CC(3) DA42

National Public Health Service for Wales

Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru

Background Information on Child Protection Service (NPHS)

1 Purpose

This briefing paper has been prepared as background information to accompany evidence to the Committee Inquiry into Domestic Abuse. It covers the role, function and achievements of the All Wales Child Protection Service (CPS) National Public Health Service (NPHS).

2 Introduction

The NHS has had a statutory duty to protect children since the implementation of the Children Act 1989. This was discharged through the appointment of designated professionals and delivered through the Health Authorities. Since April 2003 this statutory duty passed to the Local Health Boards (LHBs).

The All Wales Child Protection Service was established in response to 'The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales', Too Serious a Thing', (NAfW 2002). In the review, Lord Carlile identified that the designated professionals' (Doctor and Nurse) role is functionally public health and recommended that this function be incorporated within the public health arrangements for Wales. The review also explicitly included the protection needs of Looked After Children within this role. The designated function has been acknowledged and reinforced in recent statutory guidance under The Children Act 2004.

The Child Protection Service, working within the NPHS, provides the strategic focus and professional resource for child protection and Looked After Children within the NHS. The Child Protection Service through its designated professionals and allied professionals work on behalf of the LHBs to ensure that the NHS statutory responsibilities for safeguarding children are met.

3 What We Do

The role of the CPS and in particular the Designated Doctor and Nurse function are outlined in detail in sections 2.97 to 2.103 of the statutory guidance 'Safeguarding Children: Working Together Under the Children Act 2004', (WAG 2006). Further reference is made in sections 2.112 to 2.119 (outlining the relationship with NHS Trust Named Professionals) and 10.20 (Serious Case Reviews). The full extracts are attached as *Appendix 1*.

The CPS provides advice and support to the LHB Chief Executive, Lead Director for Safeguarding Children and Board Members to meet their statutory responsibilities under the Children Acts 1989 and 2004. The designated function assists LHBs in discharging their responsibilities by ensuring among other things the following:

That the LHB:

- Identify a representative at an appropriate level of seniority (i.e. lead executive) to sit on the Local Safeguarding Children Board (LSCB).
- Ensure it has access to a Designated Doctor and Nurse appointed by the NPHS.
- Ensure the availability of advice and support to the LSCB via their Designated Doctor and Nurse appointed by the NPHS (the Designated Professionals are prescribed members of the LSCB).

The Designated Professionals support the LHB to discharge their statutory responsibilities as outlined in the MOU (NPHS, 2005). Services include the:

- Promotion of the protection of children whilst members of the LSCB.
- Development and participation in training programmes.
- Provision of expert advice.
- Completion of the health component of serious case reviews.
- Attendance at professional abuse strategy meetings which involve health staff .

In fulfilling these functions on behalf of the LHBs the designated professionals also support NHS Trusts including the Welsh Ambulance Service NHS Trust and NHS Direct to discharge their statutory responsibilities. Support is also extended to Health Commission Wales.

In order to provide an all Wales co-ordinated approach to the development and continuous improvement of services to safeguard children the CPS has increasingly been called on by the Welsh Assembly Government to provide advice and leadership. Particularly strong links have been made with the Children and Families division, Children First Team and SSIW. The CPS have been instrumental in assisting Welsh Assembly officials in developing statutory guidance, regulations and other policy documents in respect of Safeguarding Children, for example:

- Safeguarding Children Working: Together under the Children Act 2004.
- Towards a Stable Life and a Brighter Future.
- “Keeping Us Safe” Gwenda Thomas Review.
- Welsh Risk Pool Standard 39.

4 Significant Achievements

Since being established in 2003 the CPS includes the following among its significant achievements:

4.1 **Support for commissioning**

- Produced and developed Service Specifications for child protection and related services which have been adopted by LHBs to ensure that safeguards are in place when commissioning health services.

- Developed a children's safeguards framework which has been incorporated into Welsh Risk Pool Standard 39, the 'National Service Framework for Children, Young People and Maternity Service in Wales (NAfW 2005) and the 'All Wales Clinical Governance Self Assessment Tool for General Medical Practices' (NPHS 2007).

- Established a structure of regional health fora for child protection and "Looked After" children. This provides a national framework for communication across Wales.

4.2 **Serious Case Reviews**

- Conducted and written the independent health management reviews which forms a component of serious case reviews in Wales (currently 23 health reviews in progress).

- Developed a protocol for undertaking serious case reviews (health component). This provides a standardised approach across Wales.

4.3 **Development of a range of good practice guidance and protocols**

These are available on the CPS section of the NPHS web site and include, for example:

- Sudden Unexpected Death of an Infant (SUDI) Protocol.

- A guide for safeguarding children and young people in general practice.

- A guide for child protection arrangements in General Dental Practice.

4.4 **Child Protection Training:**

- Produced and developed a child protection training strategy for NHS organisations.

- Provided child protection training level 1 to 3 to GPs, other contractor professionals and their staff.

- Agreed and delivered a training contract on behalf of the post-graduate dental department at the University of Cardiff.

- Production of a CD Rom level 1 child protection training resource for pharmacists in conjunction with Welsh College of Postgraduate Pharmaceutical Education.

- Delivered and facilitated training in academic establishments, to the wider NHS and multi agency events and conferences.

APPENDIX 1

SAFEGUARDING CHILDREN: WORKING TOGETHER UNDER THE CHILDREN ACT 2004

Role of the LHB

2.97 LHB Chief Executives have the responsibility to ensure that the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole local health economy through the LHB commissioning arrangements.

- LHBs should work with local authorities to commission and provide services which are co-ordinated across agencies and integrated wherever possible.

- LHB Chief Executives may delegate this responsibility to a 'lead officer' and 'lead' member for children and young people's services in respect of the Board's functions under section 25 of the Children Act 2004 (Co-operation to improve well-being).

- The LHBs statutory duties include involvement in, and commitment to the work of the Local Safeguarding Children's Board (LSCBs) including representation on the board at an appropriate level of seniority i.e. lead executive.

- The LHB should ensure that it has access to a designated doctor and a designated nurse provided and appointed by the National Public Health Service.

- The LHB are responsible for providing and or ensuring the availability of advice and support to the LSCB via their designated doctor and nurse (NPHS) in respect to a range of health functions.

- The LHB must ensure that all health agencies with whom they have commissioning arrangements have links with a specific LSCB and that agencies work in partnership in accordance with their agreed LSCB annual business plan and children's plan.

- LHBs should ensure all health providers from whom they commission services have comprehensive single and multi-agency policies and procedures to safeguard and promote the welfare of children which are in line with and informed by LSCB procedures and are easily accessible for all levels of staff within each organisation.

- LHBs should ensure that all health staff including independent contractor services are alert to the possibility of child abuse or neglect, have knowledge of, and comply with, local and national procedures and know how to contact the named and designated professionals.

- LHBs in their commissioning arrangements should ensure that health staff have access to paediatricians trained in examining, identifying and assessing children and young people who may be experiencing abuse or neglect, and the local arrangements include having all the necessary equipment and staff expertise for undertaking forensic medical examinations.

- LHBs will be able to develop partnership arrangements to commission services in Sexual Assault Referral Centres (SARCs) including services for children and young people, for victims of rape and sexual assault. SARCs will provide forensic, medical and counselling services involving specialist health input.

- LHBs as commissioners are responsible with their local authority partners for commissioning integrated services to respond to the assessed needs of children and young people and their families where a child has been or is at risk of being abused or neglected.

- LHBs will have service specifications which include clear service standards for safeguarding children and promoting their welfare and are consistent with child protection procedures. These service specifications should be applied throughout the health care commissioning process.

- LHBs should ensure, through their contracting arrangements, that the independent sector providers deliver services that are in line with LHB obligations with respect to safeguarding and promoting the welfare of children. LHBs will need to work with those independent providers to ensure suitable links are made to the LSCBs and that the provider is aware of LSCB procedures (All Wales Child Protection Procedures) and policies.

- LHBs are responsible for commissioning and co-ordinating the health component of serious case reviews via the designated professionals.

Child Protection Service/National Public Health Service (CPS/NPHS)

The CPS/NHS, through its designated professionals, provides the professional lead LHBs on the NHS contribution to safeguarding children. Each LHB has access to a designated doctor and nurse and support professionals through the NPHS and it is through these professionals that LHBs are able to discharge their statutory responsibilities as identified above. The designated professionals work closely with named professionals in Trusts and will be part of the health service representation on Local Safeguarding Children's Boards (LSCBs). They will play an important role in promoting the protection of children and young people through membership of LSCBs, developing and participating in training programmes, the provision of expert advice and the completion of the health component of serious case reviews. The designated professionals are accessible to LHBs, NHS Trusts, local authorities and other partner

agencies, including the independent and voluntary sector and the police, for the provision of expert advice and support.

Designated Professionals

2.99 All LHBs should have access to a designated doctor and designated nurse who work within the NPHS to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the LHB area.

2.100 The designated doctor will be an experienced senior paediatrician with appropriate and current expertise in safeguarding children. The designated nurse will be an experienced senior Specialist Community Public Health Nurse with relevant experience in safeguarding children.

2.101 Designated professionals take an overarching responsibility across the LHB area including all providers. They are an important source of professional advice on child protection/safeguarding matters to local authority social services departments, LHBs, NHS Trusts, Health Commission Wales, NHS Direct and the Welsh Ambulance Service. They also provide advice to all partner agencies and the voluntary sector. Designated professionals will provide advice and support to the named professionals in each provider Trust.

2.102 Designated professionals also provide skilled professional involvement in child protection processes in line with LSCB procedures and play an important role in promoting, influencing and developing policy and procedures at a national and local level. Acting on behalf of the LHB they will lead on the health component of serious case reviews.

2.103 Appointment as a designated professional does not, in itself, signify responsibility personally for providing a clinical service for child protection. This should be the subject of separate agreements with relevant Trusts.

Clarification of arrangements/communication between designated and named professionals

2.112 The designated professionals will liaise with each Trust through the named professionals for child protection identified by each Trust.

2.113 The named professionals will work and liaise with the designated professionals to ensure the delivery of a consistent and effective health response to safeguarding children.

2.114 The designated professionals must work with named professionals in each Trust to establish clear lines of communication within and between different Trusts and other health providers.

2.115 In a Serious Case Review the named professionals will work with the designated professionals, who have the overall responsibility on behalf of the LHB.

2.116 Named professionals should liaise with the designated professionals and seek their involvement in matters which may have implications beyond the Trust. These may include:

- Allegations of professional abuse involving a health employee (where the designated professional will represent the LHB as commissioner);
- Serious cases of child abuse and neglect;
- Allegations, suspicions or concerns about practice that may impact on safeguarding children.

Arrangements for supervision and support

2.117 The named professionals will be responsible and accountable within the managerial framework of their employing Trust. They will also carry the usual professional responsibility for their professional bodies.

2.118 Trusts should ensure that there are clear arrangements in place for the supervision and support of named professionals. This will need to be provided at an appropriately senior and knowledgeable level either within the Trust or by the designated professionals.

2.119 Where necessary, the named professional will seek guidance and advice from the designated professionals.

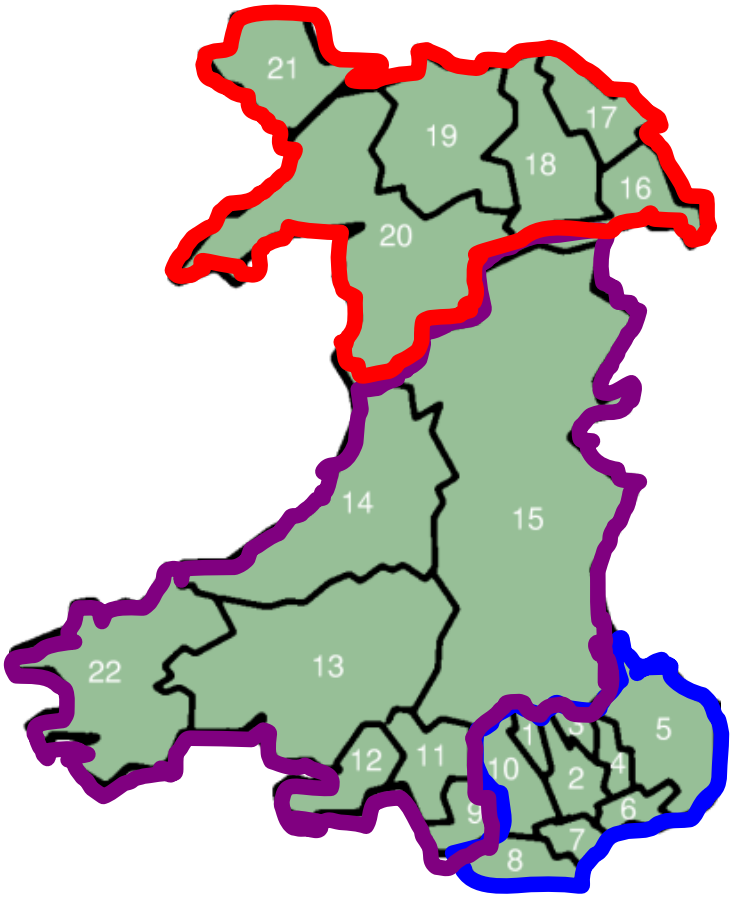
Who should conduct reviews?

10.20 Each relevant service should undertake a separate agency review of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a review, and even sooner if a case gives rise to concerns within the individual agency. Relevant independent professionals (including GPs) should contribute reports of their involvement. Designated professionals should review and evaluate the practice of all involved health professionals and providers within a Local Health Board area. This may involve reviewing the involvement of individual practitioners and Trusts and also advising named professionals and managers who are compiling reports for

the review. Designated professionals have an important role in providing guidance on how to balance confidentiality and disclosure issues.

APPENDIX 2

ALL WALES NHS CHILD PROTECTION SERVICE (CPS) GROUP



North Wales Region

NPHS Professionals

Designated Doctor Child Protection: Dr Carys Graham
Designated Nurse Child Protection: Mrs Janet Williams
Primary Care Training Facilitator: Mrs Kate McDonald
Children's Safeguards Development Manager – with All Wales Remit: Mrs Anne Eccles

Local Heath Boards

Conwy (19)
Denbighshire (18)
Flintshire (17)
Gwynedd (20)
Wrexham (16)
Ynys Mon (21)

Local Safeguarding Children Boards

Conwy: Chair – Ms Sue Maskell
Denbighshire: Chair – Ms Nicola Francis
Flintshire: - Chair – Ms Susan Lewis
Gwynedd: Chair – Mr Iwan Trefor Jones
Wrexham: Chair – Mr Bob MacLaren
Ynys Mon: Chair – Mr Richard Parry Jones

Mid and West Wales Region

NPHS Professionals

Designated Doctor Child Protection: Dr Jane Watkeys
Designated Doctor Child Protection: Dr Alison Maddocks
Designated Nurse Child Protection: Mrs Janet Evans
Designated Nurse Child Protection: Ms Dilys Calder
Child Protection Training Facilitator/Development Worker: Mrs Gloria Smith
Local Health Board children's Safeguards Advisor: Mrs Janet Morgan

Local Heath Boards

Bridgend (9)
Carmathenshire (13)
Ceredigion (14)
Neath Port Talbot (11)
Pembrokeshire (22)
Powys (15)
Swansea (12)

Local Safeguarding Children Boards

Bridgend: Chair – Ms Hilary Anthony
Carmarthenshire: Chair – Mr Vernon Morgan
Ceredigion: Chair – Mr Parry Davies
Neath Port Talbot: Chair - Mr Colin Preece
Pembrokeshire: Chair - Mr David Halse
Powys: Chair – Mr Philip Robson
Swansea: Chair – Mr Mark Roszkowski

South East Wales Region

NPHS Professionals

Designated Doctor Child Protection: Dr Hywel Williams
Designated Doctor Child Protection: Dr Aideen Naughton
Designated Nurse Child Protection: Mrs Caroline Jones
Designated Nurse Child Protection: Ms Lin Slater
Child Protection Training Facilitator/Development Worker: Mr Kevin Hogan

Local Heath Boards

Blaenau Gwent (3)
Caerphilly (2)
Cardiff (7)
Merthyr Tydfil (1)
Monmouthshire (5)
Newport (6)
Rhondda Cynon Taff (10)
Torfaen (4)
Vale of Glamorgan (8)

Local Safeguarding Children Boards

Blaenau Gwent: Chair – Mr Phil Hodgson
Caerphilly: Chair – Mr Joe Howsam
Cardiff: Chair – Ms Maria Michael
Merthyr Tydfil: Chair – Mr Leighton Rees
Monmouthshire: Chair – Mr John Waters
Newport: Chair - Ms Sharon Davies
Rhondda Cynon Taff: Chair – Ms Christine Walby
Torfaen: Chair – Mr Keith Rutherford
Vale of Glamorgan: Chair – Mr Mark Wheeler

National Public Health Service for Wales
Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru

REPORT ON THE STAKEHOLDER WORKSHOP

MEDICAL EXAMINATION FOR CHILDREN IN WALES WHO MAY HAVE BEEN SEXUALLY ABUSED

Author: Dr Cerilan Rogers, National Director, National Public Health Service
Dr Aideen Naughton, Designated Doctor, Child Protection Service, National Public Health Service

Date: 28 March 2008	**Version:**

Status: Final

Intended Audience: Workshop participants / Welsh Assembly Government / NPHS Wales (Intranet) / NPHS (Intranet) / Police Authorities / Local Authorities

Purpose and Summary of Document:

The purpose of the document is to record the proceedings and conclusions of the stakeholder workshop held on 21st February 2008 and to make recommendations to

progress these.

The document summarises the methodology adopted during the workshop, the information and issues considered and the feedback received from the breakout sessions.

Publication/Distribution:

- NHS Intranet
- Hard copy to others as outlined above

INTRODUCTION

The purpose of the stakeholder workshop was to consider:

- the current medical examination services for children in Wales who may have been sexually abused
- what the appropriate service response should be
- how it could be achieved

The following sectors were represented:

- NHS Trusts
- Local Health Boards
- Local Authorities
- Welsh Assembly Government
- Police Authorities
- National Public Health Service for Wales
- Children's Commissioner
- Voluntary Sector

A list of attendees is given as Appendix 1.

METHODOLOGY

The methodology used in the workshop was intended to ensure maximum participation and elicit common themes, areas of agreement/dissension and recommendations for action.

An outline of the programme is provided at Appendix 2. The necessary background information to inform discussion was provided via a presentation by Dr Aideen Naughton (Appendix 3) and a NPHS discussion paper (Appendix 4). Three facilitated breakout sessions were conducted.

Dr Naughton's presentation included the questions for group 1.

Feedback from all groups was received following each breakout session.

The breakout sessions were as follows:

A. Breakout session 1

Participants were asked to consider the questions raised by Dr Naughton's presentation, to identify the main areas of agreement/dissension. The questions and a summary of the responses were as follows:

Question 1: Are these figures a reasonable working assumption?

There was general agreement that data collection is a problem and that there is a need to factor in a possible increase in demand as the service improves. Therefore with the range 200-2000, the lower figure is likely to be an underestimate, but not all cases will come to the attention of the statutory services. It was suggested that a figure in the region of 500 is considered across Wales.

Question 2: Do you agree with the case definition being any child who has been referred to police /social services in relation to child sexual abuse?

The case definition should be widened to include cases referred to health for an assessment or opinion as well.

Question 3: Are there any other needs?

There was general agreement with the broad headings, but greater emphasis is needed on social (including cultural and spiritual), educational and psychological needs. The needs of

other children linked to the index case should be considered and the needs of child perpetrators should not be overlooked.

Questions 4: Should there be a cut off in the age group of children seen by this service? If yes, should this be

- *Under 16?*
- *Under 13?*

The majority view was that the service should be provided for all children and young people up to the age of 16.However there should be a flexible approach that allows the service to respond to the needs of young people in the 16-18 year age group with additional needs such as learning disability. The workforce and service needs to be structured so that the most appropriate professional can respond to the individual needs of a child.

Question5: Do you agree that 13 to 16 year olds can be assessed and treated in the adult SARC?

There was general agreement that this should only happen if there are no other facilities. However there was a 50:50 split as to whether this would be acceptable if there were appropriate child friendly/age appropriate, separate facilities provided for the adolescent group, colocated with the adult SARC.

Question 6: Do you agree that the service should address historic abuse as well as acute sexual abuse?

All groups were unanimous in the response that the service should address historic abuse as well.

Question 7: Who should be responsible for arranging ongoing care?

There were a variety of responses reflecting that it depends on the needs of the child. In general the examining doctor should be responsible for arranging care for any ongoing health

needs. Social services would be responsible for social care needs. Police would take responsibility for arranging victim support as part of the criminal justice investigation.

Question 8: Who should provide it? Examining doctor or locality paediatrician?

Many of the responses felt that this should depend on the wishes and particular needs of the child/young person. However the majority view was that this should be the locality paediatrician unless specifically refused by the child.

Question 9: Where should it be provided? Regional centre or local service?

The responses here suggested that a clear care pathway within a managed clinical network would allow for different aspects of the service to be delivered in different parts of Wales. The care pathway needs to take account of being locally responsive to child's needs, while avoiding the pitfall of the child missing out on the expertise and more specialist care available at the regional centre.

Question10: Do you agree that this list represents the required workforce? Any omissions or additions?

The following professionals were mentioned:

CAMHS (psychologist and psychiatrist), play therapists, children's rights officer, GUM services, gynaecologist, interpreters, education, voluntary sector (NSPCC, Barnardos, Women's Safety Unit)

Question 11: Do you agree that such staff should have wider responsibilities outside the service but devote sessions to the service?

The majority of responses agreed with the question, but raised the issue that the sessions devoted to the service needed to be part of the job plan for clinicians who should be accredited for this part of their work. There needs to be a balance of doing enough work to be competent and maintaining other interests.

Question 12: Should services for children be located alongside other secondary children's services?

Ideally the service would be part of a child protection suite on health premises. However many felt that what was the most important was that there were child friendly facilities with access to appropriate services on a hospital site.

Question 13: Should the service for adolescents be located in the same facility?

Adolescents should be offered the choice but could be seen in the same facility if it was designed appropriately.

Question 14: Should adolescents be seen in the SARC with appropriate separate young person facilities and clinical environment?

General agreement that this would be acceptable and could provide a choice for the adolescent.

Question 15: Should the service be available 24 hours a day every day?

Each region should have a centre, which can provide a service 24 hours a day every day. Agreement that this type of service may be needed for adolescents, but that child care is better planned for daytime hours. The police representatives in the groups clearly favoured a 24 hour facility because of concerns that acute evidence would otherwise be lost and cases would be unable to go to trial.

Question 16: Should there be a service available every day for a specified time in daytime hours?

Majority of responses favoured a service available in daytime hours every day of the year for a minimum of 4 hours.

B. Breakout session 2

Participants were organised into four groups, three "provider" groups based on geographical areas (South Wales, North Wales , Mid and West Wales) and one "commissioner" group, which included Local Health Boards, the Police and Welsh Assembly Government representatives. The provider groups were asked to consider:

- What have we got currently?
- Are there parts that are not safe?
- What would be the next few things that could make it better?
- Who do we think is responsible for taking it forward?

The responses have been summarised across Wales.

Questions raised:

- *What have we got currently?*

Service provision is very variable across the three regions in Wales. In North Wales there is a 24 hour service through daytime examination in 4 centres and an out of hours service provided by a six doctor rota. Mid and West Wales have no service in Powys or Ceredigion. Swansea has a 24/7 service on call currently dependent on 2 doctors and covers Pembrokeshire as well. Carmarthen adult SARC currently caters for children.

South East Wales has the greatest variety of service provision. Gwent has a daytime service only for children up to age of 13 but includes bank holidays. Adolescents are seen following acute sexual assaults in the adult SARC in Risca by Forensic Medical Examiners (FMEs). Cardiff and Vale provide a daytime service up to age of 16 and an on call rota to offer child protection advice. CSA examinations can be catered out of hours. Pontypridd and Rhondda try to provide a service for children up to age of 16 daytime and out of hours but is dependent on two doctors who also participate in acute general paediatric on call. In their absence the service is dependent on police FMEs. Merthyr Tydfil has a SARC where children receive counselling but are not examined. A daytime service is provided by one of two doctors (Named Doctor and a staff grade community paediatrician). Out of hours

acute cases are seen by the consultant paediatrician on call for general paediatrics (non specialist CSA) with an FME.

- *Are there parts that are not safe?*

None of the current services have identified clinical leadership. All areas have concerns that, even where it exists, the out of hours service is very fragile. Medical sustainability within the service is a major concern. There are issues of communication between all the agencies when dealing with non specialist components out of hours (Hospital Paediatricians, Non specialist police officers, Emergency Duty officers in Social Services). The service provision is non equitable. The service provision in hours (daytime Monday to Friday) is also a cause for concern as it has never been properly designed and commissioned. Many of the children are being seen by FMEs who lack the appropriate skills and competencies to undertake this specialised area of work. There are no adequate post abuse services.

- *What would be the next few things that could make it better?*

In South East Wales the non acute service could be combined between Gwent and Cardiff and Vale trusts. Doctors could be released from dedicated acute paediatric duties to provide the service when on call.

The Police and LHBs need to recognise what service is required and to come together regionally to agree how to commission the service, perhaps through developing a managed clinical network. Multi-agency training could be provided to the non specialist staff to improve the referral process for medical examinations.

- *Who do we think is responsible for taking it forward?*

LHBs and Police as Commissioners, together with CMO's office in WAG should provide leadership and appoint a clinical director to develop a managed clinical network. Trusts should take responsibility for the clinical director. A view was expressed that Health Commission Wales might be the appropriate health commissioner.

The commissioner group was asked to consider:

- *Who should set policy in this area?*

It was agreed that WAG should set policy. It was also considered important that this area was seen as a priority for development and action.

- *Who has the commissioning responsibility?*

It was felt that there was a joint responsibility between health and the police, with health having responsibility for most elements of the services for children. The interface between health and criminal justice has to be acknowledged and reflected in the commissioning process. Some elements of service would be the responsibility of social services.

- *Is an all Wales approach desirable?*

It was felt that there needed to be an all Wales framework and that a draft service specification would be helpful.

C. Breakout session 3

Participants were asked to consider recommendations for action, which are summarised in the conclusion to this report.

EVALUATION

The evaluation of the workshop was overall very positive. 54% of participants returned evaluation forms.

CONCLUSION

It was clear that there was consensus around much of the background information and the issues identified in the workshop sessions.

There was general agreement that:

1. The Welsh Assembly Government should set the policy direction for the service.
2. There is a joint commissioning responsibility between health and the police, with health having responsibility for most elements of the services for children.
3. There should be a more systematic and standardised approach to data collection.
4. Services and facilities need to be age appropriate and responsive to the needs of individuals.
5. Acute needs may require one mode of response, but ongoing needs must also be assessed and addressed.
6. SARC facilities could be part of the service response for some young people.
7. A managed clinical network i.e. services delivered in a specialist centre with other aspects that could be delivered locally as part of their managed clinical network, may provide an appropriate model for this service.
8. Clinical leadership will be required in any model adopted.
9. There is a need for all Wales approach to the issue and a draft service specification would be a useful first step (this could encompass points 4-8).
10. Consideration should be given to including this service as a future NHS AOF target.

RECOMMENDATIONS

In order to progress this issue, it is recommended that:

- WAG should issue guidance on the commissioning responsibilities for this service.
- NPHS be requested to produce a draft service specification and a proposal for improving data collection by the end of August 2008.
- A multiagency Task and Finish Group be set up to oversee the implementation of the draft service specification.
- The provision of this service be included as a target the performance management framework.

APPENDIX 1

ATTENDANCE LIST

SURNAME	FIRSTNAME	TITLE	ORGANISATION
Bowler	Ian	Senior Consultant	Gwent Healthcare NHS Trust
Brown	Linda		Gwent Healthcare NHS Trust
Burns	Mike		WAG
Cawley	Mike	Team Leader	Merthyr Council
Davies	Diane	Detective Inspector	Dyfed Powys Police
Dew	Martin	Detective Inspector	Gwent Police
Dixon	Lawrence		North East Wales NHS Trust
Ellaway	Kathy	Names Nurse Child Protection	Cardiff & Vale NHS Trust
Fletcher	Alex	Solicitor	Newport City Council
Gallagher	Elizabeth	Head of Partnership Working	Pontypridd & Rhondda NHS Trust

SURNAME	FIRSTNAME	TITLE	ORGANISATION
Galluccio	Pauline	Head of Safeguarding Children's Service / Named Nurse	Powys LHB
Greenacre	Judith	NPHS	Regional Director and Director of Health Intelligence
Groves	Lindsay		Conwy Child Protection
Harrison	Ruth		Ceredigion NHS Trust
Hayes	Steve	Safeguarding Children Coordinator	Swansea Social Services
Horn	Janet	Consultant Paediatrician	North Wales
Horrocks	Sarah		Conwy & Denbighshire NHS Trust
Hussein	Duraid	Consultant Paediatrician	Mid Wales NHS Trust
Jenkins	Ann	Acting Service Manager	Merthyr Council
Jones	Annette	Team Manager	Ceredigion Social Services
Jones	Martyn	Detective Superintendent	South Wales Police
Kinsey	Laura		Bridgend CBC
Law	Aileen	Child Protection coordinator	Flintshire CC

SURNAME	FIRSTNAME	TITLE	ORGANISATION
Lloyd	Rhiannon	Principal Practitioner Duty and Assessment Team	Social Services Conwy CBC
Ludlow	Jane		WAG
McNulty	Bridie		Newport LHB
Millar Jones	Lynne		Royal Glamorgan Hospital
Mott	Alison		Cardiff & Vale NHS Trust
Naughton	Aideen		NPHS
Obaid	Mathew	Consultant Paediatrician	Princess of Wales Hospital, Bridgend
Owen	Gwyneth	Officer for Wales	Royal College of Paediatric and Child Health
Price	Lorna	Associate Specialist Community Paediatrician	Swansea NHS Trust
Randall	Jane	Named Nurse - Child Protection	Pontypridd & Rhondda NHS Trust
Rawlinson	Alice		Gwent Healthcare NHS Trust
Picton	June		Pembrokeshire LHB

SURNAME	FIRSTNAME	TITLE	ORGANISATION
Quartermaine	Josie		South Wales Police
Richards	Elaine		Children's Commissioner for Wales
Roberts	Liz		Flintshire CC
Roberts	Lynne	Team Manager	Denbighshire CC
Rogers	Cerilan	National Director	NPHS for Wales
Scourfield	Ann	Public Protection Senior Nurse	Merthyr Tydfil LHB
Slatter	Anna		Welsh Assembly Government
Thomas	Gwil	Child Protection coordinator	North Wales Police
Walsh	Chris		Caerphilly LHB
Williams	Hywel		NPHS
Williams	Jan	Designated Nurse Child Protection	NPHS for Wales
Williams	Olwen	Consultant Genitourinary Physician	Wrexham Maelor Hospital
Woolley	Christopher	Consultant Paediatrician	N Glam Trust

SURNAME	FIRSTNAME	TITLE	ORGANISATION

APPENDIX 2

P R O G R A M M E

Thursday, 21 February 2008

Powys Suite, Metropole Hotel, Llandrindod Wells

(http://www.metropole.co.uk/index.php)

09h30-10h00	Refreshments and Registration	
10h00-10h15	Introduction	Cerilan Rogers
10h15-10h45	The Service Response	Aideen Naughton
10h45-11h30	Breakout session (1)	Groups A to F
11h30-12h00	Feedback	Group Facilitators (A to F)
12h00-13h00	**LUNCH**	

13h00-13h30	Breakout session (2) – Commissioner and Provider Perspectives	Groups 1 to 4
13h30-14h00	Feedback	Group Facilitators (1 to 4)
14h00-14h30	Breakout session (3)	Groups A to F
14h30-15h00	Feedback	Group Facilitators (A to F)
15h00-15h15	Closing remarks	Cerilan Rogers
15h15-15h30	Refreshments and depart	

Appendix 3

Sexual Abuse of Children and Young People in Wales - The Service Model

Dr Aideen Naughton
Designated Doctor
Child Protection Service NPHS

1

Guidance and Policy

- All Wales Child protection procedures (2003)
- NSF Children, Young People and Maternity Services (2005)
- Working Together to Safeguard Children under the Children Act 2004 (2006)
- RCPCH Child Protection Companion (2006)
- Cross Government Action Plan on Sexual Violence and Abuse (2007)
- RCPCH Guidance on Paediatric Forensic Examinations in relation to possible CSA(2008)

2

Definition

'Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities,whether or not the child is aware of what is happening.The activities may involve physical contact,including penetrative and non-penetrative acts.They may include non-contact activities,such as involving children in looking at,or in the production of, pornographic material or in watching sexual activities, or encouraging children to behave in sexually inappropriate ways.' AWCPP

3

What do we know about CSA?

- Age: most prevalent 5-14 yrs
- Multiple abuse: 33% abused by more than one abuser,60% repeatedly
- Family violence: CSA more likely
- LAC: of children involved in prostitution, LAC become involved 3 years earlier.
- Runaways: 21% abused whilst missing

4

Prevalence

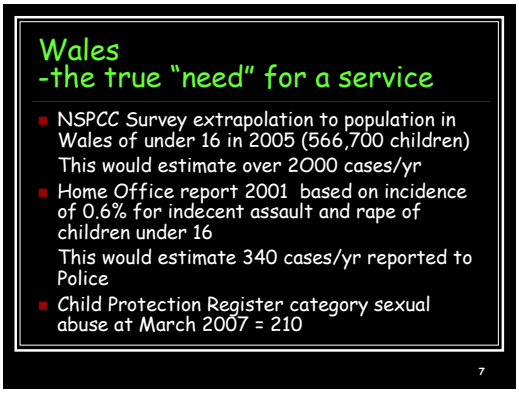
Type of sexual violence	Female	Male	Source and location of study
CSA (all forms and contact sexual abuse)	21% all forms 16% contact	11% all forms 7% contact	Cawson 2000 NSPCC
Sexual assault (16-59 yr olds experienced)	Sex assault: 23% (2.8% in last year)	Sex assault: 3% (0.6% in last year)	Finney, British Crime Survey,2004/5
Rape (16-59 yr olds experienced)	Rape: 5%	Rape: 0.4%	Finney, British Crime Survey,2004/5

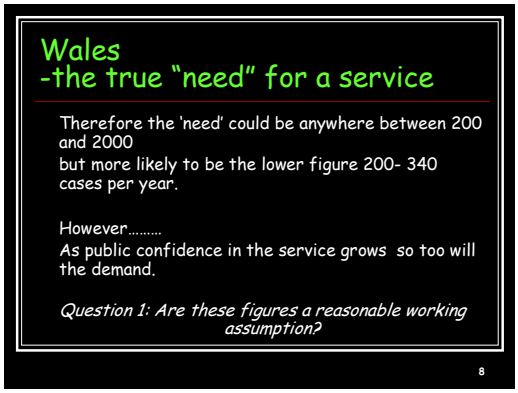
5

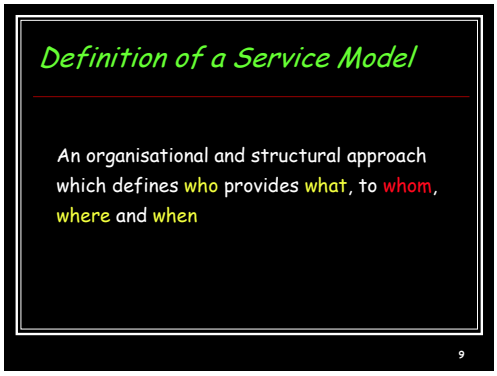
Prevalence in Wales

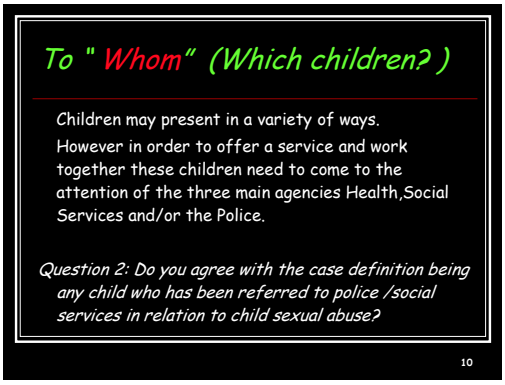
- No centralized database
- Data not collected in a uniform way or shared between organisations
- Data on Medical examinations underestimate the problem
- Police data do not record offence by age

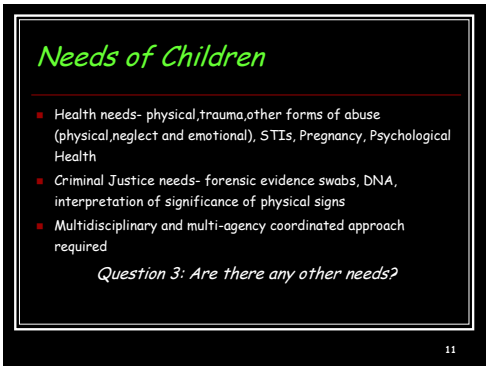
6

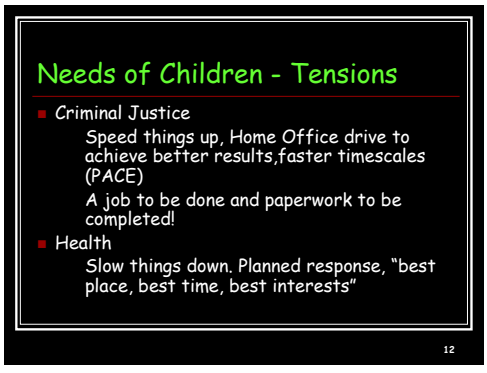

Wales
-the true "need" for a service
NSPCC Survey extrapolation to population in Wales of under 16 in 2005 (566,700 children)
This would estimate over 2000 cases/yr
Home Office report 2001 based on incidence of 0.6% for indecent assault and rape of children under 16
This would estimate 340 cases/yr reported to Police
Child Protection Register category sexual abuse at March 2007 = 210
7


Wales
-the true "need" for a service
Therefore the 'need' could be anywhere between 200 and 2000
but more likely to be the lower figure 200- 340 cases per year.
However.....
As public confidence in the service grows so too will the demand.
Question 1: Are these figures a reasonable working assumption?
8


Definition of a Service Model
An organisational and structural approach which defines who provides what, to whom, where and when
9


To " Whom" (Which children?)
Children may present in a variety of ways.
However in order to offer a service and work together these children need to come to the attention of the three main agencies Health,Social Services and/or the Police.
Question 2: Do you agree with the case definition being any child who has been referred to police /social services in relation to child sexual abuse?
10


Needs of Children
Health needs- physical,trauma,other forms of abuse (physical,neglect and emotional), STIs, Pregnancy, Psychological Health
Criminal Justice needs- forensic evidence swabs, DNA, interpretation of significance of physical signs
Multidisciplinary and multi-agency coordinated approach required
Question 3: Are there any other needs?
11


Needs of Children - Tensions
Criminal Justice
Speed things up, Home Office drive to achieve better results,faster timescales (PACE)
A job to be done and paperwork to be completed!
Health
Slow things down. Planned response, "best place, best time, best interests"
12

The 'What'

- Provision should be appropriate, adequate to meet the needs (population and individual), sufficiently funded, with the right number of right treatments / interventions at the right time with the right outcomes.

DH Draft Guidance for Commissioning Sexual Violence and Abuse Services (Children and Adults) 2008

13

The 'What'

First priority must be health and welfare of the child but forensic evidence collection takes place alongside

- Comprehensive health assessment (RCPCH 2007)
- Paediatric Forensic Examination (RCPCH 2007)

14

Comprehensive Health Assessment

- Physical development and emotional well being
- Family and social history
- Document injuries (genital/anal and other physical injuries)
- STI (screen,prohylaxis,treatment)
- Pregnancy (post coital contraception)
- Psychological/psychiatric sequelae

15

Paediatric Forensic Examination

- Colposcopy and photo documentation (still photographs,video,CD or DVD)
- Line drawings
- Forensic samples as indicated
- Contemporaneous comprehensive notes
- Statements/reports
- Plan ongoing care including re examination if indicated

16

The 'What'

Questions 4, 5 and 6?

Should there be a cut off in the age group of children seen by this service?

If yes, should this be

- *Under 16?*
- *Under 13?*

Do you agree that 13 to 16 year olds can be assessed and treated in the adult SARC?

Do you agree that the service should address historic abuse as well as acute sexual abuse?

17

The 'What'

Questions 7, 8 and 9 ?

Who should be responsible for arranging ongoing care?

Who should provide it? Examining doctor or locality paediatrician?

Where should it be provided? Regional centre or local service?

18

Single vs. Joint exams?

'Single……necessary skills, knowledge and experience for the particular case'

'Joint……..where doctors skills complement one another'

Paediatrician and Forensic Physician usually

But …..role for GUM Physician and Family Planning doctor?

19

Who provides? (The Workforce)

- Paediatricians
- Forensic physicians (SOEs,FMEs,police surgeons)
- Forensic nurse practitioners
- Counsellors
- Advocates (ISVA)
- Psychologist
- Children's Nurses (RSCN)

20

Who provides? (The Workforce)

- Clinical Director – leadership, clinical governance, audit, CPD and peer review
- Support staff-Administrator, secretaries, receptionist
- Social Workers
- Specialist Police officers

21

Who provides? (The Workforce)

Questions 10 and 11:

Do you agree that this list represents the required workforce ? Any omissions or additions?

Do you agree that such staff should have wider responsibilities outside the service but the devote sessions to the service?

22

The 'Where' - Key issues

- Exclusive and separate dedicated children's clinical environment.
- Service should be part of other secondary children's medical services and sited alongside.
- Single centralized service for critical mass.

23

The 'Where' - Key issues

- Hospital base allows ready access to further specialist health assessments and second opinions, inpatient facilities for selected children and investigations, e.g. radiology, biochemistry for complex cases.
- Privacy vital – clear boundary with shared OPD.

24

The 'Where' - Key issues

- Facility must be capable of being 'forensically cleaned' .
- Must have resources for evidence collection/storage e.g. laboratory specimens, photo-documentation, video recordings etc.
- Facilities for video interviewing by police and interviewing parents/carers.

25

The 'Where'

Questions 12, 13 and 14:

Should services for children be located alongside other secondary children's services ?

Should the service for adolescents be located in the same facility?

or

Should adolescents be seen in the SARC with appropriate separate young person facilities and clinical environment?

26

The 'When?

Questions 15 and 16:

Should the service be available 24 hours a day every day?

or

Should there be a service available every day for a specified time in daytime hours?

27

28

29

NOW IT IS OVER TO YOU!

Think about what level and quality of care sexually abused and assaulted children need and deserve.

30

Appendix 4

Medical examination services for children in Wales who may have been sexually abused:

Prevalence and service models

Contents

1 Purpose

This paper is presented to support discussion of the development of the sexual abuse medical examination services for children in Wales, by considering the following questions:

1.1 What is the number of children who may have been sexually abused and who may need a medical examination service in Wales?

1.2 What are the relevant policies and good practice guidelines for this service?

1.3 What service models exist and what is the evidence of effectiveness of those models?

2 Summary

Conclusions

There is a need for high quality services for children who may have been sexually abused, and their families, across Wales.

The numbers of children who may benefit from a service and their characteristics are difficult to find from routinely available data and hence the true need is difficult to establish.

The needs are both therapeutic and forensic and there are UK and Wales statutory duties and guidelines on how to meet these needs.

There is evidence that current service models in the UK as a whole do not meet the standards set by professional consensus on good practice.

There are potential service models for providing more integrated or co-located services but evidence for their effectiveness is limited.

The UK model based on SARCs is not specifically child focussed but the integrated model shows more compliance with good practice and is highly rated by service users.

The US Child Advocacy Centre model is more child focussed and has evidence of some outcome improvements relative to standard US services. These may not be transferable to Wales.

There is not a national process in Wales for commissioning and providing medical services for the examination of children in whom there are concerns about sexual abuse.

Recommendations

There should be a central information database to collect information on children in whom there are concerns about sexual abuse who may benefit from medical examination services.

The central database should be contributed to by all partner organisations using a commonly agreed dataset (see suggestions in Appendix 5).

The NPHS Child Protection Team should agree common good practice standards for the medical examination services in Wales and use these to lead an audit against these standards

The Welsh Assembly Government should consider issuing guidance on the commissioning responsibilities for the medical examination service for children in whom there are concerns about sexual abuse.

3 Background

3.1 Legislation

The Children Act 2004[1] placed the responsibility for ensuring the response of all partner organisations to concerns about sexual abuse in children with the Local Safeguarding Children Boards. These replaced the former Area Child Protection Committees in 2006.The objectives of a Local Safeguarding Children Board as required by the Act are:

- to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.

Section 28 of the Children Act 2004 (Arrangements to Safeguard and Promote Welfare) requires statutory agencies to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children. The arrangements in individual agencies are detailed in the guidance to Local Safeguarding Children Boards in Wales, which was issued by the Welsh Assembly Government in 2007. (Safeguarding Children: Working Together Under the Children Act 2004)

3.2 National Public Health Service (NPHS) Child Protection Service

The NPHS Child Protection Service has the purpose of advising and informing the Welsh Assembly Government, Local Health Boards and Trusts on setting standards, disseminating evidence, service specifications and monitoring[2] (see Appendix 1 for terms of reference)

It does not directly provide health services for child protection. It does have the role of ensuring that Local Health Board and NHS Trusts in Wales recognise their responsibilities to comply with Child Protection legislation and guidance.

Several, but not all, members of the NPHS Child Protection Service also have separate roles in that they provide medical examination services in their roles as employees of NHS Trusts.

3.3 Commissioning medical examination services

There is a variation in who commissions, funds and provides services in Wales and this is also the case across the UK. For instance, many services are funded and provided within the NHS but some are commissioned by the Police Service and provided by the NHS. In others there has been an outsourcing by the Police of forensic medical examination services to non-NHS providers.

In Wales, the Welsh Risk Pool Standard 39: Safeguarding the Welfare of Children, states in Assessment 6[3] that the resources for child protection should be identified within the NHS Trust. Trusts should have procedures for identifying and communicating the resources required and available for child protection but it is not clear whether this goes so far as providing forensic or even medical examination services.

There is some concern that services sometimes rely too much on the goodwill of individuals and may not be sustainable in the long term, particularly for out of hours cover (personal communication[4;5]).

Sir Liam Donaldson, the Chief Medical Officer for England has recently produced a consultation report[6] which reviews the use of medical expert witnesses within the family courts, and specifically in public law Children Act cases, and includes suggestions for commissioning these services. This is currently being consulted upon and may produce recommendations in the future that could affect commissioning models.

There is not an overall policy for Wales on how to commission this service or a model specification for Local Health Boards to use in commissioning it. In April 2007 HM Government in association with Association of Chief Police Officers, Crown Prosecution Service, Her Majesty's Court Service, National Offender Management Service, Voluntary and Community Sector published the Cross Government Action Plan on Sexual Violence and Abuse. This plan sets out the roles and responsibilities of key delivery agencies and partnerships including Local health Boards in Wales. Under key objective 2 (Increase support and health services for victims of sexual assault) it states that in 2007-08 it will publish guidance on the model of care for sexually abused children. This will include Sexual Assault Referral Centres (SARCs) that provide services for children.

4 Methods

A literature search was undertaken to identify current good practice guidance and to look for evidence of effectiveness of service models, as well as evidence of prevalence of sexual abuse in the population aged under 16. As this paper looks at service models and not clinical issues, the details of how to diagnose and assess sexual abuse have not been included.

Previous work on this topic undertaken by Dr Jane Watkeys on behalf of the NPHS was acknowledged. Dr Watkeys looked at referral patterns and numbers of children seen across Wales.

Local informants in Wales were contacted to establish the number of children who may require a medical examination service in Wales.

Further details are in Appendix 2

The data was requested from the National Public Health Service Child Protection team but was not available centrally. The routinely collected information was then requested from each Designated Doctor and from some of the Named doctors in individual Trusts. Three of the four Police Services responded to requests for information but were unable to provide any data for their areas as they do not record crime reports by age of the victim. It would have been impossible to contact all 22 Social Service Departments in the time available. It is also not possible to find out the age, gender or special needs of the children and young people seen (e.g. children or adolescents with learning difficulties or those who are looked after).

Appendix 3 shows a summary of data reported by designated doctors and some named doctors in Wales.

5 Definitions

5.1 Definition of sexual abuse

The All Wales Child Protection Procedures[7] uses the following definition:

“Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, or encouraging children to behave in sexually inappropriate ways”

In Wales, most children under the age of 13 for whom a medical examination is requested, will be seen by a paediatrician. Between the age of 13 and 16, young people may be seen by services for children or those for adult victims of sexual assault. Although this paper looks at services for the medical examination of children in Wales, these services also sometimes see children over the age of 16 if they have special needs, for instance with learning difficulties or who are looked after (personal communication[4])

5.2 Definition of a medical examination.

The All Wales Child Protection Procedures[8] state that: in every allegation of sexual abuse a medical examination should be considered, even if decided against, and that:

"The purpose of any medical examination or assessment is:

- To ensure the child's condition is medically assessed and treatment given as appropriate
- To re-assure the child as to his or her well-being
- To obtain an assessment about possible indications of abuse
- To ensure that any injuries or signs of neglect or abuse are noted for evidential purposes
- To secure forensic evidence. "

5.3 Definition of Service Model

For the purposes of this paper, a service model was taken to be an organisational and structural approach which defines who provides what, to whom, where and when.

5.4 Definitions of age to give consent to sexual activity

When a child or adult can be considered to be able to consent to any sexual activity is set out in the Sexual Offences Act 2003[9].

- **Aged under 13** Under the Sexual Offences Act 2003, children under the age of 13 are considered of insufficient age to give consent to sexual activity. The police must be notified as soon as possible when a criminal offence has been committed or is suspected of having been committed against a child unless there are exceptional reasons not to do so.
- **Aged 13 to 16** The Sexual Offences Act 2003 reinforces that, whilst mutually agreed, non-exploitative sexual activity between teenagers does take place and that often no harm comes from it, the age of consent should still remain at 16. This acknowledges that this group of young people is still vulnerable, even when they do not view themselves as such.
- **Aged 16 to 18** Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures under the Children Act 1989. Consideration still needs to be given to issues of sexual exploitation through prostitution and abuse of power. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. Young people over the age of 16 and under the age of 18 are not deemed able to give consent if the sexual activity is

with an adult in a position of trust or a family member as defined by the Sexual Offences Act 2003.

6 Need and demand for medical examination services

6.1 Surveys

The National Society for Prevention of Cruelty to Children (NSPCC) carried out a survey of 2,869 randomly chosen young adults (aged 18 to 24) from all over the UK, about their experiences of childhood[10]. There was a good response rate of 69%.This included very specific questions about experiences of sexual abuse, whether contact or non-contact, at any time throughout their childhood up to age 15.

Of those who had been aged 12 or under, or aged 13-15 but who had not consented to sexual experiences:

- 1% of the sample had been abused by parents/carers, almost all of this abuse involving physical contact
- 3% had been abused by other relatives
- 11% were abused by other known people
- 4% had been abused by strangers or someone just met

6% of the total sample considered they had been sexually abused, which is less than the above as some described sexual acts but did not consider them to have been abuse.

If we assume that every case is disclosed and we extrapolate this to the population under 16 of Wales, then every year an estimate of the true "need" for medical assessment could be said to apply for up to:

- 378 children who are sexually abused by a parent/ carer
- 1,133 children who are abused by other relatives
- 4,156 who are abused by other known people
- 2,267 children who for each year up to 16 will consider themselves to have been sexually abused when asked as adults in the future.

(In Wales, there were 566,700 children aged under 16 in 2005, which is 19.2% of the total population.[11]The survey asked for experiences when aged under 15; so this is an underestimate)

6.2 Police Crime statistics

The Police Crime Records do not record offences, even sexual offences, by the age of the victim, so that data is not routinely available. A Home Office report in 1997[12] carried out a small survey of offences recorded by the police between 1994 and 1997 in five forces chosen for their disparity: Gwent, Lancashire, Merseyside, the Metropolitan Police, and Northumbria. They found that, although in 1995 there were 3,957 offenders throughout England and Wales cautioned or convicted for sexual offences against children, there were in fact far more initial reports to the police: in 1996, for the five police force areas surveyed alone, there were 4,369

recorded sexual offences against children. (However, no denominator figure for the population concerned was given so it is not possible to calculate a rate and generalise the findings)

Another Home Office report[13] concludes from Police Crime Records that there is an incidence of 0.6% for indecent assault and rape of children under 16 per year

This would suggest 340 cases per year reported to the Police in Wales.

6.3 Local data

It was not possible to use the data provided by the Designated Doctors in Wales because of limitations in the way the data is collected and presented. (See Appendix 3)

The number of children in Wales who come into contact with health or social or police services because of a concern about sexual abuse and who may benefit from a medical examination service is therefore difficult to know, for the following reasons:

- there is no centralised database
- there is no agreed minimum dataset
- there is no agreed time period for collection
- data is collected by several organisations in different ways
- data is not routinely shared between organisations
- the Police Services are not able to extract information by age
- it is not clear whether some children are referred to services in England for medical examinations

6.4 Child Protection Registers

The numbers of children who are referred to police or Social Services every year are relatively low: for instance there were 216 children placed on Child Protection Registers (CPRs) in Wales in the year to March 2006, where a risk of sexual abuse was stated[14]. This would suggest a rate of 0.038 % (based on 2005 population).

Very few children who have been sexually abused are placed on the Register and not all those on the Register who are at risk will have been abused. Social services are not always involved in police investigations for alleged sexual abuse rendering the CPR a very insensitive indicator of the prevalence of sexual abuse.

6.5 Summary of need and demand

Therefore, the need could be estimated to be between approximately 200 to over 2000 per year, if we assume that every child under 16 who has been abused should be offered a medical examination.

However, the demand is better estimated as the number who may become known to police, health or social services and who should therefore be offered a medical examination. This is likely to be much nearer the lower figure of approximately 200 to 340 per year.

Some of these children will not benefit from, or agree to, a medical examination, so the true demand may be less than this.

The majority of children/young people can be seen during the working day; however there is a need for a responsive service so that when clinically indicated children who allege that they have been sexually abused can be seen within 24 hours of referral when the alleged incident is in the previous seven days. The evidence base for this is contained in a recent paper from Swansea (The Timing of medical examination following an allegation of sexual abuse. Is this an Emergency? Watkeys JM et al -2007 – submitted for publication).

7 Guidance and policy

In considering the framework for service provision, we need good practice guidelines which help in identifying the characteristics of a good quality service while leaving flexibility in the detail of how this can be delivered in each setting.

As stated previously, this paper looks at service models and not clinical issues so details of clinical guidance about diagnosis and assessment of sexual abuse have not been included.

Most studies found that less than 10% of medical examinations of children had abnormal findings (whether physical or forensic)[12] so that the weight of evidence is likely to rest on the results of interviews, with the child or others, rather than on the examination alone.

The main UK policy and guidance documents that have been used are:

- The All Wales Child Protection Procedures[15]
- The Children Act 2004[1]
- The Royal College of Paediatrics and Child Health Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse[16] (this will be replaced in 2008 with A Clinical handbook for Physical Signs of Child Sexual Abuse)
- The Welsh National Service Framework for Children, Young People and Maternity Services[17]
- The Royal College of Paediatrics and Child Health Child Protection Companion[18]
- Safeguarding Children : Working together Under the Children Act 2004. Welsh Assembly Government 2007 [19]

7.1 Standards

7.1.1 The Child Protection Companion[18] produced by the Royal College of Paediatrics and Child Health has detailed guidance on:

- the degree of urgency in examination
- location of the examination
- examination techniques
- the examining doctor – skills required and recommendation not to examine alone
- the need for photo documentation and forensic evidence gathering
- the need for investigations, treatment, referral and follow up

7.1.2 The Royal College of Paediatricians and Child Health and Association of Forensic Physicians have produced guidance on paediatric forensic examinations in relation to possible child sexual abuse [16], which outlines:

- the core skills, and the case dependent skills, of the examining physician.
- The desirability of facilities for photo documentation if there is a single examining doctor (for which there is specific guidance) but joint examinations are suggested if a single doctor does not have all the necessary skills.

7.1.3 The All Wales Child Protection Procedures[20] outline the minimum standards for children referred for medical examination under child protection procedures, which states that NHS Trusts should be able to respond to requests from police and social services and specify that:

- The examination should be carried out by a paediatrician and/or forensic medical examiner who meets set criteria
- If video/ photographic recording is available the examination can be done by one doctor but that the assistance of a second doctor or nurse is highly desirable.
- the service should be timely (as soon as possible, or if more than 6 days ago, the examination can be done at a convenient time for the child and doctor)
- physical examination should include developmental assessment , photo documentation and forensic samples
- there should be assessment of need for contraception, STI screening, treatment and referral.
- it should be in premises suitable for children
- there should be a high standard of record keeping

8 Service Models and evidence of their effectiveness

For the purposes of this paper, a service model is taken to be an organisational and structural approach which defines who provides what, to whom, where and when.

Currently, there is much variation in service models across the UK and elsewhere. There is little available evidence of evaluation of outcomes against good practice standards.

Medical examination services seem to have developed in response to local circumstances and there are few specified service models or commissioning frameworks in the literature. There is also not always a clear distinction between the forensic and the therapeutic requirements for a service.

Due to the heterogeneity of service provision, it is difficult to specify particular models, however, some of the commoner models referred to in the literature are:

- Multidisciplinary examiners in different locations with different sources of funding serving different age groups to different protocols with different 24 hour availabilities.

- Centres which co-locate many services for victims of sexual assault, primarily adults. There are Sexual Assault Referral Centres (SARCs) in the UK, and variations within this model. A similar model is provided in several states in Australia called Centres Against Sexual Assault (CASAs)

- Centres which co-locate many services but are only for child victims of abuse, whether sexual or other, for instance Child Advocacy Centres (CAC's) in the US

The evidence for effectiveness of these ways of providing the service is scanty, partly because of the heterogeneity of service provision and partly because of the difficulty in establishing outcome measures.

8.1 Commissioning models

There are variations in which organisations commission medical examination services and hence fund them and also which organisations provide the service and hence receive funding. The mechanisms for service specifications and for funding streams are variable.

In the UK, there are models which are funded by local Police Services or by the NHS through Trusts commissioned by Primary Care Organisations (PCOs). Police services are usually responsible for providing forensic medical examination services in cases of sexual offences, mostly using health professionals who have training in forensic medicine.

There is no evidence on whether differences in commissioning arrangements, rather than differences in service provision, have an effect on outcomes.

A suggested framework for outlining the requirements of a service according to generic principles in acute services specifications is provided in Appendix 4.

8.2 United States and Australia

8.2.1 Children's Advocacy Centres, United States.

A different approach has been taken in the US, which had also previously developed a multitude of services to meet the needs of children who may have been sexually abused. As the legal and social services and health care systems are all different, these models may not be generalisable to the UK. However, there may be useful ideas and evidence for general approaches.

The model has been to develop child focussed co-located services, so that children who may have been abused in any way are seen by a multi disciplinary team in a single location. There is a clear focus on combining therapeutic and forensic needs, with a the aim of integrating

both by professionals from social services, criminal justice and health working very closely together in a child friendly environment.

The first Children's Advocacy Centre was set up in 1985 by a District Attorney, Growth has been rapid, and there are now over 500, supported by an umbrella organisation, the National Children's Alliance[21].

Appendix 5 summarises the model. There is evidence[21] that the integrated and child focussed model advanced here can improve both therapeutic and forensic outcomes compared to standard child protection services in the US, for instance:

- 48% of children received a forensic medical examination compared to 21 %
- Team interviews were more common, 28% vs. 6%, reducing the total number of interviews.
- police were involved in 81% of child protection service investigations, compared to 52%
- patients and caregivers are more satisfied
- They provide a service to the wider community such as training for professionals, consultation to other agencies and community education.

8.2.2 Centres Against Sexual Assault, Australia.

Australia also has a federal government system with a multitude of variations in child protection legislation and guidance. However, a common service provision in several states is the Centre Against Sexual Assault[22] which provides acute service responses and ongoing support to child and adult victims. There are also separate Domestic Violence and Incest Resource Centres, which do not provide an acute or investigative service but have a remit which is largely about prevention and family support.

There is some emerging research about the effectiveness of service provision but there is little evidence easily available that could be used in the UK setting.

8.3 Current UK service provision

Pillai and Paul's report into the variations in facilities for complainants of sexual abuse in the UK in 2006[23] found:

- A robust service for 'acute child sexual assault' is virtually absent.
- many cannot provide a 24 hour service due to unavailability of medical examiners
- Inadequate numbers of forensic physicians are available for child examinations
- many have no facilities for photo documentation
- there was perceived to be a risk of contamination of evidence
- there was inadequate equipment

However, this report had only three returns from Wales, which the authors were unable to supply separately as the respondents did not respond to a request from them to do so.

The Royal College of Paediatrics and Child Health Standing Committee carried out a survey in 2006 of 383 Designated and Named doctors (response rate 41%) and to Forensic Medical Examiners[24]. They asked only about services for children. There were 10 responses from Wales, which again could not be analysed separately. Their conclusions were:

- the standards set out in the Joint Statement were not being met
- examinations are happening in many different locations, some of which are not appropriate
- some do not have access to a colposcope or screening for STDs
- about half had no formal out of hours rota
- there was a lack of peer review or support from a trusted colleague

8.4 Personnel performing examinations in the UK

There is wide variation in who provides the paediatric medical examination in all the service models, although there are standards for the core skills and competencies required (see 7.1) and it is clear that many such examinations in the UK are taking place outside a formal service model or commissioning framework and are relatively informal arrangements.

The personnel currently involved are[23;24]:

- Community and acute paediatricians, some with and some without forensic training.
- Forensic medical examiners, some without paediatric training or experience.
- Other doctors, sometimes with no paediatric or forensic training
- Several forensic nurses, a relatively recent development.

Examples of models of service provision in Wales include the following:

1. Sapphire Suite in Swansea
2. North Wales Model
3. Cardiff Children's SARC

Elsewhere in Wales the picture reflects the heterogeneity of service provision and personnel previously described. See appendix 6 for details on these models.

8.5 Sexual Assault Referral Centres (SARCs)

The main new development over the last few years in service organisation has been the setting up of Sexual Assault Referral Centres throughout the UK, based on Centres such as St Mary's in Manchester (started in 1986) and The Havens in London (started 2000). The lead has been taken by the Home Office and Department of Health jointly, for England and Wales and significant new funding has been made available for setting up new Centres.

National Service Guidelines were published in October 2005[25], and specified the minimum elements of the model (see Appendix 7)

Although all these elements would apply to services for children, they do not include child-specific guidelines. It could be said that post- pubertal or older children need similar services to adults. However, younger children have different needs and these guidelines do not address how to provide child focused services. There are increasing numbers of Sexual Assault Referral Centres, although these are by no means universal and do vary in the way they provide facilities and whether they include children at all. Some are limited to victims aged over 14 or over 16 but some see younger children.

There are also different ways of providing these – the "Integrated" model where examinations are provided on site and the "outsourced" model where examinations take place in other examination suites[26].

Evaluation of these models is as yet limited and almost non existent when services specifically for children are concerned. A Home Office research study in 2004[26] found some evidence that two SARCs with an integrated model displayed more consistently good practice and were more highly rated by service users. In comparison areas, less support was accessed and there were higher unmet needs. However, the study included few children and went on to suggest that there was a potential to increase reporting and develop more integrated models of forensic examination with respect to child abuse. Pillai and Paul[23] found that there were wide disparities in services for sexual assault victims in general, and that these were more marked between SARC and non-SARC services, with better facilities for forensic examination, photo documentation and more likelihood of a 24 hour service in the SARCs.

9 Conclusions

There is a need for high quality services for children who may have been sexually abused, and their families, across Wales.

The numbers of children who may benefit from a service and their characteristics are difficult to find from routinely available data and hence the true need is difficult to establish.

The needs are both therapeutic and forensic and there are UK and Wales statutory duties and guidelines on how to meet these needs.

There is evidence that current service models in the UK as a whole do not meet the standards set by professional consensus on good practice.

There are potential service models for providing more integrated or co-located services but evidence for their effectiveness is limited.

The UK model based on SARCs is not specifically child focussed but the integrated model shows more compliance with good practice and is highly rated by service users.

The US Child Advocacy Centre model is more child focussed and has evidence of some outcome improvements relative to standard US services. These may not be transferable to Wales.

There is not a national process in Wales for commissioning and providing medical services for the examination of children in whom there are concerns about sexual abuse.

10 Recommendations

10.1 There should be a central information database to collect information on children in whom there are concerns about sexual abuse who may benefit from medical examination services.

10.2 The central database should be contributed to by all partner organisations using a commonly agreed dataset (see suggestions in Appendix 8).

10.3 The NPHS Child Protection Team should agree common good practice standards for the medical examination services in Wales and use these to lead an audit against these standards

10.4 The Welsh Assembly Government should consider issuing guidance on the commissioning responsibilities for the medical examination service for children in whom there are concerns about sexual abuse.

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Appendix 1: Terms of Reference - NPHS Child Protection Service

Terms of reference -Child Protection (updated 21/10/05)

Terms of Reference

The group will form the core of the All Wales NHS Child Protection (Health) Service and will provide an official focus on Child Protection and Looked After Children within the NHS Wales.

Purpose

The service will take a strategic lead ensuring that the health service in Wales meets its obligations under the Children Act 1989 and 2004 and other relevant legislation, for Child Protection and Looked After Children. All designated professionals and support professionals will meet regularly to discuss and disseminate all new legislation and guidance in respect of Child Protection and Looked After Children. The service will advise and inform the Welsh Assembly Government, Local Health Boards, NHS Trusts, Welsh Ambulance Services NHS Trust, NHS Direct and Health Commission Wales on Child Protection service specifications for child health services. and lead on the implementation of recommendations made at a national and regional level. The service will be responsible for commissioning work through specific task subgroups.

Accountability

The service will be accountable to the director of the National Public Health Service (NPHS) through a regional director supported by a team co-ordinator and a professional lead who will ratify and oversee the implementation of any recommendations made. Administrative support to the service will be provided from the NPHS.

Structure

The service will meet quarterly for business meetings chaired by the regional DPH or team co-ordinator. In addition professionals will meet quarterly chaired by the professional lead. A Vice-chair will be elected from a member of the standing service. Professionals will also meet with the team co-ordinator twice per year for development days.

Membership

- Professionals with clear responsibilities for child protection i.e. designated professionals for child protection, (doctors and nurses) and support professionals. Representatives from the Welsh Assembly Government to attend Business component.
- Other representatives will be co-opted onto the service for specific issues as necessary-including

lead midwifery representative.

Responsibilities of Members

- To disseminate information to NHS Trust named professionals, Local Health Boards and other relevant agencies and back to the service as a two-way process.
- Members of the service will be involved in Task and Finish groups to which other professionals may be co-opted to provide a source of specialist advice and expertise.
- To undertake/manage Health Management reviews for Serious Case Reviews on behalf of the LHB when requested and other reviews as necessary.

Objectives

- Advisory
- Take the strategic lead for NHS Wales on child protection and Looked After Children in Welsh/UK/European guidelines and law.
- Inform Welsh policy.
- Set standards for child protection/LAC working at all levels.
- Develop necessary protocols.
- Act as a health service resource to partner agencies (joint working).
- Disseminate evidence based research outcomes to all professionals.
- Act as a source of advice in Child Protection/LAC to Local Health Boards/ACPCs, associated groups and all Health providers/commissioners.

Policy and Procedures

- Review as necessary the implementation and appropriateness of national policies and procedures with partner agencies.
- Act as an expert resource on health matters to the All Wales Child Protection Procedures Review group.
- Ensure appropriate representation on all groups that involve strategic input child protection/LAC.
- Develop national child protection/LAC specifications and standards for health providers/commissioners.
- Develop national standards for health services for Looked After Children.

Monitoring

Assist LHBs, HCW and WAG to:-

- Manage quality assurance and ensure that an effective system of audit is in place.
- Monitor agreed national standards for child protection and Looked After Children.
- Contribute to the production of health data on Children In Need and Looked After Children.

The service will be subject to continuous monitoring and functions may be subject to change when appropriate e.g. to reflect legislative changes.

Training

Provide an overview of training requirements in Child Protection/LAC. Organise higher level training on a national/regional basis. Advise and support local training. To be reviewed annually.

Appendix 2: Methodology

Review Questions:

What is the incidence and prevalence of child sexual abuse?

What are the models for service provision for the medical and forensic examination of children who may have been sexually abused?

What is the evidence of effectiveness for different models?

Search Strategy:

The key concepts were mapped on to MeSH terms, subject headings and keywords. The databases searched were: Medline, CINAHL, Cochrane database of Systematic Reviews, Cochrane Database of Reviews of Effects, HMIC, PsychINFO and Google Scholar. Searches were limited to English language, humans, and publication since 1996.

A search was also made of relevant UK and US and Australian sites: Royal College of Paediatrics and Child Health, National Society for the Prevention of Cruelty to Children (NSPCC), NPHS Child Protection Team web pages, Department of Health, Scottish Executive, Australian Government Department of Health and Ageing, The Faculty of Forensic and Legal Medicine, Home Office.

The questions were also asked via an electronic Public Health egroup (JISCmail)

National sources of data

Evidence from elsewhere was sought to try and establish the incidence and prevalence of sexual abuse. It is then possible to extrapolate incidence, prevalence and possible demand for services. Surveys, police crime statistics and child protection registers were looked for.

Local data

The routinely available data was examined for:

- The number of requests for medical examinations
- The number carried out per year in Wales.

Literature selection and retrieval: Documents were retrieved and examined and those not relevant were discarded.

Appendix 3: Table 1: Number of medical examinations of children with concerns of sexual abuse in Wales

		Cardiff and Vale (2006)	**North Wales** (Sept 2005-March 2006)	**Mid and West Wales** (2005)	**Gwent** (2005) Colposcopy clinic	**North Glamorgan** (Jan 04 – Dec 06)
Total seen		58	19 calls,11 seen (out of hours only)	109	36 (23% of all CSA referrals)	17 (13 girls 4 boys)
age	**<13**	76%	N/A	N/A	N/A	12 (6 under 5)
	13/14	17%				3
	15/16	4%				2
Place seen	**Police station**	2%	N/A		Colposcopy clinic 78% examined using colposcope	2 examined in New Pathways(SARC) – 13yrs, 16+yrs
	Children's centre	3%				
	Hospital site	95%				15
Day/time	**Regular clinic**	43%	Data only for o-o-h			
	Other in hours	26%				
	Out of hours	31% (5pm to 9am and weekends)		9% over last 30 months (7pm to 8 am and weekends)		
Forensic examination		38%	N/A		8% joint forensic examination (room not suitable)	8 Paediatrician and FME 5 Joint 2 senior paediatricians
Photo documentation		unknown	unknown	unknown	Polaroid camera	2 exams single paediatrician 1 exam FME alone
Source of referral	**police**	41%	N/A			
	Social services	40%				
	Police/social services	12%				
	Emergency dept	5%				

	Primary care	2%				

Source: Designated Doctors NPHS Child Protection Service with Named Doctors Welsh NHS Trusts

Appendix 4: Suggested Criteria for Commissioning Medical Examination Service

The National Public Health Service suggests the following key population health criteria in planning service reconfigurations[27]:

In the context of services for the medical examination of children who may have been sexually abused, the desirable outcomes are both therapeutic and forensic, and can be specified as:

1. Services of the highest possible quality

- Effectiveness
  - the extent to which the service meets the therapeutic and forensic needs of all children who have, or may have been, sexually abused.
- Efficiency
  - the provision of the best therapeutic and forensic outcomes for the resources available
- Equity
  - the provision of an equitable health service where a child's access to, and utilisation of, the service depends only on their ability to benefit.
- Accessibility
  - the extent to which a child can access the needed service
- Appropriateness
  - the extent to which the service is the right one for that child's need
- Acceptability
  - the extent to which the service meets user's expectations (in this case: children, their families, and referrers)

2. Services which are sustainable

- Demographic changes
- Workforce changes
- Technological changes
- Environmental changes
- Economic changes
- Political changes

11 Services which only tolerate the least possible risk to the health of the public and/or individuals

- robust clinical governance frameworks and risk management frameworks, for instance the use of root cause analysis for any significant event

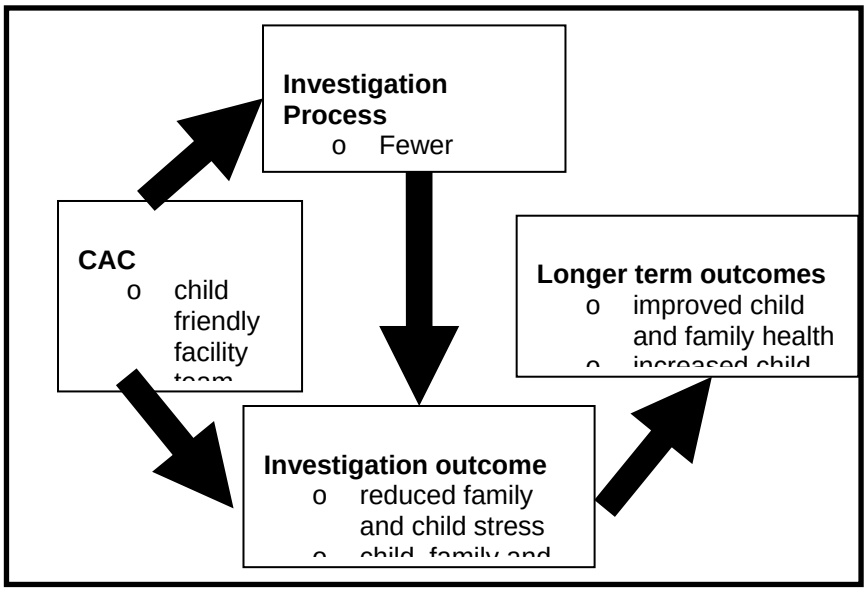
12 Services supported by the systems by which they are provided

- Facilities, equipment and training supported by all partner organisations, for instance police, health and social services.

13 Services which enjoy the confidence of the people they are designed to serve

- Requires involvement of users of the service and monitoring of satisfaction measures.

Appendix 5 : Child Advocacy Centre US model



Source: Crimes Against Children Research Centre, University of Hampshire, Figure used in Reason Foundation Policy Study[4].

Appendix 6:

Models of service provision in Wales

1. Sapphire Suite Swansea

This purpose built suite located in the children's department of Singleton Hospital in Swansea provides a service to children who may have been abused (all forms not just sexual, acute and historical).NHS Trust funds established the suite and employ the paediatricians providing the service. Population Served covers 3 LHBs and 3 LAs (Bridgend, Neath/Port Talbot and Swansea). Service provided also with discretion to children from 4 other LHB and LA areas. The suite therefore relates to 2 police forces South Wales Police and Dyfed Powys Police. Rota of 7 paediatricians for CSA (of which 1 provides out of hours service*).*

2. North Wales Model

Across North Wales covering 6 LHBs and coterminous with the North Wales Police Area a service for children up to the age of 16 who are subject to acute sexual assault hosted by Conwy and Denbighshire NHS Trust but funded by the North Wales Police is provided by a rota of 7 experienced paediatricians in 3 dedicated child friendly health premises across the region. Funding has recently been awarded to develop a SARC in Conwy.

3. Cardiff Model

Children up to the age of 14 years who may have been sexually abused are seen by experienced paediatricians usually as part of a joint examination with Forensic Medical Examiners. In early 2008 a SARC for adults and children will open in Cardiff on a hospital site with provision for independent advocacy for children and young people in addition to the examination. This will initially cover Cardiff and the Vale LHB areas. The SARC is funded by the South Wales Police and Cardiff LHB. Currently there is no identified funding for the provision of experienced paediatric input.

Appendix 7:

Service Specification for Sexual Assault Referral Centres (SARC)[25]

- Dedicated, forensically secure facility integrated with hospital services
- Availability of forensic examination 24 hours a day, within 4 hours in cases of immediate need
- Facilities for self-referrals, including the opportunity to have a forensic examination and for the results to be stored or to be used anonymously
- Choice of gender of doctor/forensic medical examiner/appropriately trained Sexual Assault Nurse Examiner. All SANEs should be supervised by doctors trained and experienced in sexual assault forensic examination, who can provide interpretation of injuries for criminal justice purposes and ensure the highest standard of forensic examination
- Crisis workers to support the victim, the examiner and the police prior to, during and immediately after the forensic examination
- Immediate on-site access to emergency contraception and drugs to prevent sexually transmitted infections including HIV
- Integral follow-up services including psycho-social support/ counselling, sexual health, and support throughout the criminal justice process
- Infrastructure to ensure ongoing client care, DNA decontamination, staffing, training and maintenance including stocking of medication

Appendix 8: Suggested minimum dataset

1. defined collection period, April to March.
2. referral source for each contact requesting advice
3. age and DOB and sex of child
4. time and day of week
5. in hours or out of hours (with agreed definitions)
6. whether examination was carried out or not
7. place where examined and distance from home for child
8. time between request and examination
9. who was present
10. photo documentation with type (e.g. number of stills taken/DVD/Video)
11. and/or colposcopy use
12. treatment or referral
13. child protection or criminal justice procedures and outcomes
14. any other issue the team chooses to audit