NHS England

Child Sexual Abuse Hub Toolkit

A practical guide for commissioners and practitioners to establish a CSA Hub

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This toolkit has been created as a practical guide for individuals and agencies with a passion to improve services for children and young people after experiencing child sexual abuse (CSA). The learning represents the culmination of the two year London CSA Transformation Programme funded by NHSE (London) and hosted by King's College University Hospital NHS Trust. Local learning and case studies come from the establishment of the Child Sexual Abuse (CSA) Hub in North Central London funded by the Department of Health.

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1. Executive summary

This toolkit has been created as a practical guide for individuals and agencies with a passion to improve services for children and young people after experiencing child sexual abuse (CSA) including child sexual exploitation (CSE). The learning represents the culmination of the two year London CSA Transformation Programme funded by NHSE (London) and hosted by King's College University Hospital NHS Trust. Local learning and case studies come from the establishment of the Child Sexual Abuse (CSA) Hub in North Central London funded by the Department of Health.

CSA hub model

The CSA hub model is a one stop shop for medical, advocacy and early emotional support for children and their families that have experienced CSA and CSE, as well as offering advice and liaison to police and children's social care services. Children and young people attending the hub can access a holistic health assessment, examination, sexual health screening and treatment. Children, young people and their parent/carer are offered early emotional support from a team of advocates and CAMHS clinicians, with case management and referral onto long-term support as needed. This evidence-based model provides early access to CAMHS or advocacy services with no threshold, and is predicted to reduce the need for long-term CAMHS intervention. Research shows that intervention within 4-6 weeks of a trauma or disclosure has been shown to decrease long term post-traumatic disorders.

The North London CSA hub pilot was evaluated after eight months and found improvements in the case management for children and young people, better access to early emotional support where needed and positive qualitative feedback from families and staff. Over 50% of children, young people and families attending the CSA hub were supported by the advocate and/or the CAMHS practitioners.

The CSA hub was reported to be a restorative experience for children and families and removed barriers to them accessing advocacy and CAMHS support by them being present in the first appointment. There was improved multi-agency and professional co-operation and better communication with children's services through advice and liaison. Awareness of the hub following the launch led to a fourfold increase in referrals at one of the CSA hub sites.

The Toolkit

The toolkit is arranged in a series of lessons based on the experiences in London. The first section **'Getting Started'** describes how to evidence the local need, identify who is who and how to create a compelling vision. The London programme worked well in sectors where there was a clear vision, change agents and local champions.

Section two '**Making It Happen'** is aimed at local commissioners and change agents. There is a need to establish the governance and partnerships, before the exciting stage of designing the CSA Hub. This will ensure that the right people are involved and own the design from the start, and that there is a clear route for later design making. The section provides guidance on creating a business case or 'Case for Change' which will include detailed proof of concept funding.

To enable commissioning decisions and support it is essential to demonstrate there has been meaningful engagement with children, young people, families and adult survivors. Listening to children and young people gives a unique perspective that challenges our assumptions and stereotypes and offers innovative ideas. Face-to-face engagement is far more effective than online surveys and the London team found that being available and accessible to respond to young people's requests following consultation was important. Children and young people's views should be taken into account rather than seen as a tick-box. They want to be involved in service design and delivery.

Finally to enable commissioners in clinical commissioning groups (CCGs) and Local Authorities to make decisions, they will require a robust sustainability plan for the future funding.

Section three **'CSA Hub Operating Model'** is a guide for provider organisations and practitioners to establish a CSA hub. The London team developed a set of agreed principles for the CSA hub service and identified the need for cultural change in the behaviours of the practitioners in the team to enable new ways of working. This section describes the team roles and advice on building the team. There also needs to be cultural change and training for other agencies to ensure practitioners are spotting the signs of CSA and CSE, and know how and when to refer to the CSA hub.

There is practical advice on the requirements of the CSA Hub including equipment, premises, supervision and governance arrangements, as well as staffing and what experience the CSA hub team should bring. The team also needs mechanisms to seek advice and make onward referrals as they only support children, young people and families in the short-term.

Section four describes the '**Evaluation and Outcomes'** with guidance on measuring the outcomes and undertaking local audits and research.

Section five describes how to plan **communications** with suggestions for the five stages of communication: creating a compelling vision, decision making, operationalising the new CSA hub, post launch communications; and raising awareness and prevention.

2. Background

At present, few children and young people who have been sexually assaulted or abused come to the attention of police, social care or health providers, and even fewer in the period soon after the abuse. It is thought that children and young people face a variety of obstacles in accessing care and support and that services and accessibility vary widely.

This toolkit provides guidance for individuals and agencies to assess local need, create a vision for improved services, and to make it happen.

It was reported by the NSPCC[1] in 2011 that 9.4% of 11 to 17 year olds surveyed experienced sexual abuse (including non-contact sexual abuse) and 4.8% of 11 to 17 years olds experienced contact sexual abuse. The same incidence as childhood asthma (9%) and more common than diabetes (2.5%), and yet many of these children are hidden from sight. When they do come forward, the minimum that all children and young people that experience sexual abuse should expect includes:

- A safe place to live
- Being listened to and believed
- Ability to tell their story
- Early emotional support e.g. strategies for coping with feelings, emotional resilience and symptoms that impact on returning to normal daily life
- Reduction in risk of further abuse

And yet that is not always the experience they report.

In 2015 NHSE (London) and the Mayor's Office for Police and Crime commissioned the "Review of the pathway following Children's Sexual Abuse in London"[2]. The CSA Review recommended the development of improved forensic services for children and young people at The Havens (London's sexual assault referral centres), a pilot of the Child House model (international best practice) and, as a first step, the establishment of Child Sexual Abuse (CSA) hubs in London.

The CSA hub model is a one stop shop for medical, advocacy and early emotional support for children and their families, as well as offering advice and liaison to police and children's social care services. The CSA Transformation Programme enabled the establishment of CSA hubs in North Central and South West London, funded by the Department of Health and local CCGs respectively.

The Child House model is a multiagency service model for children and young people following sexual abuse or exploitation (CSA/CSE). The model was further recommended in 2015 by the Children's Commissioner for England and is supported by the Home Secretary and Mayor of London. The Home Office has funded a national proof of concept of the Child House in London and Durham based on the international *'Barnahus'* model.

National and international best practice and guidance

Under the Children Act 1989 (s17), every local authority has a duty to safeguard and promote the welfare of children within their area. The Children Act 2004 extends this duty to safeguard and promote children's welfare to the local authority's partners, including health, the police, probation and youth offending, and education services, by requiring them to co-operate to improve local

children's well-being (s10 and s11). This legislation applies to children that have experienced abuse, including sexual abuse and exploitation.

CSA and CSE, like many forms of abuse and neglect, require a multiagency response to support the child or young person, their siblings and family or carers. Working Together to Safeguard Children[3] provides statutory guidance reminding us that safeguarding children is everyone's business and that:

- the child's needs are paramount, and the needs and wishes of each child, be they a baby or infant, or an older child, should be put first, so that every child receives the support they need before a problem escalates;
- all professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;
- all professionals can share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;
- local areas can innovate and changes should be informed by evidence and examination of the data.

There are a wealth of NICE guidelines related to CSA and the impact of trauma including: Child Abuse and Neglect, Looked After Children, Depression, Anxiety, Self-harm, Child maltreatment, Sexually transmitted infections and many more. See **Appendix 1: NICE and other guidance related to CSA hubs** for a full list of all related NICE guidance.

Guidance specifically for CSA medicals was been provided by the Royal College of Physicians and Child Health[4] (RCPCH) in 2015 and provides information on staffing, equipment and premises, as well as training and ongoing peer review. Some key requirements include: two suitably trained examiners, quarterly peer review, video colposcopy equipment, digital storage of images, a child friendly environment, a chain of evidence processes and sufficient throughput of cases to maintain competency.

International learning from the Barnahus in Iceland and the Child Advocacy Centres in the US, Canada and Australia provide evidence based learning and research as well as robust financial analysis of social return on investment. Some of the key principles from Child Advocacy Centres [5] and Barnahus can be applied to CSA hubs.

Guidance from the joint SCIE/NICE guideline for Child Abuse and Neglect [6] (currently out to consultation and expected Sept 2017) provides guidance on emotional support for children and young people that have experienced sexual abuse. The draft recommends evidence based programmes that emphasise the importance of the therapeutic relationship between the child and therapist and offer support drawing on a range of approaches including counselling, socio-educative and creative approaches (such as drama or art). This individual work with the child (up to 20 sessions, extending to 30 as needed) is recommended alongside parallel work with non-abusing parents or carers (up to eight sessions). The guidance also highlights individual psychoanalytic therapy or group psychotherapeutic sessions; as well as considering group or individual trauma-focused cognitive behavioural therapy for children and young people who show symptoms of anxiety, sexualised behaviour or post-traumatic stress disorder.

Barnardo's is establishing a Centre of Expertise on CSA in 2017. The role of the Centre of Expertise is to identify, generate and share high quality evidence on what works to prevent and tackle CSA, including CSE. It will also focus on turning evidence into practical solutions for practitioners and commissioners across local authorities, police, health services and the voluntary sector. The Centre of Expertise is funded by the Home Office and led by Barnardo's in partnership with academics and statutory agencies. This will provide a great resource for planning innovative services for survivors of CSA and CSE in future.

Current Commissioned services:

There are a number of related services already commissioned and accessed by children and young people after experiencing sexual abuse. These include:

Sexual Assault Referral Centres (SARCs):
In England, Police and Crime Commissioners and/or NHS England commission Sexual Assault Referral Centres (SARCs)[7] to provide acute healthcare, forensic medical examination, follow-up to address medical or psychological needs and access to Independent Sexual Violence Advocates (ISVAs). This varies across regions with some SARCs providing a paediatric SARC service and others supporting children in generic SARC services. There is also variance in the timeline of support with some SARCs offering forensic medical examinations only and others supporting children up to one year after sexual assault or even in longer term historic cases. Regional differences are seen in the level of counselling and advocacy support available to children.

Paediatrics:
Community or hospital paediatricians are commissioned to provide Child Protection medicals for children after physical or sexual abuse. These can be provided in children's outpatients or child development centres and are sometimes supported by paediatric nurses and play specialists.

Sexual offences trained police officers:
All police forces will have Sexual Offences Investigation Trained (SOIT) officers, sometimes in specialist sexual offences commands or safeguarding commands. In London there are three teams of specialists who might deal with CSA cases; those dealing with intra-familial and breach of trust (e.g. a teacher) child abuse investigations (CAIT teams), those dealing with adult victims and those child cases where the suspect is a stranger (Sapphire teams) and sexual exploitation trained (SET) teams who deal with CSE cases. Regardless of the police structure, every force will have a Superintendent responsible for safeguarding who should be able to coordinate with key local leads.

Child and Adolescent Mental Health Services (CAMHS):
CAMHS services are currently divided into four tiers of service. Tier I support is provided by frontline health workers and Tier II support is often commissioned by primary care or local authorities through early help teams. For those children and young people with a diagnosable, severe and enduring mental health condition there are Tier III CAMHS services commissioned by CCGs. Tier III services have increasingly high thresholds and in London many children and young people experiencing CSA do not meet thresholds. Tier III services usually support children with

severe anxiety, depression or suicidal ideation, severe self-harm, post-traumatic stress disorder (PTSD), severe phobia or other compounding factors such as being a looked after child oryoung offender, or having a learning disability. Tier IV services are for those children and young people requiring an inpatient admission or national highly specialised outpatients services such as complex PTSD, dissociative disorders, highly specialised autism spectrum disorder.

Independent sector providers:
There are many expert independent sector providers that support children and young people experiencing CSA or CSE, but the availability regionally is highly variable. Sometimes these services are commissioned but more often they are charity funded. Some large children's charities to look for locally include: Barnardo's, Children's Society, NSPCC.

Smaller national or local charities with helplines and local services include:

- Rape Crisis services across England and Wales,
- MOSAC (Mothers of Sexually Abused Children),
- National Association of People Abused in Childhood (NAPAC),
- Family Matters (Kent based charity offering counselling for children and adult survivors of sexual assault and rape),
- One in Four (Supporting people who have experienced CSA and trauma as well as training for schools)
- And many more local services

CSA hub model

The CSA hub model in London has been developed to make the best of existing services, creating a network of expertise and investing in additional emotional support following learning from international best practice. The CSA hub is a first step towards the Child House model, starting the cultural change and enabling system change to better support children and families.

This evidence-based model provides early access to CAMHS or advocacy services and is predicted to reduce progression to PTSD and the need for long-term CAMHS intervention. Studies by Berkowitz et al show that intervention within 4-6 weeks of a trauma or disclosure has been shown to decrease long term post-traumatic disorders.[8],[9]

The London CSA hub model includes medical, emotional and safeguarding support for children, young people and their families including:
Medical

- Holistic health assessment and examination
- Examination and evidential collection using video colposcopy if required
- Sexual health screening and treatment
- Reassurance for the child and family
- One examiner leads the examination, writes the report and provides expert opinion in court if required
- Examiners engage in peer review four times a year and undertake at least 20 examinations a year in line with Royal College of Paediatrics and Child Health guidance

- Training opportunities are provided for succession planning and development of capacity in this highly specialized field

Emotional

- Early emotional support available to all children/young people attending the clinic with no threshold
- Early support provided by a skill mixed team of advocates and CAMHS clinicians
- Children and young people are supported to share their voice, find the services that are most useful to them and supported through the court process
- Short term therapy (up to six to eight sessions) is provided usually as outreach in a suitable venue (not the CSA hub clinic)
- Trusted referral on if long-term support needed from local services including specialist CAMHS, independent sector experts, local counselling

Training and advice

- Training and professional network with CSE leads, independent sector providers, CAMHS, paediatricians, children's social care, multiagency safeguarding hubs (MASH), police child abuse teams
- Directory of services and clear referral pathway into and out of the CSA hub
- Specialist advice available to social care, police, sexual health colleagues and others

The benefits of the CSA hub model include:

- Meet the increasing level of need for support after sexual violence
- Clear pathway for children and families building on existing commissioned services in paediatrics, CAMHS and early help as well as independent sector provision
- Reduced pressure on CAMHS specialist inpatient and outpatient services, through early emotional support and stabilisation of child and family, reducing the risk of progression to long-term mental health conditions and emergency presentations in mental health crises
- High quality medical assessment – sufficient throughput to meet the RCPCH guidelines
- Children and families supported in the early days after sexual abuse or disclosure to build resilience and coping strategies
- Reduced duplication of role across social care, police and health
- Expert advice and training to build resilience in professionals

This toolkit describes how a CSA hub could be set up anywhere in England by following the lessons learnt in London.

3. Getting Started

Lesson 1: Need to evidence the local need

We do not know exactly how many children in the UK are victims of child abuse. Child abuse is usually hidden from view. However, there are a number of different sources of information that give an indication of the number of children who are affected by sexual abuse.

1 in 20 (4.8%) children aged 11-17 years reported experiencing contact sexual abuse, in an NSPCC research study in 2011[10]. However the Children's Commissioner for England[11] estimated that only 1 in 8 victims of CSA are identified by the authorities.
The 2016 NSPCC report 'How Safe are our Children'[12] tells us that there were 38,575 recorded sexual offences against children in 2014/15 with an 80% rise in reported sexual offences against under 18 year olds in England over the last 4 years.

It is believed that few children are able to report sexual abuse because:

- they may have feelings of shame, guilt and fear of being stigmatised
- they may not always recognise their own experiences as abusive
- they may be being coerced by (or may be attached to) their abuser
- they may fear the consequences of telling someone, for example that the abuse might get worse, their family will be split up or they will go into care.

Undertaking a local needs assessment should start with conversations with local professionals, experts, adult survivors, children and families to find out what they think they need, their perceptions of the gaps and best practice models. This will direct the context and content of a local needs assessment.

A local needs assessment should map the current and future demand for services to support children, young people and their families that experience CSA. National data sets and research can be extrapolated to local populations to give a local estimated prevalence. Local activity data from providers and other agencies can provide current known demand. Public Health teams can support the needs assessment with the Joint Strategic Needs Assessments (JSNA), the epidemiology and local knowledge of health needs. In addition this mapping should include a review of the current services and capacity within those services.

Demand and capacity mapping at a local level could include:

- Map all of the current physical and mental health services provided for child and adolescent victims of CSA, CSE and Female Genital Mutilation (FGM), including: CAMHS providers, sexual health clinics, paediatricians, independent sector services, school counselling services and others
- Undertake a gap analysis of services considering location, service types e.g. age specific and identify elements of the pathway that are missing
- Estimate the existing capacity in provider services
- Estimate current demand from activity data and local audits

- Predict future demand using national trends and impact of improved local pathway raising awareness amongst professionals and public

Useful data sources for mapping CSA services and need:

- Bespoke surveys and case note audits from providers to identify children and young people experiencing sexual abuse
- CAMHS transformation plans
- Joint Commissioning Strategy for mental health services or children's services
- Joint Strategic Needs Assessment (JSNA)
- Local Safeguarding Children's Boards (LSCB) annual reports
- National prevalence statistics e.g. Dept. of Education CIN national statistics
- Ofsted reports for local providers
- Other reviews e.g. Review of the pathway following Children's Sexual Abuse in London [13]
- Provider activity data e.g. KPIs Data Return, Local Authority Annual CSE report

In London, the needs assessment started at a pan-London level with the "Review of the pathway following Children's Sexual Abuse in London" and then each geographical sector drilled down with a more bespoke local needs assessment. In North Central London this was undertaken by The Brandon Centre (a local sexual health provider) and the NSPCC. There was value in using local providers and experts in the field to undertake the local needs assessment.

Lesson 2: Need to know who is who

A key element of making change happen is knowing who you need to influence, who are your decision makers and who can be your champions. Lessons 3, 4, and 9 describe this in more detail, so this lesson will focus on finding out who is who. The experience in London, where there are multiple commissioners, providers and agencies, has shown that delivery of a CSA hub can falter and delay by not getting this right at the start.

The key first step is to create a stakeholder list covering all agencies and detailing key roles, as well identifying your user group and public involvement. The London CSA Transformation programme has enabled us to identify the key stakeholders involved in commissioning and providing CSA/CSE services. **Appendix 2: Stakeholders** is a table outlining the key players in the local authority, CCGs, health providers, NHSE, the police and the independent sector.

The table describes why they matter to a team setting up a CSA Hub as it is important to know if a stakeholder has the power to make decisions, could influence others or will be essential to making it happen, as this will influence how you communicate with them. The table also indicates the potential motivating factors for these stakeholders in supporting a CSA Hub, i.e. the reasons that should help a project team gain their support.

Lesson 3: Creating a compelling vision, change agents and local champions

To mobilise change across the system with multiple agencies, locations and personalities requires a compelling vision for change, change agents and local champions. There needs to be a change agent(s) that can create a pause to 'stop, think and go in the other direction' and

share a message that will grab the attention of professionals, from front line staff to chief executives. Experiences from the Barnahus in Reykjavik, Sheldon Kennedy Child Advocacy Centre in Calgary and CSA hubs and Child Houses in London teach us that change agents can challenge, inspire and bring together agencies. The change agent can be a senior leader, an expert, a survivor or a celebrity, but the key is that they are passionate, compelling, empathetic and independent.

The system change in the London CSA Transformation programme involved 32 CCGs, 32 Local Authorities, Metropolitan Police and up to 100 health providers and independent sector organisations. Creating a compelling vision is therefore essential to achieving buy-in from this wide range of stakeholders. This may be more complex than other local commissioning models in England but wherever there is more than one key player then this lesson in creating a compelling vision will be of value.

Compelling vision

To create the momentum for change, there is the need for a compelling vision. The vision should be easy for people to understand, can be written in no more than one to two pages, communicated in minutes, is factually based but has emotional appeal. It should draw on real case studies and be relatable to people's own life experiences. It needs to make financial and ethical sense. You should be able to tell someone the vision in the time it takes to go up in a lift together, walk across a carpark or stand in the coffee queue. You need leaders that can create an *"elevator pitch".* Below are suggestions for the key points in your compelling vision.

Creating a compelling vision for improving CSA services

Why do we need to change the way we support children experiencing CSA?
Make it clear that it's a hidden issue, only one in eight tell, children are afraid to come forward, when they do there is no clear pathway of support, long-term impact on lives if we don't help

What is happening now?
Include the number of children reporting and issues such as little early emotional support, families left to navigate the system themselves, high thresholds mean children develop long term mental health conditions before they are supported, the criminal justice system re-traumatises some children

What should we do differently?
Detail the key points of the model such as early help, advocacy and case management, services organised around the child and family, one safe place to tell

What difference will it make?
Reference the evidence around less long term mental health conditions, less duplication of work, improved communication, less traumatised children and families

The lesson from the London CSA Transformation programme was that having a compelling vision has mobilised key stakeholders in each sector to be local champions and captured the heart of influential leaders across all sectors.

Using the following questions test out how compelling your vision is:
Is it positive and inspiring? A vision should focus more on how the future will be better and why. It should paint a picture of a better service and experience. It should inspire hope.

Is it bold? A vision should aim high. That way you have a chance of achieving your vision rather than settling for second best. If you don't ask you won't get.

Is it inclusive? Involving others will not only create ownership and buy-in for the vision, it will result in a better vision because one leader cannot know everything. There are a lot of ways to involve professionals, experts and service users in your vision. You can ask people upfront for their input, include them in the creation of the vision, or involve them in the implementation planning.

Is it measurable? You should know when you have arrived and delivered your goals. Be specific about what you want to achieve, by when and where.

Does it connect to the greater good? Most professionals want to feel like they are making a difference – that is what inspires us to change and go the extra mile. Does the vision tell people what a difference it will make to a child or family they know? Does it tell people how it will impact on their working life and outcomes?

During the development of the vision, test it out with the future service users if possible. Is it what they need? Is it what they want? Have you described it clearly and in plain English? Are you heading in the right direction? The vision should resonate with what are the key elements that are important to children, young people and families and what the ideal support would look like. The service users could be from existing local services such as SARCs, CSE services, independent sector providers, CAMHS.

Change agents and local champions
Now think about how you will share the vision. Visions should not be well-guarded secrets! Leaders need to get out and talk to people about the vision and that takes time. Communicating a vision is not one off, it's an ongoing process, where the vision is constantly and consistently communicated. The compelling vision cannot be communicated by one person alone.

First build up local champions, the 20% of people that you tell who are as passionate as you and prepared to advocate on your behalf. The message can then spread from those 20% until the tipping point is reached when 80% of people get the vision. People own what they create themselves and real change takes place from within the workforce.

Identifying local champions will vary in different places but the London Transformation Programme learnt that it was essential to identify a local champion from each agency. The key agencies and professions that needed a champion included social care, police, paediatrics, CAMHS, independent sector, sexual health, joint children services commissioners. The champions needed

to be senior enough to influence and well respected in their field. They needed passion and drive, as well as be willing to go the extra mile.

The champions involved in setting up the North London CSA hub benefitted from a strong existing network of local colleagues and attendance on key steering groups and forums, to provide opportunities for sharing the vision. Support in the form of standard presentations, key messages and briefings can help champions to deliver the vision, although it is often more powerful when delivered in their own words.

Personal story – Rob Senior, Medical Director, Tavistock and Portman NHS Trust

"Following the tragic death of Victoria Climbie in North London in 2000, the Tavistock and Portman NHS Trust, was commissioned to provide support for the named and designated doctors and nurses in North Central London. Informal referral pathways were strengthened, specialist expertise was acknowledged and a great deal of mutual respect and understanding developed.

North Central London, therefore, already had a strong clinical network in place and so we were not starting from scratch. There were also strong multi-agency collaborations across Local Authority and CAMHS for both commissioners and providers in a number of boroughs. If those networks don't exist already even in embryonic form then they need to be established.

For me, personally, the results of the NSPCC report and the CSA pathway review, confirmed what I already felt to be true. There are shocking gaps in both recognition and in provision of intervention to improve outcomes.
The CSA Hub concept calls for a greater geographical foot-print than any one Borough and in our case several providers. At a time when there is precious little money in the system and what money exists is so highly contested, the STP process has provided a vehicle to get the concept of an improved pathway for children and young people experiencing CSA and CSE onto the commissioning and planning agenda. One form of 'championing' that I have been able to take is both at the STP Board and also at the Local Safeguarding Board. Even the most heartless non-clinician finds it hard to refute the idea that these children deserve a better service. but it needs to be repeated frequently.

Finally, leadership and persuasion with clinical colleagues, requires engaging with the clinical work. Credibility with colleagues involves both understanding the stresses and pressures on them and being willing, sometimes, to get directly involved in the difficult and distressing work oneself.

It may be the case that high quality attention to safety and physical health together with advocacy to support recovery are as important and effective for some young people as mental health intervention. Gathering evidence of outcomes and evaluating and adapting the service as we learn will be a crucial element of the sustainability and dissemination of the model going forward. "

4. Making It Happen

Lesson 4: Establish the Governance and Partnerships

To enable system change across multiple agencies requires robust governance, even more so in times of austerity. The vision will only be mobilised if a consensus opinion can be reached across all agencies including commissioners and providers in all sectors and in some cases multiple geographical locations. For example a CSA hub service could potentially be established at a county or an STP (sustainability and transformation planning) level which would involve multiple CCGs, health and care providers, police and local authority partners.

A local steering group should be established to lead the co-design, strategic development and delivery of the CSA hub service. The steering group will facilitate local ownership of the service, shape local co-commissioning changes and make recommendations to the local borough/county, CCG, police and judicial decision-making and other forums. The steering group does not have any decision-making power but will act as an advisory forum to facilitate necessary changes. All decisions for changes to commissioning intentions will be agreed by commissioners, local Health and Wellbeing Boards, and where available sector-wide collaborations.

Specifically the steering group is responsible for:

- establishing the governance and decision making at a local level
- ensuring co-design of a local model includes commissioners and providers from all agencies, as well as independent sector experts, users and public engagement.
- agreeing local key principles and aims of the model and associated timeline for delivery
- enabling leadership of system change
- bringing together inspirational local leaders who will promote improvements to the pathway for children and young people in the sector following CSA
- advising local partners and decision making forums on improvements in operational delivery and commissioning of the CSA pathways

The **steering group** membership should include key people from your stakeholders list (see Appendix 2) and could include:

- an independent Chair holding a prominent position in safeguarding of children e.g. Chair of Local LSCB
- Key Commissioners – Joint Children's Commissioners (CCG), CAMHS Commissioners (CCG), Sexual Health Commissioners (LA)
- Senior representative from Public Health
- Senior representative of Children's Services, e.g. Director of Children's Services (DCS), Assistant Director or Head of Safeguarding
- Senior representative from any existing strategic clinical network for children
- Senior representative from specialist child abuse or sexual exploitation police teams, e.g. Detective Chief Inspector
- Designated/Named Doctor for Safeguarding
- Clinical/Medical Director of CAMHS provider
- Senior representative/s from independent sector provider of support services

Steering group members will have a responsibility to disseminate information back to their agencies, acting as a champion for the work.

In the initial stages of setting up a CSA hub it will be necessary for the steering group to meet quarterly in order to drive the vision for change. A smaller project team will deliver the change and report to the steering group. Once the CSA Hub is established, the steering group should continue to meet on a biannual basis to maintain oversight of the service, review outcomes and act as a troubleshooting forum.

The key learning from the London CSA Transformation Programme was the need to identify clear reporting lines from the steering group to local decision-making forums. As the steering group consists mainly of experts, it can only ever act as an advisory group to champion the vision and make recommendations. See Lesson 8 for decision making structure.

To maintain decision making focus in the CSA Steering Group, it is ideal to establish a number of **sub-groups of expertise**. The key sub-groups identified are:

- Paediatricians – designated and named doctors and those with expertise in CSA medical assessments
- CAMHS and independent sector providers, including national charities and local groups.
- Commissioners from CCG and local authority including Children's Services, sexual health and CAMHS
- MASH, police child abuse team and children's social care

The London CSA Transformation Programme found it difficult to engage with some MASH, police and children's social care colleagues and did not establish sub-groups, instead meeting with teams individually. This led to difficulty engaging with these teams and rework in future workshops and events to allow time for all agencies to reach the same point in the vision.

A further lesson was not to rely on Joint Children's Commissioners alone, but to seek out mental health and sexual health commissioners too. It is important to acknowledge the varied commissioning roles and responsibilities in different organisations. To deliver the CSA hub model it is essential to engage with commissioners for the following services: paediatricians that deliver the CSA medicals (usually community paediatrics but sometimes acute paediatrics), CAMHS, independent sector, sexual health.

The purpose of the sub-groups is to develop operational plans and feasibility studies based on the CSA hub model, to develop rotas and workforce planning, to review and agree evidence based practice that meets the local need, to develop care pathways and directory of services. Representatives from each sub-group will sit on the steering group.

In addition to professional sub-groups it is essential to establish a structure for children and young people's engagement. See Lesson 9 for detailed information.

Lesson 5: Design the CSA Hub

In order to design a CSA Hub which meets the identified need and works effectively for the service user as well as professionals, it will be beneficial to provide a series of co-design events.

Professional's workshops

Co-design workshops across relevant agencies provide a forum for professionals to contribute their perspective and expertise. Workshops will also raise awareness of the coming service and encourage local ownership of the model.

The workshop is an opportunity to explain what the CSA hub model is and what difference it will make. Local stakeholders and champions will be able to bring evidence of best practice and research. At later workshops and events, young people and adult survivors of CSA can bring a powerful testimony and create a momentum for change as they tell their experiences of the existing support services and criminal justice system. In London it was not always possible or appropriate to invite survivors to present but where they did it made a tangible difference to conversations and commitments in the room.

The workshop should include a celebration of what is working well in the area and is a great opportunity to share information about local services. The experience in London was that the events served to introduce professionals across health, care and police to the multitude of small and large independent sector providers that are experts in supporting children and families that have experienced CSA and CSE.

Each workshop should include an opportunity to reflect on "where we are now and what we need to do differently". A call to action is a helpful way to drive commitment to small changes after each event. "Call to action" cards were used in the London events and were posted back to workshop attendees a month later to remind them of their commitment.

Consultation with children, young people and families

Consultation with children, young people and their families should take place throughout the design, implementation and ongoing delivery of the CSA hub service to ensure the service meets need and is as accessible as possible to all children and young people. Please see lesson 9 for more detailed information on engaging children and young people.

Lesson 6: Creating a Case for Change

Following on from the 'Compelling Vision' document of 1-2 pages, it is beneficial to develop a full 'Case for Change' or business case. To seek agreement for the development and investment in a CSA hub, each organisation's senior leadership team will require a fully costed, evidenced case for change with impact analysis. This section will describe some of the key elements in a case for change document.

Case for Change:

- Executive summary
- Introduction and context of CSA – *national and international research*
- Current CSA services provided – *local demand and capacity mapping, directory of services*
- Issues
    - Patient experience – *feedback from your service users*
    - Quality of service – *gaps in current CSA service and comparator to national guidance*
    - Outcomes for children and families *-local outcomes data baseline if available*
- Evidence for change – *such as early emotional support research*
- The CSA hub model and options appraisal – *local vision for the CSA hub model*
- Impact and benefits – *financial, quality, experience, long-term outcomes*
- Clinical support - *testimonials from local champions*
- Evaluation and timescale – *proposed outcome measures and baseline where available*
- Conclusion and recommendations for change
- Appendices including: detail of current provision, local needs assessment and future demand, options appraisal details

Lesson 7: Proof of Concept Funding

Funding to develop a proof of concept of the CSA hub model can be difficult to secure due to the low numbers of children currently supported in local areas. In the London CSA review it was reported that less than 1% of the population are currently supported, and yet research suggests that CSA is much more prevalent. Commissioners can struggle to prioritise time and funding to invest in this area, as they perceive it as being for a small cohort of their population. However as public awareness increases following Rotherham, Oxford, the Independent Inquiry into CSA and most recently adult survivors reporting abuse in football, now is the time to review and commission support for these children and their families.

Lessons learnt in London when seeking funding for CSA hubs include:

- Seek funding for two 2 years as a minimum to enable evaluation of outcomes for children and families
- Involve local children's commissioners and CCGs even if funding is secured from other sources such as central government or charities
- Ensure that funding covers:
    - Upgrade to clinic premises such as décor, child friendly furniture/examination couch, video-colposcope and secure storage of images
    - Staffing to provide early emotional support including advocacy, counselling and psychotherapy from CAMHS and local independent sector providers
    - Take account of predicted increase in paediatricians activity as more children/young people are referred for CSA medical assessment
    - Play Specialist to support children and families in medical assessments – prep, during and debrief
    - Supervision and management of staff working in CSA hub
    - Project management and evaluation

Lesson 8: Clear decision-making process with commissioners

A key learning from the London CSA Transformation Programme was the need to identify clear reporting lines from the steering group to local decision-making forums. As the steering group consists mainly of experts and commissioners with a local focus, it can only ever act as an advisory group to champion the vision and make recommendations to commissioners. This section will describe the varied commissioning responsibilities which should inform local decision-making routes.

Commissioning responsibility:
The responsibility for decision-making about changes in commissioning and investment in new services for the CSA pathway is split between NHS England regional teams, local CCGs, Local Authorities and Police and Crime Commissioners.

- Health commissioning

Commissioning of SARCs is a specialist commissioning role and sits with NHS England (NHSE) regional teams. The NHSE Commissioning Framework for Adult and Paediatric SARCS[14] states that this includes NHSE commissioning sexual assault medical and Improving Access to Psychological Therapies (IAPT) services in SARCS. However it also states that the responsibility for commissioning long-term paediatric health services and CAMHS sits with local CCGs. Designated doctors and nurses have a responsibility for strategically planning and commissioning services for children at risk of sexual abuse and exploitation.

- Local Authority commissioning

Local authorities are responsible for commissioning children and family services and preventative public health. This should include children's social care teams, early help services, safeguarding services and sexual health services. Whilst sexual health services are predominantly for adults and young people 13 years and over, some do commission sexual health support to paediatric teams via tier III services.

- Police and Crime Commissioning

The SARC services for children and young people experiencing sexual assault should be co-commissioned by NHS England and local police forces/police and crime commissioners, with local police and crime commissioners responsible for the forensic medical, criminal justice and local rape support elements.

LSCBs don't have commissioning responsibility but do bring together senior leaders from multiple agencies in each area. Working Together to Safeguard Children describes that LSCBs have a statutory responsibility for developing policies and procedures for safeguarding children, raising local awareness, evaluating the effectiveness of agencies, strategically planning services for children and undertaking serious case reviews. As such they are key stakeholders to support and drive change in the development of a CSA hub.

Decision-making process:
The learning from the London CSA Transformation programme was that the London geographical sectors that engaged with key decision-makers progressed further and faster. However across

London there was no one-size-fits-all model and it is anticipated that the same will be true across England. Each geographical sector had varied decision-making forums and systems in place.

Some key forums identified locally for decision making could include:

- STP forum for a region or sector – including senior responsible officer (SRO) for children
- Local Safeguarding Children's Board
- Health and Wellbeing Board
- CCGs senior leadership team or executive team
- Local authority senior leadership team and /or cabinet
- Council member with portfolio for children and young people
- Provider services executive teams

Lesson 9: Engaging children, young people, families and adult survivors

Listening to the voices of children and young people in the design and delivery of services is a crucial element in creating an effective, accessible and appropriate service which meets need.

Listening to children and young people:

- gives a unique perspective that challenges our assumptions and stereotypes
- offers innovative ideas
- contributes to children and young people becoming engaged members of society with trust in statutory services
- is a right as enshrined by the UN Convention on the Rights of the Child

Who did we listen to?
Although many children and young people will happily never experience services after sexual abuse, it is important to gain their insight and perspective as the expert in being young, as well as to consult with those who have used services.

It may be difficult to find children or young people currently using services who are ready and able to speak with professionals about their experiences. It is important therefore to consult with adult survivors as well as professionals advocating on behalf of children/ andoung people in order to gain the service user perspective.

Groups we approached:

- children and young people who have used sexual assault services via a SARC, survivors groups, other CSA support services
- children/young people identified as at risk of CSA/CSE e.g. gang-affiliated young people, looked after children, children/young people with learning difficulties
- general population of children/young people via youth parliaments, school groups, CAMHS user participation groups
- adult survivor groups
- professionals advocating on behalf of children/young people who have been sexually abused/exploited e.g. Child Independent Sexual Violence Advocate (ISVA)

How did we listen?
It should be made as easy as possible for children and young people to contribute to service design and delivery. Contact details for rape crisis or SARC services should be shared with all participants of consultations to make sure they are able to access support following the session should they need to. It is also important to highlight in group sessions that everyone should treat each other's contributions with respect but that confidentiality cannot be guaranteed and therefore to think carefully before sharing personal experiences.

Consultation through existing forums such as youth parliaments, children in care councils and CAMHS service user participation groups provides access to young people already committed to contributing their opinions. It also ensures that young people can access additional support during or after the consultation if needed.

Children, young people and their families who have experienced CSA/CSE often prefer to consult on a 1-to-1 basis rather than in a group. Offering follow up calls or meetings allows the child or young person space to think creatively about how that experience could have been improved.

Key Learning
- Face-to-face engagement is far more effective than online surveys
- Importance of being available and accessible to respond to young people's requests following consultation and to provide programme updates.
- Children and young people want to be involved in service design and delivery

Lesson 10: Sustainability

A lesson from the North London CSA hub has been that sustainability planning needs to begin as early as possible and should be in place before the proof of concept begins. CCG commissioning intentions are developed on a 12 month cycle often 6-12 months in advance of the following financial year. Early conversations with commissioners in health, local authority and police are needed to identify priorities and evidence the need to local commissioners.

Support to enable inclusion in future commissioning intentions can include:
- public engagement with children and survivors
- robust evidence from other services such as Social Return on Investment from CACs
- support from local champions and experts
- support from LSCB
- feedback from CSA hub service users
- evaluation and outcomes from CSA hub

Influencing commissioning intentions can be complex where more than one CCG is involved. In South West London, varied need across multiple CCGs in a region was resolved with pooled funds and proportionate contribution based on local demand.

5. CSA Hub Operating Model

The CSA hub model has been developed in London to make the best of existing services, creating a network of expertise and investing in additional emotional support following learning from international best practice. The CSA hub is a first step towards the Child House model, starting the cultural change and enabling system change to better support children and families. It is a one stop shop for medical, advocacy and early emotional support for children and their families, as well as offering advice and liaison to police and children's social care services.

The CSA hub model offers:

Medical

- Holistic health assessment and examination
- Examination and evidential collection using colposcopy if required
- Sexual health screening and treatment
- Reassurance for the child and family
- One examiner leads the examination, writes the report and provides expert opinion in court if required
- Examiners engage in peer review four times a year and undertake at least 20 examinations a year in line with Royal College of Paediatrics and Child Health guidance[15]
- Training opportunities are provided for succession planning and development of capacity in this highly specialized field

Emotional

- Early emotional support available to all children/young people attending the clinic with no threshold
- Early support provided by a skilled mixed team of advocate and CAMHS clinicians
- Children and young people supported to share their voice, find the services that are most useful to them and supported through the court process
- Short term therapy (up to six to eight sessions) is provided usually as outreach in a suitable venue (not the CSA hub clinic)
- Trusted referral on if long-term support needed from local services including specialist CAMHS, third sector experts, local counselling

Training and advice

- Training and professional network with CSE leads, independent sector providers, CAMHS, paediatricians, children's social care, MASH, police child abuse teams
- Directory of services and clear referral pathway into and out of the CSA hub
- Specialist advice available to social care, police, sexual health colleagues and others

Lesson 11: Agreed principles of the CSA hub

The CSA hub team in North London has developed the following service principles which have guided the development of the CSA hub service:

- Child-centred – jointly planning with the child or young person the services and support they receive and the lead professional

- A service which is flexible and responsive to need
- Trauma-informed approach to therapeutic support
- Easy and early access to emotional and mental health support – meeting the advocate and CAMHS professional on the same day as medical assessment removes need to refer for 'mental health' support and associated stigma
- A team that listen to and believe the child
- Focus on the recovery of the child, whether or not there is an ongoing criminal justice process
- Working in partnership across agencies with a commitment to collaborative working and flexibility across professional remits – resulting in a reduction of duplication of work
- A holistic service with space for children and young people to share broader concerns such as school, bullying, housing
- Offering support to 'safe' parents, carers and siblings
- A service that meets the child or young person in the right place for them – outreach and not just clinic-based
- Balancing confidentiality with the need to share information to safeguard the child or young person
- Providing expertise and advice for professionals – within the CSA hub team and for colleagues in social care, education, police and independent sector
- Following the CPS guidelines for pre-trial therapy to ensure that there is no impact on future criminal justice process – for example therapy that focuses on improving self-esteem and self-confidence, often using cognitive/behavioural techniques. As well as support for legal proceedings and treatment of symptoms of the abuse that does not require rehearsing the abusive events.[16]

CASE STUDY: Sarah*, 8 years old

This case study demonstrates how holistic care, taking time to support parents/carers/siblings and providing outreach services are all important aspects of the model.

Sarah disclosed she had been sexually abused by her stepfather. This was reported to the police upon disclosure and the perpetrator was remanded. The family were supported to move from to another local authority as Sarah did not feel able to stay living at the address where the incident had occurred.

Sarah was referred to the CSA clinic, they met the CSA hub team and in consultation with Sarah and her mother she was seen for a holistic medical examination. The CYP advocate from this initial meeting then arranged to see Sarah and her mother at home before the court proceedings commenced. The advocate liaised, on mother's request, at times with the police and accompanied the family to court

The CAMHS practitioner worked with Sarah and her mum together in joint sessions and separately, both at home and within the community. These sessions focussed on building self-esteem and self-efficacy for Sarah and finding effective ways for her to communicate to safe adults about her thoughts and feelings (Hobfoll et al 2007[17]). Shared goals were made

around a supportive bedtime routine. Over the course of the intervention an increase in school attendance, decrease in behaviours demonstrating distress were observed, in addition to supporting Sarah's mother with thinking about ways to best support Sarah at this time (Ensink et al 2016 [18]).

An effective working relationship was built between the family and the hub team because of the joined up nature of services, and the ability to move between receiving different aspects of hub provision easily.

*all names have been changed to ensure confidentiality

Lesson 12: Team roles and building a team

The CSA hub service comprises a core team of paediatrician, child and young person's advocate, CAMHS clinician and play specialist. This section describes the roles of the core team members and the benefits of their roles. The North London CSA hub team invested time and effort in creating a sense of team and now benefit from understanding and valuing one another's roles.

Child and Young Person's (CYP) Advocate

The CYP Advocate offers holistic, child-led support, advice and advocacy in person and over the phone around the criminal justice process, housing and in accessing other relevant support. The advocate supports CYP to communicate their wishes and feelings and helps them get the services they need, all the while guiding and supporting them through the process. Advocates can liaise with other agencies on behalf of the child or family, and contribute to safeguarding processes and procedures.

The advocate usually meets the child/young person and parent/carer with the paediatrician and therapist at the hub where the service is explained. The advocate actively ensures the child/young person's view point is heard and needs are being addressed in different forums such as child protection conferences, strategy meetings. They meet monthly with the CSA hub team for case review and address ongoing concerns collectively.

One of the key benefits is that the advocate is independent of the police and social care and is there to empower the child or young person to make informed choices to help them recover from the abuse. This is child led and not pursuing a specific agenda; it may involve providing support through the criminal justice system but equally, if the CYP does not want to pursue criminal procedures, then the advocate can support them to access young peoples' projects, therapeutic support and emotional support to the CYP and safe parent. It is also beneficial for the child/young person and parent/carer to know that there is ongoing support available to them once any medical assessments and needs have been addressed.

The North London CSA hub team found that the advocate being part of the initial appointment enabled better engagement from the child/young person because the advocate is automatically seen as one part of a coherent professional team. It also gave insight into the psychological impact

and reassurance that comes from having a physical examination. This enabled the advocate to inform other professionals in social care about the service and dispel myths about re-traumatisation because of the perceived intrusive nature of CP medicals.

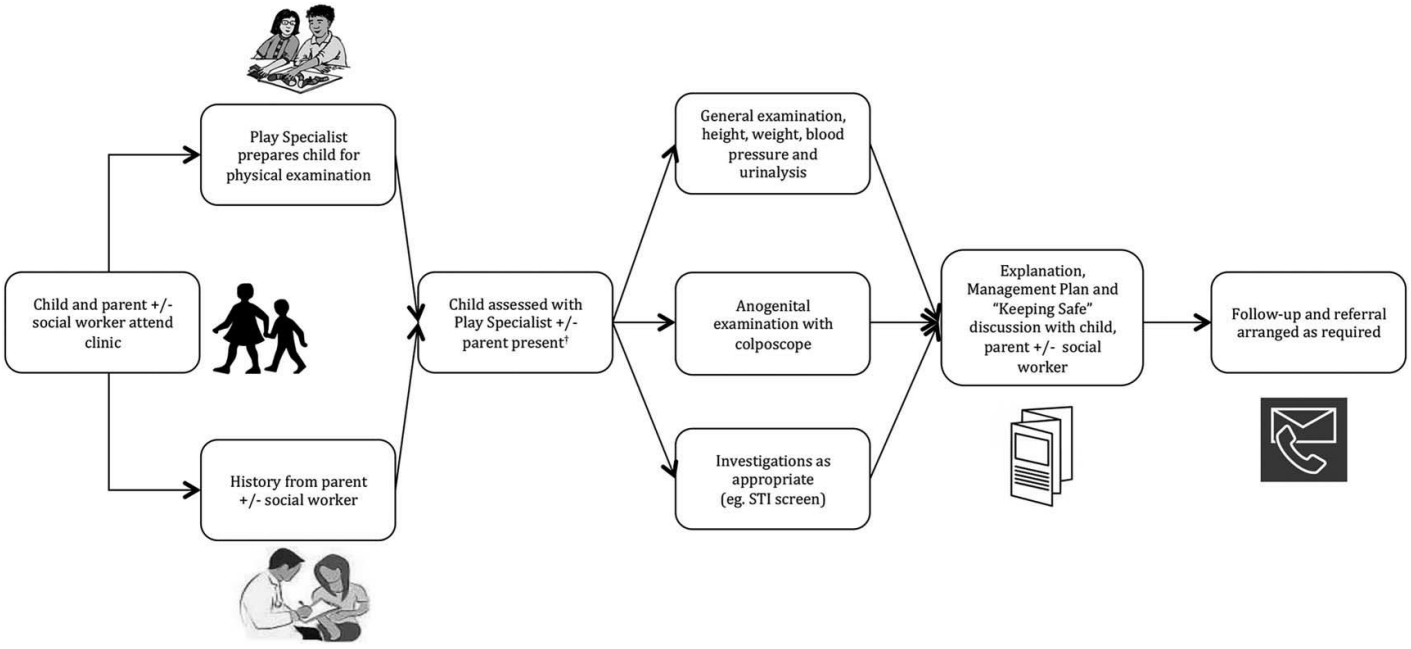
Anna Weedon, CYP Advocate from Solace said:

"Working in the CSA hub has built on my understanding of how children present when they are experiencing CSA. I have found that meeting the child and family for the first time with the rest of the team humanises the people that are there to support the child."

Paediatrician

Children and young people meet the paediatrician at the CSA hub for a holistic medical assessment. The medical assessment can include physical examination to identify signs of abuse, a general top-to-toe health check, documentation of injury, screening for sexually transmitted infections (STIs) and samples sent with a laboratory chain of evidence form. The paediatrician will also provide or arrange for vaccinations, treatment or other medical care as needed. Abnormal findings supportive of CSA are subsequently independently peer-reviewed.

Further discussion includes providing information on sexual abuse and keeping safe, management plan and follow-up. The paediatrician will also liaise with other agencies and contribute to safeguarding processes and procedures.



A retrospective study at the University College London Hospital (UCLH)[19] clinic prior to the establishment of the CSA hub provides insight into the medical needs of children and young people that are referred with suspected or disclosed CSA. Despite the last episode of alleged CSA being up to 1 year earlier, 7% had physical signs supportive of CSA, while a further 57% had a medical concern(s) related to the reason for referral, 31% had an unrelated medical concern(s) and 22% had emotional or behavioural concerns. All of this highlights the value of thorough paediatric history

and full examination. Furthermore in 22%, there was specific information relevant to social care and/or police investigations, and identification of carers requiring psychological help. The findings highlight the benefits of paediatric referral even when a child or young person presents outside the 'forensic timescale'.

Disability, including learning difficulty was present in 14.5% of children and young people the UCLH study comparable to findings of the UK survivor's survey[20], where 106/756 (14%) victims of CSA identified themselves as having a disability. The literature highlights that disabled children are 3.1 times more likely to be sexually abused[21]. Children with disabilities can be difficult to engage and examine, thus requiring paediatric expertise and the skill of the play specialist.

Many children and young people can be fearful of being examined but there is relief and reassurance when they realise 'I am normal'. The children want to know about their bodies and some enjoy watching the colposcope images during examination. Sometimes children refuse to be examined and they are not forced to be examined at the CSA hub.

Dr Claire Rohan, Paediatrician, North London CSA hub

"The introduction of the early emotional support to our clinical team has been a very positive experience. We have developed the model of meeting the child and protective carer together to discuss what is available from our services. I had some initial reservations that this might be overwhelming for the child but this has not been the case and seems to facilitate decision making by the child.

When we offered medical assessments without the advocate and CAHMS professional I worried a lot about the lack of ongoing support, particularly about the welfare of children after completion of any investigative processes when professionals tended to withdraw or after a failed conviction. The timing of this early consistent intervention along with the degree of independence from the investigative process is in my view crucial to the child's ongoing recovery."

Dr Deborah Hodes, North London CSA hub

Play specialist

The play specialist's role is in preparing the child or young person for the examination, explaining what is going to happen so it can be easily understood and providing reassurance. During the medical assessment the play specialist is in the room with the team and can talk to the child while the history is taken. Whilst the examination is taking place the play specialist can distract the child or young person, or help them engage in the examination as they prefer, for example: positioning the electronic bed, watching the examination on screen. The play specialist can sometimes hear new disclosures from children through play and this information disclosed by the child and/or parent is shared with police or social care colleagues.

Children and young people said:

"*The doctor explained everything very clearly."*
"She let me seen on the screen what was happening."
"Mags (play specialist) got my mind off what was happening EXCELLENT."

Parents said:

"*Watching my daughter magically heal emotionally in the presence of the doctor was amazing and life transforming."*
"Everything was clearly explained myself and my children were given the time to talk and more listened to."

CAMHS Clinician

The role of the CAMHS clinician in the hub is to provide advice to the team, assessment and brief intervention (up to six weeks). If longer term support is needed, the team will make a referral with a 'trusted assessment' to local CAMHS provider. The CAMHS clinician also liaises with other agencies and contributes to safeguarding processes and procedures. CAMHS clinicians could come from a background in family therapy, clinical social work, child and adolescent psychology and psychotherapy. See Lesson 17 for more details.

The approach taken in the CSA hub starts with an assessment for PTSD symptoms and help to attend to daily life problems. Sessions can include individual work with a cognitive behavioural and trauma focus, as well as family therapy involving the parent/carer and family members. A strength based model is used ensuring support and therapy is child centred, non-judgmental and non-blaming.

The CAMHS clinicians in the North London CSA hub found working alongside the paediatrician to treat physical symptoms alongside emotional and mental health symptoms promoted confidence for children and families.

Claire Mullarkey, CAMHS clinician said:

"Improved multi-agency and professional co-operation through close work with the CYP advocate helped the criminal investigation. There is close communication with Social Care and Children's services and a therapeutic approach is maintained while ensuring effective safeguarding."

Lesson 13: New ways of working

The experience in the North London CSA team has been that creating a team and new way of working for the professionals, has been essential in enabling the child to experience a holistic and supportive visit to the CSA hub. This lesson will detail a typical day in life of the CSA hub.

A day in the life of the CSA Hub – Anna Weedon, Child and Young Person's (CYP) Advocate

"At the beginning of the day, the CSA Hub team consisting of Paediatrician, therapist, advocate and registrars meet together to discuss the children and young people booked into the clinic that day. We look at the referral and accordingly plan who would be best placed to meet the child/family and any professionals accompanying them. For children/young people there for a review, we discuss any updates to ensure that we all have relevant, up-to-date information on the case.

When the child or young person arrives they are introduced to the members of the team and asked if they feel comfortable the therapist, advocate, paediatric registrars sitting in on the consultation.

There are multiple variations in the form the appointment takes. Sometimes, particularly with younger children, the child spends time with the play specialist while the paediatrician, therapist and advocate meet the (safe) parent/foster carer and/or social worker.

The child or young person is offered a medical examination, which is clearly explained to them by the doctors. When the child/young person agrees they would like a medical, the doctor carries it out, with the parent and play therapist present when wanted.

After the medical, the team, the child/young person, and the parent/foster carer and/or social worker, meet together again to reflect on the consultation and put together a plan of support.

In between appointments the team frequently hold conference calls with social workers of children/young people who have not attended the clinic. In a number of cases the CYP Advocate/and or family therapist meet the parent(s)/carer in a separate room to set up follow up appointments and to create a forum where they can also voice their concerns separately from the child/young person.
In some instances, children and young people have already been referred to a local CAMHS service so the team at the CSA hub liaises with the respective CAMHS team until we have confirmation that the referral has been accepted.

At the end of the day the CSA hub team meets to reflect on any outstanding actions, next steps and to debrief."

CASE STUDY: CSA Hub links to police and court
Anna Weedon, Child Young Person's Advocate

Millie*, age 11, stated in our first meeting with her mum and myself that she had found it very difficult that the officer during her ABE was male. She stated she hadn't really wanted to talk to a man and she had cried because she found this so difficult.

Millie had been informed that she would probably have to go to court but stated she didn't really know anything about it. When I explored this with her she stated she was really scared about it and also didn't really know what it would be like and had no idea when the trial would take place. Millie stated she was really scared about seeing the perpetrator again.

I informed Millie about how I could support her, asking her what she thinks would be helpful. Based on my conversation with Millie I liaised with the CAIT officer on the case, established the details of the trial from the officer, and updated Millie and her mother. I explained the court process in detail, exploring her concerns. We are due to visit the court for a pre-trial visit shortly.

*all names have been changed to ensure confidentiality

Lesson 14: Enabling referrals into the CSA hub

All referrals into the CSA hub follow the local safeguarding procedures and the guidance in Working Together to Safeguard Children. The referrals usually come from Multiagency Safeguarding Hubs (MASH), children's social care teams or sexual offences police officers. Social workers are increasingly phoning the North London CSA hub team for advice to discuss cases and often attend the CSA hub with the child and family on the day of the appointment.

However referrals to the CSA hub can be prevented by myths about CSA medicals being re-traumatising for children. The CSA hubs in London have worked hard to dispel these myths with varying success. At the CSA hub launch events a seven minute video of what happens at the CSA hub was shared with social care, police and education colleagues. This video explained the role of the play specialist, the clinic environment, the holistic nature of the appointment and then showed an examination underway. Showing the workings of the CSA hub and meeting the paediatricians enabled them to share just how reassuring the appointment can be for children and parents alike.

A key lesson for the CSA hub in South West London has been that communication cannot be a one-off event. Even after visits to sexual offences police teams, a launch event for 80 colleagues, newsletters, leaflets and visits to MASH and social care teams – referrals remain limited due to remaining myths about medicals. Communication needs to be an ongoing activity.

Lesson 15: Operational requirements of the CSA Hub

This lesson will detail some of the key operational elements and facilities to set up a CSA hub:

Clinic facilities

A CSA hub requires a clinical room with examination couch (allowing examinations in the left lateral position) and sufficient space for a video-colposcope, monitor and laptop; as well as room for at least 5 people and the child. This room should have a comfortable space away from the couch for the child, parent/carer and doctor to have a conversation and ideally a small play table for the play specialist and child if needed during the consultation.

A second room is required for the child and parent/carer to have a follow on conversation with the CYP advocate or family therapist, or for relatives/siblings, social workers or police to wait during the consultation.

Honorary contracts
The CSA hub involves staff from other organisations working on site in the clinic to provide the multi-disciplinary team for the CSA hub. This requires those staff not employed by the Trust hosting the CSA hub clinics for have Honorary Contracts, such as CAMHS clinicians or those from Independent sector organisations.

Weekly pre-clinic prep and post-clinic debrief and case allocation
At the start of each CSA hub clinic the team meet to discuss the children and young people booked into the clinic that day. Each referral is reviewed and the team plan who would be best placed to meet the child/family and any professionals accompanying them. Following clinic the team review all consultations and ensure a plan of support is agreed and one practitioner takes the lead with that child and family.

CSA Hub case review meetings
Each month the CSA hub core team meet with representatives from police and social care to review all open cases to the team. The team use this opportunity to review cases and any safeguarding issues arising, as well as sharing learning as they support children, young people and families immediately after disclosure and on through court processes.

The team in the North London CSA have also identified a number of key elements they would put in place in they set up a CSA hub again:
CSA Hub manager - A need has been identified for a two to three day a week resource of CSA hub manager for case follow up and safeguarding coordination

Information sharing agreements – There is a need to be clear about joint information sharing agreement on top of existing local organisation agreements in place

Shared record for each child – Record keeping for evaluation and shared case management has been difficult as the team have relied on local organisational records due to time constraints on setting up the pilot, and one provider is hosting the outcomes record for evaluation. A future aim is to have one summary shared care record with key information on medical, safeguarding and therapeutic care plans; as well as one place to record outcome measures for evaluation.

Memorandum of Understanding (MoU)
An MoU is an agreement that describes the ways of working and promises by which all the health, independent sector and criminal justice organisations working within the CSA Hub will work to support children, young people and their non-offending families and deliver a service. International best practice in Child Advocacy Centres has shown that agreement of an MoU early on the development of the model is effective in creating cultural change across organisations.

The CSA hubs in London did not agree an MoU early on but will be for the future. The MoU should include agreements such as:

- Shared roles and responsibilities - expectations of attendance at meetings (service and client focused); staff training and expectations of service delivery
- Information sharing - expectations of information sharing, confidentiality, ,
- Evaluation – expectations of data collection (including any IT system to hold core data), data security, support for the evaluation and work with local partners
- Co-ordination of the service and leadership – role of service manager from one of the organisations and their remit, areas they hold overall responsibility for, how they will deal with concerns about an aspect of the service or an individual
- Individual organisation responsibilities - staff leave, professional supervision of staff, mandatory and developmental training, essential training for the CSA hub role

Lesson 16: Staffing a CSA hub

The CSA hub in North London was created with investment in early emotional support to work alongside the existing paediatric and play specialist teams providing CSA examinations. This nine month proof of concept has identified gaps in the existing team and recommends the following skill mixed team to staff a CSA hub.

A CSA hub should ideally include:

- Consultant Paediatrician and a second suitably trained examiner for CSA medical assessments
- Play Specialist
- Emotional support team including a combination of Advocate or child/young person's independent sexual violence advocate (ISVA), Clinical Social worker from CAMHS, Family Therapist from CAMHS, Child Psychologist
- Administrative support

As well as

- Team Leader from one organisation for two to three days a week to operationally manage the team across the partner agencies
- Access to a clinical supervisor for emotional support team for monthly supervision
- Access to peer review for medical examiners four times a year
- Access to CAMHS psychiatrist for advice and guidance for one session a week
- Access to sexual health advisors and consultants for dual examinations if required

The experience of the North London CSA hub and the Children and Young Person's Havens Service (London's SARC) have been that providing a holistic service for CSA and raising awareness amongst professionals results in significant increase in demand. In 2016/17 the North London CSA hub noted a fourfold increase in referrals at one site and the CYP Havens is predicting a 75% rise in children and young people supported, particularly noting an increase in requests for case management and signposting. Learning from this increase in demand, and the nature of the support that is required, the recommended workforce planning considerations are:

- Paediatrician – 1 PA per child for examination and FU. 3 PAs for cases progressing to court requiring report and court attendance (18% of cases)
- Advocate – 10 cases at a time for an average of four months
- CAMHS professionals – 10 cases at a time providing 6-8 sessions of therapeutic support

Lesson 17: What experience should the CSA hub team bring

The North London CSA hub team was formed from local expert practitioners in their fields each bringing key skills to the team from their existing services. Most areas should have similar expertise commissioned from local providers but currently working in isolation.

Key skills and experience include:

- CAMHS clinician – experience of delivering trauma-informed services such as EMDR or trauma focused cognitive behavioural therapy (TF-CBT) as well as screening for post-traumatic stress disorder (PTSD). A skill mixed team of part-time practitioners allows for clinicians to be drawn from varied CAMHS speciality teams bring a wealth of skills and backgrounds such as family therapy, clinical social work, child and adolescent psychology and psychotherapy.

- Paediatrician - experienced in CSA medical examinations with video-colposcopy, undertaking more than 20 medicals a year and an active member of a peer review group

- Advocate - should have child protection background with experience of directly supporting children

Lesson 18: Access to advice and onward referral

The CSA hub team in North London identified the need to establish strong professional links into other agencies and experts. Whilst the children and young people referred to the CSA have a suspicion or disclosure of CSA, their emotional, practical and social needs are more complex than CSA in isolation.

The team identified a need for access to the following agencies and experts:
Health sector:

- Consultant Psychiatrist
- Trauma Specialist
- Consultant Psychologist
- Domestic violence specialist
- Eating Disorder specialist

Criminal Justice sector:

- Crown Prosecution Service lawyers
- Family Court
- Police sexual offences investigation trained officers (SOITs)

Social care sector:

- Housing
- Schools – Safeguarding Leads
- CSE experts

Case Study – CSA hub role in liaison and supporting the child and family to navigate the system

Promise

Promise was seen at the CSA clinic and described having quite severe symptoms of psychological distress, during a meeting with the Claire the CAMHS practitioner. At the clinic, advice was sought from the on-call clinician in CAMHS to ensure there was a robust enough safety and intervention plan in place for Promise. The decision was to make a referral to her local CAMHS service immediately while Claire worked with Promise to support her and her carer while she was waiting for an appointment.

While Promise waited for the local CAMHS appointment, Claire spent time liaising with her local CAMHS service and her social worker to ensure there was a joined up plan around her. This continued during in the following weeks in addition to attending child in need meetings. For every one hour of face-to-face time with Promise, there was on average two hours of liaising with local CAMHS and social care team.

Promise told Claire it was really helpful to speak to someone like her because there was no pressure on to talk about the traumatic event of her abuse. This felt different to her conversations with the police and social workers. She felt respected and treated like an individual. Claire supported Promise by providing tips for a good evening routine which helped her sleep improve, as well as strategies to manage her flashbacks and when she felt anxious. Promise said “No one can take way what’s happened to me, I’ll never forget and will always have it as a traumatic experience”. Psycho education work about PTSD has helped Promise to understand the impact of trauma on the brain and how it affects her.

To protect Promise, her carer had asked her to come straight home from college, but this was impacting on her ability to make friends. Claire enabled the conversation between Promise and her carer so that she could stay out in the evening at college and feeling safe.

Promise has chosen to seek counselling at Solace for long-term support and Claire has enabled the introductions and handover to this service.

Anna’s experience

Anna, the CYP Advocate spends one and a half days per week in the CSA hub clinics and half a day on outreach appointments, but at least 2 days a week liaising with health, social care and police colleagues on behalf of the child or young person.

Sybil’s experience

Sybil spends 60% of her time directly supporting children and young people and 40% in liaison with Social Care and referrals on to local CAMHS

Lesson 19: What happens after the CSA hub

The CSA hub model supports children, young people and their families for six to eight weeks after their first appointment. During this time of practical and emotional support the team identify the long-term needs for that child and family and help them to navigate the many options available to them.

Children and young people can be referred to CAMHS services, the local rape crisis service for counselling or their school counsellor. Others may feel they don't need counselling but value the support of a local CSE services if available. Some young people are referred on to youth and community projects designed to empower young people, such nail or yoga projects. Provision varies in different areas and a directory of service is a valuable resource to develop and keep up to date.

6. Evaluation and Outcomes

The North London CSA hub pilot was evaluated after eight months and found improvements in the case management for children and young people, better access to early emotional support where needed and positive qualitative feedback from families and staff.

Over 50% of children, young people and families attending the CSA hub were supported by the advocate and/or the CAMHS practitioners. The team found that some children referred for a CSA medical had conditions such as vulvovagintis and CSA was not suspected or disclosed, therefore no emotional support was needed.

Outcomes included:

- 144 children and young people were seen in the CSA hub between July 2016 and Feb 2017
- 85 accessed early emotional support and case management
- Restorative experience for children and families
- Shared professional learning
- Removed barriers to accessing advocacy and CAMHS support by them being present in the first appointment
- Early emotional support available to all if required with no threshold
- Improved multi-agency and professional co-operation
- Improved communication with children's services through advice and liaison
- A therapeutic approach was maintained while ensuring effective safeguarding
- Patient reported outcome measures were trialled including trauma symptom checklist for children, strengths and difficulties questionnaire and goal based outcome measures
- An outcome tracker was developed for future evaluation

Children and Families said:
"Watching my daughter magically heal emotionally in the presence of the doctor was amazing and life transforming." "Everything was clearly explained and my children were given the time to talk and were listened to."

Staff said:
"Working in the CSA hub has built on my understanding of how children present when they are experiencing CSA.
"I have found that meeting the child and family for the first time with the rest of the team humanises the people that are there to support the child."
"60% of my time is directly supporting children and young people and 40% I'm liaising with Social Care and referring on to local CAMHS"

Lesson 20: Measuring the outcomes from the CSA hub service

The CSA hubs in London found that identifying the outcomes to be measured was simple but the hardest part was measuring those across all the agencies involved in the CSA hub project. The North London CSA hub pilot was established as a virtual hub without one lead provider. A key lesson was that without a single summary care record held by a lead provider, the evaluation can be a time consuming and difficult process.

Proposed future outcome measures:

Throughput

Number of new CSA cases seen in CSA hub
Percentage of cases referred to the police that are accessing the CSA hub

Process effectiveness

Percentage of strategy discussions for suspected CSA including a paediatrician
Percentage of CYP that access advocacy and family therapy at CSA hub
Percentage of parents/carers at the CSA hub that access support
Percentage of CYP that come back for medical and sexual health follow up
Wait time for long -term counselling and therapy from local provider

Improved outcomes

CYP satisfaction
Percentage of CYP attending the CSA hub with long term mental health morbidity at 12 months
Percentage of CYP returning to education/employment after CSA (after 6 months)
Percentage of CYP in recovery from trauma – using scores such Trauma Symptom Checklist for Children, Strengths and Difficulties Questionnaire, goal based outcomes.

CASE STUDY: Difficulties in data collection whilst maintaining a child-centred approach
Written by Anna Weedon, Child Young Person's Advocate

"I had been working with Alesha, age 10, in the months leading up to the trial. She was informed by the police shortly before the trial was due to start that the perpetrator had pleaded guilty to multiple charges of CSA.*

Alesha and I had our final meeting with the police and the child protection lead at her primary school so that she could write a victim impact statement. She was vocal in expressing how enormous the relief was that she felt at not having to go court and told the officer how the abuse and all that followed had made her feel. Having spent nearly two hours with us she was exhausted

and keen to go back to join her class. We left the room altogether at the end of the meeting, the officer, Alesha and myself. She ran ahead, skipped down the corridor and quickly disappeared into the crowds of other children heading out into the playground.

This case highlights why it can be very challenging to get feedback from young people via feedback forms. In such contexts, asking Alesha to fill out a feedback form would have been inappropriate and unethical as she was exhausted and was keen to literally and metaphorically leave this experience behind her.

What is clear is that she was able to say how she how she was feeling at the end of the process and express the enormity of her relief. The symbolic significance of her stating such relief and then skipping down the corridor and disappearing into a crowd of her peers is an example that illustrates well the difficulty in data collection whilst maintaining a child-centred approach. "

**all names have been changed to ensure confidentiality*

Lesson 21: Local audits and research

There is currently very little research in the area of child sexual abuse and recovery from this type of trauma. The new NICE guidelines on Child Abuse and Neglect include all current research. However further work is required to identify the most effective ways to recover from trauma as well as ways most appropriate support for those who have experienced other Adverse Childhood Experiences (ACEs).

The work of CSA hubs will be an important source of evaluation and research for the future. The team at the UCLH site conducted an audit of cases before and after the introduction of the CSA hub model and found that CAMHS support had increased from 10% to 56% of cases. The team reported a clear benefit of having family therapist and advocate present at the consultation with the paediatrician. Some young people and their parents who were very distressed were able to access support immediately rather than waiting for an appointment in their local CAMHS service which can take several months.

An audit: The value of having a family therapist and a young person advocate in a Child Sexual Abuse Clinic. Dr Wong, Dr Hodes, Anna Weedon, Sybil Qasir, *(unpublished)*

An audit of the new CSA hub was undertaken using a retrospective notes review. The audit reviewed 20 new patients from the UCLH medical clinic and 23 new patients referred to the CSA hub.

The children and young people's ages ranged from 1 to 16 years old, with the mean age of 8 years old and most children between 5 and 13 years old. The children's parents presented with mental health conditions (6/23), substance misuse 4/23), parental CSA (3/23) and domestic violence (7/23). 50-65% of the children seen had physical problems such as genitourinary, developmental and musculoskeletal issues and 40-56% had emotional behavioural problems.

Pre CSA hub only 10% of the children seen for a CSA medical were referred to CAMHS, but in the CSA hub 30% were supported by the CYP advocate and 56% by the family therapist.

The team reported a clear benefit of having family therapist and advocate present at the consultation with the paediatrician. Some young people and their parents who were very distressed were able to access support immediately rather than waiting for an appointment in their local CAMHS service which can take several months. Some patients may not have met the local threshold for therapy as they may not yet have presented with florid symptoms and so the early support from the CSA hub was critical support.

Future research will look at the child /parent opinion as to the benefit of this immediate access and also the outcomes for the child.

7. Communication

Lesson 22: Planning communications

For each stage of implementation of a CSA hub, communications are key. There were five stages to a communication plan for implementing a CSA hub that were found to be helpful.

1. **Creating a compelling vision**
2. **Decision making**
3. **Operationalising the new CSA hub**
4. **Post launch communications**
5. **Raising awareness and prevention**

The learning from the CSA hubs in London has been that great communication is essential – whether it is in creating a compelling and convincing story to elicit change or changing the culture amongst professionals. This section details the five stages of communication that were used in London, what to tell people and some tips on how to get the message across.

STAGE	What	How
Creating a compelling vision	Clear description of the vision to create local champions and build momentum	Create stakeholder map Spend time talking to all agencies Elevator pitch Case for change – 2 pager
Decision making	Clear ask of the decision makers including: funding, sustainability, impact on agencies, benefits for the child and professionals	Identify key decision making forums Attend LSCBs, senior leadership team meetings, clinical leadership meetings
Operationalising the	Making sure referrers	Launch event for health, social care,

new CSA hub	understand the new service offer, why, who and how to refer Clear explanation of the benefits to the children/young people and the professionals	police, education, sexual health, primary care, independent sector CSA hub leaflets and referral information
Post launch communications	Make sure all referrers understand the service and benefits And then tell them again And again!	Training in local teams – including team leaders Regular refreshers such as: annual newsletter, articles for existing newsletters (ADCS, GPs etc) professional journals and conferences
Awareness Raising and Prevention	Wider campaign with local public health, police and independent sector colleagues to raise awareness of CSA To encourage reporting by children and young people	Training for professionals on spotting the signs. For example: The Children's Society 'Seen and Heard' campaign [22] Links to existing local campaigns to ensure they know about the CSA hub such as schools safeguarding leads, rape crisis services

Good luck as you set up your CSA hub!

Appendix 1: NICE guidance relevant to child sexual abuse and exploitation

NICE Code	Title and link	Published	Review	Age range	Summary
Guidance In Development (GID)					
In development [GID-SCWAVE0708]	Child abuse and neglect	Expected publication date: September 2017			
In development [GID-NG10048]	Children and young people with severe complex needs: social care support	Expected publication date: TBC			
NICE Quality Standards (QS)					
QS31	Looked-after children and young people	April 2013	Apr 2018	Under 18 years and care leavers	This quality standard defines best practice for the health and wellbeing of looked-after children and young people. NICE quality standards describe high-priority areas for quality improvement in a defined care or service area.
QS34	Self-harm	June 2013	June 2018	This quality standard covers the initial management of self-harm and the provision of longer-term support for children and young people (aged 8 years and older) and adults (aged 18 years and older) who self-harm.	NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.
QS48	Depression in children and young people	Sept 2013	Sept 2018	5–18	This quality standard covers the diagnosis and management of depression in children and young people aged 5 up to their 18th birthday.
QS53	Anxiety disorders	Feb 2014	Feb 2019	Lifespan	NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They

					draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. This quality standard covers the identification and management of anxiety disorders in primary, secondary and community care for children, young people and adults. This quality standard covers a range of anxiety disorders, including generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder. This quality standard does not explicitly address the management of generalised anxiety disorder and panic disorder in children (younger than 16 years) because these were not covered in the source guideline (NICE clinical guideline 113).
QS59	Antisocial behaviour and conduct disorders in children and young people	April 2014		Under 18 years	This quality standard covers the recognition and management of antisocial behaviour and conduct disorders in children and young people (aged under 18 years). The quality standard is expected to contribute to improvements in the following outcomes: • Emotional wellbeing of children and young people. • Emotional wellbeing of the parents and carers of children and young people. • Reducing contact with the youth justice system. • Educational attainment. • Number of 16–18 year olds in education, employment or training
QS70	Bedwetting in children and young people	Sept 2014		Under 18 years	NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.
QS116	Domestic violence and abuse	Feb 2016		16 years and over	This quality standard covers domestic violence and abuse in adults and young people aged 16 years and over. It covers adults and young people who are experiencing (or have experienced) domestic violence or abuse, as well as adults and young people perpetrating domestic violence or abuse. It also covers children and young people under 16 years who are affected by domestic violence or abuse that is not directly perpetrated against them. This includes those taken into care.

QS133	Children's Attachment	Oct 2016		This quality standard covers the identification, assessment and treatment of attachment difficulties. It focusses on children and young people up to age 18: • on the edge of care (those considered to be at high risk of going into care) • looked after by local authorities in foster homes (including kinship foster care) • in special guardianship • adopted from care • in residential settings and other accommodation	NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. .
NICE Clinical Guidance (CG)					
CG9	Eating disorders in over 8s: management	Jan 2004		8 years and over	This guideline covers assessing and managing eating disorders in adults, young people and children (aged 8 and over). It recommends effective treatments and services for people with anorexia nervosa, bulimia nervosa, and related eating disorders, in particular, binge eating disorder. It does not look at obesity, or how to diagnose or treat an eating problem that has been caused by another physical or mental disorder.
CG28	Depression in children and young people: identification and management	Sept 2005	March 2015	<18	This guideline covers identifying and managing depression in children and young people aged between 5 and 18 years. Based on the stepped care model, it aims to improve recognition and assessment and promote effective treatments for mild, moderate and severe depression.
CG89	Child maltreatment: when to suspect maltreatment in under 18s	July 2009		Under 18 years	The advice in this guideline covers the alerting features in children and young people (under 18 years) of: • physical, sexual and emotional abuse • neglect • fabricated or induced illness.
NICE Public Health Guidelines (PH)					
PH3	Sexually transmitted infections and under-18 conceptions: prevention	Feb 2007		Under 18 years	NICE recommendations include the following advice: • Assess people's risk of having a sexually transmitted infection (STI), when the opportunity arises. For example, this could happen when someone attends for contraception, or to register as a new patient. • Offer advice to people at high risk of an STI in a structured discussion, or arrange for them to see someone who is trained to give this type of advice. The discussion should cover ways to help people reduce the risks. • Help people with an STI to get their partners tested and treated. This

					might involve referring the person to a specialist. People with STIs and their partners should receive information about the infection they have. • Primary care trusts (PCTs) should make sure there are enough sexual health services locally and enough staff trained to run them. This guidance was previously called prevention of sexually transmitted infections and under 18 conceptions. It is for professionals who are responsible for, or who work in, sexual health services. This includes general practitioners and professionals working in contraceptive services, genitourinary medicine and school clinics.
PH4	Substance misuse interventions for vulnerable under 25s	March 2007	Next review date: This guideline is being updated by the NICE guideline on drugs misuse prevention	< 25	This guidance is for NHS practitioners and others involved in reducing substance misuse among vulnerable and disadvantaged children and young people under the age of 25. They may work in the NHS, local authorities or the education, voluntary, community, social care, youth and criminal justice sectors. The guidance focuses on community-based activities taking place in, for example, schools and youth services.
PH25	Contraceptive services for under 25s	Mar 2014		Under 25 years	This guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, contraceptive services. This includes those working in local authorities, education and the wider public, private, voluntary and community sectors. It may also be of interest to young people, their parents and carers and other members of the public. NICE says that young men and women should be given advice and information on all types of contraception to help them choose the best method for their needs and lifestyle. This makes it more likely that contraception will be used effectively. The recommendations emphasise the need to offer additional tailored support to meet the particular needs and choices of those who are socially disadvantaged or who may find it difficult to use contraceptive services.
PH28	Looked-after children and young people	Oct 2010	May 2015	Under 18 years and care leavers	This joint guidance from NICE and the Social Care Institute for Excellence (SCIE) is for all those who have a role in promoting the quality of life (that is, the physical health, and social, educational and emotional wellbeing) of looked-after children and young people. This includes directors of children's services, directors of public health, people who commission and

					provide health and social care services, social workers, carers (including foster carers), healthcare workers, staff in independent and voluntary agencies, schools, colleges and universities, and organisations that train professionals and inspect services.
PH40	Social and emotional wellbeing: early years	Oct 2012	2017	Under 5 years	This guidance aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education. The term 'vulnerable' is used to describe children who are at risk of, or who are already experiencing, social and emotional problems and need additional support. The guidance is for all those responsible for planning and commissioning children's services in local authorities (including education), the NHS and the community, voluntary and private sectors. It also for: GPs, health visitors, midwives, psychologists and other health practitioners, social workers, teachers and those working in all early years settings (including childminders and those working in children's centres and nurseries).
PH50	Domestic violence and abuse: multi-agency working	Feb 2014		All ages	The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people. Working in a multi-agency partnership is the most effective way to approach the issue at both an operational and strategic level. Initial and ongoing training and organisational support is also needed. The guidance is for health and social care commissioners, specialist domestic violence and abuse staff and others whose work may bring them into contact with people who experience or perpetrate domestic violence and abuse. In addition it may be of interest to members of the public.
NICE Guidance (NG)					
NG43	Transition from children's to adults' services for young people using health or social care services	Feb 2016		From 9 years in some cases (For groups not covered by health, social care and education legislation)	This guideline covers the period before, during and after a young person moves from children's to adults' services. It aims to help young people and their carers have a better experience of transition by improving the way it's planned and carried out. It covers both health and social care.
NG55	Harmful sexual behaviour among children and young people	Sept 2016	Sept 2018	'Young people' refers mainly to those aged 10 to 18 but also includes people up to 25 with special educational needs or a disability.	This guideline covers children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences. It aims to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence. It also aims to ensure no-one is unnecessarily referred to specialist services.

					This guideline does not discuss people who have experienced sexual abuse. NICE will publish a guideline on child abuse and neglect in September 2017.
NG58	Coexisting severe mental illness and substance misuse: community health and social care services	Nov 2016		Aged 14 years and over	This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.

Appendix 2: Stakeholders

Agency	Role	Why they matter	Motivating factors
Local Authority	Chief Executive of Local Authority	Decision maker and influencer	Joined up approach to safeguarding CSA across health, social care, police and independent sector
Local Authority	Director of Children's Services (reponsible for all services for children and young people)	Decision maker and influencer	Joined up approach to safeguarding CSA across health, social care, police and independent sector
Local Authority - Social care	Assistant Director of Children's Services (responsible for children's social care)	Decision maker and influencer	Joined up approach to safeguarding CSA across health, social care, police and independent sector
Local Authority - Social care	Head of Safeguarding	Influencing the social care team to change	CSA hub will provide clear pathway and support for children at risk of and experiencing CSA
Local Authority - Social care	Principal Social Worker/Social Care Team Leaders	Making change happen	CSA hub will provide advice and access to health/ emotional support services
Local Authority - Social care	MASH Manager	Making change happen	CSA hub will provide advice and access to health/ emotional support services
Local Authority - Public Health	Director of Public Health	Influencer	Better health outcomes for children and young people
Local Authority - Public Health	Sexual Health Commissioner	Referral pathways into and out of CSA Hub	CSA Hub model provides a solution for under-13s requiring sexual health input, not currently commissioned in sexual health services. CSA Hub model includes advice and access to services for young people presenting to sexual health services where there is a suspicion of CSA/CSE
Health - NHSE	Health in the Justice System Specialist Commissioning (Commissioner of SARC service)	Decision maker, influencer, potential funder	Joined up approach to safeguarding CSA providing improved early emotional support and better links to long-term mental health support services. Reduction in re-victimisation.
Health - CCG	Chief Officer of CCG	Decision maker, influencer, potential funder	Joined up approach to safeguarding CSA resulting in less duplication of work, decreasing demand for crisis interventions and long-term mental health support services.

Health - CCG	Directors of Commissioning and Finance	Decision maker	Joined up approach to safeguarding CSA resulting in less duplication of work, decreasing demand for crisis interventions and long-term mental health support services.
Health - CCG	Senior Children's Commissioner (in some cases joint with Local Authority)	Influencer, making change happen	CSA hub provides multiagency for early intervention resulting in improved service and better outcomes for children/young people and their families, decreased demand for crisis intervention and long-term mental health support services.
Health - CCG	CAMHS Commissioner	Influencer, making change happen	CSA hub provides multiagency for early intervention resulting in improved service and better outcomes for children/young people and their families, decreased demand for crisis intervention and long-term mental health support services.
Health - CCG	Children's Clinical Lead	Influencer	Children are better safeguarded and families better supported. CSA Hub as a source of professional expertise
Health - CCG	Designated Dr for Safeguarding	Influencer, making change happen	CSA Hub provides a model to meet RCPCH standards including maintaining clinical competency. Children are better safeguarded
Health - CCG	Designated Nurse for Safeguarding	Influencer, making change happen	CSA Hub provides a model to meet RCPCH standards including maintaining clinical competency. Children are better safeguarded
Health - CCG Collaborative	Senior Responsible Officer for Children for the Sustainability & Transformation Plan footprint (STP)	Influencer at a CCG collaborative level, potential funder	CSA Hub model provides an opportunity to establish an STP-level specialist service to support children and young people across health, social care and the independent sector
Health - providers	Clinical Director for local CAMHS service	Decision maker, influencer, expert advisors	CSA Hub model provides early intervention emotional support with no threshold and an evidence-based decrease in Post-Traumatic Stress Disorder (PTSD)
Health - providers	Clinical/Medical Director at local health provider	Decision maker, influencer, expert advisors	CSA Hub provides a model to meet RCPCH standards including maintaining clinical competency. Children are better safeguarded
Health - providers	Manager of Children's Services at local health provider	Influencer, making change happen	CSA Hub model facilitates multiagency working to ensure CSA clinics are holistic and not run in isolation to other support services

Health - providers	Named Dr at local health provider	Influencer, making change happen	CSA Hub provides a model to meet RCPCH standards including maintaining clinical competency. Children are better safeguarded
Health - providers	Paediatricians carrying out medical examinations	Expert advisors, making change happen	CSA Hub model allows for peer review, ensures throughput to maintain competency and access to advocacy and mental health expertise to support children/young people and their families better
Health - providers	Manager of SARC Service	Referral between SARC and CSA Hub	The CSA Hub model could provide children and young people seen at local SARC with early intervention emotional support and case management if this is not available at the SARC
Police	Commander/Assistant Chief Constable	For information	Executive responsibility for safeguarding including CSA/CSE
Police	Chief Superintendent for safeguarding	For information	Strategic responsibility for safeguarding - DV, child abuse, adult abuse, missing from home, CSE, rape
Police	Dedicated Superintendent for specialist sexual offences teams	Decision-maker, influencer	Strategic responsibility for specialist sexual offences team. CSA Hub provides one-stop shop for expert advice and shared case management with health and independent sector
Police	Detective Chief Inspector for safeguarding teams (this could include specialist teams for rape, child abuse, CSE)	Influence referrals into the CSA Hub	Operational lead for safeguarding teams. CSA Hub provides one-stop shop for expert advice and shared case management with health and independent sector
Police	Specialist sexual offences officers	Frontline officers investigating serious sexual assault, rape and child abuse cases	Access to expert advice. Emotional support provided by the CSA Hub for children/young people and their families during investigation.
Independent Sector Providers	CEO/Service Manager of Rape Crisis Service	Expert advisors, provider of CSA/CSE support services	CSA Hub model offers opportunity to be part of a mulitagency team providing an improved service for children, young people and their families. Improved communication with social care and police Potential to provide advocacy and therapeutic services in the the CSA
Independent Sector Providers	CEO/Service Manager of Organisations employing Independent Sexual Violence Advocates (ISVA)	Expert advisors, provider of CSA/CSE support services	

Independent Sector Providers	Service Manager of local Children's Charities e.g. NSPCC, Barnardo's, Children's Society	Expert advisors, provider of CSA/CSE support services	Hub
Independent Sector Providers	CEO of local/national Survivors Organisations/Networks	Expert advisors, influencers, support in service design	Opportunity to influence improvements in support for survivors of CSA/CSE
Other stakeholders	Chair of the Local Safeguarding Children Board	For information, influencers	Joined up approach to safeguarding CSA across health, social care, police and independent sector
Other stakeholders	Chair of the Local Health and Well-Being Board	For information, influencers	
Other stakeholders	Local Champions	Influencers, publicity and fundraising	Personal commitment to improved service design and delivery for children, young people and their families

Glossary of terms

There can be confusion over the use of use of words and terms to describe child sexual abuse. This glossary defines some key phrases and terms that will be used in this toolkit.

Acute abuse	Abuse that occurred recently, generally considered to be within the 'forensic window'. The 'forensic window' is a period of time when DNA evidence can be collected at a forensic medical examination. This time period is effected by age of the child and type of abuse but is generally up to three to seven days. N.B. Even when an incident of abuse is reported outside of the forensic window the recording of injuries up to three weeks after the abuse occurred can often be valuable.
Child	Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection (Working Together, 2015).
CSA	*Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children* (Working Together, 2015).
CSE	*'Child sexual exploitation (CSE) is a form of child abuse. It occurs where anyone under the age of 18 is persuaded, coerced or forced into sexual activity in exchange for, amongst other things, money, drugs/alcohol, gifts, affection or status. Consent is irrelevant, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and may occur online.'* (HM Government, 2016).
Historic/non-acute Abuse	Non-acute sexual abuse is abuse that occurred more than seven days ago, and is outside of the forensic window for a forensic medical examination.
LSCB	Local Safeguarding Children's Board
MARAC	Multi-Agency Risk Assessment Conference. This is a meeting of statutory and voluntary partners operating in a Local Authority area which considers how to manage the risk posed to victims of domestic violence and abuse.
MASE	Multiagency Sexual Exploitation Panel. This is similar to a MARAC but considers the multi-agency arrangements to manage the risks posed to child victims of sexual exploitation.
MASH	Multiagency Safeguarding Hub
SARC	Sexual Assault Referral Centre
Section 47	Section 47 of the *Children's Act 1989* places a duty on the Local Authority to investigate all allegations and suspected cases of child abuse and where a child is at risk of 'significant harm'. The investigation, usually multiagency, will form the core assessment of the child's needs and capacity of their parents/caretakers.

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