G153(P) STRATEGY DISCUSSION INVITATIONS TO COMMUNITY PAEDIATRICS – A MARKER OF THE HEALTH OF INTERAGENCY WORKING?

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10.1136/archdischild-2018-rcpch.149

Aim To analyse trends and any link between child protection medical assessments (CPMA) and strategy discussion invitations (SDI) within a community paediatric service.

Background Working Together to Safeguard Children¹ states that, 'whenever there is reasonable cause to suspect a child is suffering or is likely to suffer from harm,' there should be a strategy discussion to share information and formulate a plan to safeguard the child with minimum attendees including a health representative.¹

Method The number of non-accidental injury (NAI), child sexual abuse (CSA) and total CPMA and SDI in an inner London borough were collected from 2010 to 2017. Spearman's Rank Correlation was applied to NAI, CSA and total data to investigate any link between numbers of CPMA and SDI.

Results CPMA reduced from 212 to 144 (by 32%) and SDI from 204 to 31 (by 84.8%) despite the same criteria for assessment and attendance. Spearman's Rank Correlation coefficient for NAI CPMA/SDI was 0.5; a moderate correlation. The coefficient for both CSA and total CPMA/SDI was 0.84; very strong correlations.

Conclusions The Munro Review of Child Protection emphasised that, 'coordination and communication between professionals and agencies is crucial to success,'² in safeguarding children.

A decrease in strategy discussions may be multifactorial, including the development of HAVEN provision, but community paediatric discussion is important in ensuring optimal information sharing.

A decline in the number of CPMA and SDI may reflect barriers in communication between agencies and this data has supported interagency training.

The additional finding of a strong correlation between CPMA and SDI may not be causal but reflects general barriers in communication between Children's Social Care and Community Paediatrics.

Both the decline in CPMA and SDI as well as the correlation in the trends, merit further evaluation locally and may be relevant for other child protection services.

REFERENCES

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G154(P) HOW TO TEACH PAEDIATRIC SAFEGUARDING TO TRAINEE PHYSICIAN ASSOCIATES

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10.1136/archdischild-2018-rcpch.150

Introduction Physician Associates (PA's) are becoming an important part of the healthcare professional workforce. They are exposed to paediatric patients in primary and secondary care, and need to have a working knowledge of recognising suspected non-accidental injury, and the appropriate steps to take in managing these children. It is a core competency in their training. There is no guidance in place to assist in achieving this competency or ensure they are adequately trained in this area. Formal training was developed to rectify this.

Aims To effectively teach safeguarding principles in children to PA's. To ensure PA's are confident in recognising non-accidental injury as a possible diagnosis. To teach the management of any suspect NAI, including the safeguarding referral process.

Methods Interactive learning session through case explanations, group discussion and guidance.

Results Good engagement in session and learning objectives achieved.

Conclusions Serious case reviews and specific examples of injuries generated interactive discussions and provided a practical application to safeguarding guidance and legal frameworks: students acknowledged the relevance and importance of training, including responding if they suspect NAI and other safeguarding concerns. PA training needs to develop to ensure consistency of child protection teaching and include all forms of abuse and not NAI specific.

G155(P) MORE THAN A BREAK: THE IMPACT OF CHANGING LOCAL SKELETAL SURVEY POLICY

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10.1136/archdischild-2018-rcpch.151

Aims Given variations in practice, Wood *et al.* (2014) proposed criteria for undertaking a skeletal survey in children under two presenting with a fracture.

We incorporated these criteria into our local hospital policy for performing skeletal survey. This study aimed to establish the impact of the new guidelines on the number of skeletal surveys performed and the yield of occult fractures.

Methods We conducted a retrospective casenote review over two consecutive years: the year before the change in the skeletal survey guideline and the year following its implementation. We reviewed the electronic records of all children under two presenting to the Emergency Department with a fracture and cross-checked this with all skeletal surveys performed in this age group. Those with finger or toe fractures were excluded.

We recorded the child's age, the mechanism proposed and any delay in presentation. We noted the fracture type and whether a skeletal survey was, or should have been, performed. Any additional fractures were recorded. All records were reviewed by two researchers.

Results There were 108 records included: 64 before the policy change and 44 after. The children's mean age was 16 months (range 3 weeks to 23 months).

Before the policy change, 5/64 (8%) children underwent skeletal survey and 13/44 (30%) afterwards. There was 1/64 (2%) additional fractures identified prior to the change and 3/44 (7%) afterwards. There were four children before the policy

change who did not have a skeletal survey performed but would have qualified under the new guidelines.

Conclusions Implementing Wood's criteria increased the number of skeletal surveys performed threefold. Given the high yield of additional fractures found, we would encourage others to consider adopting this policy for skeletal survey in children under two to reduce the chance of missing occult fractures. Our experience demonstrates that such a policy is workable in a busy district general hospital.

G156(P) TOWARDS THE BARNAHUS (CHILD HOUSE) MULTI-AGENCY MODEL OF CARE FOR CHILD SEXUAL ABUSE: THE VALUE OF A FAMILY THERAPIST AND A YOUNG PERSON ADVOCATE

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10.1136/archdischild-2018-rcpch.152

Background Lack of appropriate support following sexual abuse can lead to long-term emotional, physical and social problems. The Child House will be launched in 2018. As a first step, a Child/Young Person Advocate (CA) and a Family Therapist (FT) joined the Paediatrician in an established clinic for the assessment of historic child sexual abuse.

Objectives To determine the value of integrated psychosocial and advocacy services in the clinic.

Method A retrospective review of notes for 20 patients before integration (BI), compared with 22 patients after integration (AI) was carried out. Outcome measures included emotional and behavioural needs and referrals.

Results In the BI versus AI cohort, 8 (40%) had emotional problems and 3 (15%) were in police proceedings versus 12 (55%) and 3 (13%) respectively.

Only two patients were referred to their local Mental Health Service before integration.

In the AI cohort, 10 patients had the FT in the paediatric consultation and one had a further appointment in a week, five in two or more weeks and four were referred to another FT for psychological support. Two made a new disclosure in the clinic and were referred to social care.

Six patients had the CA present at the paediatric consultation for support with the court process and one had an appointment later. One parent was referred for domestic violence support.

Conclusions This study showed having the FT and CA join the consultation provided 17 of 22 (78%) patients, immediate or early management for mental health needs and police proceedings. A multidisciplinary team supports the varied needs of our patients and is at the centre of the Barnahus model. Future research will review the child and parent opinion about this model and also the outcomes for the child.

G157(P) THE SIGNIFICANCE OF INJURY COMBINATIONS IN CHILDREN REFERRED FOR A FORENSIC MEDICAL EXAMINATION

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10.1136/archdischild-2018-rcpch.153

Objectives The significance of *injuries in combination* in physical child abuse is generally not well documented. This study investigated whether the presence of multiple injury types is suggestive of abuse, and considered whether *external* injuries can predict *internal* ones.

Methods Records of paediatric forensic medical examinations from 2011 to mid-2016 were retrospectively reviewed. Details of injuries were recorded, including type, number, and location. Additional cases involving fractures were identified from 2009–2010 records. Cases were classified as 'abuse', 'accidental' or 'inconclusive', and data compared.

Results Applying χ^2 testing, there was a statistically significant difference ($p < 0.05$) between the proportion of abused (66.04%) and accidentally injured (37.50%) children who had multiple types of 'standard' injury. Abused children were significantly more likely to have multiple injury types in the same body region than accidentally injured (52.83% vs 20.83%). The proportion of abused and accidentally injured children with co-existing bruises and abrasions did not differ significantly; however, abused children were significantly more likely to have spatially related bruises and abrasions.

Only 1/58 abusive fractures had overlying bruising; however, 7/9 abused children with fractures had bruising elsewhere. 2/2 children with accidental fractures had overlying swelling, compared to 2/9 abused (table 1).

Conclusions The presence of multiple injury types in children referred for forensic medicine examinations may suggest abuse, especially if at least one body region contains different injury types. However, these findings are not completely sensitive for, or specific to, abuse. *External* injuries appear to poorly predict *internal*.

Abstract G157(P) Table 1 Do injuries in combination discriminate between abuse and accident?

	Physical abuse (n=106)	Accidental injury (n=24)	Inconclusive (n=58)	P value: abuse vs accident	P value: abuse vs inconclusive	P value: accident vs inconclusive
Children with Multiple Injury Types (%)	70 (66.04)	9 (37.50)	35 (60.34)	0.010	0.468	0.059
Children with Multiple Injury Types (same body region) (%)	56 (52.83)	5 (20.83)	24 (41.38)	0.005	0.161	0.077
Children with Bruise and Abrasion (anywhere) (%)	61 (57.58)	9 (37.50)	29 (50.00)	0.075	0.353	0.302
Children with Bruise and Abrasion (same body region) (%)	47 (44.30)	5 (20.83)	21 (36.21)	0.034	0.312	0.173