Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE FORENSIC - SPECIALIST ASSESSMENT OF ADULTS' RISK TO CHILDREN SERVICE (SAARC)

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Mar 2023*	*New SOP. Approved at Forensic Operational Delivery Group (27 February 2023).* *26/03/24 - SOP confirmed fit for purpose and review date extended by 6 months (to end of September) by director sign-off (Paula Phillips - 26 March 2024).*
1.1	*Sept 2024*	*Reviewed. Changes made to references of Electronic Patient Record System and updated reference regarding Working Together documentation. Approved at Forensic Clinical Network group (9 September 2024).*

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1. INTRODUCTION

This procedure has been written to support the Humber Teaching Foundation Trust (HTFT) delivery of the Specialist Assessment of Adult's Risk to Children (SAARC) service. The service is provided to Hull City Council (HCC) Children, Young People and Family Services ('CYPFS'). The service is funded by Hull CCG via the block contract. The service assesses the risk of non-sexual, forensic harm presented by named adults to specific, named children on the caseload of CYPFS.

The purpose of SAARC assessments is to aid social workers in their overall decision making about the level of contact or parenting responsibility of a named adult to a named child. Forensic risk assessment forms one part of this overall decision making. Referrals may be for adults who are known to have previously directly harmed children, though other typical referrals include family contexts where there are high levels of Domestic Violence, or where one person (usually parent or partner of parent) has a history of violence, substance use or other instability. The psychology team do not accept referrals for assessments related to sexual harm (a previous contract to provide this has ceased).

2. SCOPE

The purpose of this procedure is to describe the HTFT forensic division psychology team's remit and responsibilities in the provision of the SAARC service, and the partnership governance between HTFT and HCC CYPFS. This procedure applies to employees of the Trust, including all staff who are seconded to the Trust, honorary, contract, and agency staff who complete work for the SAARC service.

3. DUTIES AND RESPONSIBILITIES

The Lead Psychologist for the Forensic Division, operational and clinical leads are accountable for the implementation and review of the procedure. The Lead Psychologist will ensure that all the psychology team across the forensic division are familiar with the procedure. Team members involved in completing risk assessments under the SAARC service are responsible for the delivery of the procedure. HCC and other external organisations are required to provide timely and accurate information to inform SAARC psychological assessments. There must also be a commitment from partners to be involved in reviewing the service specification, procedures, and contract at regular intervals.

4. CLINICAL MODEL: SAFEGUARDING

Safeguarding means protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse, and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility (NHS England, 2022). The assessment triangle in Working Together to Safeguard Children (2023) provides a model for parental capacity. This can be used to consider how the different aspects of a child's life and

context interact and impact on the child. The model emphasises that assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family. It is important that the impact of what is happening to a child is clearly identified and that information is gathered, recorded, and checked systematically, and discussed with the child and/or their parents/carers.

Figure 1: Safeguard children assessment triangle

Psychologists working within the SAARC service will refer and adhere to HTFT's policies and procedures in relation to safeguarding children (see section 10).

5. PROCEDURE

5.1. Referral process to SAARC

A professional from HCC can make an initial enquiry about the appropriateness of a referral by phone call to the Humber psychology office or to the designated SAARC e-mail address HNF-TR.SAARCreferrals@nhs.net . Following this initial enquiry, a referral form must be fully completed and submitted back to the SAARC e-mail address. The client is added to a waiting list on the Electronic Patient Record (EPR) and all information from the referral forms will be entered on to the client's record in the EPR.

5.2. Waiting list & referral decisions

When a referral is received a client will be placed on a SAARC waiting list on the EPR. The waiting list and each referral form will be discussed by the psychology team at a SAARC meeting, chaired and recorded by a principal or consultant psychologist. Following psychology team discussion there are three main outcomes:

1. Not suitable for consultation or full assessment (inappropriate referral)

2. Possibly suitable for full assessment. Request further information from the referrer and/ or arrange a consultation meeting.

3. Suitable for full assessment (referral accepted & designated to a HCPC Registered Psychologist within the Forensic Division referred to as 'case psychologist', or on occasion a trainee psychologist under the supervision of a Registered Practitioner Psychologist.

The outcomes of discussions and final decisions for each client must be communicated to the referrer by formal letter and all such information recorded on the EPR. When a client is accepted for full assessment, the responsibility for the case and accountability for decisions surrounding the case will remain with the HCC referrer and not the case psychologist.

5.3. Client consent for assessment or information sharing

On acceptance of the referral, the case psychologist will provide the referrer with a consent form and request that this is completed by the client and returned to the SAARC e-mail address. Alternatively, the case psychologist will invite the client to an informal meeting to discuss informed consent. The consent form will ensure that the client provides written consent to be involved in the assessment.

Consent can also be requested from the client to request information from appropriate organisations (see section 5.4.1.) but this may not be required. HTFT guidance on public interest disclosure considers circumstances when confidential information can be shared without patient consent, including child safeguarding concerns. Likewise, the National Police Chiefs Council (2022) guidance stipulates "consent is not required in law for the sharing of information when this is done for the purpose of safeguarding children and therefore consent **should not** be used.

The Data Protection Act and UK General Data Protection Regulation states that there is a high standard for consent which is specific, time limited and that consent can be withdrawn which is why it should not be used….It is however, best practice to **engage** with the parent(s)/carer(s) and child (if capable of understanding) and **explain** your intention to share information about them and what may happen with the information."

Likewise, case psychologists can disclose personal information without patient consent if it is in the public interest and if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential. The Information Governance Team can help advise on when a public interest disclosure can and should be made. The Trust's safeguarding team can also provide support in making the clinical decision to disclose.

5.4. Information sharing for Child Safeguarding

5.4.1. Information sharing is essential

Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe. Serious case reviews have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children (NHS England & Improvement, 2019).

5.4.2. Circumstances when information can be shared

Information can be shared to safeguard and promote the welfare of children. **Working Together 2023 is statutory guidance** for "all organisations and agencies who have functions relating to children". Specifically, it applies to all local authorities, clinical commissioning groups, police and all other organisations and agencies (which are listed in Chapter 2). It applies, in its entirety, to all schools. It applies to all children up to the age of 18 years whether living with their families, in state care, or living independently and should be complied with unless exceptional circumstances arise.

Working Together is a guide to "inter-agency working to safeguard and promote the welfare of children". It says that "practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care" (Paragraph 25 and Appendix A). Information guidance sharing therefore applies to all children and young people in all circumstances, not only when undertaking an assessment of risk. Working Together is clear that child protection "is part of safeguarding and promoting welfare"

Sharing information early helps to ensure that a child or young person receives the right services at the right time and helps to prevent a risk or need from becoming more acute. Practitioners should be alert to the need to share important information about any adults with whom a child or young person has contact that may impact the child or young person's safety or welfare. Similarly, human rights concerns, such as respecting the right to a private and family life would not prevent sharing information where there are safeguarding concerns.

5.4.3. Legal basis for sharing information

The General Data Protection Regulation was incorporated into law in the UK by the Data Protection Act 2018. You must have a legal basis for sharing information; these are set out within the UK GDPR (Articles 6 and 9). Whilst there is no single "best" basis, the most relevant for the purposes of safeguarding and promoting the welfare of children are legal obligation (article 6(1)(c) and public task (article 6(1)(e). other bases for sharing information are vital interest, legitimate interest, contract and consent. You must always choose the lawful basis that most closely reflects the true nature of your relationship with the individual and the purpose of the processing.

Schedule 1 of the Data Protection Act 2018 (Para 18 Part 2) provides conditions that need to apply if the information that is being shared is criminal data or special category personal data (See Section 6.5 below) for social care or substantial public interest purposes in Article 9 UK GDPR. Paragraph 2 and Paragraph 6 of Schedule 1 provides for special category and criminal information to be shared when exercising duties under the Children Act 1989 and 2004. Paragraph 18 of Schedule 1 allows practitioners who would usually rely on consent to share criminal data or special category data for the purposes of 'safeguarding of children and individuals at risk' in circumstances where consent cannot be given, consent cannot be reasonably expected to be obtained by practitioner, or if obtaining consent would prejudice safeguarding a child.

5.4.4. Information sharing agreement

An information sharing agreement provides a good framework for sharing information between agencies, such as HTFT, local authority, and the police. Information sharing agreements should be completed with partners and the HTFT IG Lead. However, based on the statutory guidance outlined above, advance agreements are not always compulsory to share information for child safeguarding purposes.

5.4.5. Advice concerning professional disclosures

Seek advice promptly if you are uncertain or do not fully understand the legal framework that supports information sharing – but do not leave a child at risk because you have concerns about the possible consequences of information sharing.

Where there is any doubt as to whether disclosure is in the child's best interests, it is recommended that the health professional discusses the matter anonymously with an experienced colleague, Safeguarding Children and Families Team, the Caldicott Guardian, Information Governance Manager, Provide Solicitor, their professional body, or defence body (HTFT Child Safeguarding Policy).

Record the reasons for your requests for information or information sharing decision, regardless of whether you obtain or decide to share information. When another practitioner or organisation requests information from you and you believe sharing information cannot be justified, explain why. Reconsider your decision if the requestor shares new information that might cause you to regard information you hold in a new light.

5.4.6. Sources of Information

Information from a range of organisations could be required to complete psychological risk assessments. This could include information from, but not inclusive of; Social Workers (e.g., session notes, reports, social care assessments for the child, relevant risk assessments, minutes from child protection meetings/conference, child protection plan), Probation (e.g., OASys, pre-release information/reports), Police (e.g., PNC, witness & victim statements), and GP records. If the police have previously shared information with the referrer, and/or for a strategy meeting, then the case psychologist must request permission from the police to obtain this information for the purposes of the SAARC assessment (advice received from Humberside Police Vulnerability Hub, February 2023).

5.4.7. Appropriate time frame for receiving information

Information from organisations is expected within a month of request. If no relevant information is received within a month the referrer will be notified by letter that this information is outstanding and that there will be a delay in completing the report. The case psychologist will send a reminder to obtain information. If no information is received (total of 6 weeks waiting time), then the case psychologist will decide if it is viable to proceed with a full assessment. When a full assessment has been completed, opinions in final reports will be based on the best available evidence at the time of conducting the assessment and writing the report. The sources requested that are obtained, denied, or received no response will be clearly recorded in the EPR and the final psychological assessment report or letter(s) of correspondence. The psychology team under SAARC cannot be accountable for circumstances or decisions that occur due to sources of information or evidence requested but not received.

5.5. Assessment & Reports

The case psychologist will determine the most appropriate psychological assessment to conduct based on the referral question. Most assessments will include a review of client history from information sources available, an interview with the client, and use of a structured professional judgement tool. Following all assessments, a psychological report will be prepared that will be shared with the client and referrer and stored in the clients file on the EPR in a PDF format and not password protected. If the client requires an interpreter for the assessment, then the case psychologist must request an interpreter service or funding from HCC to proceed.

5.6. Report deadlines

Case psychologists should communicate that assessments and reports will be completed within a 12-week timeframe. However, this will be extended to a maximum of 16 weeks if there are delays in receiving information (see section 5.4.3). Reports will be password protected and sent to the referrer using a HTFT .net account.

5.7. External case management meetings

Case psychologists will offer a feedback meeting to the person under assessment and the referring social worker within four weeks of report completion. If the case psychologist is required to present findings and psychological opinion at further meetings this should be discussed and agreed four weeks in advance.

5.8. Difference in opinion

The nature of the work conducted in SAARC is complex and sensitive, often involving various professionals, organisations, clients, and families. Thus, difference in opinion could arise. In the first instance, case psychologists should hold individual consultation or MDT professional meetings to discuss and resolve issues surrounding a case and discuss outcomes within their clinical supervision. If differences in opinion or other challenges remain unresolved, then the case psychologist should inform the lead psychologist of the forensic division and their designated operational manager. If required, they will escalate to the forensic service manager.

5.9. Discharge

Following final consultation meetings, the case will be closed and the client discharged using the EPR.

6. RECORD KEEPING

All communications and clinical work must be recorded in HTFT's IT electronic clinical recording system. Some specific information to be recorded has been outlined throughout relevant sections of this procedure (i.e., Section 5).

7. CLINICAL SUPERVISION & TRAINING

Psychologists who accept referrals under SAARC must receive monthly clinical supervision from a HCPC registered psychologist. Supervision is logged on Trust systems (i.e., ESR) and recorded within individual supervision records. Training needs will be identified in individual staff appraisals. Opportunities to access local training will be considered by clinical leads, whilst access to external training will be considered through the Forensic Division Workforce meeting.

8. GOVERNANCE

In line with the forensic division operational procedure (SOP19-032), psychologists working within the SAARC service are accountable for ensuring that they attend the required governance meetings to ensure that they maintain high quality standards of care, leading and participating in governance, sharing the learning from compliments, complaints, and incidents (3.4, p.5). The overall delivery, effectiveness, and quality of the SAARC service will be monitored within the forensic division governance meetings (i.e., Forensic Service Clinical Network, Clinical Governance meeting, and the Forensic Service Operational Delivery Group). Any necessary assurance, actions, or concerns can be escalated by the chair of these governance meetings within the Trust.

9. RELATED HTFT GUIDANCE, POLICY & PROCEDURES

1. Safeguarding children policy and procedure (N-045)
2. Safeguarding domestic violence and abuse policy (N-054)
3. Caldicott & data protection policy (N-027)
4. HTFT Guidance on public interest disclosure
5. Forensic services clinical governance standard operating procedure (SOP19-032)

10. REFERENCES, GUIDANCE & LEGISLATION

College of Policing (2022). Information Sharing Guidance. Available at: https://www.college.police.uk/app/information-management/information-sharing [Accessed 16th November 2022].

Data Protection Act, 2018. Data Protection Act 2018. [online] GOV.UK. Available at: https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted [Accessed 16th November 2022].

HM Government (2018). Information sharing: advice for practitioners providing safeguarding services to children, young people, parents, and carers. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062969/Information_sharing_advice_practitioners_safeguarding_services.pdf [Accessed 16th November 2022].

National Police Chiefs Council (2022). MASH & early Intervention Portfolio Police Information Sharing Guidance 2022. Unpublished draft.

National Police Chief's Council (2019). Data Protection Manual. Available at: https://www.npcc.police.uk/2019%20FOI/IMORCC/225%2019%20NPCC%20DP%20Manual%20Draft%200.11%20Mar%202019.pdf [Accessed 16th November 2022].

NHS England (2019). Safeguarding children, young people and adults at risk in the NHS: safeguarding accountability and assurance framework. NHS England & NHS Improvement.

Royal College of Psychiatrists (2017). Good psychiatric practice: confidentiality and information sharing. RCN.

Working Together to Safeguard Children (2023): a guide to inter-agency working to safeguard and promote the welfare of children. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

APPENDIX1 - FLOWCHART OF SAARC REFERRAL & ASSESSMENT PROCESS