Berkshire West LSCB Report

Report of FGM Task and Finish Group to LSCBs

In February 2014 the Designated Nurse Safeguarding for the four CCGs in Berkshire West brought to the attention of the LSCBs, an intercollegiate report published by the Royal College of Midwives (2013) entitled Tackling FGM in the UK. Multi Agency Practice Guidelines published in 2011 by HM Government, identified Reading as an area of potential high prevalence of women and girls who might have suffered, or are at risk of suffering, FGM. This is because of the diverse population of Reading.

The chair of the LSCBs requested a task and finish group be formed to review the 2013 report with reference to the three areas across Berkshire West. Members of the LSCBs were requested to identify representation on the task and finish group from their agency.

West of Berkshire Female Genital Mutilation (FGM) Task and Finish Group:

The group consisted of members from Children's Social Care Services, Thames Valley Police, Reading LSCB Business Manager, Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust, Schools Safeguarding Children Lead from West Berkshire Council and Berkshire West CCGs. The group was chaired by the Designated Nurse Safeguarding and met on five occasions between May and October.

The aim of the group was to scope local statutory responses to FGM and to develop recommendations for action based upon policy recommendations from the 2013 document. This will support a robust multi-agency and community approach to safeguarding children at risk of FGM across Berkshire West.

The action plan contained in the intercollegiate document was used as a starting point to review the local response to FGM. This is attached at appendix 1.

Actions Identified by the Task and Finish Group:

Child Protection Procedures

Berkshire LSCBs Child Protection Procedures were amended in June 2014 to reflect the 2013 Intercollegiate Document. The procedures were reviewed by the task and finish group. It was the decision of the group that further clarity is required for frontline practitioners about the need to refer all female children in cultures where FGM is known to be practised to Children's Social Care Services. This must be done with respect and sensitivity to enable a professional assessment of risk to female children within that family.

Suggested amendment to Section 5 of the Berkshire LSCBs Child Protection Procedures.

If a girl or woman is a mother or a prospective mother, her child/ren or unborn child should be considered at risk of significant harm. The professional should consult with their designated child protection advisor and should make a referral to Children's Social Care services. (Adapted from London LSCB Guidance).

The addition of a flow chart to supplement the child protection procedures is also recommended to provide clarity for practitioners.

It is of note that during the course of the task and finish group two families from cultures in which FGM is known to be practiced, were referred to Children's Social Care Services, because the families contained female children who might have been at risk of FGM. The Berkshire LSCBs Child Protection Procedures were followed and the children, at that time, were not considered to be at immediate risk of FGM. However, this raised the question within the group about how professionals could be assured that at some point in the future the risk of FGM for such children would not resurface. This is because there is no process for 'monitoring' such children. The issue reminded the group that communities and all statutory agencies, especially schools and GPs, must, at every contact with families, be alert to recognise and respond to girls at risk of FGM.

Local Health Services:

The Royal Berkshire Hospital NHS Foundation Trust (RBH) has encompassed routine questioning about FGM into all pregnancy bookings. Guidelines for midwives including a referral flowchart for midwives, following identification of pregnant women who have suffered FGM, have been developed for use within midwifery services.

It is apparent that whilst FGM is recognised within RBH maternity services, there is potential to increase recognition and response throughout other departments within the hospital. In particular, key clinical environments such as Urology, Gynaecology and the Emergency Department.

A form adopted from the Bolton FGM Assessment Tool, has been developed at RBH to be used to support referrals to Children's Social Care Services. The form is currently being reviewed within RBH internal governance processes.

The RBH is not currently listed on NHS Choices as a hospital where services for women who have suffered FGM, can be accessed. This is likely to be because there is not a specific FGM clinic at RBH. This is an issue for consideration by CCGs as commissioners of local health services, and also Directors of Public Health.

Other local healthcare providers:

The group was unable to find evidence that routine enquiries about FGM are made in other healthcare settings. There are opportunities for health care professionals to make sensitive enquiries about FGM at every contact with patients. Healthcare professionals need to follow the **'one chance rule'.** This states that the attending professional may only have one chance to speak to the victim and prevent future harm.

Schools:

LSCB members did not provide representation from schools on the task and finish group. This is unfortunate because it is well documented that schools have a crucial part to play in recognising and responding to girls at risk of FGM. Peer support and education within schools will contribute to protecting and preventing girls suffering FGM. The group is unable to comment if any action is being taken in schools to identify girls at risk of FGM.

Data collection:

Since April 2014 all NHS hospitals are required to record:

- If a patient has had Female Genital Mutilation
- If there is a family history of Female Genital Mutilation
- If a Female Genital Mutilation-related procedure has been carried out on a patient.

From September 2014 all acute hospitals are required to submit this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.

It has not been possible to establish the exact numbers of women and girls living in Berkshire West who have suffered or are at risk of suffering FGM. This is because the data is not collected by any source.

The task and finish group has identified the following possible sources to enable collection of local data:

- Use of school census information
- Thames Valley Police data
- Children's service data
- Maternity data set
- Primary care read codes
- Office of National Statistics Registration System

These sources will provide data on actual incidences and allow for predicted incidence according to local demographics.

Raising awareness and preventing FGM:

Although individual organisations attempt to raise awareness of FGM there appears to be a lack of a co-ordinated and consistent approach.

The group suggests that leaflets containing information about FGM and additional resources for help and support should be developed and made available within professional and community settings. This literature should be made available in a range of languages. This will require a commitment for funding.
There is also a wealth of on line resources.

Training:

The Home Office has recently circulated free web based training. This has been advertised within individual agencies. National conferences specific to FGM are available but it is apparent that information about FGM is not currently contained in the LSCBs training programme.

It is recommended that recognition and response to FGM is included in the LSCB training programme.

Community Approach:

One member of the task and finish group met with representatives from two community groups in Reading, ACRE (Alliance for Cohesion and Racial Equality) and Utilivu Woman's Group, to learn more about their response to FGM.

Addressing FGM is seen as a priority within both of these organisations who have emerged as key partners in addressing the issue with those affected.

It has not been possible to locate representatives from affected groups or community based groups in Wokingham or West Berkshire.

Recommendations for future practice:

The group recommend emulating the 'Bristol Model' to address the issues relating to FGM. Key components of this approach include:

- The empowerment of affected communities utilising an educative approach
- Collective ownership – commitment from all key stakeholders
- A strategic overview –how does this fit in with existing violence against women and girls strategies
- Service development and commissioning of support services eg. specialist FGM clinics for women and girls who have suffered FGM can be referred or self- refer, for discussion about surgical interventions and where psychological support can be made available.
- Training and resource development – websites, guidelines, lesson plans and leaflets to support learning and campaigning

Conclusion:

The task and finish group has established that across Berkshire West there is some awareness of FGM amongst local agencies and that some agencies are developing good practice to recognise and respond to women who have suffered FGM. The Berkshire LSCBs Child Protection Procedures support practitioners in referring girls at risk of FGM to Children's Social Care Services who then inform Thames Valley Police.

However, there is much still to be done locally. The key policy recommendations contained in the 2013 document are not fully addressed locally. A summary document is contained at appendix 1.

A co-ordinated strategic direction is required to progress local developments that will ensure girls living in Berkshire West who might be at risk of FGM are identified and protected. Most successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected. Without such co-ordinated strategic direction it will be difficult to progress key policy recommendations locally.

Recommendations (from the task and finish group) to the LSCBs:

The group suggests that the local response to FGM should be a matter raised at the Health & Wellbeing Boards in order to ensure that addressing FGM is a priority for all agencies. Thereafter, in each of the three areas of Berkshire West quarterly FGM delivery and safeguarding partnership meetings are initiated to include developing policy and practice, awareness- raising, intelligence gathering and sharing and data monitoring. This will require commitment from Directorates of Public Health. It is essential that affected communities are represented from the start.

This will inform commissioning of local services for women and girls who have suffered, or might be at risk of suffering FGM.

Amendments are made to section 5 of the Berkshire LSCBs Child Protection Procedures.

Training courses to raise awareness about FGM is made available through the LSCBs training group

Sources of funding are explored to progress the development of literature explaining about the consequences of FGM. Such literature needs to be available in a variety of relevant languages.

References:

RCM, RCN, RCOG, Equality Now, UNITE (2013) Tackling FGM in the UK: Intercollegiate Recommendations for Identifying, Recording and Reporting. London: Royal College of Midwives. (Available at www.rcm.org.uk)

HM Government (2011) Multi-Agency Practice Guidelines: Female Genital Mutilation. (Available at www.gov.uk)

Berkshire Local Safeguarding Children Boards Child Protection Procedures. (Available at http://berks.proceduresonline.com/index.htm)

Appendix 1 Key Policies Recommendations (contained in Tackling FGM in the UK 2013)

Target Audience	Policy Recommendations/Rationale	Expectations of Action to carry out recommendation	Berkshire West Progress
All Agencies	**Treat FGM as Child Abuse** and integrate it into to all safeguarding procedures across the 4 countries of the UK (England, Northern Ireland, Scotland and Wales) outlined in Working Together to Safeguard Children (2013) (England), Co-operating to Safeguard Children (2010) (Northern Ireland), Child Protection in Scotland (2010) (Scotland) and All Wales Child Protection procedures (2008)	• NICE should revise their guidance on 'When to suspect Child Maltreatment' (Clinical Guidance CG89) to include FGM. • Girls born to mothers who have had FGM should be considered at risk of significant harm. They require monitoring through the child protection system until they are at an age when they can speak about FGM and are able to seek protection for themselves. • Lead Social Work agencies should urgently work to revise and clarify referral thresholds when risk of FGM is a concern or suspicion, including conducting assessments and monitoring of the child at risk. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.	Berkshire LSCBs Child Protection Procedures updated July 2014. Suggested amendment to be made to Policy and Procedure Group. When agreed, accompanying flow chart to be incorporated. Need to develop generic risk assessment tool. RBH have developed one for use in maternity services.
NHS	**Document and collect information on FGM and its associated complications in a consistent and rigorous way:** Good documentation is important for planning and commissioning services on FGM, providing quality care for girls and women affected, for research and for monitoring trends of FGM in the UK.	• The Health and Social Care Information centre should develop specifications to code FGM in hospital episode statistics and in maternity and child health datasets. • Every woman from practicing community who books for maternity care should be asked in a sensitive manner about FGM and the discussion recorded in paper based and electronic records, to include action taken or referral to the appropriate professional. • All new patient registrations in primary and secondary care, including A&E of young girls/women, should include detailed enquiry about country of origin. If the family is from FGM practicing community, document any presence of FGM to establish a baseline for monitoring and sharing information with relevant agencies.	Since September 2014 RBH submit monthly returns re FGM to DH. Routine questioning about FGM at all antenatal bookings. Guidelines and referral flowchart for pregnant women developed and implemented for midwives to use at RBH.

		• This information should be captured at all pregnancy bookings • The Royal College of Paediatrics and Child Health (RCPCH) should update the specifications for the 'Personal Child Health Record' (the Red Book) to include a code for the mother having FGM. This should include FGM in the electronic 'Red Book' (Personal Child Health Record) • Health practitioners in maternity services should ensure FGM is coded in electronic records and information shared with child health teams. • Adequate language translation services are required in areas of high prevalence.	Midwives record risk of FGM in maternity discharge records that are sent to GPs and Health Visitors. RBH staff have access to interpreter services via Prestige Network. Information Sharing processes re FGM requires further exploration and development. PCHR is not currently used to document risk of FGM.
Health, Social Care, education and the Police	**Share information on FGM systematically:** There is a need to develop information sharing protocols between health, the police and other relevant agencies such as social care and education.	• The NHS should develop protocols for sharing information about girls at risk – or girls who have already undergone FGM with other health and social care agencies, the Department for Education and the police. • These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Information sharing processes re FGM requires further exploration and development.
Healthcare Professionals	**Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and girls' protection of girls at risk of FGM:** Ensure that health professional know how to provide quality care for girls who suffer complications of FGM.	• Health and Social Care staff must work to the WHO guidelines for nurses and midwives, the UK multi-agency practice guidelines and CPS legal guidance. www.who.int/reproductivehealth/publications/fgm/en/index.html • On the opening and re-suturing of women with Type III FGM, WHO guidelines should be followed. Guidelines can be accessed from the WHO website as follows: www.who.int/reproductivehealth/publications/maternal_perinatal_health/RHR_01_03/en/index.html • Refer all women identified with FGM for support and further	FGM guidelines in place at RBH. FGM awareness incorporated in ingle agency safeguarding children training. Access to Home Office FGM e-learning course circulated to the LSCB

		medical and psychological assessment as appropriate. This must be done very sensitively. • A multi-agency and multi-professional approach should include the Medical Royal Colleges, professional organisations and trade unions for incorporating FGM into pre-registration education/undergraduate level training and continue professional development appropriate to the individuals' levels of responsibility and accountability. This should include a mix of face to face and the development of e-learning resources on FGM, which all relevant frontline professionals can access. • A lead agency should be involved in producing e-learning materials for healthcare and other practitioners. This agency should inv9olve the main health professional bodies such as the relevant medical royal colleges and health trade unions in developing training materials. • High quality information on the effects of FGM (health, psychological and rights-based) should be provided to all women identified as having FGM. • Healthcare practitioners need to consider the needs of both the future child as well as any other female children who may already be born or resident in the household with the woman. • Healthcare practitioners need to follow the 'one chance' rule. This states that the attending professional may only have one chance to speak to the victim and prevent future harm.	Training Group with the request to consider provision of multi-agency training about FGM. RBH has developed a leaflet for pregnant women. BHFT have developed a leaflet about diversity and cultural norms.
Health, Social Care, Education and the Police	**Identify girls at risk and refer them as part of the safeguarding children obligation:** Early identification of risks of FGM to girls, referral, planned and sustained information and support to families are needed to protect girls from undergoing FGM.	• Professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk. • In cases where FGM is identified in a woman who presents at maternity services, the implications for the woman and her future child should be discussed by the midwife or doctor and a clear plan of action including communication with relevant agencies detailed in paper and electronic records. • Professionals should refer all women identified as having undergone	Incorporated in Berkshire LSCBs Child Protection procedures. RBH have developed a flow chart to support decision making and referral. Midwives inform health

		FGM who give birth the female children to the Multi-Agency Safeguarding Hub (MASH) for discussion and review. A home visit should be made by social services and further information on the law on FGM and support provided to women. This has been tried in Waltham Forest before the FGM Services closed down. Such visits have been welcomed by women. • It is important to share this information with the GP, the health visitor, school nurse and safeguarding leads in Schools so that they can engage in continuous dialogue and provide information to parents about illegality of FGM and monitor girls at risk. • Health practitioners offering travel vaccinations to children from practising communities for travel to countries where FGM is prevalent must be sensitive to the possible risk of FGM. • Girls from FGM practising communities who are put on child protection registers for other forms of abuse and those who come into contact with youth offending teams and CAMHS should be asked about their risk or experiences of FGM by trained professionals. • All responsible agencies should promote and sign post at risk girls and women to age appropriate information and support services such as the NSPCC helpline and specialist FGM clinics. • Refer all girls and women identified with FGM for support and further medical and psychological assessment as appropriate. Referral pathways must be developed so that all health and social care agencies are aware of their respective roles and responsibilities.	visitors and GPs of pregnant women who have suffered FGM.
All Agencies	**All girls and women presenting with FGM within the NHS must be considered as potential victims of crime and should be referred to the police and support services.** FGM is illegal in the UK. All professionals to be aware of the	Protocols for information sharing between health, the police and other relevant agencies such as social care and education should be developed. These protocols should be based on national guidance and should regularly be reviewed for their effectiveness by public health directors and GP commissioners.	Requires further development. Currently referrals are made to CSC who then convenes a strategy meeting with the police.

	FGM Act (2003) and able to act on cases of FGM where a crime has been committed. All girls and women who were UK residents since March 2004 and have had FGM are victims of crime, with rights to redress, regardless of whether FGM was committed in the UK or abroad.		
Local Authorities, Service Commissioners and Social Services	**The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor progress of implementing these recommendations.** Directors of Public Health, Health and wellbeing Board and Clinical Commissioning Groups to consider the needs of people affected by FGM with Joint Strategic Needs Assessment (JSNA) and local strategies (e.g. Violence against Women and Girls strategies) particularly in areas where communities affected by FGM reside. Local Safeguarding Children Boards should be charged with leading a preventative response to FGM, including ensuring that information on girls at-risk is	• Directors of Public Health, Directors of Social Care and Children's Services, Clinical Commissioning Groups, Health and Wellbeing Boards should include FGM in the Strategic Needs Assessments (JSNA) and Violence against Women and Children strategies. • JSNAs should inform preventative strategies led by the Local Safeguarding Children Boards in collaborations with the local authority and Health and Wellbeing Boards. • In the absence of local prevalence data, local authorities to use socio-demographic data; e.g. Primary Level Annual Schools Census (PLASC), to map communities affected by FGM in their local area, and to plan for services to meet those needs. • In all areas, training on FGM should be integrated into all safeguarding training conducted by LSCBs. • Practitioners should be aware of their role in prevention during the life-course of the girl at risk and be able to sensitively discuss FGM and prevention of harm with them. • In areas with high densities of communities affected by FGM, preventions should be explicit in local child protection policies. • LSCBs should publish and share their strategies in high density areas. • Preventative agendas should consider the need for empowering girls at risk to prevent harm, as well as support services for those affected by FGM. • The NSPCCs dedicated FGM helpline service is promoted across all settings, including health, social care and education as a resource	Refer to Health and wellbeing Boards

	shared across health, social care and education with information sharing protocols based on national guidance, and regular reviews of how information is shared and used. Practitioners should refer all women from FGM affected communities who have had FGM and who have female children to the Multi-Agency Safeguarding Hub (MASH) for discussion, review and assessment	for practitioners with concerns and girls at risk to claim their rights to protection. • Some practitioners – teachers, school nurses, GPs – are well placed to talk with girls at risk about prevention of harm. LSCBs should support such interventions. • Strategies for early identification of girls at risk should be put in place: At national level – health, Social Care and education performance in these areas should be monitored against the CQC and Ofsted inspections regime which are published. At local level – Develop FGM into quality standards for commissioning, by which health and social care institutions/service providers can be judged.	
UK departments for education	**Empowering and supporting affected girls and young women should be a priority consideration.** Many girls are too young to understand the implications of FGM for them. Young people may support FGM because they lack fact about it.	• In areas where affected communities reside, schools should explicitly include discussions and information on FGM within Personal, Social and Health Education (PSHE) curriculum. Teachers, School Nurses, Health Visitors, Counsellors and Safeguarding Leads in schools should provide time for 1:1 conversations and information to girls from practising communities. These could be integrated into other messages (MSPCC Pants Campaign), encouraging girls and young women to report harm such as in the preventions of physical and sexual abuse. Young people should be signposted to the MSPCC FGM Helpline on 0800 028 3550 for advice, information and counselling.	Refer to Schools
Home Office, UK Public Health Authorities and Social Services	**Develop and implement national public health and legal awareness campaigns in FGM, similar to previous campaigns on domestic abuse and HIV.** Current information provision about the health consequences is not reaching the affected communities and the general	Well-designed public health and legal awareness campaign about FG<, targeted at women and girls from at risk communities about the health and legal implications of FGM. These campaigns should also emphasise to the general public that FGM is illegal in the UK, a message endorsed by key professional organisation and NGOs.	

	public is not aware of the illegality of FGM. There is support for stringer and effective action by the governments, particularly among young women from affected communities, who want to see the practice stopped.		