

G158(P) IS THE CHILD PROTECTION MEDICAL EXAMINATION SYSTEM IN NEED OF EARLY INTERVENTION?

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Aims To analyse the referrals for Child Protection (CP) Medical Examinations for children from two urban boroughs, to improve the outcomes for their children at risk.

Methods All 75 CP Examinations completed from 1 January to 30 September 2017 were reviewed, to identify the source of the referral, the category of abuse suspected and alleged perpetrator, whether children were previously known to children's services, and whether unmet medical needs were highlighted.

Results Children's Services received 37 of the 75 referrals from schools, 12 from social workers holding existing cases, 9 from parents, 8 from police, 3 from the NSPCC, 2 each from Nurseries and Children's Centres, 1 each from a Hospice and a GP.

67 referrals for CP examinations related to suspected physical abuse, with father the alleged perpetrator in 35 cases, mother in 19, a carer in 3, another child in 2, and the perpetrator unknown in 8 cases. Marks had often faded prior to the examination.

8 referrals involved suspected neglect. Sexual abuse referrals are seen elsewhere.

47 children were previously known to Children's services, 23 with CP Plans, 6 as Children in Need, and in 18 cases, prior concerns regarding domestic violence, physical abuse, or school issues.

Unmet medical needs were identified in 34 cases, of which 14 related to development, including speech and language delay and autism, 13 to the need for CAMHS support, 3 each to chronic and acute medical conditions, and 1 to delayed immunisations.

Conclusions School teachers are key in receiving disclosures or identifying marks suggestive of physical abuse, with consequent increased vulnerability for children during holiday periods. A system for the prompt photographic recording of marks would be valuable.

With unmet medical needs identified in 45% of examinations, which were predominantly (89%) for suspected physical abuse, Designated Safeguarding Health Professionals should consider how to identify similar unmet medical needs in children referred to Children's Services for suspected neglect and emotional abuse, the majority of whom are not currently sent for CP medicals.

G159(P) USING SKELETAL SURVEYS TO INVESTIGATE SUSPECTED PHYSICAL ABUSE – ARE WE OVER-INVESTIGATING?

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Aims My audit aimed to establish if our department was upholding national guidelines on the use of skeletal surveys in child protection (CP) medicals. Specifically: performing skeletal surveys in suspected physical abuse under 2 years; documenting reasons not to if investigation not done; and performing

investigations within 72 hours for inpatients. I also used the data to assess rates of identifying undiagnosed fractures.

Methods I retrospectively reviewed case notes and radiology requests to establish how many children underwent skeletal surveys in the audit period, their ages, reason for and timeliness of investigation, and whether a fracture was identified. This was cross-referenced with a database of all CP medicals done in children under 2 years. In those who did not have a skeletal survey done, I assessed if there was documentation why not.

Results I identified 37 children under 2 years who had a CP medical done and three children over the age of 2 who had a skeletal survey performed. 21/37 under 2 years had skeletal surveys performed. In 20/21 (95.2%) cases the skeletal survey was performed because of suspicion of physical abuse. Of the 16 patients under 2 years who did not have skeletal surveys done, 13/16 (81.3%) had a clearly documented reason for not undertaking the investigation. 20/24 (83.3%) of skeletal surveys were done within 72 hours of request. Of the 24 skeletal surveys done, no fractures were found in 17/24 (70.8%), identified fractures were shown in 5/24 (20.8%), and 2/24 (8.3%) showed previously unidentified fractures. Both of the previously unidentified fractures were in patients under 1 year.

Conclusion My audit showed that our trust is upholding the RCPCH guidance by undertaking skeletal surveys in children under 2 with suspected physical abuse and documenting reasons not to investigate in most cases where we do not perform skeletal survey. However, these investigations are giving a low yield of undiagnosed fractures, which perhaps suggests we are subjecting more patients to radiation than is necessary. Is there scope for modifying the RCPCH advice on who should undergo skeletal surveys?

British Association for Community Child Health and Paediatric Educators' Special Interest Group

G160 ESTABLISHING A SPECIALIST CLINIC FOR CHILDREN WITH FASD

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Aim To establish a specialist clinic to streamline the diagnosis of children suspected of having FASD (Fetal Alcohol Spectrum Disorders).

Method There are several tools available for assessing children with FASD. The 4-digit code was chosen (Astley SJ et al), for a number of reasons including: comprehensive nature, the ability to express uncertainty, availability of photographic facial assessment. Photography was included as part of the assessment and a clinical photographer attended the clinic. The photographs were analysed using computerised analysis (fasdpn.org).

Criteria: children were accepted for referral from

- the One Stop Clinic – a clinic in Brighton for pregnant mothers with substance misuse, or

- when there was concern that a child's problems might be related to prenatal alcohol exposure.

Results 20 children were assessed in the first year.

8 children were diagnosed as having FASD. Other problems related to conditions such as attachment difficulties, ADHD and learning disability.

There were a small number of children where prenatal alcohol exposure was suspected but unknown, particularly following adoption.

Some children are still awaiting psychological assessment (due to maternity leave) before a diagnosis can be ascribed.

Conclusion It was possible to build in a specialist clinic without significant extra resources.

Additional resources required were a) software required for the facial analysis, and b) training in the use of the 4-digit code (available as an on-line module)

As the clinic developed, an increasing part of the clinic time was taken up with multidisciplinary discussion in 2 areas: what information was available at the time of referral, and what further information/assessments would be required which would be helpful in reaching a diagnosis, and in reaching consensus regarding the final diagnosis.

Informal feedback from teachers, social workers and carers has shown that they have found the clinic helpful and valuable. (formal feedback in progress).

The presence of a specific clinic dedicated to FASD helped provide a focus for referral concerns, develop and concentrate expertise among professionals, and allow ongoing collection of appropriate data.

G161

MULTI PROFESSIONAL WORKING TO DEVELOP A HEALTH OUTCOMES FRAMEWORK FOR CHILDREN IN CARE

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Aim The aim of our working group was to ensure the health outcome measures for Children in Care (CIC) reported by Providers were consistent, relevant and achievable. An objective of the framework was to be an accountable system, where the partners hold themselves to account through the framework, linked by a shared ambition.

Methods

- A service improvement forum was already in place following a long process of service mapping across social care, CIC health teams and CAMHS
- A workshop was held to establish what each service deemed important health outcomes. This was analysed and themes and specifics produced
- Members of the team met with the CIC Council to obtain their views about health outcomes and reporting
- Commissioners, Providers and Designated CIC professionals met to refine a document 'CIC health outcomes framework'

Results Themes from CIC Council meeting

- CIC like how personalised the health assessments are, and felt strongly that the information collected and used to inform planning of health services should be personalised and at an individual level
- CIC feel that health services seem more interested in physical health than mental health, but were clear that emotional health and wellbeing is an important issue; this can be difficult to uncover, so in-depth assessment, time and creative approaches are needed
- Access to health information when CIC reach adulthood is important

CIC health outcomes framework comprises of

- A 17 page document with 15 performance indicators – measured against standards, evidence, assurance, responsible agency

Conclusions

- National measures/indicators are focused on the timeliness of assessments. Local ambitions and outcomes aim to measure the extent to which we are benefiting the health of the children in our care
- There are multiple interdependencies in the CIC health system, with agencies reliant on others fulfilling their responsibilities. Local partnership of agencies could hold itself to account for its effectiveness in working together if the right outcomes were identified, and subscribed to by all parties
- There are challenges associated with having multiple organisations, including several NHS providers, in the CIC health system, particularly with regard to data collection and information sharing. Logistical and transactional challenges can be mitigated by strong and trusting relationships between partners, and a commitment to solution focused approaches

G162

EVIDENCE THAT AN IMMERSIVE VIRTUAL REALITY SCENARIO CAN BE USED TO TRAIN SAFEGUARDING TO DOCTORS IN PRIMARY CARE

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Introduction Most child protection will be seen in primary care but is often subtle.

Methods We invited GPs to undertake a medical consultation in a virtual reality 'cave'. We obtained ethical approval from UCL for this being a covert child safeguarding scenario: participants were informed that they were testing the use of Virtual Reality in GP consultation. We produced a simulated consultation using two avatars: Chris, who came for a medically challenging consultation, and his accompanying 6 year old son Tom. Safeguarding cues presented were either subtle or obvious. Chris was angry towards his son, refused to allow Tom to go to the toilet and appeared to swipe at him.

Results We recruited 63 GPs (26 male; 33 female) who ranged in age from 25 to 59 years and had worked between 1 and 36 years. Fourteen GPs failed to detect the safeguarding cues (3 in the obvious cue scenario and 13 in the subtle cue scenario). Analysis of the post scenario questionnaire provides useful information about the use of virtual reality in medical