NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Child abuse and neglect

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 5 July 2018

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for child abuse and neglect. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development sources

The key development sources referenced in this briefing paper are:

- Child abuse and neglect. NICE guideline 76 (2017). Next review date October 2020.
- Child maltreatment: when to suspect maltreatment in under 18s. NICE clinical guideline 89 (2009; updated 2017). No review schedule presented.

Additional development sources referenced in this briefing paper are:

- Harmful sexual behaviour among children and young people NICE guideline 55 (2016) Next review date September 2018
- Domestic violence and abuse: multi-agency working NICE public health guideline PH50 (2014). Next review date 2018.
- Self-harm in over 8s: long-term management NICE clinical guideline 133 (2011). Next review date 2018

2 Overview

2.1 Focus of quality standard

This quality standard will cover recognition, assessment and response to abuse and neglect of children and young people under 18. It will cover physical, emotional and sexual abuse and neglect.

2.2 Definition

In this quality standard child abuse and neglect includes inflicting harm on a child or young person and also failing to protect them from harm. Children and young people may be abused by someone they know in a family or in an institutional or community setting or, more rarely, by someone they don't know (for example through the internet). Some indicators of abuse and neglect may be indicators of current or past abuse and neglect.

2.3 Incidence and prevalence

According to the report How safe are our children? published by the National Society for the Prevention of Cruelty to Children (NSPCC), the last 5 years has seen an increasing trend in recorded offences of cruelty and neglect of children under 16 by a parent or carer in England, Wales and Northern Ireland. This is believed to be associated with increased reporting and changes in recording practices.

In England, for the year ending 31 March 2017, there were:

- 646,120 referrals to social services relating to 571,000 children
- 203,750 children in need due to abuse or neglect (52% of the total children in need)
- 51,080 children subject to child protection plans (CPPs), reasons include:
    - neglect 48%
    - emotional abuse 34%
    - physical abuse 8%
    - sexual abuse 4%
- 44,600 children looked after abuse or neglect
- looked after due to abuse or neglect
- 2,118 potential child victims of modern slavery were referred to the National Referral Mechanism (NRM) in 2017, up 65.7% from 1,278 in 2016
- 307 children were referred to the NSPCC's Child Trafficking Advice Centre (CTAC) in the year ending October 2017, up 6.9%since the year ending October 2016[1].

Self-report survey data of young people presented in the NSPCC report indicates that:

- 61.4% of 11 to 17 year olds have been exposed to some form of community violence
- by the time they reach 18, almost one quarter of children will have been exposed to domestic violence

[1] Bentley, H. et al (2018) How safe are our children? The most comprehensive overview of child protection in the UK 2018. London: NSPCC.

- 9% of 18 to 24 year olds reported that they had experienced severe neglect while under the age of 18[2].

2.4 Identification and response

2.4.1 Recognition

While some abuse or neglect may be reported, it is more likely to be brought to the attention of services because of a child or young person's behaviour and demeanour or the behaviour of caregivers. Professionals in many services need to be equipped to respond to indicators of abuse and neglect, but recognising them can be challenging.

2.4.2 Assessment

There are 2 main forms of assessment available for families experiencing difficulties:

- 'Early help' for families with relatively low level or emerging needs
- Help provided under section 17 of the Children Act 1989 for more complex needs.

In both cases, the aim of assessment is to gather information about a child and family, and analyse their needs and any risk of harm. Statutory assessments must also decide whether the child or young person is a child in need, and/or is suffering or likely to suffer significant harm. If there is cause to suspect a child is experiencing, or likely to experience, significant harm, an investigation should be undertaken under section 47 of the Children Act 1989.

2.4.3 Response

Statutory guidance on multi-agency child protection practice (Working together to safeguard children Department for Education) emphasises that local areas should provide services to meet a spectrum of different levels of need.

Various universal and targeted services address abuse and neglect at the early help stage. These include specific interventions such as home visiting and parenting programmes. Most areas have established processes for early help assessment, and arrangements for multi-agency working such as 'Team Around the Child/Family' processes.

[2] Bentley, H. et al (2018) How safe are our children? The most comprehensive overview of child protection in the UK 2018. London: NSPCC.

2.4.4 Children in need or those judged to be suffering, or likely to suffer, significant harm

Children and young people assessed as needing more intensive support after assessment under section 17 of the Children Act 1989 (relating to 'children in need') or following an investigation under Section 47 of the Children Act will receive interventions which will be co-ordinated by children's social care services, but which may be provided by a range of agencies. Alternative care placements for children, such as kinship, foster or residential care, may also be considered. Specific time-limited interventions may also be provided to prevent abuse from recurring, and to address the psychological, behavioural and other consequences of abuse. These are delivered by child and adolescent mental health practitioners (psychologists, psychotherapists, psychiatrists) including within CAMHS, professionals in specialist family intervention teams (for example social workers) and voluntary sector agencies.

2.5 Resource impact

While there may be a resource impact from activities raising awareness among health and social care practitioners, it is anticipated that implementing the recommendations highlighted in this briefing paper will be achieved from using existing resources differently.

3 Summary of suggestions

3.1 Responses

In total 22 stakeholders responded to the 2-week engagement exercise 14/11/2017-28/11/2017.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 1 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 1 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Working with families • Communicating with children and young people • Involving children and young people • Communicating with parents and carers • Involving parents and carers	AFTSP, AVA, RCPCH, SCMs
Recognition • Identifying those at risk	DfE, NSPCC, Ofsted, RCPCH, RCSLT, SCMs
Assessment • Suspected injuries • Assessing the risk • Assessing needs	ADCS, BASPCAN, CPSIG, DfE, FSRH, NSPCC, Ofsted, PHE, RCPCH, SCMs
Response • Providing support • Therapeutic interventions	ADCS, AFTSP, DfE, NAPAC, NSPCC, Ofsted, RCPCH, RCSLT, SCMs
Ways of working • Multi agency working • Continuity of care	AFC, AVA, BASPCAN, DfE, NAPAC, RCPCH, SCMs
Additional areas: • Maternal mental health • Mandatory reporting • Prevention • Relationships and Sex Education in schools • Skills, knowledge, training and supervision	AFC, AFTSP, BASPCAN, CPSIG, FSRH, IHV, NAPAC, Ofsted, NSPCC, PHE, RCPCH, SCMs

ADCS, Association of Directors of Children's Services
AFC, Action for children
AFTSP, Association for Family Therapy and Systemic Practice (UK)
AVA, Against Violence and abuse
BASPCAN, British Association for the Study and Prevention of Child Abuse and Neglect
CPSIG, Child Protection Special Interest Group
DfE, Department for Education
FSRH, The Faculty of Sexual and Reproductive Healthcare
IHV, Institute of health visiting
NAPAC, The National Association for People Abused in Childhood
NSPCC, National Society for the Prevention of Cruelty to Children
Ofsted, Office for Standards in Education, Children's Services and Skills
PHE, Public Health England
RCPCH, Royal College of Paediatrics and Child Health
RCSLT, Royal College of Speech and Language Therapists
SCM, Specialist Committee Member

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 595 papers were identified for child abuse and neglect. In addition, 72 papers were suggested by stakeholders at topic engagement and 88 papers internally at project scoping.

Of these papers, 11 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Working with families

4.1.1 Summary of suggestions

Communicating with children and young people

Stakeholders highlighted the need to understand the context in which children and young people live to allow for effective support. They highlighted that to gain that understanding and build trust, practitioners need to communicate with children and young people more effectively and ensure that they understand and agree with the process they are engaging with.

More specifically, stakeholders suggested that children and young people should always be asked for permission if a healthcare or social care practitioner needs to touch them (for example during medical examination).

Stakeholders also suggested that children and young people should agree clear communication arrangements with health and social care practitioners to ensure communication is timely, effective and safe.

Involving children and young people

Stakeholders highlighted that children and young people should be central to the process of disclosing the abuse and neglect, deciding the pathway and plan what support they need. They suggested that to ensure the lived experience of the child or young person is accurately captured, all conversations or statements should be documented with every contact. Stakeholders also suggested children and young people should be asked to sign the record of the discussion to ensure true reflection of their story.

Communicating with parents and carers

Stakeholders suggested that communicating with parents and carers should include exploring their concerns and wishes but also be honest about the safeguarding concerns and the reasons for the involvement. They suggested that a supportive approach to working with parents and carers is more effective than a punitive approach.

Involving parents and carers

Stakeholders highlighted the importance of building good working relationships with parents and carers to encourage their engagement and continued participation. They also suggested that parents and carers should retain a degree of control of the

process, be involved in planning, identifying goals and targets which would lead to improvements.

4.1.2 Selected recommendations from development source

Table 2 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 2 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Communicating with children and young people	**Working with children and young people** NICE NG76 Recommendations 1.1.5, 1.1.9
Involving children and young people	**Working with children and young people** NICE NG76 Recommendations 1.1.1, 1.1.6
Communicating with parents and carers	**Working with parents and carers** NICE NG76 Recommendation 1.1.10
Involving parents and carers	**Working with parents and carers** NICE NG76 Recommendation 1.1.11

Working with children and young people

NICE NG76 Recommendation 1.1.1

Take a child-centred approach to all work with children and young people. Involve them in decision-making to the fullest extent possible depending on their age and developmental stage.

NICE NG76 Recommendation 1.1.5

If your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do and ask for consent:

- from them if they are over 16 (follow the Mental Capacity Act 2005) or under 16 but Gillick competent or
- from their parent or carer if they are under 16 and not Gillick competent

If the child, young person or parent does not agree, respect their wishes unless touching them is essential to their treatment (seek legal advice first unless the need for treatment is immediate).

For more guidance on seeking consent for medical examination in children and young people see the General Medical Council's 0-18 years: guidance for all doctors.

NICE NG76 Recommendation 1.1.6

Produce a record of conversations with children and young people about child abuse and neglect, and any subsequent interventions as appropriate to their age, developmental stage and language abilities. This could be in writing or another format suitable to meet the child or young person's communication needs. Ensure that you:

- Accurately represent their words, using their actual words unless there is a good reason not to, for example if this would include information about another child or young person.
- Check that they have understood and agree with what is recorded (this could include both of you signing a written record) and record any disagreements.

NICE NG76 Recommendation 1.1.9

Agree with the child or young person (if age appropriate) how you will communicate with each other. Give them contact details, including for services available out of hours. When contacting them:

- be aware of safety issues such as whether a perpetrator of abuse may have access to a young person's phone
- agree what will happen if you contact them and they do not respond, for example following up with their nominated emergency contact.

Working with parents and carers

NICE NG76 Recommendation 1.1.10

Aim to build good working relationships with parents and carers to encourage their engagement and continued participation. This should involve:

- actively listening to them, and helping them to deal with any emotional impact of your involvement with their family
- being open and honest
- seeking to empower them and engaging them in finding solutions
- avoiding blame, even if they may be responsible for the child abuse or neglect
- inviting, recognising and discussing any worries they have about specific interventions they will be offered
- identifying what they are currently doing well, and building on this
- making adjustments for any factors which may make it harder for them to get support, such as refugee status, long-term illness, neurodevelopmental disorders, mental health problems, disability or learning disability

- being sensitive to religious or cultural beliefs
- working in a way that enables trust to develop while maintaining professional boundaries
- maintaining professional curiosity and questioning while building good relationships

NICE NG76 Recommendation 1.1.11

When working with parents and carers:

- be reliable and available as promised
- provide clear information about who to contact, including in an emergency
- keep them informed, including explaining what information has been shared, and with whom
- support people's communication needs, for example by using communication aids or providing an interpreter
- agree records of any conversations, and share relevant documents and plans
- be clear about the issues and concerns that have led to your involvement, and inform parents and carers if those concerns are resolved
- be clear about the legal context in which your involvement with them is taking place

4.1.3 Current UK practice

Communicating with children and young people

The expert reference group of young people involved in inspections carried out jointly by Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMICFRS) and HMI Probation (HMI Prob) in 6 local authorities found poor practice in terms of communication:

- practitioners calling during school hours - caused a disturbance and could lead to bullying from other students
- practitioners did not always check if the contact details they had were safe to use - it may be that a perpetrator would able to access the communication
- practitioners sometimes call from a withheld number which many victims of abuse will not answer due to fear of who it may be
- victims of abuse feel most anxious and alone at evenings and weekends but are often not provided with out of hours contact details
- the expert reference group also suggested that some organisations have a policy that if they are unable to reach a client after several attempts (usually 3), then they are seen as not engaging and the case is closed which does not take into

account how traumatised victims can be, and how they may not be contacted in a safe way; this can increase risk to the child/young person[3]

Involving children and young people

An evaluation of the effectiveness of the early help services for children and families provided by local authorities and their partners was carried out by Ofsted in 2015 (inspectors considered 56 early help cases in 12 local authorities). In almost a third of cases, the inspector noted the absence of the child's voice or sufficient understanding of their experiences, where this would have been expected given the child's age. In almost all cases the assessment was found to be focused on the adults' needs and not sufficiently child-focused[4].

The inspections carried out jointly by Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMICFRS) and HMI Probation (HMI Prob) in 6 local authorities found some areas of concern:

- poor engagement with children
- poor child attendance at child protection conferences
- children's voices were insufficiently heard/they were not always listened to
- children's heritage and cultural identity is not well considered

However, the inspections also found councils that were good at recording children's voices, quoting their wishes and views in case records (Peterborough) or hearing children's voices via advocates attending conferences (Workingham).

The expert reference group of young people involved in the inspections also indicated:

- lack of trust for forms and records - many had experiences of their words being 'twisted' and reports not accurately reflecting what they had said which led to inappropriate referrals/actions, lack of trust and engagement[5].

Communicating with parents and carers

An analysis of 293 serious case reviews identified issues associated with communicating with parents and carers such as poor arrangements for translation and interpretation resulting in lack of communication[6].

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[3] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018
[4] Ofsted 2015, Early help services: how well are they meeting children's needs?
[5] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018
[6] Department of Education (2016), Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, May 2016

Involving parents and carers

The analysis of serious case reviews identified issues associated with hearing the voices of the family, over-reliance on families to act on advice, working agreements lacking rigour and clarity, leaving parents and professionals uncertain of expectations and plans, and raising concerns about informed consent.

No published studies on current practice were highlighted for experiences of parents and carers.

4.2 Recognition

4.2.1 Summary of suggestions

Identifying those at risk

Stakeholders highlighted early identification of children and young people at risk of abuse and neglect as an area for quality improvement. They suggested that concerns about the child and/or family should be responded to at the earliest point in a child's life and at the first recognition of difficulties. Stakeholders also highlighted the importance of asking children and young people questions about their circumstances to encourage disclosure and specifically highlighted the role of primary care and education at this early stage.

Stakeholders highlighted specific groups of children and young people who may be at an increased risk of abuse and neglect such as children and young people with learning difficulties, those living with adverse childhood experiences including domestic abuse, children and young people with speech and language problems, children who self-harm, those with behavioural issues or exhibiting harmful sexual behaviours.

4.2.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 3 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Identifying those at risk	**Factors that increase vulnerability to child abuse and neglect** NICE NG76 Recommendations 1.2.1, 1.2.2 **Family factors** NICE NG76 Recommendation 1.2.3 **Child factors** NICE NG76 Recommendation 1.2.7 **Children and young people telling others about child abuse and neglect** NICE NG76 Recommendation 1.3.3, 1.3.5 **Behavioural and emotional alerting features** NICE NG76 Recommendation 1.3.16 **Sexual behavioural alerting features** NICE NG76 Recommendation 1.3.20

Factors that increase vulnerability to child abuse and neglect

NICE NG76 Recommendations 1.2.1

Recognise that vulnerability factors can be interrelated, and that separate factors can combine to increase the risk of harm to a child or young person.

NICE NG76 Recommendations 1.2.2

Take into account socioeconomic vulnerability factors for child abuse and neglect, such as poverty and poor housing.

Family factors

NICE NG76 Recommendation 1.2.3

Recognise that the following parental factors increase vulnerability to child abuse and neglect, and that these may be compounded if the parent or carer lacks support from family or friends:

- Substance misuse problems.
- A history of domestic abuse, including sexual violence or exploitation.
- Emotional volatility or having problems managing anger.
- Mental health problems which have a significant impact on the tasks of parenting.

Child factors

NICE NG76 Recommendation 1.2.7

Recognise that disabled children and young people are more vulnerable to child abuse or neglect.

Children and young people telling others about child abuse or neglect

NICE NG76 Recommendation 1.3.3

Recognise that children and young people may communicate their abuse or neglect indirectly through their behaviour and appearance (see recommendations 1.3.12 to 1.3.47 and NICE's guideline on child maltreatment).

NICE NG76 Recommendation 1.3.5

Explore your concerns with children and young people in a non-leading way, for example by using open questions, if you are worried that they may be abused.

Behavioural and emotional alerting features

NICE NG76 Recommendation 1.3.16

Consider current or past child abuse or neglect if children or young people are showing any of the following behaviours:

- substance or alcohol misuse
- self-harm
- eating disorders
- suicidal behaviours
- bullying or being bullied.

Sexual behavioural alerting features

NICE NG76 Recommendation 1.3.20

Suspect current or past child abuse and neglect if a child or young person's sexual behaviour is indiscriminate, precocious or coercive.

4.2.3 Current UK practice

Identifying those at risk

The Children's commissioner report found that only 1 in 8 victims of sexual abuse come to the attention of statutory authorities[7]. Many victims do not access help and do not disclose the abuse. However, the findings also indicate that telling someone does not always lead to the abuse stopping. Based on a survey carried out with adult survivors, the abuse stopped at the same time as telling someone only in 11% of cases[8].

Research on sexual exploitation of boys and young men in the UK carried out by the National Centre for Social Research (NatCen), Barnardo's and University College London (UCL) in 2013 found:

- boys are less likely to be identified as victims of exploitation, although by the time they are, they may present with particularly high risks and vulnerabilities compared with girls

[7] Children's Commissioner (2015) Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action, November 2015
[8] Children's Commissioner (2015) Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action, November 2015

- sexually exploited boys and young men are more likely to express their anger and trauma externally and be labelled as ‘aggressive’, ‘violent’ or an ‘offender’, whereas girls are more likely to internalise their distress
- male service users were more likely to be referred by criminal justice agencies and less likely to be referred by social services and education
- very few males or females were referred by health services
- 80% of male service users were referred to Barnardo’s services due to going missing[9]

[9] Barnado’s (2014) Hidden in Plain Sight: A Scoping Study into the Sexual Exploitation of Boys and Young Men, August 2014

4.3 Assessment

4.3.1 Summary of suggestions

Suspected injuries

Stakeholders highlighted timely paediatric medical assessment of physical injuries suspected to be caused by abuse as an area for quality improvement. They also suggested using radiological investigations and digital photography as specific tools to improve managing, analysing and reviewing the evidence.

Assessing risk

Stakeholders suggested that children and young people are likely to experience a range of vulnerabilities at the same time, for example children living with domestic abuse and neglect who may also be at risk of sexual exploitation and run away or go missing.

Stakeholders suggested that structured assessment tools could support practitioners and their decision making when they assess and decide if the child or young person is at risk.

Assessing needs

Stakeholders suggested that a comprehensive assessment of the child's needs should be carried out before any interventions start. They highlighted that the assessments should be child centred and consider the wider context the child lives in.

4.3.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Suspected injuries	No recommendations identified in the development source.

Assessing risk	**Carrying out assessments** NICE NG76 Recommendation 1.4.4 **Safeguarding** NICE CG133 Recommendation 1.1.20 **Identify and, where necessary, refer children and young people affected by domestic violence and abuse** NICE PH50 Recommendation 10
Assessing needs	**Carrying out assessments** NICE NG76 Recommendation 1.4.7

Carrying out assessments

NICE NG76 Recommendation 1.4.4

As part of assessment or enquiry into child abuse and neglect under the Children Act 1989, collect and analyse information about all significant people (including siblings) in the child or young person's care environment, unless it is not safe to do so (for example in cases of domestic abuse or forced marriage) or it could affect the nature of a criminal investigation. Use professional judgement to determine the risks and benefits of including people in assessment in these instances. Gather the following information about each person:

- Their personal, social and health history.
- Their family history, including experiences of being parented.
- Any adverse childhood experiences.
- The quality of their relationship with the child or young person.

NICE NG76 Recommendation 1.4.7

Analyse the information collected during assessment and use it to develop a plan describing what services and support will be provided. Make sure the plan is agreed with the child or young person and their family (also see recommendations 1.1.7 and 1.1.11). Analysis should include evaluating the impact of any vulnerability factors and considering their implications for the child or young person.

Safeguarding

NICE CG133 Recommendations 1.1.20

If children or young people who self-harm are referred to CAMHS under local safeguarding procedures:

- use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered
- consider using the Common Assessment Framework; advice on this can be sought from the local named lead for safeguarding children.

If serious concerns are identified, develop a child protection plan.

Identify and, where necessary, refer children and young people affected by domestic violence and abuse

NICE PH50 Recommendation 10

Providers of services where children and young people affected by domestic violence and abuse may be identified and those responsible for safeguarding children should:

- Ensure staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people
- Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly The violence and abuse may be happening in their own intimate relationships or among adults they know or live with
- Put clear information-sharing protocols in place to ensure staff gather and share information and have a clear picture of the child or young person's circumstances, risks and needs
- Develop or adapt and implement clear referral pathways to local services that can support children and young people affected by domestic violence and abuse
- Ensure staff know how to refer children and young people to child protection services. They should also know how to contact safeguarding leads, senior clinicians or managers to discuss whether or not a referral would be appropriate
- Ensure staff know about the services, policies and procedures of all relevant local agencies for children and young people in relation to domestic violence and abuse
- Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse.
- Monitor these policies and services with regard to children's and young people's needs.

4.3.3 Current UK practice

Suspected injuries

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Assessing risk

In 2015 Ofsted evaluated the effectiveness of the early help services for children and families provided by local authorities and their partners. Inspectors considered 56 early help cases in 12 local authorities. The quality of the early help assessments undertaken with families was variable. Inspectors considered fewer than half of the assessments to be of good quality. The assessments:

- failed to analyse information
- were overly descriptive and not clear about strengths and concerns
- relied heavily on one parent's self-reporting, with limited input or no input from professionals
- did not include the voice of the children
- did not consider the family's history nor consider the significance of the current issues
- focused too much on the parent rather than the impact of the parent's difficulties on the child
- contained limited information about the father or other partners even when they were part of the household[10].

An analysis of serious case reviews found that whilst there may be a good awareness of risk factors among staff across services, early help and specialist services, practitioners are not always rigorous in assessing and following through on all identified risks including domestic abuse. Where the threshold for children's social care involvement is not met, there may be little analysis of risks of harm[11].

The review found that the Common Assessment Framework (CAF) was rarely used by practitioners, sometimes because the family would not agree to participate. In one case there was an unfounded presumption of resilience because the young person was articulate and troublesome and they were thought of as an adult rather than a vulnerable young person. In addition, the school did not consider using the CAF because the young person was from a middle class family and their experience of using the framework was with more disadvantaged young people. At times the CAF

[10] Ofsted 2015, Early help services: how well are they meeting children's needs?
[11] Department of Education (2016), Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, May 2016

was used inappropriately for problems like neglect and sexual abuse which were much more serious and needed assessment from children's social care[12].

The review also found that almost a quarter of cases were closed inappropriately by children's social care at the point of referral. In these cases:

- risk was not well considered and action was not taken when it should have been
- there was a re-referral for the same issue in the subsequent three months that could have been addressed with the information known originally
- the referral quality was poor and the referral was closed without children's social care speaking to the referrer to establish the reason for their decision
- the case was closed without the completion of identified tasks[13].

The joint inspections carried out recently by Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMICFRS) and HMI Probation (HMI Prob) found:

- missed opportunities for joint risk-assessment of children at risk of neglect and for joint decision-making
- police not completing risk assessment forms routinely - not clear if the police have identified and responded to risk, including neglect; in over half of the neglect cases sampled, the risk-assessment was either not correctly completed by the police or was absent[14].

Assessing needs

The joint inspections carried out by Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMICFRS) and HMI Probation (HMI Prob) found that the police only focused on assessing a violent child who committed a crime instead of looking into the wider context and considering abuse and neglect[15].

In 2015 Ofsted evaluated the effectiveness of the early help services for children and families provided by local authorities and their partners. Inspectors considered 56 early help cases in 12 local authorities. The quality of the early help assessments undertaken with families was variable. Inspectors considered fewer than half of the assessments to be of good quality. The assessments:

- did not consider the family's history nor consider the significance of the current issues

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[12] Department of Education (2016), Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, May 2016
[13] Ofsted 2015, Early help services: how well are they meeting children's needs?
[14] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018
[15] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018

- contained limited information about the father or other partners even when they were part of the household[16].

[16] Ofsted 2015, Early help services: how well are they meeting children's needs?

4.4 Response

4.4.1 Summary of suggestions

Providing support

Stakeholders highlighted the importance of early response to any concerns about the child and the family. They suggested that support offered to the children and young people needs to be provided within the context of the wider family circumstances and include parents where possible.

More specifically, stakeholders suggested that early help should include interventions to increase parental capacity and coping skills as well as additional home visiting programmes for parents or carers whose children may be at risk of abuse or neglect.

Therapeutic interventions

Stakeholders highlighted the importance of access to evidence based therapeutic interventions and long term support for children and young people who were abused or neglected. Stakeholders felt it was important to offer:

- Trauma-focused cognitive behavioural therapy for child victims of sexual assault.
- Attachment-based intervention to parents or carers who have neglected or physically abused a child under 5 or to foster carers looking after abused or neglected children.
- Comprehensive mental health assessment for looked after children under 5
- Services for children with harmful sexual behaviours as a result of abuse

4.4.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Providing support	**Supporting families at the early help stage** NICE NG76 Recommendations 1.5.1, 1.5.3, 1.5.4 **Home visiting programmes** NICE NG76 Recommendations 1.5.13, 1.5.14, 1.5.15 **Therapeutic interventions for children, young people and families after child abuse and neglect** NICE NG76 Recommendations 1.7.2, 1.7.3
Therapeutic intervention	**Children under 5** NICE NG76 Recommendations 1.7.4, 1.7.5 **Therapeutic interventions for children, young people and families after sexual abuse** NICE NG76 Recommendation 1.7.17 **Early help assessment** NICE NG55 Recommendations 1.3.1, 1.3.2, 1.3.9

Supporting families at the early help stage

NICE NG76 Recommendation 1.5.1

Provide early help in line with local protocols and Working together to safeguard children, and based on an assessment of the needs of children, young people and families.

NICE NG76 Recommendation 1.5.3

Give children, young people and their families a choice of proposed interventions if possible. Recognise that some interventions may not suit that person or family.

NICE NG76 Recommendation 1.5.4

Early help should include:

- practical support, for example help to attend appointments and details of other agencies that can provide food, clothes and toys
- emotional support, including empathy and active listening, and help to develop strategies for coping.

Home visiting programmes

NICE NG76 Recommendation 1.5.13

For parents or carers at risk of abusing or neglecting their child or children, consider a weekly home visiting programme lasting at least 6 months, for example the Healthy Families model. This should be in addition to universal health visiting services available through the Department of Health's Healthy child programme.

NICE NG76 Recommendation 1.5.14

Identify parents and carers who could be supported by a home visiting programme during pregnancy or shortly after birth, wherever possible.

NICE NG76 Recommendation 1.5.15

Ensure that the home visiting programme is agreed with families and includes:

- support to develop positive parent–child relationships, including:
    - helping parents to understand children's behaviour more positively
    - modelling positive parenting behaviours
    - observing and giving feedback on parent–child interactions
- helping parents to develop problem-solving skills
- support for parents to address the impact of any substance use, previous domestic abuse and mental health problems on their parenting
- support to access other relevant services, including health and mental health services, substance misuse services, early years, educational services and other community services
- referral to children's social care where necessary, for example if current domestic abuse is discovered.

Therapeutic interventions for children, young people and families after child abuse and neglect

NICE NG76 Recommendation 1.7.2

Give children, young people, parents and carers a choice of proposed interventions if possible. Recognise that some interventions, although effective, may not suit that person or family.

NICE NG76 Recommendation 1.7.3

The choice of intervention should be based on a detailed assessment of the child or young person.

Children under 5

NICE NG76 Recommendation 1.7.4

Offer an attachment-based intervention, for example Attachment and bio behavioural Catch-up, to parents or carers who have neglected or physically abused a child under 5.

NICE NG76 Recommendation 1.7.5

Deliver the attachment-based intervention in the parent or carer's home, if possible, and provide at least 10 sessions. Aim to:

- improve how they nurture their child, including when the child is distressed
- improve their understanding of what their child's behaviour means
- help them respond positively to cues and expressions of the child's feelings
- improve how they manage their feelings when caring for their child.

[This recommendation is adapted from NICE's guideline on children's attachment.]

Therapeutic interventions for children, young people and families after sexual abuse

NICE NG76 Recommendation 1.7.17

Offer group or individual trauma-focused cognitive behavioural therapy over 12 to 16 sessions (more if needed) to children and young people (boys or girls) who have been sexually abused and show symptoms of anxiety, sexualised behaviour or post-traumatic stress disorder. When offering this therapy:

- discuss it fully with the child or young person before providing it and make clear that there are other options available if they would prefer
- provide separate trauma-focused cognitive behavioural therapy sessions for the non-abusing parent or carer.

Early help assessment

NICE NG55 Recommendation 1.3.1

Children's social services should refer children and young people who display inappropriate sexualised behaviour for an early help assessment, in line with local

thresholds and referral procedures (see recommendation 1.1.5). Focus on the child or young person as an individual and not on the presenting behaviour.

NICE NG55 Recommendation 1.3.2

At point of referral, early help professionals should identify a designated lead practitioner in the multi-agency, multidisciplinary team (see recommendation 1.1.6) who will:

- act as a single point of contact for the child or family
- coordinate early help and subsequent assessments and develop the care plan to avoid unnecessary or repetitious assessments that may be stigmatising
- coordinate delivery of the agreed actions
- involve children, young people and their families and carers in the design and delivery of early help services, as appropriate
- reduce overlap and inconsistency in services provided.

NICE NG55 Recommendation 1.3.9

If harmful sexual behaviour is displayed, refer to harmful sexual behaviour services, child protection services and the criminal justice system, if necessary

4.4.3 Current UK practice

Providing support

An analysis of serious case reviews found examples where children and young people shared important information about their family circumstances but the disclosure did not trigger concerns for safety and welfare and there was no referral to children's social care. The same review found that the police often failed to consider the welfare of children when responding to domestic abuse calls[17].

In 2015 Ofsted evaluated the effectiveness of the early help services for children and families provided by local authorities and their partners. Inspectors considered 56 early help cases in 12 local authorities and found:

- local authorities and their partners were not fully evaluating the impact of their early help work. effective planning only found in a third of cases
- plans often lacking objectives and were not regularly reviewed
- weak management oversight

[17] Department of Education (2016), Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, May 2016

- Local Safeguarding Children Boards (LSCBs) not monitoring the management oversight
- majority of their audits too focused on process and compliance and not enough on the quality of the service and the extent to which it helped improve children's lives[18].

An analysis of serious case reviews found that in some of the suicide cases, the roots of the young people's problems (e.g. relationship with family, rejection, feeling unloved) were never addressed in a meaningful way

- the voice of the young person was not heard
- when a young person articulated distress (verbally or through their behaviour) it was often not understood or responded to appropriately[19].

Therapeutic interventions

The report published by Care Quality Commission (CQC) reviewing children and young people's metal health services highlighted numerous issues around the complexities of the commissioner and provider arrangements as well as difficulties accessing the support. CQC also heard from young people that:

- the services did not always feel person centred
- the care was not always age appropriate or tailored to their stage of development
- they were not able to get more involved in decisions about their care as they got older
- they lacked choice in how, when and where they could access help
- they were not listened to[20].

The Children's commissioner has also recently published a report about children's mental healthcare in England which highlighted funding issues and poor support received by children[21].

A report published by NSPCC in 2013 on service provision for young people who have displayed harmful sexual behaviour showed a reasonably consistent profile of service provision across the local authorities included in the survey

- children who came into contact with the services were subject to an assessment (standardised framework)
- risk management, child protection measures and multiagency procedures were important elements

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[18] Ofsted 2015, Early help services: how well are they meeting children's needs?
[19] Department of Education (2016), Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, May 2016
[20] CQC 2017, Review of children and young people's mental health services, October 2017
[21] Children's commissioner 2017, Briefing: Children's mental healthcare in England, October 2017

- training was available for staff to support their work in the area of harmful sexual behaviour[22].

However, the parliamentary inquiry into support and sanctions for children who display harmful sexual behaviour (2016) found strong evidence of inconsistent practice that results in barriers to providing effective interventions:

- identification and referral to specialist services happening too late
- the significance of the behaviour on referral was not recognised/dismissed by children's services
- many children and young people who were charged with sexual offences had previously been referred to children's services for displaying harmful sexual behaviour
- not enough joined-up working with different agencies often dealing with harmful sexual behaviour in isolation
- lack of consistency in the availability of specialist services across the country
- threshold for accessing support services often very high[23].

4.5 Ways of working

4.5.1 Summary of suggestions

Multiagency work

Stakeholders suggested that clear responsibilities, pathways and consistency in responding to safeguarding concerns are key to improving outcomes for children and young people and protecting them from having to repeat their stories to different people and agencies.

Stakeholders highlighted the importance of information sharing, handovers and following up plans being put in place to protect children and young people. They also highlighted the need for practitioners who identify child abuse and neglect to build relationships and work with other practitioners and agencies involved with the family.

Continuity of care

Stakeholders highlighted the importance of continuity of care and relationships as an area for quality improvement. They suggested that working with the same practitioners over time enables building trust, improves quality of relationships with professionals and their understanding of potentially changing risks and needs.

[22] NSPCC 2013, Provision for young people who have displayed harmful sexual behaviour, February 2013
[23] Barnardo's 2016, Now I know it was wrong: Report of the parliamentary inquiry into support and sanctions for children who display harmful sexual, 2016

Stakeholders also suggested that it's beneficial for children and families to be engaged with the same service as opposed to multiple agencies.

4.5.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after the table to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Multiagency work	**Multiagency working** NICE NG76 Recommendation 1.6.1
Continuity of care	**Working with other practitioners** NICE NG76 Recommendations 1.1.12 **Planning and delivering services** NICE NG76 Recommendation 1.8.1

Working with other practitioners

NICE NG76 Recommendation 1.1.12

Coordinate your work with practitioners in other agencies so that children, young people, parents and carers do not need to give the same information repeatedly, in line with the Department for Education's advice on Information sharing: advice for practitioners providing safeguarding services.

Multi-agency working

NICE NG76 Recommendation 1.6.1

Practitioners supporting children and young people who have been assessed as being 'in need', or suffering (or likely to suffer) significant harm in relation to child abuse or neglect should:

- build relationships with other practitioners working with that family
- organise handovers if new staff members from their agency become involved
- ensure actions set out in the 'child in need' or child protection plan are completed.

Planning and delivering services

NICE NG76 Recommendation 1.8.1

Plan services in a way that enables children, young people, parents and carers to work with the same practitioners over time where possible.

4.5.3 Current UK practice

Multiagency work

The evaluation of the early help services for children and families provided by local authorities and their partners found variability in how well local authorities and their partners were sharing accountability and coordinating early help services. Highlighted issues mirror those in serious case reviews that looked at early help service:

- Opportunities to provide early help for children and their families were missed by all statutory partners.
- Referrals to social care services not followed through, no support put in place to prevent the child's circumstances from deteriorating, further referrals for social care support.
- Feedback on referrals often neither sought nor offered.
- LSCBs not effectively overseeing or challenging partner agencies with regard to effective early help[24].

Findings from the joint inspections indicate a substantial variation in practice between the six local authorities considered[25]. Some of the examples of poor practice included:

- Health visitors aware of only 26% of expectant mothers where there were safeguarding concerns.
- Staff in adult social services, substance misuse services, adult mental health services did not effectively identify children at risk of abuse and neglect.
- Health practitioners did not always have a good understanding of cumulative risk to older children – incomplete picture of risks when concerns with children's social care were raised.
- Referral information to the MASH from the national probation service (NPS) and criminal record checks (CRC) – missing offending history information, focus on adult behaviour and no links this to the risk of neglect.
- Within the youth offending system (YOS), the child's home circumstances and the underlying potential causes of exhibiting behaviours were not considered in the context of either current neglect or a history of neglect [26]

[24] Ofsted 2015, Early help services: how well are they meeting children's needs?
[25] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018
[26] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018

Research by Barnardo's into child sexual exploitation among children running away found that approximately a third of local voluntary organisations working with children and young people found it very difficult to engage with LSCB and A&E departments[27].

Continuity

The inspections carried out recently by Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMICFRS) and HMI Probation (HMI Prob) highlighted staff turnover among social workers as a problem that led to issues with continuity[28].

Research by Barnardo's recognised that high levels of staff turnover was hampering work to effectively meet the needs of the children and young people[29].

The children's commissioner report on stability index found that of the 38,905 children looked after by 78 local authorities on 31 March 2017:

- 59% experienced at least one change of social worker in 2016/17
- 25% experienced multiple social worker changes in 2016/17[30].

The report also found considerable variation across the country in social worker turnover[31].

Based on Ofsted inspections the National Audit Office found that in 2014-15:

- 16% of children's social workers were agency staff (7% in authorities judged Good and 22% in authorities judged Inadequate)
- 17% of children's social worker posts were vacant[32]

[27] Emilie Smeaton, Barnardo's: Running from hate to what you think is love: the relationship between running away and child sexual exploitation, 2013
[28] Ofsted, CQC, HMICFRS and MHI Prob, Joint inspections of the response to children experiencing neglect, January 2018
[29] Barnado's, Running away from hate to what you think is love, July 2013
[30] Children's commissioner (2017) Stability Index Overview and Initial Findings (April 2017)
[31] Children's commissioner (2017) Stability Index Overview and Initial Findings (April 2017)
[32] National Audit Office, Children in need of help or protection, October 2016

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 5/07/2018.

Skills, knowledge, training and supervision

The skills, knowledge, training and supervision of staff were suggested as areas of quality improvement.

This suggestion has not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the skills, knowledge training and supervision that enable the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased skills, knowledge and training. However, skills, knowledge training and supervision may be referred to in the audience descriptors.

Mandatory reporting

Stakeholders suggested that mandatory reporting of child abuse can deter children and young people from using services and seeking support. They suggested that this quality standard should address this issue.

This suggestions has not been progressed. Quality standards cannot address legislation changes and statutory requirements.

Maternal mental health

Stakeholders suggested perinatal mental health screening and access to interventions for women as an area for quality improvement.

This suggestion has not been progressed. Quality standard on antenatal and postnatal mental health (QS115) already covers this area.

Prevention

Stakeholders suggested prevention as an area for quality improvement. More specifically, they focused on preventing domestic violence and non-accidental head

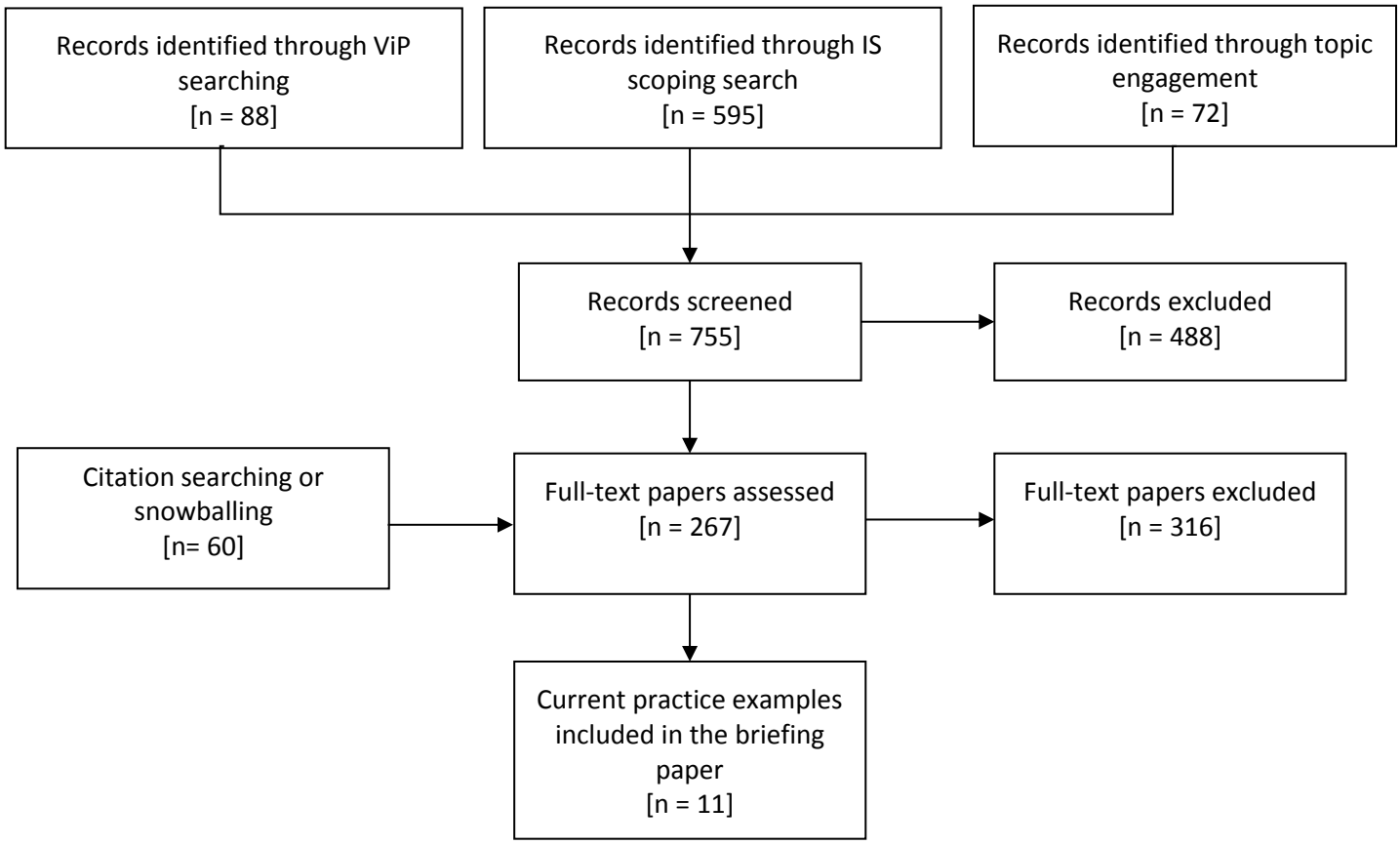
injury in infants. This suggestion has not been progressed as prevention is a broad concept rather than an action that could be captured in a quality statement.

Relationships and sex education in schools

Stakeholders suggested relationships and sex education in schools as an area for quality improvement.

The Department for Education is currently working on implementing improved programme across the country and relationships and sex education are to become a statutory requirement. Quality standards cannot address legislation changes and statutory requirements.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Working with families (section 4.1 in briefing paper)					
1	Against Violence and abuse (AVA)	Asking permission before touching someone (1.1.5)	Many young people who have experienced trauma and abuse will be extremely nervous and any kind of touch can feel threatening. Obtaining consent before touching (expect in extreme medical emergencies) is crucial	If young people are fearful that they will be touched without consent, it may stop them disclosing abuse at all, or at least stop them from seeking help for other related issues which could have presented an opportunity for that practitioner to spot warning signs or ask about abuse. Not asking for consent also undermines the child, re-traumatises them and can make them fearful of people who are supposed to help them.	See Ofsted report (2017) 'The multi-agency response to children living with domestic abuse'

2	Against Violence and abuse (AVA)	Informing young people how to contact practitioners, including out of hours, and check how they want them to safely contact young people (1.1.9)	Young people report that practitioners frequently call them during school hours, which causes a disturbance and can lead to bullying from other students. Practitioners do not always check that the contact details they have are safe to use. It may be that a perpetrator is able to access the communication. They also often call from a withheld number which many victims of abuse will not answer due to fear of who it may be. Victims of abuse feel most anxious and alone at evenings and weekends but are often not provided with out of hours contact details.	Some organisations have a policy that if they are unable to reach a client after several attempts (usually 3), then they are seen as not engaging and the case is closed. This does not take into account how traumatised victims can be, and how they may not be contacting them in a safe way. If they still live with the perpetrator, they may see texts/emails/letters or listen to voice mails. This can increase risk to the child/young person. This issue was raised by all the young people in the ERG.	

3	Association for Family Therapy and Systemic Practice (UK)	Open dialogue process to support determination of the best pathway and to support all involved to respect the complexity of the context of the child or young person they are striving to support.	Because people may often have very strong emotional reactions to abuse and neglect, it can be common to employ the coping mechanism of polarisation to manage this strong emotion. This would be where people tend to see situations in 'black and white' terms to try to help them simplify their thinking, and put them on the 'right' side of the fence. Unfortunately the contexts these children are negotiating are very complex and a system will be most supportive if they can continue to hold in mind and tolerate this complexity.	Open dialogue would invite non-hierarchical discussion, without judgement, encouraging voicing of different opinions, and ensuring the child / young person and their important relationships are central to this process. Open dialogue approaches have had promising results in helping young people and their relational contexts positively navigate the high levels of uncertainty in the context of psychosis, and have supported relational networks to effective support the young person. These ideas could be useful for navigating this equally uncertain, anxious, and risk-balancing situation. Additionally papers have been written on ways to more meaningfully and less coercively, partner with child, young people and families in this context. A mechanism for enabling open discussion, including the child / young person and their important relationship networks, and sharing of different views without criticism as part of ongoing support of decision-making should form part of the quality standards.	Seikkula & Olsen (2003) 'The open dialogue approach to acute psychosis: Its' poetics and micropolitics' Family Process 42: 403-418. Adams & Chandler (2004) 'Responsive Regulation in Child Welfare: Systemic Challenges to Mainstreaming the Family Group Conference' J. Soc. & Soc. Welfare 31 (1): 93-116. Turnell & Edwards (1999) 'Developing a co-operative case plan' Ch. 7 in Turnell & Edwards (1999) 'Signs of Safety: A solution and safety oriented approach to child protection casework'. Norton, New York. Berg & Kelly (2000) 'Investigation as Intervention and Prevention' Ch.6 and 'When you need to place a child out of the home' Ch. 9 in Berg and Kelly (2000) Building Solutions in Child Protective Services. Norton, New York.
4	SCM 5	Listening to children about their wishes and concern, and talking with them in age-appropriate ways which include explanation of professional involvement.	Children are the primary subjects of concern.	Children report not being informed and not being sufficiently involved in processes designed to help them.	NICE Guideline Child Abuse and Neglect

5	SCM 1	Communicating with Children and Young People	There is strong evidence about the skills and components that represent what is required to be able to communicate with children and young people about child abuse and neglect and their direct experiences. Without all agencies feeling confident about this, there is reduced likelihood that children will feel able to disclose abuse.	Anecdotal evidence and formal research indicated variation of response with professionals sometimes stating that they do not feel confident in recognising and responding to child abuse. This means that not all children are heard and have opportunity to disclose abuse.	
6	SCM 5	Communication with parents which consists of exploring their concerns and wishes and is honest in explaining others' concerns, without being punitive	While parents need to be clearly held responsible for child abuse and neglect, they do not usually intend to harm the child. A punitive approach is counter-productive.	Professionals often express difficulties in knowing how to talk with parents in an honest, clear, jargon-free way without blaming them and being clear about the difference between blame and responsibility.	
7	Royal College of Paediatrics and Child Health	Communication with families	In order to develop effective working relationships with families that promote cooperation and trust and in turn foster an environment that supports the well-being of children, professionals must be competent and confident in discussing sensitive issues with families and carers. This can be addressed through training and supervision.	This is an area which professionals find challenging in practice. Improved, open and honest communication will promote more meaningful engagement of families with professionals and plans, which will result in better outcomes for children.	Action for Children - Effective Relationships with Vulnerable Parents to Improve Outcomes for Children and Young People:

8	Against Violence and abuse (AVA)	Young people's opinions to be taken into account when making decisions that affect them	Victims of abuse feel disempowered and ways of working that actively seek to empower them via meaningful participation methods should be encouraged	When young people are asked for their input and their views and experiences are validated and acknowledged, they are more likely to engage as the service will be designed in a way that is more relevant for them. They are then more likely to adhere to any action plans and provide useful feedback for the further improvement of services. This also helps to build better, trusting relationships between clients and staff which have to be at the heart of any trauma informed work.	Chilypep toolkit on meaningful participation - http://www.chilypep.org.uk/uploads/pdfs/Participation-Toolkit.pdf
9	Against Violence and abuse (AVA)	Recording, in the young person's words what has been discussed and asking the young person to sign it and indicate if they disagree (1.1.6)	The expert reference group evidence clearly shows that reports, if written, are often not truly reflective of what the young person has said. Practitioners sometimes project their own opinions into the report and do not use the young person's words directly. This leads to a difference between actual experiences and what is recorded as well as a breakdown in trust due to young people not feeling heard.	Young people are often very mistrustful of forms and records. Many of the ERG had had experiences of their words being 'twisted' and reports not accurately reflecting what they had said. This led to inappropriate referrals/actions and a lack of trust and engagement from the young people.	

10	Association for Family Therapy and Systemic Practice (UK)	Central involvement of child / young person in determining the best pathway	It is of the utmost importance that the child / young person's voice is not dominated by the discourse of those who hold more power within this process. Children and young people need to be actively supported and made room for to bring forth their voices.	Open dialogue approaches to decision making (see above) or ensuring effective advocacy to support the child / young person remaining central to this process, could be helpful. Some kind of mechanism to support the child / young person being able to fully participate in decision making should form part of the quality standards.	NICE guidelines 76 (2017) recommendation 1.1 (principles of working with children) NG26 (2015) Recommendation 1.1 (principles of care)
11	SCM 7	Voice of the child	Need to reinforce the guideline's focus around disclosure, sensitivity to children etc	Recurring messages about keeping child at the centre and overreliance on actual disclosures of abuse.	
12	Royal College of Paediatrics and Child Health	Communication with children and young people	In order for children and young people to have the opportunity to share their concerns, professionals need to be able to gain parental consent to speak to the child on his or her own and then to communicate well with the child to gain their trust and confidence.	Children and young people report that they have tried to tell professionals about their abuse in a variety of ways from direct verbal disclosures to indirect disclosures through their behaviour or words. Some young people can not disclose their abuse but report that they would have liked to have been asked by a professional. Children have a right to be involved in decisions that effect them. It is fundamental to safeguarding practice that the voice of the child is heard throughout any assessments and interventions.	Final Study Report. August 2011 CYP: No one noticed, no one heard:a study of disclosures of childhood abuse. NSPCC 2013. Article 12 UNCRC 1989 The Munro Review of Child Protection: Final Report – A child-centred system. Department for Education 2011

13	Royal College of Paediatrics and Child Health	The lived experience of the child, including their thoughts and words are accurately documented with every contact.	It is crucial that professionals are able to appreciate the lived experience of the child, particularly in cases of possible neglect. The child might provide verbal and non-verbal cues but the professional must be prepared to ask difficult questions and to give children the space to describe what is happening to them.	This forms a crucial part of the child-centred approach (1.1.1 in NICE guidance) and was a key feature in the recent CQC report. It is also a recurring theme in Serious Case Reviews.	Example: CQC report Not Seen, Not Heard: *a review of the arrangements for child safeguarding and health care for looked after children in England (July 2016).*
14	SCM 2	1.1.10 Aim to build good working relationships with parents and carers to encourage their engagement and continued participation	Many parents, as well as children and young people who suffer from neglect and maltreatment, mistrust formal services. This puts children and young people at risk of further significant harm. It is therefore necessary that parents and children feel that they are not stigmatised when seeking help and that they retain an appropriate degree of control over subsequent stages of the support and protection process (It is important to) involve children and families in planning, leading to the identification of clearly specified goals and targets concerning what needs to be changed IMPROVING THE	Action for Children believe that parents are often unclear about their responsibilities towards children and the child protection system seeks only to punish parents after neglect has happened rather than trying to improve parenting. Another academic expert, Dr Brandon, argued that “because often the families where there is neglect are very complicated, difficult and confusing for practitioners, they can overwhelm individuals working with families, so they fail to see what is in front of them”.	Unless otherwise specified, the primary source for this section is one systematic review with narrative summary (Ward, 2014) - There is no guarantee that parents’ engagement with services will lead to adequate, timely change across all domains. - Parents facing multiple problems may become motivated to change in one area, but may not necessarily appreciate the need for change in others - Professionals need to be aware of the way that parents’ own experiences of attachment can affect not only their relationships but also their engagement with services. - Parents with poor communication skills may give the impression of being resistant, although they are in fact willing to engage. Equally, willingness to engage in treatment can be interpreted as willingness to change.

			EFFECTIVENESS OF THE CHILD PROTECTION SYSTEM LGA		- Practitioners need to be alert to false compliance. - Practitioners need notice when their own actions or role are creating resistance. Data Sources for this key development area: *Parental Perspectives on the Family Justice System in England and Wales: a review of research Undertaken for the Family Justice Council and funded by the Nuffield Foundation May 2010 *A systematic scoping review of parental satisfaction with child protection services ClareTilbury,SylviaRamsay
Recognition (section 4.2 in briefing paper)					
15	Royal College of Paediatrics and Child Health	Management of fabricated and induced illness	Management of fabricated and induced illness	Whilst there is recognition of severe cases, personal experience and shared reports from colleagues suggest that different agencies still fail to reach consensus as to definition of FII, and working together to remediate	RCPCH Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians. October 2009, update in progress.
16	SCM 5	Professional response at the earliest point in a child's life and at the first recognition of difficulties.	There is ample evidence for the harm to children caused by prolonged and repeated maltreatment.	In many cases of child abuse and neglect there have been previously known concerns about the child and or family which have been insufficiently responded to.	NICE Guideline Child Abuse and Neglect
17	SCM 5	An emphasis on and validation of the importance of observations by universal services – primary health and education. Encouragement to these services to express their	Primary health and education, rather than social services, are at the forefront of early recognition of indicators of concerns.	Primary health and education are not always sufficiently confident about their observations and not always clear about how to proceed. Nor are they often certain that they will be listened to.	

		concerns and ensure that they are heard and acted upon.			
18	Department for Education	identification and assessment of family factors that increase vulnerability to child abuse and neglect (see NICE guideline, paragraph 1.2.3; opportunity to cross-reference to other NICE quality standards e.g. on domestic violence and abuse, and drug misuse prevention)	All practitioners should be alert to the signs and triggers of child abuse and neglect, including in identifying family factors that can increase a child's vulnerability – including, but not limited to, domestic abuse, drug or alcohol misuse, and mental ill-health. When presented with any of these risk factors, practitioners should explore whether there may be cumulative risks of harm to the child. The impact and influence of wider family and any other adults living in the household, community and environmental circumstances should be identified and investigated as part of a comprehensive assessment. It is important that: information is gathered and recorded systematically; information is checked and discussed with the child and their parents/carers where appropriate; differences in	The Children in Need Census shows that the most common factors identified at the end of a social work assessment are domestic violence (49.9%) and mental health, of either an adult and/or child (39.7%). In order to adequately protect children from abuse and neglect, it is vital for practitioners to understand and be able to identify these wider family factors – which can pose a significant risk of harm to children, individually or particularly in combination.	The most recent Triennial Analysis of Serious Case Reviews (2016) identified the cumulative risk of harm to a child when different parental and environmental risk factors are present in combination or over periods of time. This was noted particularly in relation to domestic abuse, parental mental ill-health, and alcohol or substance misuse: parental alcohol and drug misuse were both recorded as present in over a third of reviews (37% and 38% respectively), with at least one of these in 47% of cases; in 48 cases (27%) both factors were present; and parental mental health problems were found in 53% of cases, and domestic abuse in 54%. Other family factors often co-existed with these risks, and potentially interacted with them to create harmful environments for the children. These included issues such as adverse experiences in the parents' own childhoods; a history of criminality, particularly violent crime; a pattern of multiple consecutive partners; and acrimonious separation; and social isolation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-

			views about information are recorded; the impact of what is happening to the child is clearly identified.		__Pathways_to_harm_and_protection.pdf Children in Need Census: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656395/SFR61-2017_Main_text.pdf
19	SCM 6	Gentle enquiry of 'whether something is happening to the child'	Most children do not tell an adult that they are a victim of CSA/e – nor do adult survivors. Most adult survivors say that they were waiting to be asked. There is published research that supports this statement ie waiting to be asked.	If the child is not asked, then the worker is waiting for the child to spontaneously disclose. The Childrens Commissioner for England published a report that said that authorities were only aware of 1:8 child victims of CSA; therefore we need to be able to reach out to the 7:8 and offer a pathway to disclosure.	Not sure what to put here – but we ought to see the number of disclosures going up; or we ought to be able to see the question being asked and a response. It is important that the answer is not recorded as 'no' – because it is known that children will often say no, when it should have been a yes. They say no because it is not safe enough to say yes. If you record no – then later on when the child says yes, the defence will allege that because they said no before, and yes now, that they are a liar. It is better to record 'not disclosed'.
20	SCM 7	Sexually harmful behaviours	Need to reinforce linked guidelines.	My practice experience would highlight that we can go from under intervention to over escalation. Need broader understanding of red flags to behaviour without over responding to exploratory 'non-harmful' behaviours between children.	

21	SCM 1	Ensure that there are appropriate resources and structures in place for communicating with those with additional needs	There is historic underreporting of abuse of children with disability and additional needs due to complex issues about communication, recognition, professional networks. The voices of this vulnerable group must be heard and their unique experiences understood in order for there to be a consistent and appropriate response to abuse and neglect.	Research indicates that child abuse is under-reported and not always recognised in relation to children with disabilities. They are particularly vulnerable and so their needs to be safeguarded must be fully reflected in service design and delivery.	
22	SCM 1	Develop understanding and the messages from research about emerging forms of abuse eg FGM, CSE, Modern Slavery etc.	Agencies are learning to recognise abuse and neglect in all forms and these “specialised” areas of harm are emerging. This can cause professional anxiety and role confusion. Research and best practice must be shared across agencies so that there is a safe and consistent response to abuse – children are protected and perpetrators are held to account.	There can be inconsistent recognition and response. In some respects research is in its infancy and so we need to accelerate learning in these areas so that we are better at safeguarding children and young people.	

23	NSPCC	Additional developmental areas of emergent practice • Harmful Sexual Behaviour (HSB) • Services for children living with domestic abuse	• Children and young people account for approximately a quarter of all convictions against victims of all ages (Vizard, 2004) and a third of all sexual abuse coming to the attention of the professional system (Erooga and Masson, 2006). • Children living with domestic violence may be more actively involved in the violent event than has been previously recognised (Overlien, 2010). It is currently estimated that 1 in 5 children in the UK have been exposed to this form of abuse (Radford, 2011). Research shows that children are involved in a large number of ways when they live with domestic abuse. For instance: as hostages (Ganley and Schechter, 1996), they may be in the parents' arms when an assault occurs (Mullender et al., 2002); and/or defending a parent (Edleson et al., 2003). While some studies show that children who are 'directly abused' are more	• 'Despite increasing evidence on the scale, nature and complexity of the problem, service provision across the UK remains patchy and relatively uncoordinated, with some beacons of good practice. Levels of professional confidence and competence to address the challenge are, at best, varied' (Criminal Justice Joint Inspection, 2013). The NSPCC has produced an evidence-based tool for developing coordinated, multi-agency local responses to children and young people's HSB, along with NICE guidelines. • The National Police Chiefs' Council Guidance on investigating domestic abuse states that police officers should investigate the welfare of all children who have witnessed domestic abuse or who are normally resident at an address at which a domestic abuse-related incident has been reported. 'In the UK, only 9% of children who have experienced domestic violence in the UK have access to Child and Adolescent Mental Health Services for mid to long term support (CAADA, 2014b), despite children reporting significant psychological distress in the aftermath of living with domestic violence' (Mullender et al., 2003; C. Øverlien, 2009; Swanston et al., 2014a, in Callaghan and Alexander, 2015).	Barnardo's (2017) Police figures reveal rise of almost 80% in reports of child-on-child sex offences. Callaghan, J and Alexander, J (2015) Understanding agency and resistance strategies: Children's experiences of domestic violence, Northampton University. Criminal Justice Joint Inspection Examining multi-agency responses to children and young people who sexually offend, February 2013 justice.gov.uk/downloads/publications/inspectoratereports/hmiprobation/joint-thematic/children-yp-whosexually-offend-report.pdf Hackett, S. (2014) Children and young people with harmful sexual behaviours. Humphreys, C. (2006) Relevant evidence for practice. In: C. Humphreys and N. Stanley (eds.) Domestic violence and child protection: directions for good practice Office for National Statistics (ONS) annual report: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017

			likely to show more severe impacts on their health and well-being (Carlson, 2000; Edleson, 1999; Hughes et al.,2001; Crockenberg and Langrock, 2001), other research shows little difference between witnessing domestic abuse and actual abuse (Mertin and Mohr, 2002). Research shows that children exposed to domestic violence are more likely to have behavioural and emotional problems (Humphreys, 2006).		
24	Ofsted	In Ofsted's commentary hidden children we did raise the issue of safeguarding children vulnerable children not attending school. This needs to be considered in strategic planning and commissioning.			

25	Royal College of Paediatrics and Child Health	Establishment of clear pathways for early intervention to improve the lives of children found to be living with domestic abuse	There is a clear association between fatal non-accidental injury and domestic abuse (approximately 60% serious case reviews found the victim was living with domestic abuse). Police attendances to addresses because of reports of domestic violence found children at the address in over 50% of incidents.	There is ambiguity around reporting, recording and acting to protect children when found to be living with domestic abuse. While the police in some areas notify health if there is a child under 5 in the household and arrangements may be made to remove the victim and her children, there may be limited or no follow-up once they have been rehoused and little attention paid to the short and longer-term emotional and psychological consequences on the children. It is recommended that children under 18 are referred to social care if found to be living with domestic abuse but the response varies depending on geographical location and local thresholds	Government guidance makes little mention of children https://www.gov.uk/guidance/domestic-violence-and-abuse References and guidance at http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/domesticviolence.aspx
26	Royal College of Paediatrics and Child Health	Additional developmental areas of emergent practice Recognition of male victims of honour based violence	Organisations should ensure that their training for practitioners, and their policies and procedures recognise male victims of abuse, including male victims of honour based violence and child sexual exploitation.	Men and boys are often not recognised as victims of honour based violence and CSE.	Tri.x policy briefing number 207 May 2017
27	Royal College of Paediatrics and Child Health	Additional developmental areas of emergent practice Adverse childhood experiences (ACEs)	This is a recommendation in NICE 1.8.5.It is important in respect of reflecting on practice and in being supported within what can be a challenging work environment.	If adverse childhood experiences can be prevented, or, at least, identified early, then this will break the intergenerational transmission of child abuse and neglect, with its attendant human and economic costs.	NICE should consider whether ‘routine questioning’ about adverse childhood experiences should occur in health settings. Some workers are enthusiastic about such a proposal whereas others urge due caution.

28	Royal College of Speech and Language Therapists	Having speech, language and communication needs (SLCN) also increases the risk of maltreatment; women with a history of SLCN were more likely to report sexual abuse than their peers (Brownlie et al, 2017) and boys with SLCN are at greater risk of hostile parenting (Yew and O'Kearney, 2015).	Brownlie, E., Graham, E., Bao, L., Koyama, E., Beitchman, J.H. (2017). Language disorder and retrospectively reported sexual abuse of girls: severity and disclosure. Journal of Child Psychology and Psychiatry.		
29	Royal College of Speech and Language Therapists	Disabled children are more likely to experience abuse than their peers (Stalker and McArthur 2010,) as are children and young people who experience SLCN and social, emotional and mental health difficulties. (Brownlie et al 2017)	Stalker, K. & McArthur, K. (2010), Child abuse, child protection and disabled children: a review of recent research. Child Abuse Review, 21(1), 24-40. Brownlie, E., Graham, E., Bao, L., Koyama, E., Beitchman, J.H. (2017). Language disorder and retrospectively reported sexual abuse of girls: severity and disclosure. Journal of Child Psychology and Psychiatry.		

30	SCM 3	Establishment of clear pathways for early intervention to improve the lives of children found to be living with domestic abuse	There is a clear association between fatal non-accidental injury and domestic abuse(approximately 60% serious case reviews found the victim was living with domestic abuse). Police attendances to addresses because of reports of domestic violence found children at the address in over 50% of incidents.	There is ambiguity around reporting, recording and acting to protect children when found to be living with domestic abuse. While the police in some areas notify health if there is a child under 5 in the household and arrangements may be made to remove the victim and her children, there may be limited or no follow-up once they have been rehoused and little attention paid to the short and longer-term emotional and psychological consequences on the children. It is recommended that children under 18 are referred to social care if found to be living with domestic abuse but the response varies depending on geographical location and local thresholds.	Government guidance makes little mention of children https://www.gov.uk/guidance/domestic-violence-and-abuse References and guidance at http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/domesticviolence.aspx
Assessment (section 4.3 in briefing paper)					
31	SCM 5	An assessment of concerns about the children's functioning, parent-child interaction, parental difficulties and family-social factors before offering any intervention/help.	Such an assessment will point to a hierarchy of areas of concerns, which are often interlinked and which require a systemic coherent response.	There are examples of intervention and support which are offered in isolation and without reference to other aspects being addressed simultaneously. Family are being offered a number of different interventions at the same time.	
32	SCM 6	Assessment	Trauma informed assessment		

33	NSPCC	Safeguarding assessments within families should be robust and child-centred.	Section 47 of the Children Act 1989 'places a duty on local authorities to make enquiries where it is suspected that a child is suffering, or is likely to suffer, significant harm, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child'. There is increasing consensus about the need for Structured Professional Judgment in which professional decision-making is supported by the use of standardised tools. However, there is limited evidence about the effectiveness of some of the available tools in the child protection field (Barlow et al, 2012). According to the government's Working Together Guidance for England (2013), a high-quality assessment should be: child-centred and informed by the views of the child; based on decisions made in the best interest of the child; and rooted in child development. The use of Adverse Childhood Experiences	Evidence from a range of sources has identified that 'although practitioners are good at gathering information about children and families, they find it challenging analysing complex information in order to make judgments about whether a child is suffering, or is likely to suffer, significant harm' (Barlow et al, 2012). This chimes with research highlighting the poor accuracy of much decision-making in the child protection field, with assessments being 'only slightly better than guessing' (Dorsey et al 2008 in Barlow et al, 2012). Studies, inspections and reviews highlight a set of issues which are consistently associated with poor assessment practice (Brandon et al., 2008; Farmer and Lutman, 2010;Horwath, 2010, 2013; Cossar et al., 2011; Davies and Ward, 2012; Munro, 2012; Brandon et al UEA/NSPCC, 2013; Ofsted, 2011, 2014a and b; Jay, 2014). These include: 1) Difficulties in remaining child-centred when a professional is working with families, particularly when the problems are long-standing. 2) A tendency to focus on presenting problems, practical issues and parents' needs rather than the impact of on-going neglect/abuse on the child. 3) Young people indicating they are not actively consulted about their needs, their desired interventions or the effectiveness of interventions. Graded Care Profile 2 is one such child-centred tool that helps practitioners to assess the quality of care offered to the child across five domains. It has been tested for validity and reliability, as was	National sources for data collection in this area: Department for Education (2017) Characteristics of children in need: 2016 to 2017 England Department for Education (2012) Barlow, J., Fisher, J., Jones, D. Systematic review of models of analysing significant harm Radford, L., Corral, S., Bradley, C., & Fisher, H. L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults. Child Abuse Negl, 37(10), 801-813. McGee , C., Hughes , K., Quigg Z., Bellis, M., Larkin, W & Lowey, H. (2015) A Scoping Study of the Implementation of Routine Enquiry about Childhood Adversity (REACh)

			(ACEs) in assessments appears to be a helpful focus for assessing child and parent experiences of trauma. However, where ACEs are used, proper oversight and evaluation is needed to avoid unintended harm. For example, the screening process can cause distress which is not monitored; mental health needs could be identified without appropriate care services then being provided; or abusing parents could be alerted that questions are being asked about abuse and neglect. In order to minimise these risks, the tool should be subject to the national guidelines on the use of screening tools and fully evaluated before being recommended for practice. Any dissemination of the tool should be accompanied by comprehensive staff training on its strengths and weaknesses. There should also be consistent inclusion of neglect when applying ACEs. Much of this UK research on ACEs has excluded reference to neglect. This is a	recommended by Barlow et al in 2012. The research on ACEs is still developing. The NSPCC is concerned that given the visible nature of ACEs research and its relevance to public health, commissioners and providers will implement the tool despite there being little evidence on how to do this effectively and in a way which minimises unintended negative consequences. The Routine Enquiry about Adversity in Childhood training programme developed in Blackburn and Darwen is an important first step towards expanding the evidence-base on how to support ACE-informed practice (McGee, 2015). However, the study did uncover a concerning level of variation in implementation and data collection. All services should use the same version of the tool – i.e. that which includes neglect – with comparable implementation procedures, and data collection policies.	

			significant omission given that neglect is the most prevalent form of maltreatment across the four nations of the UK, with one in six children experiencing it (Radford, Corral, Bradley, & Fisher, 2013) A failure to include neglect as the tenth ACE reduces the concept's reliability and validity.		
34	Ofsted	Need to improve strategic approach to address a range of vulnerabilities. For example where children are at risk both within the home and outside in the community. There may be various strategy in place but they often concentrate on one area and are not bought together. An example is older children going missing and at risk of child sexual exploitation, who may also be living with domestic abuse or/and neglect.			
35	ADCS	Assessment	It would be helpful if assessment was prioritised as the final guideline did not cover this in a significant way		

36	BASPCAN	Assessing whether or not sexually active young people are engaging in a consensual or exploitative sexual relationship	This is important because young people may be misled into thinking they are in a loving relationship when in fact they are being groomed for sexual exploitation, which can lead to serious consequences for a young person's mental and physical health.	Several recent court cases (e.g. in Rochdale and Oxford) have led to an increased awareness of the dynamics and consequences of sexual exploitation. Inquiries have highlighted the need for enhancing professional awareness and assessment skills.	Example: Bristol Safeguarding Children Board (2016) The Brooke Serious Case Review into Child Sexual Exploitation. Bristol BSCB
37	SCM 4	Organisations should ensure that practitioners conducting assessment in relation to abuse or neglect of disabled children or young people, or those with neurodevelopmental disorders, can access a specialist with knowledge about those children and young people's specific needs and impairments.	There is good evidence that disabled children are at higher risk of child abuse and neglect than children without disabilities.	Access to specialists with knowledge about disabled children's specific needs and impairments is variable across the country.	

38	Department for Education	Assessment of disabled children at risk of abuse and neglect	Good assessments support professionals to understand whether a child has needs relating to their care or a disability, and/or is suffering, or likely to suffer, significant harm. The specific needs of disabled children should be given sufficient recognition and priority in the assessment process, including to understand contributing factors related to a child's disability and identify any underlying conditions. Decisions and assessments relating to disabled children should be well informed by previous history and based on up-to-date multi-agency assessments, particularly co-ordinating with health services. It is important that where possible as much accurate information is gathered, in order to fully understand the context and assess the likelihood of harm to the child. It may be necessary to obtain an accurate assessment of the child's understanding and language abilities, and	Research on the protection of disabled children indicates that they are more at risk of being the subject of abuse or neglect than non-disabled children. See for example: https://www.nspcc.org.uk/globalassets/documents/research-reports/right-safe-disabled-children-abuse-report.pdf However, statistically, disabled children remain relatively under-represented in high-end child protection procedures (child protection investigations and plans). Where intervention is primarily due to disability or health needs, indicators of abuse may be misinterpreted and the risk of significant harm can go unrecognised, unchallenged or attributed to the child's disability rather than identified as a sign of abuse or neglect. Equally, the impact of a medical condition or disability on a child's development, or physical or emotional health, can be misinterpreted as being a consequence of abuse. For some children, the origins of their impairment or disability may be very complex with an underlying medical or developmental condition being further impaired by abuse or neglect. This includes, for example, consideration of invisible disabilities such as Myalgic Encephalomyelitis (ME) or Chronic Fatigue Syndrome (CPS). In these circumstances, detailed assessments are required to understand cause and effect.	The same Triennial Analysis of Serious Case Reviews (2016) identified disabled children as a particularly vulnerable group, where signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments. Around 1 in 10 children involved in Serious Case Reviews covered in the period of the analysis was found to be disabled. A number of factors were identified as potentially contributing to this vulnerability, including: - Signs of abuse or neglect may be masked by or misinterpreted as due to the underlying impairments - Professionals are less skilled in communicating with disabled children - Disabled children may be less able to communicate their concerns - Caring for a disabled child places additional stresses on parents https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf A report by Ofsted and the Care Quality Commission (CQC), 'Local area SEND inspections: one year on' (2017), found that in education, health and care plans there was very poor evidence of how social care needs had been considered and what the intended outcomes

			then take advice on communicating or working with the assistance of someone who knows the child well. No less than for any other child, local authority children's social care has a duty to ascertain a disabled child's wishes and feelings regarding the provision of services to be delivered. Assessments should involve disabled children, ensuring that their voice is heard and with consideration given to how best to obtain the child's view views, taking their disability into account.		were for children with special educational needs and disabilities. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/652694/local_area_SEND_inspections_one__year__on.pdf The Children in Need Census shows that 9.4% of children in need have 'child's disability or illness' identified as the primary need at assessment: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656395/SFR61-2017_Main_text.pdf

39	Public Health England	Vulnerabilities and adversity	Children living in certain circumstances, or at risk of certain life experiences, may be exposed to a heightened risk of vulnerability.	Children's vulnerability can arise in a wide range of circumstances. Whilst not all children living in these circumstances will have poor outcomes, it does leave them at greater risk/s. These include family circumstances e.g. parental substance dependencies, parental conflict, poverty; and for individual children: disability, mental ill health etc. There is increasing evidence that parental Adverse Childhood Experiences (ACEs), as well as the child's exposure to ACEs increase the risk of child abuse and neglect. Whilst the value of using ACEs as a screening tool has been questioned as lacking sufficient predictive value, there is a growing consensus that practitioners in health, education, social care and justice need to be "ACE aware" to inform clinical decisions about levels of risk.	The Children's Commissioner published a report earlier this year a report into vulnerabilities and children suggesting that "half a million children [are] so vulnerable that the state has to step in".[i] The Welsh and Scottish Governments have published documents on childhood adversities: - http://www.cph.org.uk/wp-content/uploads/2016/01/ACE-Report-FINAL-E.pdf - Scottish Government: A Nation With Ambition: The Government's Programme for Scotland 2017-18 (Chapter 2: Services Fit for the Future) http://www.gov.scot/Publications/2017/09/8468/9 Please see Early Intervention Foundation work on ACES: and Centre for Public Health: http://www.cph.org.uk/case-study/adverse-childhood-experiences-aces/
40	Royal College of Paediatrics and Child Health	Professionals enquire about adverse childhood experiences in cases of self-harm and suicidal behaviour	Adverse childhood experiences such as exposure to domestic violence and physical, sexual and emotional abuse have been linked with later self-harm, suicide, depression, PTSD and eating disorders in adolescents (NICE 1.3.6).	If Adverse childhood experiences can be identified in these target groups, and appropriate intervention (see below) undertaken, this will enhance the child's later physical and mental health and well-being and will be an effective intervention, both in human and economic terms (see also below).	Again, there is a huge evidence-base. Example: Banyard V et al. Health effects of adverse childhood events: identifying promising protective factors at the intersection of mental and physical well-being. Child Abuse & Neglect 2017; 65: 88-98. Caspi A et al. Childhood forecasting of a small segment of the population with large economic burden. Nature Human Behaviour 2016

41	Royal College of Paediatrics and Child Health	Neglect	Organisations should equip their practitioners with the necessary evidence based tools to effectively assess and work for sustained improvement with families where neglect is a concern.	Neglect is the most prevalent and pervasive form of child maltreatment in England and Wales with serious long term consequences for children's physical and mental health. It is often poorly assessed and managed resulting in children being exposed to chronic neglect and no effective intervention which results in sustained change.	How safe are our children? NSPCC 2017 Childhood Wellbeing Research Centre (CWRC) Working Paper 16 Second Edition Title: Decision-making within a child's timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment. Authors : Rebecca Brown and Harriet Ward Date: February 2013Date: February 2013
42	The Faculty of Sexual and Reproductive Healthcare (FSRH)	Risk assessment	Effective risk assessment will identify risks some way into the future.	It is essential to develop preventative as well as responsive approaches to abuse and neglect. There is a need to develop tools and methods that can support the work of professionals, and codify best practice. FSRH supports the introduction of Child Sexual Exploitation (CSE) risk assessment tools to aid frontline healthcare professionals in their assessment of potential risk.	One such CSE tool has been developed by the British Association for Sexual Health and HIV (BASHH) and Brook with support from FSRH. It is called "Spotting the Signs" and consists of a proforma that allows SRH professionals to use a standardised approach to identifying young people who may be at risk of or experiencing CSE.

43	Child Protection Special Interest Group	Suspected injuries are recorded with the appropriate use of digital photographic imaging.	Photographic evidence is important in order to fully document the suspected injury. This information is then available for peer review, courts and for second opinions if needed as well as in some instances teaching purposes. It also allows for remote supervision of cases prior to peer review.	Discussion with Named and Designated doctors in Greater Manchester and elsewhere has revealed a wide diversity of practice in this area. This includes the threshold for whether or not a child's injuries are photographed as well as the local availability and governance of the clinical photography of children's injuries. CPSIG is aware of a judge writing to health to comment on the lack of photographic evidence available.	The Child Protection Special Interest Group (CPSIG) presented these, and related issues to the Royal College of Paediatrics and Child Health (RCPCH) Standing Committee on Child Protection in October 2017. As a consequence a joint working group is being set up to carry out a national audit and recommend good practice regarding service delivery aspects of the medical assessment of children who are referred by social care due to concerns about physical abuse. The RCPCH Child Protection Companion 2013 gives a range of good practice guidance, including photography. In Greater Manchester a set of Service delivery Standards was agreed and are documented in an article in the national newsletter of the British Association of Community Child Health (BACCH) – [Safeguarding Standards, BACCH News, March 2016, P 17- 18. Author Elaine Burfitt] These standards have been adopted by NHS England in the Greater Manchester area and formed the basis of their benchmarking audit of services in 2017, information being gathered by each CCG and forwarded to NHSE. I do not have the results of that audit.

44	Child Protection Special Interest Group	Children with physical injuries suspected of being due to abuse are seen for paediatric medical assessment in a timely manner by an appropriately trained and supported clinician.	Bruising and burns are only present for a limited amount of time and are sometimes gone by the time a child is presented for examination making the medical opinion less helpful. Opportunities to document abuse that the child may have suffered might be lost. The medical opinion needs to be carried out in a timely manner in order to inform multiagency decision making about safe care arrangements for the child and for the child and family to be informed – particularly if the opinion is that the injury is not likely to be abusive in origin.	The origins of the delay which can occur are multifactorial, including delayed referral to social care by the individual or agency who first noticed the mark, referral by social care for a paediatric assessment and delay in providing an assessment by an appropriately trained clinician with sufficient time and resources.	Please see supporting information as outlined for quality improvement 1 as the same applies to this area.
45	Royal College of Paediatrics and Child Health	Radiological Investigation of Possible NAI	Radiological Investigation of Possible NAI	Personal experience suggests a lack of familiarity with new guidelines, and an unwillingness in particular to go beyond 1 normal skeletal survey	The radiological investigation of suspected physical abuse in children. Royal College of Radiologists 2017
Response (section 4.4 in briefing paper)					

46	Ofsted	Work being undertaken with the whole family. What we have found with older children suffering neglect is that often the focus is on the young person's presenting issue rather the underlying causes for the behaviour, therefore work is often undertaken just with the child and not with the parents who are neglecting the child which impacts on the child, therefore interventions are going to be less effective.			
47	SCM 4	Weekly home visiting programmes lasting at least 6 months, should be offered to parents or carers at risk of abusing or neglecting their child or children, This should be in addition to universal health visiting services available through the Department of Health's Healthy child programme.	There is good evidence that sustained regular and tailored home visiting support can prevent the occurrence of abuse and neglect for children at risk		
48	Department for Education	Use of evidence in protecting children from abuse and neglect	Protecting children from abuse and neglect requires informed decisions to be taken on the nature of any action required and which services should be provided. Practitioners and commissioners	DfE supports the principle that good decision-making and strong social work practice should be based on the best available evidence, recognising the benefits of developing trusted evidence on what works, and a means of testing the strength of the evidence for effective interventions. There is a growing evidence base on what	The Early Intervention Foundation report, 'Improving the effectiveness of the child protection system' (2017), found that: "Evidence could, and should, play a greater role in improving the effectiveness of the child protection system than is currently the case."

			should ensure action is taken or support provided which will be most effective in having an impact on the child's life. In making decisions about interventions and support for children at risk of, or suffering abuse and neglect, available evidence of effectiveness should therefore be taken into account. Practitioners should have access to the latest research showing which types of interventions are the most effective. Social workers and practice supervisors should reflect the latest research, and make decisions informed by the evidence available. Equally, Local Safeguarding Children Boards and in future, local safeguarding partners, should take account of recommendations from relevant research and evidence.	works in children's social care: through established organisations such as NICE and the Early Intervention Foundation (EIF); emerging evidence from DfE's Innovation Programme and Partners in Practice; and through the new Children's Social Care What Works Centre. As this evidence base grows, it is therefore important that it informs frontline practice – supporting the implementation of effective interventions and practice systems by practitioners and decision-makers. Currently, it remains that evidence-based interventions are not necessarily widely delivered in practice, despite having the potential to improve outcomes for children. Whilst other factors must also be considered in deciding what interventions to undertake (such as practitioners' professional judgment, and children and families' own views), the EIF's assessment has been that: "families and children who receive interventions shown through robust methods to improve outcomes are more likely to benefit and to a greater degree, than those who receive other services".	This was understood broadly to mean: - using evidence to understand local need and demand - selecting interventions which have evidence of improving outcomes for vulnerable children and which match local needs - where evidence of impact is not available, asking questions about other sources of evidence or knowledge that are being used as a basis for decisions.

49	NSPCC	The delivery of any services required after assessment should be both child-centred and inclusive of parents where appropriate (including where parents experience multiple needs)	There is growing evidence about the need for more effective early intervention to help support families with multiple and complex needs (Devaney et al, 2013). Research suggests that the majority of serious child abuse cases involve families where parents experience multiple challenges. In the case of substance misuse, up to 90 per cent of women who are drug-dependant are of child-bearing age (Day and George 2005). Evidence suggests that some parents using substances have a "lack of understanding about basic child development issues, ambivalent feeling about having and keeping children, and lower capacities to reflect on their children's emotional and cognitive experience' (Suchman 2005). What is more, it is the interplay between substance misuse and a range of individual, family and socioeconomic factors which is thought to generate poor outcomes (Dawe and Harnett (2007).	Specialisation between children's and adults services has generated benefits, but has also served to create a gap between services in many areas and limited the 'breadth of view' of some professionals and organisations (Roscoe, 2012). In the case of substance abuse, the Munro Review (2010) found that "despite the increasing evidence about the impact of substance/alcohol misuse on parenting capacity, there has been a significant gap in services addressing the family and child needs of substance misusing adults in the UK, with little parent-focused practice." Parents Under Pressure (PUP) is a pioneering new service for drug and alcohol dependant parents with children under the age of two and a half years. The outcomes include a focus on the parent-child relationship, on the child and on the parent. A randomised control trial (RCT) has been conducted by Warwick University, with the families of children up to 2.5 years old. The result will be made available in March 2018. The evaluation of NSPCC's Family SMILES programme also highlights the value of an approach to service delivery that works with the whole family, bringing together adults and children who may previously have been engaged with multiple agencies (Margolis and Fernandes, 2017). This has led to the development of the Young SMILES programme, which is currently the subject of a feasibility RCT, led by Manchester University.	For the estimated prevalence of children who have been maltreated in a given area, please see the Joint Strategic Needs Assessments and local transformation plans published annually by clinical commissioning groups. Devaney, J., Bunting, L., Hayes, D. and Lazenbatt, A. (2013) Translating learning into action…. Belfast: Department of Health, Social Services and Public Safety (DHSSPS) Macdonald, G. et al. (2016) The effectiveness, acceptability and cost-effectiveness of psychosocial interventions for maltreated children and adolescents…. Southampton: National Institute for Health Research. (Health technology assessment, Vol.20, Iss.69) Houmoller, K. et al (2011) Juggling Harms: Coping with parental substance misuse¬. London: London School of Hygiene and Tropical Medicine. Margolis, R and Fernandes, P (2017) Building children's confidence and improving parents' protective skills: Final evaluation of the NSPCC Family SMILES service, NSPCC. Suchman, N (2005) How early bonding, depression, illicit drug use,

			Services which promote secure attachment with a primary care-giver can play an important role in prevention of abuse and neglect (Macdonald, 2016). After physical or emotional abuse and neglect has taken place, NICE guidelines recommend attachment-based interventions, comprehensive parenting interventions, child-parent psychotherapy and parent-child interaction therapy. Research also suggests that children can be protected from further harm by being provided with the opportunity to share their difficulties in a safe setting, and developing a sustainable relationship with a trusted adult (Houmoller et al, 2011).		and perceived support work together to influence drug-dependent mothers' caregiving, American journal of orthopsychiatry, 75.3 431-445
50	Royal College of Paediatrics and Child Health	Interventions to increase parental capacity and coping skills are offered as 'early help'.	This is an evidence-based approach to enhancing parental attunement to their children (NICE 1.5.7)	Many parents, particularly those who have experienced cumulative trauma during their childhood, have difficulty in attuning to their child's needs and this, in turn, predicts later abuse. Thus, evidence-based intervention at an early stage, particularly in the antenatal period and the first months of a child's life, is crucial in preventing child abuse and neglect.	There is a large and growing evidence base, including RCTs, summarised in Safeguarding Children Across Service: Messages from Research. Carolyn Davies and Harriet Ward, 2012.

51	Royal College of Paediatrics and Child Health	Provision of services for children with harmful sexual behaviours and children with seriously disturbed behaviours as a result of sexual abuse	Children who have suffered sexual and other forms of abuse can become profoundly disturbed and exhibit harmful sexual behaviours among other manifestations.	In spite of a number of reports over the past 25 years as well as NICE guidance on harmful sexual behaviours and child and adolescent mental health there remains little provision for these severely disturbed children who may require intensive nursing care for lengthy periods of time. This is not only costly to the local health economy but circumstances can dictate that it is often delivered on an urgent and adhoc basis aimed at containment and without following any evidence based pathways or consideration for outcomes for the child.	Children and young people exhibiting sexually harmful behaviour – what have we learned and what do we need to know to propose effective intervention? https://www.coe.int/t/dg3/children/1in5/Source/PublicationSexualViolence/Jones.pdf Provision for young people who have displayed harmful sexual behaviour https://www.nspcc.org.uk/globalassets/documents/research-reports/provision-young-people-displayed-harmful-sexual-behaviour.pdf Briefing: Children's Mental Healthcare in England https://www.childrenscommissioner.gov.uk/publication/briefing-childrens-mental-healthcare-in-england/

52	SCM 3	Provision of services for children with harmful sexual behaviours and children with seriously disturbed behaviours as a result of sexual abuse	Children who have suffered sexual and other forms of abuse can become profoundly disturbed and exhibit harmful sexual behaviours among other manifestations.	In spite of a number of reports over the past 25 years as well as NICE guidance on harmful sexual behaviours and child and adolescent mental health there remains little provision for these severely disturbed children who may require intensive nursing care for lengthy periods of time. This is not only costly to the local health economy but circumstances can dictate that it is often delivered on an urgent and adhoc basis aimed at containment and without following any evidence based pathways or consideration for outcomes for the child.	Children and young people exhibiting sexually harmful behaviour – what have we learned and what do we need to know to propose effective intervention? https://www.coe.int/t/dg3/children/1in5/Source/PublicationSexualViolence/Jones.pdf Provision for young people who have displayed harmful sexual behaviour https://www.nspcc.org.uk/globalassets/documents/research-reports/provision-young-people-displayed-harmful-sexual-behaviour.pdf Briefing: Children's Mental Healthcare in England https://www.childrenscommissioner.gov.uk/publication/briefing-childrens-mental-healthcare-in-england/
53	Ofsted	Improve long term intervention for children who have experienced neglect including for children in care. There is often insufficient long term therapeutic interventions available for these children to support longer term recovery.			

54	ADCS	Therapeutic response	Another area for focus could usefully be therapeutic responses to children who have been abused and neglected, the guideline was either vague on this point or suggested services that are not easily available/accessible.		
55	Association for Family Therapy and Systemic Practice (UK)	Access to appropriate therapeutic support when children or young people are involved in social care systems, for the child / young person, alternative family, and the family of origin	Because relationships are central to development of identity, and are not simply interchangeable, therapeutic support is important for all people involved in family or caring relationships with the child. (Note: the next column has 3 points, but I have split these into different rows to permit them to be read).	1. Child / young person The family of a child or young person are usually very important in providing the social learning framework to enable them to comprehend what they are unable to comprehend on their own. This learning has trusting relationships at its centre to help the child sufficiently regulate anxiety to interact with new situations in a way that they can learn and grow. When a child is in a social care system this social learning framework may not be functional, or they may not have access to it. Furthermore they are in a situation that may be incomprehensible to them, making therapeutic support of the utmost importance. 2. Alternative carers Because relationships are so central to identity formation, therapeutic support for alternative carers is crucial to help them to resonate with a child or young person. In order for an alternative carer to be an effective support to a child or young person's identity formation, they need to both 'get' where the child is at, and provide a safe and trusting relationship to help them explore new and existing areas and relationships. The relationship history of a	NICE guidelines 76 Child Abuse and Neglect (2017) recommendation 1.7 Vygotsky, L. (1978). Interaction between learning and development: Readings on the development of children, 23(3), 34-41. Crittenden & Ainsworth (1989) Child maltreatment and Attachment theory. Ch 14. In Cicchetti (1989) Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect. Cambridge University Press, Cambridge.

				child removed from the care of their family of origin may be very different to what is 'known and familiar' to an alternative carer and without therapeutic support in building their relationship with the child / young person, they may find this experience too different and too difficult to be able to build a warm, positive, loving relationship with a child going through this difficult process. 3.Family of origin Where children or young people are returned to the care of their family of origin, therapeutic support should be available to help all of those involved make sense of the process, and sustain a positive relational environment. Even when children have been removed from the care of their families of origin, and there may be limited or no possibility of them returning, how families come to terms with this can have a big impact on how the child can make sense of what has happened in their life and relationships. Children may have some sort of ongoing contact with their family of origin, or may re-establish contact after they are 18 years old. If families of origin have had opportunities for therapeutic support, they are more likely to have capacity for supporting interactions which are supporting a positive reflection of the child's / young person's / adult's identity, despite the loss of that relationship for a period of time.	

56	SCM 4	Offer an attachment-based intervention to parents or carers who have neglected or physically abused a child under 5 or to foster carers looking after abused or neglected children.			
57	SCM 7	Choosing programmes	Need to nudge/push commissioners to engage and self assess against this and other key guidelines, for example, behaviour and attachment.	Patchy application of evidenced based programmes despite some recurring good programmes being highlighted. How will the What Works pull together – new What Works for social Care, EIF so we don't 'lose' the focus by information/evidence overload?	
58	SCM 1	Ensuring that there are sufficient, research based, therapeutic interventions available for children, families and carers	Research indicates that where a timely, supportive and therapeutic response is provided to a child or young person, they are more likely to be able to "move on" from their abuse in a positive way. There has to be access to an appropriate range of targeted and general services available to children and young people.	Once abuse is recognised, there has to be a timely restorative response to start the journey to "survival" and recovery for the child. There is sporadic provision of resource which leads to an inconsistent approach to this across the country and so there needs to be action taken to address this.	
59	NAPAC	Review suggested interventions - trauma focused CBT is inadequate for anything more than an isolated incident of sexual assault, EMDR does work for some people but not for all.			

60	NAPAC	Seek information on current trauma informed approaches to working with children and adults (I am happy to share references on this).			
61	NAPAC	Review the recommended intervention of psychoanalysis and compare with more recently developed interventions. We have found that psycho-education is very effective in addressing the shame, guilt and low self-esteem many people report, which greatly shortens the time taken to achieve recovery in one-to-one work and/or group work.			

62	NSPCC	Consistent access to comprehensive mental health assessments for looked-after children aged 0-5.	Children who have been abused or neglected may experience trauma which requires focused attention and support. There is extensive evidence that experience of childhood maltreatment can contribute to the development of a range of mental health disorders. For example, it has been found to double the risk of depression, with this depression also found to be more treatment-resistant than that which occurs without experience of childhood maltreatment (Nanni et al, 2012). Comprehensive mental health assessments are a vital means of identifying mental health disorders among children who have experienced abuse and neglect. This is an important first step in helping to ensure that children who have been maltreated can get back on track, rather than live a life shaped by the abuse they suffered. We know that when the care children receive is high-quality, consistent and supportive, they can see improvements in their	Since March 2015, it has been compulsory for Local Authorities to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional wellbeing of all children in care (Care Quality Commission, 2016). Since 2015, the SDQ has been shown to be effective in a pre-school setting (including for children aged 1-3 years), as well as children aged 4-16 (Gustafsson et al (2015)).However, the SDQ remains insufficient for detecting the full range of emotional problems that children in care may experience. Specifically, it is unable to detect complex issues such as developmental trauma and attachment difficulties (Tarren-Sweeney, 2007) (Frogley, 2016). As such, behavioural manifestation of these problems may be misdiagnosed as a conduct disorder, missing the root cause of the issue. Without a thorough needs assessment for 0-5 year olds, it is highly unlikely that care will be sufficient to meet the complex needs of children who have experienced abuse and neglect. Commissioners and providers should be made aware of the limitations of the SDQ and required to specifically consider how best they can capture the needs of 0-5 year olds when conducting mental health assessments. One positive example is the New Orleans Intervention for Infant Mental Health (NIM), a multidisciplinary team focusing on infant mental health and promoting the quality of the child's attachment through assessment and intervention. It is currently delivered in Glasgow and London for looked after children under five. The assessments are	Beckett, C., Cross, R., Hewitt-Taylor, J., & McConnell, P. (2015). Developing a process for assessment of the emotional and behavioural needs of "looked after" children: the Five Rivers model. Journal of Children's Services, 10, 324-338. doi: 10.1108/jcs-06-2014-0032 Berit M. Gustafsson, Per A. Gustafsson and Marie Proczkowska-Bjorklund (2015) The Strengths and Difficulties Questionnaire (SDQ) for preschool children-a Swedish validation. Nordic Journal of Psychiatry, 70. 567-574. doi: https://doi.org/10.1080/08039488.2016.1184309 Care Quality Commission. (2016). NOT SEEN, NOT HEARD: A review of the arrangements for child safeguarding and health care for looked after children in England. Frogley, C. (2016). Assessing the Mental Health Needs of Looked after Children: A Study Investigating the Utility of the Brief Assessment Checklist for Children. PhD THESIS. Nanni, V,., Uher, R., and Danese, A. (2012) Childhood Maltreatment Predicts Unfavorable Course of Illness and Treatment Outcome in Depression: A Meta-Analysis. Am J Psychiatry, 169: 2 Tarren-Sweeney, M. (2007). The Assessment Checklist for Children — ACC: A behavioral rating scale for children in foster, kinship and residential care. Children and Youth

			mental health, behaviour (Luke, 2014) and educational attainment (Sebba, 2015). The potential for these children to flourish is conditional on access to a comprehensive assessment on entry to care.	used to inform local authority decision-making and court judgements in care proceedings. This has shown promising findings in America (Zeanah, 2001) and is subject to an RCT being conducted by Glasgow University.	Services Review, 29, 672-691. doi: 10.1016/j.childyouth.2007.01.008 Luke, N., Sinclair, I., Woolgar, M., and Sebba, J., (2014) What works in preventing and treating poor mental health in looked after children? London: NSPCC and the Rees Centre, University of Oxford. Available from: www.nspcc.org.uk/preventing-abuse/research-and-resources/what-works-preventing-treating-mental-health-looked-after-children/ Sebba, J., Berridge, D., Luke, N., Fletcher, J., Bell, K., Strand, S., Thomas, S., Sinclair, I. and O'Higgins, A. (2015). The Educational Progress of Looked After Children in England: Linking care and educational data. Oxford. http://reescentre.education.ox.ac.uk/wordpress/wp content/uploads/2015/11/EducationalProgressLookedAfterChildrenOverviewReport_Nov2015.pdf Zeanah

63	NSPCC	Evidence-based therapeutic services offered to children and young people who have been maltreated.	The relationship between maltreatment and adult outcomes is well established (Taylor et al 2015). There is now a substantial body of international evidence that shows that children who have experienced abuse (including neglect) are at significant risk of adverse outcomes including poorer mental health.	A recent systematic review found a total absence of robust evidence for many of the interventions currently provided to children who have been maltreated in the UK (Macdonald, 2016). The strongest evidence of effectiveness is in the treatment of symptoms of PTSD, with trauma-focused cognitive behavioural therapy. The review found however, that there was a potential bias in interventions towards the psychiatric effects of maltreatment. Although these are important, they represent only one of the many adverse consequences of maltreatment on children's development – which also include harm to children's social, emotional and physical development. In order to develop the evidence base in this area, the NSPCC evaluated our therapeutic service, Letting the Future In. This was the largest multi-site RCT in the world for a sexual abuse intervention. We also awarded grants to four research projects, in partnership with the Economic and Social Research Council, to generate evidence on what works to help children get back on track after abuse. Finally, the NSPCC is providing funding to three smaller charities to support them to demonstrate the effectiveness of their work in helping children get back on track after abuse.	Macdonald, G. et al. (2016) The effectiveness, acceptability and cost-effectiveness of psychosocial interventions for maltreated children and adolescents…. Southampton: National Institute for Health Research. (Health technology assessment, Vol.20, Iss.69)

64	Royal College of Paediatrics and Child Health	Child victims of sexual assault are offered Trauma-focused CBT.	If evidence-based intervention occurs, this will considerably lessen the long-term physical and emotional sequelae of abuse (NICE 1.7.17)	There is now a large evidence base for the effectiveness of this intervention; this includes studies showing economic benefits downstream.	Example: Salloum A et al. Stepped care versus standard trauma-focused cognitive behavioural therapy for young children. J Child Psychol & Psychiatr 2016; 57: 614 – 622.
65	Royal College of Speech and Language Therapists	Abuse and neglect are very likely to impact on language development, therefore children and young people who experience this should be assessed by a speech and language therapist and given the appropriate support thereafter. This includes being in a communication-friendly environment once safe from abuse, in which adults interact with children in a way that will help them develop their communication skills.	Sylvestre et al (2015) Language Problems Among Abused and Neglected Children: A Meta-Analytic Review Results confirm that the language skills of children who have experienced abuse and/or neglect are delayed when compared to children who have not experienced abuse and/or neglect. A Meta-Analysis of Cross Sectional Studies Investigating Language in Maltreated Children (Jarrad A. G. Lum, Martine Powell, Lydia Timms, and Pamela Snow) Journal of Speech, Language, and Hearing Research, June 2015, Vol. 58, 961-976. doi:10.1044/2015_JSLHR-L-14-0056 shows a reliable association between child maltreatment and poor language skills.		
Ways of Working (section 4.5 in briefing paper)					

66	BASPCAN	Planning services in a way enables children, young people, parents and carers to work with the same practitioner over time	This is important because children and parents tell us the quality of relationship with professionals is one of the most important things to them. High staff turnover makes it difficult for children and parents to build trusting relationships. Frequent changes lead to “start again syndrome”.	Overviews of inquires into child deaths from abuse have highlighted the problems of repeatedly re-assessing families where there is a risk of abuse and the so-called “start again syndrome” which has contributed to child deaths.	Example: Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-2005 Authors: Marion Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black Also see June Thoburn’s research on centrality of professional relationship in work with complex families where there are concerns about abuse.
67	BASPCAN	Effective management of the transition between early help services and more specialist interventions when risks of abuse increase or become more apparent	This is important because thresholds for receiving services for a child in need or from child protective services are high. There is a harmful risk of drift, particularly with cases of chronic neglect . Early help services may struggle to escalate their concerns to ensure families get the type and level of intervention needed.	Delegates at BASPCAN conferences have highlighted the transitions between early help, child in need and child protection services as a growing concern, partly due to tighter gatekeeping by Children’s Services but also due to lack of confidence by early help professionals in making the argument for escalating a case which is no longer suited or not responding to early help services.	
68	SCM 6	Continuity is an issue	Professionals need to understand that providing continuity of care will improve outcomes; so this needs to be considered during care planning		

69	SCM 2	1.8.1 Plan services in a way that enables children, young people, parents and carers to work with the same practitioners over time where possible	There is significant variation in the support provided to children and young people in care. This variation exists within local authority areas as well as between them. Much of this variation is not based on need, but on the available provision in an area and individual decision-making. Source – NSPCC website	Continuity of relationships for service-users is compromised by high staff turnover. This instability cuts through the core of relationship-based practice and is likely to exacerbate the issues children and young people face. Research shows qualitative differences between the case work carried out by experienced and novice workers (Forrester, 2000) and there is a strong correlation between children achieving permanency and turnover rates amongst their caseworkers (Baginsky, 2013). Social work recruitment and retention – R.i.P 2015	Social workers' communication with children and young people in practice. Insight 34 Research consistently demonstrates that children like it when social workers have qualities such as honesty, reliability and consistency (Luckock et al, 2006; Munro, 2011). Changes of social worker can be detrimental to successful case management because they obstruct the development of constructive, supportive relationships with parents and children, and the implementation of plans. Such changes reflect the widespread use of agency staff, the high turnover of more permanent staff, and the organisation of services, which often require cases to be transferred from one team to another as families move through the system (Ward, 2014). Data Sources for this key development area: Experimental statistics: Children and family social work workforce in England, year ending 30 September 2016 Ofsted regularly research the child's journey through care which will pick up the consistency of social worker for individual children National Statistical Release and data sets can provide information on social worker recruitment and retention.

70	Action for children	Information sharing	The biggest single issue for health practitione is that of information sharing where consent is withheld and the Standard is fairly silent on this issue.		
71	Against Violence and abuse (AVA)	Multi-agency working to avoid having to re-tell stories	Many victims of abuse are re-traumatised by the process of disclosing, especially if this requires talking about your experiences multiple time to different people.	A repeated issue for the ERG and for many victims of abuse is the constant re-telling of stories. This is re-traumatising, exhausting and unnecessary. Again, it makes it less likely that people will want to disclose if they are worried who they will have to tell, how many people will have access to the information and what will happen to it (this links closely to recommendations around explaining confidentiality which young people were also very concerned about). There is a need for one key-worker to be the single point of contact for the young person, they can share information (with consent as appropriate) and advocate on their behalf – similar to the IDVA model for domestic abuse.	See Ofsted report (2017) 'The multi-agency response to children living with domestic abuse'

72	SCM 4	Practitioners supporting children and young people who have been assessed as being 'in need', or suffering (or likely to suffer) significant harm in relation to child abuse or neglect should: -build relationships with other practitioners working with that family - organise handovers if new staff members from their agency become involved - ensure actions set out in the 'child in need' or child protection plan are completed.			
73	SCM 5	Clear communication pathways between professionals, which are capable of being audited.	A number of different agencies and professionals including primarily health, education, social care, police but also legal professionals are involved in ensuring the safeguarding of children. Working in isolation and without reference to others' involvement works to the detriment of the child and family.	There is repeated evidence of the variable nature of interprofessional and inter-agency communication.	e.g. Working Together

74	Department for Education	Information sharing to safeguard children from abuse and neglect	To improve adequate, accurate and timely information sharing between practitioners for the purposes of safeguarding children from abuse and neglect, ensuring that the information shared is necessary, proportionate, relevant, and secure. Whilst data protection legislation places duties on organisations and individuals to process personal information fairly and lawfully, it is not a barrier to sharing information where the failure to do so would result in a child or vulnerable adult being placed at risk of harm. All organisations should have arrangements in place which set out clearly the processes and the principles for sharing information for the purposes of safeguarding children from abuse and neglect, including clarity on when information can be shared without consent. Effective communication requires practitioner skills and a culture that encourages information sharing	Decisions about sharing information between professionals and organisations, can have a profound impact on children's lives. Shared and triangulated information can very significantly improve how children needs are assessed and whether issues within families are identified. This in turn can therefore determine whether a child receives the right services at the right time, preventing their needs becoming more acute. In some cases, sharing information can be the difference between life and death for a child. Breakdowns in communication can happen where there is an absence of local safeguarding systems, barriers to effective multi-agency working or a failure to recognise or act on opportunities to share information to safeguard children.	A key factor identified in many serious case reviews (SCRs) has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action. There is evidence of uncertainty amongst practitioners about how and when to share information, despite national guidance. The issue of poor information sharing has also been raised in domestic homicide reviews and inspection reports. Alan Wood's review of the role and functions of Local Safeguarding Children Boards highlighted the issue of poor information sharing among local agencies (2016): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf The Government has published practice guidance, including on common misconceptions: Information sharing – Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

			through a presumption to share, as well as clear systems and guidance that enables information to be critically appraised and used to guide decision making and planning.		
75	SCM 1	Ensuring all agencies understand their core safeguarding responsibilities	The multi-agency child protection response needs to be understood and consistently applied by all agencies working with children, adults and carers so that abuse and neglect is recognised and responded to appropriately.	There can be inconsistent response.	

76	SCM 2	1.1.12 Coordinate your work with practitioners in other agencies so that children, young people, parents and carers do not need to give the same information repeatedly	Guidance for Designated Professionals Safeguarding Children and Child Protection Information Sharing (CP-IS) 2.6 Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing of information can be essential to put in place effective child protection services.	Serious Case Reviews have shown how poor information sharing has contributed to the deaths or serious injuries of children. 2.7 Concerns about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. (Guidance for Designated Professionals Safeguarding Children and Child Protection Information Sharing (CP-IS)	Learning lessons from serious case reviews 2009–2010 Implementing effective multi-agency working. The reviews highlighted the need for effective multi-agency working and the important shortcomings when things went wrong. Where practice was found to be inadequate, concerns included, *poor communication *failure to include key professionals or agencies *insufficient training or engagement of some professionals *ineffective meetings *incomplete record-keeping *a lack of follow-up of the agreed actions. Data Sources for this key development area Measuring client satisfaction with child welfare services Authors: TILBURY Clare, OSMOND Jennifer, CRAWFORD Meegan Journal article citation: Journal of Public Child Welfare, 4(1), January 2010, pp.77-90. Publisher: Taylor and Francis Place of publication: Philadelphia, USA Improving the effectiveness of the child protection system – A review of literature Anita Schrader-McMillan & Jane Barlow Departmen t for Social Policy and Intervention, University of Oxford

77	NAPAC	Develop guidance that works effectively in conjunction with the criminal justice system but also recognises that a successful conviction is very rare and even when successful will not solve all mental health sequelae.			
78	Royal College of Paediatrics and Child Health	Improvement in quality and consistency of safeguarding and child protection education	It is accepted that all children have a right to protection against abuse, neglect, exploitation and violence and many organisations have a statutory duty to safeguard and promote the welfare of children and young people. A successful approach requires effective multi-agency collaboration and a recognition of child wellbeing to be placed at the heart of the organisation.	While the Intercollegiate Training Guidelines for NHS staff sets out a syllabus for child safeguarding training. there are no national standards to ensure consistency of delivery and content of relevant educational modules. This can result in variation of agreement between practitioners and agencies and most importantly children about whether abuse has occurred. It can lead to varying local thresholds for acceptance of referral, to reluctance to refer and to accepted cases being closed too early.	Inadequacies in child protection education were highlighted in The Victoria Climbie Inquiry, 2002, https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming and in Pathways to Harm and Protection 2016 http://seriouscasereviews.rip.org.uk/wp-content/uploads/Triennial_Analysis_of_SCRs_2011-2014_Pathways_to_harm_and_protection_299616.pdf There is an EU Project developing a series of evidence based educational modules which can be delivered across agencies, providing consistent content of high standard http://mapchipp.com/project/
Additional areas (section 4.6 in the briefing paper)					
79	NSPCC	Perinatal screening and access to intervention. a) Early identification of perinatal mental health	a) Maternal antenatal depression is an important part of the link between childhood	Despite the clear link between perinatal mental health and maltreatment, the NSPCC is concerned that services are still too focused on providing specialist care at the expense of screening and preventative	Please see the NHS Benchmarking Network's Perinatal Mental Health report Gavin, N. I., Meltzer-Brody, S., Glover, V., & Gaynes, B. N. (2015).

		problems through widespread use of validated screening tools, and b) expanded access to evidence-based services which support the parent-infant relationship, as well as parental mental health.	maltreatment and childhood psychiatric disorder. It increases the risk of maltreatment occurring in the first instance, and also increases the risk of children experiencing mental health problems after maltreatment has taken place (Pawlby, 2011). b) When problems are detected, intervention must focus on both treating the parent's disorder and helping them with associated caregiving difficulties (Stein, 2014). Although maternal depression can be successfully prevented and treated, amelioration of depressive symptoms alone has not been shown to improve mother–child interactions (Stein, 2014). A failure to provide comprehensive support for the parent-infant relationship elevates the risk of maltreatment taking place.	work which can minimise the risk of problems occurring in the first instance. This position was echoed by sectoral colleagues at the recent Maternal Mental Health Alliance Ministerial Roundtable. Evidence suggests that most women with perinatal problems do not get the help they need, and it is within this context that screening is particularly important. Overall, just 24% of mothers who experience perinatal depression receive treatment (or 60% of those who are recognised clinically). Of those who receive treatment, just 40% receive adequate treatment, and of those adequately treated, 30–66% recover to the extent to which there is a measureable impact on health outcomes. This means that just 3–6% of mothers who experience perinatal depression are treated and achieve full remission without a negative impact on long-term outcomes (Gavin, 2015). From an academic review of 183 studies (funded by the NSPCC), two screening measures –the Kessler Psychological Distress Scale and Self-Report Questionnaire – were considered the most promising measures for examining the mental health of men and women with children aged between 0 and five years of age (Webb, 2018). When symptoms of perinatal anxiety and depression are detected, services often focus solely on the mother's symptoms, without addressing the impact on their developing relationships with their babies.	Is Population-Based Identification of Perinatal Depression and Anxiety Desirable? In J. Milgrom & A. W. Gemmill (Eds.), Identifying Perinatal Depression and Anxiety: Evidence-Based Practice in Screening, Psychosocial Assessment, and Management John Wiley & Sons, Ltd,. Pawlby, S., Hay, D., Sharp, D., Waters, C. S., & Pariante, C. M. (2011). Antenatal depression and offspring psychopathology: the influence of childhood maltreatment. Br J Psychiatry, 199(2), 106-112. doi:10.1192/bjp.bp.110.087734 Stein, A., Pearson, R. M., Goodman, S. H., Rapa, E., Rahman, A., McCallum, M., . . . Pariante, C. M. (2014). Effects of perinatal mental disorders on the fetus and child. The Lancet, 384(9956), 1800-1819. doi:10.1016/s0140-6736(14)61277-0 Webb, R., Ayers, S.&, Rosan, C. (2018) A systematic review of measures of mental health and emotional wellbeing in parents of children aged 0-5. Journal of Affective Disorders.

80	Action for children		• 3.1- should also refer to child sexual exploitation and note that abuse might be physical or online or both. • Flowchart not really clear and seems to suggest that assessment or early help happen after identification when assessment is needed first in all cases. • 1.3.4- expand so that staff are clear that historical abuse needs investigation in the same way even if the survivor of abuse is now an adult as perpetrators might still be in contact with other children and because a c rime might have been committed. • Section on 'alerting features' might be balanced by a description of family strengths. This is important as local authorities increasingly look to models such as 'Signs of Safety' to implement assessments of child protection risk. • Alerting features of neglect and child development concerns don't address observed signs of parents not supervising children		

			adequately, e.g. resorting to physical chastisement with young children, shouting and swearing at children, difficulties in establishing routines such as bedtimes or meal times. • Need to stress that neglect is rarely a linear issue and that parental inconsistency will lead to children appearing happier or cleaner for periods of time with dips into concern periodical over a period of time. Recording of presentations is important to assess this. • Dental well-being- the indicator of neglect is not just failing to obtain treatment but also serious tooth decay in young children requiring several extractions or similar. • Guidelines seem to focus on identification, assessment and then treatment including early help. There should be a stronger focus on referral to the local authority and on information sharing by health professionals when concerned a child might be abused- not waiting until there is confirmation		

			• More needed on working with diverse communities and esp. to stress that child abuse and neglect are never cultural norms in any culture. • The treatment and early help sections should focus more on assessment, setting outcomes for change and measuring these. There should also be focus on selecting forms of help which have a proven evidence base of some kind. • The references to Enhanced Triple P and PUP are odd as this would seem to suggest that all commissioners should favour these programmes. Incredible Years has by far the best evidence base in achieving change but the point of a Standard is not to promote interventions and rather to highlight the need to use interventions with a reliable track record or better. • Early help section advises to refer to l/a in cases of current domestic violence. We should sue the broader 'domestic abuse' term and referral		

			should be considered in all cases whether or not believed to be current or past or both. • Figure 1 re interventions looks a bit rudimentary- there are lots of interventions to use and each local area will have its own system but the main point here is to stress use of evidence as above. • Reference to SafeCare not helpful- NSPCC has not been able to replicate this model. The standards again should not refer to specific interventions but to ensuring that intervention s have a reliable evidence base. Equally, MST is mentioned but not FFT which also has an evidence base re effectiveness.		

81	The Faculty of Sexual and Reproductive Healthcare (FSRH)	No mandatory reporting of abuse	Mandatory reporting risks undermining confidentiality for those contemplating disclosure of abuse, making victims more reluctant to disclose incidents and access services. This issue is particularly pertinent in relation to young people accessing sexual and reproductive healthce services, where worries about confidentiality can act as a major disincentive for service uptake. (See key area 4 below).	Mandatory reporting of child abuse is a highly contested topic. The Faculty of Sexual and Reproductive Healthcare (FSRH) shares with other professional organisations the belief that mandatory reporting would not always be in the best interests of the child and would not come with resources sufficient to be confident that effective help could be given where and when it is needed. The Faculty supports the position set out by Brook, that mandatory reporting would deter young people from using services. Mandatory reporting would entail the reporting to social services of sexually active young people to social services. This would risk losing the cooperation of young people. In turn, this would expose these groups to increased risk of child sexual exploitation, pregnancy and sexually transmitted infections with serious consequences both for individual young people and for public health generally.	Please see: https://www.nspcc.org.uk/globalassets/documents/consultation-responses/nspcc-2016-consultation-reporting-acting-child-abuse-neglect.pdf and the FRSH's submission to the Government's consultation on reporting and acting on child abuse and neglect. https://www.fsrh.org/documents/fsrh-submission-to-governments-consultation-on-reporting-child/ For Brook's full position statement highlighting the risks of mandatory reporting: https://www.brook.org.uk/about-brook/brook-position-statement-safeguarding-confidentiality

82	The Faculty of Sexual and Reproductive Healthcare (FSRH)	Clarification of a duty to act	Analysis of the responses of organisations to prominent cases frequently identifies occasions on which institutions knew about abuse and neglect, but decided to implement an ineffective course of action. Professional accountability for dealing with abuse and neglect should be held at an institutional level, not a personal one, as individual failings can be the result of wider organisational issues and flaws. Institutions should have a clear duty to act. (See Key area 2 above).	The consequences for the welfare of children in danger of abuse are likely to be serious. FSRH believes that it is essential to place on institutions a duty to act.	See FRSH's submission to the Government's consultation on reporting and acting on child abuse and neglect. https://www.fsrh.org/documents/fsrh-submission-to-governments-consultation-on-reporting-child/
83	Ofsted	In our report The multi-agency response to domestic abuse: prevent, protect and repair we found too little is being done to prevent domestic abuse and repair the damage that it does work with families was often reactionary to individual crises rather than preventative. We need to upstream work with children suffering abuse and neglect.			

84	Royal College of Paediatrics and Child Health	Prevention of non-accidental head injury in infants	While the average rate of homicide in the UK is low in England and Wales infants under one year face around four times the average risk of becoming a victim of homicide. Most of these children exhibit evidence of non-accidental head injury and most are killed by a parent.	The first three years of life are crucial to the child's brain development. This is when the brain lays down the foundations for movement, communication, social and emotional capabilities and intellectual functioning Education for parenting is delivered inconsistently across the UK and is dependent on local circumstances, parental interest and cooperation. Some programmes stress the importance of care of the baby's head and the harm which can be caused by shaking or any other impact while others give this aspect of care reduced emphasis. The infant who has been shaken or hit can present with a wide variety of symptoms from subtle signs of drowsiness, vomiting or irritability refusal to feed to catastrophic collapse leading to severe disability or death. Infants who present with more severe symptoms often have findings indicating previous less significant episodes of trauma, providing a potential window of prevention. Educational programmes/campaigns should be mounted in relation to issues such as the fragility of young babies,	Some helpful interventions are described in NSPCC All Babies Count https://www.nspcc.org.uk/services-and-resources/research-and-resources/pre-2013/all-babies-count/ Examples of cases are given in NSPCC Case Reviews 2015 https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2015/

85	SCM 3	Prevention of non-accidental head injury in infants	While the average rate of homicide in the UK is low in England and Wales infants under one year face around four times the average risk of becoming a victim of homicide. Most of these children exhibit evidence of non-accidental head injury and most are killed by a parent.	The first three years of life are crucial to the child's brain development. This is when the brain lays down the foundations for movement, communication, social and emotional capabilities and intellectual functioning Education for parenting is delivered inconsistently across the UK and is dependent on local circumstances, parental interest and cooperation. Some programmes stress the importance of care of the baby's head and the harm which can be caused by shaking or any other impact while others give this aspect of care reduced emphasis. The infant who has been shaken or hit can present with a wide variety of symptoms from subtle signs of drowsiness, vomiting or irritability refusal to feed to catastrophic collapse leading to severe disability or death. Infants who present with more severe symptoms often have findings indicating previous less significant episodes of trauma, providing a potential window of prevention. Educational programmes/campaigns should be mounted in relation to issues such as the fragility of young babies,	Some helpful interventions are described in NSPCC All Babies Count https://www.nspcc.org.uk/services-and-resources/research-and-resources/pre-2013/all-babies-count/ Examples of cases are given in NSPCC Case Reviews 2015 https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2015/

86	Public Health England	PSHE and RE/RSE in schools	Personal, Social, Health and Economic education (PSHE); and Relationships and Sex Education (RSE) are regularly highlighted as an important preventative measure in regards to sexual abuse and exploitation.	The quantity and quality of PSHE and RSE is variable across schools.	The Department for Education (DfE) are implementing the Government's commitment to introduce statutory Relationships Education in all primary schools, and Relationships and Sex Education in all secondary schools, by September 2019. Alongside this DfE are examining the introduction of PHSE in schools on a statutory basis. Their introduction will raise awareness amongst school pupils on issues relation to abuse and may also lead to disclosure by pupils; with the anticipated additional training and pathways for schools, it may also make it easier for either children to disclose abuse or more trained staff to sport the signs. The Children's Commissioner earlier this year published a report that described the need for improvement to ensure that quality PSHE is available to all children.
87	Royal College of Paediatrics and Child Health	Improving children's participation in child safeguarding and child protection	Sex and relationship education (SRE) is compulsory from age 11 onwards. It involves teaching children about reproduction, sexuality and sexual health. Child abuse can begin in infancy but here is nothing about teaching children of any age to recognise potentially harmful behaviour and how to protect themselves.	The aim of these activities would be to ensure that children know what their rights are, what child abuse is, and to explore the ideas of feeling safe and unsafe. This education could commence in pre-school ages, where parents and carers could also be involved. Such projects could also be used to help children understand the benefits as well as risks of new technology.	The Child to Child Trust http://www.childtochild.org.uk/ have pioneered such work in developing countries and have produced a participation guide: https://www.childhope.org.uk/wp-content/uploads/2013/05/Childhope-CYPP-Toolkit-FINAL.pdf

88	The Faculty of Sexual and Reproductive Healthcare (FSRH)	In relation to sexual abuse: good sex and relationships education (RSE).	Age-appropriate RSE from a young age has been shown to cultivate a positive attitude in young people towards their sexuality and relationships, equipping them to make confident, informed choices about their sexual and reproductive health and will enable them to understand what is and what is not appropriate behaviour from the people around them. PHSE when inclusive of sex and relationships education has too shown benefits. It should be noted that any position that NICE takes on RSE will be extremely well timed in relation to feeding into the Governments' RSE implementation process and RSE curriculum.	Sex and relationships education is not evenly developed across the UK. It will not be generalised in England, for instance, until 2019, and its content has not yet been specified. A clear quality standard, underlining the importance of developing the type of sex and relationships education which can enable informed choice, would be of great benefit to children at risk of abuse. The Sex Education Forum reports that young people have repeatedly said that the relationships element of RSE is the most neglected: http://www.sexeducationforum.org.uk/resources/practice/sex-relationships-education/tender's-healthy-relationship-education-project.aspx	For further data on young people's experience of sex and relationships education see http://www.sexeducationforum.org.uk/policy-campaigns/gaps-in-sre-leave-children-at-risk.aspx For a report which highlights the benefits that come with high quality PHSE when the topic of sex and relationships is included see https://www.pshe-association.org.uk/curriculum-and-resources/resources/evidence-briefing-pshe-education-pupil-wellbeing The report highlights that when sex and relationships education is taught this has an effect on reducing the likelihood of children being bullied or bullying others, with children more likely to have positive relationships with other pupils and have feelings of belonging. Another report highlights that when pupils receive lessons on healthy relationships they are more likely to report abuse and exploitation. Highlighted here is that all schools should teach pupils about consent and healthy relationships.to combat harmful sexual behaviour amongst children: https://www.pshe-association.org.uk/sites/default/files/Curriculum%20for%20life%20May%202017.pdf An MP led report, backed by leading children's charity Bernardo's

					recommends that to prevent harmful sexual behaviour children should have access to high quality, age appropriate information and advice about healthy relationships; their rights and responsibilities to prevent harmful sexual behaviour: https://www.pshe-association.org.uk/news/pshe-association-welcomes-report-harmful-sexual
89	SCM 3	Improving children's participation in child safeguarding and child protection	Sex and relationship education (SRE) is compulsory from age 11 onwards. It involves teaching children about reproduction, sexuality and sexual health. Child abuse can begin in infancy but here is nothing about teaching children of any age to recognise potentially harmful behaviour and how to protect themselves.	The aim of these activities would be to ensure that children know what their rights are, what child abuse is, and to explore the ideas of feeling safe and unsafe. This education could commence in pre-school ages, where parents and carers could also be involved. Such projects could also be used to help children understand the benefits as well as risks of new technology.	The Child to Child Trust http://www.childtochild.org.uk/ have pioneered such work in developing countries and have produced a participation guide: https://www.childhope.org.uk/wp-content/uploads/2013/05/Childhope-CYPP-Toolkit-FINAL.pdf
90	Association for Family Therapy and Systemic Practice (UK)	Essential skills / awareness for practitioners involved in identification and assessment of abuse and neglect in children and young people	Practitioners should have a full and comprehensive understanding of the importance of attachment relationships. There also needs to be a close professional awareness that a child's or young person's identity develops from the community of which they are part.	A child's / young person's attachment and relational context is fundamental to being able to properly assess and understand possible presentations, and to inform possible interventions. Without this understanding, well-intentioned actions can have traumatic and long-lasting impacts upon a child, their relationships and their identity.	NG26 (2015) Recommendation 1.2 QS133 (2016) QS4

91	BASPCAN	Skills and knowledge to decide which evidence-based interventions are likely to be most appropriate for a particular child and family post-abuse	This is important because there is not a "one-size fits all" intervention. Selecting and adapting the most appropriate intervention requires in-depth assessment skills and knowledge of the evidence and applications for different available tertiary interventions	Practitioner knowledge of different interventions is patchy. There are limited options available in some areas.	
92	BASPCAN	Ability to assess parental capacity for change within a timeframe that meets the child's developmental needs	This is important because there is good evidence that children are harmed by repeated and over-optimistic attempts to rehabilitate them with a parent following abuse, which do not take adequate account of the child's developmental needs	Serious case reviews have highlighted child deaths associated with over-optimism about parental capacity to change. Research into children returned home from care following abuse and neglect have shown alarmingly high levels of re-abuse. In cases of neglect research shows standards and expectations are lowered and cases drift as parents are given more chances to change, while children's health and development deteriorate.	Example: Asessing Parental Capacity to Change when children are on the edge of care: an overview of current research evidence. Ward et al (2014).Example: Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003-2005. Authors: Marion Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black

93	SCM 4	Commissioners and managers should ensure that all practitioners working at the early help stage: - have an understanding of typical and atypical child development - are able to tailor interventions to the needs of the child or young person, parents and carers including any disability or learning disability - understand the parental vulnerability factors for child abuse and neglect - are aware of the possibility of escalation of risk, particularly if family circumstances change -understand how to work with families as a whole in order to better support children and young people.	There is good evidence: - that indicators of child abuse and neglect include atypical developmental behaviours - that parents and carers value interventions tailored to them - for vulnerability factors for child abuse and neglect - that practitioners do not attend to changes that can escalate risk of child abuse and neglect		
94	SCM 6	Training for professionals in how to ask the question	See above	See above	See above

95	Institute of Health Visiting	Staff knowledge and understanding of child development.	The NICE guideline 76 recognises that staff competencies for 'Early Help for Child Abuse and Neglect' include the requirement for an understanding of 'typical' and 'atypical' child development.	We are concerned about the quality of child development assessment undertaken in the context of the provision of 'early help', particularly when this is informed by social care workers/support workers whose knowledge of child development, and ability to benchmark with the norm, may be limited (see ref.). We believe that health visitors, as experts in child health and development, and in the context of universal provision, are well placed to support/undertake early help assessments.	See, for example, the DfE commissioned research which highlights the deficits in knowledge and understanding of child development amongst child care practitioners that were judged to be contributory to failings in practice in the context of serious case reviews of child abuse and neglect cases. Brandon, M., Sidebotham, P., Ellis, C., Bailey, S. and Belderson, P. (2011) Child and family practitioners' understanding of child development: Lessons learnt from a small sample of serious case reviews. London: Department for Education, DFE-RR110.The role of universal and targeted HV provision is detailed in: Department of Health, Department for Children, Schools and Families (2009) Healthy Child Programme: Pregnancy and the First Five Years. London: DH.
96	SCM 7	Vulnerability & alerting features - understanding across the workforce	Need to support a depth of understanding within a rounded assessment of needs. Need to reinforce relationship building.	SCR etc which highlight need to completed rounded assessment that take account of building risk over time – need to reinforce the importance of chronology.	

97	SCM 2	1.3.9 Senior managers should ensure staff working in community settings, including education, can recognise and respond to child abuse and neglect and are aware of child safeguarding guidance relevant to their profession, for example the Department for Education's Keeping children safe in education.	Schools play an important role in the prevention of sexual abuse. Teachers and other professionals working in schools and education settings see the same group of children regularly. They are likely to be the professional in the community, outside of the family home, with whom the child has the closest relationship. Research suggests that teachers are the trusted adult, located outside of the family and peer networks, most likely to receive a disclosure of sexual abuse Besides a disclosure of abuse, schools also have a unique role in the identification of safeguarding concerns and the initiation of an intervention. Source: Office of the Children's Commissioner (2017) Preventing child sexual abuse: The role of schools	Research has identified that education is important in enabling children to disclose if they have been sexually abused. The importance of a disclosure is clear – spotting the signs and symptoms of child sexual abuse and making a report to the local authority is not always enough. Schools do generally believe they have sufficient knowledge and resources to identify and act upon concerns relating to child sexual abuse. However, if the signs of sexual abuse are not visible or if the child does not disclose abuse, then schools believe identification is more difficult, which in turn makes it more difficult to bring concerns to the attention of the local authority, and to substantiate those concerns with the evidence necessary to meet local authority thresholds Source: Office of the Children's Commissioner (2017) Preventing child sexual abuse: The role of schools	Consideration must be given to the ways in which a school can create opportunities for a child to seek help and disclose abuse. In particular, guidance on safeguarding in schools should broaden the focus from the processes for reporting concerns to the ways in which teachers and other school professionals can support children who are the subject of concern to disclose abuse. This includes establishing a supportive and trusted relationship with the child over time and asking the child questions regarding their wellbeing. Source: Office of the Children's Commissioner (2017) Preventing child sexual abuse: The role of schools Data Sources for this key development area: Child protection training providers (e.g. Babcock LDP) and local authorities' data relating to courses offered and uptake from organisations
98	Ofsted	Training front line practitioners on a multi-agency basis to recognise and respond to neglect.			

99	Royal College of Paediatrics and Child Health	Recruitment and retention of specialist safeguarding children staff	Organisations should recruit specialist safeguarding staff with the requisite knowledge skills and competences, to provide frontline practitioners with expert advice, support and safeguarding supervision, and succession plan to retain that expertise.	There are general workforce shortages in medicine and nursing. Safeguarding is not a popular career choice. Specialist safeguarding staff tends to be senior and experienced as well as ageing so there must be effective forward planning to replace them as required.	RCPCH Paediatric workforce policy briefing April 2017 The UK nursing labour market review 2016The UK nursing labour market review 2016, RCN October 2016The UK nursing labour market review 2016
100	The Faculty of Sexual and Reproductive Healthcare (FSRH)	Training	Professionals not just in health, but in associated sectors should be trained to a high quality to ensure the provision of confidential, expert and supportive advice, using appropriate referral pathways.	A lack of appropriate training across professions has been identified as a serious weakness in the quality of provision relating to abuse and neglect. Training is an important step towards ensuring an appropriate and timely intervention to ensure that frontline professionals are up to date with the major features that may be observed or assessed in a child experiencing neglect. Insufficient training may act as obstacles to effective action. This is highlighted by the government-commissioned report referenced in the supporting evidence section of this key area.	Please see this government-commissioned report for a full range of data. http://www.cwrc.ac.uk/documents/RR404_-_Indicators_of_neglect_missed_opportunities.pdf

101	SCM 3	Improvement in quality and consistency of safeguarding and child protection education	It is accepted that all children have a right to protection against abuse, neglect, exploitation and violence and many organisations have a statutory duty to safeguard and promote the welfare of children and young people. A successful approach requires effective multi-agency collaboration and a recognition of child wellbeing to be placed at the heart of the organisation. However many public inquiries and serious case reviews have found that frontline practitioners as well as their line management and organisations' Boards have insufficient knowledge and awareness of child abuse and neglect to fulfil the roles required of them by their organisations and by regulators.	While the Intercollegiate Training Guidelines for NHS staff sets out a syllabus for child safeguarding training. there are no national standards to ensure consistency of delivery and content of relevant educational modules. This can result in variation of agreement between practitioners and agencies and most importantly children about whether abuse has occurred. It can lead to varying local thresholds for acceptance of referral, to reluctance to refer and to accepted cases being closed too early.	Inadequacies in child protection education were highlighted in The Victoria Climbie Inquiry, 2002, https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming and in Pathways to Harm and Protection 2016 http://seriouscasereviews.rip.org.uk/wp-content/uploads/Triennial_Analysis_of_SCRs_2011-2014_Pathways_to_harm_and_protection_299616.pdf There is an EU Project developing a series of evidence based educational modules which can be delivered across agencies, providing consistent content of high standard http://mapchipp.com/project/

102	Association for Family Therapy and Systemic Practice (UK)	Balanced management of change process and relational context	It is important to acknowledge that children, young people, families of origin and alternative carers are involved in a process, and a network of relationships which would benefit from active management and reflection. The consequences of decisions and changes have both positive and negative aspects, and these may be different for the different people involved. Additionally the future consequences may not always be known, and would benefit from some space to explore different possibilities, both positive and negative of decisions which are being considered.	It is important that some mechanism to check in on and reflect upon the process of change and how it is going, and what its effects are, (particularly on relationships), exists for the child / young person and family of origin and alternative carers, but also for the social care team involved, and is monitored as part of the quality standard development.	NG 76 (2017) recommendation 1.8.5 (supervision and support for staff)
103	Child Protection Special Interest Group	Peer review meetings are regularly attended by those clinicians who undertake the medical assessment of children for whom the presence of physical abuse is a concern.	Peer review of paediatric opinions is important so that paediatricians are supported to maintain high standards and do not work in isolation when assessing children in whom child abuse is a possibility.	Discussions with Named and Designated doctors in Greater Manchester and elsewhere have revealed a wide diversity of practice in this area. This includes the models of peer review in terms of frequency of meetings, proportion of cases discussed, availability of images to inform discussions and recording of the discussion outcome.	Please see supporting information as outlined for quality improvement 1 as the same applies to this area.
104	SCM 7	Critical thinking/supervision and professional judgement	Foundational skills. Need to reinforce reflective supervision and not over		

			adherence to proformas etc		
105	SCM 2	1.8.5 Organisations should support staff working with children and families at risk of or experiencing child abuse and neglect, and provide good quality supervision, tailored to their level of involvement in safeguarding work	Good reflective supervision facilitates safe practice with children and families It is vitally important that social work is carried out in a supportive learning environment that actively encourages the continuous development of professional judgement and skills. Regular, high quality, organised supervision is critical Laming, H (2009) The Protection of Children in England. TSO	Whilst regular supervision for social workers is recommended and practised, other practitioners in settings such as schools, out of school and weekend activities etc rarely receive the level of supervision required to make sense of their role and be effective in it.	Unable to locate information around prevalence of schools (for example) offering supervision to staff involved in child protection – therefore this remains a prime source of ongoing concern. Some organisations, including schools, do publish their supervision policies online. However, it is difficult to assess how many others offer this, and, if so whether it is 'in house' or bought in from external agencies.

106	Royal College of Paediatrics and Child Health	Safeguarding Supervision for Practitioners	All practitioners who work with children, young people and their families should have access to expert advice, support and safeguarding supervision. However, many public inquiries and serious case reviews have found that frontline practitioners as well as their line management and organisations' Boards have insufficient knowledge and awareness of child abuse and neglect to fulfil the roles required of them by their organisations and by regulators.	Providing this advice, support and supervision will ensure that practitioners are safe and confident when working with safeguarding concerns.	Social Care Institute for Excellence (2013, updated 2017) Practice Guide 50: Effective supervision in a variety of settings
107	Royal College of Paediatrics and Child Health	Professionals involved in safeguarding children undergo regular supervision.	This is a recommendation in NICE 1.8.5.It is important in respect of reflecting on practice and in being supported within what can be a challenging work environment.	It allows the professional to reflect on their own practice with a trusted colleague that, in turn, can only enhance practice. It provides a sounding board for the professional, particularly when she or he has a challenging case load.	This is a CQC requirement. NHS Trusts have robust supervision policies but supervision remains patchy.
Other					

108	Association for Family Therapy and Systemic Practice (UK)	Additional developmental areas of emergent practice	One of our members informed us of a useful model of practice in this area.	It is a Framework to describe, report and inform intervention for 'Harmful Parent-Child Interactions' (emotional abuse and neglect) which then tests out parental capacity to change. It breaks the assessment into 4 tiers: 0- family and social (especially how these factors affect interactions) 1 - Parental Risk Factors - with a specific focus on how these affect parent-child interactions 2- Harmful parent-child interactions (the focus is on the unintentional nature of this) - this is broken down into 5 sub-categories of harmful interactions (see below) 3 - Childs functioning – focused on change rather than cause, and testing capacity for change - it would recommend intervention at this level whether the issue is dependent on or independent of parent-child interactions. Tier 2 has 5 sub-categories 1 - Parental Emotional unavailability,unresponsiveness, and neglect 2- Negative attributions to the child 3 -Developmentally inconsistent or inappropriate interactions with the child 4 - Failure to recognise the child's individuality 5 - Failure to promote child's socialisation Informed by this assessment model, areas of intervention are highlighted and may be offered as a 'trial' intervention to test out capacity for change.	Glaser, D. (2011) 'How to deal with emotional abuse and neglect: Further development of a conceptual framework (FRAMEA).' Child Abuse and Neglect: The International Journal

109	NAPAC	Recognise that the impacts can last long into adulthood and manifest in different ways through life.			
110	Public Health England	Additional developmental areas of emergent practice Data	Looked After children (LAC) data in the Public Health Outcomes Framework (PHOF)		Although NICE has dedicated guidance for LAC, it is our view that in addition to the reference to some LAC PHOF indicators in this standard, there are a number of LAC PHOF metrics which may be helpful for this guidance to be referenced in Section 4 – these include: - 2.08i Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March - Children in Care Whilst not all children in this group will have been abused or neglected, they are a higher risk group than the general child population.
111	Royal College of General Practitioners				The scope seems appropriate to the theme
112	Royal College of Paediatrics and Child Health	Additional developmental areas of emergent practice	General	General	The RCPCH offers several online resources concerning child protection, e.g. evidence bases articles on various child protection issues based in research particularly from Cardiff University; they should be cited in the new document.

113	Royal College of Paediatrics and Child Health	Additional developmental areas of emergent practice	Hospital emergency departments are usually the first healthcare point of contact for children and young people involved in violent incidents or self-harm.	Hospital emergency departments are very busy environments where even though some staff are aware of abuse and neglect and documentation will contain reminders of safeguarding indications, certain presentations such as physical and sexual assaults, self-harm and parasuicide may not necessarily be recognised as signs of abuse.	Victim Accounts in No one noticed, no one heard A study of disclosures of childhood abuse https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/no-one-noticed-no-one-heard/ Beckett, H., Brodie, I., Factor, F., Melrose, M., Pearce, J., Pitts, J., Shuker, L., & Warrington, C. (2013). "It's wrong-but you get used to it": a qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. University of Bedfordshire with the OCC.
114	SCM 3	Additional developmental areas of emergent practice Working with hospital emergency departments to identify where abuse night be the underlying cause of the presentation	Hospital emergency departments are usually the first healthcare point of contact for children and young people involved in violent incidents or self-harm.	Hospital emergency departments are very busy environments where even though some staff are aware of abuse and neglect and documentation will contain reminders of safeguarding indications, certain presentations such as physical and sexual assaults, self-harm and parasuicide may not necessarily be recognised as signs of abuse.	Victim Accounts in No one noticed, no one heard A study of disclosures of childhood abuse https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/no-one-noticed-no-one-heard/ Beckett, H., Brodie, I., Factor, F., Melrose, M., Pearce, J., Pitts, J., Shuker, L., & Warrington, C. (2013). "It's wrong-but you get used to it": a qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. University of Bedfordshire with the OCC.