Child Protection Service Delivery Standards Audit 2023

Free text responses

This document displays the free text responses received within the 2023 RCPCH Child Protection Service Delivery Standards Audit's data collection.

Question	Responses
CPS.3.d.2: Additional information for 'What are your service arrangements for conducting skeletal surveys?' (optional)	• cases requiring this are diverted to the acute hospital (different provider) • Children under 2 years are seen in acute paediatrics hospitals • If skeletal survey required then Community Paediatrician would refer the child to [the acute hospital] and request that they arrange the skeletal survey • Images taken in our trust, 1st radiologist reports locally, second sent to [another] hospital for second opinion from radiologist • imaging and report are sourced withing the same health provider but an additional report is provided by a tertiary service • Imaging and the first report is within the same health provider organisation but the second reporter is from another health provider organisation • Imaging for skeletal surveys and initial first report are sourced within the same health provider organisation with a service line agreement to source second report from another health provider organisation. • local report by paediatric Radiologist when available but additional reporting obtained from another hospital • Our child protection medicals are undertaken in a community health centre. If investigations are required (eg bloods or imaging) then the child is referred to the hospital (which is part of our provider organisation) and the acute inpatient paediatric team picks up from where the community team left off). • Secondary reporting is available within 2 working days. Some primary reports are sourced from an external provider • Skeletal survey is done at another hospital at the same trust. • support is available from neighbouring Health Boards when required • There is additional provision of seeking second opinion from tertiary centre • This is done in the hospital as per protocol rather than community • Usually skeletal survey is undertaken and double reported within the same health provider undertaking the CP medical. We also hold an SLA to have images reviewed by a tertiary centre in cases of diagnostic uncertainty or clinician disagreement. • We have our skeletal surveys reported in house then secondary reported by another tertiary provider
CPS.3.d.4: Additional information for 'What are	• cases requiring this are diverted to the acute hospital (different provider)

Question	Responses
your service arrangements for conducting CT head imaging?' (optional)	• CT Head during working hours is available and reported within the same organisation. Out of hours the CT is carried out within the organisation but reported by a external provider. • Hospital team will answer • If CT head is required then Community Paediatrician would refer the child to [the acute hospital] and request that they arrange the CT head • Images taken in our trust, 1st radiologist reports locally, second sent to [another] hospital for second opinion from radiologist • imaging and report are provided by single health provider with an additional report provided by a tertiary provider • Imaging and the first report is within the same health provider organisation but the second reporter is from another health provider organisation • Imaging for CT Head and initial first report are sourced within the same health provider organisation with a service line agreement to source second report from another health provider organisation. • local report by paediatric Radiologist when available but additional reporting obtained from another hospital • Our child protection medicals are undertaken in a community health centre. If investigations are required (eg bloods or imaging) then the child is referred to the hospital (which is part of our provider organisation) and the acute inpatient paediatric team picks up from where the community team left off). • Primary reports may be undertaken by a commissioned external provider but these are all secondarily reported in a tertiary hospital • support available from other health Boards when required • We do not see cases that will need this, they will be seen by acute Paeds • We have our skeletal surveys reported in house then secondary reported by another tertiary provider
CPS.7.e.2: Additional information for 'Which venue option best describes where most children are seen, when referred within working hours to your service for a child protection medical assessment?' (optional)	• 2 clinical rooms and a separate waiting area and interview room which are reserved for child protection medicals every afternoon Having this dedicated space is extremely valuable • Assessment unit in cubicle • Child protection suite on hospital site • Children's Admissions Unit - separate side rooms • clinic room separate to ward or outpatients • Clinic rooms in dedicated Safeguarding Support Unit • Dedicated Child and Young Person's Clinic • Dedicated Child Protection Suite • Dedicated suite of rooms in building on main hospital site, includes police interview room • depending on the need and availability either OP, Ward or side room. • Designated child protection suite, away from ward • Designated Safeguarding department • Emergency or out of hours cases are carried out in the Emergency Department as we have no designated space.

Question	Responses
	• Paediatric Ambulatory Unit side room or OPD side room available to carry out CP medical • Paediatric assessment unit in side room • PAU clinic room Or Outpatient clinic room (space available) • Purpose designed child protection examination suite located off the main outpatients area • SARC as well apart from Outpatients Clinic room • we also attend a Young Offender's Institution and special schools or residential settings on occasion if it is not possible for the child to be seen easily in Child Development Centre
CPS.9.d.2: Additional information for 'In your service, who would usually take photographs during child protection medical assessments?' (optional)	• and Medical Photography at a different Trust usually the next working day • Camera available for clinician, but no training available, no clinical photography, can request police if needed but not always available • Clinical photographer or police photographer. • Clinical photography in hours and clinician (with links) out of hours • Clinician (OOH) or clinical photographer when available (only single photographer currently) • clinician can also take photographs • Clinicians do not take photographs • I found it difficult to answer this question as I did not know what you meant by with links to a clinical photography service. We have such a service within our provider organisation and we can refer children to there for photographs, but I'm not sure this would count as links • Limited availability of medical photography, if they are available they will take photographs, if they are not available on site then the clinician performing the medical will take the photographs • May be police • Mixture of clinical photography and clinician with links to photography service • NB clinical photography service availability dependant on photography staffing levels. • Normal clinical photography at a different venue, same day. Sometimes clinician on the day • out of hours taken by clinician using dedicated camera maintained in the ward • out of hours we have a camera that can be used by paediatrician and a written protocol to follow (broader written service arrangements are in the process of being written • PANDO app used - one photographer for hospital - police photographs occasionally available, not available routinely • Photographs usually taken at time of medical by clinician performing medical but option to request clinical photography via medical illustration dept on a different site • Photography available for CSA but not NAI. If photographs necessary, police will be contacted to do this at a later date. The answers below are for CSA only.

Question	Responses
	• Police inspector present at the child protection examination • Service Not available. we refer to Police or professional • sometimes out of hours police • Trust approved app to share digital photography . • unless out of hours, ward camera by doctor • We can refer to the Hospital Medical Photography Team • we have moved onto an electronic system that allows photography similar to smart phone to be added to records, however they are not of court standard ie no measurements and we would aim to get medical photography as well
CPS.10.e.2: Additional information for 'What are your service arrangements for conducting ophthalmological assessments?' (optional)	• Apart from the uncommon occurrence of requiring blood tests, all cases requiring investigations are seen elsewhere and not in our unit • If indicated referral would be made to General Paediatrician at local trust, who would then arrange • Ophthalmology services are not currently based at the same site as paediatric services within [our Trust/Health Board], making efficient access to ophthalmology examinations difficult • referred to Hospital A&E for assessment
CPS.14.b.1: Additional information for 'Within which age range are children accepted by your service when referred for a child protection medical assessment?' (optional)	• 1 to 16 • 18 months to 18 years • 18 months to the day before 18th birthday • 1y0m-16th birthday • 6 months - day before 18th birthday • Birth- day before 16th birthday, 16-18yrs only if looked after child/victim of exploitation/trafficking/significant learning disability • Birth to 16 plus 16-18 for certain circumstances as per our SG policy • birth to 17 + 364 days (within children social care legislation) • Birth to day before 17th birthday • community paediatricians accept referrals from 1 year to 16years. Infants under 1 year are assessed on the paediatric ward. • For CP medical assessment 1 year to 18 years and CSA it is birth to 13 years a • Generally under 16, but would consider for 16/17 year olds under care of paediatrics • Mostly birth to 16 unless still in education or vulnerabilities • non-mobile babies under 2 years • not sure right now • over 1 year to 16th birthday • over 1 year until day before 18th Birthday • SARC up until 13th birthday • With some flexibility beyond 16 • Young people are seen up to the day before 16th birthday, unless they are a LAC or have severe LD.
CPS.14.c.1: Additional information for 'When referrals for a child	• 4days/5 it is acute general rota (COTW); one day a week dedicated CP clinic with a community paediatrician.

Question	Responses
protection medical assessment are received during normal working hours, how are those children routinely seen?' (optional)	• a time is arranged for when they will attend the CDC to be seen after the doctor finishes clinic in the afternoon • acute on call rota if under 1 year of age or acute presentation to ED / ward. otherwise seen in dedicated child protection HUB • As part of acute on call rota if under 1 year of age or acute presentation to ED or ward but as part of a dedicated child protection otherwise. • As part of acute on call rota if under 1 year or if acute presentation to ED or ward. Otherwise as part of the dedicated Hub. • as part of neonatal on call rota (covered by general paediatrician) • Mostly as part of dedicated CP rota but when gaps in rota picked up by neonatal acute on call acute • seen on day unit. Separate consultant cover to acute on call • The on call consultant covers the supervision but there is a dedicated middle grade rota
CPS.14.d.1: Additional information for '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?' (optional)	• 1, but others not on rota that day support if there are more - not in job plan • 3 if they are siblings • 3 is the maximum • 3-7 - some flexibility is exercised depending on clinical need and urgency • 4 if one family 3 if multiple families then 3. • A sibling group could be seen in one day. • as required • but it is variable , can be two a day or about 3 per week • Dependent on need • 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 • depends on circumstances. usually 2 but might see 3 if siblings. • depends on whether they are sibling groups or separate families. Difficult to see more than 2 families per day • difficult to quantify as we also cover child death - JAR and contibute to all the strategies currently- but medicals are prioritised over strategy meetings and we often have trainees below ST4 level of training • dont have a dedicated rota • don't have a separate clinic or rota • Don't have dedicated clinic/rota • Don't have dedicated rota • I am not sure of exact numbers but up to 4 have been seen during day time working hours. • may be more if larger sibling groups are referred • More if sibling medicals

Question	Responses
	• no dedicated child protection assessment clinic or rota • No dedicated child protection clinic or rota, • No dedicated child protection rota or clinic. • No dedicated CP clinic or rota • no dedicated rota • no dedicated rota at present • no dedicated service but this is currently under review • No dedicated time • No dedicated time, service sees under 18 month old as planned medicals and only older children if there is not capacity in the community clinic. Most of our medicals are emergency out of hours medicals • no dedidicated clinic or rota • No fixed number but clinic just run in afternoon so maximum around 4 • No fixed number of appointments and depends on sibling groups etc... • No fixed number, varies depending on whether clinician also has another clinic that day. Generally max 2 separate families, may be more children if siblings need to be seen (siblings not automatically seen, usually index child only) • no separate rota • No specific limit set • No specific rota • Not applicable. We don't have a dedicated clinic or rota. All done ad hoc during ward shifts. • one slot but sibling examinations done together in one slot • paediatrican is on call for general paediatrics - would not refuse to do them but would have to wait if other emergency • Part of the general acute on call rota • Siblings only • There are 3 individual slots each day but we may see 2 siblings in one slot • there is no official cap, just as many as is feasible in a day. • There is no protected clinic or time for child protection examinations, as many as practical • Usually 2 but if seeing groups of siblings can see up to 4 • Varies by day and also medical type as can complete more comprehensive medicals and specialist medicals that JPFE within timeframe. Most days we have 2 doctors and 2 examination rooms for acute JPFE, specialist and comprehensive medicals. In addition once per week we can see 2 historic CSA referrals in dedicated clinic that is separately staffed. Realistically maximum number of examinations per day is probably around 5. • We can see three separate CP cases per working day, but the number of children vary, as many of the cases come as a sibling group - sometimes up to 6 children per family. • We dont have a dedicated rota • We don't have a separate rota for CP medicals. • we have 3 slots but may see siblings so at times up to 5

Question	Responses
	• We have capacity for two session a day 10 am and 2 pm however on occasions we have provided sessions for 4-7 children as part of a family • We would do everything possible to complete as many examinations as are requested/required
CPS.14.e.9: Additional information for '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?' (optional)	• only paediatricians and trainees more than S4 level • Orthopaedic Consultant, Safeguarding Children's Team • Orthopaedics, safeguarding children's team • Paediatric Registrar or Consultant • school nurse or health visitor for neglect • Seen by team comprising nurses and paediatricians. Nurses not currently delivering solo clinics • Senior Paediatric Specialty Trainee with Consultant supervision • Specialty Training Registrars ST4 and above • Trainee paediatricians
CPS.14.f.8: Additional information for 'Which health records do clinicians have access to at the time of the assessment or report writing?' (optional)	• A&E attendances can be seen digitally, but the details not quickly accessible • Access to [local patient record] gives us limited access to GP records and to ED discharge summaries and clinic reports, but this does not cover all our local hospitals. If child already known to Community Paediatrics there may be Tertiary hospital clinic reports already on patient record. • Access to GP records vary depending on practice • Access to tertiary letters as part of paediatric notes. • Acute hospital and tertiary hospital Reports and Communications that are copied and attached to Systm1 can be accessed at the time of assessment. • All of our hospital records are now electronic and we are on the same system as the tertiary hospital • Although community records such as GP, 0-19 team is not available to clinicians but can be reviewed by contacting safeguarding team as they have access to those records. • Although most consultants at our trust will have access to external digital records e.g. GP or community paediatrics it would require logging into multiple IT systems and in reality I suspect doesn't occur routinely do to the frustrations of using multiple systems and the additional time it takes • answered for majority of the time, things can be requested but not immediately available • At time of report writing paper notes can be requested if required • Can request further information from SystmOne (used by community paediatricians) but most acute paeds do not have access to this. Tertiary hospital letters, if shared with the DGH, would be available digitally. • can see some tertiary services, not all • can see some partial GP records, not all

Question	Responses
	• community paediatric child protection assessments are done in hospital with access to hospital paeds records • CSC verbal report as advised by them • currently hospital records are paper based and at the time of assessment the clinician may not have access to paper records. • Digital can be accessed by ED, ward and safeguarding nurses in hours • Digital records do not cover all areas equally and there is ongoing development to achieve this. • EMIS is used which is digitally linked with local GP records • GP records - we can access if necessary but are not doing so routinely. • GP records on same electronic system - any tertiary hospital letters shared with GP are visible, but no direct access available to tertiary hospital digital system • GP records vary depending on practice • GP, Health visitor and school nurse records are discussed at the IRD (Strategy meeting) prior to examination and further info can be sought post examination • GPs and local hospital are on different electronic patient record systems • Have access to some tertiary records but not all. • If deemed necessary relevant documents can be requested in paper form from various agencies. • Limited access to inpatient records via digital system - unable to access entire record easily as held in paper form. • limited access to tertiary records - discharge and clinic letters only • Summary care record from GP only. • Community paediatric letters if known to hospital service and have been copied to digital record. • local GPs and school nurses / HV / Young Offenders Institute are on the same electronic patient record system, which is very helpful • Majority of children are seen from [local] GPs with shared electronic patient records. Children with [different local] GPs information from the health visitor/school nursing/GP records are limited. • No direct access to GP and Health visitor records but these can be accessed by the local Safeguarding children team on request • Only access to full digital records (i.e. health visiting/school nursing) for those children in certain areas who share the same patient information system as us. We also cover children in [neighbouring] areas for whom we cannot see these records. • Hospital and GP records can be seen for all via [an electronic health record]. • We also have access to CPIS which is checked for all cases. • Our clinic is undertaken in the community. We use the EMIS IT system in the community, which is the same system that

Question	Responses
	most GP practices in our area use. We also have access to our hospital provider's electronic patient record (we are part of the same Trust). • Our safeguarding team will review community records and school nurse information and provide a summary of this information to clinicians • Paediatric Registrars would have access to acute hospital digital records as well • recent transition from paper based to digital record so some notes may still be in paper format • records access for secondary and tertiary care relies on GP uploading of letters (shared system). Not all GP practices enable sharing of their consultations with us • Registrars doing the child protection medicals don't often have Systemone access (GP and local outpatient records), but supervising consultants are able to provide. • System one is used • Tertiary only if child seen locally by acute paediatrician • There is access to trust digital folder available to all clinicians who have priority access for viewing records. • this access is only if parents have given consent . as the GP etc records are held by the GP if the parents have limited who can see the record, it is quite a lengthy process to get access to the record by the GP. this is an increasing issue. • We are a fully digital records trust, therefore no paper required. • Limited access to tertiary hospital tertiary records also, which includes letters (through a portal that has limited GP records also) • We are copied into some letters from tertiary centre for some patients - this is variable. These are scanned onto EPR. Therefore, we have some information from tertiary centre, but not all. • we cannot access a, mental health and confidential section of hospital and GP records. HV and SN have recently gone digital so we do not have access to relevant old records. • We have access to digital patient record in acute setting and record digitally loaded information from GP/ Social care or tertiary service in our health records. • We have achieved many of the standards but these are not explicitly stated in our processes and those processes are contained within separate documents. Following this, documentation will be revised and unified to make the service standards clearer to staff. • We have some records on system one which we use. • We obtain GP information by telephone and or secure email but do not have direct access to the records. • We only have access to some community notes/ letters which are available digitally and some paper records but not all of them.
CPS.14.f.8: Additional information for 'What has	•

Question	Responses
been the impact of the child protection service delivery standards on your service?' (optional)	- Time factor for timely arranging peer review and admin support. - we strive to provide regular nurse chaperone and staffing affects on weekend - we record peer review minutes. recently with variable Admin support for regular recording of peer review meeting. On many occasion, lead CP consultant aim to deliver a certificate for attendance for trainee and consultant's appraisal portfolio. - Our trust is aiming for Electronic recording. • 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 (didn't wait for this RCPCH tool) - 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 being used but not necessarily documented in all cases) • active audit with 3 monthly reviews • All that has been documented here is day-to-day experience and the standards we adhere to. We have some written SOPs but doing this audit has highlighted the areas we need to address more specifically in documents and written arrangements. Most of this is done in practice for every case but is not written in local guidance, but is included in regional guidance. This is an area that will now become part of our Safeguarding Strategy. • Allowed us to identify and work on our weaknesses. • However, progress has been negatively impacted by medical staffing issues at consultant level. • Almost all standards were being met. Not everything has been 'written down' such as chaparone needs to be qualified professional, but said at each induction and is our standard practice. Also that if there is an injury thought to be NAI needs to seen by consultant is not written down, but told to staff multiple times. • Please note that most of the 60 children who had CP medicals in our service only about 6 were in hours with a SW present (as a planned medical). However we would aim to meet these standards for all medicals completed whether the medical was urgent and out of normal working hours or at other times.

Question	Responses
	• Amendments to our policies, procedures, paperwork/electronic forms. Feedback from SW team awaited. • An opportunity to improve the service • Apart from Standard 13, our child protection practice was already following the standards outlined in the Delivery Standards. • Assessed that we need better written service guidance rather that using National Guidance • Broadened policies and allowed clarity • Aspirational goals • Benchmarking tool • Lever for change within organisation • Broadened policies and allowed clarity • Aspirational goals • Benchmarking tool • Lever for change within organisation • Coincided with establishment of CP medical Rota, allowing for planned and consultant led medicals away from acute ward. • more presence of chaperone • Currently a work in progress • Our service is being looked at both externally by commissioners and also internally as we are currently rewriting the CPMA SOP. The main issue we face is capacity • currently runs within our acute setting and hence no dedicated time for CP medicals and fitted in around acuity on ward/admissions. • Currently writing service standards to formalise what we think we are already doing. • Development of a healthboard wide safeguarding hub taking routine referrals in working hours mon-fri has reduced pressure on acute services. • Developing an SOP for HUb / acute sites has been identified as a developmental need in order to better evidence audit standards with respect to written arrangements • development of the health board wide safeguarding hub taking routine referrals 5 days a week. This has reduced pressure on acute services. Developing an SOP for the hub and acute services has been identified and a developmental need to better evidence audit standards with respect to written arrangements. • Development of the safeguarding hub has eased pressure on the acute services Monday to friday. Developing an SOP for the hub and acute sites has been identified as a need as a result of the service delivery standards. • do not have specific CP clinics factored in the job plan separate from direct clinical care, and as a result there are times the community paediatricians are covering CP on call as well as clinical cover. • Service delivery standards are affected due to inadequate staffing levels

Question	Responses
	• 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 • We are not part of the the strategy meeting discussions that happens before we see the child • Effective and very satisfactory • Examinations are conducted depending on clinical workload. • Focus on how we deliver service, eg time for clinicians, dedicated time, move to digital records • To create a more robust policy to guide practioners • 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 safeuarding 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. • generated guideline/ SOP for child protection medical assessments based on the service standards • Getting us to think how to improve service. • have made changes in line with new guidance but the policy has yet to be updated to document those changes. • have updated paperwork to bring it into line with standards, introducing patient leaflet • have created written procedure • more to do! • Helped focus areas for development. • Large number of audits expected, suggested to be reported on annual basis, which is large burden. • Helped identify areas for development and associated clinical risk. • Helped identify steps that can be taken to improve the outcome for child and family. • As I have previously discussed within the College Child Protection Standing Committee, I do think that there should be an increase in the minimum suggested elements of Consultant involvement in a CP Medical, beyond simply looking at marks and reviewing and co-signing a report. • With the introduction of Progress+, and the potential reduction in community paediatric registrars, our resourcing for CP medicals will become more difficult. • I wonder if a valuable question within the next audit would relate to whether CP Medical Service provision is organized by joining up with neighbouring health providers to provide a single rota. • helped us to create policies e.g. photography and chaperone and improvements to service, and advocate for resources • helpful to guide action plan for improvements

Question	Responses
	• helpful to advocate for resources / services e.g supervision of clinicians, photography policy, chaperone policy • 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. • In general we meet the majority of the standards so that was reassuring but we are aware we need to still meet a few • 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 • 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 focussed on our photography offer improving the quality assurance of this. • It has helped to improve the delivery of our service. • It has highlighted areas to focus on for improvement, particularly with regards to written service arrangements, patient information leaflets, and publicly available processes. • It has highlighted areas which need updating and amending. • It has prompted me as Named Doctor for Safeguarding to develop a Service Delivery Plan to incorporate associated SOPs and Guidelines and thereby identify gaps and appeal for support to mitigate or resolve gaps where this is realistically possible • it has provided a focus on what is a gold standard service recognising that not all standards are achievable in every service. • It reassured us that most of what we were doing were of good standard. However it did highlight a few areas where we need to improve and have done so. • Lack of any photography provision is an issue. • We are doing a lot of what the standards recommend but we currently don't have a written service agreement for CP medicals but it is being worked on. • Developing an information leaflet for parents about CP medicals. • Developing an initial conclusion form for social worker and Police • Lots of actions to be made to the written policy - for most of the sections I have answered 'no' to, we are already meeting the standards but it is not formally recorded in the policy document, so this will be altered to reflect the standards that we are keeping. • neglect medical referrals impact on our clinic availability • not accounted for in job plan to do strategy discussion, see patient, write report and peer review. DOne with ongoing clinics making attendance to strategy discussions difficult.

Question	Responses
	• Not much so far - we have issues with chaperones and accessing clinical photography, but the service was already working at a relatively good standard prior to me joining the team a few months ago. • Not sure • Opportunity to reflect and improve the service. • Plans to develop service further with community team - hope to have dedicated commissioned service on hospital site in future. • To develop information leaflets for attending families, • Positive impact • Prompted an update of written SOP • provision of court admissible photography is lacking • Recognition of the standard that we should be aiming and working towards • Redesign of service for CSA and < 2 years physical abuse. • Peer review process. • Timeliness of reports • Review of appropriate local guidelines in line national standards. • Review of existing processes and procedures. New CP medicals SOP formulated to comply with current published safeguarding service standards and provide assurance. • review of setting for assessments • development of access to dental assessment • consideration of reviewing chaperone policy and access to psychology support • Since introduction of the standards, our trust has made a number of improvements toward meeting the standards, including: establishing an agreed written local process for referral for CP medicals; developing regional, publicly available written information regarding CP medical assessments; amending CP proforma to include a prompt for signed parental consent for CP medicals; embedding the process of providing immediate written confirmation of clinical opinion following a CP medical assessment; • Since the standards been published, we have worked on the child protection information to parents. Positive impact. • some firming up needed of chaperone policy and recording of interpreters! • Some minor additions and amendments to SOP • Write a pt info leaflet • Explore translation into common local languages • Clarify SAS dr supervision, along with all drs supervision • The development of the safeguarding hub has eased pressure on the acute services Monday to friday. Developing an SOP for the HUB and acute sites has been identified as a need as a result of the service delivery standards. • the main thing we hadnt been doing was providing written provisional feedback.. we have been doing this for a year now and is well received.

Question	Responses
	• currently our emotional support person has left but it is on the trust radar to address as this is extremely important for us and the SUDIC service. • we currently are down on our CP drs and so only offering 4 clinics a week at present. this is on the at risk register of the trust and is being resolved, albeit slowly. • we had started producing a leaflet for families but hadn't done one yet for children and i think this stalled. • the standards are useful to flag up outstanding issues to the trust and underpins what we are trying to do. • The standards have provided us with a framework to improve our local draft procedure. • There has been a clear aim to deliver standards. Improvement is needed for writing the formal written service agreement. • This has helped us to identify areas where we need to focus further improvement work. • This has helped us to improve our service provision. Since last couple of years ,we have implemented in providing initial child protection medical opinion , which we provide, immediately after the assessment. The standard has made us to discuss formal policy around chaperone and formal Schwartz rounds. • We are considering , how to arrange for consistent provision health trained Chaperones for medical examination. • This is a good way forward. Our main issue is lack of an agree standard operating procedure • to compare our services with the national standards • To finalise our child protection medical SOP and clarify procedures with the dental department with what they can provide. • under review • Up dates on our written policy • useful in helping us to evaluate our service • useful to be able to audit against the standards • Standards are useful for ' defending' the service which is viewed as expensive in view of the fact that locally we have a consultant resource for the service • We are working towards improvement and digitalisation of documents to make communication and information more accessible to staff and partners. • We audited our practice against the standards in 2021, and we have implemented changes based on this. Our proforma has been updated to include 3 patient identifiers printed on every page and space for signature and GMC number. A SOP / written service agreement has been drawn up by [Trust/Health Board] Named Doctors, this is at the sign off stage and will then be shared with multiagency partners and available on our website. As this is not yet published thus I have answered no to all questions referencing the written service agreement, however we consulted the delivery standards as the SOP was created. A patient info leaflet has

Question	Responses
	been created and is currently with patient involvement groups. • We follow medical standards in place via [regional networks] • we have audited this twice- once in Nov 2020, and then in Aug 2022- we have improved in may areas- of note we have patient information leaflets - with stake holder participation- for carers and diff ages, which has taken time for approval within trust comms team and improved consent forms, proforma and reports. improved working with acute trust re arranging investigations. • We have been able to ensure training in photography for all clinical staff • We have managed to secure a partial nursing rota to provide a Chaperone • We have included prompts in the child protection medical proforma related to the standards to facilitate service improvement. We have ensured all consultants and trainees involved in the medicals understand that a consultant must see all visible significant injuries. We have intitiated regular meetings with named doctors from other hospitals in our region and with local childrens services. We are codeveloping information resources for parents/children. We are formalising procedures for our peer review meetings. • We have only just been able to set up dedicated CP clinics and are in the early stages of meeting service delivery standrads • We have recognised that whilst in training and peer review we discuss the standards, we do not have a written document which describes the local application of these standards. • We have updates SOP for photography and medical investigations. We have reflected on our local policies. A lot of our processes are in line with standards recommended but are not in our written policies and therefore following this audit a SOP for CP medicals will be written • We have used them to improve the information provided to our Partner Agencies • We now meet most standards but don't have a formal written agreement stating so. • They've highlighted the need for a more protected service rather than being part of the on call consultants duties but we are unable to provide that currently. • 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. • We reviewed parent and child information leaflets for child protection medicals. Reviewed the need for other languages for our child protection leaflets to offer to patients and families. • Continuing to pursue photography as part of the service in house.

Question	Responses
	• Already pursuing improvement in SOPs for the service and the standards are helping to inform and support this. • We were already meeting most of the standards but it has been helpful to identify areas for improvement that we can control. In terms of service delivery, we are meeting the majority of the standards in practice but acknowledge some may not be specifically written in service agreements. For this reason I have had to answer no to several of the audit questions even though I know they are being met in current practice. • We are able to meet standard for chaperone for planned specialist and JPF examinations and majority of acute examinations within normal hours. We provide a chaperone for all historic sexual abuse examinations. At this time we do not provide a chaperone for comprehensive medical assessments but would arrange this if parent or child asked. Finding a chaperone is more challenging outside normal hours unless child is an inpatient and accompanied by a ward nurse. It may not be always be possible if the hospital is busy.