NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Child abuse and neglect

Date of quality standards advisory committee post-consultation meeting:
1 November 2018

2 Introduction

The draft quality standard for child abuse and neglect was made available on the NICE website for a 4-week public consultation period between 10 September and 8 October 2018. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 17 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Abuse and neglect should be defined in the document.
- Confidentiality and its limits when children and young people disclose abuse or neglect should be clarified.
- Children cannot be safeguarded without adequate support provided to their families and carers.
- People who work with adults also have responsibility to safeguard children and young people. They should be alert to any health and behavioural issues of adults that may impact on the welfare or safety of children.
- Children and young people with neuro-disabilities need specialist assessment as they may be falsely identified as showing symptoms of abuse or neglect.
- Child friendly version of the quality standard would be useful.
- Implementation may be challenging as it's aimed at members of the public who cannot be held accountable unless mandatory reporting was in place.

Consultation comments on data collection

- Some organisations may have existing data collection processes in place, some may not. The standard should ensure that organisations strive to put the systems in place.
- Challenges related to different data systems across agencies.
- Quantitative data easier to collect, qualitative data requires more creative and innovative methods especially with young children.
- Suggestion to add measures on first hand qualitative accounts from children and young people.

Consultation comments on resource impact

- Funding, training, recruitment and supervision are ongoing issues that make implementation of this quality standard difficult.

- Further financial pressures and safeguarding reforms may impact on delivering the quality standard.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Children and young people who display marked changes in behaviour or emotional state are asked about anything that may be causing those changes in a private conversation.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Identifying alerting features and staying vigilant is an important area for quality improvement.
- Having a private conversation does not mean the information will not be shared. Children and young people need to be aware that it may be necessary to share the information. Statement recommending “personal” conversation rather than “private” conversation may be more appropriate.
- Inconsistency of terminology used in the statement. The phrase ‘marked changes in behaviour or emotional state’ implies that these changes are from the child’s own norm. The definition states that the change being referred to is actually ‘A departure from what would be expected for their age and developmental stage’.
- Focusing on marked changes to a child’s behaviour is narrow as it does not allow for recognising trauma related to Adverse Childhood Experiences and how these impact on behaviour and development.
- Some children are too young to have a conversation with but the reasons for not having a conversation should be recorded.
- Asking about a “cause” can be seen as coercive.
- Discussing circumstances with the parents and carers is vital.
- Staff may not have the skills to identify children at risk or to have this kind of conversation.
- Suggestion to add a measure which would gather feedback from children or young people who have been asked about abuse and neglect about their experience of this conversation.

5.2 *Draft statement 2*

Children and young people talking to practitioners about abuse or neglect have their experiences recorded in their own words.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Hearing children's voices and capturing their experiences is an important area for quality improvement.
- Currently the statement is not applicable to the youngest group who are at high risk. Important to find ways to gather information from very young children through play, observation or witnessing interactions.
- Need to highlight limits to confidentiality. Setting expectations and boundaries should improve engagement and trust with therapy services down the line.
- Many victims don't recognise they are abused but professionals still need to follow up their concerns.
- Children's testimonies written down by various people and agencies may be inconsistent and potentially undermine what they say.
- Recording children's words is important but professional terminology sometimes needs to be used to ensure the message is made clear.
- Additional measure should capture children's feedback on what has been recorded.

5.3 *Draft statement 3*

Children and young people talking to practitioners about abuse or neglect agree with them how they will communicate with each other.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Ensuring safe communication with children and young people is an important area for quality improvement.
- It should be more clear that the responsibility for safe communication is the practitioner's responsibility.

- Applying this statement to very young children and children and young people with communication difficulties would be difficult.
- The communication should be frequent to allow for checking on the children and young people who may be at risk of further harm.
- Auditing records should be done by someone independent.

5.4 Draft statement 4

Children and young people who have experienced abuse or neglect receive support from a consistent group of practitioners.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Consistency is an important area for quality improvement.
- Transient young people (such as those in supported or temporary accommodation, in detention or unaccompanied asylum seeking children) are a group that is likely to have poor experience in this area.
- Data sharing is particularly important in this context.
- Funding, training and recruitment are major challenges at the moment.
- Practitioners should have access to care supervision to support them in their role.
- Additional measure should capture how many changes children and young people experienced.

5.5 Draft statement 5

Children and young people who have experienced abuse or neglect are offered a choice of therapeutic interventions based on a detailed assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Highly desirable objective and important area for quality improvement
- Appropriate evidence-informed interventions are not freely available or accessible in many areas.

- Some of the stakeholders see this statement as unrealistic considering current capacity.
- Suggestion that the statement could be focused on making children part of the decision-making process about the services and interventions they receive.

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Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Organisation name	Statement No	Comments
1	Coram	General	Coram believes there should be a focus on children's voices. Coram's Bright Spots project demonstrated the effectiveness and importance of collecting firsthand qualitative accounts from children in care. We would recommend that this method of data collection is considered to measure progress against the five standards. For example, Statement 2's outcome concerning the primary accounts of children should consider a mechanism for gaining the young person's feedback about how understood they felt. Collecting quantitative data from local and national records may not reveal the whole of the child's experience.
2	Institute of Health Visiting	General	Health visitors generally see very young children, but they may see under 18 year-olds who are parents. School nursing should be mentioned.
3	Institute of Health Visiting	General	Important to note on document that children and young people are those aged up to 18 years (members of the public, in particular, may be unclear on this).
4	Institute of Health Visiting	General	There should be a 'child-friendly' version of the standard.
5	Institute of Health Visiting	General	Children/peers are amongst members of the public.
6	Institute of Health Visiting	General	Dissemination will be a challenge; how can members of the public be held accountable for compliance with the standard? Does this indicate a move towards mandated reporting?
7	Institute of Health Visiting	General	There is no reference to neuro-disabilities and we feel there should be - at least a link to the autism Quality Standard for example.
8	Institute of Health Visiting	General	There appear to be serious concerns that there are many children being highlighted as being potentially neglected or abused, when the cause of their behaviour and that of their parents results from their neurodisability.
9	Institute of Health Visiting	General	Children should also be assessed by specialists with an understanding of all the possible causes of behaviours that may be exhibited by those with disabilities, such as Autism spectrum disorder (ASD).

10	Institute of Health Visiting	General	Child abuse can be physical, emotional, sexual - as there is no definition in the document, this may be useful to add one to ensure clarity of different types of abuse. A Neglect indicator tool -"graded care profile" and local neglect strategy may be useful and link to Sexual Assault Referral Centres (SARC) for sexual abuse and The National Society for the Prevention of Cruelty to Children (NSPCC) for all categories of abuse and certainly safeguarding protocols and links.
11	Institute of Health Visiting	General	Signs and symptoms are not always clear to see, and some children will not talk.
12	Institute of Health Visiting	General	Professionals need to be observant and fully aware of subtle signs and be up to date with all safeguarding training to be familiar with these, including Serious case reviews and lessons learnt etc to prevent any future downfalls.
13	Institute of Health Visiting	General	Robust child protection protocol should be in place and fully implemented.
14	Institute of Health Visiting	General	Take into consideration that Data will be incorrect due to under-reporting and consideration of why under-reporting - they may think they won't be believed, fear of repercussions, etc
15	Institute of Health Visiting	General	Child abuse victims can often be mistaken for having Borderline personality disorder (BPD) when in fact it is Complex Post-traumatic stress disorder (PTSD) symptoms which need treating when the victim is ready. Eye Movement Desensitization and Reprocessing (EMDR) therapy is useful for this.
16	NHS England	General	Training for primary care professionals in safeguarding will need to be modified to incorporate these standards that will have a small resource cost. The current workforce capacity and workload difficulties in primary care means that commissioners may have to be innovative in the creation of services that are able to deliver these standards.
17	Royal College of General Practitioners	General	There is no mention in any of the statements of confidentiality and its limits – it is imperative that this is discussed with a child
18	Royal College of General Practitioners	General	There is no mention of the responsibility of all who work with adults to safeguard children/young people. All who work with adults should be alert to any health or behaviour issues of adults that may impact on the welfare or safety of a child and respond to safeguard children appropriately.
19	Royal College of General Practitioners	General	Agree in principle with all 5 statements

20	Royal College of General Practitioners	General	Children cannot be safeguarded without adequate support given to their families and caregivers. This needs to be recognised within the QS.
21	Royal College of Paediatrics and Child Health	General	The respondent is happy with this document.
22	Institute of Health Visiting	Consultation question 1	We agree that the quality statements reflect the key areas for quality improvement. However, very important to note that 'prevention' is paramount, and to ensure that the notion of ensuring a timely and helpful response is more 'upfront'. Agree that Children and Young People must have the opportunity for a 'private conversation' but confidentiality cannot be assured if they disclose information that suggests that they, or others, may be at risk of, or suffering from, child abuse and neglect
23	NHS England	Consultation question 1	The comments included in the responses to this standard would impact positively on quality improvement.
24	NHS England	Consultation question 2	Some organisations may have existing data collection processes in place, some may not, but the standard should ensure that organisations strive to put the systems in place. Quantitative data will be easier to collect than qualitative data but using creative methods especially with young children will be innovative but may possibly be impacted upon due to financial and human resource demands.
25	Institute of Health Visiting	Consultation question 2 & 3	There will be challenges related to different data systems across agencies, information governance issues and also the impact of austerity on the delivery of public services. Therapeutic services for children are very limited currently, and require significant investment if the standard is to be achieved. Any initiative to improve recognition and response to child abuse and neglect is welcome. Figures/referrals are likely to increase. Research suggests that known cases may be 'tip of iceberg'.
26	NHS England	Consultation question 3	The new safeguarding reforms are changing the leadership models for local partners. These structures need to embed, agree priorities and joint commissioning strategies. This may prove challenging to the delivery of the quality standard during times of change and fiscal pressures.

| 27 | Adoption UK | 1 | Children who have experienced historical abuse and neglect can still exhibit signs similar to those listed in this section, as a result of past trauma. The phrase 'marked changes in behaviour or emotional state' implies that these would be changes from the child's own norm, but the definition later states that the change being referred to is actually 'A departure from what would be expected for their age and developmental stage...'. This is an important distinction. Children who have experienced early trauma and abuse are at increased likelihood of displaying behaviour and emotional maturity that is a departure from what would be expected from their age or stage, whether this represents a change from their norms or not.
We are aware from our members of instances where safeguarding referrals have been made on the basis that an adopted child's behaviour is outside the norms for their age, by practitioners who are not trained to understand and recognise the impact of historical trauma, neglect and abuse. This has caused distress for adoptive families who are living with the impact of their children's past experiences, and have then experienced investigations and interventions as if the abuse and neglect was current. Where practitioners who have received only the most basic safeguarding training are involved in questioning children about the reasons behind their behaviour or emotional state, there is always the possibility that the impact of historical trauma will not be taken into account. In her book, 'The A-Z of Attachment Parenting', author and adoptive parent, Sarah Naish, recounts an incident where her adopted son was caught shoplifting batteries. The story he told his sympathetic youth worker was that he needed the batteries for his torch because his bedroom at home had no lighting or heating. The youth worker made a referral to Children's Social Care, and the family was visited by social workers who found that there was no truth in what the child had said. Past traumatic experiences had taught this child that keeping the youth worker on his side was the best way to avoid punishment for shop lifting. Children whose behaviour is a result of past trauma may have no ready explanation when asked what is behind their behaviour, but may still wish to give an answer in order to please the sympathetic person who is questioning them. Practitioners must be aware of this possibility when dealing with children who have been removed from birth families because of abuse and neglect.
While most parents and carers would accept that is it better to be safe than sorry when it comes to investigating suspicions of abuse and neglect, guidelines on safeguarding for all who have contact with children and young people must include a caveat that historical, as well as current abuse and neglect, can cause children to depart from what would be expected for their age and developmental stage, and that safeguarding procedures and investigations that involve children who have been removed from their birth families because of abuse and neglect need extra care, and should be carried out by professionals with specific expertise in this area.
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			section, as a result of past trauma. The phrase ‘marked changes in behaviour or emotional state’ implies that these would be changes from the child’s own norm, but the definition later states that the change being referred to is actually ‘A departure from what would be expected for their age and developmental stage...’. This is an important distinction. Children who have experienced early trauma and abuse are at increased likelihood of displaying behaviour and emotional maturity that is a departure from what would be expected from their age or stage, whether this represents a change from their norms or not. We are aware from our members of instances where safeguarding referrals have been made on the basis that an adopted child’s behaviour is outside the norms for their age, by practitioners who are not trained to understand and recognise the impact of historical trauma, neglect and abuse. This has caused distress for adoptive families who are living with the impact of their children’s past experiences, and have then experienced investigations and interventions as if the abuse and neglect was current. Where practitioners who have received only the most basic safeguarding training are involved in questioning children about the reasons behind their behaviour or emotional state, there is always the possibility that the impact of historical trauma will not be taken into account. In her book, ‘The A-Z of Attachment Parenting’, author and adoptive parent, Sarah Naish, recounts an incident where her adopted son was caught shoplifting batteries. The story he told his sympathetic youth worker was that he needed the batteries for his torch because his bedroom at home had no lighting or heating. The youth worker made a referral to Children’s Social Care, and the family was visited by social workers who found that there was no truth in what the child had said. Past traumatic experiences had taught this child that keeping the youth worker on his side was the best way to avoid punishment for shop lifting. Children whose behaviour is a result of past trauma may have no ready explanation when asked what is behind their behaviour, but may still wish to give an answer in order to please the sympathetic person who is questioning them. Practitioners must be aware of this possibility when dealing with children who have been removed from birth families because of abuse and neglect. While most parents and carers would accept that is it better to be safe than sorry when it comes to investigating suspicions of abuse and neglect, guidelines on safeguarding for all who have contact with children and young people must include a caveat that historical, as well as current abuse and neglect, can cause children to depart from what would be expected for their age and developmental stage, and that safeguarding procedures and investigations that involve children who have been removed from their birth families because of abuse and neglect need extra care, and should be carried out by professionals with specific expertise in this area.

28	Association of Family Therapy and Systemic Practice	1	We appreciate the attention given to privacy in asking the child or young person these sensitive questions. However from the quality measures it does not appear that the privacy (or acceptability) of the conversation between the practitioner and the child or young person is being included as a measure. We would suggest that practitioners develop systems to ask for feedback from children or young people who have been asked about abuse and neglect about their experience of this conversation.
29	British Association for Sexual Health & HIV adolescent specialist interest group	1	The term “private conversation” could be expanded on - what does this means ie is a 1 to 1 conversation without family or friends present.
30	British Association for the Study and Prevention of child Abuse and Neglect	1	It’s important to add to this statement that while children may display marked changes in behaviour or emotional state this may not be always the case, especially when abuse or neglect are chronic or gradual in onset.
31	Catholic Education Service	1	This statement does not accurately reflect the current ‘Working Together to Safeguard Children’ (2018) statutory guidance of a child -centred approach where it is every adult’s responsibility for the following two reasons: 1) The statements says “children and young people who display marked changes in behaviour or emotional state”. This does not take into account that 90% of abused children were abused by someone they knew (Radford et al. 2011), most often members of their own family. This may mean that a child has been experiencing significant abuse throughout their life and will display behavioural and emotional difficulties throughout and will not display “marked changes”. 2) Furthermore, the statement says that “children are asked about anything that may be causing those changes”. The Children’s Commissioner 2015 report found that only 1 in 8 victims of sexual abuse come to the attention of statutory authorities as many victims do not disclose abuse. Furthermore, only 1 in 3 children sexually abused by an adult did not tell anyone (Radford et al. 2011). Merely asking a child about anything that might have caused their behaviour will not guarantee disclosure and significant actions must be taken to ensure the child feels safe enough to disclose.

32	Coram	1	Coram agrees that recognising and responding to any warning signs of child neglect or abuse is a key indicator for standards of quality. Coram supports vulnerable children including those who are in care, adopted and children who are subject to immigration controls. Many have experienced trauma. For these children behaviour may not follow typical patterns in the face of new challenges, so symptoms of abuse can easily be missed. Practitioners require training in the specific needs of these groups of children to identify when changes in behaviour may be due to safeguarding issues rather than being due to disability or previous trauma.
33	Institute of Health Visiting	1	A change in presentation (clothing/cleanliness) should be overtly noted.
34	Institute of Health Visiting	1	We need something that says ‘those identified with Autism spectrum disorder (ASD) or other neurodisability should be clearly identified at the outset and assessed and supported by practitioners with expertise in this area. For example, use of child in need assessments for both groups is leading to confusion and even causing harm. The easiest way to build this in may be for the ‘equality and diversity‘ sections to be added to. They currently talk about the problems of communication, but should also highlight the importance of assessments taking full account of any special needs For example – Quality Statement 1…. A sentence could be added at the end. Children and young people who are displaying a marked change in behaviour or emotional state may have problems with communication, for example because they are very young or because of disability, speech or language problems. They should be supported to communicate in a way that meets their individual needs.
35	NHS England	1	In a GP context it would be difficult/impossible to measure this as there are no relevant codes to describe and distinguish these metrics. It would be possible to ensure that this quality standard was included in safeguarding policies and procedures in GP practices. This could be overseen in the routine assessment of practices by CQC.
36	NHS England	1	Children and young people may display different behaviours for a variety of reasons, not always related to CSA. However practitioners should apply due diligence and sensitivity when raising their concerns and the focus should be on listening.
37	NHS Kernow	1	Alerting features: This should have added to the statement: …’in the light of their age and level of understanding’ as some children will be too young and / or immature too ask. In addition: The information in the records should indicate whether or not the child was asked and a reason(s) provided for the occasions when this wasn’t asked.

38	NSPCC	1	The current quality standard overlooks the impact of Adverse Childhood Experiences on child development and does not support professionals to understand how trauma relating to ACES can manifest in a child behaviour and development. This may present as marked changes in behaviour or emotional state, but this is too narrow and does not encourage professionals to understand and respond to broader range factors that contribute to a full understanding of child's development and potential safeguarding requirements .
39	Parent Infant Partnership (PIP) UK	1	Infants (age to second birthday approximately) will be unable to use verbal communication effectively, especially when this is focussed on an emotionally troubling topic. (The same applies to children with a language or global developmental delay.) After about 18 months (sometimes earlier) they can still be 'asked' about what is troubling them through the medium of play. So appropriate play material should be made available and utilised once they have formed a positive relationship with the therapist / assessor involved. The toys should include a flexible dolls' house family that matches the child's, a small dolls' house with furniture, wild and domestic animals, a soft 'comfort' toy and something to bash. The play should be led by the child; this is a natural way to communicate anxiety for all small children. It should be noted that traumatised infants may resort to the heightened parasympathetic 'freeze' response when experiencing stress or anxiety, and so all forms of communication will be compromised; this may look like a quiet child who is not looking for interaction or attention. For babies and infants the alerting features will be communicated by behaviour. This will signal both the direct impact of trauma on the stress response system and the change in attachment related behavior when a parent has become a scaregiver. The observable coping responses of very young children exposed to trauma are affected by their: • information processing skills; • immaturities in emotional regulation; • relationship with the caregiver (attachment); • level of social cognition and difficulty in taking another's perspective; • expressive and receptive language ability; • memory capacity. Some practitioners might be alerted to such behaviours and start from an assumption that there is a problem with the child. In this context it is safer for practitioners to begin by asking themselves "What has happened to this child?" This is a 'trauma informed' approach that should become standard practice for any age of child or young person. These are the changes in behaviour frequently seen when a baby has been traumatised by direct abuse, neglect and witnessing violence in the household:

			• intense and prolonged crying; • unresponsiveness to soothing; • motor disruptions such as flailing, muscular rigidity, restlessness and agitation; • eating problems such as lack of appetite or excessive eating; • sleeping disorders such as difficulty falling asleep, frequent night waking; • elimination problems such as constipation and diarrhea without apparent organic causes; • numbing of affect which might show as sadness or actual depression, a subdued demeanor and unresponsiveness to age-appropriate stimulation. And as the infant grows older: • Sleep disturbances, e.g. nightmares or night terrors, poor sleeping habits and night waking. • Immature or regressed behavior, with loss of developmental skills (e.g. toileting, language). • Physical complaints, general poor health (continued activation of the stress response affects the auto-immune system). • Emotional distress (crying, irritability, restlessness, insecurity, hyperactivity). • Aggressive or withdrawn behaviors with emotional instability and tantrums. • Self-endangering behavior, which may be passed off as accidental. • Post-traumatic stress symptoms. • Behaviours associated with disorganized attachment and a loss of capacity for regulating emotions. • Frozen watchfulness and hyper-vigilance. • Loss of 'basic trust' in adults. • They become more attuned to aggressive stimuli (e.g. verbal conflict, angry expressions) and show a conditioned enhanced distress response. These are all patterns of behavior that a children's centre or nursery would be able to observe. But note, any of the above could have another cause apart from maltreatment; concern should be heightened when there is a range. Although this is beyond the infancy remit of PIP UK, a similar approach may be taken for older children where the following behaviours, if appearing in a cluster rather than individually, could be an indicator that the child is or has been suffering maltreatment: • Friendship relations are disturbed; maltreated children exhibit more withdrawal from their peers. • A lowering of self-esteem coupled with feelings of guilt, humiliation, shame and taking on responsibility for the abuse (In sexual abuse within the family this is sometimes directly reinforced by the abuser to ensure the

			child does not tell anyone) which may cause the child to withdraw from social contact with peers and adults and so become 'unnoticed'. • Depression. • Heightened aggression that may be directed at other children, the sympathetic, 'fight and flight' system is on high alert. – Often they hurt those showing distress. • Or the child may withdraw, with a tendency for the 'freeze' or dissociative response, and become the quiet child at the back of the class who causes no trouble and so remains unnoticed. • Thinking about mental states (reflective function or mentalization) may become something to be avoided. • School functioning is compromised, another reason for self-esteem to fall. • Alteration in the regulation of affective impulses, including difficulty with modulation of anger and self-destructive impulses (self harm includes eating disorder). • Alterations in attention and consciousness, in extreme instances leading to amnesia and dissociative and depersonalization episodes. • Somatization of the problem – distress is communicated by physical illness. • Street drugs / alcohol misuse as a form of self-medication. NB. From clinical experience most childhood abuse has begun during infancy, though not necessarily in the manner that has been detected or disclosed in later years; for instance, the sexual or physical abuse of a school-age child often has a precursor in domestic violence/ control as the abuser (usually a non-biological parent) has set out to dominate the family from the start for their future 'safety' on the assumption that he or she can ensure a pattern of submission. (In instances of personality disorder this may not be conscious.) And neglect or violence in the household discovered in school age children invariably were present in infancy. Quality measures. Structure. (p.4) Bringing in the importance of observing behavior in the early years has implications for further education and procedures for some agencies where this might not have been a standard part of their core training. Questions for consultation; responses. 1) For verbally competent children this draft standard does reflect a key area for potential quality improvement. If this was to include recording observations then it would more accurately reflect the needs of the full age range. 2) Yes, appropriate systems should already be in place that could be utilized, or easily adapted, to record

			observations, and should be a component of the area's safeguarding policy. 3) There are no implications for increased resources here beyond training and supervision.
40	Royal College of General Practitioners	1	The conversation should be "personal" rather than "private" because if the child is at risk it would be necessary to share information. The child must not be misled.
41	Royal College of General Practitioners	1	Regarding the phrase 'are asked about anything that may be causing those changes in a private conversation' Very often in the primary care setting children and young people attend with a parent, guardian, family member etc. It should be made clear in the guidance in this quality statement that the responsibility to arrange a private conversation lies with the professional involved i.e. it's not ok to say to the child 'would you like mum to leave so we can have a chat?' A young person will find it very hard, if not impossible, to be the one to ask the accompanying person to leave the room. The healthcare professional's responsibility is to politely and firmly make sure the accompanying person leaves the room to allow the space for a confidential conversation. In the case of general practice this should be corroborated by practice policy so a clinician can say to the accompanying person 'it's our policy to see young people alone so please could you take a seat outside and I'll call you back in after we've had a few moments to chat.' From training experience, a large number of clinicians do not appear to feel confident to ask the accompanying person to leave the room. They often report that they often just ask the child or young person if they would like that person to leave. This is an area people struggle with in practice and that is why it is important that the onus being on the clinician should be made clear and emphasised in these quality standards.
42	Royal College of General Practitioners	1	The phrase "anything that may be causing" suggests that there is a "cause". "How do you account for?" would seem less coercive and invites a story rather than a single "cause".
43	Royal College of General Practitioners	1	It is also vital that parents/care givers are asked about circumstances at home that may be affecting a child e.g. domestic abuse

44	Royal College of General Practitioners	1	It should be recognised that many children and young people who are being abused or neglected will not recognise that they are victims and they may not think they are being abused. However, if practitioners suspect abuse or neglect, even if a child or young person does not agree, safeguarding action must still be taken. Practitioners need to balance a child's wishes/rights/needs with their duty to protect them from abuse and neglect.
45	Spectrum Community Health CIC	1	This statement can be measured by auditing the referrals to children's social care which will evidence the conversations that practitioners have had with children where there are concerns.
46	Spectrum Community Health CIC	1	This can be measured by auditing training records to ensure that staff are adequately trained to recognise changes in a child's behaviour may indicate possible abuse or neglect.
47	The Faculty of Sexual and Reproductive Healthcare	1	FSRH notes that Q3 of the 'Questions for Consultation' concerns issues of resourcing, as preconditions of the achievability of the quality standards. In this context, FSRH would seek assurance that all staff in educational settings have been trained to the point where there is a consistent capacity to identify children and young people experiencing abuse and neglect and converse with them. The Department of Education's current proposals for staff training in relation to RSE are not on a scale commensurate with tasks of this sort. https://neu.org.uk/latest/new-guidance-sex-education-vital-says-national-education-union. FSRH would advise specifically highlighting the need for professionals not just in health, but in associated sectors, to 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. Appropriate 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.pd

48	The National Association for People Abused in Childhood (NAPAC)	1	Q1: The recognition of these behavioural changes in children would be a great improvement. Q2: We do not see that systems and structures are in place to collect data on this statement. One way in which it might be improved is to ensure that clinicians are aware of trauma informed ways of working with young people who display marked changes in behaviour as described for working with adults by Bellis et al for Public Health Wales at http://www.aces.me.uk/files/2215/3495/0307/REACh_Evaluation_Report.pdf . Q3: NAPAC is unable to comment on the adequacy or otherwise of current resourcing but it is clear that the NHS generally is overstretched.
49	Association of Family Therapy and Systemic Practice	2	We are very supportive of this quality standard encouraging recording the child or young person's actual words and co-signing records and documenting areas of disagreement between children or young people and professionals. In process a, the numerator is the number of children who have experiences recorded in their own words – we strongly feel that there should be a process of verification here, otherwise practitioners are simply saying that they have used the words of the child / young person. What makes a difference here is that children and young people are properly listened to and involved and consulted, so the process should include a place where the child or young person can give feedback on what has been recorded, and utilisation of this could be a more appropriate numerator.
50	British Association for Sexual Health & HIV adolescent specialist interest group	2	In terms of achieving best evidence [ABE - forensic medicine perspective] - refraining from the collecting of detailed information of events / timelines etc as when likely that agencies such as the police and social services are going to be involved and there may be discrepancies between all the statements taken, that is then detrimental to criminal proceedings.
51	British Association for Sexual Health & HIV adolescent specialist interest group	2	There is no reference in any of the statements about limits of confidentiality and discussing this with children and young person who do have rights and also in the context of the GDPR era.

52	British Association for Sexual Health & HIV adolescent specialist interest group	2	There is no references as to how to communicate to children and young people what information will be shared and who their information will be shared with. This is a very important issue as setting expectations and boundaries should improve engagement and trust with therapy services down the line.
53	British Association for the Study and Prevention of child Abuse and Neglect	2	In agreement
54	Coram	2	Children and young people should feel that their experiences of abuse and neglect are listened to and understood. We agree that there should be a focus on children's voices and that this is a key area of focus. Coram's Bright Spots project demonstrated the effectiveness and importance of collecting firsthand accounts from children in care. We would recommend that a similar method of data collection is considered to measure the outcome for this standard.
55	NHS England	2	This should form part of routine safeguarding policies and part of training. It is difficult to measure as it's qualitative – review of samples of records in primary health care could be used for internal quality improvement and review.
56	NHS England	2	Very young children may not be able to describe in words what's happened but SARCs use role play and art to gather information, these alternative methods of gathering information need including in the standard.
57	NHS Kernow	2	Accurate Records: In addition to the child's experiences being recorded in his / her own words the practitioner must also record the details of the reported experience(s) in professional terminology. Rationale - The records need to be accurate and it is important to ensure that an agreement with the child about the exact words used does not water down / diminish the gravity of what the child has disclosed – consequently the practitioner may need to disagree with the child about what is recorded in order to accurately convey the conversation / concern

58	NSPCC	2	The NSPCC is currently undertaking a project called Professionals Breaking the Silence, that is bringing together what children have said about their experiences of disclosing abuse or neglect with research on multiagency professionals views on their confidence to notice and respond to disclosures from children. This project is using an innovative approach by consulting with and bringing the views of young people and professionals together to design a resource that will have the greatest impact for children and young people. The professional survey was completed by 1514 professionals and we had 91 professionals in total attend our four focus groups. The Professionals Breaking the Silence project will develop a resource that can be used by professionals across sectors (police, education, social care and health), when a child or young person discloses abuse and/or neglect during a conversation. The resource will help professionals better hear and respond to young people's disclosures, and to ultimately improve children's experiences of the disclosure process. The NSPCC has concerns that the proposed quality standards do not sufficiently address the concerns that we hear form professionals about their participation in the disclosure process. The current standards may risk inadvertently reinforcing some of the barriers professionals report as undermining their ability to have a disclosure conversation with children. We would be happy to meet with the Quality Standard development team to discuss the emerging findings from our research and its implications for the development of the abuse and neglect quality standard.

59	Parent Infant Partnership (PIP) UK	2	The peak of serious child abuse takes place at a time when the child cannot talk. The NSPCC reports that the under one's are the age group most at risk, and the highest rate of murder occurs in the first year of life. For very young children this quality statement needs an additional reminder that practitioners should accurately record both their own observations of the child's behaviour, especially in interaction with their caregivers, as well as observations made by others who will have seen the infant, such as health visitor, children centre staff, volunteer home visitor and relatives (if appropriate). Observations should be recorded 'as seen' without any interpretation or speculation (this should be recorded separately as well as discussed in detail in reflective supervision) so as to reduce bias based on opinion influencing those who might be adding to this record. Details of play could be included with the same caveat. And in many instances a video record might be appropriate as long as parental permission has been given as this widens the available expertise, although in some instances circumstances may make this unfeasible. Such recordings should be appropriately stored as part of the child's records. For a standardised video record it may be noted that PIP UK uses The Keys to Interactive Parenting Scale (KIPS) as a means to analyse interaction between a caregiver and infant within a therapeutic setting. This is an evidence-based and cost-effective online training in a video based assessment that also has clinical applications. http://www.comfortconsults.com The training is applicable and accessible to anyone who works in Early Years. Quality measure (a) – Structure. (p.12) This should acknowledge the importance of recording observations as well, since an emphasis on speech forecloses 'seeing' the significance of behaviour as a form of communication in very young children. Questions for consultation; responses. 1) This quality standard is a key area for improvement, but as it stands it does not apply to pre-verbal children and so would benefit from being adapted slightly. 2) If there was a change to reflect the needs of infants then there might be some training implications or a demand for a specialist service to take on this work as well as act as consultants to other agencies involved. 3) There are no implications for increased resources here beyond training and supervision, unless a specialized team is set up as above.
60	Royal College of General Practitioners	2	It should be recognised that many children and young people who are being abused or neglected will not recognise that they are victims and they may not think they are being abused. However, if practitioners suspect abuse or neglect, even if a child or young person does not agree, safeguarding action must still be taken. Practitioners need to balance a child's wishes/rights/needs with their duty to protect them from abuse and neglect.

61	Spectrum Community Health CIC	2	Records can be audited to provide assurance that conversations are recorded in a child's/young person's own words. It may be hard to measure whether a child has agreed with and signed the record of conversation as all records are computerised.
62	The National Association for People Abused in Childhood (NAPAC)	2	Q1: Yes, this would be a great improvement. Q2: It should be possible to measure and evidence improvements in achieving this statement. Q3: NAPAC is unable to comment on the adequacy or otherwise of current resourcing but it is clear that the NHS generally is overstretched.
63	Association of Family Therapy and Systemic Practice	3	Agreed methods of communication are vital to prevent further increasing risk for a child or young person in a risky situation. For the process of quality measures we would suggest that frequent updates and checking out are also important – it is not sufficient to have been done once and recorded in a context which might be changing. We would suggest that dating entries and setting time periods for review which are appropriate to the particular context are important parts of measuring quality in this area.
64	British Association for the Study and Prevention of child Abuse and Neglect	3	In agreement
65	Coram	3	An agreement between young people and practitioners about how best to communicate is an important standard. The wording of the current standard could be improved so that the onus is more clearly on professionals to try to reach an agreement with children and young people. We would also suggest recognising that some children may need interpreters to do this effectively. We support the recommendation to audit the records of children's accounts however suggest that this is performed by someone independent from the case.
66	NHS England	3	This should form part of routine safeguarding policies and part of training. It is difficult to measure as it's qualitative – review of samples of records in primary health care could be used for internal quality improvement and review.
67	NHS England	3	This is very important to ensure victims are not put at further risk; the main concerns are how this statement is applied to very young children, children with disabilities and children where English may not be a first language and parents who could be potential abusers are used as interpreters?

68	NHS Kernow	3	Communication: Agreeing a means of effective and safe communication between the child / young person and workers is vital and this is a very welcome quality standard that should go a long way to achieving this. Comment: Practitioners would benefit from having some practical training in regard to this standard and it should be reflected in relevant safeguarding / child protection policies / procedures.
69	NSPCC	3	The NSPCC is currently undertaking a project called Professionals Breaking the Silence, that is bringing together what children have said about their experiences of disclosing abuse or neglect with research on multiagency professionals views on their confidence to notice and respond to disclosures from children. This project is using an innovative approach by consulting with and bringing the views of young people and professionals together to design a resource that will have the greatest impact for children and young people. The professional survey was completed by 1514 professionals and we had 91 professionals in total attend our four focus groups. The Professionals Breaking the Silence project will develop a resource that can be used by professionals across sectors (police, education, social care and health), when a child or young person discloses abuse and/or neglect during a conversation. The resource will help professionals better hear and respond to young people's disclosures, and to ultimately improve children's experiences of the disclosure process. The NSPCC has concerns that the proposed quality standards do not sufficiently address the concerns that we hear form professionals about their participation in the disclosure process. The current standards may risk inadvertently reinforcing some of the barriers professionals report as undermining their ability to have a disclosure conversation with children. We would be happy to meet with the Quality Standard development team to discuss the emerging findings from our research and its implications for the development of the abuse and neglect quality standard.
70	Spectrum Community Health CIC	3	This statement can be measured by auditing records.
71	The National Association for People Abused in Childhood (NAPAC)	3	Q1: Yes, this would be a great improvement. Q2: It should be possible to measure and evidence improvements in achieving this statement. Q3: NAPAC is unable to comment on the adequacy or otherwise of current resourcing but it is clear that the NHS generally is overstretched. Effective and trauma informed communication takes time which seems to be one thing clinicians are lacking.

72	Association of Family Therapy and Systemic Practice	4	We agree that consistency is important. We would suggest that the measurement include not only whether the child or young person has had a change in social worker or therapist in the last 12 months, but also if so, how many times. Consistency is not either / or and in monitoring those who have a higher number of changes, it can help to identify greater risk and address this, Even if the quality standard is not to have any changes at all over 12 months, it is still important to measure degree.
73	British Association for the Study and Prevention of child Abuse and Neglect	4	In agreement
74	Coram	4	Based on findings from Coram's Bright Spots project we know that continuity of practitioner is important to children who are in care. Our national survey found that there was a statistically significant association with the lack of trust and having had three or more social workers. Young people in this survey wrote about their dislike of the frequent changes in social worker. We therefore believe that Statement 4 should be a key measure in quality standards. The standard needs to take into account transient young people such as those in supported or temporary accommodation, in detention or unaccompanied asylum seeking children. The importance of continuity of care is also urged in the Department for Education and Spring Consortium's Seven Features of Practice and Seven Outcomes (2017). It highlights that successful innovation programmes in children's social care focused on ensuring that children and families had access to a single, consistent practitioner who provided intensive support over time.
75	NHS England	4	Fully support this ambition, sharing of information should be highlighted as an imperative and practitioners should receive specific case supervision to support them in their roles.
76	NHS Kernow	4	Continuity: This is an excellent standard. Comment: It would help to add something along these lines to the standard: 'Practitioners should not transfer the child / young person's case to another team member simply because the child has moved address / changed GP / school without considering the potential negative impact of such a change on the child / young person and where reasonably practicable avoid such changes - If a change still needs to take place the rationale for it must be recorded'.

77	Parent infant Partnership (PIP) UK	4	This is an important quality statement from the perspective of the child. Children of any age will communicate in a more emotionally honest manner if they have built up a sense of trust in the adult with whom they are working. This especially applies to infancy as this is a period where the biologically based attachment system is most influential and the quality of the child's relationships is more likely to be person specific. If the infant begins to form a positive relationship with a helper, or a foster parent, then breaking this relationship will be contra-indicated. Thus continuity is very important in the early years, a necessity and not a luxury. It is the responsibility of both practitioners and their managers to protect the continuity of relationships here, as that will be in the best interests of the very young child both in the present and the future. As a corollary, continuity of helping agency when working with parents is equally important. Quality measure (a) (p.15) as applied to infants implies the availability of specialised infant mental health provision where the child can be helped by the process of strengthening their relationship with whoever is, or will be, their primary caregiver as well as directly addressing any sequelae of the trauma that risk becoming a personality trait of the child. This will need a relationship-based intervention as specified by PIP UK in their network of infant mental health teams. https://www.pipuk.org.uk See below for details of good practice. Questions for consultation; responses. 1) This quality statement is especially important for infants (very important for all ages too) since the continuity with a therapist or other helping and benevolent adult is a key component in helping improve the child-parent relationship where this has been compromised by trauma. This applies to the importance of continuity in foster parents. 2) As for statement 3. 3) As for statement 3.
78	Spectrum Community Health CIC	4	This can be measured by audit of clinical records to identify whether practitioners have been consistent in the young person's care.
79	The Faculty of Sexual and Reproductive Healthcare	4	Again, in response to Q3 of the Questions for Consultation, the FSRH would point out that there are resource issues which inhibit the realisation of this standard. Achieving consistency of support is difficult in a context of continuing cuts, where staff turnover is a serious issue: Addressing the resource problems that work against consistency has several dimensions, including funding, training and recruitment. A 2018 CQC survey, for instance, identified that "Issues with capacity were mentioned throughout the fieldwork in all 10 areas. High turnover of staff, inadequate skills and increased demand all contributed to reduced workforce capacity. The lengthy process and cost of recruitment and the shortage of well-trained staff put extra pressure on existing staff". https://www.cqc.org.uk/sites/default/files/20180308_arewelistening_qualitative.pdf

80	The National Association for People Abused in Childhood (NAPAC)	4	Q1: Yes, this would be a great improvement. Q2: It should be possible to measure and evidence improvements in achieving this statement. Q3: One sequence of six, 12 or 18 sessions of trauma-focused CBT is not sufficient to process and recover from prolonged and complex trauma in the form of sexual/physical/emotional abuse and/or neglect. NAPAC has learned through 20 years of working with adult survivors of childhood trauma that if the underlying causes of symptoms such as marked behavioural changes are not addressed they will manifest problematically many years later in adulthood.
81	Association of Family Therapy and Systemic Practice	5	We support that children are offered choice in interventions, since this is key to engagement and acceptability. However in the briefing paper (see below) only trauma-focused CBT and attachment-based interventions were mentioned. We are keen to ensure that systemic interventions remain open to choice, since these can be effective for the child or young person by also including relationships and context (whether this be family relationships, carer relationships or school and peer group relationships), however they may be overlooked if an individualistic treatment model of choice is adopted. We support monitoring the acceptability of interventions to the child or young person by involving them in a dialogue about what feels helpful and what doesn't, however services will need to have the capacity and flexibility to be able to learn from this, and adapt approaches or change interventions in response to feedback, otherwise asking becomes meaningless, and children and young people become disempowered further. In considering therapy for children, young people, families and carers, it is important that a systemic approach be taken. The briefing paper talks about trauma-focused CBT for children and attachment-based interventions for families and carers. Whilst these can be helpful interventions, it is important to also support useful interventions which look at the child, young person, family and carers in relationship, and in context. There are 10 functional family therapy teams across the UK working with families where children have experienced abuse and neglect, and there is recent research looking at the effectiveness of this approach. Turner, C., Robbins, M., Rowlands, S. & Weave, L. (2017) Summary of comparison between FFT-CW and Usual Care sample from Administration for Children's Services Child Abuse & Neglect Volume 69, July 2017, Pages 85-95

82	British Association for the Study and Prevention of child Abuse and Neglect	5	This statement is problematic. We agree that children should be part of the decision-making process about the services and interventions they receive and should be assisted through age appropriate explanations to make informed choices. However, the statement is potentially misleading as there may be no appropriate choices of intervention available to them locally. In addition, young people may choose to have no services/intervention at that time, but safety considerations may mean some provision is essential in their best interests and this could override their wishes in some circumstances.
83	British Association for the Study and Prevention of child Abuse and Neglect	5	A choice of appropriate evidence-informed interventions is not freely available or accessible in many areas. While this is clearly a highly desirable objective and important area for quality improvement it is currently unrealistic to set this as a standard.
84	Coram	5	While choice of therapeutic intervention is an important principle, this can only be realised when there are a range of service options present in a locality. There should be a comprehensive range of resources available so that treatment is suitable and easily available for children who have experienced abuse and neglect. Practitioners need to understand the 'Gillick competence' whereby children under 16 years old can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. Coram's Adoption Support Gateway is an example of a service that provides adoptive families with easy access to a range of interventions such as art and music therapy and mentalisation-based therapy. The service incorporates expertise from clinicians from different organisations ensuring that families get the right support at the right time. The choice of interventions for young people should link to the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) programme.
85	NHS England	5	Fully support this ambition, the new legislation set out in the Children and Social work Act 2017 and the new leadership framework should ensure joint commissioning and integrated regulation of CSA therapeutic services are assured and audited.
86	NHS Kernow	5	Therapeutic interventions: This is an excellent standard although depending on the nature of therapeutic intervention required not all services / areas may have the resources / staff to be able to offer the child / young person a choice(s). However – services / agencies should be striving towards being able to achieve this standard. Comment; Consequently, the standard should include reference to striving towards it if it is not currently achievable e.g: 'Agencies / services should offer / be striving to offer children young people who have experienced abuse or neglect a choice of therapeutic interventions based on a detailed assessment'.

87	NSPCC	5	The current guideline makes insufficient reference for the need for both evidence based assessments and therapeutic interventions. 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). 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 recommended by Barlow et al in 2012.

88	Parent Infant Partnership (PIP) UK	5	In respect of traumatised infants and their caregivers both Infant/Child-Parent Psychotherapy and Attachment and Bio-behavioral Catch-up are mentioned in the NICE Guideline on Child abuse and neglect, 9 October 2017. (Sections 1.7.6, and 1.7.4.) Some version of Interaction Guidance, or video-feedback, could be added such as VIPP or VIG or based on KIPS; or the Mellow Parenting and Circle of Security therapeutic group interventions, both based on attachment theory. When the child is an infant a major part of any therapeutic work is to strengthen their attachment relationship in order to help this become as secure as possible. This implies a shift of perspective from some forms of treatment offered to older children, as with infants the 'patient' is the relationship and not the child. Specialist Infant Mental Health Teams, integrated with the range of early years provision, should be available in every locality to do this work, currently this is indeed a 'post code lottery'. Quality measures. – Structure. (p.19) Since Infant Mental Health Services are very scarce it may be appropriate to specify here that the therapeutic intervention should be appropriate for the age of the child and provided by qualified practitioners, in order to reinforce the mention in the 2017 Guideline. Questions for consultation; responses. 1) An accurate reflection of needs for all traumatized children and a crucial quality statement that needs to be reinforced based on best practice. Infant oriented treatment is mentioned in the 2017 Guideline, as referred to above. 2) There may be a data collecting system in place, but without appropriate treatment being made available there will be no data to collect on treatment for infants and their caregivers. PIP UK has developed a data and outcome measure tailored to providing therapeutic services from pregnancy until the child's second birthday and would be please to share this. 3) This quality standard will not be achieved across the age range unless there are dedicated resources in each area that support a specialised Infant Mental Health Team. Currently this is not the case.
89	Royal College of General Practitioners	5	There is a severe lack of therapeutic services/interventions available to children who have been abused or neglected – children and families must be given accurate information about what is (and what is not) available. How does NICE anticipate this QS to be fulfilled when so little intervention is available?
90	Spectrum Community Health CIC	5	The effectiveness of therapeutic interventions can be audited from clinical records.

91	The National Association for People Abused in Childhood (NAPAC)	5	Q1: NAPAC believes that is very important that this target is achieved for young people and for the adults who suffered childhood abuse but received no support during childhood or adolescence. Q2: It would be fairly easy to measure improvements in service delivery to those who come to the attention of health service providers, but many young people who suffer go unnoticed. Q3: As in our response to Q3 in Statement 1, more trauma-informed inquiry by clinicians into patients' adverse childhood experiences would help identify people who suffer abuse. There may be a need for more training of clinicians in implementing trauma-informed approaches in order to be able to offer an informed choice of therapeutic interventions. The range of interventions currently approved by NICE does not include empowerment and trauma informed approaches which NAPAC has found to be effective in supporting adult survivors of childhood trauma. Such approaches are recommended in the NHS Strategic Plan for Sexual Assault and Abuse Services at https://www.england.nhs.uk/publication/strategic-direction-for-sexual-assault-and-abuse-services/ . It is unlikely that the Statement will be adequately achieved without offering a wider choice of therapeutic interventions. NAPAC is disappointed that this consultation has not addressed the central question of assessment for approval of the newer and more effective interventions. NAPAC hopes that in the near future NICE will be able to address the difficult but important question of finding other ways to assess interventions and not simply restrict acceptable assessment methods to randomised control trials. The effective interventions used in much of the third sector are not possible to assess using the RCT methodology.
92	Royal College of Nursing	No comments	Apologies for the delay in response, but this is just to inform you that nurses were invited to review the draft quality standard ON Child abuse and neglect and there are no further comments to make on this document on behalf of the Royal College of Nursing. Thank you for the opportunity to participate.

Registered stakeholders who submitted comments at consultation

- Adoption UK
- Association of Family Therapy and Systemic Practice
- British Association for Sexual Health & HIV adolescent specialist interest group

- British Association for the Study and Prevention of Child Abuse and Neglect
- Catholic Education Service
- Coram
- Institute of Health Visiting
- NHS England
- NHS Kernow
- NSPCC
- Parent Infant Partnership (PIP) UK
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Spectrum Community Health CIC
- The Faculty of Sexual and Reproductive Healthcare
- The National Association for People Abused in Childhood (NAPAC)