Safeguarding and Promoting the Welfare of Children

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Introduction

1. All NHS organisations and staff have a responsibility to ensure that safeguarding and promoting the welfare of children and young people is an integral part of all their work. This includes where health or social care workers are working directly with a child but also where they have knowledge, information and understanding (e.g. through working with a parent, carer or significant adult) that is relevant to the protection or development needs of a child and wherever else they can contribute to a child’s safety or welfare. Our overall aim as a Trust is to ensure we have a culture that integrates safeguarding and the promotion of children’s welfare in the work of all clinical and non-clinical teams and departments.

2. Adult and children’s mental health staff should have knowledge and understanding of the risks of (for example) neglect, emotional abuse, Child Sexual Exploitation, Female Genital Mutilation (FGM), risks of radicalization to children and young people (PREVENT) substance misuse and domestic violence. They also have responsibilities to identify and ensure the wellbeing of young carers. Assessments of child welfare and risks will often require multiagency involvement and practitioners should have a sufficient understanding of multiagency responsibilities to protect and promote the welfare of children. Adult mental health services have responsibilities to consider the needs of children and young people as part of their assessments and direct work with adults in the context of whole-family/’Think Family’ approach. This includes supporting the parenting and caring capacity of adult service users. This Policy is designed to support all Trust staff in fulfilling these legal, policy and professional responsibilities.

3. This policy will be shared with the Local Child Safeguarding Boards in Wandsworth, Merton, Kingston, Sutton and Merton. Feedback from the Boards may be used to amend the policy. If there is any discrepancy between this policy and LSCB policy in a particular locality, the LSCB policy will prevail.

Purpose

4. The aim of this policy is:
   - To clarify the statutory and policy responsibilities of the Trust with regard to child safeguarding and promotion of child welfare
   - To provide the policy framework for the actions to be taken when there are concerns about children and the processes for sharing and escalating concerns.
   - To describe the training, knowledge and resources required to ensure staff can protect and safeguard the welfare of children, including the unborn child.
   - To clarify the roles and responsibilities of the Executive and senior management leads, Named Professionals and all Trust staff.
   - To set out agreed ways for managing risk to children who are service users or related or connected with service users, and support for parents
   - To set out how the Trust will provide specialist advice and support
   - To show how the Trust will incorporate learning into its practice

Children and Young People affected by this Policy

5. This policy applies to the following (this is an indicative not an exhaustive list):
   - Unborn children of service users who are pregnant or are expectant fathers.
   - All children and young people up to age of 17 who are service users of South West London and St George’s Mental Health NHS Trust or their siblings
   - Children who are the offspring of service users whether living in the same household or not
• Other children and young people up to the age of 17 whom Trust staff encounter in the course of their work who may be at risk of harm from Trust service users or others
• Children who live in households shared with, or visited by, service users
• Any child who may be currently in contact with a person whom a service user has disclosed as an abuser
• Children at risk of harm from Community based violence such as gangs, group and knife crime, abuse through sexual exploitation or through radicalisation (see also 'Prevent' policies)
• Girls and young women at risk of female genital mutilation

Legal and Governance Framework.

6. The United Nations Convention on the Rights of the Child (UNCRC) is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children’s rights to expression and receiving information

7. All public sector organisations in England have a duty to:
• Take all reasonable measures to ensure that they minimise risk of harm to the welfare of children
• Take appropriate action when there are Safeguarding concerns, by working to agreed local policies and procedures, in full partnership with other agencies

8. Local Authority (LA) Children’s Social Care have key legal powers to protect children. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in order to safeguard children. Local authorities have a duty to investigate where it has reason to suspect that a child is suffering or likely to suffer significant harm.

9. Section 27 of the Children Act, 1989 provides that a Local Authority may request help from any NHS Trust (and other bodies). Section 47 of the Children Act, 1989 places a duty on any NHS Trust (and other bodies) to help a Local Authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, unless doing so would be unreasonable in all the circumstances of the case.

The Principles of the Children Act, 1989 are:
• The welfare of the child is paramount
• Children are generally best looked after by their own families
• The child and family race, religion and culture must be taken into account
• Children have a right to be consulted about decisions affecting them
• Children's wishes and feelings must be taken into account
• Delay in decision-making is harmful for children

10. The Children Act 2004 requires each local authority, health and partner agencies to make arrangements to promote cooperation between the authorities, each of the authority’s relevant partners. The arrangements are made with a view to improving the wellbeing of children in the authority’s area – which includes protection from harm or neglect alongside other outcomes (section 10). The Children Act 2004 (section 11) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged with regard to the need to safeguard and promote the welfare of children.

11. More recent legislation and guidance outlines the responsibilities of all agencies, including adult mental health, CAMHS and addictions services. This is set out in Working Together to Safeguard...
Children, a guide to inter-agency working to safeguard and promote the welfare of children. (HM Government 2013).

12. Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children, (HM Government March 2015), defines safeguarding children and young people, and promoting their welfare, as

- Protecting children from maltreatment
- Preventing wherever possible impairment of children’s health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and
- Taking action to enable all children to have the best outcomes.

13. The guidance states “children are best protected when professionals are clear about what is required of them individually, and how they need to work together.”

14. The London Safeguarding Procedures 5th Edition (May 2015) are to be followed by all agencies and outlines the roles and responsibilities of staff working within mental health trusts. There is a section on the intranet under ‘Policies and Procedures’ where the London Safeguarding Procedures and a range of other documents are located.

Compliance priorities for the Trust

15. South West London and St Georges Mental Health Trust has statutory responsibilities under (amongst other legislation) Section 11 of the Children Act 2004, and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to protect children from harm. The latter introduced new fundamental standards from April 2015 that all providers of regulated health and social care must meet. These standards underpin the Care Quality Commission’s (CQC) safeguarding standards (Statement on CQC’s roles and responsibilities for safeguarding children and adults June 2015)

16. The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

17. The CQC essential standards Outcome 7 describes the responsibilities for ensuring that service users are safeguarded from abuse as detailed below:

The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of—
(a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and
(b) responding appropriately to any allegation of abuse.

18. Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or restraint being—
(a) unlawful; or
(b) otherwise excessive.

19. For the purposes of paragraph (1), “abuse”, in relation to a service user, means—
(a) sexual abuse;
(b) physical or psychological ill-treatment;
(c) theft, misuse or misappropriation of money or property; or
(d) neglect and acts of omission which cause harm or place at risk of harm.
Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
20. The 2015 CQC fundamental standard states that care or treatment (of children or adults) must not:

(i) discriminate on the grounds of any of the protected characteristics of the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation)
(ii) include acts intended to control or restrain an adult or child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint
(iii) be degrading to the adult or child
(iv) significantly disregard the needs of the adult or child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

21. In response to new threats to the safety of some children and adults, a number of Organisations named in law including NHS Trusts and Foundation Trusts, have been given a statutory duty to have regard to the need to prevent people from being exploited, radicalised and drawn into terrorism under the ‘Prevent’ strategy. The strategy includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

Leadership of child safeguarding

22. The Trust provides Trust wide leadership and practice advice on child safeguarding through ensuring

- an Executive Director is appointed to provide Board leadership
- a senior manager is appointed to provide practice and policy oversight
- a lead nurse/practitioner and lead doctor are available for direct advice and practice leadership.
- Service Directors provide local senior management leadership, including representation on the Local Safeguarding Children’s Boards
- Directorate/Borough and team practice leads for child safeguarding are appointed to ensure local compliance and good practice.

23. Safeguarding is embedded in the Trusts risk and safety governance system. The structure chart below shows the Trust’s current governance system.
24. Senior, Interagency and External Accountability

The Trust Board is accountable for safeguarding children within the Trust.

The Trust is accountable to Local Safeguarding Children Boards LSCBs in Merton, Sutton, Kingston, Richmond and Wandsworth

The Trust has a duty to:

- Provide senior representatives on the five LSCBs and to associated LSCB sub groups which are identified in each individual borough.
- Contribute to Serious Case Reviews ensuring the single agency investigation process is integrated with SUI processes and that SCR timescales are met;
- Embed learning from Serious Case Reviews;
- Ensure that staff are trained with regard to their responsibilities for safeguarding children;
• Ensure that in all risk assessments of service users, the needs and vulnerabilities of any children associated with the service user are considered;
• Ensure that appropriate referrals are made to Children’s Social Care when there are child protection concerns;
• Ensure that ‘children in need’ are referred to Children’s Social Care or assessed under the CAF;
• Ensure that staff contribute to child protection processes and share information in line with statutory requirements.

The CAMHS Consultants in each of the boroughs provides the role of Clinical Lead for safeguarding and attend the local Safeguarding Children Board meetings. The Borough Service Directors attend as the Senior Manager Representatives. These roles are supported by the CAMHS Team Leads in each borough who attend the Quality Assurance sub groups, supported by the Named Nurse.

Internal governance

The Trust Safeguarding Children Group meets bi-monthly and oversees the Trust’s statutory responsibilities for safeguarding children. It communicates and makes links with other committees and groups in the Trust Governance Framework. The Safeguarding Children Group is chaired by the Named Nurse for Safeguarding Children on behalf of the Trust Medical Director. This group’s responsibilities include:

• Monitoring the progress and learning from local Serious Case Reviews.
• Reviewing local and national trends and policy change.
• Contributing and reviewing local Section 11 audits and CQC/Ofsted inspections
• Contributing to the annual Trust report for Safeguarding Children.

Specialist Advice and Support for Practitioners

This is available from the Borough/Directorate child safeguarding leads and from the Named Nurse and Named Doctor. Their role includes advising on:

• Information gathering, record keeping, risk assessment and management;
• Inter-agency working and information sharing;
• Decision-making and the management of referrals to Children’s Social Care;
• Preparing reports for, and attending Child Protection Conferences;
• Staff member’s role when service users are involved in any type of court proceedings regarding children;
• Safeguarding children/child protection issues for unborn children and care planning for pregnant women if appropriate;
• All issues regarding children with which staff require support;

The Safeguarding Children Named Professionals are also involved in direct inter-agency liaison work including:

• Child protection allegations against members of staff;
• Multi agency Public Protection arrangements (MAPPA);
• Domestic abuse panels (MARAC);
• Links with acute hospital services
• Joint training and safeguarding events.
25. Ratification process

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Trust staff roles, responsibilities and duties

Staff must consider and assess the needs of children and the support needs of their parents on a routine basis whether or not there are immediate and obvious child protection concerns. This must be in line with the CQC standards and other relevant legislation and guidance.

26. Processing Referrals

When assessing referrals and case allocations, staff should routinely record core information regarding children for whom a service user has parental responsibility whether or not they live with their children. The most recent RiO protocol should be followed to capture basic details including:

- Name
- Gender.
- Date of birth/age
- Relationship to service user
- Where children live if not resident with service user
- Expected date of delivery for pregnant woman
- Health Visitor (for children under five)
- School/nursery
- GP
- Whether children are known to local authority Children’s Social Care and whether they are or have been subject to a Safeguarding plan.

This must be recorded on the RiO system on the Safeguarding Children forms using the latest Safeguarding the Welfare of Children Protocols

Staff should also:

- Assess whether there are any Safeguarding concerns or family support needs that may warrant a discussion with other agencies involved or referral to local authority Children’s Social Care
- Assess whether the service user’s illness is or may have a detrimental impact on their parenting capacity.
- Consider whether the child/children are providing unacknowledged support to the service user, without which the service user's condition would be liable to deterioration e.g. children take on additional chores, impacting on school attendance, accompany parents to appointments or activities etc.

Where safeguarding concerns are identified, referrals must not be closed or redirected until the safeguarding issues have been discussed with the referrer and a plan for the management of the referral agreed
27. Mental Health Act (MHA) Assessments

Assessment of parent/adult in family

Consideration for the protection of other persons must include the impact on the welfare of any children if their parent is admitted to hospital.

Where possible, the presence of children should be ascertained before the assessment and LA Children’s Social Care involved in planning the assessment if there are likely to be childcare needs, whether or not admission to hospital is required.

It is good practice to take account of the views of children and any information that they may have about the parents’ illness. Research shows that service users and children benefit if children are given an explanation about their parent/relative illness, the role of professionals, what is happening and what will happen next.

Children must not be left unsupported with caring responsibilities if the service user is not hospitalised.

Identified young carers should be referred to children’s social care and to relevant young carers’ services within the Borough of residence

Staff should make a referral to local authority Children’s Social Care if the family needs additional support.

Staff should ensure children have not been left at school, nursery or elsewhere waiting to be collected if a parent is detained and transported to hospital.

If there is a delay in carrying out a Mental Health Act assessment staff must ensure that the welfare of children is not compromised and that they are safe and supported in the meantime.

All staff involved in MHA assessments should take account of the relevant parts of the MHA Code of Practice 2015 statutory guidance.

28. Assessment of children under the MHA

Staff referring for or carrying out an assessment of a child and arranging admission (or a less restrictive alternative) under the MHA must refer to relevant parts of the Code of Practice 2015 which is statutory guidance for all Trust staff.

If a child or young person under 18 is detained under the MHA or admitted informally, the MHA Code of Practice 2015 guidance must be followed, and further advice sought if needed, with regard to the application of relevant legal authority (MHA, Mental Capacity Act 2005 for 16 and 17 yr olds, the Children and Families Act 2014 (and relevant other children’s legislation) to restrict or deprive a young person or child of their liberty and/or require them to receive treatment, care and support within the inpatient ward. Staff treating young people and children on inpatient wards must be trained in relevant legislation, statutory guidance and its application.

29. Risk Assessments

Staff should have open discussions with an adult service user receiving Trust services about any potential risk to children arising from their illness or addiction. Consideration should be given to the level of insight service users have about the impact of their illness on their children including any actual or potential risk.
Risks will vary according to the age of the child and research shows that children under four, especially infants, are particularly vulnerable. The potential impact of puerperal psychosis should be considered when working with pregnant women or women with infants.

All risk assessments must include an assessment of any current or potential risk to children in the household and/or in the wider community or to future children. Risks that should be considered include:

- Risks of injury to a child as a result of aggressive or dangerous behaviour by an adult
- Child involvement in adult delusional state
- Neglect especially of children under five
- Impact on child emotional state
- Living in a household where there is domestic violence

Information must be clearly recorded in the risk assessment. Identified risk and relevant actions required must be reflected in the service user Care or Management Plan.

If the service user lives apart from their children, staff must endeavour to find out the extent of the contact and whether it constitutes any risk.

If identified risks could lead to actual or potential significant harm to children staff must make a referral to local authority Children’s Social Care and provide full written information about the risks identified.

**Multi Agency Information Sharing and Referrals.**

The Multi Agency Safeguarding Hub (MASH) OR Single Point of Access (SPA) in each Local Authority provides:

- Single point of contact for all agencies with regards to safeguarding children concerns.
- Share information and intelligence rapidly and efficiently.
- Early multi agency response and feedback to alerts of possible harm/safeguarding/welfare concerns.
- More effective multi agency interventions.
- Improved audit and base lining

All Trust clinical teams should have information and access details for the local MASH or SPA (or other direct referral point) and information on the local escalation policy if a referral is urgent and/or no timely response is forthcoming from the local authority.

### 30. Needs Assessments of adults who are parents

Staff should consider service user’s parenting support needs. Staff should discuss with the service user their own concerns about how their illness is affecting their confidence and functioning as a parent and any support they may need in their parenting role.

Staff should discuss with the service user about their perceptions of how their illness is affecting their children and in what ways. If the service user does not live with their children staff should discuss with them how they perceive this arrangement is affecting them and their children.

Adults with parental responsibility requiring support to maintain their parenting role (i.e. to maintain their family and to care for a child) should be offered an assessment by the local authority under the Care Act 2014. The local authority is obliged to carry out a needs assessment when they become aware that someone may be in need of care and support. Trust staff should support parents to be referred or refer themselves for social care assessment and support where appropriate.
31. Contingency and Emergency Planning for Adults with child care/parental responsibility

Staff should discuss and clearly record details of who will look after the children in the case of emergency. They should satisfy themselves, in collaboration with other agencies that the proposed arrangements will keep the children safe and well.

Staff should provide, as needed, information and support for alternative carers and children about what is happening to their parent/relative.

If there are no appropriate family members available, staff should engage in a joint planning process with LA Children’s Social Care about arranging emergency foster care.

The Local Authority Private Fostering Team must be informed by law if the alternative carers are not close relatives as the situation may constitute a private fostering arrangement. If it is an emergency placement such as in response to a Mental Health Act assessment, notification should take place within 48 hours. In all cases, the Private Fostering Team must be notified within 6 weeks of the placement starting.

In these circumstances, staff should seek advice from a Trust Staff Named Professional.

32. Potential Risk of Harm to an Unborn Child

The needs of pregnant women and their unborn children must be considered at the earliest opportunity whether or not there are immediate Safeguarding concerns.

Staff should consider pregnant service users as well as male service users with a pregnant partner or other service users in close contact with a pregnant woman.

In order to address any needs a multi-agency planning meeting should be convened.

If one or more of the criteria set out below are met staff should make a referral to LA Children’s Social Care for them to instigate the meeting. It will be chaired by an LA Children's Social Care Manager.

- There has been a previous unexplained death of a child whilst in the care of either parent
- A parent or other adult in the household has committed an offence on the Government list of offences posing a risk to children (formerly known as Schedule 1 offender)
- A sibling in the household is subject to a Safeguarding plan.
- A sibling has previously been removed from the household either temporarily or by Court order Domestic violence is known to have occurred
- The degree of parental substance misuse is likely to significantly impact on the baby safety or development
- The degree of parental mental illness/impairment is likely to significantly impact on the baby safety or development
- There are concerns about parental ability to self-care and/or to care for the child e.g. unsupported young or learning disabled mother
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricated or inducing illness in a child

For further information on pregnant women and expectant fathers refer to the London Safeguarding Procedures 4th edition. (2011)

33. Outpatients Arrangements for Service users with Children

Staff should consider the child care arrangements of service users when offering appointments. If service users need to take or collect children from school these times should be avoided if possible.
Staff should be aware in advance of whether a service user may need to bring a child with them to an appointment and have arrangements in place as to how to deal with this situation that are agreed and understood by all relevant staff.

If children are brought to an outpatient area consideration should be given as to the suitability and safety of the environment for children and clear expectations provided about the supervision of children.

34. Children Visiting Relatives in Hospital

Inpatient services should have suitable and safe designated space for visits by children to take place. Staff should ensure that any visits by children to inpatients are in the child best interests. This should be assessed or discussed with specialist children staff.

A Child Visiting Plan must be discussed and recorded and placed in the service user notes. For further information about child visiting procedures refer to the Trusts Child Visiting Policy (TWC04)

35. Arrangements when on s17 (MHA) leave from hospital or visiting home during an informal admission

Staff should discuss with service users where they will be staying when they are on leave/visiting home and whether they will be caring for or in contact with children. Through discussion with the service users, the leave/home visiting plan should consider the potential impact on children and must be clearly recorded in the service user notes.

If a service user does not usually reside with their own or other children, assessments should be made as to whether they are likely to be visiting or staying in a household with children and whether this poses any risks or practical problems for the household.

Staff must ensure that leave/home visiting arrangements are shared with other agencies as appropriate and comply with plans made at Child Protection Conferences or as part of local authority Children's Social Care assessment plans.

36. Discharge from hospital and from care of the Trust

Discharge arrangements – whether return home from hospital or full discharge from Trust - must take account of any impact on children in the family, household or wider community. There must be a clear discharge plan that evidences this.

Before closing a case or transferring a case to another team, staff must consider any impact on the children or unborn child if the service discontinues contact with the family. If local authority Children’s Social Care are involved in the case they must be invited to any transfer or closure/discharge meeting and be sent a copy of the discharge report

Discharge planning meetings for full discharge from Trust care should routinely include local authority Children’s Social Care staff, if they are already involved with the family. If there is a child under five, the health visitor should be invited. Schools may also need to be informed of the discharge of a child parent/carer. Discharge letters should be copied, with the service user's knowledge, to relevant health and social care children professionals involved with the family.

Where safeguarding concerns are identified or there is a Child Protection or safeguarding plan, cases must not be closed or discharged from Trust care independently by CAMHS or adult mental health services. If children are subject to a Safeguarding plan, staff should ensure transfer or closure plans are discussed and agreed first with the Core Group and/or with the Social Worker involved with the family, also the GP

Staff should ensure that there are appropriate family/parenting support services in place if necessary.
Post-discharge, mental health services should remain involved in the safeguarding process where appropriate.

Discharge letters should be copied, with the service user's knowledge, to relevant health and social care children professionals involved with the family.

37. Young Carer Assessments

If a service user has children under the age of 18 staff should discuss with the service user and directly with the young person whether the child/ren/ are carrying out any caring responsibilities towards their parent(s), sibling(s), grandparents or other relatives.

Staff should assess the impact this caring role has on their own development, education, leisure activities etc.

Children under 16 with caring responsibilities are entitled to a Child in Need Assessment carried out jointly with local authority Children's Social Care. Staff should discuss this option with the family and make a referral when required. Young people over 16 with caring responsibilities are entitled to a Carer's Assessment.

Staff should consider applying for Carer Grants to support the children.

Staff should find out about borough young carer groups and offer to facilitate the child or young person to attend.

38. Information Sharing

It is recognised that Information sharing and patient confidentiality is a challenging issue as staff and can be unsure about what information they can legally share. It is best practice to discuss with service users, any concerns and any intention to share information, unless by doing so there would be increased risk to a child or children.

Staff can share confidential information with the service user's consent and without consent if the information is in the public interest. Risk to children is covered by the public interest exemption.

The Government has produced guidance for all practitioners to follow which promotes integrated working to improve outcomes for children and young people. This also applies to practitioners who work in services provided for adults, for example mental health services and drug and alcohol services, as many of the adults accessing those services may have parenting or caring responsibilities.

Where a member of staff has serious concerns about the immediate health and wellbeing of an individual or others that might come into contact with that person, then guidance on sharing personal information with another organisation without the individual's consent must be sought in the first instance from a line manager.

Where the risks to the individual or another person are considered so great, and/or the individual is either unwilling or unable to give consent to disclosure, then the member of staff or line manager, acting in good faith, should disclose this personal information to the relevant organisations immediately. Failure to do so might be viewed as failure of the organisation that is aware of the risk to discharge its duty of care, particularly if there is resultant harm.

Staff should always record on the service user’s notes the reason for disclosing information and whether disclosure was with or without the service user’s consent. Information shared with other agencies must be as factual as possible and provide evidence and sources of information. It should be discussed with the service user unless doing so would put a child at further risk of harm.
Child protection and Safeguarding concerns take precedence over confidentiality considerations and worries that staff may have about potential damage to a therapeutic relationship.

Advice should always be sought from team managers, members of the Safeguarding Children Team or the Trust’s Caldicott Guardian who is legally responsible for the Trust’s compliance with information sharing guidance.

39. Dealing with Differences of Opinions

If Children’s Social Care services decide that an initial Child Protection Conference is not required but Trust staff remain seriously concerned about the safety of a child, they should seek further discussion with the social worker and their manager. Staff should involve their manager and one of the Safeguarding Children Team and the trust escalation protocol should be applied.

Concerns, discussions and any agreements made should be recorded in the service user’s notes.

If concerns remain, a member of the Safeguarding Children Team, formally request that Children’s Social Care convene an initial child protection conference in accordance with the London Child Protection Procedures.

If this approach fails to achieve agreement or where differences of opinion across agencies occur about risk the procedures for resolution of conflicts in the London Child Protection Procedures should be followed.

Where differences of opinion occur within a Trust multi-disciplinary team advice should be sought from the Trust’s Safeguarding Children Team. If necessary, the situation will be escalated to the Executive Lead for Safeguarding Children.

40. Serious Case Reviews

Working Together to Safeguard Children (HM Government 2013) sets out criteria for the circumstances for when Local Safeguarding Children Boards should instigate a multi-agency serious case review (SCR).

A SCR is held when a child dies or sustains serious injury and there is suspected or actual child abuse or when there is a child protection issue with a major public concern.

The purpose of a serious case review is to:
- Establish where there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result, and hence
- Improve inter-agency working and better safeguard children

Each agency involved in the case must carry out an internal management review (IMR) to contribute to the overall serious case review. The Trust’s IMR will be carried out by a Serious Incident Panel chaired by one of the Named Professionals.

The Trust’s Safeguarding Children Named Professionals oversee the process and will be the main Trust link with the LSCB. All IMRs are collated and analysed by an independent author, commissioned by the LSCB. They will write an overview report for the LSCB which may contain recommendations for the Trust not previously identified in the Trust IMR.

The implementation of Serious Case Review Action Plans will be monitored through the Trust Serious Incident Governance Group and the Quality Governance Department..
41. Training Needs

In order to ensure the health, safety and well-being of our service users and staff, the Trust aims to address the needs and impact of its corporate, mandatory and statutory training with a comprehensive and robust training needs analysis procedure. To this end, all Trust procedural documents which have risk management training needs for permanent staff are included in the ‘Training and Development Policy and Training Needs Analysis’ document as managed by the Training and Development Department. This document is available on the Trust intranet, under ‘Training and Development’.

Duties within this area are as follows:

Author  
Responsible for informing the Training and Development Department of amendments to policy training needs

Ratification Body  
The ratification body is responsible for ensuring all permanent staff are adequately trained as appropriate to the employee’s duties and work location and to follow up on refresher training needs.

Staff responsibility  
To ensure they attend all relevant training as detailed in their induction and annual development review

Training and Development Department  
To provide access to training for all permanent staff. To maintain monitoring, reporting and review systems as per the ‘Training and Development Policy and Training Needs Analysis

Statutory government guidance in Working Together to Safeguard Children (para 2.52) requires NHS Mental Health Trust staff to be “trained in how to safeguard and promote the welfare of children, be alert to potential indicators of abuse or neglect in children, and know how to act on their concerns in line with LSCB procedures”.

The Safeguarding Children Group is responsible for ensuring the Trust has a Safeguarding Children Training Strategy and that training is delivered. The Trust delivers the training itself and courses are run centrally as well as on site in service directorates and team bases. The Trust also has access to and encourages attendance at multi-agency LSCB training.

It is mandatory that all staff attend Level 1 training on Arrangements for Safeguarding Children within the Trust. All new staff receive this training at Induction which is run bi-monthly.

All clinical staff whose work may involve direct contact with children or adults who are parents/carers of children must also attend the trust or LSCB Level 2 course within two years of attending Level 1. Staff should attend a refresher course every three years. Borough Safeguarding Leads and all staff working in CAMHS should attend the trust or LSCB Level 3 training course 3 yearly.

Attendance registers are kept for all courses and records are kept electronically by the Training Department. Staff should use the personal development planning and appraisal process to monitor access to mandatory training and identify any additional training needs.

The Trust will continue to develop training in the light of identified staff training needs, learning from local and national Serious Case Reviews and changes to guidance and procedures.

42. Safe Recruitment


- Following standard procedures to draw up job descriptions, person specifications and advertisements
• Conducting assessment centres for all nursing posts which test a candidate’s ability, including the use of written and other aptitude tests.
• Taking up at least 2 references prior to appointment – at least one of which should be the previous employer.
• Conducting Disclosure and Barring Service (DBS) checks for all staff with potential contact with adult or child service users and repeat of these as per Trust policy.
• Ensuring that new staff have a full induction, including an introduction to the organisation’s child protection policies and procedures.
• Ensuring that new staff are made aware of the organisation’s whistle blowing policy.

43. Child Protection Allegations against Staff

Allegations against staff in relation to child protection either while carrying out their work or in relation to their private lives must be dealt with in accordance with the London Child Protection Procedures.

All allegations made against Trust staff must be brought to the attention of the relevant director immediately and advice sought from a trust named nurse and the local authority designated officer (LADO) with overall responsibility for ensuring London CP. The trust is responsible, with advice from the LADO, for carrying out a risk assessment to ensure safeguarding arrangements are in place. The Local Safeguarding Children Boards require the Trust to designate a Named Senior Officer in relation to allegations against staff. This individual with the trust Named Professionals has overall responsibility for:

• ensuring that the organisation deals with allegations against staff in accordance with the London Child Protection Procedures;
• resolving inter-agency issues;
• liaison with the LSCB.

The named senior officers for the trust are the named Nurse for Safeguarding Children and the Trust Senior H.R. Manager.
### Monitoring Compliance Table

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Acting on recommendations and Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
</table>
| The complete policy will be monitored. | Named Nurse | *Attendance at child protection conferences.*  
*Recording of dependent children.*  
*Admissions of minors to adult wards.*  
*Serious Incidents involving minors.*  
*Allegations against staff.*  
Tools:  
*Trust Quality Account.*  
*LSCB Performance Indicators.*  
*Serious Incident performance indicators.*  
*LSCB section 11 assessment* | Quarterly  
Monthly  
Per incident  
Weekly  
Quarterly | Quality and Safety Compliance Group.  
LSCB Boards and Q.A sub groups.  
Safeguarding Children Group.  
Quality Accounts Operational Group | Trust Safeguarding Children Group.  
Required actions will be identified and completed in a specified timeframe.  
A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. | Required changes to practice will be identified and actioned within a specific time frame. |
45. Associated Documentation

- Training and Development Policy.
- Training Need Analysis Matrix.
- Criminal Records Bureau (CRB) Policy.
- Health and Social Care Records Policy.
- Child Visiting Policy.
- Multi Agency Public Protection Arrangements Policy
- Accident and Incident Reporting Policy
- Reporting, Investigating and Learning from Serious Incidents
- Guidance and Procedure on Raising Concerns (Including Whistle-blowing)
- Allegation of Abuse Policy
- Clinical Risk and Vulnerability Training
- Safeguarding Vulnerable Adults Policy

46. References

- *Health and Social Care Act 2001*
- *The Human Rights Act 1998*
- *The Equal Pay Act (as amended) 1970*
- *NHS Act 2006*
- *The Equality Act 2010*
- *The Children’s Act 2004 London. Office of Public Sector Information*
- *The Children’s Act 1989 London. Office of Public Sector Information*
- *Intercollegiate Document - Safeguarding Children Young People: Roles and Competences for Health Care Staff (September 2014.)*
Appendix 1

Flow chart 1: Referral

1. Practitioner or member of the public has concerns about child’s safety and welfare
2. Practitioner discusses with manager and/or other senior colleagues as they think appropriate

- Still has concerns
  - Practitioner refers to LA children’s social care, following up in writing within 48 hours
    - Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day
      - Initial assessment required
        - Concerns about child’s immediate safety
      - Feedback to referrer on next course of action

- No longer has concerns
  - No further child protection action, although may need to ensure services provided
  - No further LA children’s social care involvement at this stage, although other action may be necessary e.g. onward referral, common assessment
Safeguarding Children
Supervision Structure

- Safeguarding Children Borough Lead
- Level 4 Training and Supervision with Named Nurse for Trust
- Contribute to Borough LSCB
- Links to Designated Professional

- Identified Safeguarding Lead in Team
- Level 3 Intercollegiate Trained
- Provide advice, guidance and links to Borough Leads and Other Agencies

- Case Load Review
- 1:1 Supervision – Professional, Managerial, Clinical. 4-6 Weekly
- Safeguarding Children integrated in Supervision Policy

Safeguarding children embedded in:
- CPA’s / Care Plan Reviews / Discharge Summaries / Risk Assessments
- Team Supervision / Discussion – MDT Range of Disciplines
- Zoning Review – Minimum weekly including Safeguarding Status
- Recording of Dependent Children
Appendix 3

Definitions of Child Abuse
Working Together to Safeguard Children, HM Government 2010 and the London Child Protection Procedures (2011) define child abuse according to the categories listed below. These define the type of situation which professionals from agencies must refer.

They define the type of situation which will be investigated by the local authority (in conjunction with the police if a crime may have been committed). Although there is overlap with the criteria for making a child subject of a child protection plan, the definitions here are necessarily broader than those criteria.

Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or more rarely, by a stranger. They may be abused by an adult or adults or another child or children.

Neglect
Neglect is 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 and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision including the use of inadequate care-takers or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to a child’s basic emotional needs.

Emotional Abuse
Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child he/she is worthless, unloved or inadequate or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations of children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve more serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child, though it may occur alone.

Physical Abuse
Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child. Female genital mutilation is also a form of physical abuse.

Sexual Abuse
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. This may involve physical contact including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. Sexual abuse also includes non-contact activities, such as involving children in looking at or in the production of pornographic material, or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.
Appendix 4. Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 (“the 2003 Act”). It is a form of child abuse and violence against women. FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons.

Mandatory Reporting.

Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report ‘known’ cases of FGM in under 18s which they identify in the course of their professional work to the police. The duty applies from 31 October 2015 onwards.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second. SWLSTG Trust will support individual practitioners in the management of this responsibility. This support will be provided by the trust Named Safeguarding Nurse and Doctor. Any incident or concerns regarding FGM should be reported directly to these professionals and through the trust Incident Reporting System.

Failure to comply with the duty

Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession. FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.

For health and social care professionals, failure to comply with the duty may be considered through fitness to practise proceedings by the regulator with whom the professional is registered. Regulators will use their frameworks to consider a professional’s ability currently to practise safely. This will therefore take all aspects of the circumstances of the case into consideration, including the safety of the individual child and her immediate needs. This may result in a wide variety of recommendations as to suitable action (e.g. re-training or supervision). Regulators may wish to issue guidance to their registrants as to how to act and when action may be taken.
Mandatory and Multi-agency response to FGM in children.

This process map is intended to demonstrate where the FGM mandatory reporting duty fits within existing processes. It is not intended to be an exhaustive guide, and should be considered in the context of wider safeguarding guidance and processes.

Timeframe for reports
Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day, unless any of the factors described below are present. Staff should act with at least the same urgency as is required by your local safeguarding processes. Cases should immediately be reported to the trust Named Nurse and Doctor for Safeguarding Children who will support the practitioner in their mandatory reporting responsibility within these time frames.
Appendix 5 Child Sexual Exploitation.

Child sexual exploitation is a form of child abuse which involves children and young people (male and female, of a range of ethnic origins and ages, in some cases as young as 10) receiving something in exchange for sexual activity. Perpetrators of child sexual exploitation are found in all parts of the country and are not restricted to particular ethnic groups.

Frontline practitioners from voluntary and statutory sector organisations (including, for example, health and education) should be aware of the key indicators of children being sexually exploited which can include:

- going missing for periods of time or regularly coming home late;
- regularly missing school or education or not taking part in education;
- appearing with unexplained gifts or new possessions;
- associating with other young people involved in exploitation;
- having older boyfriends or girlfriends;
- suffering from sexually transmitted infections;
- mood swings or changes in emotional wellbeing;
- drug and alcohol misuse; and
- displaying inappropriate sexualised behaviour.

Practitioners should also be aware that many children and young people who are victims of sexual exploitation do not recognise themselves as such.

Child sexual exploitation is therefore potentially a child protection issue for all children under the age of 18 years and not just those in a specific age group.

Referring cases

Where child sexual exploitation, or the risk of it, is suspected, frontline practitioners should discuss the case with a manager or the designated member of staff for child protection. If after discussion there remain concerns, the concern must be recorded on the trust incident reporting system and local safeguarding procedures should be triggered, including referral to local authority (LA) children’s social care and the police, regardless of whether the victim is engaging with services or not.

Appendix 6

**Child Protection Conferences, Meetings & Core Groups**

This guidance applies to:
- Child Protection Initial and Review Conferences
- Child Protection Pre-Birth Conferences
If you are invited to a Child Protection Conference you should:

Inform your borough Safeguarding Lead or a member of the Safeguarding Children Team, giving date, time and venue of conference, name, date of birth and address of child and service user

Prepare a typed report, using the Child Protection Report pro-forma, including your assessment of risk

Send report to the conference chair/administrator and record on the trust Rio system.

Wherever possible and appropriate, share contents of your report with your service user in advance as he/she will be invited to the conference

Attend conference and take enough copies of your report or, if unable to attend, send a colleague who you have adequately briefed

At the conference, verbally present your report

When asked by the Chair, express a view about whether the child should be subject of a Child Protection Plan and consider your role as part of the Core Group which will be implementing the Child Protection Plan

The Safeguarding Children Team provides support, consultation, supervision and guidance. The team can:

- help in the preparation of the report.
- Provide guidance and advice in preparation for the meeting and the roles and responsibilities.
- Can attend and contribute to the meetings as alongside staff.
Appendix 7

SWLStG’s Named Professionals
- Executive Lead for Safeguarding: Dr Emma Whicher 020 3513-6381
- Named Nurse for Safeguarding Children; Ian Higgins. 020 3513-6755. 07789-501526
- Named Doctor for Safeguarding Children) Dr Alex Doig 0203 513-5183

Wandsworth LA Children’s Social Care
- Social Services for Children 020 8871 6622 mailto:childreferraldutymanager@wandsworth.gov.uk
- Wandsworth LA Switchboard/Emergency Duty Team out of hours.020 8871 6000

Merton LA Children’s Social Care
- Merton Children’s Social Care Access and Assessment Team 020 8545 4227/4226
  020 8770 5000 (out of hrs)
  mailto:childrensdayservice@merton.gov.uk

Sutton LA Children’s Social Care
- 020 8770 4263 or 020 8770 4343
- Sutton Children’s Emergency Duty Team
  (5pm – 6am Mon-Fri and all day Sat, Sun and Bank Hols) 020 8770 5000

Kingston LA Children’s Social Care
- The Safeguarding Duty Service is delivered by the Safeguarding Teams based at Guildhall 2, High Street, Kingston-upon-Thames, KT1 1EU
- 020 8547 5004 Monday to Thursday, 8.45am – 5.00pm, Friday 8.45am – 4.45pm only
- Emergency Duty Social Worker 020 8770 5000 (out of hrs)

Richmond LA Children’s Social Care
- Phone the Single Point of Access on 020 8891 7969 (Monday to Thursday - 9.00am to 5.15pm, Friday - 9.00am to 5.00pm. mailto:spa@richmond.gov.uk
- Out of hours contact the Emergency Duty Team on 020 8744 2442.

SWLStG’s Child and Adolescent Mental Health Services
- Wandsworth CAMHS 020 3513-4644
- Merton CAMHS 020 8254 8061
- Sutton CAMHS 020 3513-3800
- Kingston CAMHS 020 3513-5183
- Richmond CAMHS 020 3513-3279
## Guidelines and examples of adaptations used in clinical practice

### NICE guidelines with relevance to Safeguarding Adults Policy:

<table>
<thead>
<tr>
<th>Title</th>
<th>NICE Standard/ Guideline Number</th>
<th>Date published on NICE website</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disabilities: challenging behaviour</td>
<td>QS101</td>
<td>01/10/2015</td>
<td><a href="http://www.nice.org.uk/guidance/qsl01">http://www.nice.org.uk/guidance/qsl01</a></td>
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<tr>
<td>Autism: NICE quality standard</td>
<td>QS51</td>
<td>01/01/2014</td>
<td><a href="http://www.nice.org.uk/guidance/qsl51">http://www.nice.org.uk/guidance/qsl51</a></td>
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<tr>
<td>Domestic violence and abuse: multi-agency working</td>
<td>PH50</td>
<td>01/02/2014</td>
<td><a href="http://www.nice.org.uk/guidance/ph50">http://www.nice.org.uk/guidance/ph50</a></td>
</tr>
<tr>
<td>Autism in under 19s: support and management</td>
<td>CG170</td>
<td>01/08/2013</td>
<td><a href="http://www.nice.org.uk/guidance/cg170">http://www.nice.org.uk/guidance/cg170</a></td>
</tr>
<tr>
<td>Psychosis and schizophrenia in children and young people: recognition and management</td>
<td>CG155</td>
<td>01/01/2013</td>
<td><a href="http://www.nice.org.uk/guidance/CG155">http://www.nice.org.uk/guidance/CG155</a></td>
</tr>
<tr>
<td>Psychosis with coexisting substance misuse (CG120)</td>
<td>CG120</td>
<td>23/03/2011</td>
<td><a href="http://www.nice.org.uk/guidance/cg120">http://www.nice.org.uk/guidance/cg120</a></td>
</tr>
<tr>
<td>Child maltreatment: when to suspect maltreatment in under 16s</td>
<td>CG89</td>
<td>01/07/2009</td>
<td><a href="http://www.nice.org.uk/guidance/cg89">http://www.nice.org.uk/guidance/cg89</a></td>
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</tbody>
</table>
# Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Race</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Nationality</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Gender</td>
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</tr>
<tr>
<td></td>
<td>• Culture</td>
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</tr>
<tr>
<td></td>
<td>• Religion or belief</td>
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</tr>
<tr>
<td></td>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Age</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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</tr>
<tr>
<td>2.</td>
<td><strong>Is there any evidence that some groups are affected differently?</strong></td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td><strong>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Is the impact of the policy/guidance likely to be negative?</strong></td>
<td>No</td>
</tr>
<tr>
<td>5.</td>
<td><strong>If so can the impact be avoided?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td><strong>What alternatives are there to achieving the policy/guidance without the impact?</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td><strong>Can we reduce the impact by taking different action?</strong></td>
<td>N/A</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please refer it to Ian Higgins, Nurse Consultant, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Ian Higgins, ian.higgins@swlstg-tr.nhs.uk