NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Issue date: July 2009

When to suspect child maltreatment

NICE clinical guideline 89
Developed by the National Collaborating Centre for Women's and Children's Health

Open for definitions of **CONSIDER** and **SUSPECT** and information on using this guidance.

Definitions of consider and suspect

The alerting features in this guidance have been divided into two categories, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

CONSIDER means maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.

SUSPECT means serious level of concern about the possibility of child maltreatment but not proof of it.

Using this guidance

If you encounter an alerting feature described in this guidance it is good practice to follow the process outlined below.

Listen and observe

Take into account the whole picture of the child or young person. Sources of information that help to do this include:

- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party
- child's appearance, demeanour or behaviour
- symptom
- physical sign
- result of an investigation
- interaction between the parent or carer and child or young person.

Seek an explanation

Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner. An **unsuitable explanation** is one that is:

- implausible, inadequate or inconsistent:
  - with the child or young person's presentation, normal activities, medical condition (if one exists), age or developmental stage, or account compared with that given by parent and carers
  - between parents or carers
  - between accounts over time
- based on cultural practice, because this should not justify hurting a child or young person.

Record

Record in the child or young person's clinical record exactly what is observed and heard from whom and when. Record why this is of concern.

CONSIDER child maltreatment

If an alerting feature prompts you to consider child maltreatment:

- look for other alerting features of maltreatment in the child or young person's history, presentation or parent– or carer–child interactions now or in the past.

And do one or more of the following:

- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children.
- Gather collateral information from other agencies and health disciplines.
- Ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting features.

At any stage during the process of considering maltreatment the level of concern may change and lead to exclude or suspect maltreatment.

SUSPECT child maltreatment

If an alerting feature or considering child maltreatment prompts you to suspect child maltreatment refer the child or young person to children's social care, following Local Safeguarding Children Board procedures.

Exclude child maltreatment

Exclude child maltreatment if a suitable explanation is found for the alerting feature. This may be the decision after discussion of the case with a more experienced colleague or gathering collateral information as part of considering child maltreatment.

Record

Record all actions taken and the outcome.

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'When to suspect child maltreatment' (NICE clinical guideline 89).

Who should read this booklet?

This quick reference guide is for all healthcare professionals working in the NHS who work with children and young people. It may also be of interest to people outside of the NHS who work with children and young people.

Who wrote the guidance?

The guidance was developed by the National Collaborating Centre for Women's and Children's Health, which is linked with the Royal College of Obstetricians and Gynaecologists. The Collaborating Centre worked with a group of healthcare professionals (including paediatricians, GPs and child mental health professionals), people affected by maltreatment, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Where can I get more information about the guidance?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guidance for members of the public, and tools to support implementation (see the back page for more details).

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This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual child or young person, in consultation with the child or young person and/or guardian or carer.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Introduction

- The effects of child maltreatment can be severe and last into adulthood.
- Children may present with both physical and psychological symptoms and signs that constitute alerting features of one or more types of maltreatment.
- Maltreatment may be observed in parent– or carer–child interactions.
- Obstacles to identifying child maltreatment exist. However, these should not stop healthcare professionals from acting to prevent harm to the child. Examples of possible obstacles include:
  - concern about missing a treatable disorder
  - healthcare professionals are used to working with parents and carers in the care of children and fear losing a positive relationship with a family already under their care
  - discomfort of disbelieving, thinking ill of, suspecting or wrongly blaming a parent or carer
  - divided duties to adult and child patients and breaching confidentiality
  - an understanding of the reasons why the maltreatment might have occurred, and that there was no intention to harm the child
  - losing control over the child protection process and doubts about its benefits
  - stress
  - personal safety
  - fear of complaints.
- Alerting features of maltreatment in children with disabilities may also be features of the disability, making identification of maltreatment more difficult.

Sharing information about children and young people

If you are worried about sharing information about a child or young person, seek advice from named or designated professionals for safeguarding children. If your concerns are based on information given by a child, explain to the child that you may be unable to maintain confidentiality, explore the child's concerns about sharing this information and reassure the child that they will continue to be kept informed about who the information is being shared with and what action is being taken. When gathering collateral information from other health disciplines and agencies, use judgement about whether to explain to the child or young person the need to gather this information for their overall assessment.

Exclusions from the guideline

The following topics were outside the scope of this guideline and have therefore not been covered:

- risk factors for child maltreatment, which are well recognised (for example, parental or carer drug or alcohol misuse, parental or carer mental health problems, intrafamilial violence or history of violent offending, previous child maltreatment in members of the family, known maltreatment of animals by the parent or carer, vulnerable and unsupported parents or carers, pre-existing disability in the child)
- protection of the unborn child
- children who have died as a result of child maltreatment
- diagnostic assessment and investigations (for example, X-rays)
- treatment and care of the child if maltreatment is suspected
- how healthcare professionals should proceed once they suspect maltreatment
- healthcare professionals' competency, training and behaviour
- service organisation
- child protection procedures
- communication of suspicions to parents or carers, or the child or young person
- education and information for parents or carers, or the child or young person.

Key to terms used in this document

Child maltreatment includes physical, emotional and sexual abuse, neglect, and fabricated or induced illness. The definitions of child maltreatment in 'Working together to safeguard children' (2006)[1] are used in this guidance.

- The following terms are used to describe children of different ages:
  - infant (under 1 year)
  - child (under 13 years)
  - young person (13–17 years).

[1] Available from: www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/workingtogether/workingtogethertosafeguardchildren [Accessed 6 July 2009]

Physical features

Alerting features that should prompt you to CONSIDER child maltreatment:

- Any serious or unusual injury with an absent or unsuitable explanation.
- Cold injuries (for example, swollen, red hands or feet) in a child, with no medical explanation.
- Hypothermia in a child, with an unsuitable explanation.
- Oral injury in a child, with an absent or unsuitable explanation.

Alerting features that should prompt you to SUSPECT child maltreatment:

- Bruising in the shape of a hand, ligature, stick, teeth mark, grip or an implement.
- Bruising or petechiae (tiny red or purple spots) not caused by a medical condition (for example, a coagulation disorder), with an unsuitable explanation, including those:
  - in a child who is not independently mobile
  - that are multiple or in clusters
  - of similar shape and size
  - on non-bony parts of the face or body, including the eyes, ears and buttocks
  - on the neck that look like attempted strangulation
  - on the ankles and wrists that look like ligature marks.
- Human bite mark thought unlikely to have been caused by a young child.
- Lacerations, abrasions or scars on a child that have an unsuitable explanation, including those:
  - on a child who is not independently mobile
  - that are multiple or have a symmetrical distribution
  - on areas usually protected by clothing, or the eyes, ears and sides of face
  - on the neck, ankles and wrists that look like ligature marks.
- Burn or scald injuries on a child:
  - with an absent or unsuitable explanation **or**
  - who is not independently mobile **or**
  - on soft tissue areas not expected to accidentally come into contact with a hot object (for example, backs of hands, soles of feet, buttocks, back) **or**
  - in the shape of an implement (for example, cigarette or iron) **or**
  - that indicate forced immersion (for example, scalds to buttocks, perineum and lower limbs, to limbs in a glove, stocking or symmetrical distribution or with sharply delineated borders).

- One or more fractures in a child if there is no medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta or osteopenia of prematurity), or if the explanation is absent or unsuitable, including:
  - fractures of different ages
  - X-ray evidence of occult fractures (for example, rib fractures in infants).
- Intracranial injury in a child if there is no major confirmed accidental trauma or known medical cause in one or more of the following circumstances:
  - there is an absent or unsuitable explanation
  - the child is aged under 3 years
  - there are also other inflicted injuries, retinal haemorrhages, or rib or long bone fractures
  - there are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage to the brain.
- Retinal haemorrhages or injury to the eye in a child if there is no major confirmed accidental trauma or medical explanation, including birth-related causes.
- Signs of spinal injury (injury to vertebrae or within the spinal canal; for example, cervical injury with inflicted head injury, or thoracolumbar injury with focal neurology or unexplained kyphosis) in a child if there is no major confirmed accidental trauma.
- Intra-abdominal or intrathoracic injury in a child if there is no major confirmed accidental trauma, with an absent or unsuitable explanation, or with a delay in presentation. There may be no external bruising or other injury.

See page 3 for definitions of 'consider' and 'suspect' and information on using this guidance.

Sexual abuse

Alerting features that should prompt you to CONSIDER sexual abuse:

- Persistent or recurrent dysuria or anogenital discomfort, or an anal or genital symptom (for example, bleeding or discharge) in a girl or boy, without a medical explanation (for example, worms, urinary infection, skin conditions, poor hygiene or known allergies).
- Gaping anus in a girl or boy observed during an examination, without a medical explanation (for example, a neurological disorder or severe constipation).
- Evidence of a foreign body in the vagina or anus, indicated by, for example, offensive vaginal discharge.
- Hepatitis B in a child younger than 13 years if there is no clear evidence of vertical transmission, non-sexual transmission from a member of the household or blood contamination.
- Hepatitis B in a young person aged 13–15 years if there is no clear evidence of vertical transmission, non-sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity with a peer.
- Hepatitis B in a young person aged 16 or 17 years and there is:
  - no clear evidence of vertical transmission, non-sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity **and**
  - a clear difference in power or mental capacity between the young person and their sexual partner (in particular when the relationship is incestuous or with a person in a position of trust, for example, a teacher, sports coach or minister of religion) **or**
  - concern that the young person is being exploited.
- Anogenital warts in a child younger than 13 years if there is no clear evidence of vertical transmission or non-sexual transmission from a member of the household.
- Anogenital warts in a young person aged 13–15 years if there is no clear evidence of vertical transmission, non-sexual transmission from a member of the household or that the infection was acquired from consensual activity with a peer.
- Anogenital warts in a young person aged 16 or 17 years and there is:
  - no clear evidence of non-sexual transmission from a member of the household, or that the infection was acquired from consensual sexual activity **and**
  - a clear difference in power or mental capacity between the young person and their sexual partner (in particular when the relationship is incestuous or with a person in a position of trust) **or**
  - concern that the young person is being exploited.
- Gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection in a young person aged 13–15 years if there is no clear evidence of vertical transmission, blood contamination or that the STI was acquired from consensual sexual activity with a peer[2].

[2] In these circumstances, consider should include discussion of your concerns with a named or designated professional for safeguarding children.

- Gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection in a young person aged 16 or 17 years and there is:
  - no clear evidence of blood contamination or that the STI was acquired from consensual sexual activity **and**
  - a clear difference in power or mental capacity between the young person and their sexual partner (in particular when the relationship is incestuous or with a person in a position of trust) **or**
  - concern that the young person is being exploited.
- Pregnancy in a young woman aged 13–15 years.
- Pregnancy in a young woman aged 16 or 17 years and there is:
  - a clear difference in power or mental capacity between the young woman and the putative father (in particular when the relationship is incestuous or with a person in a position of trust) **or**
  - concern that the young woman is being exploited **or**
  - concern that the sexual activity was not consensual.

Alerting features that should prompt you to SUSPECT sexual abuse:

- Persistent or recurrent genital or anal symptom (for example, bleeding or discharge) in a girl or boy, without a medical explanation, that is associated with behavioural or emotional change.
- Genital, anal or perianal injury in a girl or boy, with an absent or unsuitable explanation.
- Anal fissure, when constipation, Crohn's disease and passing hard stools have been excluded as the cause.
- Gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection in a child younger than 13 years if there is no clear evidence of vertical transmission or blood contamination.
- Unusual sexualised behaviours in a prepubertal child (for example, oral–genital contact with another child or doll, requesting to be touched in the genital area, or inserting or attempting to insert an object, finger or penis into another child's vagina or anus).

Sex with a child under 13 years is unlawful. Therefore pregnancy in a girl of this age means that she has been maltreated.

See page 3 for definitions of 'consider' and 'suspect' and information on using this guidance.

Neglect

Neglect is a situation involving risk to the child or young person. It is the persistent failure to meet the child or young person's basic physical or psychological needs that is likely to result in the serious impairment of their health or development. This may or may not be deliberate. There are differences in how parents and carers choose to raise their children, including the choices they make about their children's healthcare. However, failure to recognise and respond to the child or young person's needs may constitute neglect.

There is no diagnostic gold standard for neglect and therefore decision-making in situations of apparent neglect can be difficult and thresholds hard to establish. It is essential to place the child or young person at the centre of the assessment.

Alerting features that should prompt you to CONSIDER neglect:

- Severe and persistent infestations (for example, scabies or head lice) in a child.
- Parents or carers who do not administer essential prescribed treatment for their child.
- Parents or carers who have access to but persistently fail to obtain NHS treatment for their child's tooth decay.
- Parents or carers who repeatedly fail to attend essential follow-up appointments that are necessary for the health and wellbeing of their child.
- Parents or carers who persistently fail to engage with relevant child health promotion programmes which include immunisation, health and development reviews, and screening.
- Child who is consistently dressed in clothes or shoes that are inappropriate (for example, for the weather or the child's size).

Instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather or slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.

- Faltering growth (failure to thrive) in a child because an adequate or appropriate diet is not being provided.
- Child or young person is not being cared for by a person who is able to provide adequate care.
- Animal bite on an inadequately supervised child.
- Injury (for example, a burn, sunburn or an ingestion of a harmful substance) if the explanation suggests lack of appropriate supervision.

Achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult. However, if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm it may constitute neglect.

Alerting features that should prompt you to SUSPECT neglect:

- Medical advice is not sought, compromising the health and wellbeing of a child, including if they are in ongoing pain.
- Child who is persistently smelly and dirty.

Children often become smelly or dirty during the course of the day. However, the nature of the child's smell may be so overwhelming that the possibility of persistent lack of provision or care should be taken into account. Examples include:

- child seen at times of the day when it is unlikely that they would have had an opportunity to become smelly or dirty (for example, an early morning visit)
- if the dirtiness is ingrained.

- Repeated observation or reports of any of the following home environments that are in the parents' or carers' control:
  - poor standard of hygiene that affects the child's health
  - inadequate provision of food
  - living environment that is unsafe for the child's developmental stage.

It may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents' or carers' ability to meet their child's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.

If a child has been abandoned this is child maltreatment.

See page 3 for definitions of 'consider' and 'suspect' and information on using this guidance.

Emotional, behavioural, interpersonal and social functioning

Alerting features that should prompt you to CONSIDER child maltreatment:

- Any behaviour or emotional state in a child if it is inconsistent with their age and developmental stage or there is no medical explanation (including a neurodevelopmental disorder, for example, ADHD or autism spectrum disorders) or other stressful situation unrelated to maltreatment (for example, bereavement or parental separation). Behaviour or emotional states that may fit this description include:
  - fearful or withdrawn emotional state
  - low self-esteem
  - aggressive or oppositional behaviour
  - habitual body rocking
  - indiscriminate contact or affection-seeking
  - over-friendliness to strangers
  - excessive clinginess
  - persistently resorting to gaining attention
  - demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
  - failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
  - coercive controlling behaviour towards parents or carers
  - very young children showing excessive comforting behaviours when witnessing parental or carer distress.
- Child or young person regularly has responsibilities that interfere with essential normal daily activities (for example, school attendance).
- Marked change in behaviour or emotional state not expected for the child or young person's age and developmental stage (for example, recurrent nightmares with similar themes, extreme distress, becoming withdrawn, markedly oppositional behaviour or withdrawal of communication) in the absence of a medical explanation or known stressful situation unrelated to maltreatment.
- Repeated, extreme or sustained emotional responses shown by a child that are out of proportion to a situation and are not expected for the child's age and developmental stage (for example, frequent rages at minor provocation, anger or frustration expressed as a temper tantrum in a school-aged child or distress expressed as inconsolable crying) in the absence of a medical explanation, neurodevelopmental disorder (for example, ADHD or autism spectrum disorders) or bipolar disorder when the effects of any known past maltreatment have been explored.
- Dissociation (transient episodes of detachment that are outside the child's control and that are different from daydreaming, seizures or deliberate avoidance of interaction) displayed by a child, not explained by a known traumatic event that is unrelated to maltreatment.

- Deliberate self-harm. Self-harm includes cutting, scratching, picking, biting or tearing skin to cause injury, pulling out hair or eyelashes and deliberately taking prescribed or non-prescribed drugs at higher than therapeutic doses.
- Child or young person who has run away from home or care, or is living in alternative accommodation without the full agreement of parents or carers.
- Unusual, unexpected or developmentally inappropriate response by a child to a health examination or assessment (for example, extreme passivity, resistance or refusal).
- Secondary day- or night-time wetting in a child, which persists despite adequate assessment and management, if there is no known stressful situation unrelated to maltreatment or medical explanation (for example, urinary tract infection).
- Deliberate wetting by a child.
- Encopresis (repeatedly defecating a normal stool in an inappropriate place) or repeated, deliberate smearing of faeces by a child.

Alerting features that should prompt you to SUSPECT child maltreatment:

- Child who repeatedly scavenges, steals, hoards or hides food with no medical explanation.
- Indiscriminate, precocious or coercive sexual behaviour in a child or young person.
- Repeated or coercive sexualised behaviours or preoccupation in a prepubertal child (for example, sexual talk associated with knowledge, drawing genitalia or emulating sexual activity with another child).

See page 3 for definitions of ‘consider’ and ‘suspect’ and information on using this guidance.

Clinical presentations

Alerting features that should prompt you to CONSIDER child maltreatment:

- Unusual pattern of presentation to and contact with healthcare professionals, or frequent presentations or reports of injuries.
- Poor school attendance that the child's parents or carers know about that is not justified on health (including mental health) grounds, and formally approved home education is not being provided.
- Bleeding from the nose or mouth in an infant who has an apparent life-threatening event and a medical explanation has not been identified.
- Hypernatraemia if a medical explanation has not been identified.
- A near-drowning incident that suggests a lack of supervision.

Alerting features that should prompt you to SUSPECT child maltreatment:

- Repeated apparent life-threatening events in a child, if the onset is witnessed only by one parent or carer and a medical explanation has not been identified.
- Poisoning in a child in any of the following circumstances:
  - deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs
  - unexpected blood levels of drugs not prescribed for the child
  - reported or biochemical evidence of ingestions of one or more toxic substances
  - the child could not access the substance independently
  - repeated presentations of ingestions of substances in the child or other children in the household
  - there is an absent or unsuitable explanation.
- Child has a near-drowning incident with an absent or unsuitable explanation.

Fabricated or induced illness

Alerting features that should prompt you to CONSIDER fabricated or induced illness:

- Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations, leads to a discrepancy with a recognised clinical picture, even if the child has a past or concurrent physical or psychological condition.

See page 3 for definitions of 'consider' and 'suspect' and information on using this guidance.

Alerting features that should prompt you to SUSPECT fabricated or induced illness:

- Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture plus one or more of the following, even if the child has a past or concurrent physical or psychological condition:
  - reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer
  - an inexplicably poor response to prescribed medication or other treatment
  - new symptoms are reported as soon as previous symptoms stop
  - biologically unlikely history of events
  - despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms
  - child's normal daily activities (for example, school attendance) are limited, or they are using aids to daily living (for example, wheelchairs) more than expected from any medical condition that the child has.

Parent– or carer–child interactions

Alerting features that should prompt you to CONSIDER child maltreatment:

- Potentially harmful parent– or carer–child interactions (emotional abuse), including:
  - negativity or hostility towards a child or young person
  - rejection or scapegoating of a child or young person
  - developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining
  - exposure to frightening or traumatic experiences, including domestic abuse
  - using the child to fulfil the adult's needs (for example, in marital disputes)
  - failure to promote the child's appropriate socialisation (for example, not providing stimulation or education, isolation or involving them in unlawful activities).
- Emotional unavailability and unresponsiveness from the parent or carer towards a child (in particular towards an infant) (emotional neglect).
- Parent or carer prevents you or another healthcare professional from speaking to the child or young person alone when it is necessary for the assessment of the child or young person.
- Parents or carers punishing a child for wetting despite professional advice that the wetting is involuntary.

Alerting features that should prompt you to SUSPECT child maltreatment:

- Persistent harmful parent– or carer–child interactions (emotional abuse).
- Persistent emotional unavailability and unresponsiveness from the parent or carer towards a child (in particular towards an infant) (emotional neglect).

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG89

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for members of the public.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N1900 (quick reference guide)
- N1901 ('Understanding NICE guidance').

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see www.nice.org.uk

Published

- Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004). Available from www.nice.org.uk/CG9
- Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004). Available from www.nice.org.uk/CG16

Under development

- Constipation: the diagnosis and management of idiopathic childhood constipation in primary and secondary care. NICE clinical guideline. Publication expected May 2010.
- Nocturnal enuresis: the management of bedwetting and nocturnal enuresis in children and young people. NICE clinical guideline. Publication expected October 2010.

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at www.nice.org.uk/CG89

Implementation tools

NICE has developed tools to help organisations implement this guidance. These are available on our website (see www.nice.org.uk/CG89).

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