

Title: Female Genital Mutilation		 <p>Salford Safeguarding Children Board</p> <p>Keeping children safe IN Salford</p>	
Authors Name: Chris Broadbent/ Jackie Price			
Contact Name: Chris Broadbent			
Contact ; Safeguarding Children Unit			
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1. Introduction
 2. Definitions
 - Type 1 - Circumcision (Sunna)
 - Type 2 - Excision (Clitoridectomy)
 - Type 3 - Infibulation (also called Pharaonic Circumcision)
 - Type 4 - Unclassified
 3. Background Information
 4. UK Context
 5. Local Context
 6. Consequences of FGM
 7. Possible Indicators of FGM
 8. Principles
 9. Procedure for Safeguarding Children from FGM
 - 9.1 Initial Referral and Strategy Meeting
 - 9.2 Initial Assessment
 - 9.3 Outcomes
 10. Special Circumstances
 - 10.1 Children in Immediate Danger
 - 10.2 Historical FGM
- Appendix 1 - The Legal Framework
- Appendix 2 - Bibliography/Further Reading

1. Introduction

- 1.1 This procedure has been designed to aid practitioners in understanding the practice of Female Genital Mutilation (FGM) and how to respond to cases.
- 1.2 FGM affects a group of young people who are particularly vulnerable, therefore any decisions or plans for these children/young people need to be based on good quality assessments and be sensitive to the issues of race, culture, gender, religion and sexuality, so as not to stigmatise the child or the practising community.

2. Definitions

- 2.1 FGM is a collective term used for different degrees of mutilation of the female external genitals. It is commonly referred to as "female circumcision", implying an analogy with male circumcision. However, the degree of cutting in the female is more extensive and damaging and carries a far greater risk of physical damage, psychological damage and in some cases, death.

- 2.2 There are four forms of FGM:

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type 2 - Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

Type 3 - Infibulation (also called Pharaonic Circumcision) - Approximately 15% of women and girls affected are thought to experience this more radical infibulation which involves further cutting of the labia majora. This is a narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris. After cutting the raw areas of the labia majora are brought together to heal and form a hood over the urethra and the vagina with an artificial opening the size of a matchstick left for the passage of urine and menstrual blood. This practice is commonly believed to prevent wives from having illicit intercourse.

Type 4 - Unclassified - This involves all other operations on the female genitalia including pricking, piercing and stretching the vulva region, incision of the clitoris and/or labia.

- 2.3 Although these mutilations are commonly performed without anaesthetics, the practice is not generally perceived as abusive or harmful by those arranging the operation.

3. Background Information

- 3.1 Historically FGM in varying degrees has appeared in all the continents of the world, albeit in many places the practice has died out. Currently, it is known to take place in western, eastern and north-eastern parts of Africa and some parts of the Middle East and South East Asia, with geographical factors being highly significant in relation to the practice.
- 3.2 The reasons given for continued practice of FGM include:
- Family honour
 - Custom and tradition
 - Hygiene and cleanliness
 - Preservation of virginity/chastity
 - Social acceptance, especially for marriage
 - Sense of belonging to a group and conversely the fear of social exclusion
 - Local structures of power and authority, such as community leaders, religious leaders
- 3.3 It should be noted that the practice of FGM can be carried out within faith groups and non-faith groups alike.
- 3.4 An estimated 100 to 140 million girls and women worldwide are currently living with FGM
- 3.5 Female genital mutilation (FGM) includes procedures that intentionally alter or injure female genital organs for non-medical reasons.
- 3.6 The procedure has no health benefits for girls and women
- 3.7 Procedures can cause severe bleeding and problems urinating, and later, potential childbirth complications and newborn deaths.
- 3.8 It is mostly carried out on young girls sometime between infancy and age 15 years.
- 3.9 In Africa an estimated 92 million girls from 10 years of age and above have undergone FGM.
- 3.10 FGM is internationally recognized as a violation of the human rights of girls and women.

- 3.12 FGM can be viewed as one of the extreme forms of oppression of females seen across cultures - it is now considered by many as an act of extreme violence against women and female children.
- 3.13 95% of FGM is performed on girls whose age ranges from birth to 16 years of age. These children and young people usually do not have the knowledge to understand the full implications of FGM and can exercise little informed choice.
- 3.14 3 million girls in Africa are estimated to be at risk of FGM each year.
- 3.15 It has been estimated that up to 24,000 girls under the age of 8 are at risk in the UK.

4. UK Context

- 4.1 FGM is much more common than most people realise, both worldwide and in the UK.
- 4.2 It is reportedly practised in 28 African countries and in parts of the Middle and Far East but is increasingly found in Western Europe and other developed countries, primarily amongst immigrant and refugee communities. However while there are substantial populations from countries where FGM is endemic residing in London, Liverpool, Birmingham, Sheffield and Cardiff, it is likely that communities in which FGM is practised reside throughout the UK.
- 4.3 Girls are particularly at risk of FGM during the school summer holidays. This is the time when families may take their children abroad for the procedure. Many girls may not be aware that they may be at risk of undergoing FGM.
- 4.4 UK communities that are most at risk of FGM include Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians and Eritreans. However women from non-African communities that are at risk of FGM include Yemeni, Kurdish, Indonesian and Pakistani women.
- 4.5 Those who are affected by FGM may be British citizens born to parents from FGM practising communities or women resident in the UK who were born in countries that practise FGM. These may include immigrants, refugees, asylum seekers, overseas students of the wives of overseas students.

5. Local Context

- 5.1 The 2001 Census identified that 0.33 per cent of Salford's population were of Black/Black British African. The next census will be undertaken in 2011.

- 5.2 With this low percentage of ethnic groups within Salford, FGM has not been thought to have been a problem locally. However as the ethnic mix grows with immigration it is essential that workers are aware of the issues surrounding FGM

6. Consequences of FGM

- 6.1 FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.
- 6.2 Many women appear to be unaware of the relationship between FGM and its health consequences; in particular the complications affecting sexual intercourse and childbirth which occur many years after the mutilation has taken place.

It is important to note that, depending on the degree of mutilation, it may sometimes cause immediate fatal haemorrhaging.

- 6.3 Short-term health implications:

- Severe pain and shock, occasionally death;
- Infections;
- Urinary retention
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint
- Damage to other organs.

- 6.4 Long-term health implications:

- Excessive damage to the reproductive system;
- Uterine, vaginal and pelvic infections;
- Infertility;
- Cysts;
- Complications in pregnancy and childbirth;
- Psychological damage; including a number of mental health and psychosexual problems, e.g. depression, anxiety, frigidity (BMA 2001);
- Abscesses
- Sexual dysfunction
- Difficulties in menstruation
- Difficulties in passing urine
- Increased risk of HIV transmission.

- 6.5 Concerns exist for the unborn/newborn babies of women who have undergone FGM, particularly type 3. Obstructed or prolonged labour, if unchecked, can cause fetal distress, anoxia (lack of oxygen to the body's tissues) and fetal death. RCN 2006

There is the risk of transmission to babies during birth, of HIV and other communicable diseases, where unsterilised instruments are used for several different girls/women when FGM is performed

7. Possible Indicators of FGM

- 7.1 The age at which girls are subjected to FGM varies greatly, from shortly after birth to any time up to adulthood. The average age is 10 to 12 years.
- 7.2 Professionals need to be aware of the possibility of FGM. The following are some potential risk indicators that FGM may occur or has occurred (this is not an exhaustive list):
- Professionals become aware that a child is suffering with a bladder or severe menstrual problems, which cause frequent and prolonged absences from school
 - The family originates from a community/region that is known to practice FGM, e.g. Somalia, Sudan and other sub-Saharan countries
 - A child may spend long periods of time away from the class during the day with bladder or menstrual problems
 - Older women in the family have been victims of FGM, this may increase the likelihood of female children becoming victims
 - A child may talk about a long holiday to her country of origin and may confide to a trusted adult, such as a teacher, school nurse, learning mentor or adult helper that she is to have a 'special procedure' or to attend a special occasion
 - Parents state that they or a relative are to take the child out of the country for a prolonged period of time, in particular to an area where FGM is practiced
 - Conversations with a child may refer to FGM
 - Prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has undergone FGM
 - Some teachers have described how children find it difficult to sit still and appear uncomfortable or may complain of pain between their legs, or talk of 'something somebody did to them, that they are not allowed to talk about'.
- 7.3 Taken in isolation some of these indicators alone do not necessarily suggest abuse has occurred. However a combination of indicators should raise levels of concern and prompt further investigation/enquiries.

8. Principles

- 8.1 FGM is considered an abusive act towards the child and as such all children have a right to protection, irrespective of race, colour, religion or culture. Addressing this issue is an integral part of child protection.
- 8.2 All agencies should work in partnership with members of local communities, to empower individuals to develop support networks and education programmes.
- 8.3 Staff who have responsibility for child protection work must be acquainted with any local preventative programmes which exist.
- 8.4 All attempts to intervene within cultures practicing FGM must be approached in a culturally-sensitive and non-punitive manner with appropriate and helpful personnel who can communicate effectively with the family concerned.
- 8.5 It will be necessary to work closely with community representatives who can help to bridge the gaps between the communities involved and Children's Social Care.
- 8.6 It is possible to change attitudes towards FGM through supporting and re-educating families. If extreme strategies or policing of families is used, this is likely to alienate communities, and to drive the practice further underground.
- 8.7 The ultimate aim is to prevent and discourage the practice of FGM, by appropriate educational and preventative approaches.

9. Procedure for Safeguarding Children from FGM

9.1 Initial Referral and Strategy Meeting

- 9.1.1 Any individual or agency who receives information, or has reason to believe that a child is at risk of undergoing any form of FGM, should refer the case to the Referral Investigation and Assessment Team within Children's Social Care in accordance with the Referrals Procedure. This referral must be discussed with the Duty Team Manager who will subsequently inform the Safeguarding Children Unit. In all cases, professionals should not discuss the referral with the parents/carers until a multi-agency action plan has been agreed.
- 9.1.2 Referrals can be made by telephone but must always be followed up in writing with 48 hours using the multi-agency referral form. The RIAT Team should acknowledge receipt of the referral within 3 working days; it is the duty of the referrer to follow up if this is not received.
- 9.1.3 If a referral is received concerning one child in a family, consideration must be given to whether siblings are at similar risk. There should also

be consideration of other children from other families once concerns are raised about an incident or the perpetrator of FGM.

- 9.1.4 Under no circumstances should any individual or individual organisation conduct an initial investigation or assessment of suspected cases of FGM. Investigation of such cases requires a sensitive and co-ordinated, multi-agency response.
- 9.1.5 In response to the initial referral, the Team Manager of the RIAT Team will convene and chair a Strategy Meeting. It will be the Team Manager's responsibility to access relevant information on the practice, and identify specialist help either within or outside Salford to assist in the sensitive planning of enquiries.
- 9.1.6 The Section 47 Strategy Meeting should include:
- The Team Leader, RIAT, to chair and co-ordinate the meeting
 - The allocated social worker responsible for the enquiry
 - A member of the Police Public Protection Investigation Unit (PPIU), (for consultation only at this stage)
 - A legal representative should be available for consultation
 - Any other relevant professional who may have knowledge or involvement with the child or family, e.g. Health Visitor, teacher etc.
 - Local specialist services
- 9.1.7 The Section 47 Strategy Meeting should cover, at a minimum, the following issues:
- Family history and background information, including if either parent, carer or child have had access to information about the harmful aspects of FGM.
 - Scope of the investigation, what needs to be addressed and who is best placed to do this.
 - Roles and responsibilities of individuals and organisations within the investigation, with particular reference to the role of the police.
 - As to whether a medical examination/treatment is required and if so who will carry out what actions, by when and for what purpose.
 - What action may be required if attempts are made to remove the child from the country (see Appendix 1 - Legal Framework)
 - Identify key outcomes for the child and family.
 - Implications and impact on the wider community.
 - A Contingency Plan.
 - Leads and timescales for actions must be agreed and recorded on the Record of Strategy Meeting Pro Forma
 - If the conclusion of the Section 47 strategy meeting is that there are significant concerns for the welfare of the child, the case must be discussed with the Safeguarding and Quality Assurance unit in order to convene a FGM strategy meeting.

- 9.1.8 Evaluation and analysis of the information will be the responsibility of all agencies involved, as is the identification of the current level of risk and the most appropriate intervention.
- 9.1.9 Consideration should be given to the need for either a Child Protection Conference or Family Action Meeting in line with Salford's Thresholds for Safeguarding Children.
- 9.1.10 At the close of the Strategy Meeting, a date should be agreed to reconvene and discuss the outcomes from the Initial Assessment. However this meeting can be reconvened earlier should circumstances dictate.
- 9.1.11 Minutes from the Initial Strategy Meeting should be circulated as soon as possible after the meeting. At the very least, the decisions and recommendations from the meeting should be circulated to all those in attendance within one working day.

9.2 Initial Assessment

- 9.2.1 Where a child has been identified as at risk, it may not be appropriate to take steps to remove the child from an otherwise loving family environment. Experience has shown that often the parents themselves can experience pressure to agree to FGM. Therefore it is essential that when first approaching a family about the issue of FGM a thorough Initial Assessment should be undertaken, with particular focus on:
- Parental/carer attitudes and understanding about the practice and where appropriate:
 - Child/young person's knowledge, understanding and views on the issue
- 9.2.2 Every attempt should be made to work with parents/carers on a voluntary basis to prevent abuse. It is the duty of the Duty and Investigating Team to look at every possible way that parental co-operation can be achieved. However, the child's best interest is always paramount.
- 9.2.3 Some thought and consideration should be given to where the Initial Assessment is undertaken. For example it may be beneficial to talk to the family outside the home environment to encourage them to acknowledge the impact FGM would have on their daughter/s.
- 9.2.4 An interpreter must be used in all interviews with the family, and more importantly the child or young person, if their first language is not English. The interpreter must not be a family relation and not known by family. The interpreter must be female.
- 9.2.5 In cases where an interpreter is not used, and English is not the child's first language, the reasons for not using an interpreter must be recorded, as part of the assessment.

9.2.6 All interviews with children should be undertaken in a sensitive manner, and should only be carried out once. Parental consent and the child's agreement should be sought before interviews take place. All attempts must be made to work in partnership with parents, and to endeavour for parents to retain full parental rights in these circumstances; where consent is not given, legal advice should be sought.

9.3 Outcomes

9.3.1 The Strategy Meeting should reconvene as agreed to discuss the outcomes and recommendations from the Initial Assessment. At all times the primary focus is to prevent the child undergoing any form of FGM by working in partnership with parents, carers and the wider community to address risk factors. However where the Initial Assessment identifies a continuing risk of FGM to the child or young person then, the first priority is protection and the local authority should consider the need to undertake a Section 47 Enquiry. In doing this the following options should be considered:

- A Child Protection Case Conference.
- Legal action
- Criminal prosecution

9.3.2 If a Child Protection Case Conference is deemed necessary and a Child Protection Plan is to be formulated, the Category of Abuse or Neglect should be Physical Abuse.

9.3.3 Following all enquiries into FGM, regardless of the outcome, consideration must be given to the therapeutic/counselling needs of the child and the family.

9.3.4 Medical examination of the child, if necessary, must only be undertaken with the child's and the parents' consent.

9.3.5 In the majority of cases there should only be one medical examination of the child or young person. In cases where subsequent medical's are required, clear reasons for this decision should be recorded as part of the assessment.

9.3.6 If a surgical procedure is required, and parents refuse consent, legal advice must be sought immediately.

10. Special Circumstances

10.1 Children in Immediate Danger

10.1.1 Where the child appears to be in immediate danger of mutilation and parents cannot satisfactorily guarantee that they will not proceed with it,

the Police and the Duty and Investigation Team within Children's Social Care should be contacted.

10.1.2 When the immediate danger to the child/young person has been addressed, a Strategy Meeting should be convened in accordance with the process set out in Section 3 of the Section 47 Enquiry Procedure.

10.1.3 If any child is found to require medical attention following FGM, this must be sought with appropriately qualified medical staff. If parental consent is not given, consultation with Legal Services will be necessary.

10.2 Historical FGM

10.2.1 Where a woman has already undergone FGM and this comes to the attention of any professional, consideration needs to be given to child protection implications, i.e. for younger siblings, daughters, extended family members and a referral should be made to the RIAT Team of Children's Social Care in accordance with the Referrals Procedure. The referral must be discussed with a Team Leader within that team.

10.2.2 Where the woman is the mother of a female child or has the care of female children, this procedure should be initiated.

Appendix 1 - The Legal Framework

The prohibition of Female Circumcision Act 1985 makes FGM an offence, except on specific physical and mental grounds. This Act was replaced by the Female Genital Mutilation Act 2003 which was brought into force on 3 March 2004.

It is always illegal to practice FGM in the UK and to assist in its practice. The Act strengthens and amends the 1985 legislation. It makes it an offence for the first time for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out FGM abroad, even in countries where the practice is legal. The 2003 Act also increases the maximum penalty for committing or aiding the offence from 5 to 14 years imprisonment. http://www.uklegislation.hmso.gov.uk/acts/acts2003/ukpga_20030031_en_1

Civil Law

Section 47(6) of the Children Act 1989 imposes a duty on local authorities to investigate a child's circumstances who they have reasonable cause to suspect is suffering or is likely to suffer Significant Harm. The enquiries have to be sufficient to enable the local authority to decide whether it should take any action to safeguard or promote the child's welfare, i.e. to protect the child.

Therefore, the local authority having decided the FGM of whatever degree, on the face of it, constitutes Significant Harm, upon being made aware that a child has suffered from, or is likely to suffer from this practice, must decide what action is ought to take to protect the child. The investigation of this matter should be done jointly with the Police and considered within a multi-disciplinary context.

Powers available to the Local Authority to prevent removal of a child from the country

The local authority can apply to the Court for leave to apply for a Prohibited Steps Order to prevent parents from removing a child from the UK believing that mutilation can be carried out while the child is abroad. Given the nature of the matters under consideration, the most appropriate forum for such an application to be made is to the High Court.

Under Court rules, the local authority would usually have to give a child's parent 21 days notice of an application to the Court for a Prohibited Steps Order.

However, given the obvious need for speed in such circumstances the local authority can apply to Court for the Notice period to be abridged and come before the Court in a much shorter period of time for an Emergency Interim Prohibited Steps Order to be considered by the Court.

A full Prohibited Steps Order could last until the child is 16 years old or 18 in exceptional circumstances.

Emergency Protection Order

Section 44 of the Children Act 1989 enables the local authority to apply to the Court for an Emergency Protection Order (EPO).

If circumstances are so acute as to require an EPO immediately and an application for an ex-parte EPO is made and is successful, the local authority would then consider issuing proceedings for a Prohibited Steps Order and requesting the matter, among other matters, be transferred immediately to the High Court.

As Section 8 proceedings under the Children Act are not 'specified proceedings' within the meaning of the 1989 Act, the Court would not ordinarily appoint a Children's Guardian. However, in these circumstances the Court would normally appoint the Official Solicitor as the Children's Guardian.

Inherent Jurisdiction of the High Court

In exceptional circumstances and where no other legal routes are possible, the local authority could liaise with the Official Solicitor and seek an order to protect the child using the inherent jurisdiction of the High Court. It would be the responsibility of Legal Services to advise as to the appropriate forum for legal intervention.

Criminal Injuries Compensation

Claims for criminal injuries compensation should be considered in all cases of FGM. This procedure can be adopted by the local authority for children in their care (i.e. who are Looked After), and assistance can be offered to those outside the care system or who have reached the age of 18, should they request it through Children's Services. Any application for a child in care should be made in consultation with Legal Services. In other circumstances, the child/young person should be encouraged to seek their own independent adviser.

Appendix 2

Where to Get Further Information and Services:

Guidelines for professionals

A number of professional bodies have produced resources and guidelines to enable frontline staff to respond effectively to girls and women who have either undergone FGM or are at risk of undergoing FGM. These include the London Safeguarding Children's Board's child protection procedural document "Safeguarding children at risk of abuse through female genital mutilation". Other professional resources on FGM are from the British Medical Association, the Royal College of Midwives, the Royal College of Obstetrics and Gynaecology and the London Metropolitan Police.

Department of Health

The 2007 "Statistical Study to Estimate the Prevalence of Female Genital in England and Wales" was funded by the department of Health(DH). FORWARD, the London School of Hygiene and Tropical Medicine and City University Midwifery Department carried out the study in order to help authorities plan services for the communities affected by FGM. (<http://www.forwarduk.org/key-issues/fgm/research>)

In 2007, the DH also produced a DVD for health professionals to enable them to provide effective and sensitive care for women who have undergone FGM. Developed in conjunction with the specialist voluntary sector and health professionals as a practical resource, it provides factual and clinical information.

Specialist African Well Women Clinics

There are 14 specialist clinics that provide tailored care for women affected by FGM across London and in some other major urban centres in the UK. For more information please visit please visit <http://www.forwarduk.org/resources/support/well-woman-clinics>

All the clinics have trained and culturally sensitive staff who offer a range of healthcare services for women and girls including reversal surgery. Services are confidential and in many instances interpreters are available. The clinics are open to women to attend without referral from their own doctor.

WHO Media centre

Telephone: +41 22 791 2222

E-mail: mediainquiries@who.int

For bibliography, RCN.

Appendix 3 - Bibliography / Further Reading

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Endorsed by:		
Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
	Executive Committee SSCB	
	Salford Safeguarding Children Board	
	Policies and Procedures Sub Group SSCB	

Record of Changes to Document					
Changes approved in this document by - SSCB Policies and Procedures Sub Group					
Section Number	Date	Amendment (<i>shown in bold italics</i>)	Deletion	Addition	Reason

Diversity & Equality Screening Questionnaire

Organisations are legally required to ensure that all new policies and documents are assessed for their impact both positive & negative on equality target groups ; religion/beliefs, disability, age, gender, religion & sexual orientation & transgender.

If you wish to discuss any aspect of this assessment process please contact the Equality Advisor, HR dept.

	Name of policy, document or leaflet;
1	Whom is this document or policy aimed at ?
2	<p>Is this document a specific user group? if yes, why ? (what are the demographics of your target audience?)</p> <p>How will you ensure that this policy is cascaded to the target group ?</p>
3	Is there any evidence to suggest that different groups have different needs in relation to this policy or document (positive or negative; for example; elderly, patients with disabilities, issues on gender etc) ?
4	If you a revising a policy are any the changes to this policy likely to impact on any groups?
5	<p>Have you undertaken any consultation/involvement with service users or other groups in relation to the new policy ?</p> <p>If yes, what format did this take? face/face or questionnaire? (please attach evidence of this)</p> <p>Were service users who may require additional support (e.g. visually impaired) involved ?</p> <p>Has any amendments been implemented as a result of this</p>

exercise?			
6	Are you aware if a request has been made for the policy to provided in alternative formats?		
	If yes, how/was this achieved?		
7	Does the document require any decision to be made which could result in some individuals receiving different treatment, care, outcomes to other individuals (could any group be excluded for any reason)?		
	On what basis would this decision be made ?		
	Could this impact on any particular group ?		
8	Are you aware of any complaints from service users in relation to the application of this policy ?		
	If yes, how was the issue resolved ?		
9	Looking at the above points does this indicate that any of the groups listed below have different needs, experiences or priorities groups in relation to the document ?		
	Yes	No	unsure
Age			
Disability			
Gender			
Marital Status			
Racial group			
Religious belief			
Sexual orientation			
Transgender			
Low Income			
10	Any additional comments		
	If any impact has been highlighted by this assessment, you will need to undertake a full equality impact assessment:		
	Will this policy require a full impact assessment? Yes/No (delete)		

(if yes please contact Equality Advisor, HR for further guidance)