

Trusts that do request feedback often employ multiple strategies to achieve this, with different members of the MDT using a combination of methods at various points in time. We can use their experience to help develop a standardized system in our own trust and using this feedback to improve the service we provide to children.

REFERENCE

1. Good practice service delivery standards for the management of children referred for child protection medical assessments, RCPCH

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AN AUDIT OF THE NORTH EAST LONDON CHILD SEXUAL ABUSE HUB AGAINST RCPCH CLINICAL & SERVICE STANDARDS BETWEEN 2019–2021

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Aims The North East London Child Sexual Abuse (CSA) Hub was established in April 2019 following a 2015 review by Goddard et al. This review – commissioned by NHS England and the Mayor's Office for Police and Crime – identified an unacceptable variability in service provision for children experiencing sexual abuse.¹ Consequently, multiple CSA hubs were created across London to provide a 'one-stop shop' for medical assessment, advocacy, and early emotional support for children and their families.

Since its creation, this hub has been audited annually. The second cycle aimed to:

- Analyse our patient demographics.
- Investigate whether the hub met the RCPCH quality standards.
- Compare the 2019–2020 cycle with current data to evaluate the impact of COVID-19.

Methods The service received 64 referrals in 2019–2020 and 51 in 2020–2021. Our exclusion criteria included non-CSA cases, cancellations, or cases that only required a referral to other services (see figure 1). Patient care records were used to collate:

- Demographic information from all CSA referrals (including cancellations).
- Compliance against the 11 RCPCH quality standards for the clinical evaluation of children who may have been sexually abused.² This data was collected for patients seen in clinic and was assessed using referral letters and clinic reports.

Results Most patients were aged between 1–9 years old. Over 80% of children across both years were female.

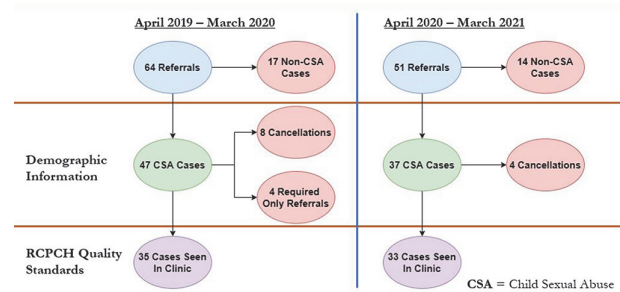
2020–2021 saw 13 fewer CSA referrals. Despite the pandemic, the hub continued to prioritise face-to-face assessments.

The RCPCH quality standards were well met. However, some areas of improvement were identified:

- Ideally, non-urgent CSA cases should be seen within 2 weeks of referral. This occurred in 34% of cases in 2019–2020 and 45% in 2020–2021. Hiring another doctor would reduce waiting times but requires additional funding.
- Play therapists supported 76% of appointments in 2020–2021. This requires improvement as therapists act as chaperones during assessments. Fortunately, funding has recently been approved for a dedicated play therapy team.
- There should be better documentation of the reasons why STI screening and/or psychological follow-up was not offered to many children (e.g. parental refusal). Therefore, we

have implemented dedicated sections for both in the clinic assessment proforma. Providing leaflets about psychological services may also help.

- Chain-of-evidence documentation was rarely completed. Performing appropriate documentation only for repeat STI samples might be more efficient. This remains compliant with BASHH guidelines, which state that positive samples must be repeated.³



Abstract 564 Figure 1 Methods

Conclusion The North East London CSA hub continued to adhere to RCPCH quality standards. Our recommendations focused on reducing waiting times, facilitating greater support from the play therapy team, amending the clinic assessment proforma, and improving awareness of psychological services. Our aim for 2021–2022 is to collect patient experience data to better understand our patients' needs.

REFERENCES

1. Review of pathway following sexual assault for children and young people in London (2015), Goddard et al.
2. Service specification for the clinical evaluation of children and young people who may have been sexually abused (2015), RCPCH.
3. BASHH National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People (2021), Ashby et al.

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INVESTIGATING NON-ACCIDENTAL INJURY – TIME FOR A SECOND LOOK?

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Aims Identifying child abuse and investigating suspected non-accidental injury remains a key responsibility for paediatricians. Guidance published in 2017 by the Royal College of Radiologists defines strategies for investigation. Previous literature found evidence of new fractures in up to 15.6% of repeat skeletal surveys,² however, the safeguarding team within our NHS Trust felt this did not reflect their experience. This study aimed to assess how often follow up skeletal surveys found additional evidence of non-accidental injury in paediatric patients across three hospitals, including one trauma centre, over a 5-year period.

Methods We used PACs to search for all skeletal surveys performed in an NHS Trust from January 2016 to September 2021. Patients over 16 years, or where some investigations occurred in another trust were excluded, leaving 198 patients, 88% less than 2 years old. Radiology reports and electronic patient notes were used to assess what investigations these patients had, and their results.

Results 198 cases were reviewed. In 79/198 (40%) the initial skeletal survey was negative. There were suspicious findings in 33/198 (17%) patients, 17 (9%) of which were ruled out as normal variants on the second skeletal survey, therefore identifying additional fractures in 16/198 (8%) patients.

Follow up skeletal surveys were performed in 131/198 patients (66%), this increased to 104/141 (74%) after new guidance in 2017. In 78 (60%) cases repeat surveys were performed within the recommended 11-14 days. Three follow up surveys showed new suspected fractures which were ruled out with plain film during another repeat survey a head swelling was clinically apparent. CT head showed a new skull fracture, however, as per protocol, this was not imaged in the follow up skeletal survey. Additional findings were identified in 2/131 (1.5%) secondary skeletal surveys: a radial head dislocation of uncertain significance, and rib fractures in a patient with previously described multiple rib fractures. The impact of these findings on safeguarding investigations is unclear.

Conclusion

Conclusion We found a significant reduction in additional findings on follow up skeletal surveys compared to the literature, with new findings described in 1.5% of second surveys. No new findings were found on second skeletal surveys where the initial survey was normal. The repeat survey was most useful to clarify if suspected abnormalities on the initial survey represented fractures. We note that as clinicians are following guidance to have a low threshold for initial and follow up skeletal surveys the proportion of children with non-accidental injury, and thus the detection of occult fractures, may have reduced. We also consider double reporting by paediatric radiologists may have contributed to improved detection of fractures in the initial survey.

We suggest further investigation into results of follow up skeletal surveys following the introduction of new guidance. If our results are mirrored in other paediatric settings, then a review of the guidance would be warranted. More targeted follow up imaging for equivocal fractures could reduce the burden of repeat skeletal surveys to children, their families and the NHS.

REFERENCE

1. Harper NS. 'The utility of follow-up skeletal surveys in child abuse'.

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DO WE DOT THE I'S AND CROSS THE T'S WHEN CONSENTING FOR SAFEGUARDING INVESTIGATIONS?

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Aims In 2018 the Royal College of Radiologists (RCR) published guidelines on radiological investigation of suspected physical abuse in children stating that written consent from a person with parental responsibility should be obtained by the referring clinician for all imaging of suspected physical abuse.¹ This recommendation was supported by the Royal College of Paediatrics and Child Health (RCPCH) within standard 3 and 10 of 'Good practice service delivery standards for the management of children referred for child protection medical assessments' 2020.² An audit was completed reviewing local practice with respect to consent for child protection investigations to see if local procedures adhered to the national

guidance on the consenting for the investigation of suspected physical abuse.

Methods Data was collected over a 20 month period (September 2019 - April 2021) regarding patients who underwent a skeletal survey in our trust, for suspected physical abuse. Patients were identified from our Radiology database and audited against the national guidance. Data on demographic profile, clinical presentation, results of skeletal survey, if they required other investigations and if they had written consent for skeletal survey and Computed Tomography scans of the head (CT scans), if clinically required, and if it was documented that they could withdraw consent as per RCR guidelines. Outcomes were collected from patient records.

Results In 20 months, 29 children underwent skeletal surveys for suspected physical abuse. The majority (97%) were younger than 2 years old, 55% being younger than 1 year old. 100% of cases were consented for skeletal survey. Out of the 15 children that required CT-scans only 1 had clear documentation that specific consent was obtained. 5 children did not attend their second skeletal survey, 2 cases were closed prior to the second scans. There was no documentation found within the notes that specified that parents can withdraw consent. 38% had documentation that leaflets (which include information about the procedures and radiation doses) were given.

Conclusion Consent for skeletal survey was performed in all cases however no documentation could be found in relation to advise regarding withdrawal of consent. Documented consent rates for CT-scans were low. These results were presented to the safeguarding and medical teams so that educational needs could be highlighted. Specific learning was targeted to ensure discussions about consent and consent withdrawal with parents is performed by managing clinicians. Safeguarding training encouraged the use of written consent forms for skeletal surveys to also be used for CT-scans and need to remain in the patient's notes. The radiology department was involved in the learning discussion and now require consent for CT-scans prior to the investigation. Information leaflets given to parents were redesigned to highlight that the legal guardians can withdraw consent. Child protection checklists usage was encouraged as they provide a prompt to ensure consent is documented and ensure clear documentation of the discussions that have occurred.

REFERENCES

1. The Radiological Investigation of Suspected Physical Abuse in Children, RCR, 2018.
2. Good Practice Service Delivery Standards for the Management of Children Referred for Child Protection Medical Assessments, RCPCH, 2020.

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DEBRIEF SESSIONS FOR STAFF INVOLVED IN CHILD SAFEGUARDING

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Aims The difficulties faced by health care professionals involved in child safeguarding can negatively impact their physical and mental health.² Literature research revealed that 'debrief sessions' have empirically improved mental wellbeing and performance.^{3,4} This project aimed to 1)