Original tool: Dr Om Prakash Srivastava
Update: Dr Om Prakash Srivastava, Dawn Hodson, Richard Fountain

Graded Care Profile 2

MEASURING CARE, HELPING FAMILIES

Guidance and theory

NSPCC

EVERY CHILDHOOD IS WORTH FIGHTING FOR

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Foreword

Dr Om Prakash Srivastava

The Graded Care Profile is the product of 15 years of work as a community child health paediatrician (which later evolved as community paediatrics) in a deprived area of Barnsley, South Yorkshire. It involved whole population child health and developmental surveillance, child protection, and managing developmental disabilities from infancy to school leaving age. This meant close first-hand knowledge of families resident in that area, and their children, as the population was not mobile. A disproportionate number of children in this area were on the child protection register, with the majority in the category of neglect. Knowing some of these families, I became sure that it was due to a variety of factors but the most important of these were deprivation and learning disability.

After persuading the local social care and health leads, we formed a working group to decide how to deal with the problem of neglect in a way that was more equitable and child focused. Various approaches were discussed but it was difficult to come to a consensus because of our own values, which generated intense debate. Finally I proposed an approach based on children's developmental needs and measuring parental compliance. Parental compliance would be measured through their actual commitment as it is in line with the evolutionary processes (commitment to ensure survival of progeny for continuation of DNA copies). This has been shown to be the determinant of child outcomes in the medium and long term in a longitudinal study 'The Newcastle Thousand Families'.

My research at the University of Nottingham took this work forward — finally culminating in the Graded Care Profile in 1995. I tried it in practice for reliability and it yielded a very reliable tool in reproducing the scores on test and retest by case naïve practitioners. It was then introduced in practice in Barnsley through the Area Child Protection Committee. It was tested again by a social worker who was undertaking her Masters at Huddersfield University — showing its user-friendliness qualities.

After its publication in 1997, the Graded Care Profile spread to other areas and was even translated into Japanese, but its use in Luton gave a real insight when I moved there with my work. I shall remain grateful to the Luton Area Child Protection Committee (1999), and Richard Fountain (Children's Social Care service manager) in particular for formally introducing it in practice under a protocol as a multiagency tool in dealing with neglect. We evaluated its usefulness through users' feedback which showed for the first time that even the carers liked it, as it helped diffuse the tension by making all parties focus on the issues.

With widespread use in areas outside Luton, quality control became a problem. Some even sought to modify it to suit their particular needs — many of which I was not even aware of. However, some sought my permission to modify it and kept me informed but without my input. My main reason for allowing these modifications was to see if these modified versions yielded a better result. Unfortunately, for many reasons, it did not materialise. Anecdotally I was made aware of a variety of interpretations of the GCP in different areas because of lack of proper training, ongoing support and supervision. This meant that the results could also be quite variable if it was not being used as intended.

It was at this time that the NSPCC approached me seeking to carry out the first national evaluation of the tool. The initial research showed that it was found to be useful (which will be described elsewhere), but it also showed that some modifications would enhance its usefulness. This time I was glad to be involved in order to accommodate modification while retaining core properties of the GCP. Suggestions were analysed, debated, tested and — if in line with the core structure and properties — were incorporated. Along with the management of the NSPCC I am particularly grateful to Ruth Gardner, Richard Cotmore and the tireless efforts of Dawn Hodson in leading the project. Of course Richard Fountain has been with us steadfastly.

The result is the Graded Care Profile 2. I feel optimistic that it will be even more useful in delineating neglect and bringing issues to the fore so that parents and carers can work collaboratively to improve outcomes for children. All this will be done in the least adversarial manner while still identifying those cases where protection will become inevitable. It has many other potential uses, especially in the field of developmental paediatrics, which will continue to develop.

Once again I want to thank all those who helped along its journey and who, until now, have not been named.

Dr. Om Prakash Srivastava
Consultant Community Paediatrician
& Director, Paedicare and Safeguarding Limited

28 Eisenhower Road,
Shefford, Bedfordshire, SG17 5UP
omsriva@hotmail.com

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Introduction

The original Graded Care Profile (1995) is a tool designed to provide an objective measure of the care of children. The GCP model is primarily based on the qualitative measure of the commitment shown by parents or carers in meeting their children's developmental needs.

Update
The GCP2 is the updated version — building on the NSPCC national evaluation — which retains the core concepts, design and structure of the original GCP but adds value in relation to new, more accessible language. We have made sure it hasn't lost the weight of gradation but now also includes new 'items' such as obesity and online safety. We have also enhanced the guidance to make sure the tool is easier for practitioners to understand and use, and fits into the current legislative context.

Following the research it was decided that in the GCP2, the area of 'love and belonging' would change to 'emotional care', and 'esteem' to 'developmental care'. All amendments were tested by a focus group of practitioners who had training and experience in using the Graded Care Profile. Once all amendments were incorporated, the finished product was called the Graded Care Profile 2 and tested for its reliability and validity.

What the GCP2 measures
The GPC2 measures the quality of care delivered to an individual child over a short window of time (representative of the current level of care) and scales it between 1 (best) and 5 (worst). It can be used right across the continuum of need. The GCP2 doesn't explore reasons for a particular level of care, but does encourage further interpretation of the reasons at the analysis stage, which can be captured in the report or accompanying recording sheets. It is important to record the dates during which the GCP2 is completed. It is widely recognised that care can fluctuate over time, so being able to set the results of the current level of care within a short window means that when the scoring is repeated, it can reflect the improvement or not in the level of care for that particular child. This is particularly important if the tool is being used in the measurement of 'capacity to change' as described by Paul Harnett.[1]

* TOP TIP *
Encourage parents to score themselves using the Graded Care Profile.

Theoretical concept of this model

Version 2, like the original Graded Care Profile, is based on the concept of 'instinctive parenting'[2] (see Fig 1 on page 6). It is a distinct biological trait, well-known to evolutionary biologists, which all human beings have in common with other species. In evolutionary terms, there is a biologically-hardwired, powerful drive to ensure survival of the progeny to a point of independent existence.

Evolutionary biologists measure this in terms of Lifetime Reproductive Success (LRS[3]), which is calculated by 'parental investment' in terms of personal sacrifices made. This trait in humans has also been acknowledged by sociologists and has been given various names, including 'a thing called love'[4] and the 'main parenting system'.[5] For the purpose of the GCP we have used the term 'instinctive parenting strength' (IPS) and, as with any other natural trait, its strength can vary in a given population — stronger in some and weaker in others. Those with stronger 'instinctive parenting strength' would withstand the pressure on parenting more than those where it's weaker. This has also been observed in a post-war longitudinal study 'Newcastle Thousand Families'.[6, 7]

Looking at what a parent is actually doing to care for their child, and then differentiating how much parental investment has gone into providing that care can best assess this 'instinctive parenting strength'.

The instinctive parenting strength also interacts with other factors: social-environmental (poverty, debt, accessibility to support), the parent's own attributes, issues and personality (mental health issues, drug and alcohol, own upbringing, trauma), and the child. The 'net care' or what is seen as being delivered is the outcome of such interaction. It should be noted that if the instinctive parenting strength is greater, it can better withstand negative effects of these extraneous factors. We must also acknowledge the damaging effects of poverty on parenting capacity and the need to make sure services mitigate those effects as far as possible while we assess parental care.

In each case, the care is measured against the backdrop of a particular set of these contextual circumstances — called a 'steady state' or 'normal circumstances' (Fig. 1). The Graded Care Profile sets out to capture the 'instinctive parenting strength' through the proxy of the 'net care delivered' and then analyse the contextual circumstances to understand it fully.

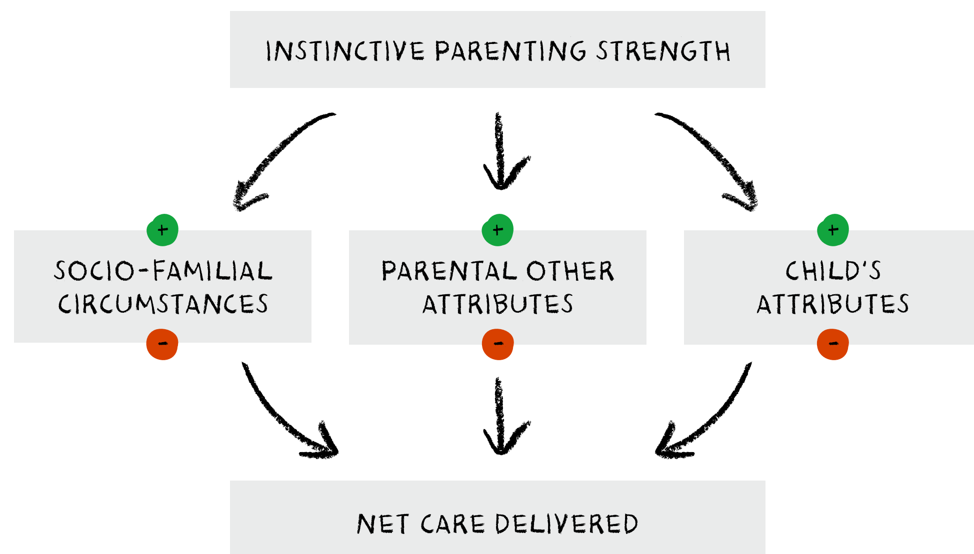
The Graded Care Profile 2 (GCP2)
Within the Graded Care Profile 2 there are five grades of care on a scale from positive to negative. The grades are based on the extent to which the needs of a child are currently being met and looks at the commitment of the parent/carer on similar principles as applied in the Newcastle Thousand Families study.[8] These grades are applied to the areas of care that relate to particular developmental needs of children based on Maslow's principles — physical care, care of safety, emotional care (love and belonging), and developmental care (care of esteem) which have been broken down into directly observable units.

The GCP2 gives a picture of the quality of care from grade 1 (excellent) to 5 (poor) in all areas of the child's needs. This allows an understanding of how these needs are being met given the family's steady state (normal circumstances), and identifies the areas in which the care is deficient and to what scale. It needs to be noted that if the family's normal circumstances (steady state) change then the grades are likely to be impacted too. These changes should be less noticeable if grades are predominantly grade 1 or 2, more so if grade 3.

In summary, the GCP2 gives a measure of care from the child's perspective in a given steady state of usual circumstances.

Maslow's theory of need
Maslow's human needs theory[9] is used as the basis for defining the child's needs (it has been updated in the GCP2 as described above). The GCP2 is not hierarchical as described by Maslow but is used because of its comprehensiveness. These areas — physical care, safety, emotional care and developmental care — are then further subdivided. These sub-areas have been drawn from findings from research and empirical evidence, emotional and developmental care are based on the principles of developmental psychology (Mussen et al[10]), and meal times on work undertaken by Bradley[11] and backed up by the work of Caldwell.[12]

Fig 1. Net care in a steady state



The scale of care
Based on the above principles, the qualitative descriptors of grades of care are outlined below. The scale is descriptive and ranges from 1 to 5: 1 being the best and 5 being the worst.

1 — **Always met**
All the child's needs are always met, and the parent goes the extra mile. The child is always first.

2 — **Met**
All essential needs are always met. The child is priority.

3 — **Met most of the time**
Most of the time the essential needs of the child are met. The child and the carer are at par.

4 — **Not met most of the time**
Most of the time the essential needs of the child are not met. Child is considered second.

5 — **Never met**
The child's essential needs are not met. May be due to intentional disregard. The child is last or not considered.

User requirements

Using the tool
The Graded Care Profile 2 can be used:

1. by professionals involved in evaluating the care of a child. In the context of neglect this could, for example, include;
   - social workers, Cafcass (children's guardian)
   - teachers, family support workers (schools and nurseries), education welfare officers or equivalent
   - health visitors, school nurses and other healthcare staff.
2. by parents or carers who want to evaluate their care of a child themselves provided they can understand the constructs and instructions
3. by young people who want to evaluate care that they received from their parent or carer.

Purpose of the GCP2
1. Where neglect is suspected:
   - to assess the current quality of care and give a base line measurement
   - to target intervention
   - to monitor progress after interventions.
2. Where quality of care is of interest:
   - in targeting resources
   - in understanding educational outcomes for a child
   - in understanding emotional or behavioural outcomes for a child.

Composition of the GCP2
The tool is made up of:

Guidance (this document)
A document that gives an understanding of the history of the tool, the underlying theory, and instructions on its administration. This guidance summarises all aspects of the GCP2 and provides instructions on how to score and use the GCP.

Handbook
A user-friendly booklet that assists with using the tool with families.

Tool
A manual explaining the grades, which includes a brief construct (description) against each observable unit to help decide the appropriate grade of care for that particular area, sub-area or item.

The summary sheet
This displays the score for the main areas and their constituent sub-areas. It gives an overview of the areas where there are concerns and areas where the parent has displayed strengths.

Score sheet A — schematic
A sheet that provides a full structure of the layout in a schematic way and serves as an index for the main report.

Score sheet B — descriptive
Provides an alternative way to record all gradings relating to a particular child and carer. You can either use the schematic or descriptive version.

Implementation guidance
Checklist and guidance for implementing GCP2.

Report template
Can be used and adapted to produce a report.

Leaflets
Explanations of the tool, available for parents and children.

* TOP TIP *

Always score what you see then interpret and explain.

Instructions for scoring

1. Be as objective as possible and try to avoid pre-judgement.
2. Make sure scores are being made, as far as is possible, in a steady state (normal circumstances) and not during a state of extreme transient upset like recent bereavement, recent loss of job, recent diagnosis of a major illness in the immediate family, and so on. If the child is ill it might be an opportunity to observe the carer's response to this.
3. When scoring for Emotional Care make sure observations are done in a state that is as far as possible representative of daily life. If the child is truly upset for reasons other than care (eg bullied at school) please revisit.
4. Make a note of concerns that need to be returned to after scoring. This shouldn't influence the scoring, which should focus on the care of the child.
5. Take account of 'extraneous factors'. For example, take note of what other agencies doing house repairs or decorations and focus on what contribution the carer has made or is making. You may want to note initiatives taken by the carer/s to get agency help.
6. If the carer is trying to mislead by deliberately giving a wrong impression or information, score as indicated in the manual.
7. Constructs are not exhaustive and prescriptive but indicative. If there's information that aligns with a sub-area or item but is not mentioned exactly in the constructs, please align such information with the item or sub-area that it most closely resembles and score the grade that it fits most closely with. For example, daily routines are not mentioned separately but could be noted in the organisation of meal times.
8. Age band stratification: some sub-areas and items are split into age bands where relevant. These are for guidance only and, if relevant, can be used for any particular age.

Who should we use the GCP2 with?
It's important to be clear about whose care and which carer the Graded Care Profile is measuring.

- The scoring is done on the current care of a child provided by a given carer. If there are a number of children in the family, the professional should decide which child should be the focus of the scoring. This could be the child who first came to notice or was referred. However, it's up to the practitioner to decide if the GCP2 should be carried out on more than one other child in the family.
- Where there is reason to believe that the care provided by one parent/carer is substantially different from the other parent/carer, each should be scored individually. Otherwise one score will represent the care of that child in that family. Minor variation in care by the other parent may be noted on the same form.

NB. While the GCP2 may focus on the care of a particular child, if you become aware of concerns about another child or children then this should be followed up in accordance with local guidelines.

* TOP TIP *
GCP2 can be used for more than one child in the family simultaneously.

Disabled children
For children with a physical or intellectual disability it is important that the practitioner undertaking the GCP2 has a good understanding of the child's particular needs and what the parent should be providing. As the GCP2 captures the actual care provided to a child, their ability or disability should not be a barrier to an assessment as long as it is realised that some children with disabilities cannot care for themselves even when they are older. This applies particularly in the sub-area Hygiene within the Physical area of care for those children who require intimate care.

For those children with diets associated with their needs, this is covered as an item in the assessment.

You then work through the tool as normal, observing the parents' quality of and commitment to provide the care, based on that child's individual needs. There may potentially be areas which cannot be completed depending on the individual child's disability but this can be explained in the report.

For those children with emotional or behavioural challenges, the GCP will allow the practitioner to observe what the quality of the care provided is. Any issues with the care potentially being perceived as too harsh (level 4 etc) can be explained as part of the report.

Scoring methods

- Qualitatively, the grades of the GCP2 cover a continuum from best care to worst. Grade 1 is the best, 2 is satisfactory, 3 is adequate (but can vary more easily than other grades), 4 is unsatisfactory, and 5 is the worst level of care.
- The main way to gather information is by observing. However, evidence could also be gathered from health records or professionals (eg non-attendance, immunisations, health surveillance), but the quality of the information should always be noted on the report. Make sure all information is based on reliable sources.
- The assessment and gradings should be fully explained to the parent/carer. If the child is of a suitable age and understanding, fully explain to the child too.
- Go through each unit of scoring one at a time. Review the observation against the description in the relevant construct, score to the one that is closest.
- Where any unit cannot be scored because of a lack of reliable information, review, but don't guess.
- Only score the behaviour observed by you or another professional within the relevant dates.
- When feeding back to the parent/carer explain what information you have and how the score has been decided. If there's disagreement about the information, note it down but score on information that you have. If in doubt, recheck the source.
- Always score as you observe. If there's important contextual information that you think gives another view, note this down (see section on interpretation). Sometimes this may feel unjust due to circumstances. If this is so, write your reasons why in the comments for analysis.
- Where there's no credible information, it's better to leave units unscored than to score based on assumption. Complete the rest of the GCP2 leaving those unscored areas blank for completion next time in order to proceed with intervention, which is deemed more important.
- Home visits are necessary to gather some information such as safety, housing, nutrition, and so on. Practitioners may even like to undertake unannounced visits.
- It's vital that information for scoring is based on credible evidence. This can be from many sources and incorporated into the grading as long as the source of the information is credited.
- Individual practitioners can undertake GCP2 but support can be sought from colleagues or managers.

Scoring — Using the GCP2
Areas of care are as follows:

- Area A: Physical care
- Area B: Safety
- Area C: Emotional care
- Area D: Developmental care

Sub-areas are denominated by numbers. For example, Nutrition is sub-area 1.

Items are also denominated by numbers. For example Quality is 1.

So, putting those together, an example would be A1.1, where the area is Physical care (A), the sub-area is Nutrition (1) and the item is Quantity (1).

Area | Sub-area | Item

A1.1

Once the items are scored, the following system can be used to derive the score for corresponding sub-areas, and then in turn for areas:

- Look at the spread of scores for items within a sub-area.
- If any item score is above 3 (4 or 5), that will supersede other scores and will be the score for that sub-area. This is to ensure that the areas of actual or potential risk to the child are highlighted. Positive scores will still be there in the full reference scheme or individual summary sheet to encourage the carer.
- If scores are spread from 1 to 3, use the mode (most frequently occurring score).
- If there are two numbers that appear (such as 2,2 or 3,3) use the highest number of those that most frequently occur. In this example it will be 3.
- If there is no clear mode and scores are spread from 1 to 3, use the higher score (3 in this case).

Simply put, if the scores are between 1 and 3, use the most common score. If there is a 4 or 5, use the highest score. This method is the same when scoring the items to give a sub-area score and for the sub-areas to give an area score.

Area

Grading for an item of a sub-area.

The reason for the N/A should also be noted.

Sub-area of greatest concern.

Overall grade is recorded here.

A Physical

Sub-area	Item	Item	Item	Item	Item	SUB-AREA SCORE	AREA SCORE
A1 Nutrition	4 1.1 Quality	2 1.2 Quantity	N/A 1.3 Specific diet	3 1.4 Preparation	4 1.5 Organisation	4	
A2 Housing	4 2.1 Facilities	4 2.2 Maintenance	5 2.3 Decor			5	
A3 Clothing	1 3.1 Weather appropriate	2 3.2 Fit	2 3.3 Look			2	5
A4 Hygiene	1 4.1 Hygiene					1	
A5 Health	3 5.1 Seek	3 5.2 Follow up	3 5.3 Checks	N/A 5.4 Disability		3	

Sub-area

item

Illustrations for scoring
For the area you're scoring, record your results on the reference scheme document as you go along. As an example, the above diagram shows the results for the area of Physical care.

Sub-area: Nutrition

Items: for Quality there is a score of 4, Quantity a score of 2. The child does not have a disability that requires a Specific diet so this has been recorded as N/A. For Preparation the score is 3 and for Organisation the score is 4.

When the scores are 1, 2 or 3, record the most common number. If there's an equal number the highest should be logged.

When the score is 4 or 5, record the highest number in the sub-area rectangle.

So, as the Quality and Organisation items have been scored as a 4, the overall rating for the Nutrition sub-area is 4.

When each of the sub-areas has been scored, the same process is applied for the area score. If there are some sub-areas or items that can't be scored, the scoring should be based on the information available but the reason for the N/A should also be noted.

So as the sub-areas scored the following:

- Nutrition: 4
- Housing: 5
- Clothing: 2
- Hygiene: 3
- Health: 3

The overall grade for the Physical care area for this particular child is 5.

So you can see that for this child, there are some concerns in relation to Physical care as shown by the area score of 5.

The sub-area of greatest concern is for Housing as that also has a score of 5.

Within the Housing sub-area, Decor is of greatest concern, so for this child the house they are living in is dirty, filthy and in need of complete redecoration.

On the positive side, the child has appropriate clothing for all weather conditions, with a good look and fit.

Interpretation of the GCP2

Contextual information
All care should be graded as observed. However, the practitioner may need to note other important contextual information or concerns to make a hypothesis. Some of these could be:

False positives
Grooming for sexual abuse may be suspected if the care observed between individual children is substantially different. For example, some children score 4s or 5s and one particular child scores 1s or 2s; and the practitioner observes behaviour that may lead them to suspect sexual grooming is happening. The GCP2 is not the main tool or route for this work and alternate analysis and enquiries will be required.

Diagnosed behavioural issues
A small minority of children may have behavioural issues due to diagnosed medical issues. The carer's behaviour or care delivered may be seen to be necessary in the context of the child's needs, however the grading should always be scored as seen and then explained in the analysis. It's vital that the quality of care is not mitigated at the point of scoring.

Adult concerns
Parental issues can impact on the quality of care they deliver. These are issues such as parental learning difficulties, domestic abuse, parental substance misuse and parental mental health issues, which aren't measured within the GCP2. The practitioner may become aware of these during home visits. It's vital to note these issues as they will assist in understanding where to focus the work with the family. As always, the scoring should only be based on the quality of care delivered by the parent and then explained in the analysis in the report produced.

It's important to view the scores in their totality — this will help to explain the overall standard of care the child is experiencing.

Score profiles
Scores can be:

- uniformly good or satisfactory (all grades either 1 or 2)
- uniformly unsatisfactory or bad (all grades either 4 or 5) which may require an immediate response
- uneven — (where scores are spread right across the scale, from 1 to 5). Professionals need to decide a suitable response and particularly what immediate actions are possible and should be taken to improve areas of grade 4 or 5
- uneven (grades of 3 to 5). If the uneven spread is from 3 to 5 this will denote clear and serious concerns.

Analysis
All areas, sub-areas and items need to be reviewed taking into account the family context and history which is best taken from any relevant chronology that is available. This will help with the development of any suitable plan. Areas of strength will also be highlighted as they could potentially be used as areas to build the work with the family from.

The GCP2 does not review the reasons for poor care, which may include parental learning disability, parental drug/alcohol misuse, parental mental illness or domestic abuse/violence. These may also need their own assessment to review the level of risk — for example, using the Domestic Abuse Stalking and Harassment tool (DASH).

Once the GCP2 is analysed and the quality of care delivered is understood, this should be viewed alongside the family's context and history. This will help you understand the potential reasons for the neglectful parenting and help with the development of a suitable and targeted plan.

Levels of application
The GCP2 can be used to assist with the following.

1. Prevention: it can be and has been used by universal services like health visitors for children where there is suspicion of neglect. The GCP2 would show in which area(s) care is deficient (for example, uneven with some grade 4) which should be targeted for improvement before neglect becomes entrenched.
2. Timely referral: where there's an uneven care profile (grades 4–5) and the carer seems to be engaging, the work on improvement should continue. However, if care grades deteriorate or remain static, then a referral to social care should be made promptly to avoid a drift.
3. Prompt action: where neglect is suspected and the GCP2 shows mostly grade 5, cases need to be referred promptly to minimise harm or escalated up for legal advice.

At all stages, the GCP2 will help to identify strong areas of parenting that can help to engage the family as a basis for constructive joint work.

Using the GCP2 with other assessments

The GCP2 itself doesn't review or collate the causes that may have led to suboptimal parenting, but it does provide an excellent way to measure and scale the quality of care delivered whilst keeping the child at the centre. It therefore works well alongside assessments such as single, CAF, IA or S47. It can be used at all levels of the spectrum of need as already discussed.

National definitions
Working Together 2015 describes neglect as:

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Working Together also states that the assessment of neglect cases can be difficult as neglect can fluctuate both in level and duration. Practitioners should rigorously assess and monitor children at risk of neglect to make sure they're adequately safeguarded over time and plans should be reviewed regularly to analyse whether sufficient progress has been made to meet the child's need.[13]

The GCP2 can be used to support you with your roles as defined in *Working Together 2015*.

Local Safeguarding Children Board guidance
For the purpose of clarity, each Local Safeguarding Children Board area needs to agree locally how to respond at each level. However, the authors have agreed that some guidance would be useful. This is provided on the opposite page based on the work undertaken by Diane DePanfilis.[14] This has been amended for the UK setting.

GCP2 GRADE	DESCRIPTION	RESPONSE
1, 2	**No neglectful parenting** Consistent good quality parenting where the child's needs are always paramount or a priority.	Normal universal access: further assessment as and when indicated.
3	**Mild neglect** Failure to provide care in one or two areas of basic needs, but most of the time a good quality of care is provided across the majority of the domains.	Usually does not warrant a report to the Local Authority, but might require a single agency targeted short-term intervention or potentially CAF until resolved. May escalate if care deteriorates.
4	**Moderate neglect** Failure to provide good quality care across quite a number of the areas of the child's needs some of the time. Can occur when less intrusive measures such as community or single agency interventions have failed, or some moderate harm to the child has or is likely to occur (for example, the child is consistently inappropriately dressed for the weather — wearing shorts and sandals in the middle of winter).	This requires a multi-agency co-ordinated intervention, potentially with a CAF or at CIN level (or similar) for further support where needed. All cases need formal monitoring for referral to children's services if they don't improve. If there's evidence of no improvement, if associated with substantial risk factors, or where care is grade 4 in most areas, a referral should be made from the outset. May also be managed at CP level parents aren't engaging with work or there have been concerns for a substantial period of time.
5	**Severe neglect** Failure to provide good quality care across most of the child's needs most of the time. Occurs when severe or long-term harm has been or is likely to be done to the child or the parents/carers are unwilling or unable to engage in work.	Where care is grade 5 in more than one area, a referral to children's services will be required. If the child is subject to child protection arrangements then the GCP2 should be repeated for each review, or as agreed. If this persists across a period of time or care is grade 5 in all areas, then discussion about a legal option may be required. The GCP2 can be used as part of the evidence for legal planning.

Conclusion

This guidance and theory booklet provides background, underlying theory and instructions on how to score and use the updated GCP2 tool. For more specific guidance on grading each area and interpreting results, please refer to the practitioners' handbook.

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The GCP2 is the only authorised and fully tested update of the original GCP. It is a more user-friendly and comprehensive tool that helps professionals with their assessment and subsequent work with families. But it keeps the original principles and values — ensuring that it retains its integrity in the way it scales and supports work with families.

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