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for Education

Evaluation of the National Female Genital Mutilation Centre

Evaluation report

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Key messages

The National Female Genital Mutilation Centre (NFGMC) aims to achieve system change in the provision of services for children and families who are affected by Female Genital Mutilation (FGM) and Harmful Practices (HPs), including breast ironing and flattening, and child abuse linked to faith or belief.

The evaluation focused predominately on one strand of the NFGMC's provision, that is, the introduction of embedded specialist FGM and HP social workers (employed by Barnardo's) in local authorities. Findings illuminate that:

- Preventative work was at the core of the NFGMC specialist role. Practitioners and managers from children's social care and partner agencies acknowledged the importance and value of the work that was undertaken by these experts to build professionals' confidence and capacity to respond to this complex and hidden form of harm.
- Delegation of selected duties to the NFGMC specialist workers was welcomed as a vehicle to improve service responses and upskill local authority social workers. Locating NFGMC workers at the Front Door was seen to be beneficial to establish levels of risk and determine whether or not further assessment was required to safeguard children from harm.
- Multi-agency auditing facilitated understanding of barriers to referral (from health to children's social care). In the Wave 2 local authorities findings suggested that further work was required to train and equip professionals from a range of services and disciplinary backgrounds with practice skills so that they are confident to 'ask the right questions' and respond where issues of ethnicity and culture intersect with safeguarding.
- The distinct identity of the NFGMC specialists and their employment by Barnardo's, alongside their expertise and understanding of complex sociocultural practices, was perceived to facilitate culturally sensitive and non-stigmatising services for families. However, the NFGMC specialists could feel isolated in the local authorities in which they were embedded and recruitment and retention of workers was a problem. Lack of consistency of worker and gaps in the presence of an embedded specialist could delay progress. It would be worthwhile to consider strategies to support recruitment and retention, including supervision and support structures for specialists who are embedded outside their employing organisation.
- The NFGMC specialist spent around half a day to 1 day a week on direct case work and the remainder on activities to promote whole systems change. Protected time for the latter was recognised to be essential, even though the impact of this preventative work on outcomes for children and families and savings

to the public purse may not be observed in the short to medium term. Twenty five Female Genital Mutilation Protection Orders (FGMPOs) were secured in Wave 2 to protect girls from the commission of FGM offences (3 FGMPOs in the local authorities that were evaluated).

Executive summary

Introduction

The National Female Genital Mutilation Centre (NFGMC) aims to achieve a system change in the provision of services for children and families who are affected by Female Genital Mutilation (FGM) and Harmful Practices (HPs), including breast ironing and flattening, and child abuse linked to faith or belief.

The NFGMC project was initially funded for two years (April 2015 to March 2017) through Round 1 of the Department for Education's Children's Social Care Innovation Programme (Innovation Programme hereafter) to develop a system change in how local authorities respond to cases of FGM (see McCracken et al., 2017a,b). Six local authorities participated in the first round of the project (Essex, Hertfordshire, Norfolk, Suffolk, Thurrock and Southend). Each of these local authorities were initially identified as having low FGM prevalence (Macfarlane and Dorkenoo, 2015), although subsequent engagement with the NFGMC suggested that this was not the case.

In Round 2, the NFGMC is being part funded through the Innovation Programme to work with Brent, Harrow and Redbridge, which have relatively high FGM prevalence, based on findings from a study by City University (Macfarlane and Dorkenoo, 2015). The evaluation focused predominantly on the NFGMC's social work provision. Specialist social workers and project workers were embedded in local authorities to support and manage cases of FGM, breast flattening and child abuse linked to faith and belief (HPs). The continuum of intervention ranged from providing information and advice on FGM and HP cases; direct work and support; joint working with the allocated social workers; specialist social work intervention; and full delegated authority.

The project

The project aims to:

- Prevent new cases [of FGM, breast flattening and child abuse linked to faith or belief], by building effective strategies for the identification and support of at risk children and creating changes in community attitudes.
- Protect children, through proactive safeguarding and effective prosecutions.
- Support those who have been affected by FGM, breast flattening and child abuse linked to faith or belief by providing long-term holistic support for survivors.

- Partner with stakeholders to deliver solutions, bring together experience and learning on what works for tackling FGM, breast flattening and child abuse linked to faith or belief¹.

The package of support provided by the NFGMC in the Round 2 local authorities included:

- Embedded support from a full time NFGMC social worker based in the local authority
- Three full days or 6 half days CPD accredited training for local authority social workers and managers
- Community engagement events and awareness raising activities across the safeguarding partnership (including use of the FGM assessment tool)
- Expert input and advice on FGM, HP and Violence Against Women and Girls (VAWG) strategies and policy developments.

The process and impact evaluation

The process and impact evaluation commenced in July 2018 and concluded in February 2020. A mixed methods approach was employed to answer the evaluation questions outlined below:

- What are the needs and circumstances of families coming to the attention of children's social care services because they are at risk, or affected by FGM or HPs?
- What are the strengths and limitations of the 'full delegation', 'delegation of selected duties' and 'directly embedded support' models of delivery in response to FGM and HPs?
- To what extent has implementation of the NFGMC model of delivery ('embedded specialist') increased identification, and improved service response to HPs? How does this compare with business as usual in a high prevalence area that is not involved in the Round 2 Innovation Programme and that does not employ specialist workers to respond to FGM and HPs?
- What are children and families' views on the strengths and limitations of the NFGMC's service response?
- What impact has the project had on outcomes for children and their families?
- What factors facilitated or inhibited implementation and the achievement of better outcomes for children and their families?

¹ Source: National FGM Centre website: <http://nationalfgmcentre.org.uk>

- What are the unit costs of social care activities in response to FGM and HPs in NFGMC authorities and how does this compare to 'standard' practice?
- What lessons are there for wider roll out of the project?

Methods included:

- Collation and analysis of the NFGMC tracker and outcome data on all Round 2 cases (July 2018 to February 2020)
- Collation of 2016/17, 2017/18 and 2018/19 CiN census data on FGM and abuse linked to faith and belief from Round 1 and Round 2 local authorities, the comparator local authority and statistical neighbours
- Interviews with key stakeholders, including strategic leads, 'frontline' team managers, health professionals and business managers from Local Safeguarding Partnerships
- Interviews with the Head of the NFGMC and specialist FGM workers
- Collection and analysis of data from case records
- Interviews with parents and young people
- Costing exercise to explore 'time use' activity and the costs of NFGMC specialist worker input on referrals and assessments.

Key findings

- Over a 20 month period (July 2018 to February 2020) specialist workers provided direct input on 79 cases in the Round 2 local authorities. Fifty-six percent of the families had unborn children or children aged under 1 at the time of referral. During pregnancy it was often identified that mothers had been affected by FGM and this was a common reason for referral to children's social care services. In other cases, referrals were made by professionals when they became aware that children were travelling abroad to visit relatives in FGM affected countries.
- The specialist workers are embedded in each of the pilot local authorities but are not directly employed by children's services. In most cases FGM specialist workers fulfilled selected statutory social work duties and other duties as required by the local authority. They provided 'directly embedded support', including expert advice and support at the Front Door and to social workers undertaking assessments. The FGM specialist workers were perceived to have played an important role in capacity building and raising awareness of levels of risk and which cases require further assessment.
- Each of the Round 2 local authorities engaged in targeted work with health to encourage appropriate referrals. A multi-agency audit in 1 local authority revealed that cases that met the threshold for referral were not being referred to children's social care. The auditors' noted that some health professionals were concerned

that referring these cases to children's social care was discriminatory. An action plan was developed by the safeguarding partnership to address the issues that had been identified. The specialist worker spent time in the health clinics to support staff to conduct preliminary assessments and engage with the women. Training for health personnel was also initiated, but it was acknowledged that changes of personnel (including the FGM health lead) had slowed progress in upskilling health personnel.

- Qualitative interviews with the specialist workers illuminated the following as features of high quality FGM assessments:
 - a trauma-informed and rights based approach
 - eliciting the mother's experience and journey from when she was cut (whilst recognising that this can be difficult because she may not have full recall, or have recall bias)
 - engaging fathers and understanding their perspectives and family history (and being aware that in some communities men would not normally talk to women about this issue)
 - access to and understanding the wider family perspectives on FGM and understanding risk across generations.
- A consistent message from professionals was that the specialist social worker role was valued because these practitioners were seen to have played a central role in upskilling the workforce (in children's social care and partner agencies) to support improved practice in responding to FGM and HPs.
- During Round 1 and 2 of the Innovation Programme 35 FGMPOs were granted, with the support of the NFGMC. York Consulting estimated that the total cost savings to the state through prevention based on the granting of these 35 Orders to be in the range of £42,982- £73,205 (Allan and Tordoff, 2019, p. 11-14)². In Round 2, a total of 3 FGMPOs were granted with an estimated total cost saving based on prevention through the granting of these 3 Orders to be in the range of between £3,684.17 and £6,274.71.
- York consulting also estimated cost savings in cases where the risks of FGM occurring were assessed to be high, had the NFGMC not intervened (including, for example, siblings of the girls to which FGMPOs related). In Round 1 and 2 they estimated 182 non-FGMPO cases were prevented with a total estimated saving to the state through prevention of £223,505. In Round 2, they estimated that 92 non-

² See the full report for details of the methodology

FGMPO cases were prevented with a total estimated saving to the state through prevention of £112,976.

Lessons and implications

- High prevalence of FGM, based on prevalence data, does not guarantee a high volume of referrals to children's social care. This serves to reinforce the importance of training multi-agency professionals to understand this hidden form of harm and providing them with the skills and competencies to fulfil their respective roles and responsibilities in tackling it. Understanding barriers to referrals and developing strategies to overcome these is an important aspect of the NFGMC's work.
- Delegation of selected duties to the NFGMC specialist workers was welcomed as a vehicle to improve service responses, as well as educating, training and upskilling local authority social workers. Specialist workers were able to provide expert advice and the wider team were able to listen to the conversations they had with families to establish levels of risk and determine whether further assessment was required.
- Input from specialist social workers was perceived by local authority social workers and managers to support timely and appropriate service responses that were culturally sensitive and non-stigmatising and sought to minimise re-traumatisation of victims of FGM.
- The NFGMC specialist spent around half a day to 1 day on direct case work. It was recognised that it was important that they did not hold a full case load as this would undermine their capacity to engage in the work necessary to promote whole system changes.
- FGM and HPs are complex areas of social work practice; professionals can find it challenging when issues of ethnicity and culture intersect with safeguarding. High quality, CPD accredited training and support was perceived by professionals from the safeguarding partnership to be required to help increase cultural competence and religious literacy.
- The NFGMC specialists are Barnardo's employees. Being able to position themselves as advocates supporting those at risk or affected by FGM, rather than as local authority social workers, was perceived to be advantageous to facilitate engagement with families.
- The specialist social worker in post had changed at least once in every local authority. These changes meant that additional time had to be spent building effective working relationships within children's services, with partners and the wider community; and that delays were encountered in embedding best practices. Consideration needs to be given to recruitment and retention strategies, including: supervision and support structures for specialists who are embedded outside their

employing organisation; reviewing salaries for specialist workers, compared to their local authority counterparts; developing career pathways and progression routes.

1. Overview of the project

Project context

The prevalence of FGM in England and Wales is unknown but it has been reported that an estimated 137,000 women and girls with FGM, born in practising countries, were permanently resident in England and Wales in 2011 (Macfarlane and Dorkenoo, 2015). Using birth registration statistics it is further estimated that from 1996 to 2013, 77,617 girls were born in England and Wales to migrant women with FGM. Macfarlane (2019) noted that these estimates should now be taken with caution, as there is a shift in attitudes, but this has taken place against the backdrop of reports of girls being subjected to FGM or at risk of it. In 2018/19 FGM or abuse linked to faith or belief was identified in 2,950 child and family assessments (Department for Education, 2019).

The National Female Genital Mutilation Centre (NFGMC) aims to achieve a system change in the provision of services for children and families who are affected by Female Genital Mutilation (FGM), breast ironing and flattening, and child abuse linked to faith or belief. Harmful practices (HP) have a detrimental effect on the physical and mental health of children and take place more widely than has been previously recognised.

The complex social and cultural dimensions of HP, gaps in professional knowledge skills and confidence in recognising and responding to such cases, and the need for multi-agency co-ordination make this a challenging area of social work practice. The project aims to improve understanding of 'what works' in preventing and responding to cases involving FGM and other HP and improve outcomes for those affected.

Project aims and intended outcomes

The project aims to:

- Prevent new cases [of FGM, breast flattening and child abuse linked to faith or belief], by building effective strategies for the identification and support of at risk children and creating changes in community attitudes.
- Protect children, through proactive safeguarding and effective prosecutions.
- Support those who have been affected by FGM, breast flattening and child abuse linked to faith or belief by providing long-term holistic support for survivors.

- Partner with stakeholders to deliver solutions, bring together experience and learning on what works for tackling FGM, breast flattening and child abuse linked to faith or belief³.

Project activities

The NFGMC project was initially funded for 2 years (April 2015 to March 2017) through Round 1 of the Department for Education's Children's Social Care Innovation Programme (Innovation Programme hereafter) to develop a system change in how local authorities respond to cases of FGM (see McCracken et al., 2017a,b). Six local authorities participated in the first round of the project (Essex, Hertfordshire, Norfolk, Suffolk, Thurrock and Southend). Each of these local authorities was initially identified as having low FGM prevalence (Macfarlane and Dorkenoo, 2015), although subsequent engagement with the NFGMC suggested that this was not the case.

In Round 2 the NFGMC is being part funded through the Innovation Programme to work with Brent, Harrow and Redbridge, which have relatively high FGM prevalence, based on findings from a prevalence study (Macfarlane and Dorkenoo, 2015).

The NFGMC's functions include providing a knowledge hub with FGM resources and training for children's services practitioners, partner agencies and community organisations. The Centre promotes a collaborative approach to tackling FGM and other harmful practices in a sustainable way, through community engagement and fostering strategic partnerships. The evaluation focused predominantly on the NFGMC's social work provision. Specialist social workers and project workers were embedded in local authorities to support and manage cases of FGM, breast flattening and child abuse linked to faith and belief (HPs). The continuum of intervention ranged from providing information and advice on FGM and HP cases; direct work and support; joint working with the allocated social workers; specialist social work intervention; and full delegated authority. The NFGMC's theory of change is presented in [Appendix 1](#).

The package of support provided by the NFGMC in the Round 2 local authorities included:

- Embedded support from a full time NFGMC social worker based in the local authority

³ Source: National FGM Centre website: <http://nationalfgmcentre.org.uk>

- Three full days or 6 half days CPD accredited training for local authority social workers and managers
- Community engagement events and awareness raising activities across the safeguarding partnership (including use of the FGM assessment tool)
- Expert input and advice on FGM, HP and Violence Against Women and Girls (VAWG) strategies and policy developments

The Centre aims to improve the quality of professional responses to FGM and HPs in order to: reduce the level of risk or harm to women and girls; raise awareness about effective safety strategies; and facilitate access to necessary health care, and information about housing, benefits and other support services that are available. These developments are intended to promote positive social, cultural and religious identities and improve families' health and wellbeing.

2. Overview of the evaluation

Evaluation questions

- What are the needs and circumstances of families coming to the attention of children's social care services because they are at risk, or affected by FGM or HPs?
- What are the strengths and limitations of the 'full delegation', 'delegation of selected duties' and 'directly embedded support' models of delivery in response to FGM and HPs?
- To what extent has implementation of the NFGMC model of delivery ('embedded specialist') increased identification, and improved service response to HPs? How does this compare with business as usual in a high prevalence area that is not involved in the Round 2 Innovation Programme and that does not employ specialist workers to respond to FGM and HP?
- What are children and families' views on the strengths and limitations of the NFGMC's service response?
- What impact has the project had on outcomes for children and their families?
- What factors facilitated or inhibited implementation and the achievement of better outcomes for children and their families?
- What are the unit costs of social care activities in response to FGM and HPs in NFGMC authorities and how does this compare to 'standard' practice?
- What lessons are there for wider roll out of the project?

Evaluation methods

The process and impact evaluation commenced in July 2018 and concluded in February 2020. A mixed methods approach was employed to answer the evaluation questions outlined above.

- Collation and analysis of the NFGMC tracker and outcome data on all Round 2 cases (July 2018 to February 2020)
- Collation of 2016/17, 2017/18 and 2018/19 CiN census data on FGM and abuse linked to faith and belief from Round 1 and Round 2 local authorities, the comparator local authority and statistical neighbours
- One interview with a key stakeholder from a Round 1 local authority that did not retain the NFGMC model in Round 2 to explore reasons for non-continuation, current model of delivery and changes that were sustained when the local authority came to the end of their formal engagement with the NFGMC.
- Fourteen interviews with strategic lead and 'frontline' team managers to explore organisational contexts and practice in relation to FGM and child abuse linked to

faith or belief, strengths and limitations of the model and impact on service delivery and outcomes (data collection once in 3 low prevalence Round 1 LAs, n=8; data collection twice in 3 high prevalence Round 2 LAs, n= 5 at T1 and n=1 at T2).

- Three interviews with health professionals from partner agencies to explore their experiences of working with the specialist FGM worker and strengths and limitations of the model (n=1 in a Round 1 LA; n=1 at T1 and n=1 at T2 in a Round 2 LA).
- Four interviews with Business Managers from the Local Safeguarding Partnerships in Round 2 LAs to explore organisational contexts in relation to FGM and child abuse linked to faith or belief, strengths and limitations of the NFGMC model and impact on service delivery and outcomes (n=2 at T1; n=2 at T2).
- Nine interviews with specialist FGM workers to explore the embedded specialist role, strengths and limitations of delegated duty models, the needs and circumstances of families, risk and protective factors and their perspectives on best practice in FGM and HP cases (data collection once in 3 low prevalence Round 1 LAs, n=4; data collection twice in 3 high prevalence Round 2 LAs, n= 3 at T1 and n=2 at T2).
- Six interviews with parents and 2 interviews with young people from Round 2 LAs to explore their views on the strengths and limitations of the NFGMC's service response.
- One interview with 2 parents from the comparator LA to explore their views on the strengths and limitations of the NFGMC's service response.
- Seven in-depth case studies in Round 2 LAs (case record analysis and case specific interviews with allocated/FGM worker) to assess quality of practice, case progression and outcomes and how this compares with business as usual.
- Case record analysis on 6 cases from the comparator local authority.
- One interview with the Head of the NFGMC to explore their perspectives on the programme and 'what works' in responding to FGM and HPs.

Changes to evaluation methods

When the research was designed there was an expectation that the NFGMC specialist workers would be holding and assessing a number of families at any given time. However, in practice the majority of the specialist workers' time was spent on wider engagement and training activities rather than direct case work. The specialist workers recorded the time they spent on providing indirect advice to referrers (tier 1) and direct advice and guidance to referrers (tier 2) cases, but not on those cases involving assessment and/or direct work with the family (tier 3) or high risk, long term direct work (tier 4) (based on the NFGMC's classification system). Given the limitations in the data the research team utilised Holmes and colleagues' unit costs for core social work

processes and Personal Social Services Research Unit (PSSRU) data to understand time use and the costs associated with referrals and assessments. Barnardo's also commissioned York Consulting to undertake additional cost benefit analysis (Allan and Tordoff, 2019).

The original proposal did not include interviews with professionals from partner agencies or business managers from the Local Safeguarding Partnerships, but it was identified that their views and experiences would provide additional insight into the role and contribution of the NFGMC, so these were undertaken to complement the interviews with children's services personnel.

Limitations of the evaluation

Referral rates were lower than anticipated in the Round 2 local authorities and specialist social workers were only involved in a small number of child in need assessments and child protection (s.47) enquiries. This meant that purposive sampling of cases across the risk spectrum was not possible and the pool of children and families to participate in the research was much lower than anticipated. Strategies adopted to try and increase the recruitment of children and families included creating a family friendly video from the research team that workers could show families to explain the research; and seeking participants from a Round 1 local authority that continued with the NFGMC model. However, only a small number of families gave their informed consent to participate and all the cases the team accessed were assessed to be low risk. In part, this reflects the fact that FGM and HPs are hidden forms of harm and the population could be considered hard to reach (Ellard-Gray et al., 2015).

There were a number of changes of personnel during the course of the evaluation. This meant that it proved difficult to obtain a longitudinal perspective from managers and specialist social workers on how the FGM model had evolved over time, or on the rationale for key decisions and perceptions on changes in practice and outcomes.

Efforts were made to contact staff who had moved into new roles or to other local authorities but it only proved possible to interview 1 member of staff from a Round 1 local authority that did not retain the NFGMC model in Round 2. This therefore limits understanding of the reasons for non-continuation and sustainability of changes once formal engagement with the NFGMC ended.

The tracker was completed by NFGMC specialist workers during the course of the evaluation but a number of fields were not completed in Round 2, thus limiting reporting on some key items (for example, time spent on assessment and/or direct work with

families (tier 3) and high risk, long term direct work (tier 4) cases and the NFGMC outcomes outlined on pp.13-14, above).

Many of the activities undertaken by the NFGMC are intended to promote system-change and involve education, training and capacity building with the aim of improving service responses to FGM and HP and preventing future harm. The timescales for realisation of the benefits are long-term and the potential benefits and outcomes are likely to be observed beyond the timeframe for the evaluation.

3. Key findings

Characteristics of families at risk of or affected by FGM and HPs and outcomes

Over a 20 month period (July 2018 to February 2020) specialist workers provided direct input on 79 cases in the Round 2 local authorities. Thirty six of the mothers who were referred for information or advice, or assessment came from Somalia, but the countries of origin of the sample spanned 19 countries.

Health made the most referrals (n=34) to Round 2 local authorities, followed by social care (n=16), and education (n=11) and the police (n=11). Fifty-six percent of the families had unborn children or children aged under 1 at the time of referral. During pregnancy it was often identified that mothers had been affected by FGM and this was a common reason for referral to children's social care services. As one manager reflected:

It's usually immediately after child birth, because the hospital has identified FGM, and at the point when mum is recovering from the birth of a child, and the next thing they've had a conversation with the midwife, who will then get the social worker to make contact.

In other cases, referrals were made by professionals when they became aware that children were travelling abroad to visit relatives in FGM affected countries.

Overall, sixty-five of the cases were categorised as 'FGM only'. In 3 cases HPs were a specific cause of concern and in the remaining cases FGM and another form of harm (e.g. physical chastisement) were noted. Table 1 below provides an overview of the tiers of intervention in each of these cases, by local authority.

Table 1: Level of NFGMC intervention (based on the NFGMC's categorisation)

Tier of intervention	Round 2 Local Authorities			
	Brent	Redbridge	Harrow	Total
Tier 1: Indirect advice to referrer	4	0	0	4
Tier 2: Direct advice and guidance to referrer	7	3	3	13
Tier 3: Assessment and/or direct work with family	23	23	13	59
Tier 4: High risk, long term direct work	2	0	0	2
Total	37	26	16	78 ⁴

⁴ Missing data in 1 Brent case

Source: NFGMC Tracker

Information on case throughput and levels of intervention in Round 1 local authorities in the early stages of implementation, and in the last 20 months, are presented in [Appendix 2](#), for comparison. The Round 1 local authorities that retained an NFGMC specialist worker have seen an increase in the volume of FGM and HP cases requiring intervention. In the first 20 months of operation the specialist workers provided direct input on a total of 105 cases. In the last 20 months the figure was 143. Provision of direct advice and guidance increased from 29 to 69, and the number of cases involving high risk, long term direct work rose from 2 to 10. The input of the NFGMC over time is likely to be a contributory factor.

Table 2 below, provides an overview of the status of the cases that the NFGMC specialist workers were involved in during Round 2.

Table 2: Case status based on the NFGMC tracker

Case Status (based on NFGMC tracker data)	Number of cases
Contact	2
Consultation/No Further Action	13
Early Help	1
Single Agency (Centre only)	17
Section 17 Children Act 1989	27
Section 47 Children Act 1989	10
Other or missing data	9
Total	79

Source: NFGMC Tracker

In at least 22 cases the NFGMC supported the local authority to assess the family and in a further 17 cases they did a single assessment (without the involvement of the local authority social worker). In 17 cases the NFGMC specialist worker engaged in direct work with children. The NFGMC adopts a rights based approach in their work with children and young people, including use of a toolkit for direct work developed by the Centre, as well as the National Society for the Prevention of Cruelty to Children (NSPCC)

PANTS talk. Table 3, below provides a summary of the outcome of the cases, as recorded on the NFGMC tracker.

Table 3: Outcome of the cases

Outcome (based on NFGMC tracker data)	Number of cases
Closed at the point of contact/no concerns or advice to referrer	13
No further action: children’s social care decision	3
No further action following risk assessment	7
Family visited by the NFGMC specialist worker: Assessed to be no or low risk	9
Family visited and the NFGMC specialist undertook direct work to reduce risk prior to closure	9
Not specified on the tracker	38
Total	79

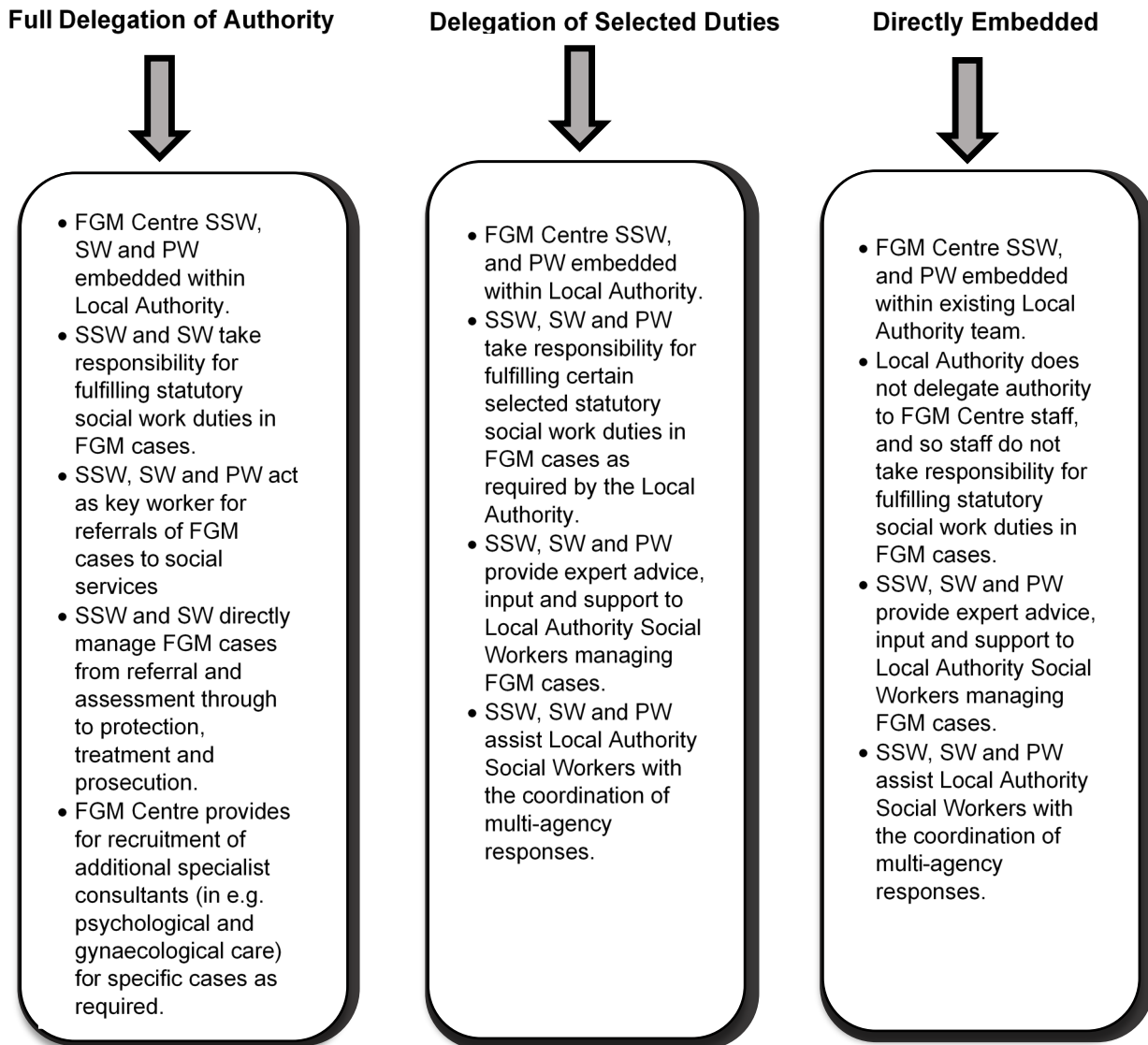
Source: NFGMC tracker

The NFGMC also provided expert input and advice to the Round 2 local authorities on 3 FGMPOs, an interim care order and 1 prohibited steps order to safeguard children from harm.

Strengths and limitations of specialist models of delivery

The NFGMC developed an offer to provide specialist social workers and project workers to manage cases of FGM (and HPs in Round 2). The specialist workers are embedded in each of the pilot local authorities but are not directly employed by children’s services. In the Round 1 evaluation report it was noted that there were variations in the nature and extent to which duties were delegated to the NFGMC workers (McCracken et al., 2017a). Figure 1, below, provides an overview of the continuum of delegation.

Figure 1: Continuum of delegation



Source: McCracken et al., 2017a, p17

Interviews with specialist social workers, strategic leads and frontline managers in Round 1 and 2 local authorities explored how the specialist or embedded role has evolved over time and facilitated examination of the strengths and limitations of the delegated models that were employed.

In Round 1 Hertfordshire did embed a fully delegated model, but they subsequently adjusted their model and reduced the degree of delegated authority. One of the managers highlighted the value of full delegation at the outset of the project on the following basis:

We needed a pathway directly in and we needed a very clear-cut response...It was important that we had somebody taking that lead, conducting that piece of work themselves...Partner agencies knew exactly who to contact.

However, since then the local authority had adapted the model because they had recognised that when the original specialist FGM worker got a new post 'she took the knowledge with her'. In response they were keen to adjust arrangements to ensure 'enough cross over of knowledge and skills into the organisation'. Hertfordshire moved the FGM specialist worker from the Joint Child Abuse Investigation Team to the Multi-agency Safeguarding Hub (MASH). Over time it was recognised that only a small number of the FGM cases that were being referred met the threshold for s.47 enquiry and thus locating the FGM specialist worker in the Joint Child Abuse Investigation team was not necessarily the most appropriate positioning.

The models in operation at the time of interview were similar across the 6 local authorities. In respect of most cases FGM specialist workers fulfilled selected statutory social work duties and other duties as required by the local authority⁵. They provided 'directly embedded support', including expert advice and support at the Front Door and to social workers undertaking assessments, as one manager explained:

At the point of contact, whether it's a referral or not, so at the point of contact the FGM lead will be contacted and asked for their advice or guidance around if it's unclear about what needs to happen, it's also to see if there is a role for them, particularly around going back to the referrer to help them understand what's required of them...If it goes to a social worker, the social worker will always hold the case, but the FGM worker will work alongside them.

A consistent message from strategic leads and frontline managers was that positioning the specialist FGM worker at the Front Door was a strength. First, it was noted that the number of contacts and referrals that progress to assessment was low and so co-location at the Front Door was desirable. Second, the arrangement was perceived to facilitate everyone in the team gaining knowledge, understanding and confidence in responding appropriately to cases concerning FGM and HP.

We're having a lot of conversations over the phone, it's an extremely sensitive subject and I know that a lot of people find it extremely difficult to ask the questions that need to be asked, and I think by listening and observing you start to understand how you can approach the topic.

⁵ Brent and Harrow permitted full delegation (NFGMC specialists case holding and fulfilling statutory social work duties on FGM cases), but managers also acknowledged the value of joint-working on cases and capacity building to upskill local authority social workers and professionals from partner agencies.

In this respect the FGM specialist workers were perceived to have played an important role in capacity building and raising awareness of levels of risk and which cases require further assessment.

Each authority had arrangements in place to ensure that specialist social workers' knowledge and expertise fed into cases that were transferred to the Assessment Team. Joint visits and co-working arrangements were viewed to be advantageous as the social workers 'learn about FGM and how to undertake assessments [and] how you get parents working with us'.

Impact of embedded specialists on identification of FGM and HP and subsequent service responses

Identification of cases

At the outset the NFGMC and strategic leads had anticipated that the engagement of NFGMC workers in the Round 2 local authorities, which have a high prevalence FGM, based on findings from City University's prevalence study (Macfarlane and Dorkenoo, 2015), would result in a marked increase in the identification of cases. In practice, there was widespread acknowledgement that referral rates had not increased as much as expected (see above). However, it was also noted that early intervention and preventative work are important and FGM is a form of hidden harm and a complex issue to address. One senior manager reflected:

With FGM and HP people want stats and numbers...That's used to gauge the impact that we've been able to generate...In relation to FGM the attitude seems to be if we don't have the numbers it doesn't exist. When we look at it we have had 500 Female Genital Mutilation Orders for something that's hidden, which is phenomenal. When we look at DfE Child in Need Stats on abuse linked to faith and belief it's around 1950 a year and rising, for something we don't know much about and that's not on the radar...To be generating that number of cases suggests it's just the tip of the iceberg.

The number of children's social care assessments in which FGM was identified as a factor fell between 2016/17 and 2018/19 in Brent and Redbridge (from 31 to 16 and 12 to 0 respectively). In Harrow, 10 cases were identified in 2016/17 and 12 cases were identified in 2018/19. There was an increase in the number of assessments in which abuse linked to faith or belief was identified in Brent and Harrow. In Redbridge the number of cases in which this factor was identified peaked in 2017/18, with 45 cases, and fell back, to 18, in 2018/19 (Department for Education, 2017, 2018a, 2019). In Leeds, the comparator local authority FGM was identified as a factor in 21 assessments in

2016/17, 64 in 2017/18 and 40 in 2018/19. Abuse linked to faith or belief was identified in 42 assessments in 2016/17, 28 in 2017/18 and 63 cases 2018/19 (ibid).

Further data, from the Department for Education's children in need statistical return, including comparisons with statistical neighbours and the comparator local authority are presented in [Appendix 3](#) and [4](#).

In each local authority the NFGMC workers had been engaged in raising awareness of FGM and HPs. In Brent, for example, 55 awareness raising sessions were undertaken. Each of the Round 2 local authorities also engaged in targeted work with health services to encourage appropriate referrals. In one of the authorities there was a reported increase in referrals from hospital midwifery services, which was attributed to the specialist FGM worker. In another local authority the NFGMC identified that health referrals were low, compared to other local authorities in the region. The specialist worker was part of a multi-agency team that audited a sample of cases. The audit revealed that cases that met the threshold for referral were not being referred to children's social care. One manager explained:

The risk assessment tool was absolutely fine, it was how they applied it, so there was a training issue. Some of the cases had several 'risk' factors where health personnel had just entered 'unknown' or 'undisclosed' with insufficient exploration and weight given to risk factors.

It was noted that some professionals were concerned that referring these cases to children's social care was discriminatory. However, the desire to be culturally sensitive can have unintended consequences if situations that may put children at risk are not assessed by workers with the confidence and knowledge to work with families from different cultures and religions (Bernard, 2019). An action plan was developed by the safeguarding partnership to address the issues that had been identified. The specialist worker spent time in the health clinics to support staff to conduct the assessments and engage with the women. Training for health personnel was also initiated, but it was acknowledged that changes of personnel (including the FGM health lead) had slowed progress in upskilling health personnel.

Assessment

Turney and colleagues (2011) have identified the following as features of good quality assessments:

- Ensure that the child remains central
- Contain full, concise and relevant and accurate information
- Include a chronology and/or family and social history

- Make good use of information from a range of sources (Turney et al., 2011, p.13).

It is also important to give due regard to family and environmental factors, including relationships with relatives and friends and community engagement. These factors have traditionally received less attention than children's developmental needs and parenting capacity in assessments (Horwath and Platt, 2019). Attention has also been drawn to the complexities of making accurate assessments when 'parents' child-rearing practices are buttressed by cultural and religious belief which are not in line with UK law' (Bernard, 2019, p.657).

The NFGMC have developed an FGM assessment tool and best practice guidance. This highlights that assessments should provide a holistic overview of the following:

- family's views around FGM
- the people who may pose a risk to the girl(s)
- any support the girl/women may need as a result of FGM
- the girl(s) knowledge of FGM (National FGM Centre, 2016, p.8).

They also recommend drawing a genogram with the family to explore family dynamics.

A small sample of assessments completed by NFGMC specialist workers from the Round 2 local authorities (n=7) were reviewed and compared with assessments undertaken by field social workers in a comparator local authority (n=6). Table 4, below, provides a summary overview of these cases.

Table 4: Summary data from the FGM assessment records

	Assessment form	Number of visits	Views of parents obtained (direct)	Views of wider family explored with parents/guardian	Views of wider family obtained (direct)	Child(ren) seen	Genogram	Support services or signposting	Assessment outcome
Round 2 local authorities									
Case 1	FGM assessment tool	1	√	√	X	√	X	FGM specialist clinic for counselling Early help referral (housing and finances)	Case closed/no further action
Case 2	FGM assessment tool	1	√	√	X	√	X (parents declined to complete)	None specified	Case closed/no further action
Case 3	FGM assessment tool	1	√	√	X	√	X	None specified	Case closed/no further action
Case 4	FGM assessment tool	3	√	√	√	√	√	FGM specialist clinic for counselling Direct work around body rights, human rights and children's rights completed with daughter	Case closed/no further action
Case 5	FGM assessment tool	4	√	√	√	√	√	None specified	Case closed/no further action
Case 6	Child and family assessment	1	Mother only	√	X	√	√	Direct work around body rights, human rights and children's rights completed with daughters	Case closed/no further action
Case 7	Child and family assessment	0 (phone call)	Mother only	X	X	X	X	Educational work with the family	Case closed/no further action

	Assessment form	Number of visits	Views of parents obtained (direct)	Views of wider family explored with parents/guardian	Views of wider family obtained (direct)	Child(ren) seen	Genogram	Support services or signposting	Assessment outcome
Comparator local authority									
Case 1	Child and family assessment	0 (phone calls)	N/A	√	X	X	X	Specialist FGM services for health needs	Case closed/no further action
Case 2	Child and family assessment	1	Mother only	X	X	√	X	None specified	Case closed/no further action
Case 3	Child and family assessment	4	Mother only	√	X (Mother declined to supply details)	√	X	Signposting to housing support	Case closed/no further action
Case 4	Child and family assessment	2	√	X	X	√	X	None specified	Case closed/no further action
Case 5	Child and family assessment	1	√	X	X	√	X	None specified	Case closed/ further action
Case 6	Child and family assessment	6	√	√	X	√	X	None specified	Case closed/no further action

In all the cases that were the subject of analysis the assessing social worker concluded that the risk of FGM was low and that cases could be closed with no further action. In all these cases the research team reviewed the records, and assessed that the information that was collected to inform the assessment was proportionate, in the context of the referrals, and that sufficient information was recorded to support the decisions that were reached. In both the Round 2 local authorities and in the comparator local authority the child, or children, also remained at the centre of the assessment.

The FGM assessment tool questions and risk matrix were fully completed in all the cases where this was used to assess risk and protective factors to inform the specialist worker's professional judgement about whether further action was required to safeguard the child, or children, from harm. In addition to completion of the structured questions the specialist workers provided a brief summary of the key information that they had obtained to inform their decision on the appropriate outcome in the case. In the comparator authority a traditional child and family assessment proforma was completed, with more free text information, in lieu of the risk matrix and score that is generated when the FGM assessment tool is used. The research teams' professional judgement was the analysis that was presented summarised the case, outlining the views of the child or children and their parents, as well as the professionals involved. Ambiguities or conflicting accounts were explored and the rationale for the decisions that were taken were transparent. However, fewer of the case records in the comparator local authority explored the views of the wider family or integrated generational perspectives on FGM (3 out of 6 in the comparator and 6 out of 7 in the Round 2 local authorities).

Qualitative interviews with the Head of the NFGMC and specialist workers facilitated exploration of their perspectives on the features of a high quality FGM assessment (rather than the quality of recording) and explored the approaches that were adopted during direct work with families affected, or at risk of, FGM or HPs. These discussions illuminated the importance of:

- a trauma-informed and rights based approach
- eliciting the mother's experience and journey from when she was cut (whilst recognising that this can be difficult because she may not have full recall, or have recall bias)
- engaging fathers and understanding their perspectives and family history (and being aware that in some communities men would not normally talk to women about this issue)
- accessing and understanding the wider family perspectives on FGM and understanding risk across generations.

The NFGMC specialist social workers highlighted that the fact that they were employed by Barnardo's, with a remit to support women affected by FGM and HPs, facilitated their

engagement with families. For example, one parent who was having her third child and had discussed FGM with the midwife questioned: “Am I being asked all these questions because I’m black and have FGM”, and she felt that she had not been listened to. The NFGMC worker was able to explain her specialist role and that once she had completed an assessment and uploaded it on to the system then professionals would know her views. The specialist social workers also suggested that it was desirable to adopt a conversational style and asking open ended questions, so that families could narrate their own stories. We don’t ask “What do you think about FGM? We ask about their extended family and their community” “Do you go to church, do you go to mosque or church?” “Do you talk to your friends about this?” Specialist workers and FGM leads suggested that professionals who have not had specialist training do not always feel culturally competent, or sufficiently confident to ask families questions about religious beliefs and cultural values even when these contribute to understanding risk or protective factors in familial and community networks.

It was highlighted that in gerontocratic family systems the older generation has the power, influence and control; going against them has consequences for your place within the family. Workers explored these dynamics within their assessments, for example:

We spoke about her family’s beliefs around FGM, were her family supportive? Was there any pressure, which she wasn’t able to identify any. We completed a genogram of her family...My assessment was that she was quite educated about the issue, and she was able to articulate her reasons, and she had a good plan in place in terms of protecting her daughter.

In the context of collectivist rather than individualistic cultures the Head of the NFGMC and specialist workers suggested that it is important for professionals to explore behavioural change with families - if it is a generational practice – and the parents attitudes do not align with previous generations – what would account for this change in attitude and what evidence can parents provide to evidence their knowledge and understanding?

Supporting service improvement

A consistent message from professionals was that the specialist social worker role was valued because these practitioners were seen to have played a central role in upskilling the workforce (in children’s social care and partner agencies) to support improved practice in responding to FGM and HPs. As one professional reflected:

Previously it would have been dealt with by a social worker who lacks an understanding of FGM, so they might not have the right way of asking, being able to gather information, knowing the right questions to ask, the right information to give to families, and that will have an impact on the result of the assessment....

Input from the NFGMC specialist was perceived by professionals to support timely and appropriate service responses that were culturally sensitive and non-stigmatising and sought to minimise re-traumatisation of victims of FGM. Modelling of best practice in discussing concerns (responding to contacts and referrals and information gathering) and in direct work (joint visits) were expected to enhance the skills of the workforce. In both respects specialist input was understood to enable local authority staff to do skilled direct work.

Another perceived benefit was that the specialist FGM workers were able to maintain contact with families over time and build relationships, as well as providing support beyond formal case closure. These developments were perceived to have resulted in positive changes to practice and better experiences for families. For example, one of the specialist workers explained:

I get to work with the families right from the start and I'm able to work with them through the Multi-Agency Safeguarding Hub [MASH] to assessment, be able to support them beyond the assessment... This model works in terms of continuity for families.

A manager also reflected that:

Specialist workers will do some pieces of work with these women just around the support that is available to them, because obviously they're talking about traumatic events... one minute you've got all these professionals asking you various questions about your children and really worried about your kids... but [the specialist worker] will do some work with them just in regards to their own experiences and what support they feel they need, and being able then to signpost to other support services that they feel they might need.

Families' views on the strengths and limitations of service responses

Interviews were undertaken with 8 parents (6 from Round 2 and 2 in 1 interview from the comparator local authority) and 2 young people (Round 2) to explore their views and experiences of FGM service responses. All those who participated in the interviews were explicit that they were anti-FGM and many reflected on the pain and trauma that they or their loved ones had experienced as a result of the procedure.

It should be condemned to be honest, it's cultural but it's not a good culture, and to be honest workers who work with it should be appreciated because people should be raising awareness of it.

All the participants were accepting of, or resigned to, a social work visit, and anticipated that it would be 'fine' because they had 'nothing to hide'. In all but 2 cases, referrals had been made by health professionals following GP or maternity appointments and the explanation for the referral was that it was 'compulsory' or a 'legal requirement' because of their history of FGM and the fact that they had, or were expecting daughters. A mother who was notified that children's services would be in touch, as she was being discharged from hospital said:

"I have nothing to hide...I don't want to do that [FGM] anyway, so she can come", basically that's what I said to the hospital.

A father also reflected that practitioners think:

"They're from a region that practice it, it's part of their culture", they're thinking it is a warning sign...OK, I'm not hiding anything, let them come. They're just doing their job.

In the majority of cases the social worker only visited the family once to explore their attitudes towards FGM and to offer advice. In a couple of cases the worker also signposted the family to additional services, which was welcomed. Workers were described as 'friendly' and 'really nice' and their approach to information gathering was not perceived to be intrusive or culturally insensitive. As one mother reflected:

She was very nice, like she made everything easy. It wasn't like, you know, I've heard from certain people that some social workers can be a bit tough...but she was nice and friendly.

In a couple of cases mothers reflected that having to re-tell their stories was traumatic, although they felt that the specialist workers had been sensitive in their approach. One compared her experience of health professionals and the FGM specialist and reflected that:

The midwife and health visitor keep bombarding me about my FGM...But the social worker was a great lady.

Only one parent who was interviewed was negative about his contact with the NFGMC's specialist workers and the service he received. He had contacted children's services because he was concerned that his daughter was at risk of FGM. Based on his experience he outlined that:

In a nutshell, it wasn't professional, it was rushed, it was concluded swiftly. It was concluded in the way, "We've figured it out already", that's it. "She was abused, because of that she's not going to do it to her daughter, because she's a victim herself", so they were dismissive of the risk.

His perception was that the information he supplied children's services with was not taken seriously, but that when his ex-partner said she would not perform FGM on their daughter this was taken at face value due to gender bias.

Overall, families generally accepted that social workers had a 'job to do' and understood that risks needed to be assessed to safeguard children from harm. Parents also reflected that discussions with their children (where these had taken place) had been managed sensitively and age-appropriately. The fathers who participated also emphasised the importance of men's active participation in educational initiatives in local communities to challenge the practice of FGM and to assert that 'this is not something we want for our daughters'.

Factors facilitating or inhibiting implementation

Diffusion of Innovation theory suggests that (1) relative advantage over current practice; (2) compatibility with existing values and practices; (3) complexity or simplicity of implementation; (4) trialability or piloting of new ideas; and (5) observability or seeing results swiftly support innovations to embed within an organisation (Rogers, 1995; Brown, 2015; Bostock et al., 2018). Interviews suggested that a number of these features applied in the Round 2 sites. Senior and operational managers in the local authorities recognised that there was a need to strengthen service responses to FGM and HPs and that there were gaps in knowledge and understanding in respect of this area of practice and so there was 'buy in' from leaders within children's social care services. Round 2 local authorities contributed to resourcing the innovation, but their investment was less than the salary and costs for a full time social worker and they also benefitted from embedded support from a specialist, as well as Continuing Professional Development (CPD) accredited training and expert input and advice from the wider NFGMC team.

The NFGMC's values and practices align with those of the social work profession. The FGM assessment tool and practice guidance are underpinned by the same conceptual model as other types of assessments (with attention given to development of the child or young person; parents and carers; and the wider family and environment). It is also acknowledged that direct work should be strengths-based. The package of support delivered via the Innovation Programme has enabled sites to develop and refine their local protocols, as required to meet statutory requirements (Department for Education, 2018b).

The specialist workers were all employed by Barnardo's but based in local authorities. They utilised the local authority's recording systems and operated within existing local safeguarding protocols. Being employed by Barnardo's and working for the NFGMC was perceived to be advantageous, as one manager explained:

They're not bogged down with the day to day cases, if their focus is on a specific area, it means that they can support practitioners to gain a better understanding and skill base.

Being outside children's services was also seen to facilitate direct work with families because they could explain their work for the NFGMC and their commitment to preventing FGM and HPs and supporting those affected by these practices. Their separate role, identity and skill-set were recognised as helpful for the delivery of direct work and community engagement, but this was not without challenges.

Specialist social workers can experience a sense of isolation and loneliness as they are not part of the local authority team and they only meet with their NFGMC colleagues at team meetings on a three-weekly basis. Recruitment and retention of workers has been a recurrent problem; one of the Round 2 local authorities experienced 3 changes of workers over the course of the project. Where there were gaps between appointments, local authorities were able to access support from the NFGMC but managers suggested that the changes in personnel meant that relationships within the local authority and with partner agencies had to be re-established which could delay progress on cases and in upskilling the workforce, thus slowing implementation.

While the approach the NFGMC specialists adopted in their work was compatible with social work practices, it was noted that professionals from partner agencies, particularly health, were not necessarily comfortable or confident in assessing risk and referring when thresholds were met. Measures were being taken to understand the barriers to referral and to develop strategies to respond, but it is noteworthy that there was not an observable increase in referrals as a result of implementation. Nonetheless, managers were overwhelmingly positive about the project and its contribution to the development of a more robust infrastructure to support improved service responses to FGM and HPs, via training and education to prevent harm and protect and support children and families.

Costs

Holmes and colleagues (2012) have undertaken a programme of research which adopts a 'bottom up' costing methodology to understand costs and outcomes in child welfare services and how social workers spend their time (see also, Beecham, 2000). Data they have collected on the standard time that social workers spend on core social work processes have been used as a framework to explore the time that NFGMC specialist social workers from the Round 2 local authorities have spent on contacts and referrals, assessments and care proceedings during the lifetime of the evaluation.

Information from the NFGMC tracker, complemented by the case record data and interview data, were used to inform decisions about how the tiers of intervention above, aligned with the case management processes adopted in Holmes and colleagues

research. For each process the PSSRU hourly unit cost for a social worker (including London weighting) has been multiplied by the reported 'time use' on each process and the number of cases (Curtis and Burns, 2019). Table 5 below shows the 'time use' activity and associated costs for the cases that involved direct NFGMC specialist social work input.

Table 5:NFGMC specialist social worker involvement in core social work processes over a 20 month period

Process	Brent		Redbridge		Harrow		Round 2 Total	
	NFGMC specialist social worker activity	Cost of activity	NFGMC specialist social worker activity	Cost of activity	NFGMC specialist social worker activity	Cost of activity	NFGMC specialist social worker activity	Cost of activity
Process 1: Initial contact and referral	65 hours	£3,403.40	17 hours 45 mins	£929.39	17 hours 45 mins	£929.39	100 hours and 30 mins	£5,262.18
Process 2: Initial Assessment	90 hours 45 mins	£4751.67	90 mins 45 minutes	£4751.67	49 hours 30 mins	£2591.82	231 hours	£12,095.16
Process 5: Core Assessment	215 hours	£11,257.40	215 hours	£11,257.40	125 hours 25 mins	£6571.18	555 hours and 15 mins	£29,085.98
Process 7: Section 47 Enquiry	15 hours and 45 mins	£824.67	N/A	N/A	N/A	N/A	15 hours and 45 mins	£824.67
Process 8: Public Law Outline	35 hours and 20 mins	£1,871.87	N/A	N/A	N/A	N/A	35 hours and 20 mins	£1,871.87
Total	436 hours and 50 mins	£22,109.01	323 and 30 mins	£16,938.46	192 hours and 20 mins	£10,092.39	937 hours and 50 mins	£49,139.86

Notes: 1) Case management processes and activity times for each process based on bottom up costing research (see Holmes and McDermid, 2012). 2) Unit cost of social worker (children's services) based on PSSRU data for 2018/19, including the London multiplier (Curtis and Burns, 2019). 3) Although initial and core assessments have been replaced by a single assessment process case information suggested that a proportion of the NFGMC assessments were similar in scope/volume of activity to initial assessments and so we have used these time use activity data for the costings.

Table 5 shows that the NFGMC specialist workers spent, on average, half a day to 1 day per week on direct FGM case work⁶, with the remainder of their time spent on wider engagement activities (e.g. developing strategies to improve recognition of and responses to FGM and HPs, training and capacity building within children's social care and with partner agencies and community engagement). Professionals acknowledged the importance of the wider engagement work that the specialists undertook to support whole-system change, spread learning across their services and in working with communities to eradicate FGM and HPs. It was noted, for example that informal advice and guidance and training in respect of FGM and HPs should reduce the number of inappropriate referrals and improve the quality of information supplied to children's services to support timely assessment when thresholds were met, thus yielding cost savings.

The NFGMC social workers spent between 5% (Redbridge) and 15% (Brent) of the time that was dedicated to direct FGM case work on initial contacts and referrals. In each authority the majority of time and resource was spent undertaking assessments. Again, it was noted that completion of quality assessments should reduce the number of re-referrals to children's social care in respect of FGM and HPs over time. These potential benefits were acknowledged alongside recognition that much of the work that the NFGMC is engaged in is of a preventative nature and the financial and human cost benefits will not be apparent for years to come, as Allan and Tordoff (2019) acknowledge:

The work the Centre is doing now with victims of FGM could result in a multitude of benefits relating to physical and mental health, wellbeing, self-confidence and attitudinal and behavioural changes towards FGM amongst future generations. But these benefits will occur at different points of time – some may take months, others may take years (p.1).

Engaging communities and educating families was seen to be extremely important, as one professional said:

If we know that families have the awareness and the education they need to safeguard their children then these cases aren't going to continually come back, so I think it minimises re-referrals.

Another manager highlighted that:

We work with young boys, and they can play an integral part...If they have knowledge then they can act protectively of young sisters, friends and

⁶ Taking into account the fact there were periods during the course of the evaluation when full time NFGMC specialists were not in post.

cousins...It's really holistic, it's about getting the entire community involved...That's how you make changes.

Cost savings through prevention

York Consulting have undertaken work to estimate the saving to the state that arise as a result of the Centre's work to prevent new cases of FGM, including savings to the health service arising as 'a consequence of post-FGM physical and mental health support not being required (because the Centre has prevented FGM from occurring)', including:

- Cases where an FGM Protection Order (FGMPO) has been put in place.
- Cases where there is not an FGMPO, but where the Centre believes that there is a genuine risk of FGM occurring in the absence of their work. This includes, for example, siblings of the girls to which an FGMPO related.

Drawing on data from *Estimating the costs of Female Genital Mutilation services to the NHS*⁷ York Consulting generated average unit costs for treatment in response to FGM, including treatment for short-term complications, de-infibulation, psychological problems and long-term complications. As it was difficult to establish what proportion of women or girls would need these treatments they developed 'low', 'medium' and 'high' scenarios to calculate potential cost savings through prevention.

During Round 1 and 2 of the Innovation Programme 35 FGMPOs were granted, with the support of the NFGMC. York Consulting estimated that the total cost savings to the state through prevention based on the granting of these 35 Orders to be in the range of £42,982- £73,205 (Allan and Tordoff, 2019, p. 11-14)⁸. In Round 2, a total of 3 FGMPOs were granted with an estimated total cost saving based on prevention through the granting of these 3 Orders to be in the range of between £3,684.17 and £6,274.71.

York consulting also estimated cost savings in cases where the risks of FGM occurring were assessed to be high, had the NFGMC not intervened (including, for example, siblings of the girls to which FGMPOs related). In Round 1 and 2 they estimated 182 non-FGMPO cases were prevented with a total estimated saving to the state through prevention of £223,505. In Round 2, they estimated that 92 non-FGMPO cases were prevented with a total estimated saving to the state through prevention of £112,976.

⁷ <https://www.york.ac.uk/healthsciences/research/health-policy/research/health-policy-projects/prepare/reports/>

⁸ See the full report for details of the methodology

Overall, longer term follow up is required to assess and establish whether the potential benefits of the NFGMC's work have been realised and the associated savings to the public purse have been realised.

Summary of outcomes

There was widespread acknowledgement from strategic and operational managers from Round 1 and 2 local authorities and from partner agencies that the package of support provided by the NFGMC had served to facilitate the following:

- understanding of FGMPOs and what to include in court orders and the conditions to attach to these ('The questioning and the support of the NFGMC was critical in moving us along so quickly and identifying the issue' and 'the NFGMC were critical in raising awareness, and being confident in securing that order, and delivering it in a child-centred and sensitive way with the family as well')
- development of strategies and action plans in respect of FGM and HP (for example, one of the local authorities had developed a 3-year action plan to: strengthen early intervention, prevention and support; improve practice and multi-agency working; develop cultural competence across the workforce; and increase senior leadership knowledge, and engagement in championing the cause)
- identification of barriers to referral and adoption of strategies to overcome these (for example, heightened awareness of professionals' fear of being perceived as stigmatising or discriminatory against certain cultures; NFGMC workers spending time based in health clinics to conduct preliminary assessments and engage with the women)
- upskilling the workforce, including increasing frontline professionals' confidence to ask the right questions in a culturally sensitive and non-stigmatising way
- enhanced understanding of risk and improved screening and risk assessment processes
- strengthened partnership working to respond to FGM and HPs
- early intervention and preventative work, including raising awareness raising that FGM is illegal and educating families with the aim of preventing FGM in the future.

Professionals acknowledged that, on the whole, the impact of these activities and their contribution to improved outcomes for children and families would be realised in the years to come, but there was near universal acknowledgement that the involvement of the NFGMC had supported developments in policy and practice, as one manager reflected:

It's only when you start unpicking [it] and start delving deep that you realise what you're not doing and what you could be doing better, and so I think certainly [involvement in the programme] and the support of the full-time social worker, FGM specialist, but also the expertise of the Centre, I'd recommend that to any local authority.

4. Summary of key findings on 7 practice features and 7 outcomes

As reported in the Children's Social Care Innovation Programme Round 1 Final Evaluation Report (2017), evidence from the first round of the Innovation Programme led the DfE to identify 7 features of practice and 7 outcomes to explore further in subsequent rounds.⁹ The features of practice that are most relevant to the NFGMC evaluation, and key findings in respect of these are summarised below.

Strengths-based practice frameworks

Barnardo's have developed FGM Good Practice Guidance and an Assessment Tool for social workers, with the aim of promoting 'consistency in assessing the risk of FGM in a culturally competent manner with families' (National FGM Centre, 2016). The conceptual underpinning of the tool aligns with the Assessment Triangle (Department for Education, 2018b) and it is designed to facilitate identification of risks but also strengths and protective factors. The NFGMC also adopt a trauma informed and rights based approach to their work. All, but 1 of the small sample of parents who had been assessed, were positive about the service response they had received.

Family Focus

Specialist NFGMC social workers adopt a whole family approach in their work. They create genograms, looking at families, relationships and their strengths and vulnerabilities. In the context of FGM and HPs it was acknowledged that it is important to explore and understand the wider family network's perspectives on FGM to obtain an understanding of risk across generations.

Enabling staff to do skilled direct work and high intensity and consistency of practitioner

The NFGMC aims to change frontline practice in a number of ways, including:

- using delegated authority to manage and co-ordinate cases and supporting multi-agency responses to FGM and HP

⁹ Sebba, J., Luke, N., McNeish, D., and Rees, A. (2017) *Children's Social Care Innovation Programme: Final evaluation report*, Department for Education, available [here](#).

- providing evidence and information for professionals
- supporting professionals to identify and response to FGM and HPs
- nurturing strategic partnerships to respond collaboratively to FGM and HPs.

Although the NFGMC specialist social workers do undertake direct case work they do not hold a full case load. This was widely recognised as important as it enabled them to provide timely and more intensive support (where required), but also allowed them to invest time in educating, training and supporting professionals in children’s social care and partner agencies to respond to FGM and HPs in a culturally sensitive and non-stigmatising way.

The NFGMC specialist social workers follow FGM and HP cases from referral and assessment through to long term work (where required). They may also offer advice and support following formal case closure, thereby supporting continuity and consistency for families.

Round 2 authorities highlighted that the involvement of the Centre had illuminated areas where direct work could be strengthened (e.g. in health settings) to facilitate best practice and appropriate referrals to children’s social care.

Recruitment and retention of NFGMC specialists proved challenging in Round 1 and 2 local authorities. Access to the expertise of the wider NFGMC team was welcomed as local authorities continued to have access to advice and guidance in respect of FGM and HPs even when there was not a specialist worker in post within the local authority. However, the lack of continuity in embedded workers did lead to delays in implementation of action plans; additional time was also spent on building and re-building professional relationships.

Multi-disciplinary skill sets

An important part of the NFGMC model is making sure that the specialist workers work collaboratively with local authority social workers and with the police, education and health.

Round 2 local authorities have experienced challenges in getting referrals from Health but with input from the NFGMC they have undertaken multi-agency audits to understand barriers to referral. The process also illuminated the importance of high quality training for the professional network to strengthen culturally competent practice and support practitioners to ‘ask the right questions in a culturally sensitive way’.

Reducing risk

The NFGMC's work focused on reducing risk by carrying out robust assessments and providing expert advice and training to raise awareness and upskill the wider workforce to assess risk and better support families. During the course of the evaluation the specialist workers have undertaken these activities, as well as educating parents and children with the aim of changing attitudes and beliefs to reduce incidents of FGM and HPs in communities where it is prevalent. The impact of this range of measures is difficult to quantify in the short to medium-term but during Round 2 the NFGMC have provided expert input and advice on 3 FGMPO orders, an interim care order and 1 prohibited steps order to safeguard children from harm.

5. Lessons and implications

- High prevalence of FGM, based on prevalence data, does not guarantee a high volume of referrals to children's social care. This serves to reinforce the importance of training multi-agency professionals to understand this hidden form of harm and providing them with the skills and competencies to fulfil their respective roles and responsibilities in tackling it. Understanding barriers to referrals and developing strategies to overcome these is an important aspect of the NFGMC's work. The Round 1 local authorities that retained an NFGMC specialist worker have seen an increase in the volume of FGM and HP cases, including high risk and complex cases, requiring intervention. In the first 20 months of operation the specialist workers provided direct input on a total of 105 cases. In the last 20 months the figure was 143. The input of the NFGMC is likely to be a contributory factor. This also suggests that longer term specialist input may be required to improve identification of FGM and HPs and increase appropriate referrals.
- Delegation of selected duties to the NFGMC specialist workers was welcomed by strategic leads and frontline managers as a vehicle to improve service responses, as well as educating, training and upskilling local authority social workers. Locating NFGMC workers at the Front Door was perceived to be beneficial as the volume of medium to high-risk cases was relatively low in Round 1 and 2. Specialist workers were seen to be able to provide expert advice and the wider team were able to listen to the conversations they had to establish levels of risk and determine whether further assessment was required.
- Input from specialist social workers was perceived by professionals to support timely and appropriate service responses that were culturally sensitive and non-stigmatising and sought to minimise re-traumatisation of victims of FGM.
- The NFGMC specialist spent around half a day to 1 day on direct case work. It was recognised that it was important that they did not hold a full case load as this would undermine their capacity to engage in the work necessary to promote whole system changes.
- Local authorities were committed to upskilling the workforce to respond effectively to cases of FGM and HP. However, it was noted that when the throughput of cases is low, opportunities to apply learning in practice can be limited.
- It was widely acknowledged that FGM and HPs are complex areas of social work practice and that professionals can find it challenging when issues of ethnicity and culture intersect with safeguarding. High quality CPD accredited training and support was perceived by professionals from the safeguarding partnership to be required to help increase cultural competence and religious literacy.

- The NFGMC specialists are Barnardo's employees. Being able to position themselves as advocates supporting those at risk or affected by FGM, rather than as local authority social workers, was perceived to be advantageous to facilitate engagement with families. With one exception, the small number of parents and children we interviewed were positive about their intervention.
- The specialist social worker in post had changed at least once in every local authority¹⁰. These changes meant that additional time had to be spent building effective working relationships within children's services, with partners and the wider community; and that delays were encountered in embedding best practices. Consideration needs to be given to recruitment and retention strategies, including: supervision and support structures for specialists who are embedded outside their employing organisation; reviewing salaries for specialist workers, compared to their local authority counterparts; developing career pathways and progression routes.
- Awareness raising sessions in the community, including boys and men, were identified by families and specialist workers as likely to be extremely important to enhance knowledge and understanding of FGM and HP and that these acts are abusive, as well as to shift cultural attitudes towards these practices.

Appendix 1: The NFGMC's theory of change

Current reality	Changing frontline practice	Outcome for local authorities	Long-term benefits
<p>Growing number of reported cases in England of children experiencing harmful practices as FGM, breast flattening, CALFB, forced marriage and "honour"-base abuse Professional cultural Incompetence leading to children not being safeguarded Complex social and cultural dimensions to preventing new cases and supporting survivors Multi-faceted , acute and long-term harmful effects of harmful practices (HP) on individual's health and wellbeing. Increasing cost to statutory services to meet the needs of survivors and train staff</p> <p>A fragmented, inconsistent response Lack of coordination within agencies and across professionals interacting with those affected with HPs Lack of knowledge skills and confidence among professionals in identifying and responding to HPs Multi-agency network struggle to respond appropriately where culture and ethnicity intersect with safeguarding concerns Inappropriate understanding of thresholds when responding to HPs cases Poor strategic response to tackling HPs</p> <p>A lack of sustainable, community led change Lack of understanding of prevalence at a local level Low Trust and engagement from community and faith groups and chance to lead change Low reporting of cases by communities of HP</p>	<p>Developing understanding of what works when responding to cases of HPs and working effectively where culture, ethnicity and faith feature Providing tools and resources to improve practice and supporting professionals to identify cases Develop understanding of how HPs are connected with issues of adverse childhood experiences, trauma and poly-victimisation Listening to and involving children affected by HPs Co-production at the centre of strategic response to tackle harmful practices</p> <p>Outcomes for families and communities Families and communities are more aware of HP as a safeguarding issue and engaged to tackle it Families and communities are empowered to work with statutory agencies and lead the change in relation to HP Families and communities given opportunities to support professionals with having cultural encounters</p> <p>Outcomes for professionals Professionals are better informed about HPs through access to quality assured resources Professionals have increased skills for working with children, parents and communities and are more confident in identifying and responding to HPs Professionals are more confident in assessing how ethnicity, culture and faith interact with safeguarding</p>	<p>LAs are more able to provide timely, consistent and appropriate responses to children and families at risk of or affected by HPs LAs are better able to meet inspection requirements for children's safeguarding Schools are equipped to teach FGM, forced marriages and "honour"-based abuse as part of the new RSE curriculum LAs have a better understanding of what works when implementing system-change in social work around HPs LAs adopt the model delivered by specialist workers LAs are more able to implement a cost-effective model of working to prevent HP cases from being managed incorrectly Workforce able to develop a set of congruent behaviours, attitudes and policies that enables staff to work across cultures and faiths</p> <p>Innovative system-change in response to HPs and improving cultural competence More effective multi-agency working to prevent, protect and support children and young people affected by HPs in order to develop sustainable services Increased awareness and implementation of best practice for tackling HPs Services are responsive to the beliefs, practices and cultural and linguistic needs of diverse communities</p>	<p>Impact for children and young people Children and young people having a greater understanding of their rights and how to keep themselves safe from HPs Children and young people at risk of or affected by HP are identified and have access to high-quality protection and support Improved social, emotional and physical well-being of children and young people at risk or affected by HPs Children and young people's cultural and ethnic identity are appropriately assessed, and used as a protective factor</p> <p>Impacts for families and communities Families, communities and community leaders are involved in effective change in their communities Families receive appropriate and co-ordinated response from agencies and know where to access support services Community organisations are able to challenge and address HPs with confidence and skill as a result of more effective models of community work</p> <p>Impact for local authorities LAs have a robust process in place to identify children and young people at risk of or affected by HPs Centre's model delivers cost-effective and high-quality solution for LAs in their response to HPs</p> <ul style="list-style-type: none"> • Savings in health, social care and legal costs • A sustainable response to HPs • End of new cases of target HPs and developing effects

Appendix 2: Level of NFGMC intervention in Round 1 local authorities

Level of NFGMC intervention (based on NFGMC's categorisation) between Sept 2015 to March 2017

Level of intervention	Round 1 Local Authorities			
	Essex	Hertfordshire	Thurrock	Total
Level 1: Indirect advice to referrer	15	4	1	20
Level 2: Direct advice and guidance to referrer	28	5	6	39
Level 3: Assessment and/or direct work with family	6	22	16	44
Level 4: High risk, long term direct work	0	1	1	2
Total	49	32	24	105

Level of NFGMC intervention (based on the NFGMC's categorisation) between July 2018 and February 2020

Level of intervention	Round 1 Local Authorities			
	Essex	Hertfordshire	Thurrock	Total
Level 1: Indirect advice to referrer	9	12	0	21
Level 2: Direct advice and guidance to referrer	34	31	4	69
Level 3: Assessment and/or direct work with family	17	8	18	43
Level 4: High risk, long term direct work	2	2	6	10
Total	62	53	28	143

Appendix 3: Data on FGM and abuse linked to faith and belief in Round 1

Round 1 local authorities that have retained NFGMC workers and their statistical neighbours	Factors identified at the end of the assessment (year ending 31 March)					
	Female Genital Mutilation			Abuse linked to faith or belief		
	2016-17	2017-18	2018-19	2016-17	2017-18	2018-19
Essex	X	X	X	X	X	22
Kent	7	12	9	24	31	28
Central Bedfordshire	0	3	7	0	0	3
Staffordshire	22	12	3	0	19	22
Hertfordshire	10	11	28	29	26	32
Hampshire	X	X	X	X	X	11
Oxfordshire	7	13	9	12	7	18
Buckinghamshire	7	0	0	6	11	0
Thurrock	X	X	X	10	13	9
Bexley	6	6	16	14	20	11
Dudley	60	28	21	14	8	3
Telford and Wrekin	0	X	X	8	11	3

Source: Department for Education (2017, 2018a, 2019) Characteristics of Children in Need. London: Department for Education

X = between 1 and 5 case

Appendix 4: Data on FGM and abuse linked to faith and belief in Round 2

Round 2 local authorities with NFGMC workers and comparator local authority and their statistical neighbours	Factors identified at the end of the assessment (year ending 31 March)					
	Female Genital Mutilation			Abuse linked to faith or belief		
	2016-17	2017-18	2018-19	2016-17	2017-18	2018-19
Brent	31	39	16	7	X	12
Ealing	15	12	6	14	25	18
Waltham Forest	0	6	X	X	10	6
Haringey	0	X	X	X	11	12
Harrow	10	X	12	X	9	8
Redbridge	12	0	0	22	45	18
Hounslow	6	8	X	X	14	8
Ealing	15	12	6	14	25	18
Redbridge	12	0	0	22	45	18
Hillingdon	X	X	13	24	X	6
Hounslow	6	8	3	0	14	18
Ealing	15	12	6	14	25	18
Leeds (Comparator/No NFGMC worker)	21	64	40	42	28	63
Sheffield	18	28	24	21	25	26
Darlington	0	0	X	0	0	X
Calderdale	0	X	0	X	6	8

Source: Department for Education (2017, 2018a, 2019) Characteristics of Children in Need. London: Department for Education

X = between 1 and 5 case

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