission of audit data as easy as possible for clinical teams. We were looking to understand the overall feasibility of the audit; to detect any functionality issues with the data collection platform; and to identify whether any edits were needed to the dataset questions. This report outlines the results of this pilot phase undertaken between December 2022 and January 2023.

Participation

We invited services across the UK to participate in the pilot with the following 21 services providing a full or partial data submission to the pilot phase:

- Barnsley Hospital - England (North East and Yorkshire)
- Bradford Teaching Hospitals - England (North East and Yorkshire)
- Calderdale And Huddersfield - England (North East and Yorkshire)
- Child Development Centre, Warrington - England (North West)
- Community Paediatrics, Solihull - England (Midlands)
- Hull Royal Infirmary - England (North East and Yorkshire)
- Manx Care - Isle of Man
- New Cross Hospital - England (Midlands)
- Oxford University Hospitals - England (South East)
- Royal Bolton Hospital - England (North West)
- Royal Stoke University Hospital - England (Midlands)
- Royal Victoria Infirmary - England (North East and Yorkshire)
- Salford Royal - England (North West)
- Sheffield Children's Hospital - England (North East and Yorkshire)
- Sherwood Forest Hospitals - England (Midlands)
- Solent - England (South East)
- South Tyneside and Sunderland - England (North East and Yorkshire)
- The Great Western Hospital - England (South West)
- The Mid Yorkshire Hospitals - England (North East and Yorkshire)
- Worcestershire Acute Hospitals - England (Midlands)
- Wycombe Hospital - England (South East)

Many thanks to all participating services.

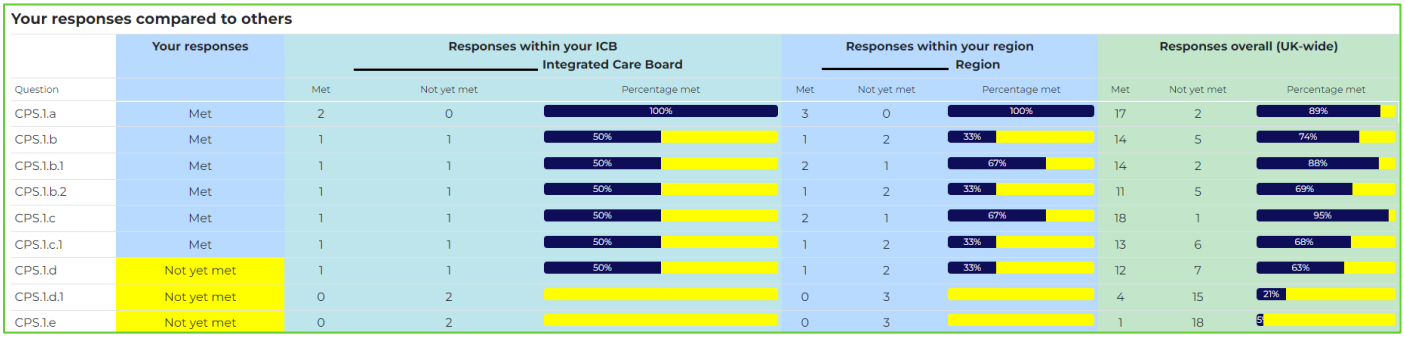
Data collection platform

We worked with software company Eastface to build an online data collection platform on the RCPCH Data Portal.

Participation requires services to log in to the Portal to complete a simple online data form:

On the resulting data summary page, responses can then be viewed in comparison with others from:

- The service's Integrated Care Board (ICB) if applicable [*42 ICBs*]
- The service's region/country [*England (East of England), England (London), England (Midlands), England (North East and Yorkshire), England (North West), England (South East), England (South West), Northern Ireland, Scotland, or Wales*]
- The UK overall [*All submitting services*]



Your responses compared to others

	Your responses	Responses within your ICB — Integrated Care Board			Responses within your region — Region			Responses overall (UK-wide)		
Question		Met	Not yet met	Percentage met	Met	Not yet met	Percentage met	Met	Not yet met	Percentage met
CPS.1.a	Met	2	0	100%	3	0	100%	17	2	89%
CPS.1.b	Met	1	1	50%	1	2	33%	14	5	74%
CPS.1.b.1	Met	1	1	50%	2	1	67%	14	2	88%
CPS.1.b.2	Met	1	1	50%	1	2	33%	11	5	69%
CPS.1.c	Met	1	1	50%	2	1	67%	18	1	95%
CPS.1.c.1	Met	1	1	50%	1	2	33%	13	6	68%
CPS.1.d	Not yet met	1	1	50%	1	2	33%	12	7	63%
CPS.1.d.1	Not yet met	0	2		0	3		4	15	21%
CPS.1.e	Not yet met	0	2		0	3		1	18	5

Feedback

Time taken to complete

The pilot found that each section of the audit takes up to 5-10 minutes to complete, with the whole audit able to be completed within 1-2 hours.

General comments

We received general comments on the audit data submission platform, the data submission form and the data summary page:

"Like being able to compare with other regions"

"Easy to follow and really useful way of being able to benchmark practice with local vs national data"

"Interesting to see where we are in comparison, and it would appear there are similar themes where standards are met or not met"

"Not that easy to assess at this early stage" (*RE: summary page dependent on subsequent data submission from other services)

"Summary page appears really useful, and good to highlight where our Trust is in comparison to other areas"

"Most sections were relatively easy to complete"

"Looking at the questions has prompted me to look at the service arrangements and facilitate them to be updated and amended where necessary with the safeguarding team."

"Really good to have something to benchmark against, will be useful when discussing the service at division and strategic level. Took a second to work out the numbers but liked the colour rating"

"Fantastic idea, and think the online form works well"

"I have filled in the rest, and I think the rest of the sections were fine."

“Generally easy to use tool”

“Very easy to use – not as scary as I thought it would be”

“Very helpful to have a summary page like this.”

“Really helpful!!! I like this”

“Very useful process, really helpful in guiding evaluation of our practices and targeting areas for improvement.”

“We completed all sections. The things that took time were clarifying whether things were actually written down anywhere even though we know they are happening.”

The data collection platform and early pilot data were presented to the RCPCH Child Protection Standing Committee whose members also provided comment:

“Exciting to see… the potential to be able to collect this information around the country and make such meaningful change.”

“Really, really useful”

"It's really focused on making meaningful change to individual departments and networks and units”

“It's really powerful and helps to understand where the resource is lacking… we can potentially use that as evidence to try and improve services.”

Comments specific to dataset questions

We also received comments and suggestions on specific dataset questions, which we've addressed in the “Changes to the audit” section below.

Changes to the audit

Following the comments we received in relation to specific questions, we have:

- added clarity to certain dataset questions by either making the wording or response options clearer, or by adding additional examples in the help notes that appear on screen.

- removed a question regarding the use of risk tools within the models of service delivery section. The inclusion of this question was based on a previously used local audit risk tool that we had initially planned to adapt and incorporate into the audit. However, for several reasons we decided against this and decided instead to understand the appetite for, and current use of, risk tools in the first instance. Responses showed that this question was not well understood:
    - *…”I wasn't overly sure what the risk tools for assessing our service meant”; “I was not entirely clear which type of risk tools were being alluded to”; “Not sure risk assessment tool can be understood in this context”…*

  with the responses given (see the data summary below) being too varied to collate and draw any meaningful conclusions from.

In terms of platform functionality:

- We received suggestions to allow additional free text boxes, 'Partially met' and 'Don't know' response options. We consciously limited use of these outside of the models of service delivery questions, as we need to be able to form a clear view on whether standards are being met exactly as stated to enable reliable benchmarking and comparison.

- We are making the 'Save' button more visible and adding a prompt to save as you go, to ensure no data is lost during completion of the data form.

- We are building section dividers into the summary data page, so you can view results for each standard in isolation.

Additionally, following feedback:

- We are removing the word 'planned' from the inclusion criteria:
  'We would like all services providing ~~planned~~ child protection medical assessments within working hours (Mon-Fri, 9am-5pm) to participate in this audit.'
  Our focus is to understand working hours service delivery arrangements for all services providing child protection medical assessments. The word planned was preventing certain services who do provide child protection medical assessments within working hours from participating.

  We are not including out-of-hours arrangements for this round of the audit as out-of-hours arrangements can understandably differ from typical working hours practice and would need to be audited in isolation to ensure a like-for-like comparison between services' responses.

- We would like to highlight the definition of a child protection medical assessment for the purposes of this audit. We are following the definition as written on page 7 of the published standards:

  '...a child protection medical assessment is a medical assessment which is undertaken either at the request of social care or police or when a referral has been or is about to be made by a clinician to social care in the context of concerns for the wellbeing of a child already receiving clinical care.

  It is a comprehensive assessment which includes the clinical history and examination, and detailed documentation including the use of line drawings and photo documentation. Additionally, the assessment includes obtaining any relevant investigations, arranging any necessary aftercare and writing a report with an opinion.'

- We would like to emphasise that we create a separate data entry form for each type of service, so if for example, there is a community service as well as an acute service within a Trust/Health Board, we can create a separate data entry form for each. Either email us to let us know at cpaudit@rcpch.ac.uk or state the separate services on your registration to participate submission.

Pilot phase data summary

For the purposes of this document, we have only included UK overall responses in the data summary table below as numbers by individual ICB and region/country are too small to report on at this stage of the audit.

We can begin to gain insights from this pilot data. For example, if we consider question Child Protection Standard (CPS).1.a below, we can see that this is being met quite well across the board, as, promisingly, many items are. While if we look to questions CPS.1.d.1 and CPS.1.e which relate to information available on the medical assessment process (having it in age appropriate language, and in different languages spoken in the area) we can already begin to identify that these might be areas that need more focus, if the same pattern of results appear in the main audit.

Pilot Data on Standards 1 – 13 at a UK level

There are thirteen overarching high-level standards within the published service delivery standards for the management of children referred for child protection medical assessments, with each standard having between three and eleven indicators of good practice which take the form of detailed, auditable statements that are expected to be achieved in order to comply with the standard. The questions that appear here relate exactly to each of these good practice indicators.

Percentages are highlighted as follows, showing whether an indicator has been met by: <25% of all responding services 25%-49% of all responding services 50%-74% of all responding services 75%-99% of all responding services 100% of all responding services

Question		% Met	No. of services who provided an answer	Met (Answered Yes)	Not yet met (Answered No)
CPS.1 Multiagency arrangements					
CPS.1.a	Our geographical area has a written pathway describing how to access child protection medical assessments for infants, children and young people, 0 to 18 years of age.	89%	19	17	2
CPS.1.b	Our service maintains online instructions regarding how to request a child protection medical assessment from us.	74%	19	14	5
CPS.1.b.1	Our online instructions contain contact numbers.	88%	16	14	2
CPS.1.b.2	Our online instructions contain details of the age range of children who we will see.	69%	16	11	5
CPS.1.c	Our service contributes to multi-agency child protection arrangements.	95%	19	18	1
CPS.1.c.1	These arrangements are published online.	68%	19	13	6

CPS.1.d	Our service has written information available for families explaining the child protection medical assessment process.	63%	19	12	7
CPS.1.d.1	Our service has written information available for children explaining the child protection medical assessment process in age-appropriate language.	21%	19	4	15
CPS.1.e	Our service has written information available explaining the child protection medical assessment process in most of the languages spoken by families accessing the service in the local area.	5%	19	1	18
CPS.2 Timing of assessments					
CPS.2.a	Our service enables assessments of children and/or infants with suspected physical abuse to normally be commenced within 24 hours, if the referral is received within working hours, Monday to Thursday.	93%	14	13	1
CPS.2.a.1	Our service enables assessments of children and/or infants with suspected physical abuse to normally be commenced within 24 hours, if the referral is received within working hours on a Friday.	86%	14	12	2
CPS.2.c	We have written service arrangements, outlining how to respond to child protection medical assessment referrals.	79%	14	11	3
CPS.2.c.1	Our written service arrangements are available for all staff to view on our intranet.	77%	13	10	3
CPS.2.d	Our written service arrangements state that clinicians should document discussions about child protection referrals in the child's health record, regardless of whether the child is then seen for a medical assessment or not.	57%	14	8	6
CPS.2.d.1	Our clinicians have sufficient access to the child's health record in order to do this.	71%	14	10	4
CPS.2.e	Our written service arrangements state that a clinician with appropriate expertise should be available during normal working hours to engage with partner agencies in a strategy discussion for the child/young person undergoing assessment.	93%	14	13	1
CPS.3 Consent					
CPS.3.a	Our written service arrangements state that where possible, written consent for the child protection medical assessment should be taken from a person with parental responsibility.	94%	16	15	1
CPS.3.a.1	Our written service arrangements state that a Gillick competent child or young person can provide consent if necessary.	88%	16	14	2
CPS.3.a.2	Our service has a consent form available to facilitate written consent for the child protection medical assessment to be taken.	94%	16	15	1
CPS.3.b	Our service has a consent form available that allows for specific consent to be taken for clinical photography.	88%	16	14	2
CPS.3.c	Our service has a consent form available that allows for specific consent to be taken for the use of photographs for teaching and/or publication.	88%	16	14	2
CPS.3.d	Our service has a consent form available that allows for specific consent to be taken for imaging investigations such as skeletal survey and/or neuroimaging.	88%	16	14	2
CPS.3.e	Documentation used by our service facilitates the recording of discussions and any subsequent actions where consent is withheld for any part of the assessment.	81%	16	13	3
CPS.4 Competencies					
CPS.4.a	Our written service arrangements state that child protection medical assessments should be carried out by clinicians working at ST4 level or equivalent or above, with relevant Level 3 child protection competencies.	77%	13	10	3
CPS.4.a.1	There are sufficient clinicians at ST4 level or equivalent or above, with relevant Level 3 child protection competencies available in our team to ensure this.	92%	13	12	1

CPS.4.b	Our written service arrangements state that child protection medical assessments should be carried out or supervised by doctors who actively engage in relevant continuing professional development.	69%	13	9	4
CPS.4.b.1	There is a sufficient amount of time in doctors' job plans/rotas to support active engagement in continuing professional development for maintaining skills in seeing child protection cases.	77%	13	10	3
CPS.4.b.2	Our written service arrangements state that child protection medical assessments should be carried out or supervised by doctors who have regular supervision.	54%	13	7	6
CPS.4.b.3	Our written service arrangements state that child protection medical assessments should be carried out or supervised by doctors who attend peer review meetings.	62%	13	8	5
CPS.4.b.4	There is a sufficient amount of time in doctors' job plans/rotas to attend peer review meetings.	77%	13	10	3
CPS.4.c	Our written service arrangements state that appropriate supervision or regulatory measures would be put in place, in line with GMC guidance, if there were recurrent or significant concerns regarding a clinician's ability to produce clear, balanced, and reasonable opinions and actions within the context of child protection medical assessments.	38%	13	5	8
CPS.5 Supervision					
CPS.5.a	Our written service arrangements state that when child protection medical assessments are carried out by clinicians in training, the supervising senior clinician, as a minimum, sees the visible findings or injuries that have raised concern and reviews and co-signs the report.	73%	15	11	4
CPS.5.b	Our service has local agreements in place for the supervision of SAS clinicians.	87%	15	13	2
CPS.5.c	Our written service arrangements state that children seen for a child protection medical assessment should have a documented, named supervising senior clinician responsible for the child protection opinion.	87%	15	13	2
CPS.6 Chaperone					
CPS.6.a	Our written service arrangements state that during child protection medical assessments, a named chaperone should be present as a witness, and to support the child and clinician.	58%	12	7	5
CPS.6.a.1	A process is in place for staff to be made available to undertake this role.	82%	11	9	2
CPS.6.b	Our written service arrangements state that chaperones should be trained with respect to that role.	33%	12	4	8
CPS.6.b.1	There is sufficient resource, in terms of training available, for this to be completed by all chaperones.	45%	11	5	6
CPS.6.c	Our written service arrangements state that chaperones should be qualified health professionals.	50%	12	6	6
CPS.6.d	Our written service arrangements state that chaperones should not be students.	50%	12	6	6
CPS.6.d.1	Our service has enough qualified health professionals available to act as a chaperone.	55%	11	6	5
CPS.7 Child & family support					
CPS.7.a	Our written service arrangements state that when an interpreter is used, their identifying details should be recorded on the child protection medical assessment proforma.	75%	12	9	3
CPS.7.a.1	The proforma is designed to facilitate the recording of an interpreter's identifying details.	67%	12	8	4
CPS.7.b	Our written service arrangements state that only interpreters from organisations approved by the health provider organisation, social care department, or police are to be used.	67%	12	8	4
CPS.7.c	Our written service arrangements state that children and young people are given a choice about who accompanies them in a child protection medical assessment, including not having a relative or social worker present.	42%	12	5	7

CPS.7.d	Our written service arrangements state that children, young people, and families who have a disability should be provided with appropriate support.	42%	12	5	7
CPS.7.d.1	The necessary support for children, young people, and families with disabilities, is likely to be available at our service.	83%	12	10	2
CPS.7.e	Venues designated for use by our child protection medical assessment service are age and developmentally appropriate spaces for children and young people to access.	83%	12	10	2
CPS.7.f	Venues designated for use by our child protection medical assessment service afford private spaces for the assessment and associated discussions to be undertaken, such that discussions are unlikely to be overheard by other children and families.	92%	12	11	1
CPS.8 Communication					
CPS.8.a	Our written service arrangements state that clinicians should record all decisions made during strategy discussions, either before or after a child protection medical assessment.	83%	12	10	2
CPS.8.a.1	Clinicians have sufficient access to the child's health record in order to be able to do this in a timely way.	100%	12	12	0
CPS.8.b	Our child protection medical assessments are documented on a standard proforma.	100%	12	12	0
CPS.8.b.1	Our standard proforma contains body maps for line drawings to record the sites and measurements of any injuries.	100%	12	12	0
CPS.8.b.2	Our standard proforma contains fields for three patient identifiers on each page (e.g., name, date of birth, NHS number).	83%	12	10	2
CPS.8.b.3	Our standard proforma contains a field on each page for the examining clinician's signature.	67%	12	8	4
CPS.8.c	Our written service arrangements state that clinicians should provide attending social workers and/or police officers with a written provisional report at the time of the child protection medical assessment, containing the professional medical opinion regarding the likelihood of abuse based on the history and clinical findings.	58%	12	7	5
CPS.8.d	Our service has a standard form available for written provisional reports.	75%	12	9	3
CPS.8.d.1	Our standard form contains fields for the responsible senior clinician's identifiers, including the clinician's name and that of their employing organisation.	100%	11	11	0
CPS.8.d.2	Our standard form contains a field to name an additional examining clinician as appropriate.	91%	11	10	1
CPS.8.d.3	Our standard form contains fields for three patient identifiers (e.g., name, date of birth, NHS number).	91%	11	10	1
CPS.8.d.4	Our standard form contains a field for the date of examination.	100%	11	11	0
CPS.8.e	Our written service arrangements state that a copy of the assessment (standard proforma), provisional report and final typed report should be kept in the child's health record.	75%	12	9	3
CPS.8.f	Our written service arrangements state that feedback, including results of investigations, is given as appropriate to children, young people, and carers.	58%	12	7	5
CPS.8.g	Our written service arrangements state that a comprehensive type-written report with a full professional opinion should be dispatched to social care (and police if involved), within 10 working days of a child protection medical assessment.	100%	12	12	0
CPS.8.h	Our written service arrangements contain an agreed process for the secure delivery of type written reports to social care and police.	75%	12	9	3
CPS.8.i	Our written service arrangements state that information from a child protection medical report should be securely shared with relevant health professionals (e.g., GP, Health Visitor or School Nurse).	83%	12	10	2

CPS.8.j	Our written service arrangements provide clarity on who is to provide the opinion and write the report when child protection medical assessments require further investigations or admission to hospital.	75%	12	9	3
CPS.9 Photography					
CPS.9.a	Our written service arrangements state that photographs should be taken of all significant visible findings.	77%	13	10	3
CPS.9.b	Our written service arrangements state that photographs taken should be of a standard that is suitable to be used in court.	62%	13	8	5
CPS.9.c	Our written service arrangements state that photographs of significant visible findings should always be taken at the time of the child protection medical assessment.	62%	13	8	5
CPS.9.d	Photography is readily available at our service.	62%	13	8	5
CPS.9.e	Our written service arrangements contain committee approved guidance for clinicians taking clinical photographs.	46%	13	6	7
CPS.9.f	Our written service arrangements state that photographs taken as part of child protection medical assessments should be stored securely in line with RCPCH guidance and FFLM PICS Working Group Guidelines on Photography.	38%	13	5	8
CPS.9.g	Our service has a governance mechanism in place involving a clinical photography department quality assuring the process of clinicians taking clinical photographs.	38%	13	5	8
CPS.9.i	Our written service arrangements state that photography involving intimate images should comply with the intimate images guidance written by the FFLM and RCPCH.	54%	13	7	6
CPS.9.j	Our written service arrangements state that clinical photographs should not be routinely sent with the report.	46%	13	6	7
CPS.9.k	Our service has a process in place to enable clinical photographs to be made available in a secure and timely manner to social care, police or a court on request via our legal department.	77%	13	10	3
CPS.10 Investigations					
CPS.10.a	Our service processes for haematological investigations are in line with RCPCH guidance.	100%	12	12	0
CPS.10.b	Our written service arrangements for requesting skeletal surveys are in line with the RCR (Royal College of Radiologists) guideline 'The radiological investigation of suspected physical abuse in children'.	100%	12	12	0
CPS.10.b.1	Our written service arrangements contain practical information regarding how radiology guidance is implemented.	83%	12	10	2
CPS.10.c	Our written service arrangements state that when a fracture is suspected to be secondary to abuse, relevant biochemical blood tests are taken, in line with RCPCH guidance.	67%	12	8	4
CPS.10.d	Our written service arrangements contain practical local information regarding how to make a referral to a range of specialist services.	67%	12	8	4
CPS.10.e	Our written service arrangements contain practical information regarding how to obtain an ophthalmological assessment.	92%	12	11	1
CPS.10.f	Our written service arrangements contain information on how to routinely access a general dental assessment for children undergoing a child protection medical assessment, for use where there is concern about potential dental neglect.	33%	12	4	8
CPS.10.g	Our written service arrangements contain practical information on how to access a paediatric dentist, for use when further dental assessment is needed.	17%	12	2	10
CPS.10.h	Our written service arrangements contain practical information on how to make a referral to a forensic odontologist, for use when further assessment of a bite mark is needed.	25%	12	3	9
CPS.11 Peer review					

CPS.11.a	Our local terms of reference state how frequently peer review meetings should take place.	82%	11	9	2
CPS.11.a.1	Our service maintains peer review meeting attendance records with minutes of the meetings kept.	100%	11	11	0
CPS.11.b	At peer review meetings there is access to the line drawings and/or photographs of visible findings or injuries being discussed.	100%	11	11	0
CPS.11.c	At peer review meetings, there is access to the medical reports relating to the assessments being discussed, in order to review the wording of the opinions given.	100%	11	11	0
CPS.11.d	Regular feedback is obtained from local legal services or senior social work managers regarding the clarity of child protection medical assessment medical reports.	18%	11	2	9
CPS.11.e	Clinicians at our service make links with clinicians in other health provider organisations as part of formal or informal clinical networks to keep in touch with mainstream paediatric and child protection opinion and practice.	100%	11	11	0
CPS.12 Service QI					
CPS.12.a	Regular (minimum annual) monitoring and audit of aspects of the child protection medical assessment service are undertaken by our service.	91%	11	10	1
CPS.12.b	There are processes in place to collect feedback from service users to inform our regular monitoring.	36%	11	4	7
CPS.12.c	Our service actively seeks to remain up to date with research themes in children's safeguarding.	91%	11	10	1
CPS.12.c.1	Our service is open to being involved in research regarding children's safeguarding.	100%	11	11	0
CPS.12.c.2	There is a sufficient amount of time in staff job plans/rotas to allow for research related work.	27%	11	3	8
CPS.13 Clinician support					
CPS.13.a	Clinicians carrying out child protection medical assessments have allocated time in their job plans/rotas for the assessment, associated administration and interagency working.	67%	12	8	4
CPS.13.b	Supervising senior clinicians have allocated time in their job plans/rotas to directly supervise child protection medical assessments.	75%	12	9	3
CPS.13.c	Trainees have appropriate time in their job plans/rotas to carry out child protection medical assessments.	75%	12	9	3
CPS.13.d	All clinicians involved in safeguarding work have access to formal emotional support such as Schwartz rounds and/or psychology support.	58%	12	7	5
CPS.13.e	All clinicians involved in safeguarding work have access to legal advice and support if required.	83%	12	10	2
CPS.13.f	There is support available for a clinician's personal security as appropriate.	92%	12	11	1

Models of service delivery data at a UK level

Questions that appear here do not look to answer whether or not an indicator or standard is being met, but instead serve to provide further information on the service delivery environment and give context to responses for standards 1-13.

Questions and thematic responses		No. of services who provided an answer
CPS.3.d.1	**What are your service arrangements for conducting skeletal surveys?** • Both the imaging for skeletal surveys and report are sourced within the same health provider organisation undertaking the child protection medical assessment: **12/16** • Skeletal surveys are available on request, though both the imaging and report are delivered by a different health provider organisation to that undertaking the child protection medical assessment: **3/16** • Imaging for skeletal surveys is delivered by the same health provider organisation that undertakes the child protection medical assessment, but the report is obtained from another health provider organisation: **1/16**	16
CPS.3.d.3	**What are your service arrangements for conducting CT head imaging?** • Both the imaging for CT head and the report are sourced within the same health provider organisation undertaking the child protection medical assessment: **12/16** • CT head is available on request, though both the imaging and report are delivered by a different health provider organisation to that undertaking the child protection medical assessment: **3/16** • Imaging for CT head is delivered by the same health provider organisation that undertakes the child protection medical assessment, but the report is obtained from another health provider organisation: **1/16**	16

CPS.7.e.1	**Which venue option best describes where most children are seen, when referred within working hours to your service for a child protection medical assessment?**
	• Outpatient clinic room: on main hospital site: **5/12**
	• Other [Please state]: **4/12**
	  o Clinic rooms in dedicated Safeguarding Support Unit
	  o Dedicated Child and Young Person's Clinic
	  o Designated child protection suite, away from ward
	  o PAU clinic room Or Outpatient clinic room (space available)
	• Outpatient clinic room: not on hospital site (includes community health centre): **2/12**
	• Ward: side room: **1/12**
		12

CPS.9.d.1	**In your service, who would usually take photographs during child protection medical assessments?**
	• Clinical photographer: **6/13**
	• Other [Please state]: **2/13**
	  o Mixture of clinical photography and clinician with links to photography service
	  o Clinician (OOH) or clinical photographer when available (only single photographer currently)
	• Police photographer: **2/13**
	• Clinician: with no links to a clinical photography service: **1/13**
	• Clinician: with links to a clinical photography service: **1/13**
	• Photography is not available: **1/13**
		13

CPS.9.d.3	**Is photography available at the same venue as the child protection medical assessment?** • Yes, it is available at the same venue: **9/13** • No, photography is not available: **3/13** • No, it is accessed at a different venue: **1/13**	13
CPS.9.d.4	**Are photographs usually taken on the same day that the child protection medical assessment takes place?** • Yes: **11/13** • No: **2/13**	13
CPS.10.a.1	**In your service, are blood tests available at the same venue as the child protection medical assessment?** • Blood tests are accessed at the same venue: **12/12**	12
CPS.10.e.1	**What are your service arrangements for conducting ophthalmological assessments?** • An ophthalmological examination is available from within the same health provider organisation undertaking the child protection medical assessment: **10/12** • An ophthalmological assessment is available from a different health provider organisation to that undertaking the child protection medical assessment: **2/12**	12
CPS.14.a	**Approximately how many children and young people were referred to your service for a planned child protection medical assessment in 2021?** • Median: **156** • Range: **62 to 400**	19
CPS.14.b	**Within what age range are children accepted by your service when referred for a child protection medical assessment?** • Birth - 17 years 11 months: **13/19** • Birth - 15 years 11 months: **4/19** • 2 years 0 months - 17 years 11 months: **1/19** • Other [Please state]: **1/19** o Birth to 15 years 11 months, usually but extended by 2 years if LAC / neurodevelopmental issues etc	19
CPS.14.c	**When referrals for a child protection medical assessment are received during normal working hours, how are those children routinely seen?** • As part of a dedicated child protection clinic or rota: **15/19** • As part of the general acute on call rota: **2/19** • Other [Please state]: **2/19** o A time is arranged for when they will attend the CDC to be seen after the doctor finishes clinic in the afternoon o 4 days/5 it is acute general rota (COTW); one day a week dedicated CP clinic with a community paediatrician	19

CPS.14.d	**With respect to having a dedicated child protection clinic or rota, what is its capacity regarding the number of child protection medical assessments that can be undertaken by the within hours team per day?** • Capacity for 3 CPMAs: **6/19** • Other [Please state]: **5/19** o Dependent on referrals. We do sometimes see 5 or 6 kids in an afternoon, but only if for example a good chunk of that is one family. There is only ONE consultant on for SG rota per afternoon session (no morning sessions) so just depends what they can fit in and whether can stay past 5pm. Anything needing doing same day that cannot be fitted into this would go to the on-call person o There are 3 individual slots each day but we may see 2 siblings in one slot o Depends on whether they are sibling groups or separate families. Difficult to see more than 2 families per day o No fixed number of appointments and depends on sibling groups etc... o No dedicated time • Capacity for 4 CPMAs: **4/19** • Capacity for 2 CPMAs: **3/19** • Capacity for 1 CPMA: **1/19**	19
CPS.14.e	**When children are referred to your service for a child protection medical assessment by social care or police within working hours, with concerns about physical abuse or neglect, clinicians from which clinical background/s see those children to provide that medical safeguarding opinion?** • **All 19 services** selected: o Advanced nurse practitioner o Emergency care medical practitioner o Forensic medical examiner o General practitioner o Nurse o Nurse consultant o Paediatrician o Physician associate • **2/19** services also selected: Other [Please state]: o Seen by team comprising nurses and paediatricians. Nurses not currently delivering solo clinics o Senior Paediatric Specialty Trainee with Consultant supervision	19

CPS.14.f	**Which health records do clinicians have access to at the time of the assessment or report writing?**
	• General practitioner records:
	  o Digital only 11/19
	  o No access 8/19
	• Local acute paediatric care records:
	  o Digital only 14/19
	  o Digital & Paper 3/19
	  o Paper only 1/19
	  o No access 1/19
	• Local health visiting records:
	  o No access 11/19
	  o Digital only 8/19
	• Local outpatient community paediatric care records:
	  o Digital only 15/19
	  o Digital & Paper 3/19
	  o No access 1/19
	• Local outpatient general paediatric care records:
	  o Digital only 15/19
	  o Digital & Paper 4/19
	• Local school nursing records:
	  o No access 12/19
	  o Digital only 7/19
	• Tertiary hospital records:
	  o Digital only 9/19
	  o No access 7/19
	  o Digital & Paper 2/19
	  o Paper only 1/19
		19

CPS.14.g	**Name/briefly describe any risk tools your service uses as part of its service delivery evaluation:** • Nil specific • I'm unsure as to what this is referring but we audit all of our child protection reports, we audit was not brought and Bruise, Burns and Scalds in non-mobile children and we conduct regular peer review • I'm not aware of any risk tools that has been used or has been used at the moment - but might be because I don't know • RAG rating • Audits of reports and pathways • Normal governance processes • We use audit to look at the quality and timing of the reports sent out to partner agencies. • Currently undertaking a QI project gathering feedback from the families seen for child protection medical examinations.	8

CPS.14.h	**What has been the impact of the child protection service delivery standards on your service?** • It has given us a focus on the information that is available to the other agencies we work with. Making sure that we publish our referral standards in an easy to find location and they are easy to follow. We have also focused on our photography offer improving the quality assurance of this. • It has encouraged us to review our current practice, advise of paediatric colleagues of expected standards, also discussed with regional colleagues as to their current compliance • Doctors don't have enough time or admin within their job plan, so this impacts on timing and clinical work. We do not get any feedback regarding our reports or examination • I have initiated the implementation of a booklet/information leaflet explaining the process to parents and children, in process of being checked for circulation. We have recruited a full time chaperone to support CP medicals. Information on how to book CP medicals is now online and shared with partner agencies. • Allowed us to identify and work on our weaknesses. However, progress has been negatively impacted by medical staffing issues at consultant level. • Following the RCPCH standards, developed Standard Operating Procedure which is published on intranet; Started provision of Interim /Provisional Medical report on the day of child protection examination; Leaflets for parents regarding the safeguarding process, examination and leaflets approved by governance awaiting final approval; Peer review Terms of Reference revised and implemented; AUDIT to check compliance with RCPCH standards completed. • We reviewed our service against the standards when they came out. A result of this was that we wrote our guideline for referrers which has been disseminated to primary care, CSC and police. • Not much so far - we have issues with chaperones and accessing clinical photography, but the service [is] working at a relatively good standard. • Some minor additions and amendments to SOP; Write a pt info leaflet; Explore translation into common local languages • Assurance that the department is mostly practising to a high standard, with added impetus to strengthen photography standards, supervision of cases seen out of hours by middle grades and provision of immediate written provisional report. • Helped focus areas for development; Large number of audits expected, suggested to be reported on annual basis, which is large burden • Currently runs within our acute setting and hence no dedicated time for CP medicals and fitted in around acuity on ward/admissions. • 1. We realised we are doing reasonably well compared with other units! We did however develop our own tool and action plan for assessing where we are with standards after published in Oct 2020 - we were proactive in identifying gaps. We have attached evidence to our action plan. 2. More formalised written guidance for organising CP medicals - we did have this before but have expanded and strengthened 3. Developed electronic version of proforma for secretaries taking referrals for medicals - now direct in electronic record. The idea was to also make it easier to record those where medical declined and reason but it isn't so easy, especially for out of hours medicals! 4. Changes to arrangements for trainees doing medicals and level of supervision, although this was also happening in response to a CSPR at the time. 5. Need to document chaperone and interpreter better (both used but not necessarily documented in all cases)	13