



Children Visiting Mental Healthcare Settings Policy

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Ratifying committee or executive director	Clinical Governance Committee	
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Executive director	Chief Nursing Officer/ Executive Director of Quality and Safety	
Policy lead	Head of Safeguarding	
Policy author (if different from above)		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	Yes	

Policy context

The Trust has specific duties under Section 11 of the Children Act 2004 to make arrangements to safeguard and promote the welfare of children and is committed to its responsibilities in respect of safeguarding and supporting children and their families.

This policy sets out our organisation's expectations in respect of children visiting BSMHFT premises. The emphasis is on the importance of facilitating a child's contact with their parents or other key family members (Children Act 1989 and 2004).

Policy requirement (see Section 2)

An assessment should always be undertaken to ascertain the desirability of contact between children and patients/clients, highlighting any concerns and risks to the child/children. The Multi-disciplinary Team (MDT) will make a decision whether or not the patient is able to receive children visitors.

Ward Staff are responsible for facilitating contact with those caring for the child/children and are also responsible for ensuring the safety of the child/children. The nurse in charge is responsible for ensuring appropriate and sensitive supervision of all children visits.

All children visiting Wards or visiting rooms away from the ward are to be accompanied by a responsible adult who is known / agreed by the family. This adult is to be made aware that they are responsible for the care of the child for the duration of the visit.

Children must not be left unaccompanied on the Ward or inpatient premises at any time.

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1: Introduction

1.1. Rationale

- 1.1.1 The Trust has specific duties under Section 11 of the Children Act 2004 to make arrangements to safeguard and promote the welfare of children and is committed to its responsibilities in respect of safeguarding and supporting children and their families.
- 1.1.2 The revised Mental Health Act Code of Practice 1999 (26.3) provides guidance on the visiting of psychiatric inpatients by children. It states all, 'hospitals should have written policies and procedures regarding the arrangements for children who visit patients in hospital and for visits to patients who are children or young people'.
- 1.1.3 This policy sets out our organisations expectations in respect of children visiting BSMHFT premises (**see also the flow chart on page 8**). The emphasis is on the importance of facilitating a child's contact with their parents or other key family members (Children Act 1989 and 2004).
- 1.1.4 This document should be read in conjunction with the Trust Safeguarding Children and Young People Policy.
- 1.1.4 National guidance emphasises that most visits by children to inpatients/residential settings are central to the maintenance of normal healthy family relationships. In the majority of cases, contact between children and adults who are inpatients/service users will be in the child's best interests. In a small number of cases however, there may be concerns about the impact such contact may have on the child and more rigorous clinical risk assessments may be required.

1.2. Scope

- 1.2.1 This policy will apply to all children visiting all inpatient settings in the Trust, whether the patient is detained under the Mental Health Act (2007) or has informal status.

1.3. Principles

- 1.3.1 A number of general principles need to be taken into consideration when considering the visiting of children to inpatient services:
- Visiting arrangements should be supportive of both child and adult and maximise the therapeutic value of such contacts, whilst ensuring that the child's welfare is safeguarded; and that the impact on the child is considered alongside the benefits to the service user.
 - Any decisions involving children visiting inpatient services must take account of the needs and wishes of the child/children as well as the patient/service user. The process for facilitating child visiting should not be bureaucratic, nor cause delay.
 - Any risks to the child should be identified and managed. These may be from the service user or from the environment in which visiting will take place. Therefore, a comprehensive

assessment including risk should ascertain the desirability of contact between children and patients/clients, highlighting any concerns, risks to the child/children and to consider any further action required to safeguard the child(ren).

- All inpatient services should try to ensure that there is an environment that is conducive to child visiting. In forensic settings children will only visit in designated family rooms or visiting rooms and will not visit in ward areas
- Where a family room is available, or there is a separate room away from the general ward area, these facilities should always be used. In non-forensic inpatient settings, if there is no alternative but to allow a child or children onto a ward environment, then this must be subject to a clinical risk assessment to ensure that the child's or children's welfare is safeguarded.

2: The policy

- 2.1 An assessment should always be undertaken to ascertain the desirability of contact between children and patients/clients, highlighting any concerns and risks to the child/children. Visits that are not considered to be in the best interests of the child cannot be allowed, however much the service user would benefit from the visit.
- 2.2 On admission, or as soon as possible, identification of who has parental responsibility is essential. Permission from the person who has parental responsibility for a preplanned visit to take place must be sought.
- 2.2 Ward Staff are responsible for facilitating contact with those caring for the child/children and are also responsible for ensuring the safety of the child/children. The nurse in charge is responsible for ensuring appropriate and sensitive supervision of all children visits.
- 2.3 The Multi-disciplinary Team (MDT) will decide whether the patient is able to receive child visitors. In some cases, there may be concerns about a visit going ahead. It is important for staff to check whether there are any specific court orders or protection plans in place, consultation with Children Services and the safeguarding team will clarify this. In these circumstances other forms of contact could be considered e.g. telephone or letter.
- 2.4 All children visiting the Wards or off-ward visiting rooms are to be accompanied by someone with parental responsibility or a responsible adult who is known / agreed by the person who has parental responsibility. This adult is to be made aware that they are responsible for the care of the child for the duration of the visit.
- 2.5 Children must not be left unaccompanied on the Ward or building at any time.

3: Procedure

- 3.1 Names and date of birth of children should be recorded in the appropriate section of RIO, which is the children and siblings form in the demographic section. Recorded information may relate younger siblings/relatives of inpatients who are considered to be children (Children Act 1989). Details of children who will be visiting should ideally be provided in advance to Ward

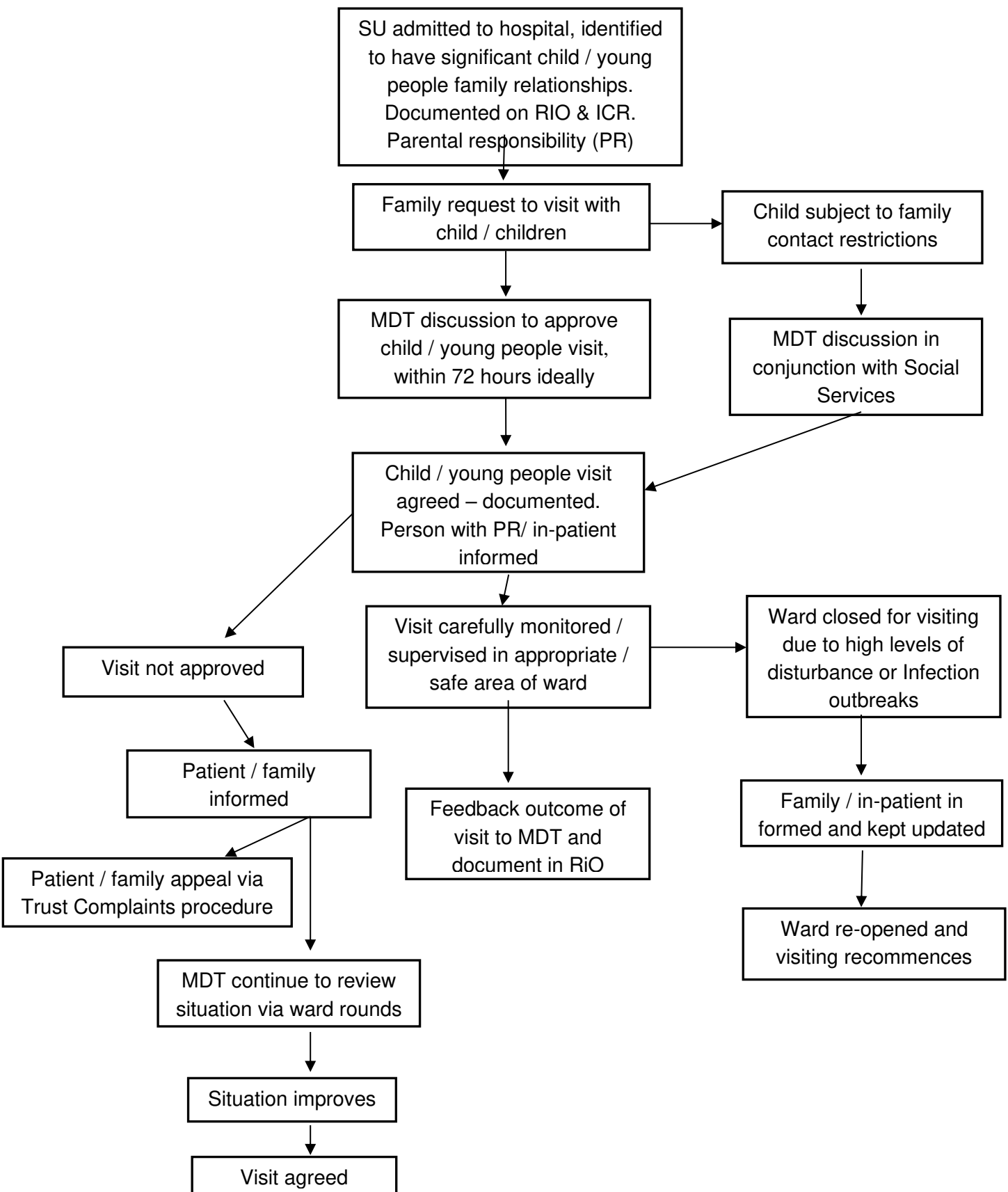
staff or as soon as possible via the Care Coordinator, Social Worker, patient/service user or family. All child visits should be preplanned and organised with an agreed plan in place prior to any visit taking place.

- 3.2 Written/video information about the Ward which includes reference to child visiting should be provided for all patients/service users, their children, and their families/carers to support the admission procedure.
- 3.3 All patients, during the admission procedure, will be asked to share personal details of children who are likely to visit them on the ward, i.e. the name and date of birth of children they have parental responsibility for, or where there is a significant relationship around providing care for a child. This will include 'Looked After Children' and details of any involvement with Children Social Care. These details will be recorded in the children and siblings form on RiO. If a child is regularly visiting a patient, it should constitute part of the patients care plan and should be fully documented within the assessment, risk and care planning sections of RiO.
- 3.4 All decisions to allow child visiting should be informed by clinical risk assessment recorded in a risk screening/assessment tool that meets the agreed Trust standard.
- 3.5 Ideally decisions to allow child visiting should be made within 72 hours and recorded on the 72-hour care plan but this will depend on how long it takes to gather information to inform the decision. In some circumstances this may take longer.
- 3.6 Ward Staff are responsible for facilitating contact with those caring for the child/children and are also responsible for ensuring the safety of the child/children. The nurse in charge is responsible for ensuring appropriate and sensitive supervision of all children visits.
- 3.7 A separate area on the Ward should be available for in-patients to receive children visitors i.e. not in communal areas.
- 3.8 Children must not visit areas that have not been designated.
- 3.9 Only in exceptional circumstances will children be allowed to visit a service user who is being cared for in one of the Trust's psychiatric intensive care facilities, which may include seclusion or segregation. Such visits should take place at a suitable location away from the unit with appropriate escorting and supervision arrangements.
- 3.10 The Multi-disciplinary Team (MDT) will make a decision whether or not the patient is able to receive child visitors. This will be dealt with sensitively and any outcome recorded, including the wishes and feelings of the child. Details of agreed decisions and arrangements for children visiting or any decision to not agree visiting by a child will be recorded in the Care Plan. It may be appropriate, in many circumstances, for the patient themselves to act as the adult responsible for the care of the child for all or part of the duration of the visit but this must be fully risk assessed and the responsibility made clear to the patient.
- 3.11 Decisions not to allow visits will be continually reassessed by the MDT and will always be based on the child's best interests. This may depend upon the service user's mental state,

the wishes, and feelings of the child according to their developmental age. This will also consider other factors on the ward. In certain circumstances (e.g. acute disturbance on the ward), the child visiting plan may be overruled. This will be the decision of the nurse-in-charge of the ward at that time.

- 3.12 All children visiting the non-forensic inpatient Wards are to be accompanied by a person with parental responsibility or a responsible adult who is known / agreed by the person who has parental responsibility. This adult is to be made aware that they are responsible for the care of the child for the duration of the visit.
- 3.13 During the visit every effort must be made to ensure that the child has contact only with the patient for whom permission has been given for that child to visit. All Ward staff on duty must be aware of the child's presence on the Ward and with whom contact is authorised. All staff on duty must remain vigilant to ensure that the child/children are not left with, nor approached by, anyone else.
- 3.14 The nurse in charge may terminate visits before the agreed time if concerns arise over the patient's behaviour or mental state, or if there is a perceived risk to the child. Any decision to terminate a visit must be fully documented within the patient's Integrated Care Record, including details of the circumstances and rationale for the termination.
- 3.15 Staff should not be left to care for any child whilst their parent or responsible adult is visiting the patient.
- 3.16 It may be necessary to be flexible with designated visiting times to accommodate the needs of the child and to enable visiting to promote family life (Children Act 2004 - Human Rights Article 8).
- 3.17 Careful consideration must be given to requests for child visits to the ward when there is a known person who poses a risk to children (previously known as 'schedule 1 offender') It may not be appropriate to arrange a visit, but rather arrange a visit in a venue away from the ward. Local Children's Services may be able to advise on suitable venues for such contact.
- 3.18 **Visits of children involved with Social Services**
Visits of children arranged by Children's Social Care must be accompanied by a Social Service representative at all times. This may include younger siblings of inpatients who are considered to be children (Children Act 1989).
- 3.19 Where restrictions on children visiting have been put in place by Social Services then discussions about visiting must be made by the MDT consultant with the lead social worker and carefully documented.
- 3.20 When existing contact arrangements are in place, a decision as to whether the continuation of these is appropriate must be made by the MDT in conjunction with Social Services. The final decision as to whether a child / children can visit will rest with the MDT following consultation with Social Services representatives and the family.

3.21. Any incident which has caused harm or introduced significant risk of harm to the child during a visit must be reported via Eclipse as a safeguarding incident. **Flowchart for Child / Young People visiting In-Patient Units**



3.22 **Dealing with unexpected visits by children:**

Where an unexpected visit of a child is experienced, the ward manager / nurse in charge should make every effort to facilitate the visit, having due regard to issues of safety and desirability. However, the current environmental and clinical circumstances of the ward must be considered, together with the best interests of the child, when faced with such a request or situation.

3.23 When an unexpected visit by a child occurs, the nurse in charge may be required to make a unilateral decision. The Responsible Clinician, Lead Nurse, senior operational manager responsible for the ward and Safeguarding Lead for Children & Young People, are available for advice and consultation. Out of hours the on-call consultant and/or manager are available. If there are any concerns about the child's safety, then the visit must be deferred or must take place under the close supervision of staff.

3.24 The decision to allow an unexpected visit to proceed must be carefully documented in the Integrated Care Record.

3.25 Where unexpected visits from children occur, the ward manager or nurse in charge, must inform the accompanying adult or parent of the Child Visiting Policy, and explain the procedures, including the need for a detailed assessment, for future approval for visiting by the child/children.

3.26 **Section 17 Leave (MHA 2007)**

Responsible Clinician and MDT must take into account any potential child protection or welfare issues when granting leave of absence under Section 17 (MHA 2007) to facilitate child contact or visits.

3.27 **Visiting outcomes & incidents**

Outcomes of any child/children visits will be documented in the Integrated Care Record including an account of how the patient responded to the visit and any other observations. The patient's clinical care plans and/or clinical risk assessments should be updated if necessary.

3.28 Any significant outcomes must be recorded on RiO and communicated throughout the multi-Agency Team e.g. MDT, Health Visitor, Social Worker, School Nurse as appropriate.

3.29 If a member of staff witnesses anything that causes them concern about the safety of the child/children then they are required to contact the Local Authority Children Services in accordance with Trust Safeguarding Children and Young People Policy (2022), Working Together to Safeguard Children (2023) and Birmingham or Solihull LSCP Safeguarding Children Procedures (dependent upon the locality of the inpatient setting).

3.30 The patient's risk assessment and risk history must be updated and if required staff should seek further guidance from their operational managers in the first instance, and then as needed, seek additional support from the Trust Safeguarding Team and the event reported on Eclipse as an incident.

- 3.31 Decisions to refuse visits:**
Decisions to refuse visits will be exceptional and should be supported by clear evidence of concerns. The patient, child/children (if age appropriate) and other appropriate family members and those with parental responsibility must be notified. The decision must be confirmed in writing and documented on the Integrated Care Record.
- 3.32 If a decision is taken to refuse visits telephone contact should be encouraged if this is assessed as a desirable means of continued contact and communication. It is the responsibility of the nurse in charge to ensure that the patient is provided with access to a telephone in a private area where calls can be made or received. In exceptional cases it may be appropriate for nursing staff to closely supervise the patient during telephone conversations to ensure that the conversation is appropriate, particularly if there are known child protection concerns.
- 3.33 If the child does not have ready access to a telephone at the address at which they are residing then arrangements should be made to facilitate telephone contact by the family.
- 3.34 Decisions to refuse permission for children visiting must be reviewed regularly by the MDT and also documented on RiO. Reviews would normally occur at a Ward round but may be arranged at other times if appropriate. The patient, child/children (if age appropriate) and the family and those with parental responsibilities must be kept informed of the outcome of reviews.
- 3.35 It may be necessary, because of the mental state of other patients on the Wards, or general level of disturbance, to exclude all children visiting the Ward for a period. Members of the MDT will only take such decisions, following careful consideration of the clinical risks. Such decisions may also be discussed between the Ward Manager, Ward Consultant Psychiatrists, the Care Coordinator, the Patient, the Family and the Trust Safeguarding Named Nurse for Children & Young People or Head of Safeguarding. In these instances, arrangements may be made for a visit off the Ward.
- 3.36 The Ward Manager retains the option to refuse visits in exceptional circumstances where the safety of the child may be compromised (e.g., critical incidents occurring)
- 3.37 The Ward Manager may curtail visits in cases where it is judged that the child is excessively distressed.
- 3.38 The patient or others with parental responsibility may appeal against the initial decision or any subsequent reviews of the decision. Such appeals should be dealt with under the BSMHFT Complaints Policy and Procedures.
- 3.39 The safety of the child remains paramount (Children Act 2004)**

3.40 **Training**

Child safeguarding training is mandatory for all Trust staff and helps to facilitate staff recognition and understanding of the child's need to maintain good and positive relationships with parents and other adults with whom the child has developed appropriate attachments.

3.41 Level 3 training focuses on the 'Think Family' approach that helps to improve outcomes for parents with mental health problems and their families.

3.42 Training attendance is closely monitored via the relevant operational performance Boards and the Safeguarding Management Board with exception reporting to the Trust Clinical Governance Committee, Quality, Patient Experience and Safety (QPES) and Trust Board.

4: Responsibilities

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All inpatient setting staff	Understand this policy and their responsibilities regarding all children visiting all inpatient settings, whether the patient is detained under the Mental Health Act (2007) or has informal status.	
Service, Clinical and Corporate Directors	Local Implementation: Implement the policy within their department. Team Leadership and Support: Leads and supports their team in policy application. Feedback and Reporting: Provides feedback on policy impact and suggests improvements.	
Policy Lead (Head of Safeguarding)	Policy Development: Leads the creation and drafting of the policy, ensuring it aligns with organisational goals, legal requirements, and best practices. Stakeholder Coordination: Coordinates with various stakeholders, including clinical and non-clinical staff, to gather inputs and achieve consensus on the policy content. Implementation Strategy: Develops and oversees the implementation strategy for the policy, ensuring it is communicated and understood across all levels of the organisation. Monitoring and Reporting: Regularly monitors the implementation and impact of the policy, reporting on its effectiveness and any issues encountered. Policy Review and Update: Reviews the policy at regular intervals or as required, making updates to reflect changes in legislation, best practices, or organisational needs.	

	<p>Feedback Integration: Incorporates feedback from staff and stakeholders to continuously improve the policy.</p> <p>Risk Management: Identifies and addresses potential risks related to the policy, ensuring measures are in place to mitigate these risks.</p> <p>Collaboration with External Bodies: Works with external bodies or regulators as necessary, representing the organisation's policy positions and ensuring external compliance.</p>	
Chief Executive Officer	<p>Strategic Oversight: Aligns policy with overall strategic goals.</p> <p>Resource Allocation: Ensures resource availability for effective implementation.</p> <p>Compliance and Accountability: Ensures organisational compliance with regulations and standards.</p>	
Executive Sponsor (Chief Nursing Officer)	<p>Policy Development and Advocacy: Leads policy development, focusing on clinical interventions, patient care, and service user outcomes.</p> <p>Clinical Governance: Ensures the policy is in line with clinical governance and patient safety standards.</p> <p>Clinical Leadership and Expertise: Provides clinical leadership and expertise.</p> <p>Implementation and Training: Oversees policy implementation and training requirements.</p> <p>Monitoring and Evaluation: Monitors policy effectiveness and facilitates decision making regarding updates.</p> <p>Quality and Outcomes Monitoring: Monitors clinical outcomes and quality improvements related to the policy.</p>	
Medical Director	<p>Medical Leadership: Guides and supports medical staff in policy implementation</p> <p>Interdisciplinary Collaboration: Collaborates with other departments for cohesive policy adherence.</p>	
Allied Health Professionals	<p>Collaborative Practice: Implements policy in a manner consistent with collaborative, multidisciplinary care.</p> <p>Professional Standards Adherence: Ensures policy adherence to professional standards and ethics.</p> <p>Patient-Centered Care: Focuses on delivering patient-centred care in line with the policy.</p> <p>Continuous Improvement: Contributes to the continuous improvement of policy through professional expertise.</p>	

5: Development and Consultation process:

Consultation summary		
Date policy issued for consultation	August 2024	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	Date(s)	
Safeguarding Management Board	27/10/23 and 26/04/24	
Policy Development Management Group	11/09/24	
Trust Clinical Governance Committee		
Where received	Summary of feedback	Actions / Response
Policy Lead	Make clear difference in arrangements for child visiting in Forensic settings (not ward but Family/Visiting Rooms)	Policy changed to make clear children do not visit on wards but in designated visiting rooms
Policy Lead	Changes to wording and language used to make content clearer and less ambiguous. Changes to assurance section.	Text changed according to feedback.

6: Reference documents:

Chapter 11(Visiting Patients in Hospital) Revised Code of Practice MHA 1983 (DH 2008), Section 11.19 (Children & Young People)

The Children Act' (1989 and 2004)

'Working Together to Safeguard Children in need and their Families' (DoH 2023)

Guidance on the visiting of psychiatric inpatients by children Code of Practice MHA 183 (DH 2008);

Child Visiting policy (Northumberland, Tyne & Wear NHSFT March 2010);

Policy for Children Visiting Inpatient & Residential Units (Northamptonshire Healthcare NHSFT Jan 2011);

Children visiting relatives in inpatient mental health wards policy (Berkshire NHSFT May 2011)

Children of parents with mental health problems (West Midlands Regional Child Protection Procedures Dec 23 [2.12 Children of parents with mental health problems | West Midlands Safeguarding Children Group \(procedures.org.uk\)](#))

7: Bibliography:

Working Together to safeguard children – a guide to inter-agency working to safeguard & promote the welfare of children (DH March 2023)

Revised Code of Practice MHA 1983 (DH October 2008);

MHA 1983 Code of practice: (HSC 1999/222: LAC (99)32;

8: Glossary:

The term “**child**” in this document refers to a child or young person aged 0-18 years.

Safeguarding is a term which is broader than ‘child protection’ and is used generically throughout both child and adult safeguarding to include promotion of welfare and prevention of harm;

Looked After Children - the term 'looked after' was introduced by the Children Act 1989 and refers to children who are subject to care orders and those who are voluntarily accommodated. Wherever possible, the local authority will work in partnership with parents.

Parental Responsibility - As defined in the Adoption and Children Act 2002, amended from the Children Act 1989 (all the rights, duties, powers, responsibilities, and authority which by law a parent of a child has in relation to the child). From the 2002 Act, a mother has this automatically and a father has this if his name is on the birth certificate from the 1st of December 2003. An unmarried father can also have obtained parental responsibility through having a parental responsibility agreement with the mother or via a parental responsibility agreement from a court. In specific circumstances, people other than biological parents could have obtained parental responsibility, these might include stepparents, grandparents or same sex partners.

Local Safeguarding Children Partnership (LSCP) - each Children's Service Authority in England was required by the Children Act 2004 to establish a Local Safeguarding Children Board by the 1st April 2006. These are now known as Local Safeguarding Children Partnerships and are the key statutory mechanism for agreeing how organisations working with and providing services for children in each local area will co-operate to safeguard and promote the welfare of children and to ensure the effectiveness of the work done for that purpose.

9: Audit and assurance:

9.1 The below elements will be monitored across inpatient sites.

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Are service areas aware of the policy?	Matrons/ Safeguarding Team	Regular matron monitoring via checklist/ Safeguarding Assurance visits	Annually	Safeguarding Management Board
Is there a place to visit off the main ward?	Matrons/Safeguarding Team	Regular matron monitoring / Safeguarding Assurance visits	Annually	Safeguarding Management Board
Eclipse reports regarding children visiting inpatient settings	Named Nurse for Safeguarding Children & Young People	Eclipse reports	Ongoing	Safeguarding Management Board

10. Appendices

Appendix 1 equality analysis Screening Assessment

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
<http://connect/corporate/humanresources/managementsupport/Pages/default.aspx>

Title of Policy	Children Visiting Mental Healthcare Settings Policy		
Person Completing this policy	Mel Homer	Role or title	Head of Safeguarding
Division	Corporate Nursing	Service Area	Safeguarding
Date Started	August 2024	Date completed	August 2024
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy sets out our organisation's expectations in respect of children visiting BSMHFT premises. The emphasis is on the importance of facilitating a child's contact with their parents or other key family members (Children Act 1989 and 2004).			
Who will benefit from the policy?			
The Trust, Staff, Service users and Visitors			
Does the policy affect service users, employees or the wider community? <i>Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward</i>			
The policy affects service users their families and employees in a positive way			
Does the policy significantly affect service delivery, business processes or policy? <i>How will these reduce inequality?</i>			
No. This policy will however encourage families to feel comfortable and safe when making visits			
Does it involve a significant commitment of resources? <i>How will these reduce inequality?</i>			
No visits for service users are already in place			

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
No				
Impacts on different Personal Protected Characteristics – Helpful Questions:				
<i>Does this policy promote equality of opportunity? Eliminate discrimination? Eliminate harassment? Eliminate victimisation?</i>			<i>Promote good community relations? Promote positive attitudes towards disabled people? Consider more favourable treatment of disabled people? Promote involvement and consultation? Protect and promote human rights?</i>	
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age	X			The policy supports staff to think about the needs of the family and children visiting. It is anticipated that age will have no impact in terms of discrimination as this policy ensures that all should be treated in a fair, reasonable and consistent manner irrespective of this including their age and how this affects their needs.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	X			The policy supports staff to think about the individual needs of the person, including if they have a disability, and how this affects their needs. This may be a physical disability, a sensory or neurodiverse issue or a learning disability. It is anticipated that disability will have no impact in terms of discrimination as this policy ensures that all should be treated in a fair, reasonable and consistent manner.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				

Gender	X			It is anticipated that gender will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner irrespective of their gender identity.
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships	X			It is anticipated that marriage or civil partnerships will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner irrespective of their gender identity.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			It is anticipated that pregnancy or maternity will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. However, if an individual chose to disclose their pregnancy than reasonable adjustments will be considered and made where possible.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	X			It is anticipated that race or ethnicity will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner irrespective of their race or ethnicity.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				

Religion or Belief	X			It is anticipated that religion or belief will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner irrespective of their religion or belief.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			It is anticipated that sexual orientation will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner irrespective of their sexual orientation.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			It is anticipated that transgender and gender reassignment will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service should be treated in a fair, reasonable and consistent manner irrespective of transgender or gender reassignment.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights	X			The policy supports staff to think about the best interests of children and their rights. It is anticipated that the policy will have no impact in terms of discrimination as this policy ensures that all employees/visitors and service users should be treated in a fair, reasonable and consistent manner.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				

If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)

	Yes	No N/A		
What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.

If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead**.

Action Planning:

How could you minimise or remove any negative impact identified even if this is of low significance?

Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns

How will any impact or planned actions be monitored and reviewed?

Feedback from reporters of concerns, escalating concerns through governance routes.

Regular audits and policy updates, communication to managers through meetings and committees

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.

Policy will be trust wide promoted in ways accessible to ALL staff.

Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis