Whittington Health NHS

Female Genital Mutilation (FGM) Policy

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Date Ratified	
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Designation of Author	**Head of Safeguarding, Whittington Health & Named Midwife and Islington Community, Specialist Midwife for Female Genital Mutilation**
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Version Control Sheet

Version	Date	Author	Status	Comment
1	12.3.13	Named Midwife for Child Protection, Named Nurse for Islington Community		First integrated care document for hospital and community
2	13.5.15	Head of safeguarding		Amended version in light of DOH guidance

1. Introduction

"Whittington Health is committed to safeguarding all children and vulnerable adults and expects all staff and volunteers to share this commitment."

This policy is written in line with the Female Genital Mutilation Multi-Agency Practice Guideline 2011[1] Working Together to Safeguard Children 2013[2] London procedure for safeguarding children at risk of abuse through female genital mutilation (2007) and Department of Health Multi Agency Practice Guidelines: Female Genital Mutilation (2014).[3] Department of Health Female Genital Mutilation Risk and Safeguarding Guidance for professionals March 2015.

The policy is intended to support health professional working within Whittington Health in supporting women who are victims of female genital mutilation (FGM) and safeguarding children and girls who are at risk of the procedure.

Female Genital Mutilation (FGM) is a harmful practice prevalent in several cultures, religions and ethnic groups in Africa, the Middle East and Turkey. The London Central Mosque has spoken out against FGM on the grounds that it 'constitutes doing harm to one's self or others which is forbidden by Islam' as stated in the Female Mutilation Multi-agency practice guidelines.

"It is critical that all nurses and midwives are clear in their minds that FGM is abuse, and that they have a responsibility to act to protect girls from this type of abuse. To fail to act because of labels of culture, tradition, religion or because of the fear of being labelled 'racist' is unacceptable!"[4]

The issues around FGM

- Female Genital Mutilation is a form of physical abuse, has severe significant physical and mental health consequences in the short and long term which must not be excused, accepted or condoned.
- It is an offence for anyone in the UK to practice FGM or for a child to be taken to another country for FGM to be performed.
- All agencies must act in the interests of the rights of the child as stated in the UN Convention for the Rights of The Child 1989.[5]

It is believed that FGM happens to British female children in the UK as well as overseas.

FGM constitutes all procedures that involve partial or complete removal of the external female genital for non-medical reasons. It is estimated 66,000 women in England and Wales are affected.

20,000 female children under the age of 15 are at risk in the UK

- Women's cultural, religious and linguistic background must be respected but any practice that is harmful or abusive must not be accepted.

- All health care must be sensitive and accessible, underpinning all care and interventions.

2. Purpose

To inform and support health professionals working in Whittington Health who provide/ participate in the care of all women who have experienced FGM and those children and young people who are at risk of FGM.

UK Legislation

'It is an offence for anyone in the UK to perform FGM. Under the Female Genital Mutilation Act 2003, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a child or woman's labia majora, labia minora or clitoris except for clinically necessary surgical operations and operations carried out in childbirth. It is also an offence to assist a child or young woman to mutilate her own genitalia, or take a child or young woman outside the UK for the purpose of carrying out FGM. Responsibility for investigating whether FGM has been carried out rests with the police and should not be conducted by Health Professionals.[6]

It is also an offence for a UK national or permanent resident to assist a non-UK person to perform any act relevant to FGM abroad. This would include taking a child or young woman abroad to be subjected to FGM.

Local authorities can apply to the courts for various orders to prevent a child being taken abroad for mutilation. [7]

Specific to section 47 of The Children Act is 'anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police'

3. Duties

Duties within the Organisation

Chief Executive – The Chief Executive has overall responsibility for ensuring effective processes, education and policy is in place to support staff in this area

Chief Operating Officer - The Chief Operating Officer is responsible to the Chief Executive for ensuring that effective process and practice are in place across the organisation.

Trust Board - The Trust Board is responsible for ensuring that a culture of openness, trust, service improvement and sharing of learning is present within the organisation. It has overall responsibility for ensuring that the Trust's duties with regard to the management of serious incidents and safeguarding children are appropriately discharged, including ensuring compliance with this policy. The Board will receive assurance of this through the Quality Committee.

Director of Nursing and Patient Experience

- To ensure appropriate processes are in place to safeguard and promote the welfare of children
- To ensure a culture of openness, trust, service improvement and ensuring there is a mechanism for the sharing of learning within the organisation.
- To ensure that appropriate processes are in place for being open with patients following a serious incident.
- To be clear that FGM is abuse and that the risk to female infants and children must be recognised if a mother is found to have had FGM herself

Heads of Nursing/Midwifery

- Promote a culture of openness, trust, service improvement and sharing of learning within their services.
- To ensure the Female Genital Mutilation Policy is shared and implemented within their service area.
- To be clear that FGM is abuse and that the risk to female infants and children must be recognised if a mother is found to have had FGM herself.
- Be clear about communication pathways and risk assessment when FGM is identified.

Divisional Operational Directors and Clinical Directors

- Disseminate the policy within their area of responsibility and ensure it is implemented by providing advice and support to staff and managers.
- Ensure that reported incidents are reviewed within the directorate and any recommendations made as a result of investigations are put into place.
- To ensure risks are identified and incorporated on the divisional risk register as appropriate.
- To be clear that FGM is abuse and that the risk to female infants and children must be recognised if a mother is found to have had FGM herself

4. Definitions

World Health Organisation Classification of FGM, 2008. [8]

Female Genital Mutilation can also be referred to as 'cutting', 'circumcision' or 'initiation'.

Type I

Partial or total removal of the clitoris and/or the prepuce (clitoral hood).

Type II

Partial or total removal of the clitoris and the labia minora (smaller lips) with or without excision of the labia majora (larger lips).

Type III

Narrowing of the vaginal opening with creation of a covering seal by cutting, oppositioning and sewing up the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV

All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising and cauterisation.

Reasons given for practising FGM:

- It brings status and respect to the girl.
- It preserves a girl's virginity/chastity.
- It is part of being a woman.
- It is a rite of passage.
- It gives a girl social acceptance, especially for marriage.
- It upholds the family honour.
- It cleanses and purifies the girl.
- It gives the girl and her family a sense of belonging to the community.
- It fulfils a religious requirement believed to exist.
- It perpetuates a custom/tradition.
- It helps girls and women to be clean and hygienic.
- It is aesthetically desirable.
- It is mistakenly believed to make childbirth safer for the infant.
- It rids the family of bad luck or evil spirits.

5. Development of the Policy

The development of the policy is to ensure that clinical staff within Whittington Health have an awareness of the topic of FGM and know which service to refer women and children to.

A specialist midwifery team who review women with FGM is already in existence within the organisation.

The nominated author of this policy is the Named Midwife and Head of Safeguarding.

The Safeguarding Children's Committee has responsibility for monitoring the development of this policy.

6. Policy Headings

6.1 Key Principles of Safeguarding Children

Staff should follow guidance in the London Child Protection Procedures and Safeguarding Children at Risk of Abuse through Female Genital Mutilation.[9& 11]

Staff must recognise the risk to female children if a woman is found to have experienced FGM herself. A set of risk assessment questions should be asked and the responses documented clearly in the medical/midwifery notes (see below).

All staff must consider the ongoing potential risk of future harm including FGM to female babies and siblings within the family. Therefore key health professionals should be informed when a female child is born to a mother who has experienced FGM (health visitor/school nurse/GP).

There is a mandatory duty for all professionals under the proposed Serious Crime Act (2015) to act as safeguards for young women and children at risk. The duty requires that:

- Girl victims identified under the age of 18 are to be referred to the police within one month of disclosure/identification depending on the circumstances of the case. This will not necessarily trigger automatic arrests. The police will work with the relevant agencies to ensure appropriate safeguarding responses are put in place. Consider including that a new mandatory duty is being introduced during 2015, through the Serious Crime Act to report cases of FGM.
- The mandatory duty will:
- Apply in cases of 'known' FGM – i.e. instances which are disclosed by the victim and/or are visually confirmed. ••
- Be limited to girls under 18
- Apply to all regulated healthcare and social care professionals, and teachers
- Require reports to be made to the police within one month of initial disclosure/identification – depending on the circumstances of the case, this will not necessarily trigger automatic arrests; the police will then work with the relevant agencies to ensure an appropriate safeguarding response is put in place which places the interests of the child front and centre
- Failure to comply with the duty will be dealt with via existing disciplinary measures, which may include referral to the professional regulator as appropriate – this will ensure that all breaches are dealt with appropriately and in accordance with the specifics of the individual case

RISK ASSESSMENT QUESTIONS to consider:

1. What is woman's attitude to FGM?
2. What age was procedure carried out on her? In which country?
3. Does she support the practice of FGM and would she consider FGM on her own daughter?
4. Are there any external influences on woman influencing her decision ie. Partner views/extended family views/cultural and environmental beliefs to consider.
5. Are there any long term effects from the procedure (emotional and physical health)?

If concerns are raised in response to any of the above questions, the Named midwife/member of Safeguarding team should be consulted and a referral to social care should be considered.

The patient's medical notes should always be updated with whatever discussions or actions have been taken. In addition, any referral to social services/police or specialist clinic should be recorded appropriately.

Female children born to victims of FGM should have the information shared on their mother's FGM status with the health visitor and GP. Risk assessments as indicted above should still be carried out when necessary by health visitors and GP's and recorded in the medical notes.

The entry 'mother victim of FGM' should be entered in the Personal Child Health Record (red book) birth details page after birth. Parents should be informed that this information is being recorded in their daughter's red book and if they do not consent to this, the Head of Safeguarding should be informed.

An alert (flag) must be added to the community (RIO) and hospital health record of all female children whose mother has experienced FGM to raise awareness throughout the organisation of the possible future risk to female children within the family e.g. Emergency Departments, School Health etc.

An alert must be added to the child/children's RiO record under the category of 'Client has Medical Alert' and then in the comments box 'Family history of FGM' to be entered.

Professionals have a responsibility to ensure that families know that FGM is illegal, and should ensure that families know that the authorities are actively tackling the issue. This knowledge alone may deter families from having FGM performed on their children, and save children and women from harm.

Any medical provision for the pregnant woman who has herself been the subject of FGM provides an opportunity for recognition of risk to female children and for preventative work with parents. In addition a child may be considered at risk if it is known that older children in the family have been subject to the procedure.

A 'Health Passport' or 'Statement Opposing Female Genital Mutilation' leaflet can be offered to victims. It is designed to be used by victims recently immigrated to the UK, who do not want their children to be subjected to FGM to outline the law and potential criminal penalties. It can be shown to family members if cultural and social pressures are applied by wider or family or community contacts. **Copies can be obtained from https://www.orderline.dh.gov.uk.**

Consideration should be given to the parent's capacity to safeguard the child if they have been identified as a vulnerable adult.[10]

The age at which children and young women undergo FGM varies according to the community.

The process may be carried out when the child is newborn, during childhood or adolescence, just before marriage or during the first pregnancy.

The majority of cases of FGM are thought to occur between the ages of 5 to 8 and therefore female children within that age bracket are at a higher risk.

If after being informed of UK law a woman requests re-infibulation after childbirth, this should be treated as a child protection concern. Whilst the request for re-infibulation is not in itself a child protection issue, the fact that the woman does not wish to comply with UK law, raises concerns regarding any female children she may have at present or in the future. The child should be considered to be at risk of significant harm.

The age that the woman had FGM should be ascertained as a female child is likely to be at increased risk of harm at that age. If it was performed when she was an infant then an immediate referral to children's social care should be considered.

The Midwife has a duty to and must inform the GP and Health Visitor of any female child born to the victim of FGM. This is achieved by means of a letter from the FGM specialist midwife. The letter states that the client has been asked the above questions regarding her and her family's views of FGM. It should be ascertained that the client understands the family's legal position regarding UK law. The assurance of this system is available on Medway Maternity electronic patient records.

If there are additional risk factors identified during the antenatal or intra partum period which mean the child may be at immediate risk of significant harm, child protection procedures need to be instigated and an immediate referral to Children's Social Care made. Examples of cases that need immediate attention are where the woman or her wider family suggest they support the practice of FGM, where there is an older female sibling or where the culture of the family is for FGM to be undertaken when the child is a baby.

6.2 Maternity Clinical Management

Booking Interview

All midwives must discuss FGM at booking with women who are at risk due to their country of origin. This is regardless of whether the client has previously had vaginal births.

The midwife must specifically ask the client if she has been 'cut'. This question must not be asked in the presence of any other person including the woman's partner.

If the woman does not speak English then a female interpreter must be accessed, a family member must not be used to interpret.

Interpreters can be booked via Anglia Ice system. This is linked to the Patient Advisory Liaison Service (PALS). In an emergency where language difficulties exist, "Bigword" language service **must** be used.

The FGM Specialist Midwife is available to support and advise midwives when required.

At the booking interview, all women identified as having had FGM, regardless of any repair which is reported must be referred to the specialist midwife for assessment and plan of care.

Verbal consent must be obtained prior to the referral to the specialist midwife and recorded in the clients antenatal and electronic patient records.

The woman should be reassured that an examination will only be undertaken by the Specialist midwife.

A culturally sensitive approach must be used at all times. The wording "female genital mutilation" must **never** be used when discussing FGM with women.

Words such as "female circumcision," "cutting," or "are you open or closed down there" should be used.

The woman's right to privacy and dignity must be respected. The woman must be assessed in the absence of medical students, unless the woman has given consent for their presence.

A referral to the psychology department should be considered and discussed as personal accounts from women indicate that FGM is an extremely traumatic experience for women and children, which remains with them for the rest of their lives. However, some women accept FGM as a necessary cultural practice. This belief needs to be carefully considered in respect of their own children and repeating the practice.

The type of FGM should be recorded in the woman's medical records, including a detailed description of the genitals identifying the presence/absence and condition of each structure. A record must be made in the Antenatal/Labour case notes in the Special Information section, in the Information for Labour section and entry is also required on the electronic patient record.

The Health Visitor and GP receive a copy of the booking history which identifies if the client has FGM and type.

Ante-Partum

Options for intervention must be offered and must include de-infibulation. The options are antenatal de-infibulation or de-infibulation during the first stage of labour.

Antenatal de-infibulations should only be performed between 20 and 32 weeks gestation allowing time for the scar tissue to be fully healed prior to delivery.

Local anaesthetic should be offered although a spinal or general anaesthetic must be considered. Women whose preference is for de-infibulations in labour must have their request respected and granted.

De-infibulation

De-infibulation involves cutting of the scar tissue upwards until the urethral meatus is visible which has formed remnants of the labia majoria stitched together, thus exposing the vaginal opening, allowing enough room for the tissue to stretch over the baby's head. The raw edges on either side are then over sewn with an absorbable suturing material by the specialist midwives or an experienced obstetrician.

The GP and health visitor must be sent a letter from the FGM specialist team for those women reviewed and de-infibulated. A copy of this letter is also sent to the woman, then placed in the communication section of the woman's hospital case notes

Intra-Partum

De-infibulation should be performed in the first stage of labour rather than the second stage.

If the midwife or obstetrician has any doubt about performing de-infibulation on a client they must **desist from commencing** the procedure and seek a more expert opinion.

In such cases the delivery of the baby must be by a qualified midwife and not a student as this reduces the risk of further trauma to the vulva.

If needed, an interpreter or "Bigword" must be used to ensure the client understands the limit of resuturing – a family member **must not** be used to provide client consent.

Local anaesthetic/epidural can be offered, however epidural is recommended.

When an episiotomy is indicated, a medio-lateral episiotomy should be performed. On no account should a bilateral episiotomy be performed.

Post-partum

Re-infibulation (complete resuturing) is against the law and must never be performed.

Details of the FGM should be written in the postnatal notes – titled Plan of Care.

The healing of the perineum must be observed and the woman advised accordingly.

The potential risks associated with female genital mutilation for the female child and the legal consequences **must** be discussed with the woman and family by the specialist midwife.

If a woman has been found to have experienced FGM then the information must be entered onto the discharge summary in the free text box to ensure both the GP and Health Visitor are aware.

This information will also alert the Health Visitor and General Practitioner to the potential risks for female members of the family, including female siblings.

The midwife must discuss this with the Health Visitor prior to discharge from midwifery services.

Guidance can be obtained from the specialist midwives on 0207 288 - 3482/3483/3990/3991

6.3 Community Midwifery

All women will receive routine postnatal care with their generic community midwifery team.

All women who have experienced FGM will be offered at least one postnatal follow-up visit at home by the specialist team.

Where a woman no longer resides within the integrated care organisation the specialist midwife will contact a service local to her needs.

6.4 Non Pregnant Women

Where a non pregnant client has referred herself to the Specialist Midwife for review of the client's FGM type, the client will then be advised to provide evidence of GP registration. If not registered with a GP, the client will be informed how to register with a GP by the Specialist Midwife and a referral letter from the GP requested.

A hospital number will be allocated to the client. The specialist Midwife will then ensure a copy of review and actions is placed in the hospital case notes and a copy sent to the woman's GP.

6.5 Paediatric Services

A child or young woman may present at any of the community agencies involved in the care provision e.g.: school, social care, community youth workers and also directly to health services (e.g. Accident and Emergency, Inpatient settings, hospital clinics, General Practitioners, community child health clinics) and either make an allegation regarding her concerns about a threat of FGM or to disclose an acute or non acute assault that has already taken place.

In Islington, any disclosure relating to FGM must be directed to the local child protection team who can be contacted at Hornsey Rise Health Centre on the contact number: **0203 316 1885**

The child protection administrator will direct the member of the agency to either the Named Child Protection Doctor in Islington community or to the Paediatric Consultant on call.

In Haringey, In Haringey any disclosures relating to FGM must be directed to the child protection medical team based at the Paediatric Assessment unit at the North Middlesex Hospital on **0208 887 2493**

In Haringey the child will directly be referred to a specialist clinic at University College Hospital, which is dedicated to the complex sexual and gynaecological health problems related to abuse including female genital mutilation and trafficking.

The multidisciplinary team working in this clinic consists of two Paediatricians, a Consultant Gynaecologist with unique experience in treating children and adolescents with complex gynaecological problems including female genital mutilation, a nurse and a specialist play therapist.

If a client does not reside in either Islington or Haringey, then the Named Nurse who works in the area where the client is receiving services should be contacted so that the appropriate children's social care department can be informed.

6.6 Education and Training

The topic of FGM is included in all safeguarding children training. Staff with access to children and pregnant women as part of their role (level 3 of The Intercollegiate Document) receive enhanced FGM training every three years. Staff who identify additional training needs in relation to FGM will be signposted to the relevant training as a priority.

FGM is a topic which appears regularly within the In-Service training syllabus for midwife and other maternity staff both under the heading of FGM and Domestic Abuse. This training is provided by the FGM specialist midwife.

The topic of FGM is covered in the induction programme for new Doctors and Midwives when they start within the maternity unit.

All grades of maternity staff, health visitors and school nurses must read this policy and acquaint themselves with the information and practice contained.

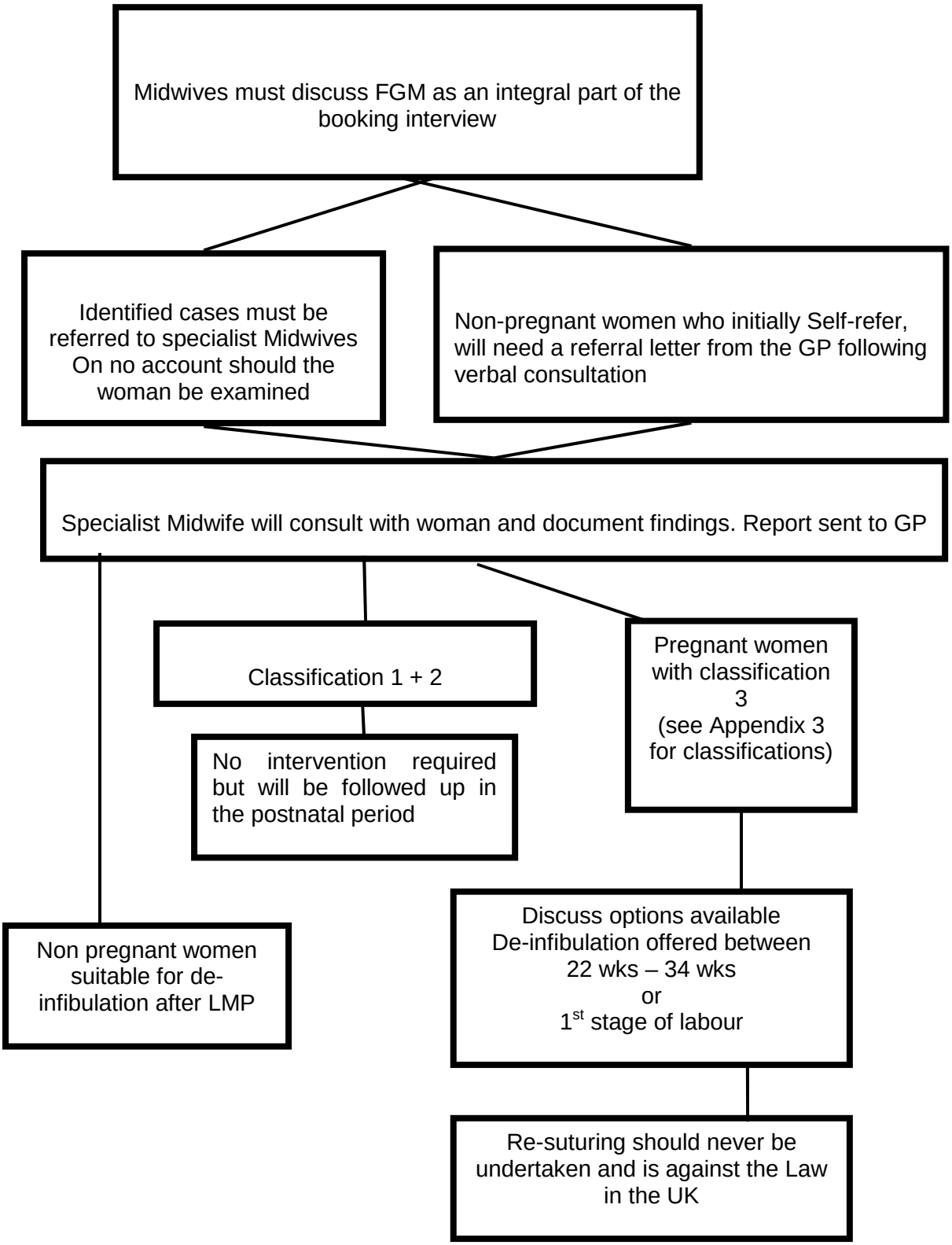
Circulation and display of relevant posters and leaflets helps inform both staff and service users.

6.7 Audit

Whittington health service providers should collect information in respect of FGM to improve the uptake of the service in order to safeguard children and improve health outcomes.

Yearly audits of FGM practice and policy adherence will be performed to ensure that documentation, communication and risk assessment are in accordance with this policy.

6.8 Obstetrics FGM Pathway



6.9 Contacts

Specialist Midwives

Specialist Midwife	020 7288 3482/3383
Out of hours	020 7288 5111

Named Professionals

Named Midwife for Child Protection	07876 588526
Named Nurse Whittington Hospital	07884 187592
Named Doctor Whittington Hospital	07947 883972
Named Nurse Child protection Islington Community	020 3316 1885/07747862255
Named Doctor Islington Community	07816 627378
Named Nurse Haringey Community	020 8489 3066/07970269539
Named Doctor Haringey	020 8887 4404/02088872493

If a client does not reside in either Islington or Haringey, then the Named Nurse who works in the area where the client is receiving services should be contacted so that the appropriate children's social care department can be informed.

Children's Social Care

Haringey Children's Social Care, Referral and Advice	020 8489 4470/5785
Islington Children's Social Care, Referral and Advice	020 7527 7400

FORWARD (Foundation for Women's Health, Research and Development)

Suite 2.1 Chandelier Building
Second Floor, 8 Scrubs Lane
London
NW10 6RB

Tel: 020 8960 4000
Email: forward@forwarduk.org.uk

BWHFS (Black Women's Health & Family Support Group)

82 Russia Lane
London
E2 9LU

Tel: 020 8980 3503
Email: bwhfs@btconnect.com

Kurdish Middle Eastern Women's Organisation in Great Britain (KMEWO)

North London Branch
Caxton House
129 St. John's Way
London
N19 3RQ

Tel: 020 7263 1027

7. Consultation, Approval and Ratification Process

7.1 Consultation process

This policy has been developed in consultation with the FGM Specialist Team and the safeguarding Children Team to be ratified by the Children's Safeguarding Committee.

7.2 Policy Approval and Ratification Process

Ratification at the Safeguarding Children Committee and the Clinical Policy Review Group.

8. Dissemination and Implementation

Whittington Health will ensure that the policy is circulated to all relevant staff and is promoted via the maternity department newsletter, Whittington Health's staff induction programme and the intranet site.

9. Process for Monitoring Compliance and Effectiveness

9.1 The Operational Safeguarding Team will ensure that incidents related to FGM and failure to follow FGM policy are reported on the Trust Datix system and where appropriate are reported and investigated using the Trust SI Policy framework.

9.2 The Named Professionals for safeguarding children will record all incidents, complaints and claims on the Datix risk management database for their service area of responsibility.

9.3 Where there is a Serious Incident (SI) related to FGM this will be reported as with all SI's through the STEIS system and investigated using the Root Cause Analysis (RCA). The investigation and resulting action plan will be approved and signed off by the WCF division and will be approved by the SI Executive Review Group before being submitted to NHS England in line with the SI Policy. Implementation of actions will be monitored by the WCF Divisional Patient safety committee and assurance provided to the Trust Patient Safety Committee which reports to the Quality Committee a formal subcommittee of the Trust Board.

10. References

1. HM Government, Female Genital Mutilation Multi-Agency Practice Guideline, 2011 p 2, 7, 15-19, 27-30.

2. Department for children, schools and families, Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2013, p. 6.14 - 6.19, 195-196.

3. London safeguarding children board, Safeguarding Children at Risk of Abuse through Female Genital Mutilation, 2007, p. 3.4.1

4 Royal College of Nursing, Female Genital Mutilation: An educational resource for nurses and midwives, 2007, p.2.

5. United Nations, United Nations Convention on the Rights of the Child,

Article 3: Best interests of the child, Article 19 Protection from all forms of violence,

6. The Children Act 1989, legislation.gov.uk

7. World Health Organisation, Classification of Female Genital Mutilation, 2009

8 London Child Protection Committee, London Child Protection Procedures:

Female Genital Mutilation, 2010, pg. 150-151

9. Whittington Health NHS Policy, Protecting Adults at Risk, Policy Ref: C/ RM/ 107, September 2011

10. Multi-Agency Practice Guidelines: Female Genital Mutilation. HM Government 2014.

11. Female Genital Mutilation Risk and Safeguarding: Guidance for Professionals. March 2015.

Appendix 6 Tool to Develop Monitoring Arrangements for Policies

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of the multidisciplinary team or others if any.**	**What tool will be used to monitor/check/observe/Assess/inspect/ authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report?** **How often is the need to share the report?**	**What committee will the completed report go to?**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
Incidents related to FGM and failure to follow FGM Policy is reported on the Trust Datix system.	The Named Professionals for safeguarding children will record all incidents, complaints and claims on the Datix risk management database for their service area of responsibility.	Audit/ monitoring tool to be developed by Safeguarding Children Team	Annually	Safeguarding Children Committee
Serious Incident related to FGM will be reported through the STEIS system and investigated using the Root Cause Analysis (RCA).	WCF Divisional Patient Safety Committee.		Annually	Trust Patient Safety Committee which reports to the Quality Committee.

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

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

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

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Checklist for the Review and Approval of Procedural Document

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

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	To be disseminated to Consultants, Midwives, Health Visitors and School Nursing forums
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		

	Title of document being reviewed:	Yes/No	Comments
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	Being developed
	Is there a plan to review or audit compliance with the document?	Yes	Annually
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	Named Midwife for Child Protection

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name		Date	
Signature			
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			