

Good practice service delivery standards for the management of children referred for child protection medical assessments

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Foreword

When concerns are raised about possible child abuse and neglect it is important for that child and family that there is an appropriate response from all agencies^[1]. Part of that response includes the availability of health services which are appropriately resourced and managed to deliver an agreed high standard of care. Through discussion between named and designated doctors for safeguarding children it has become clear that there is significant diversity between geographical areas in the way in which children, families and professionals experience the process of a medical assessment when there are child protection concerns related to physical abuse and neglect.

Diversity can often be a good thing, leading to innovation and better ways of working, but not when it describes inequitable services, either through inadequate resources, different interpretations of or lack of awareness of existing guidelines. Examples include the level of written and photographic documentation, availability of written policies and the nature of peer review.

The Royal College of Paediatrics and Child Health (RCPCH) and the Child Protection Special Interest Group (CPSIG) have therefore published this set of standards about the service delivery aspects of child protection medical assessments with the aim of reducing unwanted variation in care across all four nations of the United Kingdom. The standards bring together the range of processes and procedures that make up the often complex situation of a medical assessment in the context of child protection concerns. They are about the front line aspects of child protection work, hence will be of use to named doctors and their equivalents in Scotland who are tasked to ensure that their health provider organisation delivers a high level of care when their clinicians are called upon to carry out these assessments. In order to achieve some of the standards, named doctors will need to be supported by designated doctors for safeguarding and their equivalents in Scotland and by clinical directors and senior managers who are able to influence the working arrangements of those on the front line of this difficult but important work.

It is anticipated that this document will set a benchmark and therefore can be used to inform conversations between providers of health services, service planners and commissioners to enable child protection medical assessment services to be delivered appropriately. It is acknowledged that across the four nations of the United Kingdom commissioning and service planning arrangements differ, plus services will vary in terms of the amount or type of additional commissioning or investment that might be needed in order to achieve these standards.

In England the 2017 Children and Social Work Act led to the establishment of local safeguarding partnerships in which health is an equal partner with the local authority and police when safeguarding children^[2]. RCPCH and CPSIG therefore suggest that these standards should inform the benchmark expected in health provider organisations when addressing child protection concerns where a medical assessment is indicated.

These standards can also be seen through the lens of the United Nations Convention on the Rights of the Child^[3]. They are supported by a number of Articles, in particular Article 3 covering the best interests of the child, Article 12 highlighting the importance of respecting the views of children and Article 19. Article 19 states that "Governments should do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them." Part of fulfilling this duty is surely to have a health system which is able to respond with the very highest level of care on every occasion that a child protection medical assessment is needed.

Summary

There are thirteen overarching high level standards each 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. These standards were primarily developed for children where there are concerns about physical abuse and neglect, rather than child sexual abuse, though there will be overlapping principles. With the child's journey in mind the standards follow the process from the initial referral by a social worker or a police officer, ensuring that they can readily find out the local practical arrangements regarding how to request a child protection medical assessment from a particular health provider organisation, through to the timeliness of seeing the child or young person, who carries out the assessment, the level of documentation and support during the assessment and arranging investigations. The service is supported by the availability of appropriate peer review, service evaluation and on-going support for the clinician^[4].

This document is produced by RCPCH and CPSIG hence it relates to the standards expected of paediatricians in carrying out child protection medical assessments, but also with respect to their part in setting up and publishing local child protection pathways, roles undertaken by paediatricians, named doctors, designated doctors and those with equivalent duties in the four nations of the UK. Some of the standards refer to processes that are beyond the control of the paediatrician and clearly it is beyond the remit of paediatricians or this document to set standards for other professional groups. It is though within our remit to ask named and designated doctors to establish what the arrangements are locally and to record them in local guidance so that there is clarity. This is important not only to inform strategic discussions but also so that front line doctors have ready access to that information and do not have to establish the facts for themselves during a busy on call shift at the weekend.

It is beyond the scope of this document to provide a service specification, but RCPCH would encourage health provider organisations to use these standards to benchmark their services.

It is anticipated that many of the indicators of good practice will already have been achieved by many services, whilst others may see some aspects as aspirational. However, it is envisaged that by having these service delivery standards agreed, service leads such as named and designated doctors working with senior managers, will be supported to negotiate for change where necessary.

These are standards that relate to the service delivery of child protection medical assessments and whilst they seek to support the good governance of the child protection assessment process, they do not however bear a direct relationship to the quality of an individual clinical opinion. Hence the medical opinion of clinicians working in services which do not currently achieve compliance with these standards is still valid. By way of explanation of this point, albeit with an extreme example, a child with malaria may be seen by clinicians with good clinical skills and acumen in rural hospitals with poor facilities in some developing countries. It is preferable that the child is seen and treated in a better equipped venue but the clinical skill and opinion is still good in both situations.

Regarding the response to requests for comment on photographs of possible child abuse see 'Guidance on medical photography of possible physical abuse in children'^[5].

Doctors should also be familiar with GMC guidance 'Protecting children and young people' and '0-18 years – guidance for all doctors' which deal with a range of issues related to these service delivery standards^[6].

It is recognised that children are seen for child protection medical assessments in a wide range of

paediatric services and venues from community clinics to tertiary children's hospitals. There is no one service delivery model that is necessarily the best, however all models should be able to work to the same set of service delivery standards.

Terminology relating to child protection medical assessments varies across the four nations of the United Kingdom. Further information about terminology used in Scotland can be found in their National Guidance^[7].

Case for change

A child protection medical assessment can be seen as part of a service that is delivered by health for that child and family, in a similar way to delivering an epilepsy or neuro- disability service, but with the added complexity that the service users are also our partners in social care and the police. It is important that there are equitable standards of service delivery regardless of the geographical location in the United Kingdom in which that assessment is carried out and whether or not that assessment takes place in a hospital or another clinical setting, hence these standards are applicable to all clinicians undertaking child protection medical assessments.

The RCPCH Child Protection Companion is a valuable resource for clinicians based on the best scientific evidence where such material exists. It is constantly updated on a wide range of child protection topics and has helped to inform the development of these service delivery standards. Whilst the Companion does offer advice for good practice it does not provide a full set of detailed, auditable standards and indicators of good practice that safeguarding clinical leads are able to work towards when considering the governance of their service.

Child protection medical assessments can be stressful for all concerned, particularly for the children and families but also for police officers, social workers and doctors. Nothing will remove that stress but it can be mitigated to some degree by making sure that the child is seen by the right people at the right time and with the right facilities and processes in place.

The importance of photographic documentation is highlighted in learning from serious case reviews, as collated by the NSPCC. The NSPCC tells us that there are “delays in taking photographs of injuries which can hamper child protection investigations”^[8]. Through discussions with safeguarding leads it has become clear that in some health organisations photographic documentation of injuries is routine and reasonably easy to access most of the time, but in others such photographic documentation is less frequent and difficult to access. A recent survey carried out at a CPSIG conference in 2019 provided evidence of wide unwanted variation in the availability of photo documentation in child protection medical assessments^[9].

Peer review is another area where there is significant diversity, not only of the frequency of peer review but also its nature. Emotional support for paediatricians has been found to be limited^[10]. Anecdotally trainees feedback that while moving between departments through their training they experience wide variation in service delivery and they would welcome more uniformity and understanding around how child protection medical assessments are managed.

Developing the standards

Through discussions between the named and designated safeguarding doctors from health provider organisations and CCGs across the ten authorities of Greater Manchester, it became clear that there was unwanted diversity in the service delivery of child protection medical assessments. It was recognised that there is a wide range of service delivery models for child protection medical assessments with no one model being necessarily right or wrong. In 2016 it was agreed that all service models should be able to work towards one set of service delivery standards; these then formed the basis of an audit by NHS England in Greater Manchester via the CCGs. Paediatricians have been able to use the standards locally to help improve their services.

The original Greater Manchester standards were published in BACCH News in March 2016^[1]. Those standards have now been further developed by a Joint Working Group led by CPSIG (Child Protection Special Interest Group) with the RCPCH Child Protection Standing Committee.

A programme of teleconferences was undertaken, involving representatives from the four nations of the United Kingdom as well as a representative from the FFLM (Faculty of Forensic and Legal Medicine). Each standard and indicator of good practice has been considered and adapted to be relevant to the range of services across the United Kingdom.

It is recognised that there is a set of Scottish child protection standards however these mainly relate to the Scottish model of arranging joint paediatric and forensic examinations. Northern Ireland has a similar system of joint examinations for some children plus it is recognised that in some parts of England and Wales children may be examined jointly by a forensic clinician and a paediatrician.

These are service delivery standards and they do not seek to replace the work of the RCPCH Child Protection Companion or Child Protection Evidence. Rather, one of the aims of these standards is to make sure that all services signpost to these information resources via local policies and procedures.

Further development

It is anticipated that these Good Practice Service Delivery Standards will develop further over time, particularly as more becomes known through audit and research. It is acknowledged that there are currently areas of diversity that these standards do not yet address, such as forensic clinicians taking part in medical assessments for suspected physical abuse. On-going work by the Child Protection Standing Committee, supported by CPSIG, is anticipated in this area including that of peer review amongst others.

Key terms

Child or children	Infants, children and young people under the age of 18 across the UK.
Child protection medical assessment	<p>For the purposes of this document 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.</p> <p>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.</p>
Child protection	A part of safeguarding and promoting welfare, which refers to the activity that is undertaken to protect children who are suffering, or likely to suffer, significant harm as a result of abuse or neglect.
Safeguarding	<p>Promoting the welfare of children through:</p> <ul style="list-style-type: none"> • Protecting children from maltreatment • Preventing impairment of children's health or development • Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care • Taking action to enable all children to have the best life chances.
Named doctor for safeguarding children	<p>All health provider organisations in the England, Wales and Northern Ireland have a named doctor who as part of their job role has a responsibility to:</p> <ul style="list-style-type: none"> • Support all activities necessary to ensure that the organisation meets its responsibilities to safeguard / protect children and young people • Be responsible to and accountable within the managerial framework of the employing organisation • See also https://www.rcpch.ac.uk/sites/default/files/Named_Doctor_for_Child_Protection_-_model_job_description_and_competences_2014.pdf <p>In Scotland this role is not clearly defined.</p>

<p>Designated doctor for safeguarding children</p>	<p>Designated doctors provide clinical expertise relating to safeguarding children in the context of strategic matters. In England they work with Clinical Commissioning Groups, in Wales they work from within Public Health Wales and in Northern Ireland with Safeguarding Board Northern Ireland. The post of designated doctor does not exist in Scotland; however the role is carried out by a Health Board Lead Paediatrician for Child Protection, although this role is not statutory.</p> <p>At all times and in relation to the roles and responsibilities listed, work as a member of the safeguarding / child protection team across the health community</p> <ul style="list-style-type: none"> • Lead and support all activities necessary to ensure that organisations within the health community meet their responsibilities to safeguard and protect children and young people • Advise and support all named professionals across the health community • See also : https://www.rcpch.ac.uk/sites/default/files/Designated_Doctor_for_Child_Protection_-_model_job_description_and_competences_2014.pdf
<p>Social worker</p>	<p>Professionals with, or are working towards, a social work qualification; they are usually employed by the local government authority and have statutory duties to assess and support children who may have, or are, in need of support and protection by statutory services in order to develop to their full potential and be protected from harm</p>
<p>Person with parental responsibility</p>	<p>All mothers and most fathers have parental responsibility, which means that they have legal rights and responsibilities regarding their children. Parental responsibility can be shared and is rarely removed. For more information see RCPCH Child Protection Companion^[12].</p>
<p>Parents and carers</p>	<p>Adults who have taken on a parenting or caring role for that child. However, they may not automatically have parental responsibility, for example step parents or foster carers.</p>
<p>Health provider organisation</p>	<p>A licensed organisation that provides healthcare services. In England this is likely to be an NHS Health Trust but in other UK nations may be a health board. It may be a private organisation.</p>
<p>Service planners</p>	<p>Organisations or individuals responsible for planning, commissioning and providing health services in a local area.</p>
<p>Forensic physician / forensic medical officer/ forensic clinician</p>	<p>A medical practitioner who has particular expertise in examining children and adults with a view to providing assistance to the Police and the Courts, which may include collecting samples for evidence. They are likely to be a member of the Faculty of Forensic and Legal Medicine.</p>
<p>Paediatrician</p>	<p>A medical practitioner specialising in children and their diseases.</p>

Healthcare professional / clinician	A clinically qualified person who is working within the scope of practice as determined by their relevant professional body and who is registered with that body as competent to practise, for example, the General Medical Council (GMC), Nursing and Midwifery Council or the Health and Care Professions Council.
Paediatric dentist	A dentist specialising in children's dental care.
Forensic odontologist (forensic dentist)	A person who studies the structure and diseases of teeth, especially one who uses their knowledge to identify people and help solve crimes
Haematologist	A medical doctor specialising in diseases related to blood.
Radiologist	A radiologist is a medical doctor who specialises in diagnosing and treating disease and injury, using medical imaging techniques such as x-rays, computerised tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET), fusion imaging and ultrasound.
Geographical area	The geographical area that is relevant to the delivery of these standards will vary depending on the local arrangements in place throughout the UK. For example in England the geographical area is likely to be the area covered by the local safeguarding partnership arrangements which will encompass one or more local authorities, the partners being the local authority, clinical commissioning group and the police.
Professional opinion	The opinion of the examining/treating clinician. If the clinician providing the professional opinion is called to court then they are a 'witness to fact', or a 'professional witness'. This is different from an expert opinion which is commissioned by the court.
Provisional report	This is the report that is provided to the social worker or police at the time of the child protection medical assessment and sets out the professional opinion of the examining doctor, as far as they are able at that time, regarding the likelihood of abuse based on the history and examination of the child.
Child protection medical report	This is the typed report of the child protection medical assessment which is sent to social care and or the police. It contains the professional opinion of the examining/ treating clinician regarding the likelihood of abuse being the cause of the presenting signs and symptoms of the child and how they came to arrive at that opinion.
Court report	This is a report written purely to assist the court and often takes the form of answering specific questions put to the clinician by the court
Senior clinician	A non-training grade clinician, usually an experienced consultant, SAS doctor or nurse consultant.
SAS doctor	Staff grade, associate specialist or specialty doctor.

Summary of the Service Delivery Standards

Standard 1:

Health provider organisations work with local agencies to provide information for families, social care and police about child protection medical assessments for children of all ages in that geographical area.

Standard 2:

Clinicians at the health provider organisation respond to requests for a child protection medical assessment in a timely fashion, following agreed documented local processes.

Standard 3:

Child protection medical assessments are undertaken with appropriate consent.

Standard 4:

Child protection medical assessments are carried out and supervised by clinicians with appropriate competencies.

Standard 5:

Child protection medical assessments are carried out by clinicians with appropriate supervision.

Standard 6:

Child protection medical assessments are carried out with the support of an appropriate chaperone.

Standard 7:

There is appropriate support for the child and family during child protection medical assessments.

Standard 8:

The assessment, professional opinion and outcome resulting from a child protection medical assessment is clearly recorded and is communicated to the requesting professional as well as to the family and child as appropriate.

Standard 9:

There is a managed process to obtain photographic documentation of all significant visible findings.

Standard 10:

Medical investigations, as part of a child protection medical assessment, are undertaken in line with available guidance.

Standard 11:

The child protection medical assessment service has a peer review process which is in keeping with national peer review guidance.

Standard 12:

There is regular review of the quality of the child protection medical assessment service

Standard 13:

Clinicians undertaking child protection medical assessments are appropriately supported through their job plans as well as having access to formal and informal emotional support, psychological support, legal support and personal security.

Standard 1

Health provider organisations work with local agencies to provide information for families, social care and police about child protection medical assessments for children of all ages in that geographical area.

Indicators of good practice to achieve Standard 1

- a. Each geographical area has a written pathway describing how to provide child protection medical assessments for infants, children and young people 0 to 18 years of age.
- b. Health provider organisations maintain clear online instructions, including telephone numbers, regarding how to request a child protection medical assessment from that organisation; this includes details of the age range of children who will be seen by that service.
- c. Health provider organisations should contribute to multi agency child protection arrangements which should be published online regarding the local practical arrangements for requesting and carrying out child protection medical assessments both in and out of working hours. This encompasses the role of social care and police, including whose responsibility it is to arrange an interpreter when needed. The arrangements should also document when and how the police may assist by taking photographs as part of a child protection assessment and how paediatricians can access those photographs for purposes of report writing and peer review.
- d. Information is available for children in age appropriate language and to families explaining the child protection medical assessment process. This should be available for social workers and police officers to signpost families to, as well as being available on arrival at the venue in which the assessment will take place. This should take the form of information on a website though a leaflet with the same information would also be appropriate for those families who may not be able to access online resources.
- e. Information explaining the child protection medical assessment process is available in most languages of the families who are likely to use the service in that local area.

Rationale and guidance for Standard 1

Health provider organisations differ in their arrangements for accessing a child protection medical assessment plus basic details need to be readily accessible to social care or police staff both in and out of working hours. Staff who need access to this information may be new in post or may not have needed to make such a referral in that geographical area before. They may have made a previous referral but for a child of a different age. In some areas there may be two or more health providers who differ in the age ranges of children who they will see for such an assessment and their contact hours may be different; all will have different telephone numbers, venues to attend etc. Health staff too need access to such information, particularly locum staff and trainees out of hours. The best way to maintain this information is via a website, either of the health provider organisation, that of the local area safeguarding partnership or regional safeguarding board in Wales.

The geographical area will need to ensure that there is access to child protection medical assessments for children of all ages; that information will need to be agreed at a strategic level and documented in such a way as being accessible at all times.

Information about agreements that are or are not in place regarding the role of police photography, social care attendance etc. also needs to be documented so that there is clarity at all times. It is acknowledged that this responsibility goes beyond that of the named doctor or other health provider staff, however such staff do have a role in both cooperating in making such information available and in advocating for agreements if not currently in place.

Some areas have leaflets that explain what takes place at such a medical assessment and where that might take place. These are made available to families, possibly some aimed at children themselves. It might be helpful to come to an agreement about a generic leaflet or web based information for a wider geographical area that can be adopted by each health provider. Such an arrangement might facilitate its translation into relevant languages for that geographical area.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> Evidence of an online document or documents that set out the local pathway and relevant contact details 	<ul style="list-style-type: none"> Regular feedback from social care service managers regarding ease of access to this service in health
<ul style="list-style-type: none"> Evidence of online information, plus or minus leaflets explaining the child protection medical assessment in English and other languages as locally appropriate 	<ul style="list-style-type: none"> Rate of complaints about difficulties accessing the service Adverse incident reporting regarding inappropriate attempts to access a child protection medical assessment, e.g. via a GP where they are not part of the agreed pathway Audit of the number of families who have been offered a leaflet Service user feedback surveys to include a question about leaflets / written information

Standard 2

Clinicians at the health provider organisation respond to requests for a child protection medical assessment in a timely fashion and following agreed, documented local processes.

Indicators of good practice to achieve Standard 2

- The medical assessment of a child with suspected physical abuse should normally be commenced within 24 hours of referral to health; timing should be based on clinical need. If this standard is not met then the reasons are clearly recorded in the child's health record and reported via the health provider organisation's governance reporting system
- Medical assessment of suspected physical abuse in infants should normally be commenced within 24 hours of referral to health; timing should be based on clinical need. If this standard is not met then the reasons are clearly recorded in the child's health record and reported via the

health provider organisation's governance reporting system

- c. Each health provider organisation has a standard operating procedure outlining the process for responding to child protection medical assessment referrals; this is available for all staff to view on that organisation's intranet.
- d. Clinicians should record all discussions regarding child protection referrals in the child's health record as soon as is possible, regardless of whether the child is then seen for a medical assessment or not. For those referrals where the medical assessment does not take place for some reason then the reason for not proceeding should be documented if known. This could be that a medical assessment was not deemed to be appropriate or that consent was withheld.
- e. A clinician with appropriate expertise should be available within a reasonable period of time during normal working hours to engage with partner agencies in a strategy discussion regarding the potential need for medical assessment, safe care plan arrangements and further steps. Such availability will need to be factored into job planning.

Rationale and guidance for Standard 2

It is important that children are seen as soon as is reasonable when visible signs might be present as these can soon become less visible or disappear completely.

The RCPCH Child Protection Companion recommends that children are seen for an assessment of possible physical abuse within 24 hours though it may be clinically appropriate to be seen more urgently, depending on the context^[13]. Good practice indicators 2(a) and 2(b) are stated separately in order to address potential questions about whether infants should be seen more urgently than older children; currently the working group is not aware that evidence exists that infants should necessarily be seen more urgently.

With respect to the statement "Timing should be based on clinical need" a number of factors need to be taken into account including the period of time that any visible findings are likely to remain available for examination and the timeliness of relevant laboratory / radiological investigations in that particular clinical context.

In addition there are broadly two main risks to be managed, one being the clinical risk and the other the safeguarding risk, i.e. the infant or child is medically well and is in a safe environment. Hence, for example, a child of 6 months who is well and has been found by a GP or health visitor late in the afternoon to have a bruise to the leg might appropriately be seen for child protection medical assessment the following day. This is because the clinical risk is likely to be low in this situation. The safeguarding risk however might be high and safety arrangements overnight will need to be in keeping with the level of safeguarding risk which should be determined through discussions with social care and police. A range of safety arrangements should be explored, not just admission to hospital which in itself is not necessarily a place of safety, unless other measures are put in place by social care and police. In contrast a 2 month old found to have a bruise to the chest and who is irritable should be seen urgently because of a high clinical risk. In both examples the safeguarding risk might be equally high but because of the higher clinical risk and increased probability of multiple investigations then it is likely to be more appropriate to not only see the 2 month old child urgently but to admit the child to hospital until a well-developed clinical opinion can be established.

It can sometimes be appropriate for either an infant or older child to be seen urgently out of hours in order to assess whether or not they are medically fit and then for the child protection medical

assessment to be undertaken later, within working hours. A mechanism should be available in order to preserve evidence of significant visible findings for example out of hours photography, particularly during the early part of a weekend, see Standard 1.

These standards apply both in the outpatient situation and for those children who are admitted for a medical reason such as trauma or unexplained collapse where subtle signs might be important or laboratory tests need to be considered in a timely fashion before evidence is lost.

There are various reasons why not all children who are referred for a child protection medical assessment are actually seen and the circumstances of each case need to be documented contemporaneously or as soon as access to the health record is available. The reasons for not being seen vary from lack of consent from parents or the child themselves, to not being able to attend on time but then not arranging to be seen on another day. The clinician may not deem the assessment necessary which may or may not be in agreement with the social worker. All such cases would benefit from being recorded so that they are available for peer review discussions and audit. The information is also helpful when building a picture over time for that individual child when other concerns, possibly behavioural concerns might come to light in the future.

It is important that there is a discussion between an experienced health professional and the referrer, either social care or the police, about the need for, timing of and expectations of a child protection medical assessment. That clinician could be an experienced member of the nursing safeguarding team working closely with clinicians undertaking child protection medical assessments or a clinician who undertakes such assessments. In terms of job planning one option is that the role might link to a period of time dedicated to office based administration duties but have additional time factored in to account for the likely impact of such multiagency telephone discussions, as per the usual frequency of such experienced by that local service.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> • Evidence of a standard operating procedure in the health provider organisation that details the process and timescales regarding arranging child protection medical assessments. • Evidence in health provider organisation that there is a mechanism by which the timings of the receipt of the referral and commencement of the child protection assessment are in place 	<ul style="list-style-type: none"> • Regular feedback from social care service managers regarding ease of access to this service in the health provider organisation • Review of adverse incident reporting systems • Audit of the timeliness of response to requests for a child protection medical assessment • Reviews and audits of referrals for child protection medical assessments to include any children who were referred but not seen and reason if known • Peer review minutes to include children referred but not seen in a timely fashion or not at all and any learning points identified • Evidence to appraisal discussions of attendance at strategy meetings

Standard 3

Child protection medical assessments are undertaken with appropriate consent.

Indicators of good practice to achieve Standard 3

- a. Informed written consent from a person with parental responsibility is taken for each child protection medical assessment, where there are exceptions to this then the reasons are clearly documented in the child's health record. Consent may be from the child or young person if they are deemed to have capacity. If a child or young person refuses to assent or consent to all or some of a medical assessment then this too needs to be documented.
- b. Specific written consent is taken for clinical photography unless a person with parental responsibility is not available and it is deemed to be in the child's best interest. Efforts to obtain verbal consent should be made. When taking consent it should be explained that the photographs will become part of the child's health record and be made available for peer review and that social care, the police and the Courts may request copies of the photographs.
- c. Specific written consent from a person with parental responsibility is taken for the use of photographs in teaching or publication
- d. Specific written consent is taken for other imaging investigations such as skeletal survey in line with national guidance, see standard 10, good practice indicator (b).
- e. If consent is withheld for any part of the assessment, including examination, photography or investigation then this is recorded, including subsequent discussions and any actions taken.

Rationale and guidance for Standard 3

Consent should always be sought to examine a child for any reason. If consent is withheld by the person with parental responsibility for the child then a discussion needs to take place with social care regarding further action which may be needed in order to proceed to examine the child which might include an emergency protection order. Please see further details in the RCPCH Child Protection Companion regarding capacity, consent and when consent is not available^[14]. There also needs to be assent to the examination from a child who is not yet competent to consent though this needs to be within reason, for example a fractious 18 month old's objections are quite different from a 6 year old's objection to inspection of their genital area, particularly if that area was not the focus of concern. Therefore reasonable dissent should be respected.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> Evidence of appropriate consent form /s Evidence of specific consent for photographic documentation and its level of use – i.e. health records / teaching / publication 	<ul style="list-style-type: none"> Audit of documentation of level of consent for each child protection medical assessment, including verbal or written and status of the person providing the consent e.g. person with parental responsibility / young person / local authority who shares parental responsibility Evidence that the consent for photographic documentation is clearly linked to or stored with the images Evidence of appropriate consent for imaging such as skeletal surveys and CT brain

Standard 4

Child protection medical assessments are carried out and supervised by clinicians with appropriate competencies^[15].

Indicators of good practice to achieve Standard 4

- Child protection medical assessments are carried out by paediatric clinicians working at ST4 level or equivalent and above with relevant Level 3 child protection competencies^[16].
- Child protection medical assessments are carried out or supervised by doctors who actively engage in relevant continuing professional development, have regular supervision and attend peer review meetings to enable them to keep up-to-date and maintain their skills.
- If recurrent or significant concerns arise regarding a clinician's ability to produce clear, balanced and reasonable opinions and actions within the context of child protection medical assessments then appropriate supervision or regulatory measures are put in place in line with GMC guidance.

Rationale and guidance for Standard 4

Child protection medical assessments should be undertaken by clinicians who have sufficient experience and knowledge of child development and clinical paediatrics. There will be some situations where more specialist knowledge, such as radiology or metabolic bone disease, will be needed.

Standard 4 indicator of good practice (a). primarily applies to child protection medical assessment rotas which provide staff to carry out the child protection medical assessment of children referred to the health provider organisation by social care or police. It will sometimes be the case however,

that more junior clinicians who are not yet at ST4 level will see children who have attended with medical symptoms but on assessment there are symptoms or signs which lead to child abuse being considered or suspected. In such circumstances the examining clinician should record the history and examination findings, including the clinician's opinion that maltreatment should be considered or suspected, but that clinician should also then alert their supervisor immediately. The supervising clinician should also examine the child before developing a further management plan which should also be recorded and may include a child protection medical assessment; if so that should be undertaken by an appropriately senior clinician.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> The standard operating procedure in the health provider organisation sets out which staff roles are eligible to carry out child protection medical assessments. 	<ul style="list-style-type: none"> Audit of the child protection medical assessments to include the clarity of documentation regarding the status of the clinician carrying out the medical assessment, whether their status is in line with the guidance. Child protection work is specifically discussed and documented in the clinician's appraisal, to include evidence of relevant continuing professional development, on-going clinical experience and attendance at peer review as relevant to their job role.

Standard 5

Child protection medical assessments are carried out by clinicians with appropriate supervision.

Indicators of good practice to achieve Standard 5

- Child protection medical assessments that are carried out by clinicians in training are closely supervised, which as a minimum includes the supervising senior clinician seeing the visible findings or injuries that have raised concern and reviewing and co-signing the report.
- The supervision of SAS clinicians should be agreed locally depending on the level of experience of the examining clinician.
- All children seen for a child protection medical assessment, or those children who are admitted in whom there is a child protection concern, have a named supervising senior clinician responsible for the child protection opinion.

Rationale and guidance for Standard 5

When a child or young person has a child protection medical assessment the clinicians involved need to be clearly identified, particularly when the examining clinician is a trainee or locum who may have moved to another post when the case is reviewed for whatever reason.

When the examining doctor is a trainee then the supervising paediatrician should also always be identified. There should always be a lead clinician who would normally be the consultant paediatrician though this may be a sufficiently experienced specialist doctor or in some instances a consultant surgeon or consultant nurse. The RCPCH Child Protection Companion highlights the particular need for clarity about who is the lead clinician for the safeguarding aspects of children who are admitted to hospital^[17].

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> • The standard operating procedure in the health provider organisation sets out which staff roles are eligible to carry out child protection medical assessments and the level and nature of supervision required. • Evidence of a standardised proforma with appropriate fields to record information recommended in this standard 	<ul style="list-style-type: none"> • Audit of the child protection medical assessments to include the clarity of documentation regarding the status of the clinician carrying out the medical assessment, whether their status is in line with the guidance, the level of supervision and the name of the supervisor. • Child protection work is specifically discussed and documented in the clinician's appraisal, to include evidence of continuing professional development, on-going clinical experience and attendance at peer review as relevant to their job role.

Standard 6

Child protection medical assessments are carried out with the support of an appropriate chaperone.

Indicators of good practice to achieve Standard 6

- a. A named chaperone is present as a witness and to support the child and clinician. Their name should be recorded on the child protection medical assessment proforma^[18].
- b. The chaperone should be trained with respect to the role of a chaperone.
- c. The chaperone should be a qualified health professional, particularly during the examination.
- d. The chaperone should not be a student as they need to be able to be of sufficient experience and confidence to report what they have observed to senior staff and potentially a court.

Rationale and guidance for Standard 6

The use of a chaperone is not only important for the child but the examining clinician as well in order to have an independent professional who witnessed the consultation in case of concerns being raised at a later date. The use of students as a chaperone is unlikely to be appropriate due

to them being harder to trace in the future but also that they need to be sufficiently comfortable to be able to report their experience if needed. There may be circumstances where the chaperone during the history taking is a social worker. Whilst it is usually appropriate for the social worker to be present for the history part of the assessment, the examination should be chaperoned by a qualified member of health staff^[9].

GMC guidance refers to intimate examinations however this guidance can equally be applied to the whole child protection medical examination hence, as recommended by the GMC, the chaperone should:

- a. be sensitive and respect the patient’s dignity and confidentiality
- b. reassure the patient if they show signs of distress or discomfort
- c. be familiar with the procedures involved in a routine intimate examination
- d. stay for the whole examination and be able to see what the doctor is doing, if practical
- e. be prepared to raise concerns if they are concerned about the doctor’s behaviour or actions.

For the purposes of child protection medical examinations it would be reasonable for a nurse to act both as chaperone and to assist in the examination at the same time, if such assistance were to be required. This is because to bring in an additional nurse to give assistance, whilst another nurse is purely acting in a chaperone role is unlikely to be appropriate given that there are often already several people present and another may contribute to the situation becoming overwhelming. Ways in which a nurse chaperone might support the examination might be by helping to dress or undress a small child, holding the arm of a child or holding a ruler during photography, occupying a small child whilst their parent is talking with professionals etc. This is in line with the well-respected Cambridge chaperone policy which allows for “providing practical assistance with the examination” (Cambridge University Hospitals NHS Foundation Trust. *Chaperones: Requirement for use of chaperones*. 2016 <https://www.cuh.nhs.uk/sites/default/files/publications/Chaperones%20-%20requirement%20for%20the%20use%20of%20chaperones.pdf>). It is good practice to enquire about and accommodate a child or young person’s preference as much as possible regarding who acts as chaperone, such preferences may well include the sex of the chaperone.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> • The standard operating procedure in the health provider organisation sets out which staff roles are eligible to carry out the role of chaperone. • Evidence of a standardised assessment proforma with appropriate fields to record who the chaperone was and their staff role. 	<ul style="list-style-type: none"> • Audit of the child protection medical assessments to include the clarity of documentation regarding the name and job role of the chaperone. • Formal and informal collection of service user feedback from families, and social workers. • Feedback from CQC and other inspections.

Standard 7

There is appropriate support for the child and family during child protection medical assessments.

Indicators of good practice to achieve Standard 7

- a. If an interpreter is used their name, identification number and the language used is recorded on the child protection medical assessment proforma.
- b. Only interpreters from organisations approved by the health provider organisation, social care department, or police are used.
- c. 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. A chaperone would still be needed.
- d. Children, young people and families who have a disability are provided with appropriate support.
- e. Child protection medical assessments are carried out in age and developmentally appropriate venues.
- f. In order to maintain confidentiality, wherever possible the assessment should be carried out in venues which afford privacy both during the assessment and also for the social worker or police during their various discussions.

Rationale and guidance for Standard 7

It is well established in health that members of the family should not be used as interpreters; that principle is of utmost importance in the child protection arena. To maintain an audit trail and to be able to answer any future challenge it is important that appropriate details of the interpreter who supported the assessment are clearly recorded.

Children will vary with respect to their wishes as to who if anybody should accompany them during the medical assessment, indeed sometimes young children say that they do not want to have sight of their parent if that person is the alleged perpetrator of abuse; the child should not have to be accompanied by the alleged perpetrator if possible.

In keeping with all other paediatric services delivered by that health provider organisation, the assessment should be conducted in an age appropriate venue in order to limit, as much as possible, the amount of stress that the child endures throughout that assessment.

Suitable privacy is unlikely to be achieved on an open ward or in an emergency department cubicle hence such venues should be avoided if possible.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> The standard operating procedure in the health provider organisation sets out the venues in which this service should be delivered. Evidence of a standardised assessment proforma with appropriate fields to record information recommended in this standard. 	<ul style="list-style-type: none"> Audit of the child protection medical assessments to include the clarity of documentation regarding the venue in which this assessment took place. Formal and informal collection of service user feedback from families, and social workers. Feedback from CQC and other inspections.

Standard 8

The assessment, professional opinion and outcome resulting from a child protection medical assessment is clearly recorded and is communicated to the requesting professional as well as to the family and child as appropriate.

Indicators of good practice to achieve Standard 8

- Any decisions made during strategy discussions, either before or after a child protection medical assessment should be recorded in the child's health record by the clinician.
- A standard proforma is used to document the child protection medical assessment similar to that recommended in the RCPCH Child Protection Companion, which has body maps for line drawings to record the site and measurement of any injuries^[20]. Each page has three patient identifiers (name, date of birth and NHS number) and each page is signed by the examining clinician.
- A written provisional report which gives the professional medical opinion regarding the likelihood of abuse based on the history and clinical findings is provided to the social worker and police officer if present. This is provided at the time of the child protection medical assessment though it may contain a proviso that more information may be required, investigations to be undertaken or the case discussed with colleagues.

This is for children who have had a planned / booked child protection medical assessment; for children who are an inpatient, written updates should be provided to enable multi-agency decision making.

- The provisional report is written on a standard form which clearly identifies the health provider organisation that employs the responsible senior clinician, the name of that senior clinician and any other examining clinician, the name, date of birth and another identifier of the child or young person concerned and the date of examination. The form may be handwritten but must be signed by the examining clinician; their name clearly written and the clinician's unique identifier, such as their GMC number, provided.

- e. A copy of the assessment, provisional report and final typed report are kept in the child's health record.
- f. Feedback to children, young people and carers should be given as appropriate, including results of investigations.
- g. A comprehensive type written report with a full professional opinion is dispatched to social care and police if involved, up to 10 working days of the child or young person being seen, or sooner if needed, such as for a court hearing. Additional information such as investigation results can be sent at a later date as received.
- h. The typed written report is delivered securely to social care and police if involved either by hand, registered post or a secure email link to a generic account not just a personal email account. An agreed process should be documented in the standard operating procedure for that health provider organisation.
- i. In keeping with local guidance a copy of the child protection medical report is shared securely with relevant health professionals e.g. GP and universal health services such as Health Visitor or School Nurse.
- j. If the initial child protection medical assessment requires further investigations or admission to hospital then clear arrangements are made and documented regarding who is to provide the opinion and report writing in each case.

Rationale and guidance for Standard 8

A lot of background knowledge, experience, careful history, examination, investigations and thought will have helped the clinician to form a professional opinion regarding whether or not the child they have been asked to see is likely to have suffered from abuse of some kind. In order for this to benefit the child it is equally important that the professional opinion that the clinician has arrived at is clearly documented and communicated to partners in social care, police if involved and other relevant health professionals. Failure to do so has resulted in inappropriate decision making regarding safety planning for the child leading to further abuse for the child or siblings. Sometimes it needs to be acknowledged and clearly communicated that the medical assessment has not been helpful in elucidating whether or not the symptoms or signs in question are likely to be as a result of abuse or not.

The medical opinion should be provided verbally and backed up in writing to minimise any source of confusion; a copy should be retained in the child's health record. Social care need to make plans for the safety of the child or children and the clinician should aim to help them by being clear about the medical opinion as far as is possible; hence the provisional report should be sufficiently detailed to enable social care to make the appropriate safety plans. The type written report can follow, up to 10 working days later or sooner if needed for court proceedings, for example when an emergency protection order is being applied for.

With increasing use of electronic records it is likely that more documents will be digitally produced. Such documents should have similar patient identifiers to the paper ones described in the good practice indicators above, as well as containing visible evidence of who wrote it and when; this is in addition to the digital audit trail which will be available. The use of a generic log in would therefore not be appropriate.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> Evidence of a template style document with appropriate fields for identifiers and information outlined in these standards. Evidence of the health provider organisation standard operating procedure that describes processes which fulfil the good practice recommendations. 	<ul style="list-style-type: none"> Audit of child protection medical assessments to include the use of the provisional report and typed report. Feedback from social care regarding appropriate engagement of health provider staff in multiagency strategy meetings. Feedback from social care or local authority legal staff regarding the clarity of the professional opinion.

Standard 9

There is a managed process to obtain photographic documentation of all significant visible findings.

Indicators of good practice to achieve Standard 9

- Photographs are taken of all significant visible findings unless consent is withheld. Note Standard 1 good practice indicator (c) regarding images taken by the police.
- Photographs should be of a standard that is suitable to be used in court.
- If possible photographs should be taken at the time of the child protection medical assessment.
- Photography is readily available and is carried out by a clinical photographer in a health provider organisation or a police photographer. If those services are not readily available then a clinician in the health provider organisation can take the photographs as long as it can be demonstrated that the clinician has received appropriate training, maintains competencies and that the images are taken as part of a service which operates in line with good practice described in this standard.
- Where a clinician is taking clinical photographs then an appropriately detailed standard operating procedure should be available that has been approved by the relevant committee/s in the clinician's health provider organisation and includes details about training.
- Photographs carried out by a clinician or clinical photographer, or brought into a health provider organisation from elsewhere, are stored securely in line with RCPCH guidance and FFLM (Faculty of Forensic & Legal Medicine) PICS Working Group Guidelines on Photography 2017, including clear labelling, password protection and chain of evidence^[21]. Storage via clinical photography systems should be explored.
- Where a clinician is taking clinical photographs then a governance mechanism involving a clinical photography department is in place as part of a quality assurance process.

- h. When clinical photographs are taken by clinical photography or the police then it is expected that those professionals engage in appropriate quality assurance processes.
- i. All photography involving intimate images should comply with the intimate images guidance written by the FFLM and RCPCH in 2014^[22].
- j. Clinical photographs are not routinely sent with the report.
- k. Clinical photographs are made available in a secure manner to social care, police or a court on request via the health provider organisation's legal department in a timely manner with appropriate consent from the clinician.

Rationale and guidance for Standard 9

Whilst developing these standards it has become clear that there is wide variation regarding both whether or not photographic documentation is carried out and the arrangements for doing so; this unwanted variation is an area of concern. Line drawings remain important as photographs do not always capture the visible findings. However photographs are frequently a helpful method of recording visual findings, not only for social care, the court process and peer review but also at times for the child themselves and family members for verification of allegations. Ideally photographs should be taken at the time of the child protection medical assessment, this is so that the child does not have to experience what is in some respects a second examination. Also having the clinician present helps to ensure that the relevant visible findings are imaged.

Many departments use the services of clinical photographers however this is not always possible, often due to lack of availability in that health organisation or the geographical distance from where the medical assessment is being undertaken. It is also helpful for the child to have the photographs taken at the time of the examination and a number of clinicians now take these photographs themselves at that point. It is important however that good governance arrangements are in place with a clinical photographic department and that the arrangement includes the training of the relevant clinicians. Clinical photography departments are invaluable not only in terms of training and setting up the camera and systems to store images but also for each image in terms of the colour / grey scale processing and the quality assurance of the images with appropriate feedback to the clinician. Clinicians who undertake this work should be able to demonstrate that they have had sufficient training, that their work is monitored and that they are involved in taking images frequently enough to be able to maintain skills at an appropriate level.

As not all health organisations have a clinical photography department then solutions should be sought so that the quality of the child protection medical assessment for those children is not compromised through lack of evidence. Solutions might be found through arrangements with the police, alternatively neighbouring health organisations may be able to carry out the photography or possibly engage in an arrangement to support the local clinicians to take the images themselves, with the safeguards outlined in this standard.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> Evidence of a standard operating procedure in the health provider organisation to include the expectations and process to obtain photographic documentation of significant visible findings and how requests from partner agencies for copies of photographs are responded to, both for photographs taken in health or by police. If clinicians are to take photographs then evidence of a specific standard operating procedure to include details of the training of clinicians and quality assurance processes linked to a clinical photography department as well as evidence that the process has been agreed by the provider assurance structure, such as a governance board meeting. 	<ul style="list-style-type: none"> Audit of the proportion of children undergoing a child protection medical assessment who have photographic documentation, how it was accessed and any concerns about the quality of images. Audit of images used in the court arena and whether there were concerns about the quality of the images. Feedback from service users including families and social workers regarding the process to obtain photographic documentation. To invite feedback from the local authority and justice system regarding the availability and quality of photographic documentation.

Standard 10

Medical investigations, as part of a child protection medical assessment, are undertaken in line with available guidance.

Indicators of good practice to achieve Standard 10

- Haematological investigations should be taken in line with RCPCH guidance^[23].
- Skeletal surveys are requested in line with the RCR (Royal College of Radiologists) guideline 'The radiological investigation of suspected physical abuse in children' 2017, revised 2018.

The local standard operating procedure (Standard 2, Indicator of good Practice item (c)) has practical information regarding how the radiology guidance is implemented in that health provider organisation. This might include relevant contact details and clinical referral pathways.

- When a fracture is suspected to be secondary to abuse then the relevant biochemical blood tests are taken, in line with RCPCH guidance^[24].
- The local standard operating procedure (Standard 2, Indicator of good Practice item (c)) has practical local information regarding how to make a referral to a range of specialists services, even though the services themselves might not be local. Services to include are orthopaedics, metabolic bone clinic, haematology and neurosurgery.

- e. The local standard operating procedure (Standard 2, Indicator of good Practice item (c)) has practical information regarding how to obtain an ophthalmological assessment. This is for instances where abusive head trauma is a possibility.
- f. The local standard operating procedure (Standard 2, Indicator of good Practice item (c)) includes how to routinely access a general dental assessment for children undergoing a child protection medical assessment where there is concern about potential dental neglect^[25].
- g. The local standard operating procedure (Standard 2, Indicator of good Practice item (c)) has practical information regarding how to access a paediatric dentist when further dental assessment is needed, for example for intra-oral injuries or an opinion regarding possible dental neglect that may be suspected by the local general dental practitioner.
- h. The local standard operating procedure (Standard 2, Indicator of good Practice item (c)) has practical information regarding how to make a referral to a forensic odontologist when the assessment of a bite mark/s is needed. Access to a forensic odontologist is likely to be on a regional or national basis as it is acknowledged that current availability of such services is very limited.

Rationale and guidance for Standard 10

There is a range of guidance available regarding the investigations that might be needed in order for the medical opinion to be fully developed. Local guidance will need to provide the practical arrangements as to how that guidance should be implemented, such as how to go about obtaining a skeletal survey or ophthalmology opinion. This information is sometimes passed down by word of mouth however this method is inefficient and a possible source of confusion, particularly for new staff.

If the non-urgent specialist referral is purely to help a court to further clarify the medical evidence then this can be seen as obtaining an expert opinion, for example a forensic odontologist or paediatric dentist, then it is appropriate that the referral is commissioned by the local authority legal team or the police. It is not unreasonable however to facilitate this by providing information and hence for the standing operating procedure to contain practical information regarding how those agencies can make such a referral if such information is known.

Dental neglect is increasingly recognised and routine dental assessment at the time of a child protection medical assessment is now being undertaken in some services, as recommended in the RCPCH Child Protection Companion^[26].

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> • Evidence of a standard operating procedure that outlines the local process to be followed and contact details needed to obtain investigations in each of the categories mentioned in this standard. 	<ul style="list-style-type: none"> • Audit of the appropriate use and timeliness of investigations.

Standard 11

The child protection medical assessment service has a peer review process which is in keeping with national peer review guidance.

Indicators of good practice to achieve Standard 11

- a. Peer review meetings are carried out regularly in accordance with local terms of reference. An attendance record is maintained and minutes are kept of the meetings.
- b. Peer review meetings have access to the line drawings and / or photographs of visible findings or injuries being discussed.
- c. Peer review meetings have access to the medical reports relating to assessments being discussed in order to review the wording of the opinions given.
- d. Peer review meetings obtain regular feedback from local legal services or senior social work managers regarding the clarity of child protection medical assessment medical reports
- e. Clinicians should consider making links with clinicians in other health provider organisations as part of formal or informal clinical networks as one way to keep in touch with mainstream paediatric opinion and practice, plus it may facilitate clinical decision making support if such is not available locally. Appropriate information governance safeguards will need to be in place.

Rationale and guidance for Standard 11

It is recognised that it is good practice for clinicians who undertake child protection medical assessments to regularly attend peer review^[27]. For the discussions at peer review to be meaningful it will usually be important for clinicians to be able to review the photographic evidence and line drawings of the child being discussed.

Owing to the importance of the clarity of the phrasing of the medical opinion then it is important that there is access to both a copy of the provisional report and the final typed report.

For all services it may be helpful to be part of a clinical network in order to discuss challenging cases and to keep in touch with mainstream paediatric opinion and practice. For smaller services joining in peer review meetings of other services will also help to maintain skills. This is in addition to normal continuing professional development.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> • Evidence of a terms of reference for peer review document in that health provider organisation. • Evidence of attendance lists for peer review meetings. • Evidence of minutes of peer review meetings. • Evidence of arrangements in place to enable review of elements of the child's health record in the peer review meeting, including photographic documentation, line drawings, the provisional report and typed report. 	<ul style="list-style-type: none"> • Evidence that all clinicians undertaking child protection medical assessments attend an agreed proportion of the peer review meetings as per the terms of reference. • Evidence that clinicians undertaking child protection medical assessments are being peer reviewed and learning points documented in meeting minutes. • Evidence that on a regular basis feedback is sought from senior social care managers regarding the quality of child protection medical assessment reports.

Standard 12

There is regular review of the quality of the child protection medical assessment service

Indicators of good practice to achieve Standard 12

- Regular, ideally annual, monitoring and audit of some or all aspects of the child protection medical assessment service should be undertaken by each health provider organisation which provides such a service. This would usually be undertaken by the named doctor and the results discussed within the health provider organisation's governance structures. It may be appropriate for named or designated nurses to support such reviews.
- Regular monitoring should include feedback from service users, including children and young people, their families and partner agencies such as social care, police and local voluntary organisations if involved in some capacity.
- The service has an awareness of research themes and is open to being involved in research.

Rationale and guidance for Standard 12

As is the case for all services it is important for regular monitoring of the way that service is being implemented. This information will be helpful for internal quality assurance as well as informing discussions with external partners and agencies. Information from service users is recognised as being particularly valuable.

It is important that the care of children and young people is as evidence based as possible, aiming for improved outcomes. This includes undertaking research into the many aspects of children's safeguarding.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> • Evidence of audits of the delivery of child protection medical assessments. • Evidence that audit results are discussed at governance meetings in the health provider organisation. • Evidence that feedback has been actively sought from service users. • Evidence that clinicians are open to learning about research ideas, such as individual or group subscription to child protection / safeguarding related specialty groups or journals such as the Association of Child Protection Professionals. 	<ul style="list-style-type: none"> • Changes to the standard operating procedure as the result of audit or feedback findings. • Use of language in reports reflects current thinking, for example regarding adverse childhood experiences. • Departmental meeting / journal club meeting reflecting child protection topics. • Audit or research results shared in regional or nation newsletters, journals or meetings. • Appraisal evidence of individuals engaging with research findings or new research.

Standard 13

Clinicians undertaking child protection medical assessments are appropriately supported through their job plans, as well as having access to formal and informal emotional support, psychological support, legal support and personal security.

Indicators of good practice to achieve Standard 13

- a. Clinicians carrying out child protection medical assessments have allocated time in their job plan or rota for the assessment itself and for associated administration and interagency working.
- b. Supervising senior clinicians have allocated time in their job plan to directly supervise child protection assessments, for example it is not appropriate for the supervising consultant to be carrying out a booked clinic at the same time.
- c. Trainees have appropriate time in their rotas to carry out child protection medical assessments
- d. All clinicians involved in safeguarding work should have access to a range formal emotional support such as Schwartz rounds and/or psychology support. Other staff members such as secretarial staff who type the potentially distressing reports and medical photographers who photograph children's injuries may also need access to support which should be made available.
- e. All clinicians involved in safeguarding work should have access to legal advice and support if required related to cases that they are involved with.
- f. There is support for clinician's personal security as appropriate.

Rationale and guidance for Standard 13

Child protection work by its very nature is often stressful for all concerned, including clinicians and allied health staff. Failure to recognise and address the emotional toll on staff who are exposed to this work can contribute to poor staff wellbeing and possibly contribute to staff avoiding this difficult area of work. The sources of stress are both vicarious through being aware of the trauma endured by the children and young people themselves and more direct when there are sources of conflict such as a contested medical professional opinion. Workload beyond the time of being acutely on call is another source of stress, such as attendance at strategy meetings, taking phone calls, writing reports to tight timescales for court despite the clinician being expected to deliver their usual clinical work such as busy outpatient clinics. More extreme examples can involve clinicians being directly threatened, either in person or via social media.

Anecdotal evidence, as well as evidence from a recent survey, suggests that the support made available to staff by their employers is limited and often it is left to colleagues to provide emotional support in unstructured ways with differing degrees of success^[28]. Other professions such as psychology have mandated supervision from an emotional point of view. It is important that the demands of child protection work are similarly acknowledged and appropriate support provided. It is likely that a range of support will need to be made available, from facilitated group support to individual psychological support.

Through the external consultation process for this document the BMA (British Medical Association) have pointed out that they provide 24/7 wellbeing counselling and peer support free of charge to all doctors, whether members or not; this can be accessed by calling 0330 123 1245. Wellbeing services are listed at (<https://www.bma.org.uk/advice/work-life-support/your-wellbeing/counselling-and-peer-support>).

There should be advice and support for personal security such as not working alone and secure access to car parking at the time of a child protection assessment. Further measures such as the provision of personal security lone worker devices may be needed when personal threats have been or are likely to be made regarding individual cases.

There are sometimes occasions when it would be helpful for clinicians to have access to legal support which can be difficult to obtain. Medical defence unions may not have specific relevant experience to offer such support and individual health trusts should make appropriate arrangements as needed.

Suggested metrics

Process	Evidence of the process in use
<ul style="list-style-type: none"> Evidence of availability of regular group psychological support, in addition to peer review meetings. Evidence that there is a pathway to access individual psychological support if needed. Evidence in the standard operating procedure of how to access support for emotional, legal or personal security concerns 	<ul style="list-style-type: none"> Increased staff wellbeing as measured by health trusts. Provider level or wider survey reports regarding how well staff feel supported. Evidence of an appropriate response to threat to a member of staff if applicable.

Joint working group members

Elaine Burfitt, Chair of Child Protection Special Interest Group

Alison Livingstone, RCPCH Child Protection Standing Committee Representative for Northern Ireland

Lorna Price, RCPCH Child Protection Standing Committee Representative for Wales (retired)

Katherine McKay, Deputy Chair of RCPCH Scotland Child Protection Subcommittee

Linda Teebay, RCPCH Child Protection Standing Committee representative for FFLM

Rowena Yates, Child Protection Special Interest Group

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