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National FGM Centre: an evaluation of the second phase

Research report

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Executive Summary

The project

The National FGM Centre (NFGMC) was established in 2015 to prevent new cases of female genital mutilation (FGM) among girls living in England within 15 years, to protect girls from FGM, to support those affected by FGM, and to partner with statutory agencies, government departments and grassroots organisations to deliver services. The NFGMC ultimately aimed to create a system change in the way that social work services are provided to girls affected by FGM and their families. The Centre was a partnership between Barnardo's and the Local Government Association (LGA).

The NFGMC worked in 6 pilot local authorities (LAs) with an estimated lower than average number of identified FGM cases and where there was limited multi-agency experience of working with those affected by FGM: Essex, Hertfordshire, Norfolk, Southend, Suffolk and Thurrock.

The NFGMC sought to provide professional expertise and embed good practice in the provision of social work services for girls from potentially-affected communities and their families, by integrating social workers (SW) and projects workers (PW) into social care teams, and working with delegated authority or delegated duties on cases with LA social workers. Continuing Professional Development (CPD) training and consultation work aimed to enhance practice and learning.

The evaluation

The evaluation of the first phase of the pilot (1 April 2015 – 31 March 2016) focused on understanding the process of start-up, as direct services had only been provided for a maximum of 6 months in each LA by the time of reporting.¹ The evaluation of the second phase (1 April 2016 – 31 March 2017) focused on assessing the impact of the pilot on services and members of potentially-affected communities, while concentrating more closely on the model of delegated authority and on support given to families above and below statutory social care intervention thresholds. This evaluation draws out lessons from the NFGMC's work for best practice in the children's services response to FGM, and for collaboration between services and communities.

¹ 'National FGM Centre: an evaluation':

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585158/National_female_genital_mutilation_centre_evaluation.pdf

To understand the central processes, challenges and models of good practice in working to end FGM, interviews were undertaken with 10 Barnardo's staff, including senior managers, Senior Social Workers (SSWs), SWs and PWs from the NFGMC. Interviews with 4 women who had been supported by the project were conducted across 3 pilot sites to improve understanding of their experiences and views of the pilot. Case study interviews were conducted with local authority social workers and NFGMC workers regarding cases in 2 pilot areas.

Additional interviews were conducted with 5 senior stakeholders from LAs, including directors, managers, commissioners of adult and children's services, and safeguarding leads, to identify how and why the model was adopted within the pilot sites, and their perspectives on the development of the pilot. Semi-structured or opportunistic interviews and semi-structured observations were conducted to evaluate the NFGMC's consultancy and stakeholder engagement work.

Findings and recommendations

NFGMC SSWs, SWs and PWs worked on 120 new cases between 1st April 2016 and 31st March 2017. Six FGM Protection Orders were granted during the second phase of the evaluation across 4 pilot areas (2 were granted during the first phase of the evaluation). Four of these cases were explored further through case study interviews with practitioners and service users.

Training continued to be delivered by the NFGMC across pilot sites and other local authorities. Monitoring and assessing the CPD-accredited training outputs and attendance was not the focus for this evaluation. However, the NFGMC reported that training was provided across 12 different LAs, with 929 professionals completing post-training evaluations. 74 per cent reported that they had not previously done FGM-specific training, 80 per cent reported that the training increased their knowledge of FGM, and 85 per cent reported that it increased their confidence to deal with known cases of FGM. Further training was delivered in conjunction with Olive Branch Arts²; to primary age students and their teachers in a number of schools in partnership with Norbury Primary School, and to professionals through Learning Forums. These sessions are evaluated in full below.

Evidence from the evaluation identified several lessons for best practice in the social care and children's services response to cases of FGM, in the multi-agency response, and

² <http://olivebranch-arts.com/>

with regard to collaboration with families affected by FGM and with potentially-affected communities.

Preventative work below statutory social care intervention thresholds

- An early help approach engaged with families affected by FGM, often facing isolation in LAs with very small potentially-affected communities, who did not meet LA intervention thresholds and so would have been likely to fall through the gaps in support, had the NFGMC provision not been in place. This also recognised the:
- Life-cycle of a case, in which risk to a child can change with circumstances. This was shown to be effectively assessed in a nuanced and expert manner by:
- Specialised NFGMC professionals whose time was protected from being absorbed into general case work.

This early help work sought to prevent new cases of FGM by empowering families with information and supporting them to maintain protective factors for themselves and their children. It understood that FGM risk can change over time, is affected by different external factors and that interventions with families should be approached sensitively and transparently. Evidence from interviews and observations demonstrated the value of this offer for families who may need additional support, and which children's services' safeguarding teams are unable to provide due to threshold or time restrictions.

In some cases, work with families below statutory thresholds uncovered risk and led to NFGMC workers supporting families to seek FGM POs, and implement other safeguarding measures. It is likely that these needs would not have been uncovered or support offered without the time and flexibility available to NFGMC workers, in addition to their expertise in assessing FGM risk.

Delegated authority to a specialist provider

The NFGMC was organised across 2 different models: full delegated authority in which an NFGMC social worker managed all aspects of a case, and the delegation of certain duties to an NFGMC practitioner (that is, an NFGMC SSW, SW or PW).

- Full delegated authority enabled specialist NFGMC SWs to work along a continuum from low risk cases where direct work could be undertaken below LA thresholds, to Section 47 or FGM Protection Order cases which required court work and extensive statutory responsibilities.
- This delegation to a service that was highly-specialised in managing FGM cases was an effective way for LAs to ensure the best possible case management. Having an NFGMC SW able to take responsibility for all aspects of a high-risk case saved the allocation of other SWs and SW teams to these cases.

Improving professional knowledge and multi-agency working

A key part of NFGMC work in LAs was building and improving partnership working; recognising that FGM is not just a children's services' safeguarding issue but also the responsibility of partners in health and education.

- Partnership working on cases, and training or presenting to different agency teams across LAs, enabled NFGMC staff to raise professional awareness about FGM, referrals (including what to include in a 'good' referral), and local context.
- The practice of joint visits to families by NFGMC workers and LA SWs functioned as an important educational exercise; enabling LA SWs to observe best practice in communicating with and supporting families affected by FGM, in addition to assessing risk. Pilot LA SWs had generally had little direct experience of working with families affected by FGM.

Work with communities

- Community engagement work enabled NFGMC workers to reach members of potentially-affected communities who may not have otherwise come to the attention of LAs, because they were unlikely to be referred (i.e. 49% of referrals were made from health, particularly pregnant women affected by FGM).
- Engaging with community groups raised awareness of the service for people who may benefit from support but would not meet LA thresholds, and helped to build the picture for LAs about potentially-affected communities and how they can support them. It recognised that social care interventions take place in a community context.
- Community champions were identified and trained by NFGMC practitioners in the course of their community engagement work in the pilot LAs. These were individuals affected by FGM, who were committed to building a network of support in their local communities.

The project

Literature review

A review of relevant literature was undertaken for the evaluation of the first phase of the National FGM Centre pilot, and can be found in full in the report for that evaluation. The most relevant key findings are reproduced below.

- Effective and meaningful engagement and co-production of services with key stakeholders from potentially affected communities is vital to prevention efforts.
- Sensitivity, including cultural and linguistic sensitivity, should be at the forefront of engagement with women and girls. Significant diversity in practices and attitudes around FGM means that professionals should ensure that their practice is tailored to individuals and communities.
- Specialised services that understand the range and complexity of issues around FGM and which implement a gender-sensitive, survivor-centred approach are best-placed to meet the specific needs of women and girls who have undergone, are at risk of, or are affected by FGM.
- Health, social care, education, police and other relevant professionals have an important role to play in identifying girls and families affected by FGM; reporting concerns; initiating protective measures for girls at risk of FGM; and ensuring appropriate care and support is provided to those who have undergone FGM. All relevant professionals, and particularly those to whom disclosures may be made, should have strong knowledge of best practice in cases of FGM.
- Multi-agency working and collaboration is crucial to the identification of local needs and suitable prevention strategies, and to the successful provision of effective and holistic services to people who are or could potentially be affected by FGM. This requires effective information sharing and trust between agencies.

As set out in the 'key findings' section below, this evaluation of the NFGMC provides further evidence of the importance of a social care response to FGM that is specialist, sensitive in its engagement with families, alert to the potential for changes in the level of risk over time, and able to effectively work with partner agencies. The report also sets out concrete proposals for how these can be achieved, based on analysis of project implementation across the pilot areas.

Local context

The second phase of the NFGMC pilot took place in LAs with relatively low prevalence of FGM and with smaller, more isolated and geographically disparate populations from potentially-affected communities.

Table 1: Pilot local authorities and levels of delegation: April 2016 – March 2017

Local Authority	Degree of delegation	Notes on delegation and local context/structure
Hertfordshire Work began: January 2016	Full delegated authority	<ul style="list-style-type: none"> ▪ 24 families since 1 April 2016 ▪ Joint Child Protection Investigation Team (JCPIT) receives all incoming referrals. JCPIT ordinarily receives referrals that meet only Level 4 threshold and require police intervention (not all referrals for Children’s Services). FGM is the only area of ‘concern’ that is NOT dispersed to area teams but sent to JCPIT regardless of threshold. ▪ SSW sits in the JCPIT team ▪ SSW has statutory responsibility for cases
Thurrock Work began: January 2016	High level of delegated duties	<ul style="list-style-type: none"> ▪ 17 families since 1 April 2016 ▪ NFGMC SW receives referrals from the MASH ▪ NFGMC SW sits in the MASH ▪ Joint-working model between NFGMC SW and allocated SWs
Suffolk Work began: October 2015	High level of delegated duties	<ul style="list-style-type: none"> ▪ 23 families since 1 April 2016 ▪ PW on the MASH pathway for FGM referrals ▪ PW sits in the Make A Change team, which also manages the LA’s response to trafficking, gangs and child exploitation. ▪ Joint-working model between NFGMC PW and LA SWs
Norfolk Work began: October 2015	Intermediate level of delegated duties	<ul style="list-style-type: none"> ▪ 18 families since 1 April 2016 ▪ SSW sits in the MASH ▪ Duties delegated to SSW include data recording, conducting joint home visits, recording case notes
Essex Work began: January 2016	Intermediate level of delegated duties	<ul style="list-style-type: none"> ▪ 33 families cases since 1 April 2016 ▪ PW sits in the Hub ▪ Delegated duties include giving advice to professionals within social care and referring agencies and some joint home visiting
Southend Work began: April 2016	Intermediate level of delegated duties	<ul style="list-style-type: none"> ▪ 2 families since 1 April 2016 ▪ Duties delegated include the provision of advice to professionals and performing joint home visits

The NFGMC also operated in the national context, by hosting or participating in conferences, coordinating national policy responses, and engaging the media. It also worked to build stakeholder networks, by offering CPD-accredited training packages and consultancy to relevant agencies, and developing and promoting the intelligence-sharing and network-building work of the Knowledge Hub.

Project aims and activities

The NFGMC aimed to provide LAs with a cost-effective solution to FGM case management that reflected best practice. The NFGMC met the costs of providing specialist staff, through funding from the Department for Education Children's Social Care Innovation Programme. Whilst some pilot LAs incurred additional in-kind costs, such as, for example, the cost of providing desks for NFGMC workers, the overall cost to each LA of participation in the pilot was either neutral or minimal.

Aims of the NFGMC

1. **Prevent** new cases, by building effective strategies for the identification and support of at risk girls and creating changes in community attitudes.
2. **Protect** girls through proactive safeguarding and effective prosecutions.
3. **Support** those who have been affected by FGM, providing long-term holistic support for girls and their families .
4. **Partner** with stakeholders to deliver solutions, bring together experience and learning on what works for tackling FGM.

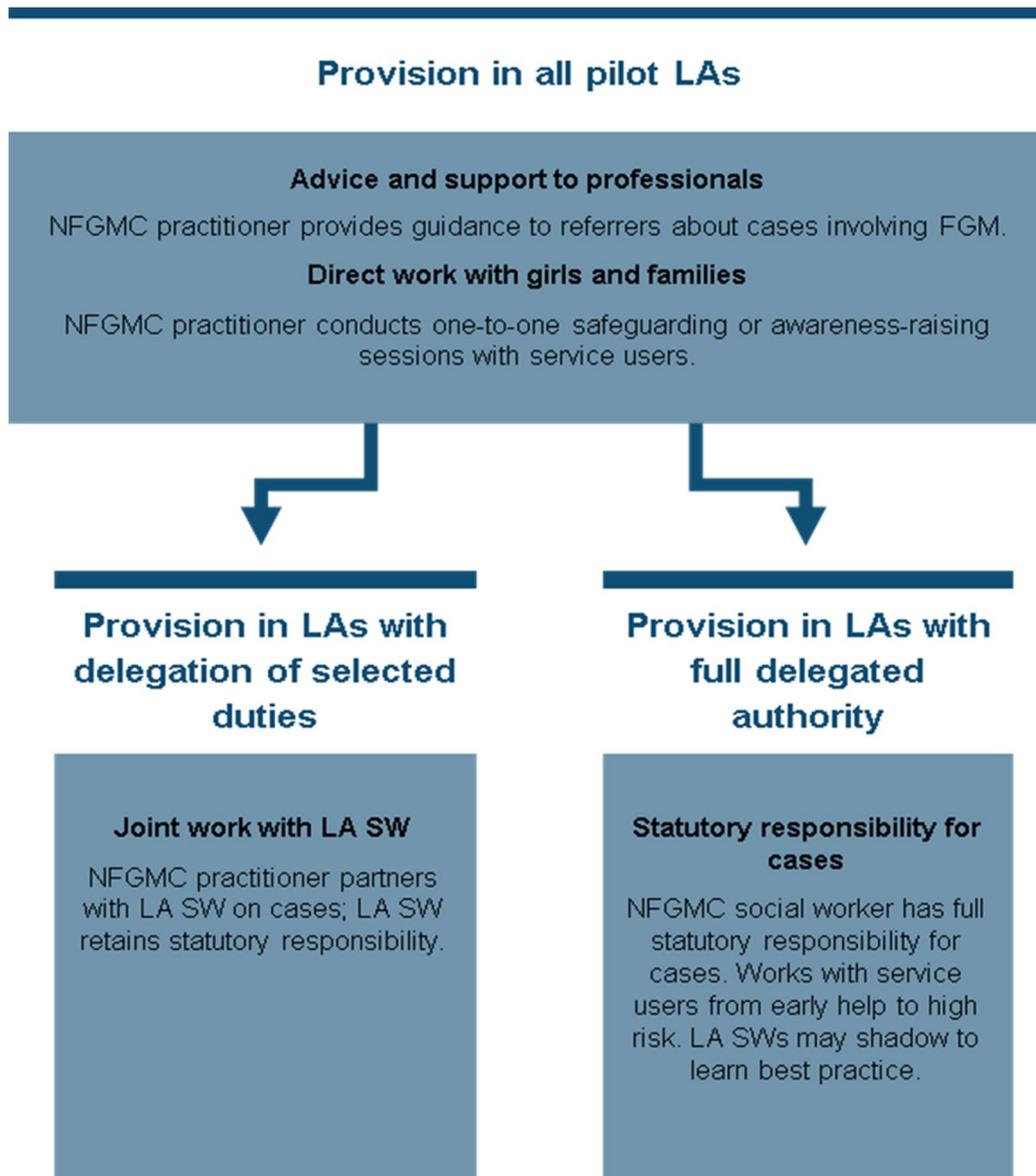
Source: NFGMC website, <http://nationalfgmcentre.org.uk/about-us/>

Pilot areas were selected by identifying LAs with seemingly relatively low FGM prevalence, which did not have appropriate resources or clear pathways to provide support and safeguarding in relation to FGM. Early negotiations with a small number of LAs in the East of England during the development of the NFGMC model identified regional interest. Neighbouring LAs expressed interest as the model became operational in the first 3 pilot LAs, following a presentation about the implementation of the project in

the initial pilot authorities. This reflects a regional partnership approach to managing referrals and providing specialist services, which research shows to be effective.³

Variations in the delivery of the model

Figure 1: NFGMC social work provision in pilot local authorities



³ City University London, Trust for London, Equality Now, Rosa – The UK fund for women and girls, and The Royal College of Midwives (2015). *Taking Local Action on FGM: An Essential Guide for Local Authorities*. London

The model of social work provision offered to LAs allowed for a degree of flexibility in delivery. Practitioners (social workers or project workers) were placed directly into LA safeguarding teams. Depending on the nature of the case or level of risk, practitioners gave advice and support, and undertook direct work with individuals or families. Depending on the degree of delegation granted by the LA, practitioners undertook all these activities and also worked jointly on cases with LA SWs or, where full delegated authority was granted, qualified SWs from the NFGMC held statutory responsibility for a case. All aspects of this model are explored in full in this evaluation.

The evaluation

The evaluation of the first phase of the National FGM Centre pilot examined 3 central questions:

- Has the continuum of delegated social work intervention improved the social care response for children affected by FGM?
- To what extent are professionals working in social work, health, education and the police better informed about FGM in both the pilot LAs and in England, as a result of the project?
- Was the intervention effective in working with community groups to change attitudes towards FGM?

The evaluation of the second phase of the pilot refined answers to these questions, while focusing in more detail on the early intervention work with low risk FGM cases at one end of the continuum of delegation, and full delegated authority at the other.

In order to answer these questions, the evaluation used a range of methods.

A review of monitoring data on case management was conducted to understand the scale and outcomes of casework. In-depth, one-to-one, semi-structured interviews were conducted with key professionals involved in the development and delivery of the pilot in the 6 pilot local authority sites, including the 2 SSWs, 1 SW and 2 PWs; and with 5 members of the NFGMC managerial team. The interviews identified how the pilot has been implemented in the different pilot LAs, key lessons from the pilot, and the main enablers of, and barriers to, success.

An online learning journal was developed and disseminated to NFGMC practitioners on a fortnightly basis. The journal asked practitioners to engage in reflective exercises on their work, and provided the evaluation team with further information about NFGMC practice in the pilot LAs.

In-depth, semi-structured interviews with 4 women supported by the project were conducted across 3 pilot sites, to explore their experiences and views of the pilot. A family session, which included direct work with 2 children, was observed in 1 of the pilot sites. Five Service Managers were interviewed, as well as 2 LA social workers who had worked alongside NFGMC workers on particular cases, to understand their experiences of the project.

To understand the consultancy work undertaken by the NFGMC, 4 interviews were conducted and 1 community event was observed. Semi-structured observations of non-CPD training sessions were undertaken.

Key findings

The continuum of delegated social work

Embedded NFGMC practitioners were involved in the social work response to 120 separate cases related to FGM during the evaluation period (1 April 2016 – 31 March 2017). Their work included responding to formal referrals that required an assessment, and providing advice and guidance to professionals before a referral was made through the LA system (for example, to child protection or multi-agency teams).

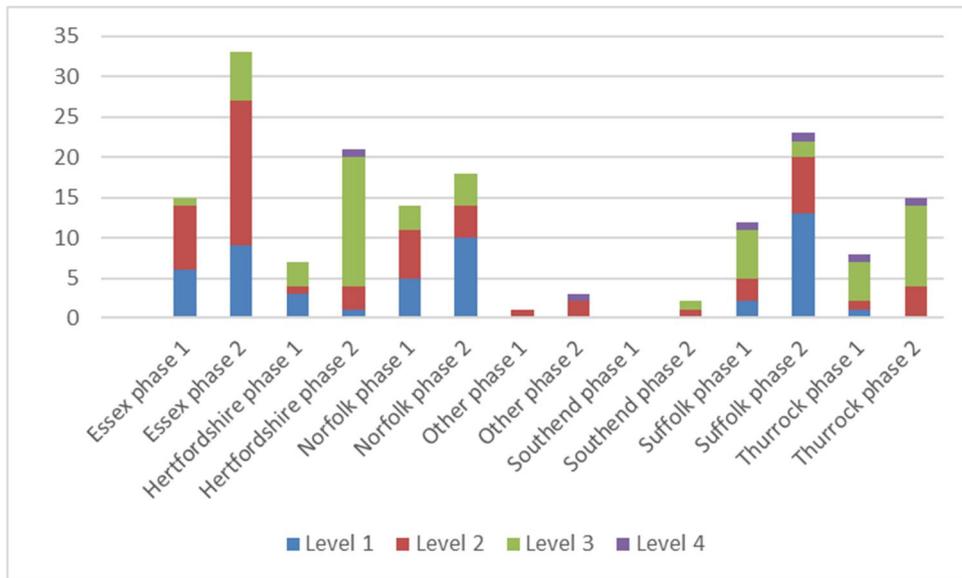
The outcomes achieved as a result of direct involvement with case management varied with the level of risk and the needs of individuals and families. However, analysis of case management data shows some evidence for outcomes which correlate with the project's theory of change (Appendix 4). For interventions at levels 1-2 (lower risk), outcomes included signposting families to health or community services, to enable longer-term medical or psychological care and to improve general well-being through holistic support services. Level 3-4 (higher risk) interventions resulted in formal child protection measures, including 6 FGM Protection Orders.⁴

The table below demonstrates the number of cases of different levels opened at each pilot site during phases 1 and 2. A full break down of numbers of cases at phases 1 and 2 in each pilot area can be found in Appendix 2. As these data show, there was a notable increase in cases opened during phase 2, compared with phase 1.

⁴ FGM protection orders are granted by a court, and offer a legal means to protect and safeguard survivors and those at risk of FGM. Further information can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573786/FGMPO_-_Fact_Sheet_-_1-12-2016_FINAL.pdf

Figure 2: Numbers of cases during phases 1 and 2, by pilot site and level



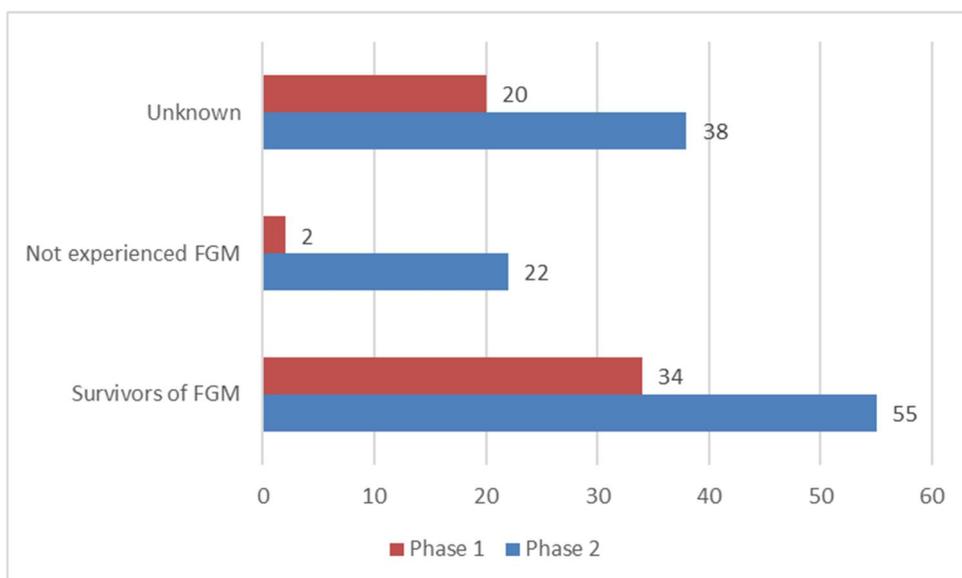
Source: National FGM Centre

Base: all cases opened between September 2015 and 31 March 2017

See Appendix 3 for key of levels

The figure below illustrates the number of girls and women identified as having undergone FGM during phase 1 and phase 2, based on cases referred to FGM practitioners in the pilot LAs. This shows a significant increase in the numbers of girls and women receiving a specialist intervention related to their FGM.

Figure 3: Number of girls and women identified during phases 1 and 2 as having undergone FGM



Source: National FGM Centre

Base: all cases opened between September 2015 and 31 March 2017

LA respondents at each pilot site reported that, before the start of the pilot, there had been no consistent recording of FGM on children’s services case files. The figures above demonstrate that, where data on numbers of girls and women with FGM are unavailable, low prevalence should not be assumed: pilot areas which were previously thought to have very low prevalence of FGM (such as Thurrock and Suffolk) in fact had significant numbers of cases.

The table below illustrates the average number of days that cases of different levels were open for at each site. Please note that the average lengths of cases are based on closed cases only: cases that remained open at the end of the evaluation period are excluded. The numbers of closed cases on which these averages are based are given in the left-hand column. As these data show, there is a significant degree of positive correlation between the level of need and the length spent on a case: the higher the level of need, the longer the case tended to remain open. However, it should also be noted that a case could be open and with no activity intermittently, due to difficulties in engaging with the family or individual; not necessarily because of the level of need.

Table 2: Average length (days) of cases, by site and level: April 2016 – March 2017

Average length of cases	Level 1	Level 2	Level 3	Level 4
Essex (n=9,18,6,0)	1	6	54	-
Hertfordshire (n=1,1,12,0)	29	14	35	-
Norfolk (n=6,4,3,0)	10	18	36	-
Other (n=0,2,0,1)	-	1	-	139
Southend (n=0,1,0,0)	-	52	-	-
Suffolk (n=10,5,1,0)	24	37	37	-
Thurrock (n=0,4,7,0)	-	9	44	-

Source: National FGM Centre

Table 3 shows the aggregate numbers of referrals from key agencies across all pilot sites, during the evaluation period. A significant proportion came from health services; detailed analysis of case tracker and interview data shows that the majority of health referrals came from midwifery. NFGMC respondents noted an ongoing issue with varying-quality referrals from midwives, who were not always clear what to include in a

referral to children’s services. Transparency in referral procedures was also viewed as paramount. As one woman referred to children’s services by her midwife commented in an interview:

‘She [the midwife] should have explained to me at that point what she is going to do with that information. I wasn’t told [...] that I’m going to be referred to social services. [...] I just had the phone calls coming in left and right; and I was guilty before they really assessed me as a person.’

Table 3: Sources of referrals: April 2016 – March 2017

Referral sources	Totals	Level 1	Level 2	Level 3	Level 4	Percentage
Health	57	13	12	31	1	49.6%
Education	31	14	17	0	0	27.0%
Social care	12	6	2	3	1	10.4%
Police	4	0	2	1	1	3.5%
Community organisation	3	0	2	1	0	2.6%
Other	9	1	5	2	1	7.8%

Source: National FGM Centre

Preventative work with service users

The evaluation of phase 1 of the NFGMC examined NFGMC workers’ preventative, early help work with service users. During the second phase, openness to NFGMC SSWs, SWs and PWs engaging with families who did not meet LA intervention thresholds continued, and in some cases, increased among some pilot LAs. This was attributed by LA and NFGMC respondents to a recognition of the value placed by service users on support which they may not have otherwise received, and the value of proactive work to prevent new cases of FGM in families which were not viewed as sufficiently high risk to warrant a social care intervention.

In most pilot LAs, the NFGMC SSWs, SWs and PWs sat in multi-agency safeguarding teams, which receive high risk child protection referrals. Other pilot LAs placed the NFGMC practitioners in specialist social care teams. Interviews with NFGMC practitioners and LA managers set out the further work undertaken to ensure that effective referral routes to the NFGMC workers were incorporated into referral pathways.

In most cases, NFGMC practitioners were notified when an FGM referral came in, and were either consulted at the first stage about how the case should be treated (for example, designated 'No Further Action' (NFA) or marked for a risk assessment), or contacted by the allocated LA social worker to consult on the case or make a joint visit to the family.

Consultation with the NFGMC practitioner at the earliest stage of assessing referrals ensured that cases were not marked 'NFA' without this expert input. This was achieved by LA managers embedding this practice in the assessment process. In a number of pilot LAs, NFA cases were passed to the NFGMC practitioner to speak with or visit the family, to explore any further needs or raise awareness about FGM. The practitioner then conducted an initial risk assessment using the NFGMC's risk assessment matrix (RAM), exploring what the family understood about the practice, and any needs related to FGM, such as visiting a specialist clinic or accessing counselling. This direct work on NFA cases represented a unique offer; families were offered support related or unrelated to FGM, despite the absence of risk to a child.

One LA manager noted that the contribution of the NFGMC worker at the early help stage had been 'pivotal.' Direct work with families below social care thresholds represents an innovative part of the NFGMC model: because NFGMC workers' time was 'protected' to focus on FGM cases, and because they were specialists in the field, they were able to work with women, children and extended families in a direct, creative and time-generous manner. The NFGMC team used both their own and pre-existing tools and activities in sessions with children and families.

In some cases, NFGMC workers engaged with families over several months, offering therapeutic and safeguarding support in a manner tailored to the family's needs. This ranged from safety planning activities with children in the family, to supporting parents to seek legal safeguards. The following case studies demonstrate the nature of this work in more depth.

Case study 1

The context for this case was a pilot LA in which the NFGMC PW conducted joint assessments with LA SWs, and was delegated the power to undertake sessions with families whose cases had been designated NFA. The case study was compiled through observation of a session between the NFGMC PW and the family, an interview with the NFGMC PW, and an interview with the children's mother.

Following an initial joint assessment by the LA SW and NFGMC PW, which concluded that the case did not require social service involvement, the family (a woman and her 2 children) agreed that the PW would support them through a series of sessions at home. During an interview, the woman detailed her frustration with the lack of support from statutory services to address the risk of FGM posed to her daughter, and reported that she therefore welcomed specialist support. The PW introduced herself to the children as a Barnardo's worker, who was there to help them to keep safe. FGM was only later raised with the daughter, who knew nothing about FGM or its practice. Sessions were varied in nature and framed within a rights-based approach. They included creative exercises focused on how the body works, understanding different forms of abuse (sexual, physical and emotional), and managing and expressing worries. FGM was introduced to the daughter in a one-to-one session; she then made a poster to teach her brother what she had learned about the practice.

The children's mother emphasised that the PW, 'always made it fun' for the children, so that they 'didn't feel bombarded.' The family appreciated that the PW was always open, honest and consistent in her approach, which they felt had not been their experience with SWs. The NFGMC PW worked with the family through therapeutic whole-family and one-to-one sessions. In addition to this work, the PW supported the children's mother to apply for an FGM PO, connecting her with a lawyer to work on the case. The children's mother noted that she had had no previous knowledge of FGM POs.

Case study 2

The context for this case was a pilot area in which high statutory intervention thresholds in the LA meant that the NFGMC practitioner was only able to visit a quarter of women with known FGM (where there was a 'direct risk' to a child) referred to children's services. The case study was compiled through an interview with the NFGMC practitioner.

The NFGMC received a call from a woman living in a pilot LA with her partner, son and daughter. The family sought asylum in the UK from a country in which FGM is practised in certain ethnic groups, but not widely across the country. She was advised by an LA SW to call the NFGMC for advice, because her case did not meet statutory thresholds.

The woman reported to the NFGMC practitioner that before coming to the UK, she had narrowly avoided FGM and Forced Marriage. She then sought asylum in the UK, fearing that if she returned to her country of origin, she would be forced to marry and to undergo FGM, and that if her children were deported with her, her daughter would also be forced to undergo FGM. However, her asylum claim was rejected.

The NFGMC practitioner offered emotional support to the woman, who she believed was suffering from depression, encouraged her to access help from her GP with regard to her mental health, and connected her with a local children's centre for support for herself and her children. The woman felt that she did not have the knowledge or correct language to discuss her experiences or concerns with her partner. The NFGMC practitioner therefore provided her with information about the practice and guidance about broaching the topic. The woman was also concerned about the emotional impact on her daughter. The NFGMC practitioner did a session with her daughter, which included using the Signs of Safety 'Three Houses' tool. She was able to reassure the mother that her daughter was a happy and secure child.

Finally, the NFGMC supported the woman to apply for an FGM PO and a Forced Marriage PO. The practitioner made clear that this would not necessarily affect her asylum claim, but could offer added protection and serve as an additional piece of evidence in her appeal.

Improving the social work response to high risk cases

NFGMC practitioners worked on 3 Level 4 cases in 3 of the LA pilot areas during the evaluation period, and on 1 case elsewhere in England. Level 4 cases are those in which there is acute need in relation to a child, requiring resource-intensive service provision. Findings from interviews with NFGMC practitioners and LA SWs, and learning journal analysis, demonstrate the significant contribution that the NFGMC made to cases that were complex in nature, and so required extensive and sensitive interaction with affected families, and effective multi-agency engagement. In particular, NFGMC practitioners reported that their high-level expertise had enabled them to make positive and important contributions to court cases, including improving understanding of FGM generally and the nuances of specific cases, among judges, barristers and solicitors.

This was particularly valuable given the relative inexperience that pilot LAs had with managing high risk FGM cases, and the notable progress achieved in pilot LAs' knowledge and confidence in managing complex high risk cases. As one LA manager reflected on a Level 4 case which had been referred by the police:

'The last big case we had, it worked extremely well. It was like a well-oiled machine. It came in, [... and the NFGMC worker] did a really good piece of work with the 3 children. [...] That nurturing of the children at that stage was really beneficial and led to some more information coming out.'

The NFGMC practitioner participated in meetings with the police, strategy meetings and visits to the family's home. The LA manager noted that, 'she was impeccable throughout the process.' As reflected in the case study above and this example, the nature of FGM risk has meant that NFGMC practitioners working on low risk cases have nonetheless sought legal safeguards; and equally, high risk cases have required NFGMC practitioners to draw upon their skills in undertaking therapeutic, direct work. This reflects the complexity of FGM risk. The ability of NFGMC practitioners to span the range of this continuum, sometimes within the space of one case, was a significant strength of the model.

Delegated authority: lessons from practice

Delegated authority, in which the NFGMC practitioner had full statutory responsibility for cases related to FGM, operated in one of the pilot LAs: Hertfordshire. As Table 2 above demonstrates, 24 cases were referred to the Hertfordshire NFGMC practitioner across levels 1 to 4. The majority of these were at level 3. Level 3 cases were those that met the Social Care threshold and required Statutory Child and Family Assessment. They were usually families where a history of FGM was confirmed, and which also had female (born or unborn) children. Level 3 cases could also have additional needs such as homelessness, mental health, immigration issues and children not attending school.

Delegated authority required the SSW to address all needs identified in the case, and not just those related to FGM. The SSW worked to put protective factors in place, by building the child's resilience through direct work, safety planning with the parents, referring the family to additional Early Help Services and in some cases developing a Child in Need (CIN) Plan. CIN cases remained open to the LA and were transferred to the long-term safeguarding team after initial work by the SSW.

Delegated authority enabled the NFGMC practitioner to take responsibility for all aspects of a case. This meant that the LA had in place a highly-qualified specialist able to manage every aspect of a case, including service user support, case notes, strategy meetings and so on. It is important to note that the NFGMC model meant that the practitioner also led workshops, awareness raising sessions and community engagement in addition to the 'standard' case management for which LA social workers are responsible. Delegated authority to the NFGMC therefore gave the LA specialist case management by a practitioner able to both work along all aspects of the continuum (which might otherwise require the involvement of multiple LA SWs), and develop or support multi-agency and community-level capacity and knowledge around FGM.

The NFGMC SSW in Hertfordshire worked in similar ways to NFGMC colleagues in other pilot LAs and in a similar way to the LA's own SW (with the addition of the FGM intervention). For example, in managing a case, the NFGMC SSW would request welfare reports on all assessed children (for instance, from school, the GP, health visitor and all other involved professionals) as the LA's SWs would do, and complete the FGM RAM which all NFGMC workers would use, in addition to a Statutory Assessment report for the LA in all Level 3 and Level 4 cases. This Statutory Assessment explores all aspects of risk that the LA assesses in all families regardless of the concern (including, in particular, risk of Domestic Violence, Substance Misuse and Mental Health, otherwise known as the toxic trio).

The following case study highlights the depth and breadth of work which came with full delegated authority.

Case study 3

This was a level 4 case. The case study was compiled through case file analysis and an interview with the NFGMC SSW.

This case was referred by Health and designated level 4. The risk to the child was considered sufficiently high that the LA was granted an interim FGM PO, preventing travel until a full assessment of the family both in the UK and overseas could be conducted. The LA did not have a template for making an application for an FGM PO. Therefore, the NFGMC SSW developed one to be used for all such cases going forward. The referral came in to the Joint Child Protection Investigation Team (JCPIT) and was allocated to the NFGMC SSW, who participated in a Strategy meeting and conducted a Section 47 assessment with the family. The NFGMC SSW was responsible for coordinating and completing all work associated with this assessment process.

Case file analysis highlighted the breadth of documentation produced by the SSW, including a Child In Need (CIN) Plan, the initial court application, the addendum report to court, a report to the Child and Family Court, and a risk assessment and recommendations for the judge. As part of the risk assessment of the family overseas, the SSW consulted a Child Protection Agency abroad and FGM Lead at the Foreign & Commonwealth office to explore ways of assessing risk that overseas family members posed to the child.

The NFGMC SSW undertook all recording on the LA's system. The SSW anticipated continuing involvement once the case moved to the LA's long-term team, particularly in relation to court work and consultation following the international SW's assessment.

Building social work and multi-agency capacity

In every pilot LA, whether there was full delegated authority or the delegation of certain duties, NFGMC practitioners worked in close partnership with LA SWs. Respondents noted largely positive and collaborative working relationships between NFGMC practitioners and LA SWs. Interviews with LA SWs particularly highlighted the value that they had derived from observing NFGMC practitioners' interactions with families affected by FGM. Social workers in 2 different LAs noted that the families felt that the NFGMC practitioners were their advocates, and that in observing their interactions with families, the LA SWs had gained a better understanding of how to have conversations with families about FGM in a sensitive and compassionate manner. One LA SW, who had shadowed the NFGMC SW on a home visit to a family in which the FGM risk was considered to be low, explained that she took the learning from that visit, including broaching FGM sensitively and making use of FGM-specific tools (such as the NFGMC's world prevalence map), back to her team for a discussion about how to improve their assessment practice.

NFGMC practitioners also undertook work in pilot LAs to build multi-agency knowledge and collaboration on FGM cases. This included attending steering group meetings, participating in or managing FGM working groups, and running training sessions for agency partners.

The Knowledge Hub

The Knowledge Hub was a digital resource created by the NFGMC to provide a central access point for guidance, research and best practice about FGM. Assessing the efficacy of the Knowledge Hub was not a central focus of this evaluation. However professionals interviewed were asked about their use of the website and the materials that it makes available. It was found to be generally welcomed and viewed as well-resourced. In particular, its provision of materials such as an interactive World FGM Prevalence Map and easily accessible tools that could be used in practice, was judged to be useful. The NFGMC regularly assesses the use of the Knowledge Hub, reviewing site traffic and site use analytics.

By the end of the evaluation period, the Knowledge Hub had received a total of 31,302 page views, from 3,731 users. Most users (3,079, or 82.5%) were located in the UK, though the site did attract a smaller number of users from the US, Canada, and 11 other countries across Europe, Africa, Asia and Australasia. Within the UK, nearly half of those accessing the Knowledge Hub were located in London (1,497, or 48.6% of all UK users). The remainder were located in the areas around Birmingham, Norwich, Manchester, Chelmsford, Leeds, Ipswich, Southend-on-Sea, Basildon, Maidstone, and Belfast, with between 37 and 67 users accessing the site from each of these areas.

Other than the home page, the most popular page of the Knowledge Hub was the interactive FGM World Prevalence Map, which received a total of 2,963 views. This map enabled users to click on different countries to reveal country-specific information regarding FGM prevalence, most practised types, most common age range at which FGM is practised, regional prevalence, practising ethnic groups, and the law on FGM. The training and resources section of the website (which provided, for example, resources ranging from leaflets explaining the law, to videos and lesson plans for under 18s) was accessed 2,226 times. The 'What Is FGM?' page (which explained the types of FGM as well as indicators of risk and occurrence, health implications, and why people practise FGM) received 1,613 views.

Stakeholder engagement: training, outreach events and consultancy

Engagement with multi-agency and potentially-affected community stakeholders was a core part of the NFGMC model, bringing together experience and learning on what works in addressing FGM, and developing and sharing effective and sustainable solutions.

Learning Seminars

The Learning Seminar programme was developed and delivered in pilot LAs and elsewhere across England during the second phase. The aim was to disseminate learning from the pilot, to consult with local stakeholders and to stimulate multi-agency learning.

The evaluation team observed a Learning Seminar in a pilot LA. The 23 participants included professionals from social care, education, health (including midwifery), police, and third sector and community organisations. Topics included the different strands of work within the pilot, what makes a good FGM referral, appropriate practice in case management, NFGMC resources (for example, the Knowledge Hub), and an overview of the number of cases with NFGMC involvement, referral sources, and outcomes. Opportunistic interviews with participants indicated that they found the seminar useful and informative, and particularly successful in framing FGM within the context of safeguarding, and explaining how safeguarding skills already employed by participants can be used to prevent FGM. Some participants reported that they had wanted and needed more of an introduction to FGM, including more information on how it is practised, suggesting the need to ensure that publicity material to promote events makes very clear the level at which events are pitched.

Awareness raising events in pilot LAs

NFGMC staff also participated in events in the pilot LAs to raise awareness about FGM and NFGMC services, amongst both professionals and potentially-affected communities. The evaluation team observed a BME Health Conference in one pilot LA, organised by a local community organisation. The 47 participants included local councillors, professionals and volunteers from a range of third sector and community organisations (including BME organisations, a rape crisis centre, and a youth club), and LA staff (including from safeguarding, equality and diversity, and community engagement teams). The NFGMC practitioner gave an introductory-level presentation on FGM, followed by a question and answer session. Topics included types of FGM, estimates of UK and global prevalence, mandatory reporting and recording, health implications, why FGM is practised, the legal framework, and the work of the NFGMC.

Opportunistic interviews with participants indicated that they found the presentation and subsequent discussion clear, engaging and informative. In particular, some audience members found it useful to learn about some of the reasons that loving parents may believe FGM is in their daughters' best interests: this appeared to have enabled some misconceptions to be dispelled.

Following this, the NFGMC practitioner led a workshop with a subset of participants, who were asked to play the role of different agencies responding to a case of FGM. The intention of the workshop was to spread awareness about how to interpret different indicators of risk, as well as to highlight the need for all referring agencies to include as much information as they can on referrals. The format was effective for this purpose. However, as places in the workshop were limited, due to logistical reasons, only those who participated were able to benefit from it. Nonetheless, the subset of conference participants who were able to take part reported that they found the workshop useful in improving their knowledge and confidence in responding to FGM cases.

Primary School training sessions

The NFGMC partnered with a primary school in Harrow to run sessions on FGM for pupils at 9 schools in London. The evaluation team observed 2 sessions at a local primary school: 1 delivered to 20 year 6 girls, and 1 delivered to 14 year 6 boys. The sessions were led by a teacher and a safeguarding professional from Norbury Primary School. The facilitators led discussions and activities on 'my body, my rules'⁵, the UN Convention on the Rights of the Child, how Articles of the Convention relate to 'my body, my rules', and body shaming (including why there should be no need to change your

⁵ See: <http://www.fpa.org.uk/sites/default/files/my-body-my-rules-female-genital-mutilation-information.pdf>

body in order to be accepted by your community). With this context established, FGM was discussed in explicitly 'scientific language', and explained as a harmful practice that is illegal because it violates rights. Different words for FGM in various languages were translated, and 'justifications' for the practice debunked.

Pupils were also asked to anonymously write down any questions that they had, which were then answered by the facilitators. Finally, pupils were all encouraged to continue talking about FGM after the session, and it was suggested that they could create posters to raise awareness of the issue. Facilitators emphasised that they should tell a friend or trusted adult if they ever had any concerns. Overall, the sessions appeared highly effective in achieving the aim of providing age-appropriate education to pupils about their rights, about FGM, and what to do if they have any concerns relating to FGM. Pupils appeared to engage well with the session, asking some very insightful questions. The facilitators were confident and enthusiastic in their delivery of appropriate, well-paced, and engaging activities. However, while one facilitator attended a meeting with parents in advance of the session to explain its purpose, the parents of a significant proportion of the year group had their children opt out of the session. This suggests that there may be a need for some schools to engage with parents to develop understanding of how educating children about FGM helps to safeguard them from harm.

Bloodlines training with Olive Branch Arts

Bloodlines was an interactive play developed by the NFGMC and Olive Branch Arts, to explore FGM through a range of different perspectives, represented in 4 key characters. It examined the challenges that professionals face with identifying potential survivors of FGM, explored early warning signs and good practice, and reflected on how to start the conversation about FGM with parents.

Olive Branch Arts were commissioned by the NFGMC in late 2016 to develop a training session for professionals. The 2 organisations worked to bring together the NFGMC's expertise for the FGM-specific content, with Olive Branch Arts' interactive theatre model. Interviews with Olive Branch and NFGMC staff highlighted that focus was placed on changing participants' understanding about how you learn, and about supporting engagement. It was reported that participants responded positively to exploration of the emotional and interpersonal impact of professionals on those affected by FGM, and vice versa; how people can be 'emotionally safeguarded.' FGM was placed at the beginning of the performance within the broader Violence Against Women and Girls (VAWG) frame. The drama sessions began with a 20 minute theatre piece, followed by audience interaction with characters, including giving advice directly to characters playing professionals and family members. A particular focus was highlighting the lack of shared language used with regard to the trauma done to this part of girls' and women's bodies. As one respondent noted, 'we still talk about "down there."'

Interviews with participants revealed enthusiasm for the interactive nature of the training, and the way in which it challenged the 'tick box' culture by encouraging practitioners to respond to emotional needs and the wider context in complex situations, and manage the human interaction to respond. Respondents noted the way in which the performance drew out the complexity of FGM cases, both in terms of the family dynamics portrayed, and the complicating factors that may be present in addition to FGM (such as coercion and control, domestic violence and so on). Some respondents felt that the half day session, which encouraged professional reflection on practice and engagement with families affected by FGM, gave insufficient time to explore in depth the issues raised in the performance, in contrast to the full day training. These shorter sessions should therefore ensure that sufficient time is given to participant reflection and discussion about next steps for their practice or organisational processes.

Consultancy work

Consultancy work continued to be undertaken on an ad hoc basis in response to requests from partners or agencies. This was varied in nature and predominantly unpaid. Phase 1 of the NFGMC evaluation noted the NFGMC's contribution to a proposed protocol for ambulance services providing care to pregnant women who have undergone FGM. This work was continued and concluded during the second phase of evaluation. The NFGMC were asked to consult on the development of this protocol, in partnership with the East of England Ambulance Service and the International Academies of Emergency Dispatch (IAED). IAED develops and maintains standards for the Advanced Medical Priority Dispatch System (AMPDS), a unified system used to dispatch appropriate aid to medical emergencies, including pre-arrival instructions given to ambulance dispatch professionals. A Council of Standards approves new protocols, after which it becomes finalised and rolled out for use.

One respondent from the East of England Ambulance Service and another respondent from the IAED explained that it was recognised that there can be clinical risks for women in active labour which should be accounted for in pre-arrival instructions for ambulance and hospital services, to protect mother and baby. The 3 organisations therefore worked together to develop an FGM-specific proposal to effect changes in the international pregnancy protocol, to provide universal guidance related to FGM and pregnancy or childbirth. There was no guidance in place related to FGM and pregnancy or childbirth prior to this work. The IAED compiled a skeleton of the instructions, and the NFGMC and East of England Ambulance Service provided a clinical perspective and guidance about how much education call handlers require, and how much detail was needed in the protocol with regard to FGM. Discussions also took place about the NFGMC supporting the East of England Ambulance Service to develop a training package related to patients with FGM in active childbirth, which could ultimately go to all ambulance crews.

Consultancy work also included the provision of community engagement work to agencies seeking to provide effective support and services to potentially-affected communities, but in need of guidance about how to do so. Evaluators observed an event run by the NFGMC in Belfast and commissioned by the Safeguarding Board for Northern Ireland. The event was attended by around 20 women affected by FGM, by a small number of staff from statutory agencies and by third sector professionals. The event aimed to improve understanding of how to provide effective local services, by speaking directly to women affected by FGM and supported by the NFGMC.

The NFGMC facilitator began by providing information about FGM prevalence, the types of FGM, the health implications of FGM, and the legislative context. A discussion followed about why FGM is practised in some communities and what can be done to challenge the practice. Participants explored the different cultural practices related to FGM, and how it is viewed in their communities in the context of living in Northern Ireland, where there are no specialist FGM services available to women. Two participants explained that they had begun to organise an awareness raising and support group, but that there was a degree of community resistance to discussing FGM. This event demonstrated the ways in which NFGMC expertise and learning from practice could be used to support better community engagement and service provision in non-pilot areas.

Limitations

This evaluation mainly drew upon qualitative data gathered from observations, case study interviews, and interviews with professionals. This qualitative data was also triangulated with monitoring data on case management to understand the scale of casework and whether intended outputs were achieved. However, it was beyond the scope of this evaluation to assess the final impact in terms of reducing the number of cases of FGM. There were a number of reasons for this. Primarily, to demonstrate that the intervention avoided cases of FGM, it would be necessary to compare National FGM Centre clients and beneficiaries to a comparison group that received no intervention (or received 'business as usual' – that is, usual practice in managing FGM referrals). This presents many problems. First, there is no routine screening or assessment for FGM and prevalence figures of FGM in the UK are estimates only. Therefore, any assessment of whether FGM was avoided would depend on the self-reported data of the intervention and comparison group, much of which may be unreliable given the controversial and sensitive nature of the practice. Moreover, data collection would have to occur longitudinally, throughout childhood, to ensure that the period during which girls are at risk is covered. Whilst a limited time period over which to obtain data could be used (for example one year), the outcome of interest – FGM taking place or not - is a binary measure and its harm no less diminished for being delayed. Thus, a longer time frame to collect data would be needed.

An attempt was made to compare the rates of initial referrals of FGM that result in a follow up enquiry or fuller assessment between areas or a time period with and without the NFGMC (a 'business as usual' state). The intention was to provide some insight into whether the pilot improved or increased the rates at which FGM risk is assessed. However, enquiries into the practices of how FGM risk or indication is recorded during a 'business as usual' state revealed that there were no uniform methods for doing so. Thus, a comparative analysis would have been meaningless as any differences detected may not have been attributable to the pilot or otherwise.

This evaluation was designed to support the process of change and help to spread good practice. The detailed narratives provided by the evaluation were drawn from in-depth research methods involving a wide range of respondents who repeatedly reinforced the importance of core themes. The evaluation therefore provides an understanding of how the project was implemented and what it achieved, including some projections of the impact that it is likely to have in future, should it be continued.

Implications and recommendations

Answers to the central evaluation questions

National FGM Centre practitioners worked on 120 new cases during the second phase of evaluation: 33 cases at level 1, 40 at level 2, 43 at level 3, and 4 at level 4. Six new referrals of families resulted in FGM POs. Almost half of families were referred from health agencies, demonstrating that women with FGM often first come to the attention of LA attention when they access health services. This highlights the need for sensitive, informed care and transparency about any onward referral to children's services. Several level 1 cases were closed within a day, but the length of cases tended to increase with increased levels of need. More time tended to be spent on complex and high risk cases. Has the continuum of delegated social work intervention improved the social care response for children affected by FGM?

Early help approach

NFGMC staff operated in pilot LAs as an additional, specialist resource whose time was protected to focus on FGM referrals. The numbers of higher-risk cases were relatively low across all pilot LAs, enabling NFGMC practitioners to pursue preventative and early help work. Nonetheless, that a number of high-risk FGM referrals were recorded is notable, given that most pilot LAs had had no recorded high risk referrals before NFGMC involvement. This suggests that the pilot resulted in better awareness and protocols for identifying and referring potential cases of FGM risk.

Preventative work with families affected or at risk of being affected by FGM enabled a level of social care engagement which LAs generally do not have the capacity or specialist knowledge to provide. NFGMC practitioners undertook scenario work, safety planning, awareness raising, use of therapeutic tools and signposting to universal or specialist services as part of this early help approach. This was framed within a service that was expertly-informed about FGM and mindful of the ways in which risk of FGM to a child can change over time. It also enabled NFGMC practitioners to support families with other needs both related and unrelated to FGM, which may have otherwise remained unknown to local authority services.

- Preventative work below social care intervention thresholds with families affected by FGM contributed significantly to the welfare and wellbeing of families in areas of relatively low FGM prevalence, who may have been isolated within the community or had little access to specialist services. It recognised the changing dynamic of FGM risk over time, and supported families to maintain protective factors. The evaluation found strong evidence that this was an important service for families, and was best delivered by a specialist provider.

- Early help work on low risk or NFA cases by NFGMC practitioners uncovered serious risks to children and women, which in some cases required legal safeguards. This demonstrates the significant value of specialist assessment – including home visits to families – of all FGM referrals. As demonstrated by the work of NFGMC practitioners, this assessment should be done sensitively and with the family’s needs at the centre.

Higher risk referrals

NFGMC practitioners worked on 3 high risk level 4 cases at 3 pilot areas and 1 non-pilot LA. Two of these cases were in pilot areas with high levels of delegated duties, and 1 in an area with full delegated authority. These cases were complex and involved multi-agency partnership, including with criminal justice. None of the cases in the pilot LAs had closed by the end of the evaluation period, and each had been open for around 4 to 5 months, suggesting that level 4 cases often required significant investment of time.

In most cases, work by the NFGMC did not result in children being removed from families. Instead, LAs were supported to develop safety plans (including use of FGMPOs) to ensure that children remained as safe as possible in their parents’ care. The contribution of the NFGMC to these cases was reported by LA respondents to have been significant. Moreover, evidence from the phase 2 evaluation pointed to greater confidence, knowledge and improved processes and procedures in pilot LAs in managing these high risk cases. This was attributed in large part to the contribution of the NFGMC, and its provision of day-to-day case management or support, expert knowledge about FGM and how to engage with affected families sensitively, and strategic support to the LA in best practice in managing high risk FGM cases.

- The provision of a specialist FGM resource for high risk FGM referrals ensured a more confident, informed statutory response.
- It generally also resulted in an improved experience for families in what could be a challenging and emotionally-charged time, with NFGMC practitioners providing sensitive, culturally-informed and expert interventions.
- Working alongside LA SWs on high risk cases enabled NFGMC practitioners to model best practice in engagement with families and case management. This helped to develop LA understanding of FGM risk in the context of the immediate family, extended family, and wider community, and the interplay between these levels.

Delegated duties and delegated authority

The model of delegated authority enabled NFGMC practitioners to take full responsibility for all stages of a case, from consultation with a referrer or initial assessment, through to direct work with families or reporting to court as part of FGM PO processes. This

provided a consistent and specialist intervention to families. It also represented a significant resource for LAs. It ensured that often complex cases were managed entirely by a specialist service, enabling the time resource of LA SWs to be directed elsewhere, whilst allowing for the development of LA knowledge about FGM through shadowing, training and consultation work.

- LAs benefited most from the NFGMC model when NFGMC practitioners were delegated the ability to engage with all families referred to social care, including those below statutory intervention thresholds, and to work in partnership (as a minimum standard) with allocated LA SWs on those above statutory thresholds. This ensured that risk could be fully assessed in both the immediate and medium-to-long terms and that protective factors could be put in place.
- Delegated authority to a specialist FGM service was an effective way to ensure an expert and informed social care response to FGM. It relied upon having practitioners in place who had specialist understanding of the nuances of FGM risk (both in the immediate term and as it may change over time), were able to engage with and support families sensitively and in a culturally-informed manner, and could manage cases at all levels of risk as they developed.

To what extent are professional staff working in social work, health, education and the police better informed about FGM in both the pilot LAs and in England, as a result of the project?

The phase 1 evaluation noted that embedded NFGMC practitioners operated in large geographical areas, in which potentially-affected communities were relatively widely dispersed. It also found that there were large numbers of social work and other teams in each area with whom the practitioners needed to connect and work, meaning that their awareness raising and engagement work required significant mobility and time. This continued to be the case throughout phase 2. An already small staff team was placed under greater pressure when practitioners left the service and colleagues had to cover additional pilot areas for periods of time. This did not appear to impact negatively on case management: LA managers reported that negative outcomes had been avoided, due to the skill and flexibility of NFGMC practitioners. However, while NFGMC practitioners reported positive responses to awareness raising amongst LA professionals, they also reported having less time to spend on this aspect of their work.

- To embed best practice in FGM case management where there are only a small number of specialist practitioners available to offer direct support and consultation, senior management must champion the issue of FGM and ensure the development and implementation of processes and procedures, and training programmes to all relevant teams.

- The 2 training programmes designed by the NFGMC, in collaboration with Olive Branch Arts and Norbury Primary School respectively, demonstrated an innovative approach to engaging professionals in the issue of FGM and encouraging them to reflect on and develop their practice.
- The question of whether it is best for LAs to delegate duties or authority, or to mainstream understanding of how to work with FGM among their own workforce, is an important one. An argument against delegating authority to an outside provider is that LAs will not develop their own capacity to work with these risks. However, the argument in support of delegating duties is that specialist workers' time will be preserved for working specifically with FGM cases, and their expertise on FGM risk maintained. Moreover, evidence from this evaluation suggests that families in these cases appeared to respond positively to case workers who were perceived to be different from social services. In areas with low prevalence, arguments for the outside provider model appear to be stronger, because in these areas, a low volume of cases means that it may take longer and be more difficult to maintain specialist skills and knowledge. However, findings from this evaluation also strongly suggest that it should not be assumed that areas have low prevalence of FGM without some form of testing.

The pilot project demonstrated that areas which were previously thought to have low levels of prevalence turned out to have a significant number of cases. On the other hand, areas with relatively low prevalence (and, therefore, greater need for outside expertise) may also be less able to justify spending resources on permanent provision of specialist services. To address this challenge, commissioners may consider pooling resources with other LAs. Indeed, NFGMC staff involved in this pilot worked over a large area.

Was the intervention effective in working with community groups to change attitudes and behaviour towards FGM?

The NFGMC developed a collaborative outreach model to engage women from potentially-affected communities in pilot LAs, by combining the NFGMC's specialist knowledge with local community partners who were drawn from or had long-standing relationships with potentially-affected communities.

A strength of the NFGMC model was the ability of practitioners to undertake case work, build multi-agency capacity through training and consultation, and engage with potentially-affected communities; all of which were key to improved safeguarding outcomes. NFGMC practitioners worked to build links with community organisations, working with them to hold awareness-raising events, and signposting families referred to social care to specialist community groups for onward support. However, time pressures limited NFGMC practitioners' ability to engage in community outreach.

- Given the increased numbers of referrals seen over the course of phase 2, and the continuing need to raise awareness amongst professional partners, it may prove effective to build in resources to commission specialist community partners to undertake more concerted programmes of community outreach.

Appendix 1: NFGMC Outcomes for intervention

Overall Outcome			Core Outcome
Healthy	1	1.1.01	Receives necessary health care
	2	1.2.13	Improved mental health and well-being
	3	1.2.15	Positive social/cultural/religion Identity
Free from abuse, victimisations and exploitation	4	2.1.08	Reduction in level of risk/harm
Nurtured	5	4.1.15	Aware of own rights and those of others
Respected	6	7.1.08	Access to information on housing, health, benefits and support needs.
	7	8.2.05	Improved carer capacity to prevent abusive/ harmful behaviours

Appendix 2: Numbers of cases during phases 1 and 2

Numbers of cases during phases 1 and 2, by pilot site and level

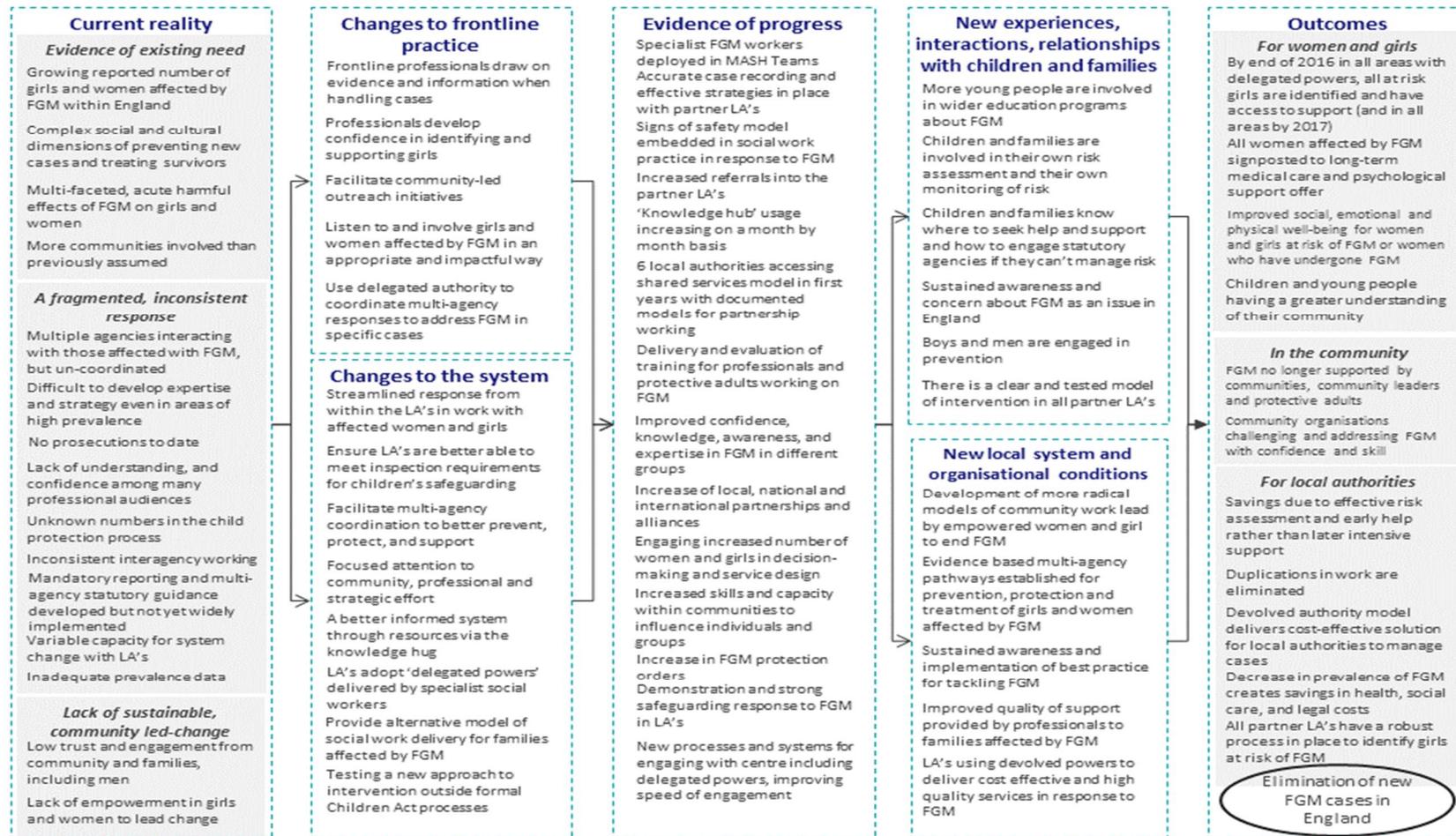
Number of cases	Level 1	Level 2	Level 3	Level 4	Totals
Essex phase 1	6	8	1	0	15
Essex phase 2	9	18	6	0	33
Hertfordshire phase 1	3	1	3	0	7
Hertfordshire phase 2	1	3	19	1	24
Norfolk phase 1	5	6	3	0	14
Norfolk phase 2	10	4	4	0	18
Other phase 1	0	1	0	0	1
Other phase 2	0	2	0	1	3
Southend phase 1	0	0	0	0	0
Southend phase 2	0	1	1	0	2
Suffolk phase 1	2	3	6	1	12
Suffolk phase 2	13	7	2	1	23
Thurrock phase 1	1	1	5	1	8
Thurrock phase 2	0	5	11	1	17
Totals phase 1	17	20	18	2	57
Totals phase 2	33	40	43	4	120

Appendix 3: NFGMC Levels of Intervention

<p>Level 1</p> <p>Cases are referrals where National FGM Centre staff advise more investigation or no further action at arrival due to lack of evidence of risk</p>
<p>Level 2</p> <p>National FGM Centre staff indirectly work with the family, often by advising the referrer (e.g. school) on work to do with the girl, and conversations to have with the parents. There are indications that without the provision of services, needs may escalate or circumstances deteriorate to the detriment of the children or families concerned.</p>
<p>Level 3</p> <p>Cases which require more targeted and enhanced support that will on occasions include specialist provision. As far as possible, all engagement with services will be sought on a voluntary basis; however, it is likely that some children and families within the upper end of this level of need will be at risk of harm and statutory powers may be required to ensure participation.</p>
<p>Level 4</p> <p>Needs that can be described as acute, either in terms of urgency, complexity or in terms of the degree of risk to which a child or young person is exposed. While relatively speaking, very few children and young people fall into this category of need, services provided tend to be resource intensive, very costly and children with these needs are often at risk of having the poorest outcomes.</p>

Appendix 4: National FGM Centre Theory of Change

National FGM Centre Theory of Change





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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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