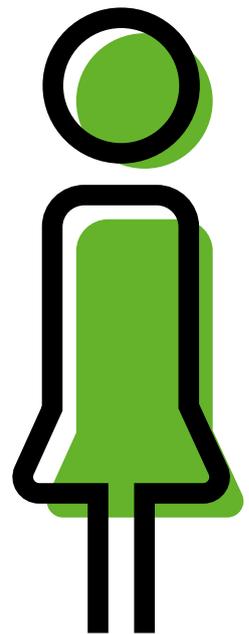
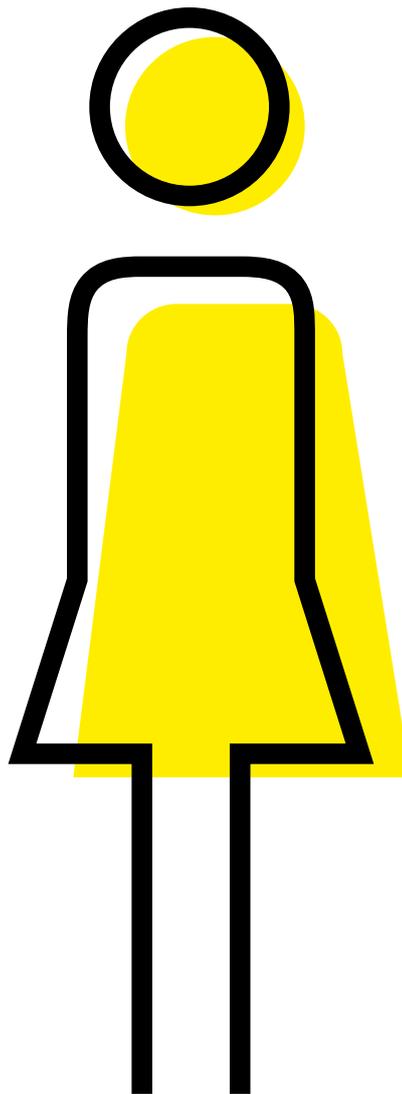
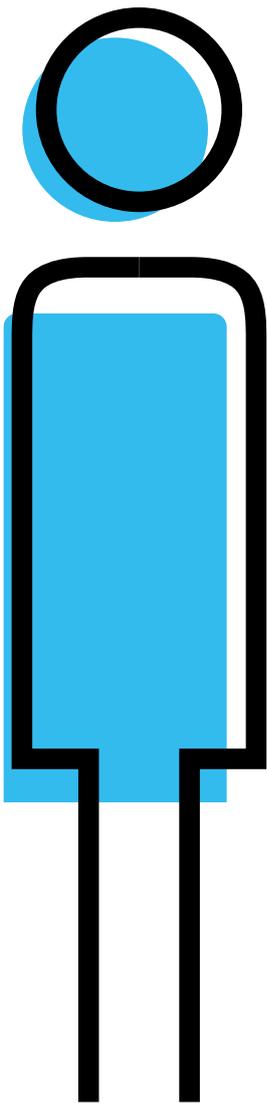


Commissioning  
services to meet the  
needs of women  
and girls with **FGM**



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## 1. Executive summary

FGM is child abuse and illegal. This harmful practice is a violation of human rights against women and girls. Survivors of FGM living in England can expect care and treatment to meet their healthcare needs caused by FGM.

NHS organisations have [statutory responsibilities](#) to safeguard women and girls against FGM. This guidance advises commissioners how to approach these responsibilities and what information and resources are available to inform their decisions.

NHS England has committed to support NHS organisations to tackle FGM, by improving the care and support to women and girls who have FGM and to protect those at risk of FGM.

Many commissioners will find that this means adaptation of existing commissioned services. This will often mean improving access or identifying individual needs and making sure that these are either met within the pathway, or referred appropriately.

The estimated annual cost of care for women and girls with FGM in England and Wales is £100million; a significant proportion of which is either unmet needs or non-recurrent. Provision of services to support women and girls with FGM will reduce the need for services, thus reduce this figure. Investment in good FGM services leads to long-term significant savings to the NHS.

There are 10 recommendations which, if met, will help commissioners provide the services in their area which best meet the needs of the women and girls who have had FGM, and of those at risk.

The document has been developed with help from expert clinicians, commissioners, survivors of FGM, and other stakeholders following consultation, workshops, discussion; we are very grateful to the many contributors who helped along the way. Thank you.

## 2. Introduction and context to recommendations

Female genital mutilation is the illegal procedure where the female genital organs are injured or changed, but there is no medical reason for this. It can seriously harm women and girls' physical and mental health and wellbeing in the long term.

Commissioners should make sure they understand the full context of FGM and, as a minimum, review:

- [www.nhs.uk/fgm](http://www.nhs.uk/fgm) - an overview of what FGM and some basic information
- [HMG Multi-agency statutory guidance on female genital mutilation](#), April 2016 which places responsibilities on NHS organisations
- [An Introduction to FGM](#) – the introductory e-learning session, free to access to all NHS employees

Many clinicians report that some health consequences are caused because patients delay seeking care for conditions because they have FGM, which can lead to complications and/or other conditions. Delaying asking for help might be because a woman is embarrassed, worried about how the doctor will react to her FGM, concerned that she might be reported to the police or many other complicated factors.

**UK Prevalence rates** - An estimated 137,000 women and girls with FGM live in England and Wales, and a further 60,000 girls have been born to mums with FGM, so are potentially at risk. It has been estimated that [no local authority area in England is likely to be entirely free from FGM](#).

**How many patients have FGM** - Between Apr 15 and Dec 2017, 15,390 women and girls presented to NHS services where FGM was identified as a relevant condition and/or treated. For full reports, visit NHS Digital [FGM Enhanced Dataset](#) reports for full details.

**Global Prevalence rates** – Access the [UNICEF country profiles](#) to understand where FGM happens globally, with at least [200 million women and girls](#) living with FGM today.

**Estimated cost of treatments relating to FGM** - a health economics report commissioned by the Department of Health estimated the [annual cost is £100 million, if all needs were met/ treated in a single year](#). This comprises £34m physical health needs and £66m mental health needs.

*To note: a significant aspect of this need is currently unmet. If met, many costs would not be recurrent.*

**Provision of services to support women and girls with FGM will significantly reduce the need for services, thus reduce this figure.**

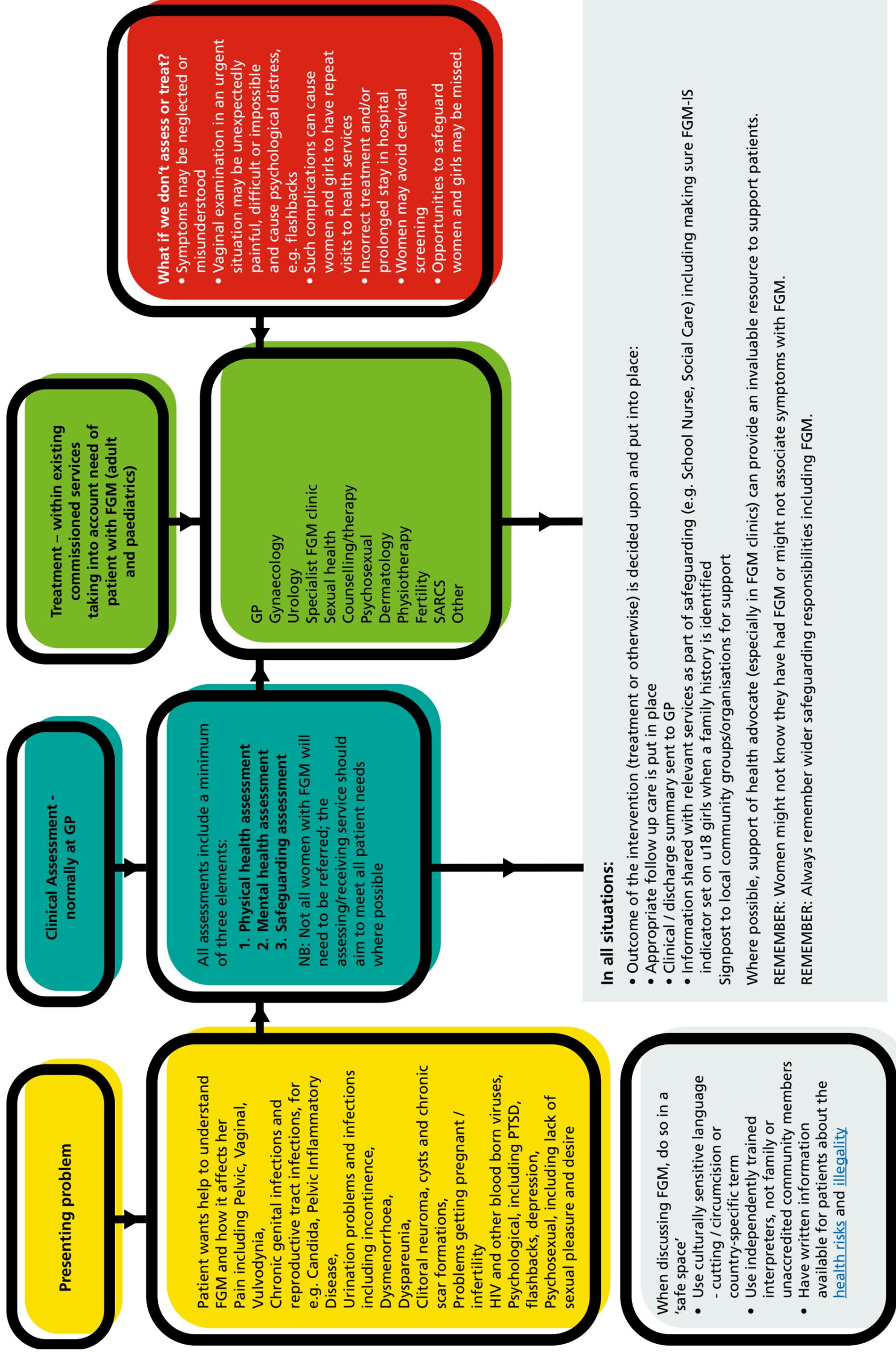
**Clitoral reconstruction** – this emerging surgery is offered in some European countries. The [World Health Organization currently states that there is no evidence to support this](#). Until clinical evidence emerges, commissioners are strongly advised not to commission.

**Examining under 18s for FGM** – commissioners must make sure that whenever there is a report that an u18 girl has had FGM, she is examined in a suitable service, following [existing service standards](#).

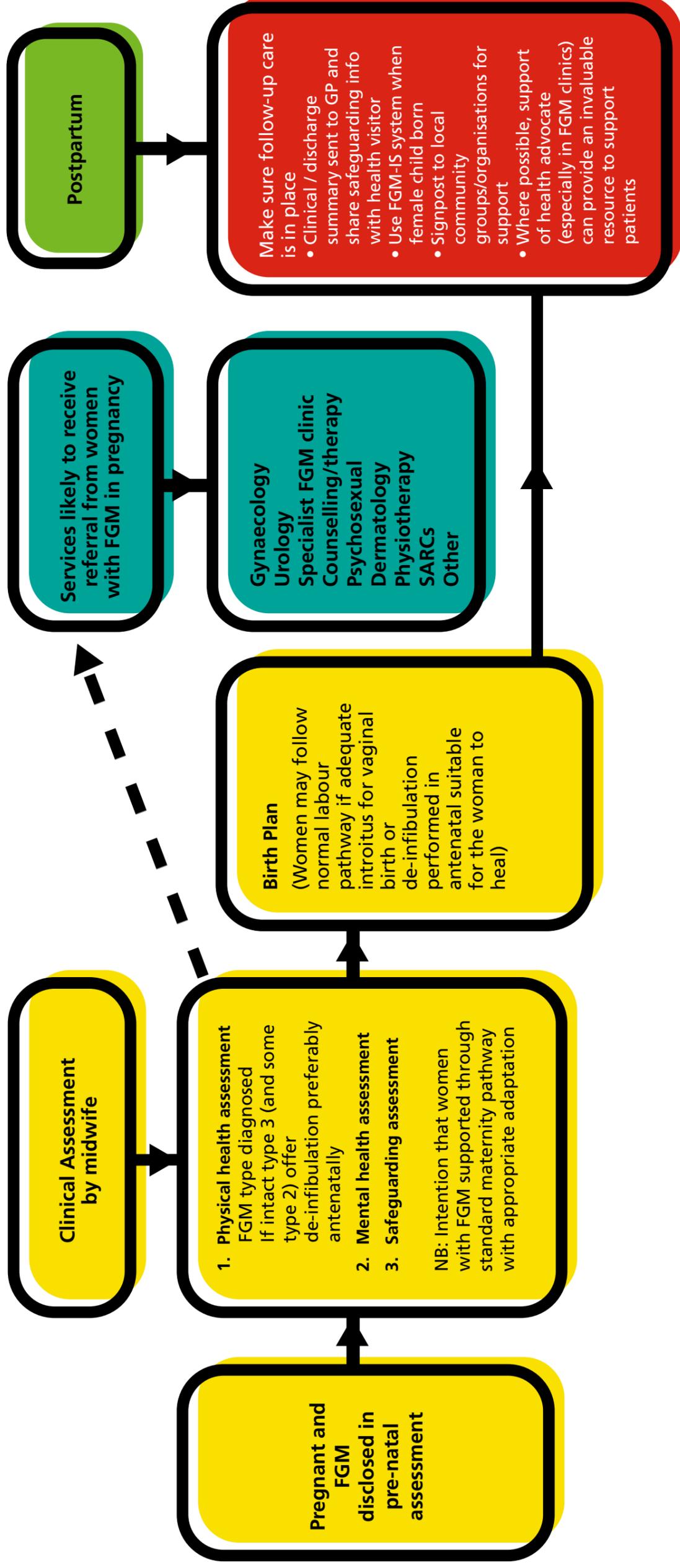
### **3. Commissioning pathways**

Two pathways have been developed to demonstrate types of physical and mental health services where the needs of women and girls with FGM need to be met. They help commissioners to determine where their local services are already seeing FGM survivors and then identify where contract, agreement or service changes are needed to meet the needs of patients.

# Healthcare pathway for Non-pregnant Woman/Girl with FGM



# Healthcare pathway for Pregnant Woman/Girl with FGM



When discussing FGM, do so in a 'safe space'

- Use culturally sensitive language
  - cutting / circumcision or country-specific term
- Use independently trained interpreters, not family or unaccredited community members
- Have written information available for patients about the [health risks](#) and [illegality](#)

**What if we don't assess and treat?**

- Undiagnosed scarring and/or infibulation may compromise optimal management of birth
- increased risk of caesarean section
- Postpartum haemorrhage.
- Increased anxiety

REMEMBER: Women might not know they have had FGM or might not associate symptoms with FGM.  
 REMEMBER: Always remember wider safeguarding responsibilities including FGM.  
 REMEMBER: When sharing information, consider information governance / consent requirement being aware that consent is not required to share details to support safeguarding.

#### 4. Top 10 recommendations for commissioning quality services

1.	Each organisation should have a nominated FGM lead and a suitably trained workforce, and all maternity and obstetric services have a FGM clinical lead
2.	Commissioners must understand local population needs in relation to FGM
3.	All maternity services support and offer a high quality service to women with FGM, meeting their individual needs
4.	Commissioners should review existing services to which GPs are likely to refer for conditions relating to FGM
5.	Commissioners should consider services to support non-pregnant women and girls wanting support and/or in relation to their FGM
6.	Effectively safeguard girls and women and risk of FGM
7.	Include patient and public voice in service design and review
8.	Services must comply with information requirements
9.	Work in partnership with the police and social care
10.	Work with health advocates, introduce ongoing monitoring and evaluation arrangements

## 4.1 Each organisation should have a nominated FGM lead and a suitably trained workforce, and all maternity and obstetric services have a FGM clinical lead

- An FGM lead who is responsible for implementing, sustaining and reviewing local and national FGM policy and strategy. For example, in an NHS Trust and Local Authority this role may be a strategic role or met by a safeguarding lead. In a CCG, this is likely to be a designated nurse.
- Organisations need to incorporate the [Female Genital Mutilation: Training standards for healthcare professionals](#) within their training needs assessment and provision.
- In all maternity and obstetric services, there is additionally a clinical FGM lead
- Evidence suggests that it is very rare but not impossible that girls are admitted to emergency care settings immediately or soon after being cut. To allow for this, staff working in unscheduled care settings should have appropriate [awareness and training](#).

Patients have told us that skills, understanding and empathy displayed by professionals are the most important factors. Patients with FGM have already been through a traumatic experience; services supporting them need to recognise this.

### Useful Resources

- NHS England has a National Safeguarding Steering Group, to which reports the NHS England National FGM sub-group, chaired by the National FGM Lead, who is also Safeguarding Lead in London. The NHS England National FGM sub-group meets quarterly to discuss strategic issues relating to FGM across the country. FGM leads are encouraged to approach members of these meetings for support, advice and to share good practice and discuss potential challenges.
- The NHS statutory responsibilities which support and protect women and girls from FGM are outlined in the Government's Multi-agency guidance: [Multi-agency statutory guidance on female genital mutilation](#)
- NHS England has recently launched the *Female Genital Mutilation: Training standards for healthcare professionals* which aligns with [Safeguarding Children and Young People: Roles and competences for health care staff](#), the requirements by profession for training around FGM and safeguarding.
- The FGM strategic/organisational leads should receive the strategic training package (or equivalent) as detailed in [Female Genital Mutilation: Training standards for healthcare professionals](#)
- The FGM clinical leads should receive the training package which aligns with level 3 (or equivalent) as detailed in [Female Genital Mutilation: Training standards for healthcare professionals](#)
- All leads are recommended to take part in the RCM online clinical network.
- Health Education England developed an FGM e-learning package for healthcare professionals which can be found here (<http://www.e-lfh.org.uk/programmes/female-genital-mutilation/>).

Our patients have told us that when professionals working in mental health services do not understand about FGM, this has led to difficulties. Several patients talk about how when they disclose FGM to a counsellor, they have had to explain what it is and then spend time helping them understand. If the counsellor had appropriate training and understood FGM and the need to treat the patient having been through a trauma, the experience would have been a lot better.

## 4.2 Commissioners must understand local population needs in relation to FGM

Although FGM is often hidden, evidence demonstrates that all local authorities in England are likely to have women living within their area who have been cut. In addition, the types of FGM and rates of prevalence vary significantly across the many communities within which it is practiced, and there is evidence to suggest that practices are changing.

In areas where there are few women and girls affected by FGM (areas of low prevalence), the services should be designed to recognise that these individuals may feel more isolated and less empowered to ask for help and support, that professionals in such areas may not be as aware of the signs/symptoms of FGM and are likely to be less experienced in meeting the needs of survivors, and that there are likely to be fewer community-based or voluntary and community sector (VCS) services in the area to advocate for patients and to signpost to the health services.

Commissions should also use the published evidence data base to inform their work, including statistical publications from NHS Digital, the Government-commissioned prevalence estimates, and UNICEF published country profiles.



Many communities where FGM is an issue have either significant stigma attached to accessing MH services, or little recognition of the importance of mental wellbeing. Therefore when considering offering services to meet this need, commissioners and providers need also to consider a campaign to combat this stigma and education patient groups.

### Points to consider:

- All maternity services, regardless of geography, need to be prepared to support a pregnant woman with FGM.
- Include FGM in local Joint Strategic Needs Assessment with partners, including Public Health and Local Authorities recognising the need for care and support services, for preventative services within the local health visitor and school nurse service specifications. Projects may be supported in partnership with your local Police and Crime Commissioner, recognising the need to transition any short term funded project into enduring and sustainable change.
- Take time to engage with your local population and understand their needs in relation to FGM.
- Use information from the FGM Enhanced Dataset publications to see current provision, and work with submitting organisation to enrich the information they submit.
- Given the relatively low patient numbers in some areas, commissioner may wish to consider the need across a Sustainability and Transformation Plan footprint or across a region.
- Use the City University research (links below) to understand the expected prevalence of FGM in your local population; the research publishes population prevalence estimates at Local Authority level. Take time to consider both the full report and to analyse the data tables, accessible at the link, which provide rich data about your local area.
- Share anonymous population-level information with multi-agency partners to get a better understanding.

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- Use the FGM Enhanced Dataset Scorecard (circulated via safeguarding networks) to help understand the information relating to your local provider and your local population.

### Useful Resources

- Home Office commissioned/City University - Estimates the number of women with female genital mutilation (FGM) living in England and Wales.  
[FGM in England and Wales](#)
- [UNICEF - FGM country profiles including trends in provenance and attitudes](#)
- [NHS Digital Quarterly and annually published statistics](#) from FGM Enhanced Dataset.
- Bristol Health and Wellbeing Board have incorporated FGM into their Joint Strategic Needs Assessment for several years, which has provided the strategic recognition supporting the provision of services. The 2016/17 report is [online](#)

### 4.3 All maternity services support and offer a high quality service to women with FGM, meeting their individual needs

Commissioners should make sure that all maternity services are prepared to support women with FGM through a maternity pathway, having introduced routine enquiry at prenatal booking appointments. Following an initial assessment to understand her needs, services are expected to provide care within the standard pathway where appropriate, or refer her as part of an adapted pathway to other service, preparing for a safe delivery.

Our patients tell us that some maternity services are known to 'treat you differently after you disclose you have FGM', making you attend extra appointments even if you have already given birth and been supported through your FGM. Balancing the need to safeguard, our patients ask that we make sure extra appointments are available because they need help and support which can't be delivered through the standard maternity pathway.

#### Points to consider:

1. All midwives should be trained and supported to be confident in asking about FGM, taking a history where appropriate and identifying type (recognising difficulties in identifying some cases).
2. Wherever FGM is disclosed or identified within a maternity pathway, the service should
  - a. always complete a safeguarding assessment at an appropriate point through the pathway, and share information / refer accordingly
  - b. collect and submit information in line with the FGM Enhanced Dataset
  - c. add the FGM Information Sharing indicator to girls born where a family history of FGM is identified
  - d. assess every woman to consider physical and mental health needs in relation to her FGM, recognising additional needs. Some women will need to be referred for additional support, and referral pathways must be open and known, including to specialist FGM clinics, urology, maternal mental health, VCS groups in the community providing support. Wherever possible and suitable, the aim should be to support the patient through the standard maternity pathway.
3. Wherever FGM is disclosed or identified within a maternity pathway, all pathways must include a safeguarding assessment, recognising this through the tariff where appropriate.
4. De-infibulation procedures are mainly needed by patients who have Type 3 FGM, though services need to recognise and allow for some patients who have Type 2 to need a de-infibulation.
5. Regardless of whether elective de-infibulation is offered, all maternity settings need to be ready to de-infibulate in an emergency/unscheduled setting, with a consultant obstetrician being able to do this if others are not trained.
6. If, after FGM is identified and the patient's needs are assessed, she does not have any complications (for example she might have slight scarring, and have already been de-infibulated in a previous pregnancy and been supported to understand her FGM), services should aim not to routinely refer outside of the standard maternity pathway.

## Useful Resources

[\*Tackling FGM in the UK\*](#). Intercollegiate recommendations for identifying, recording and reporting November 2013.

- [\*Female Genital Mutilation and its Management\*](#). Royal College of Obstetricians & Gynaecologists Green-top Guideline No 53 July 2015.
- **HEE e-learning sessions** Health Education England FGM e-learning including a session covering 'FGM: Issues, presentation and management in women and around pregnancy'.

#### 4.4 Commissioners should review existing services to which GPs are likely to refer for conditions relating to FGM

Consultation with existing services has demonstrated the need for care to be provided by existing outpatient services, such as gynaecology, fertility, urology, counselling/therapy, dermatology, physiotherapy or other services.

Clinicians would frequently report that these services may not recognise that FGM may lead to a referral to these services, and have historically relied upon informal contacts to make sure referrals are accepted.

To meet the needs of women and girls in this context, commissioners may need to make sure that these services will accept referrals and that they have staff appropriately trained.

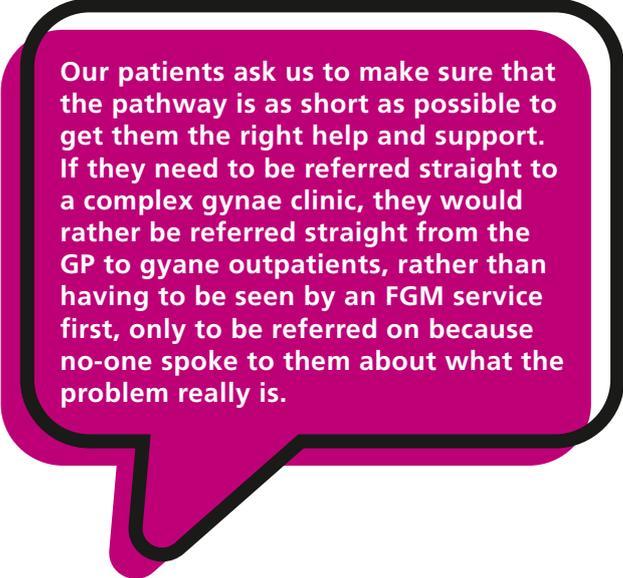
Commissioners need to make sure that in their area, GPs and any referring service can identify FGM, decide upon a care pathway with the patient, and that a referral to the appropriate services will be accepted based on the need caused by FGM.

It is critical that GPs remain empowered and able to refer their patients to the services best able to meet the needs of their patient. It would not be appropriate to introduce a system whereby all women with FGM who need outpatient care are referred by their GP firstly to an FGM service, to then be referred on to outpatient services.

Following the review, commissioners will be able to compare the provision with the identified need (see recommendation 2) and identify where they need to take action.

##### Points to consider:

- What is the capacity in provider services, e.g. are the needs of women/girls being met within acceptable parameters?
- Are the services on offer provided as a result of contractual arrangements and are enduring funding arrangements in place (subject to review and change)?
- Is the provision of FGM support and care standardised across all pathways and regions?
- How can you make sure that the services offered are provided on a sustainable basis?
- De-infibulation procedures are mainly needed by patients who have Type 3 FGM, though services need to recognise and allow for some patients who have Type 2 to need a de-infibulation.



Our patients ask us to make sure that the pathway is as short as possible to get them the right help and support. If they need to be referred straight to a complex gynae clinic, they would rather be referred straight from the GP to gynae outpatients, rather than having to be seen by an FGM service first, only to be referred on because no-one spoke to them about what the problem really is.

## Useful resources

- The pathways in section 3 outline where you might need to look for current service provision.
- Appendix offers a sample service checklist which can be completed once commissioners have identified the services supporting women and girls with FGM.
- Some FGM clinics are published online at [www.nhs.uk/fgm](http://www.nhs.uk/fgm). Please note this is not exhaustive and may not be up to date.

## 4.5 Commissioners should consider services to support non-pregnant women and girls wanting support and/or treatment in relation to their FGM

Consultation with existing services and patients recognises that the care needed by women because they have FGM can include a wide range of services and treatment pathways. These include:

- Diagnosing what type of FGM a woman has.
- Supporting her to understand and know what her options are (including de-infibulation where required).
- A safe space and supportive environment where she can learn about what FGM is, and understand fully how it has affected her.
- Where she can discuss relationships with her family and potentially her partner/spouse and partner's family, and consider how she will protect her daughters, if she has or will have children.
- Offering her counselling and support in relation to the trauma that was FGM.



Many patients have told us how important this service has been to them, in understanding FGM and what happened to them, and in understanding how and why they can and must protect their daughters.

There are examples where services offer this to non-pregnant women, usually open to self-referral. Such services often offer de-infibulation as part of the clinic in simple cases (following clinical risk assessment).

A number of services which offer support to non-pregnant women also offer cervical cancer screening, family planning services and other services which the provider and local patient groups have identified as being services which this group of patients have difficulty in accessing. Some work in partnership with early intervention teams and projects from local Children's Social Services, allowing there to be a multi-agency and supportive safeguarding assessment, and support and offer access to housing and benefits advice.

Health advocacy is essential at this kind of clinic. Commissioners need to make sure that in their area, GPs and any referring service can identify FGM. On identification, clinicians should then know to where they can refer a woman for this kind of help and support.

At the service, women with FGM should be offered an appointment at what can be described as a 'needs assessment' FGM clinic. Not all women with FGM have to be seen at this clinic; as a GP or maternity service (or other) will often be able to either meet the needs of the patient or refer appropriately themselves (see above). Additionally, patients may not want to use this service. However all patients for whom FGM is identified or who disclose, should be offered the opportunity to visit an FGM clinic to receive appropriate and specialist advice based on their circumstances. This clinic should also allow for patients to self-refer, meaning that a patient can disclose that she has FGM to a professional working in a specialist clinic.

As highlighted in the patient involvement comment, designing this type of service successfully will always rely on patient involvement. Your local patient population will help you understand some of the barriers which may prevent them asking for help. Other clinics have considered the following:

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1. Location of the clinic; with the majority of patient groups asking for this clinic to be based in a community setting which might be a local GP surgery, a community centre, or a local health centre.
2. Opening times of the clinic; different patient groups have highlighted.
3. Access and transport links to the clinic; being close to public transport, especially larger transport hubs if this clinic serves the needs of a local population.
4. The name of the clinic; so that if the patient has an appointment letter at home, it is not obvious to a different family member that she is going to an appointment at an FGM clinic. Many clinics use flower names but this is not a recommendation; services are advised to consult with patient groups as there are many views. It should be noted that a number of clinics stopped using the phrase 'African Well Woman's Clinic' as this both excluded women with FGM who did not come from Africa, and equally was argued to continue with the false stereotype that FGM happens only in Africa. Clinics also had patients present for any number of non-FGM related conditions.
5. Sensitivity at booking; making sure that when the patient arrives, her name is not announced as attending an FGM clinic in a public setting.
6. Proximity to or association with other services; there has been a consensus that these clinics should not be part of maternity or sexual health clinics.
7. Provision of health advocates; often in part recruited/chosen because of their translation abilities, with the ideal situation being that health advocates speak the languages of the largest patient population group.
8. Clinical staffing; many patient groups have suggested a preference for a midwife-led service, offered under the scope of supporting women pre-pregnancy. When designing such a service, commissioners will consider costs of different models.

It is very important that if a clinic for non-pregnant women with FGM is offered which provides the services outlined, there must be clear referral pathways in place if women do present with complex conditions or who need more support that can be offered at this clinic. Health advocates may be able to support a woman who is referred for an outpatients clinic to help her access the service she has been referred to. The pathway in chapter 3 details the services this clinic would offer.

There are different models which have offered this service:

- Midwife-led delivered outside maternity services, sometimes in community or non-hospital settings.
- GP-led delivered in primary care services.
- Consultant-led delivered within or alongside obstetrics clinics.

### **Points to consider:**

- What is the capacity in provider services, e.g. are the needs of women/girls being met within acceptable parameters?
- Can co-operation with neighbouring CCGs or within a Sustainability and Transformation Plan provide a suitable platform to consider service provision?
- If in a low prevalence area, what is an appropriate referral pathway which patients can

access, and would it be appropriate to enter into an agreement with a service provider in a different area, taking into account if support with transport is also required?

- How can you make sure that the services offered are provided on a sustainable basis?
- De-infibulation procedures are mainly needed by patients who have Type 3 FGM, though services need to recognise and allow for some patients who have Type 2 to need a de-infibulation.

### **Useful resources**

- The pathways in section 3 outline where you might need to look for current service provision.
- Appendix offers a sample service checklist which can be completed once commissioners have identified the services supporting women and girls with FGM.
- Some FGM clinics are published online at [www.nhs.uk/fgm](http://www.nhs.uk/fgm). Please note this is not exhaustive and may not be up to date.

## 4.6 Effectively safeguard girls and women and risk of FGM

Commissioners must be confident that effective safeguarding policies and procedures are followed by services providers with active partnerships with the police and local children's services. This includes using the FGM Information Sharing (FGM-IS) system.



Our patients recognise that high quality treatment services can provide a positive and trusted environment, within which effective safeguarding and preventative work can start. In particular, FGM services/clinics supporting women and girls prior to pregnancy and/or marriage are essential to help women understand their important role in ending FGM.

### Points to consider:

- All Children and Young People's and Adult's Safeguarding policies include FGM.
- All services supporting women with FGM always include a safeguarding assessment with actions taken if appropriate.
- Policies and training clearly incorporate the FGM mandatory reporting and pathways allow for appropriate follow-up care and investigation after a report is made under the mandatory reporting duty.
- Services should add FGM-IS indicators to a child's record where the service has identified a family history of FGM, and (where systems allow) should view the FGM-IS indicator to support safeguarding.
- All healthcare professionals need to be provided with adequate supervision when working with FGM survivors and those at risk of FGM.
- Opportunities for feedback, learning and reviews should be in place to learn from the outcomes of a safeguarding investigation. Learning should be sought from all cases, where there was little action taken and those where ongoing safeguarding measures were put in place as a result of the investigation.

### Useful resources

- Department of Health and Social Care [best practice guidance](#) including a pathway, quick reference guide and templates for safeguarding assessments available.
- **Health passport** HM Government publishes a '[Statement Opposing Female Genital Mutilation](#)' leaflet, commonly referred to as the Health Passport. This pocket-sized document sets out the law and the potential criminal penalties that can be used against those allowing FGM to take place. It is designed to be discreetly carried in a purse, wallet or passport. Copies are available in different languages and can be obtained from the Health and Social Care Order [online](#)
- **Leaflet about FGM** Commissioners are advised to make sure if services produce and use their own materials, that locally produced materials are of a high quality and take into account the best practice when communicating about FGM. Copies are available in different languages and can be obtained from the Health and Social Care Order [online](#)
- Guidance on [FGM: mandatory reporting](#) in healthcare.
- Scenario-based animations are available [here](#) to support clinical development and training on how the FGM-IS system is incorporated into clinical practice alongside wider safeguarding practices.

## 4.7 Include patient and public voice in service design and review

Listening to the voices of girls and women in the design and review of services is critical when developing an effective, accessible and appropriate service. Commissioners must recognise that communities affected by FGM might not be represented in patient and public user groups.

To remain current, commissioners should make sure services have clear measurable outcomes and undertake regular reviews, incorporating the views of the patient representatives and local community.

Though patient involvement is very important in the design of all services, it is perhaps most important when supporting non-pregnant women and girls in these clinics. The decision to ask for help is often difficult for our patients especially for younger women who may be about to get married.

### Points to consider:

- Are the voices of women with FGM represented in the local Maternity Voices Group?
- Are there FGM community support groups in your area to provide information to women who have recently given birth?
- How do services capture patient experience? Are the voices of women with FGM heard in your maternity services review?
- If commissioners do not know a group locally with whom they can discuss the needs of women and girls in relation to FGM, it may be possible to contact a group from a neighbouring area or a national VCS group.
- Lessons from patient consultation in relation to FGM is that trust may need to be built between the organisation wanted to develop the service, and the patient and service user group. Many clinics who have run coffee mornings to discuss any aspect of FGM, including what support services can offer, find that a number of events may need to be held to build trust that the discussion will be useful and that they will be listened to.
- It can be assumed that all services aiming to meet the needs of women and girls with FGM will fall under the Public Sector Equalities Duty, and therefore commissioners will need to complete an Equality and Health Inequalities Assessment in relation to this work. Contact your local Equality and Health Inequalities team for support and guidance.
- Ensure quality standards are incorporated into contract specifications.
- Develop a monitoring framework and measurable outcomes.
- Use evidence of what works and build new evidence through evaluation.

## Useful resources

- [Six Principles were developed by the NHS to give practical support to services as they deliver the 'new relationship with people and communities'](#)
- [NHS England Choosing and Buying Services Together – Patient and Public Engagement in Commissioning](#)
- [Evaluation of FGM Prevention among Communities Affected by FGM: A Participatory Ethnographic Evaluation Research \(PEER\) Study, May 2016](#)
- [Healthwatch Oxfordshire supported the charity Oxford against Cutting to review local specialist FGM services](#)
- Appendix offers a sample service checklist which can be completed once commissioners have identified the services supporting women and girls with FGM.

## 4.8 Services must comply with information requirements

Since 2015, acute trusts, mental health trusts and GPs across England have been required to collect and return information about patients they treat who have FGM to NHS Digital.

In addition, there are information standards requiring all organisations across the NHS to keep accurate and detailed (coded) records which detail information about FGM, and to share this information in clinically appropriate situations or where it is required to effectively safeguard.

There are also information standards relating to the FGM Information Sharing (FGM-IS) system, requiring system suppliers to connect to and interact with the FGM-IS system.

### Points to consider:

Commissioners should make sure service providers comply with national information standards, as detailed within the standard contract.

- How many acute and mental health Trusts and GPs are submitting data in your area? Review the statistics making sure that services are providing complete and rich data. Use the FGM Enhanced Dataset scorecard, circulated via the designated safeguarding professionals networks.
- Do statistics published about your area compare to the demographics of your local area?

### Useful resources

- NHS Digital Quarterly and annually published statistics from FGM Enhanced Dataset <http://content.digital.nhs.uk/fgm>
- [Data Provision Notice](#): issued by NHS Digital to inform acute and mental health Trusts and GPs of requirement to comply with information standards.
- Department of Health and Social Care produced a [one-page safeguarding pathway](#) which incorporates safeguarding, the mandatory reporting duty, how the FGM enhanced dataset aligns with this, and how and when the FGM-IS system needs to be used.

## 4.9 Work in partnership with the police and social care

As outlined within the HMG FGM Multi-agency guidelines, efforts to safeguarding against FGM will only be successful when there is effective partnership working between the police, social care, education and health.

Partnership includes strategic planning and development of approaches, sharing of information (anonymous where required) and designing innovative approaches to tackle FGM, and recognising the changing and developing nature of the challenge faced. FGM is a complex issue and where communities believe in practicing FGM, these beliefs can be deeply held and will require long-term and sustained efforts to change practice.

Local authorities and public health have an important role to play in relation to make sure that universal health services take opportunities to prevent FGM wherever possible. Many patients report that accessing high-quality services themselves provided a context in which they could discuss FGM and then understand the importance of ending the practice and protecting their daughters, so the provision of services to support women and girls with FGM is critical to long term prevention.

There are a number of successful community partnership projects, where collaboration between health services, local authorities, children's social services, the police and VCS and community groups have led to change. Police and Crime Commissioners and Health and Wellbeing Boards may be in a position to collaborate with CCGs or other bodies to establish a joint project to tackle FGM together.

### Points to consider

- Are there established communication channels between services?
- Does the local safeguarding children's board have an action plan to introduce effective working together?
- What feedback is received from police and social care after a referral / mandatory report is made?
- Local information sharing agreements and information governance should be put in place between multi-agency partners
- Are there agreements with any non-statutory bodies involved (for example VCS and community group partners) to make sure that there are suitably robust safeguarding processes in place, and that if information is obtained by one part of a joint project which needs to be followed up by a statutory agency, all parties understand these processes and are compliant?

### Useful resources

- [Working together to safeguard children, March 2015](#)
- Information on [FGM protection orders](#)
- [Evaluation of FGM Prevention among Communities Affected by FGM: A Participatory Ethnographic Evaluation Research \(PEER\) Study, May 2016](#)
- The six year Tackling Female Genital Mutilation Initiative (TFGMI) was a coordinated change programme, supporting community based projects. The programme developed

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[best practice guidance](#) on working with communities to tackle FGM which outlines recommendations and shares learning about working together.

- Example of partnership working: Bristol Community Project on [Female Genital Mutilation](#), demonstrating outcomes from a partnership between FORWARD, Refugee Women of Bristol working with statutory bodies across the city.

## 4.10 Work with health advocates

Commissioners should consider how to include health advocates in services supporting women and girls with FGM.

Experience demonstrates that health advocates can play a critical role. In a manner similar to that offered by the Independent Sexual Violence Advisers (ISVAs) and Independent Domestic Violence Advisers (IDVAs), FGM Health Advocates provide help and support to women attending clinic, they will:

- Help and encourage women to access services.
- Support both patient and midwife (other health professionals) and act to bridge any potential differences in understanding or in expectations.
- Normally act as translator where required (and develop experience discussing FGM in multiple languages and can therefore pick up on nuance and important detail where standard interpreter services may find this more challenging).
- Offer a link to a patient's community setting when discussing and make sure that patients can access or know about other appropriate services or support.
- Advocate for the patient in a setting in which she may find challenging.



Our patients tell us that health advocates have made the difference between them turning up to services, or being too worried and feeling too alone to walk through the door. Many health advocates develop invaluable networks and links across communities, encouraging women to access support.

Health advocates need training and support themselves, in the same manner as others working in the clinic. Some health advocacy services are provided by third sector or charitable bodies, but commissioners will need to ensure that on whatever basis the provision is provided, certain statutory requirements such as working in line with safeguarding policies are met.

### Points to consider

- Ensure quality standards are incorporated into contract specifications.
- Develop a monitoring framework and measurable outcomes.
- Use evidence of what works and build new evidence through evaluation.

### Useful resources

- Appendix offers a sample service checklist which can be completed once commissioners have identified the services supporting women and girls with FGM.

## Appendix: Service checklist and information

The following checklist has been developed and can be used by a range of commissioning bodies to ensure the needs of women and girls with FGM are fully considered within services, including maternity, gynaecology, paediatrics, and FGM services.

The checklist suggests specific commissioning questions that address and incorporate quality standards.

		Notes
<b>What is the service?</b>	Description / location of services	
	Head of Midwifery/Service	
	Is there a service specification?	
	Is there a standard patient pathway?	
	Referral criteria (e.g. GP, self-referral?)	
	Which staff roles work in the service?	
<b>Location and frequency of service</b>	Where is the site for provision of the service?	
	When is the service provided? For example, in maternity does the 16 week appointment include an option for an FGM assessment?	
	How is the FGM assessment incorporated within the service?	
<b>How many women and girls does the service see?</b>	What is the number of referrals each year?	
	Is every woman asked about FGM in booking/in assessment?	

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		Notes
<b>Quality information and outcomes</b>	How is the service audited?	
	What specific outcomes are measured?	
	How is patient experience captured and measured?	
	Are appropriate tariffs claimed for enhanced aspects of care?	
<b>Quality standards</b>	All staff appropriately trained in FGM?	
	Is there a safe space for confidential discussion?	
	Are professionals directly asking about FGM? Is culturally sensitive language being used?	
	Is FGM part of the children and adult safeguarding policy? Are all regulated healthcare professionals complying with the mandatory reporting duty?	
	Do referral pathways exist to external services?	
	Are independent qualified interpreters used?	
	Is the service submitting data through the enhanced dataset?	
	What information is available to patients? Including details of service and health risks and legal status of FGM.	
	Does the service have a health advocate?	
<b>Have patients and the public been involved in developing and auditing the service?</b>		