

Barnet, Enfield Haringey Mental Health Services and Barnet, Enfield Haringey safeguarding Children Boards

Safeguarding Children where there are concerns of Parental Mental Health Protocol

Barnet, Enfield and Haringey 
Mental Health NHS Trust



Acknowledgments

This inter-agency document was produced by BEH Mental Health Services and Barnet, Enfield and Haringey Safeguarding Children Boards.

Thanks are due to everyone involved, either in the project or reading the drafts and responding to them.

Important Note

This protocol should be read in conjunction with the London Child Protection Procedures, 4th Edition (*London Safeguarding Children Board, 2010*) and Working Together to safeguard children (2010)

This protocol aims to facilitate information sharing and clarify the role of **all** practitioners working with families where there may be concerns regarding parental mental health. This includes children and young people whose care may be affected because of their parent's mental health.

The term Children's Service has been used throughout to refer to Local Authority Children's Services in Barnet, Enfield and Haringey

Contents

	INTRODUCTION	4
1	PURPOSE OF THE PROTOCOL	4
2	KEY OBJECTIVES	4
3	PRINCIPLES	5
4	CHILDREN'S SERVICES	6
5	CONFIDENTIALITY	6
6	ADULT MENTAL HEALTH SERVICES	7
7	MENTAL HEALTH TRUST - INPATIENT SERVICES	9
8	SEVERE PARENTAL MENTAL HEALTH DIFFICULTIES	9
9	MENTAL HEALTH ACT ASSESSMENTS	10
10	INPATIENT SERVICES	11
11	CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)	14
12	PRIMARY ROLES WITHIN CHILDREN'S SERVICES	14
13	REFERRALS TO CHILDREN'S SERVICES WHERE THERE IS NO MENTAL HEALTH INVOLVEMENT	15
14	JOINT VISITS	15
15	PREGNANCY AND CHILD PROTECTION	16
16	YOUNG CARERS	17
17	TRAINING	18
18	MANAGING PROFESSIONAL DISAGREEMENT AND ESCALATION	18
19	DEFINITIONS AND TERMINOLOGY	20
20	CHILDREN ACT 2004	21
	APPENDICES	22
	ENFIELD KEY CONTACTS	23
	REFERRAL FLOW CHART	24
	KEY HARINGEY CONTACTS	25
	REFERRALS TO HARINGEY FIRST RESPONSE	26
	KEY BARNET CONTACTS	27
	CHILD PROTECTION/ SAFEGUARDING CHILDREN ESCALATION GUIDELINES	29

INTRODUCTION

Although this protocol has been developed to assist collaboration between Children's Services and Mental Health Services in Barnet, Enfield and Haringey, the general principles can be applied to working across other services in the community, for example, the voluntary and independent mental health sector. These principles represent good practice in working across the interface with any adult focused service.

1 PURPOSE OF THE PROTOCOL

To establish clear joint working arrangements between Children's Services and Mental Health Services in Barnet, Enfield and Haringey (BEH-MHT) for managing safeguarding and child protection issues.

To increase knowledge across all organisations of structures and referral pathways to enable this work to take place effectively.

This protocol is intended to be a living document, and will be updated regularly in response to service developments .It will be reviewed annually

To facilitate a cross agency process for assessing and working with mentally ill parents and carers and their children to ensure a co-ordinated approach

2 KEY OBJECTIVES

- 2.1 To promote a shared understanding of service thresholds.
- 2.2 To ensure that supportive interventions for parents or carers with mental health difficulties reflect multi-agency and collaborative approaches in accordance with Working Together 2010.
- 2.3 To support parents to minimise any adverse affects of their mental health difficulties on their parenting/caring capabilities.
- 2.4 To ensure that all professional intervention across Adult's and Children's services is sufficiently child focused.
- 2.5 To recognise the circumstances where parental mental health difficulties significantly impair parenting and ensure that professional intervention achieves safe outcomes for children.
- 2.6 To assist child orientated teams to always identify if a parent has mental health difficulty.
- 2.7 To ensure adult orientated teams (i.e. Adult Mental Health Services) to always identify if there are children living with, dependant or in regular contact with their client. (child is defined in the Children Act 1989 as anyone under the age of 18 years).

3 PRINCIPLES

What follows are the over-arching principles that guide work with children and families

- 3.1 The child's need and safety are paramount¹. In the event of concerns about a child's safety, the London Child Protection Procedures 2010 must be followed. This can be accessed on line at www.londonscb.gov.uk
- 3.2 Wherever possible, children's needs are best met within their own family. All professionals involved have a responsibility for the safety and well-being of children².
- 3.3 Children's needs are best met when parents are supported.
- 3.4 Parents with mental health difficulties have a right to be supported in a non-judgemental way that enables them to fulfil their parental responsibilities.
- 3.5 Parents with mental health difficulties and their children are one of the groups most likely to be excluded from accessing services and community resources. This is likely to be further exacerbated if the family are from a minority ethnic group or newly arrived to this country. Services need to work to improve unequal access, and ensure that services are truly needs-led.
- 3.6 Children have a right to services that promote their physical and emotional well-being and development so that they can achieve their potential.
- 3.7 The wellbeing of children and their families is best served by a multi-agency approach where different services work effectively together.
- 3.8 Risk is reduced when information is shared in a timely manner.
- 3.9 Whilst many parents with mental health and or substance misuse or domestic violence problems successfully care for their children with the support of family/ friends, these are risk factors that can impact on children's safety and welfare. Health professionals need to consider this possibility and be aware and alert to any signs of poor parenting or safeguarding concerns. National research into Serious Case Reviews by Brandon et al (2008) has highlighted the need for vigilance when there is more than one risk factor present. The co-existence of mental health, domestic violence and substance misuse significantly escalates the risk of children being harmed.
- 3.10 For those parents with signs of more serious mental health illness, consistent monitoring and ongoing review of their level of vulnerability and impact on their parenting capability is essential.

¹ The Children Act 1989

² Working Together to Safeguard Children 2010

4 CHILDREN'S SERVICES

- 4.1 Social workers should routinely consider whether a parent has mental health problems at the point of initial contact. This should include known history, previous treatments and descriptions of symptoms of thoughts, feelings and behaviours. Social Workers should seek advice from a mental health practitioner if they are unsure.
- 4.2 A decision should be made about whether the child is potentially a child in need, or a child in need of protection within the terms of the respective borough within 24 hours of a referral.
- 4.3 If a child is thought to be at risk of suffering significant harm and a parent is thought to be experiencing significant mental health difficulties, Child Protection (section 47) processes must be used. The Children and Families social worker will take the lead professional role in joint assessment with BEH MHT.
- 4.4 When a referral to children's services is made to consider an assessment of a child's needs, parents and children (where appropriate) should be informed of the referral and their consent obtained to contact other agencies. If a referral is made where there is likely or actual risk of harm to a child, consent is not required (DOH Information Sharing Guidance).
- 4.5 When a referral is made, there should be a check to ascertain whether a Common Assessment Framework (CAF) has been undertaken and if so, this should feed in to any subsequent assessment.
- 4.6 Parents and children (where appropriate) should receive copies of assessments in accessible formats.

5 CONFIDENTIALITY

- 5.1 Where there are child protection concerns, Children's Services may make enquiries under s47 of the Children Act 1989: "*Where a local authority...Has reasonable cause too suspect that a child who lives, or is found, in their area is suffering, or likely to suffer, significant harm, the authority shall make, or cause to be made, such enquires as they consider necessary to enable them to decide what action they should take to safeguard or promote the child's welfare.*"
- 5.2 The 1998 Data Protection Act allows for the disclosure of personal information in appropriate circumstances. Where enquires are taking place under s47 Children Act 1989 (child protection), Adult Mental Health Services may be asked to divulge relevant information about the service user without their consent having necessarily been obtained. Adult Mental Health Services may be asked for information about past and present contact including services used, names of consultants, dates, past diagnoses, general assessments and assessed risks to self and others.
- 5.3 The London Child Protection Procedures give the following guidance regarding information sharing where there are concerns about significant harm:
 - Professionals who work with, or have contact with children, parents or adults in contact with children should always share information with Local Authority Children's Services where they have reasonable cause to suspect that a child may be suffering or may be at risk of suffering significant harm.

- Whilst, in general, Professionals should seek to discuss any concerns with the family, and where possible, seek their agreement to making referrals to Children's Services, there will be some circumstances where professionals should not seek consent, e.g. where to do so would:
 - Place a child at increased risk of significant harm;
 - Place an adult at risk of serious harm;
 - Prejudice the prevention or detection of a serious crime;
 - Lead to unjustified delay in making enquiries about allegations or significant harm.

5.4 In some situations there may be a concern that a child may be suffering, at risk of significant harm or of causing serious harm to others. Professionals may be unsure whether what has given rise to concern constitutes 'a reasonable cause to believe'. In these situations, the concern must not be ignored.

5.5 Professionals should always talk to their agency's nominated child protection adviser and, if necessary and where they have one, a Caldicott Guardian – who will have expertise in information sharing issues, though not related to child protection. The child's interests must be the overriding consideration in making any decisions whether or not to seek consent.

5.6 Where there are no child protection concerns, similar information may be requested, within the context of the service user's consent having been obtained.

5.7 It should be borne in mind that information is generally needed within a short timescale, either in order to assess immediate risk to children, or so that the initial assessment can be completed within the 10 day timescale.

Sources of Guidance

- London Child Protection Procedures 4th Edition 2010 London Safeguarding Children Board
- Cross Government Information Sharing Guidance 2006
- DOH Statement of Duties
- Royal College of Psychiatrists Statement

6 ADULT MENTAL HEALTH SERVICES

6.1 The Community Mental Health Teams provide an assessment and care planning service to people with serious mental health difficulties. There are multi-disciplinary teams comprising of psychiatrists, nurses, occupational therapists, social workers and administrators working together in the community. Each team has the same functions of care management and assessment.

6.2 The Community Mental Health Team (CMHT) will refer directly to Children's Services if in the course of their work they have any child protection or safeguarding concerns.

- 6.3 Patients are offered a service based on assessed need. This may or may not be under the Care Programme Approach (CPA). The care plan is managed by a care coordinator, who is usually a nurse or social worker.
- 6.4 There is an out of hour's service, accessed through the Emergency Duty Team (EDT). Details for the respective boroughs are included in the appendix.
- 6.5 Mental Health Workers should routinely record whether there is a child in the family or in contact with the adult. The worker should ask routine questions at their initial contact that consider whether and how the adult is able to meet the needs of the child and carry out their parenting responsibilities.
- 6.6 When a patient has a child, the Mental Health Worker should identify the existing child based services working with the family (Health Visiting, school nursing, nursery, school, children's centre etc).
- 6.7 Mental Health professionals should record all incidents and actions taken in relation to child care concerns in their ongoing recording, including any decisions and their rationale. BEH MHT care plans should identify who will help the parent in communicating with their child. This should also consider the child's wishes and feelings of the child regarding the parent's illness.
- 6.8 When it is thought that additional children's services are not required, the mental health worker should carry on with their usual assessment and care planning process. *This should always include frequent and active consideration of whether the child's needs are being met and if further contact with Children's Services is required.*
- 6.9 Mental health workers must ensure that their care planning includes explicit details about issues and interventions required to help their clients in their parenting role. There should be explicit details of agreed plans in regard to the client's child in the event of a mental health crisis, within the crisis and Contingency section of the CPA (care programme approach) care plan. Children should be given clear information about who to contact in the Mental Health Trust if they become worried about their parent.
- 6.10 The needs of children should be explicitly considered within the CPA or other planning processes. Where there are concerns about service users' ability to care for their children due to their mental state, and following referral, Children's Services should be invited to attend CPA meetings. The needs of children should be considered during all stages in the planning and the 'No Health Without Mental Health' ³ strategy gives emphasis to the need for early intervention and prevention in the provision of psychological therapies to children and young people.

³ No health without mental health strategy - 2011

7 MENTAL HEALTH TRUST - INPATIENT SERVICES

- 7.1 When a parent needs inpatient mental health treatment, it is imperative that at the point of admission enquiries are made regarding any children that the adult is responsible for. It is important to establish who is looking after them as there have been cases where children have been left to fend for themselves without knowledge of parent's situation.
- 7.2 BEH-MHT child visiting policy should be used. In addition to this policy, someone on the ward should be identified to talk with the adult client about issues and anxieties that will be present as a result of their parent/child separation.
- 7.3 When a parent has been receiving mental health inpatient treatment, it is imperative that children's services are invited to discharge planning meetings prior to discharge, and joint assessment procedures agreed according to level of need. This should be incorporated into existing discharge planning processes (including informal, CPA and section117) when appropriate.

8 SEVERE PARENTAL MENTAL HEALTH DIFFICULTIES

- 8.1 The majority of parents who suffer mental ill-health are able to care for and safeguard their child/ren and/or unborn child.
- 8.2 In some instances, severe parental mental health difficulties will seriously affect the safety, health and development of children. Where professionals believe that this may be the case a referral must be made to Children's Services.
- 8.3 The following parental risk factors may justify an assessment of whether a child has suffered or is at risk of suffering significant harm:
 - i. Previous history of mental health problems
 - ii. Predisposition to or severe post natal illness
 - iii. Delusional thinking involving the child or not
 - iv. Self-harming behavior and suicide attempts
 - v. Altered states of consciousness e.g. Splitting/dissociation, misuse of drugs, alcohol, medication, etc.
 - vi. Obsessive compulsive behavior that impacts on the child
 - vii. Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on the child
 - viii. Disorder designated 'untreatable' either totally or within time scales compatible with the child's best interests
 - ix. Domestic violence and/or relationship difficulties
 - x. Unsupported and/or isolated parents without community ties

- xi. Newly arrived to this country /suffering from Post Traumatic Stress Disorder

N.B Research into Serious Case Reviews nationally conducted by Brandon et al (2010)⁴ has highlighted the significance of multiple risk factors especially when mental health, domestic violence and substance misuse are present. In cases where more than one risk factor is present, the likelihood of abuse or neglect is much greater and an assessment by Children’s Services should always be considered

- 8.4 The following factors may also lead to the conclusion that a child has suffered or is at risk of suffering significant harm:
 - i. A child acting as a ‘young carer’ for the parent when their own needs are not met
 - ii. Impact on child’s growth, development, behavior and/or mental/physical health, including alcohol/substance misuse and self-harming behavior
 - iii. The parent/carer’s needs or illnesses take precedence over the child’s needs
 - iv. Insufficient alternative care for the child within the extended family/network.
- 8.5 When assessing the risk of significant harm, views should be sought from relevant, involved childcare professionals e.g. Schools, Health Visitors, Pediatricians, CAMHS etc.

9 MENTAL HEALTH ACT ASSESSMENTS

- 9.1 Assessments under the Mental Health Act occur when a patient needs to be detained in hospital against their will for either their own safety or the safety of the community. Where children are involved in such circumstances it is likely that they will be placed at risk. Assessments are conducted by an approved mental health practitioner (AMHP) and two psychiatrists.
- 9.2 When conducting a Mental Health Act assessment, AMHP’s are required to check whether there are children involved, and to ensure appropriate arrangements are in place for them. Where there are difficulties making arrangements, AMHP’s will contact Childrens Services for assistance.
- 9.3 Sometimes Mental Health Act assessments are requested for children. Adult mental health services will request joint work with Childrens Services to look at alternatives to compulsory admission where possible.
- 9.4 Children’s Services will take responsibility for co-ordinating an initial assessment within 10 working days of referral if this is the decided course of action The Children’s Social Worker is expected to see the child and complete the assessment documentation. The MHT worker should complete their assessment forms.

⁴ Brandon et al, Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-2007

10 INPATIENT SERVICES

10.1 Admission

When an adult is admitted to an inpatient psychiatric ward, the admitting nurse should enquire if the person has parental responsibilities or contact with children. They should note any childcare issues on the nursing assessment, including:

- i. Details of who is looking after the children and detailed care arrangements throughout the parent's admission in hospital.
- ii. To ascertain whether a risk assessment has been carried out, in order to maintain the safety of the child.
- iii. Any concerns about the care of the children while the patient is on the ward.
- iv. Any issues about visiting, taking into account ward and trust policy
- v. Issues about parental leave.
- vi. List the relevant agencies to be involved.
- vii. Establish if the child(ren) are known to Children's Services
- viii. There is a legal responsibility to inform the Health Visitor in the case of an infant (0-5 yrs).
- ix. Ascertain the views and opinions of parents and carers with regard to the admission, its impact on the child (ren), to ensure the necessary support is made available and that Children's Services are informed.

10.2 If, due to the nature of the patient's illness or for any other reason, it is not possible to gather information about the children, this should be sought from other sources available. In the first instance, ward staff should contact Children's Services to see if the family is known, if it is believed that there are children involved. Any gaps in information about a patient's child or children should be noted in the case records and must be followed up with the patient, their relatives or other professionals involved, for example the GP or health visitor, within five days.

10.3 Patient known to Children and Families

Children's Services must be telephoned to find out if a child is under a child protection plan when an adult is admitted. Where the family of an adult patient is known to Children's Services, it is essential to inform Children's Services when:

- i. A patient is admitted.
- ii. If the patient is going on leave.
- iii. If the patient is absent without leave.
- iv. Planning for the patient's discharge.
- v. If the patient's discharge is imminent, whether or not joint planning has been possible.

10.4 If Children's Services are involved, they should be invited to all care planning meetings under the CPA. If the patient does not agree to the Children's Services social worker being invited to their CPA meeting, the ward manager or senior nurse will discuss the

patient's objections with them and explain the importance of professionals working together for the benefit of themselves and their children. It may be possible to arrange for the Children's Services social worker or another children's worker to attend part of the meeting. Whether or not childcare professionals attend the CPA meeting, where there are concerns about the wellbeing of the children, the need to share information takes precedence over the patient's right to confidentiality (see section 7).

10.5 Discharge Plans

Where there are issues about children's welfare, discharge plans must involve and be agreed by all professionals working with the family. Copies of plans must be filed in both adult Mental Health and Children's Services files.

10.6 Referrals to Children's Services

If the patient and their family are not known to Children's Services, the patient's care coordinator in whatever setting is responsible for initiating a referral or contact with Children's Services.

10.7 In the event of any difficulties in negotiations, advice should be sought from the named nurse for the respective borough. If there is no care coordinator or the care coordinator is not available and the situation is urgent, the admitting or primary nurse must consult the ward manager or senior nurse. They will decide if a referral to Children's Services is required following child protection procedures, if the child is considered to be at risk of significant harm. Advice can be sought from the duty team in Children's Services in the relevant borough. If child protection thresholds (see appendix 4) are not met, consideration should be given to a CAF provided you have the patient's consent.

10.8 Any mental health worker who becomes concerned about the welfare of a child should make a referral to Children's Services and seek advice from a manager

10.9 **Where the concerns are of an urgent nature, referral should be made immediately by telephone**, to be confirmed in writing within 48 hours. Referrals should be made in writing using the Referral for Assessment Form (see appendix).

10.10 Children's Services will process the referral according to either s47 Children Act 1989 (child protection) or s17 Children Act 1989 (child in need). For further detail on these definitions see appendix 1. An Initial Assessment will be completed as part of this process within 10 days. The referrer may be asked for more information to complete this assessment.

10.11 **Your input and contribution to the initial assessment will be required in order to :**

- Identify the core needs of the mentally ill parent or person in caring role.
- Explore the degree of permanency of the parent's mental health difficulties.
- Identify the child's developmental needs, and the parents' capacity to meet those needs within the context of their development
- Take account of known variations in the need for assistance, such as additional support during school holidays, weekends,
- Agree a joint action plan with the parent(s) and child (if appropriate). This identifies the care package to be provided, responsibility for provision and timetable for review. Clear links between childcare procedures and Mental Health procedures (i.e Care Program Approach) should be apparent
- This plan should include contingencies such as fluctuating medical conditions, hospitalisation of parent or child, and partner's absence so that prior authorization of services can be obtained
- Decide whether a full core assessment is required

10.12 Where there are significant child protection concerns, Children's Services will convene a **strategy meeting** of professionals only, to plan further investigation and assessment and protection of the child/ren. Where there is a need for immediate action, this can take the form of a strategy discussion on the phone between Children's Services and the Police. The strategy meeting or discussion must be convened within 3 working days of child protection concerns being identified. Where there is serious risk of harm to a child, this should happen on the day of the referral.

10.13 Where concerns are validated following investigation, a **Child Protection Conference** will be convened. This will consider the risks to the child/ren, consider whether the children concerned need to be made subject to child protection plans or family support plans. Parents/carers and all professionals involved with the family will be invited to these meetings. Where the concerns are primarily as a result of parental mental ill-health, it will be of crucial importance for all mental health professionals involved to attend.

10.14 Where there are significant child protection concerns, or in complex situations, Children's Services will initiate a **Core Assessment**. This is a more in-depth assessment, following on from the **Initial Assessment**. All professionals involved with the family will be expected to contribute detailed information to form the basis of the **Core Assessment** as set out in the statutory guidance Working Together to Safeguard Children 2010

10.15 **The Core Assessment: conducted by Children's Services**

A full core assessment should be carried out when:

- The needs of the parent are complex
- There is a risk of significant harm to a child in the family
- The adult's impairment or illness is stable, but the child's/children's needs are complex.
- The absence of a full/core assessment is likely to lead to a re-referral.
- Repeat initial assessments have been carried out within the last 12 months that could suggest unmet need.

10.16 Adult Mental Health Workers should work in conjunction with Children's Services when:

- The parent has significant, acute, and enduring complex need and requires a package of care to support them in their parenting role, in the absence of child protection concerns. A joint visit may be required

A Core Assessment should be led by Children and Families when:

- There is a risk of significant harm to a child in the family
- The adult's impairment or illness is stable, but the child's /children's need are complex.

At the end of a Core Assessment, a plan of action should be jointly agreed between the Children's Service and the Mental Health Trust. This should be recorded in agencies care plans. Team managers should support and agree the plan

10.17 Where a child is made subject of a **Child Protection Plan, Core Groups** will be held regularly to implement and monitor the progress of the plan. All professionals involved with the family and contributing to the plan are expected to attend core

group meetings as detailed in Working Together and the London Child Protection Procedures

10.18 **Children visiting Wards**

Barnet, Enfield & Haringey Mental Health NHS Trust has a policy for children visiting wards. The aims of this policy are:

- a. To ensure that the child's safety and welfare are at the heart of all decisions and arrangements involving any child who may be present on Trust premises.
- b. To ensure that children have access to visit their parents or relatives whilst they are in hospital, where it is in the child's and the service user's best interest to do so, taking account of the needs and wishes of both the child and the service user.
- c. To set standards for the provision of facilities for child visiting which
 - i. ensure the safety of all children visiting Trust premises
 - ii. are supportive of children and adults
 - iii. facilitate appropriate visiting and maximise the advantage of such visits to all concerned
 - iv. ensure that any risks are identified and appropriately addressed
 - v. children visiting their parents/relatives in hospital need to be child-focused with the child's interests paramount at all times.

10.19 Any concerns about the welfare of children on hospital premises must immediately be reported to Childrens Services.

11 **CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)**

11.1 CAMHS provides a mental health service to children aged 0-18 and their families. Teenage parents who are experiencing mental health difficulties would be referred to this service.

11.2 The principles outlined in this protocol should be understood as also applying to parents and children who are receiving a service from CAMHS.

12 **PRIMARY ROLES WITHIN CHILDREN'S SERVICES**

12.1 **Children's Services** is responsible for taking all outside referrals regarding children who may be in need or about whom there are child protection concerns. They screen all initial referrals, conduct initial assessments (10 days) and core assessments (35 days) where necessary. Children's Services lead multi-agency child protection investigations and will take relevant cases to initial child protection conference. They will also initiate legal action to protect a child where this is necessary in emergency. Children's Services also provide services for children in need under S17 of The Children Act 1989. A child is taken to be in need if

- o *he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision to him of services by the local authority by a local authority under this part;*

- *'his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or*
- *'he is disabled.'*

12.2 The first point of contact for each of the boroughs is included in the appendix, together with the contact details for the out of hour's emergency service.

12.3 Boroughs will also have other specialist teams, for example, working with disabled children or children in the care system.

12.4 There are also a range of preventative services that work with children and families where the threshold for statutory intervention has not been met.

13 REFERRALS TO CHILDREN'S SERVICES WHERE THERE IS NO MENTAL HEALTH INVOLVEMENT

13.1 Children's Services receives a significant number of referrals where there are concerns of parental mental ill-health expressed by the referrer or arising during the initial assessment, but where there is no information about involvement of Adult Mental Health Services.

13.2 Children's Services and Mental Health Services will work together in co-ordinating checks in relation to the adult's involvement with Mental Health Services.

13.3 In urgent and/or serious situations requests may be made directly to the CMHT for joint assessment (see section below). The service user's GP should be copied into the request. Where the situation is concerning but not urgent, referral should be made to the service user's GP, and CMHT should be copied in.

13.4 There are a significant number of families who are not registered with any GP, due to either recent arrival in the UK or other reasons. Where an initial mental health assessment is needed, contact should be made with the Adult Mental Health Services covering the area in which the person appears to reside.

14 JOINT VISITS

14.1 Children's Services will conduct visits to children and families at home if it is decided that the referral warrants an initial assessment being completed. Children's Services may ask for a joint visit with a mental health worker, to help assess parenting capacity and inform the initial assessment. Joint visits will be agreed between managers from the two services.

15 PREGNANCY AND CHILD PROTECTION

Where an agency or individual anticipates that a prospective parent may need support services to care for their baby or that a baby may be at risk of significant harm, a referral to children and families referral and assessment service should be made as soon as the concerns are recognized. Research has shown that it is vitally important to include both partners, even if they are not living together

- 15.1 Newborn babies are particularly vulnerable due to their total dependence and need for 24-hour care, supervision and protection. Parents who are experiencing symptoms of poor mental health may not be in a position to attend to all the care needs of a newborn infant appropriately. Unborn babies may be harmed by parental substance misuse, attempts at self-harm or where the parent is exposed to violence. Where a practitioner is concerned about the current or future welfare of an unborn baby, they must make a referral to Children's Services.
- 15.2 Referrals should be made at the earliest opportunity to allow practitioners time to make full assessments, and put in place any arrangements or services needed for when the baby is born.
- 15.3 **The Midwifery Service** offers support to all women through pregnancy and after childbirth. Referral to the service should take place at the earliest opportunity, to ensure that women access screening early within the pregnancy. Referral to the service often happens at a much later stage for women who are isolated or not in touch with services. In practice, a number of women receive no antenatal care up to the time they go into labour and this is a known risk factor for infant morbidity.
- 15.4 Midwives will conduct a screening based on NICE guidelines and will ensure information sharing takes place with health professionals including CMHT and CAMHS.
- 15.5 The Midwifery Service may make a child protection referral at any stage of this process, depending on the circumstances and the expected date of delivery. Any pregnancies of girls 13 and under are automatically referred to the Police. Girls aged 14 who are pregnant would normally be referred to Children's Services depending on the circumstances.
- 15.6 A pre birth initial assessment should be completed on all pre-birth referrals and a strategy meeting held where:
 - 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 presents a risk to children
 - A sibling in the household has a child protection plan.
 - A sibling has been previously removed from the household either temporarily or by court order.
 - Domestic violence is known to have taken place
 - Parental substance misuse is likely to significantly impact on the baby's safety or development
- 15.7 Upon receiving a referral, the Childrens Services Assessment Team may hold a discussion or meeting with the referrer and any other agencies involved with the parent. If there are significant child in need or child protection concerns about the unborn child, a pre-birth core assessment will be initiated. Any services working with the adults, including mental health, must attend

15.8 The meeting must decide:

- Whether an s.47 enquiry and pre birth core assessment is required.
- What areas need to be considered for assessment
- Who needs to be involved
- How and when the parent (s) are to be informed of the concerns
- Required action by ward staff when the baby is born

The assessment should be completed within 10 working days.

15.9 Where there are child protection concerns, a **pre-birth child protection conference** will be convened, within 15 days of the strategy meeting. Pre-birth conferences should ideally be held at least 10 weeks before the expected date of delivery. The conference will decide whether the unborn child needs to be made subject to a child protection plan, and will devise this plan. Such a plan will typically make arrangements for the safety of the child with the maternity ward and make plans for where the child and mother should be discharged for further assessment.

15.10 The first **review child protection conference** will be held within one month of the birth of the baby, or within 3 months of the initial conference, whichever is sooner. This will review the child protection plan made at the initial conference, decide whether the child still needs to be subject to a child protection plan, and make any new plan required to protect or support the child.

15.11 **New Born Infant Discharge Planning Meetings** are usually held where there are child protection concerns or Children's Services are involved. The decision to hold one is made jointly between the Midwifery Service and Children's Services. The role of the meeting is to plan the services and actions required so that newborn babies can be safely discharged from hospital. The **Discharge Planning Meeting Form** should be used as a checklist for the agenda of the meeting and to record the discussion and decisions.

16 YOUNG CARERS

16.1 Mental Health Staff should be aware of children who may be young carers. In many families, children contribute to family care and wellbeing as a part of normal family life. A young carer is a child who is responsible for caring on a regular basis for a relative who has an illness or disability. Children of parents with mental health problems are vulnerable to becoming young carers due to their parents' temporary or permanent incapacity in certain areas. Their caring responsibilities may include a large burden of household management, emotional support to their parent or care and supervision of siblings and assume a level of responsibility, which would usually be associated with an adult. Factors which usually influence the extent and nature of young carers tasks and responsibilities include the illness/disability, family structure, gender, culture, religion, income, and the availability and quality of professional support services.

16.2 Caring responsibilities can significantly impact upon a child's health and development. Many young carers experience:

- i. Social isolation;
- ii. A low level of school attendance;
- iii. Some educational difficulties;
- iv. Impaired development of their identity and potential;

- v. Low self-esteem;
- vi. Emotional and physical neglect;
- vii. Conflict between loyalty to their family and their wish to have their own needs met.

16.3 Professionals in all agencies should be alert to a child being a young carer. Where a young carer is identified, professionals should consider the child's support needs using the Common Assessment Framework. There are circumstances in which a young carer can be suffering, or at risk of suffering, significant harm through emotional abuse and / or neglect.

16.4 Where professionals have these concerns, they should make a referral to Children's Services, or directly to an appropriate agency.

16.5 When a young person is undertaking any caring role within the family important consideration should be given to whether or not the adult is receiving the necessary services. Referrals to Children Services in relation to young carers should therefore automatically be referred to the community mental health teams and a joint assessment carried out. Any young carer is entitled to an assessment of their ability to care under section 1 (1) of the carers act 1995 and the local authority must take that assessment into account in deciding what community care services to provide for the parent

17 TRAINING

17.1 Child protection and mental health is a complex area of practice where the risks to children can be high. Good interagency working in this area is crucial if children are to be effectively protected. Adult mental health services have mandatory child protection training for their staff. Staff from all agencies working in this area should avail themselves of suitable training when the opportunity arises. The Safeguarding Children Board in each borough provides an annual programme of child protection training that is open to mental health staff and circulated to BEH MHT. Advice regarding the appropriate course and level can be sought from the BEH MHT workforce strategy based on the recommended guidelines in Working Together and the Inter Collegiate Document for Roles and Competencies in Health

18. Managing Professional Disagreement and Escalation

18.1 Professional disagreement is to be expected as part of the process of inter-agency working and has a positive role in bringing different perspectives to bear. It is important that this is resolved constructively and Practitioners should follow the principles outlined in the London Procedures (18:5) and escalate concerns through the line manager.

BEH MHT is structured on service lines and each service area has an Assistant Director with responsibility for service provision.

The first point of contact within BEH should be the Lead Nurse for the respective Borough. They may not necessarily be able to resolve the situation but will signpost to the appropriate manager and maintain an overview to ensure resolution.

Within Children's Services, the first point of contact should be the Team Manager

and thereafter the Service Manager, following the line of management as outlined in the London Procedures.

Contact details are provided in the appendix

An operational group of Social Care managers and Barnet, Enfield and Haringey Mental Health Trust managers has been established in each borough. The focus is to improve collaborative practice in relation to ongoing safeguarding children cases that both agencies share. This also provides an avenue to explore professional difference of opinion in a constructive manner.

The Trust Escalation Policy which is consistent with the London Procedures, is also attached as an appendix

19. DEFINITIONS AND TERMINOLOGY

Mental Health/Illness/Disorder

Throughout this protocol the terms mental health and mental health difficulties will be used for consistency and familiarity, although the term mental disorder is used in the 1983 Mental Health Act.

Safeguarding

The Government has defined the term 'safeguarding children' as:

'The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully. (Working Together to Safeguard Children 2010)

Child Protection

The process of protecting individual children identified as either suffering, or at risk of suffering, significant harm as a result of abuse or neglect.

Common Assessment Framework - CAF

The CAF is a nationally standard approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. It can be used by practitioners across children's services in England. The CAF is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development

Definitions of s17 and s47 Children Act 1989

Section 17 covers services and local authority duties towards Children in Need.

S17 (1) states: *'It shall be the duty of every local authority...*

- vi. 'to safeguard and promote the welfare of children within their area who are in need; and*
- vii. 'so far as is consistent with that duty, to promote the upbringing of such children by their families.'*

S17 (10) states: *'a child shall be taken to be in need if...*

- viii. 'he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision to him of services by the local authority by a local authority under this part;*
- ix. 'his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or*
- x. 'he is disabled.'*

Section 47 covers local authority's duties to investigate child protection concerns.

S47 (1) states: *'Where a local authority...have reasonable cause to suspect that a child who lives, or is found in their area, is suffering or likely to suffer significant harm, the authority shall make or cause to be made such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.'*

20 CHILDREN ACT 2004

19.1 Section 10 requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners (such as health services) and such other persons or bodies working with children in the local authority's area, as the authority consider appropriate. The arrangements are to be made with a view to improving the well-being of children in the authority's area - which includes protection from harm or neglect, alongside other outcomes. This section of the *Children Act 2004* is the legislative basis for Children's Trust arrangements.

19.2 Section 11 requires a range of agencies (including Health services, Police, Probation) to make arrangements for ensuring that their functions, and services provided on their behalf, are discharged with regard to the need to safeguard and promote the welfare of children.

This protocol is informed by:

- The Children Acts 1989 and 2004.
- Framework for the Assessment of Children in Need and their Families (DoH 2000).
- Working Together to Safeguard Children (2010).
- Supporting Parents, Safeguarding Children (CSCI 2006).
- London Child Protection Procedures 2010.
- Mental Health Act 1983 and Code of Practice.
- Social Exclusion Unit Report 2004.
- Cross Government Information Sharing Guidance.

It particularly draws on concepts laid out in the Children Act 2004 relating to, the need for inter - agency governance, integrated strategies, integrated processes and integrated frontline service delivery.

APPENDICES

ENFIELD KEY CONTACTS	23
REFERRAL FLOW CHART	24
KEY HARINGEY CONTACTS	25
REFERRALS TO HARINGEY FIRST RESPONSE	26
KEY BARNET CONTACTS	27
CHILD PROTECTION/ SAFEGUARDING CHILDREN ESCALATION GUIDELINES	29

Appendix 1

Enfield Key Contacts

If you have any concerns about a child

Assessment Team (Mon-Fri - 9am-5pm) 020 8379 2507
Fax 020 8379 2498

Out of Office Hours

Emergency duty social work team 020 8379 1000

Police Child Abuse Investigation Team 020 8733 5070

Alcohol and Drug service

Enfield designated doctor 020 8375 2620
Enfield designated nurses

Chase Farm hospital

Named doctor 020 8375 2915
Named nurse 020 8216 5207

North Middlesex University Hospital

Named doctor 020 8887 2945
Named nurse

Integrated Support Teams 020 8372 1500

CAMHS 020 8379 2000

To report allegations against staff

Local Authority Designated Officer 020 8379 2850

Safeguarding children and quality assurance service 020 8379 2850

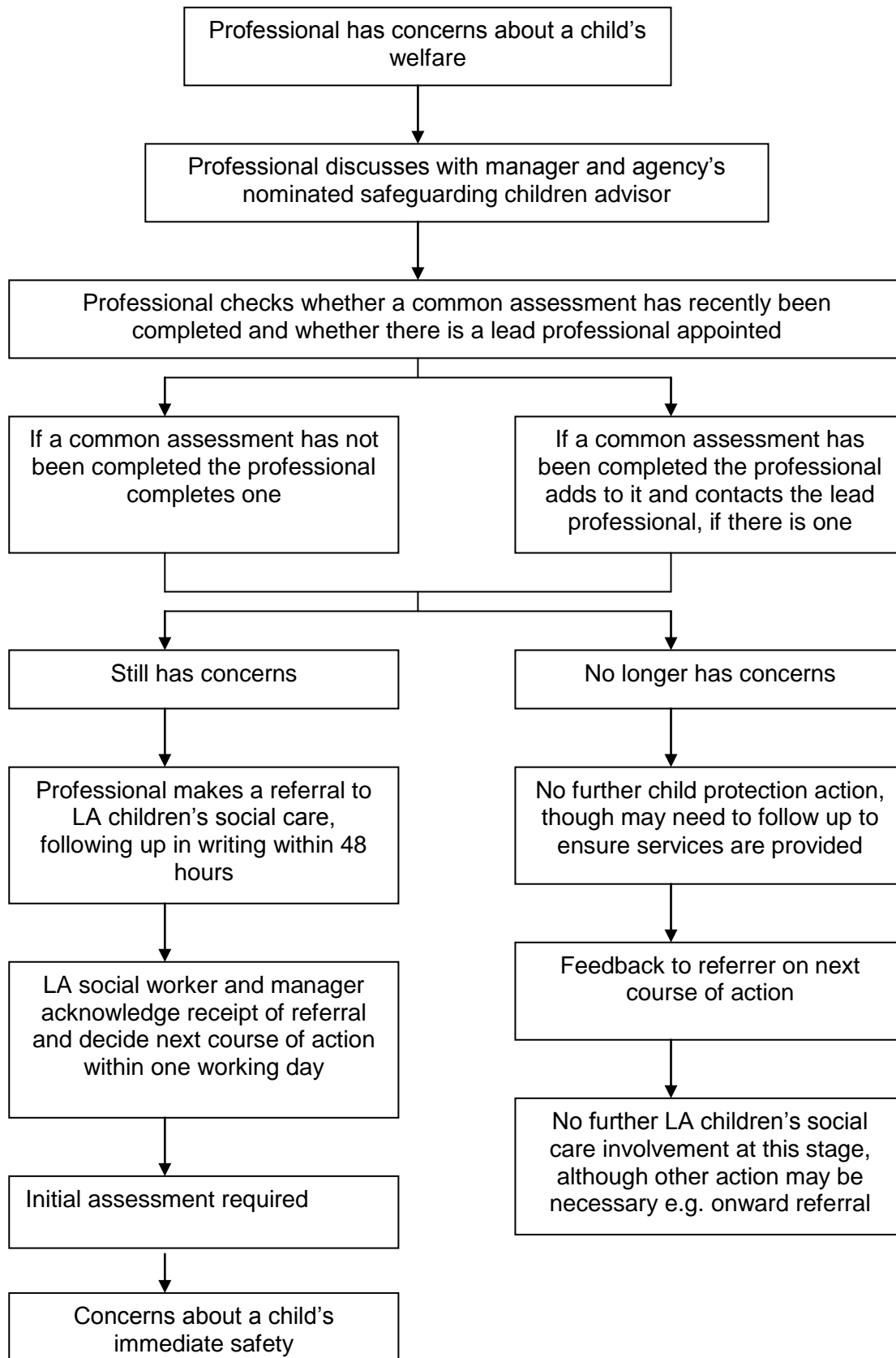
Safeguarding Children Board Development Officer 020 8379 2767
(For advice and information about training, policies and procedures)

Communication

It is not sufficient to leave messages about a patient on voicemail or answer phones; all voicemails should leave a number that can be dialed and which will be answered by a social worker in person. Information must be left with the patient's Children's Services social worker, the duty worker or the relevant administrative officer and a record made of the person spoken to. Out of normal office hours, information should be passed to the emergency duty social worker. It should then be faxed to the relevant duty team the next working day.

Appendix 2

Referral Flow Chart



APPENDIX 3

KEY HARINGEY CONTACTS

CHILDREN & YOUNG PEOPLE'S SERVICE

FIRST RESPONSE	020 8489 4592/5652/5762
Child Protection ADVISERS	020 8489 5426/7976/5462/1061
DESIGNATED NURSE	020 8442 5409
NAMED NURSE COMMUNITY HEALTH	020 8489 3096
NAMED NURSE PRIMARY CARE	020 8442 5857
POLICE CHILD ABUSE INVESTIGATION TEAM	020 8345 2246

ADULTS' SERVICES

INTEGRATED ACCESS TEAM	020 8489 1400
SAFEGUARDING ADULTS MANAGER	020 8489 3191

OUT OF HOURS SOCIAL WORK SERVICE

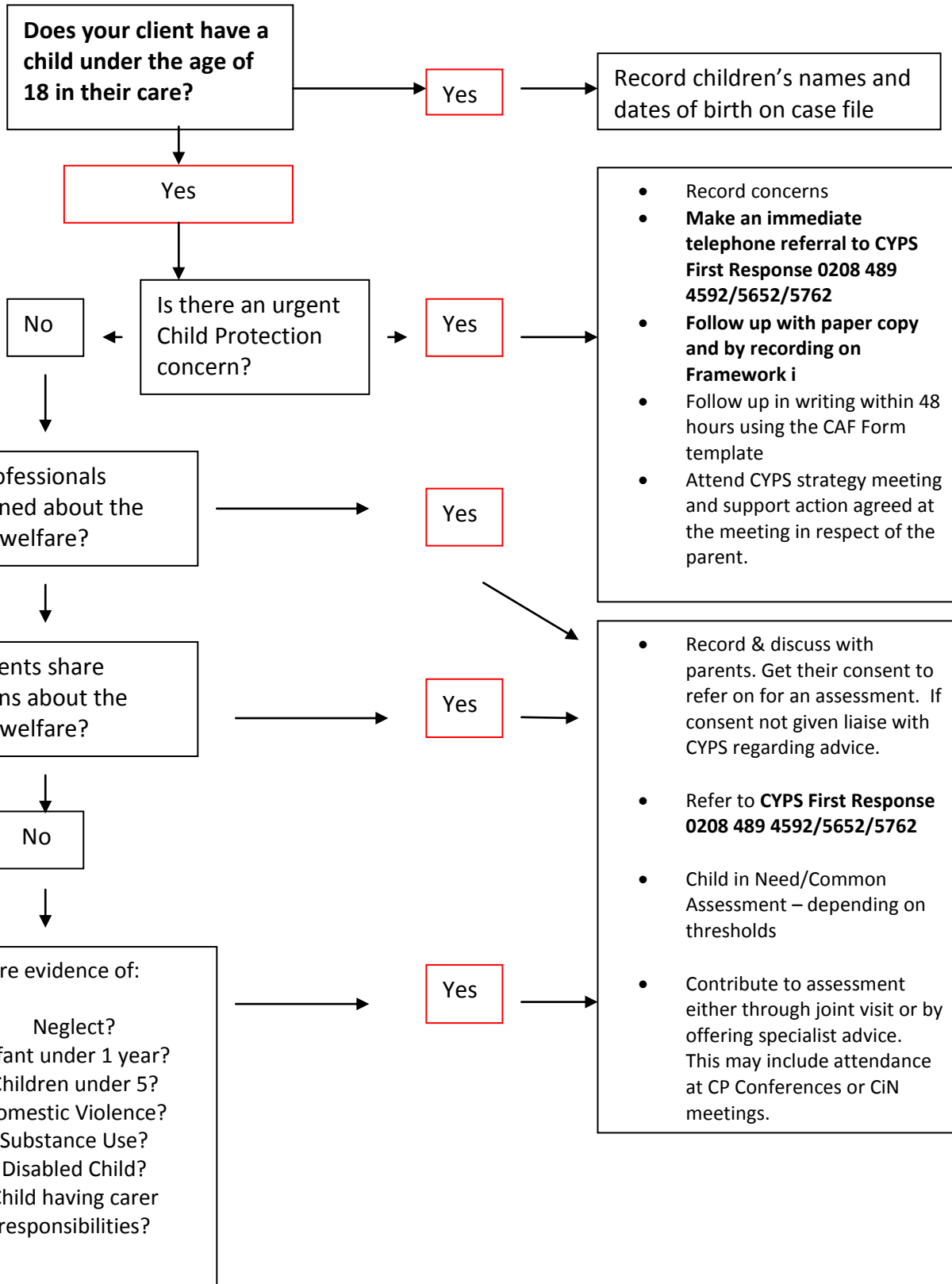
020 8348 3148

(5pm – 8.45am; weekends; Bank Holidays)

WWW.HARINGEYLSCB.ORG

APPENDIX 4

Referrals to Haringey First Response



APPENDIX 5

Key Barnet Contacts

If you have any concerns about a child:

Children's Social Care Referral and Assessment Team **Tel: 020 8359 4066 / 4097**
Secure Fax: 0871 594 8766

Opening Hours:

9am – 5.15pm Monday to Thursday
9am – 5pm Friday

9am to 12.30pm Referrals / Discussions / Advice with Duty Workers
1.30pm to 5pm Emergency Calls Only

Out of Office Hours Emergency Social Work Service Tel: 020 8359 2000

(Including out of hours Child Protection Referrals)

The Barnet Council Emergency Service Controller will take initial details and contact the appropriate out of hours officer.

Children's Social Care Service Manager, Assessment Tel: 020 8359 4075

(Responsible for the Referral and Assessment service)

CAF Team

CAF Coordinator

Tel: 020 8359 4405/ 4406

Email: e-caf@Barnet.gov.uk

Web: www.barnet.gov.uk/caf

Consultation Line (9.30am - 11.30am Tuesday and Wednesday) Tel: 020 8359 4336

This number is available for consultation, advice or when you just want to talk over a situation and case names are not required.

This number is not for referrals.

Disabled Children's Team Duty (9.00am – 4.30pm Monday to Friday) Tel: 020 8359 4246

Divisional Managers, Safeguarding Division

Tel: 020 8359 4532

(The Safeguarding Division monitors and promotes best practice in relation to children who are receiving a social care service, promotes Safeguarding work within the wider community and handles all allegations by children against people in a position of trust)

Hospital Social Work Team Duty

Tel: 020 8359 5333

For unborn and children admitted to hospital

Allegations against professionals working in a position of trust with children in Barnet should be made to:

Investigation Officer

Tel: 020 8359 6056

Police Child Abuse Investigation Team (8am-6pm)

Tel: 020 8733 5070

At all other times-contact this number where the controller will take initial

details and contact the appropriate out of hour's officer. **Tel: 020 8200 1212**

Private Fostering

For general enquiries about Private Fostering Contact **Tel: 020 8359 5315**

Barnet Kinship and Permanence Team

Dutykinship&permanency@Barnet.gov.uk

To make a Private Fostering Referral contact the Referral and Assessment Team (contact details above)

Barnet Safeguarding Children Board Development Manager

For advice and information about training, policies and procedures **Tel: 020 8359 4540**

Web: <http://www.barnet.gov.uk/practitioners-training>

Barnet Safeguarding Children Board Administrator **Tel: 020 8359 4519**

Web: www.barnet.gov.uk/safeguarding-children-board

For further guidance for professionals who are working with children and families in Barnet who may have a concern about a child, young person or unborn child can be found in:

[Barnet Children's Service CAF and Social Care Thresholds: A Guide for Practitioners in the Children's Workforce](#)

Appendix 6



Enfield Community Services

Child Protection/ Safeguarding Children Escalation Guidelines

Review Date:	July 2014
Policy Number:	
Policy Lead/Author	David Robinson/Carole Bruce-Gordon/ Dee Harris
Department	Clinical Care and Practice

Please note dependent on immediate risk to the child/young person escalation may not follow this route and may progress straight to Team Manager level, dependent on the status of who you have been negotiating with

Issue	Date Amended	Section /page	Author/ Amended by	Summary of Change

Introduction

The Child Protection Team acknowledge that in some situations, when cases have been referred to the Local Authority where Child in Need and / or child protection concerns have been identified, there are sometimes disagreements regarding the decisions and or actions taken by the Local Authority. This is because the referrer believes that the original concern has not been addressed and the child/young person is still considered to be “at risk”. These disagreements are most likely to arise around:

- Levels of need/thresholds
- Roles and responsibilities
- Progressing plans
- Communication

In cases where the referrer/practitioner considers that appropriate action has not been taken in regards to a referral the following escalation process should be followed. When this process begins the Lead Nurse for Child Protection should be notified and will advise on the appropriate level of escalation.

These guidelines have been developed in line with the guidance set out in Working Together to Safeguard Children, 2010⁵. (See paragraph 3.26 and 5.80) to ensure that practitioners have a quick and straightforward means of resolving professional differences in specific cases and in order to safeguard the welfare of children and young people. Effective working together depends on resolving disagreements to the satisfaction of workers and agencies, and the belief in genuine partnership and joint working to safeguard children.

Problem resolution is an integral part of professional cooperation and joint working to safeguard children. Professional disagreement is only dysfunctional if not resolved in a constructive and timely fashion. At no time must professional disagreement detract from ensuring a child is safeguarded. The child’s welfare and safety must remain paramount throughout.

Attempts at problem resolution may leave a worker believing that a child/children may be at risk of significant harm. The practitioner has a responsibility to communicate concerns through agreed child protection procedures on the same working day.

Disagreements could arise in a number of areas, but are most likely to arise around determining levels of need, roles and responsibilities, and the need for action and communication.

Resolving Disagreements

The aim should be to resolve difficulties at practitioner/case worker level between agencies. When there is recognition that there is a disagreement over a significant issue, which impacts on the safety and welfare of a child, the practitioner must identify explicitly what the problem is and have absolute clarity about the nature of the disagreement and what they believe the outcome should be.

⁵ HMG (2010) Working Together to Safeguard Children. London

It should be recognised that differences in status and/or experience may affect the confidence of some workers to pursue this unsupported. If unresolved, the problem should be referred by each worker to their respective team leader, line manager or child protection team, who in turn is expected to discuss with their opposite number in the other agency.

A clear record must be kept at all stages, in particular this must include written confirmation between the parties about an agreed outcome of the disagreements and about how any outstanding issues will be pursued.

Where Professional Disagreements Remain

If professional disagreements remain unresolved following discussions between respective managers, the matter must be referred to the child protection team. In the unlikely event that the steps described above do not resolve the issue and the discussion has raised significant policy issues; the issue should be referred to the Assistant Director for Safeguarding Children in Barnet, Enfield and Haringey Mental Health Trust.

Following the Use of the Escalation Guidelines

It may be useful for individuals to debrief following some disputes in order to promote continuing good working relationships. When the issue is resolved, any general issues should be identified and noted in any child protection updates for consideration to inform future learning.

Professionals should attempt to resolve differences through discussion within ONE WORKING WEEK or a timescale that protects the child from harm (whichever is shortest).

Most case/referral issues can be resolved at social worker/team manager level. If concerns remain, follow escalation guidelines.

Stage 1

Any worker who feels that a decision is not safe or is inappropriate should initially consult their team manager to clarify their thinking in order to identify the problem, to be specific as to what the disagreement is about, and to identify the desired outcome. The practitioner should then have a discussion with the social worker to try and resolve the problem. This discussion must take place as soon as possible and could be a telephone conversation or a face-to-face meeting. There may be instances where disparity in perceived status or experience may inhibit the ability of some workers to resolve the disagreement without support; this can be offered by the practitioner's manager or supervisor.

Most disagreements regarding decisions and actions resulting from referrals can and should be resolved at this level. It may be that the Local Authority does not have enough information to progress the referral and/or there is a lack of understanding on both sides and there is difficulty understanding the level or immediacy of risk of harm. Equally, the Local Authority may have advised that they are not taking any further action following an

initial assessment, strategy etc. These conversations must be documented in the child's notes.

Stage 2

If the problem is not resolved at Stage 1 the worker should contact their supervisor who should have a discussion with the equivalent supervisor/ Manager in the Local Authority. This stage of escalation may be progressed to where there is still disagreement with the team manager with whom you may have been negotiating but no further action has been taken and you consider that the child remains at risk of harm. Depending on the case the practitioner's supervisor may suggest a professionals meeting. The local authority should be invited and/or issue escalated. The meeting should be minuted and a copy sent to all attendees and documented in the child's notes.

Stage 3

If concerns persist despite negotiations within Stage 2 the referrer can and should pass the escalation responsibility to the Lead Nurse who will support the referrer/practitioner and ensure that the escalation proceeds upwards (to Director level if necessary). There is always scope to discuss with Independent Reviewing Officer, Deputy Head of Service/Head of Service and/or the Head of Safeguarding before Stage 3 is activated. All interactions should be documented in the child's notes.

Stage 4

When a resolution has not been achieved at Stage 3, the Chair of the LSCB should be approached to identify a Board member from an uninvolved agency to chair a meeting of the most senior managers with operational responsibility for the case. This meeting will review the issues and provide a final opportunity for the involved agencies to ensure that there is a full understanding of the issues before the decision is finalised. The Chair of this meeting will then report on issues arising from this process to the Serious Case Review Sub Committee.



Enfield Community Services

Practitioner Contact
Details

Date:

ESCALATION NOTIFICATION

Dear (Duty Team Manager)

Re: Child's name
Address
DoB
NHS number

The above named child/young person who was referred to your service on, but we have since been informed that the case does not meet the Local Authority threshold. Following discussion with (name of CP professional) a decision was made to escalate the case according to the Trust's escalation process (enclosed).

We acknowledge that most disagreements with Local Authority decisions are resolved at Team Manager level and we seek to ensure that this happens. You will be contacted by (CP Professional).

In some cases there may be a need to escalate cases about this level. If this is necessary you will be contacted by the Assistant Director for Safeguarding Children BEH MHT.

Cases progressing beyond Team Manager level will be copied to the Head of Safeguarding.

This procedure has been adopted in an effort to ensure a robust and accountable system is in place where concerns continue following a referral from Community Services to the local authority where:

- CP concerns exist
- A response is not in line with Child Protection policy and/or procedure
- There is disagreement between Local Authority and the Trust regarding plans for a child/young person.

When replying to this letter would it be possible to list the reasons that this case has not reached the Local Authority threshold for intervention; this is to enable us to learn from


these issues and ensure that all the correct detail and depth is included in the future. It is hoped that a speedy reply will enable practitioners in this case to continue to work together to safeguard the above child/young person.

Yours faithfully,

Denise Harris
Lead Nurse Child Protection.

Enc
Escalation Process

EQUALITY IMPACT ASSESSMENT

Name of the policy/service/function being assessed: Child Protection/Safeguarding Children Escalation Guidelines	
Person responsible for carrying out the assessment: Dee Harris	
Main aim, objectives and intended outcomes of the policy / function / service development?	
Aim: To ensure that staff are adequately supported when they wish to challenge decisions from other agencies in regard to child protection	
Objective: To guide staff through the process	
Intended outcomes: Practitioners feel supported and are aware of how to challenge decisions in regard to safeguarding of children.	
1. Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups? NO	
2. Which group or groups may be disadvantaged / experience negative impact?	
Race:	NO
Disability:	NO
Gender:	NO
Age:	NO
Sexual Orientation:	NO
Religion/Belief:	NO
Other:	NO
4. Does the policy/service show that the nine principles of mental health recovery have been taken into account. 1. Hope and Optimism 2. Personal responsibility and self determination 3. Collaboration 4. Support networks 5. Strengths approach 6. Service user involvement 7. Community integration/social inclusion 8. Spirituality 9. Positive risk taking. YES	
5. If the policy / function / service development positively promotes equality, please explain how? Promotes equality of all children irrespective of race, colour or creed.	
6. From the screening process, do you consider the policy / function / service development will have a positive or negative impact on the equality of any group or groups? Please rate the level of impact and summarise the reason for your decision. POSITIVE: likely to promote equality and improve relationship between groups.	
Date completed: 29 June 2011	
	
Signed:	

Print Name: Dee Harris

If the initial impact assessment has shown a potential for a negative impact a full impact assessment needs to be carried out.

Please send completed electronic copy of the Equality Impact Assessment to: