Berkshire Local Safeguarding Children Boards

Data and Information Sharing Agreement for Agencies Working with Children and Young People

February 2017

CONTENTS

This document is broken down into three separate parts:

1. Part 1 is the overarching Information Sharing Agreement which is approved by partners of the six Berkshire Local Safeguarding Children Boards.

2. Part 2 is the template for the development of a local Information Sharing Agreement to support the delivery of multi-agency work at an operational level, or to support specific multi-agency service delivery activity.

3. Part 3 consists of annex documents with additional information for practitioners.

PART 1 – INFORMATION SHARING AGREEMENT

1. INTRODUCTION

Information sharing within Berkshire services for children, young people and families

Sharing information is key to the goal of delivering better, more efficient public services that are coordinated around the needs of the individual, families and communities. It is essential to enable early intervention and preventative work, for safeguarding and promoting welfare of children and young people and for wider public protection. Information sharing is a vital element of improving outcomes for all.

Each time a Serious Case Review is published there is always a shortfall in the practice and process of sharing information between agencies which have led to failures in protecting the child. Continuous recommendations are made that systems are put in place in every local authority area to ensure that information about children and young people can be shared appropriately within and between agencies.

This Agreement provides a framework for agencies to share information about children, young people and families who are receiving services or for whom they have a concern and to support information sharing to develop services to support children, young people and families. It sets out the principles for sharing information and gives the legal context in which we share information.

If there are concerns that a child or an adult may be at risk of significant harm, then it is your duty to follow the relevant procedures without delay. Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

Principles for Information Sharing – Seven Golden Rules from HM Government

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You should go **ahead** and share information without consent if, in your judgement, that lack of consent can be overridden in the public interest, or where a child is at risk of significant harm. You will need to base your judgement on the facts of the case.

5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the **information** you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Key Points on Information Sharing

1	You must explain to children, young people and families at the onset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. *The exception to this is where to do so would put that child, young person or others at risk of significant harm or an adult at risk of significant harm, or if it would undermine the prevention, detection or prosecution of a serious crime, including where seeking consent might lead to interference with any potential investigation.*
2	You must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration.
3	You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information if, in your judgement based on the facts of the case, there is sufficient need to override that lack of consent.
4	You should seek advice where you are in doubt, especially where your doubt relates to a concern about possible significant harm to a child or serious harm to others.
5	You should ensure that the information you share is relevant, accurate and up to date, necessary for the purpose for which you are sharing it, shared only with those people who need to see it and shared securely.
6	You should always record the reasons for the decision, whether it is to share information or not.

Good information sharing is based on good recording practice. Records should be accurate, relevant, kept up to date, and kept for no longer than is necessary for their purpose. An audit trail of requests made and disclosures given will provide a record of events if required in the case of investigations or local inspections

Sharing information to support children

When there are child protection concerns consent is desirable but not necessary. The information needs to be proportionate. Each Local Authority will have developed an information sharing agreement for their Multi-Agency Safeguarding Hub (MASH), please contact your local MASH for further information.

There is an increasing emphasis on integrated working across children's services so that support for children, young people and families is provided in response to their needs. The aim is to deliver more effective intervention at an earlier stage to prevent problems escalating and to increase the chances of a child or young person achieving positive outcomes.

Whether the integrated working is across existing services or through specific multi-agency structures, success depends on effective partnership working between universal services (such as education and primary health care) and targeted and specialist services for those children, young people and families at risk of poor outcomes.

Preventative services working in this way will be more effective in identifying concerns about significant harm, for example, as a result of abuse or neglect. However, in most situations children, young people and family members will require additional services in relation to education, health, behaviour, parenting or family support, rather than intervention to protect the child or young person from harm or to prevent or detect serious crime.

Effective preventative services of this type will usually require active processes for identifying children and young people at risk of poor outcomes, and passing information to those delivering targeted support. Practitioners sometimes express concern about how this can be done lawfully.

Statutory guidance **Working Together to Safeguard Children (2015)** states that effective sharing of information is essential for effective identification, assessment and service provision. It also states that early sharing of information is the key to providing effective early help where there are emerging problems.

Specific information sharing guidance has been developed by health partners – Female Genital Mutilation and Child Sexual Exploitation.

			
Female_Genital_Mutilation_GL837_V6.1.pc	Management of Female Genital Mutilat	FGM_Decision_Making_and_Action_Flowcl	Information sharing for CSE RBFT FINAL.P
Appendix 1	Appendix 2	(included in Appx 1)	Appendix 3

There are clear statutory requirements to share information in the event of a child death. For more information please see the Berkshire Child Death Overview Panel (CDOP) website: **http://www.westberkslscb.org.uk/professionals-volunteers/cdop/**

Sharing data and information to support organisations in their duty to safeguard

This list is not exhaustive.

- Flagging on IT systems – children with Child Protection plans and Looked After Children
- Provision of appropriate care services
- Monitoring and protecting public health, improving the health of the population
- Managing and planning services (where data has been suitably anonymised)
- Commissioning and contracting services (where data has been suitably anonymised)
- Developing inter-agency strategies
- Performance management, audit and quality assurance
- Research (subject to the Research Governance Framework)
- Investigating complaints or serious incidents
- Reducing risk to individuals, service providers and the public as a whole e.g. Domestic Abuse data with Community Safety Officers
- Staff management and protection e.g. Local Authority Designated Officer (LADO)
- Statutory inspections

2. LEGAL CONTEXT OF INFORMATION SHARING

There is no general statutory power to share information, just as there is no general power to obtain, hold or process data. The Data Protection Act 1998 governs the obtaining, holding and processing of personal information while some Acts of Parliament give public bodies 'express statutory powers' to share information. These are often referred to as 'statutory gateways' and are enacted to provide for the sharing of information for particular purposes.

The Human Rights Act 1998 and the European Convention of Human Rights

The European Convention on Human Rights has been interpreted to confer positive obligations on public authorities to take reasonable action within their powers (which would include information sharing) to safeguard the Convention rights of children. These rights include Article 8, and recognise a right to respect for private and family life:

Common law duty of confidentiality

The common law duty of confidentiality requires that unless there is a statutory requirement to use

information that has been provided in confidence, it should only be used for purposes that the subject has been informed about and consented to.

Data Protection Act 1998

This Act deals with the processing of personal (i.e. sensitive and non-sensitive) data. Personal data is data which relates to a living person, including the expression of any opinion or any indication about the intentions in respect of the child or young person is considered personal data. Sensitive personal data is personal data relating to racial or ethnic origin, religious or other similar beliefs, physical or mental health or condition, sexual life, political opinions, membership of a trade union, the commission or alleged commission of any offence, any proceedings for any offence committed or alleged to have been committed, the disposal of proceedings or the sentence of any court in proceedings. Organisations which process personal data must comply with the data protection principles set out in schedule 1 of the Act.

Specific legislation containing express powers or which imply powers to share

The Children Act 1989

Sections 17 and 47 of the Children Act 1989 place a duty on local authorities to provide services for children in need and make enquiries about any child in their area who they have reason to believe may be at risk of significant harm. Sections 17 and 47 also enable the local authority to request help from other local authorities, education and housing authorities and NHS bodies and places an obligation on these authorities to co-operate. The Act does not require information to be shared in breach of confidence, but an authority should not refuse a request without considering the relative risks of sharing information, if necessary without consent, against the potential risk to a child if information is not shared.

The Children Act 2004

Section 10 of the Act places a duty on each Children's services Authority to make arrangements to promote co-operation between itself and relevant partner agencies to improve the well-being of children and young people from pre-birth to 19 years (25 in case of those with disabilities) in their area. Relevant partners must cooperate with the local authority to make arrangements to improve children's wellbeing. This statutory guidance for section 10 states that good information sharing is key to successful collaborative working and that arrangement under section 10 of the Act should ensure that information is shared for strategic planning purposes and to support effective service delivery. It also states that these arrangements should cover issues such as improving the understanding of the legal framework and developing better information sharing practice between

and within organisations.

Section 11 of the Act places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The section 11 duty does not give agencies any new functions, nor does it override their existing functions, it simply requires them to:

- Carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children;
- Ensure that the services they contract out to others are provided having regard to that need.

In order to safeguard and promote the welfare of children, arrangements should ensure that:

- All staff in contact with children understand what to do and the most effective ways of sharing information if they believe a child and family may require targeted or specialist services in order to achieve their optimal outcomes;
- All staff in contact with children understands what to do and when to share information if they believe that a child may be in need, including those children suffering or at risk of significant harm.

Education Act 2002

The section 11 duty of the Children Act 2004 mirrors the duty placed by section 175 of the Education Act 2002 on LAs and the governing bodies of both maintained schools and further education institutions to make arrangements to carry out their functions with a view to safeguarding and promoting the welfare of children and follow the guidance in Safeguarding Children in Education (DfES 2004). The guidance applies to proprietors of independent schools by virtue of section 157 of the Education Act 2002 and the Education (Independent Schools Standards) Regulations 2003.

Education Act 1996

Section 13 of the Education Act 1996 provides that an LA shall (so far as their powers enable them to do so) contribute towards the spiritual, moral, mental and physical development of the community, by securing that efficient primary and secondary education is available to meet the needs of the population of the area. Details of the number of children in the local authority's area and an analysis of their needs is required in order to fulfil this duty so there may be an implied power to collect and use information for this purpose. Section 434 (4) of the Act requires LAs to request schools to provide details of children registered at a school.

Learning and Skills Act 2000

Section 117 provides for help to a young person to enable them to take part in further education and

training. Section 119 enables Connexions services to share information with the Benefits Agency and Jobcentre Plus to support young people to obtain appropriate benefits under the Social Security Contributions and Benefits Act 1992 and Social Security Administration Act 1992.

Education (SEN) Regulations 2001

Regulation 6 provides that when the LEA are considering making an assessment of a child's special educational needs, they are obliged to send copies of the notice to social services, health authorities and the head teacher of the school (if any) asking for relevant information. Regulation 18 provides that all schools must provide Connexions Services with information regarding all Year 10 children who have a statement of special educational needs.

Children (Leaving Care) Act 2000

The main purpose of the Act is to help young people who have been looked after by a local authority move from care into living independently in as stable a fashion as possible. To do this it amends the Children Act 1989 (c.41) to place a duty on local authorities to assess and meet need. The responsible local authority is to be under a duty to assess and meet the care and support needs of eligible and relevant children and young people and to assist former relevant children, in particular in respect of their employment, education and training. Sharing information with other agencies will enable the local authority to fulfil the statutory duty to provide after care services to young people leaving public care.

Protection of Children Act 1999

The Act creates a system for identifying persons considered to be unsuitable to work with children. It introduces a 'one stop shop' to compel employers designated under the Act (and allows other employers) to access a single point for checking people they propose to employ in a child care position. This will be achieved by checks being made of criminal records with the National Criminal Records Bureau and two lists maintained by the Department for Children, Schools and Families.

Immigration and Asylum Act 1999

Section 20 provides for a range of information sharing for the purposes of the Secretary of State:

- To undertake the administration of immigration controls to detect or prevent criminal offences under the Immigration Act;
- To undertake the provision of support for asylum seekers and their dependents.

Local Government Act 2000

Part 1 of the Local Government Act 2000 gives local authorities powers to take any steps which they consider are likely to promote the wellbeing of their area or the inhabitants of it. Section 2 gives local authorities 'a power to do anything which they consider is likely to achieve any one or more of the following objectives:

- The promotion or improvement of the economic wellbeing of their area;
- The promotion or improvement of the social wellbeing of their area;
- The promotion or improvement of the environmental wellbeing of their area.

Section 2 (5) makes it clear that a local authority may do anything for the benefit of a person or an area outside their area, if the local authority considers that it is likely to achieve one of the objectives of Section 2(1). Section 3 is clear that local authorities are unable to do anything (including sharing information) for the purposes of the wellbeing of people - including children and young people - where they are restricted or prevented from doing so in the face of any relevant legislation, for example, the Human Rights Act and the Data Protection Act or by the common law duty of confidentiality.

Criminal Justice Act 2003

Section 325 of this Act details the arrangements for assessing risk posed by different offenders:

- The "responsible authority" in relation to any area, means the chief officer of police, the local probation board and the Minister of the Crown exercising functions in relation to prisons, acting jointly.
- The responsible authority must establish arrangements for the purpose of assessing and managing the risks posed in that area by:
    - **a.** Relevant sexual and violent offenders; and
    - **b.** Other persons who, by reason of offences committed by them are considered by the responsible authority to be persons who may cause serious harm to the public (this includes children).
- In establishing those arrangements, the responsible authority must act in co-operation with the persons identified below. Co-operation may include the exchange of information.

Crime and Disorder Act 1998

Section 17 applies to a local authority (as defined by the Local Government Act 1972); a joint authority; a police authority; a national park authority; and the Broads Authority. As amended by the Greater London Authority Act 1999 it applies to the London Fire and Emergency Planning Authority from July 2000 and to all fire and rescue authorities with effect from April 2003, by virtue of an amendment in the Police Reform Act 2002. It recognises that these key authorities have responsibility for the

provision of a wide and varied range of services to and within the community. In carrying out these functions, section 17 places a duty on them to do all they can to reasonably prevent crime and disorder in their area.

National Health Service Act 1977

The Act provides for a comprehensive health service to England and Wales to improve the physical and mental health of the population and to prevent diagnose and treat illness. Section 2 provides for sharing information with other NHS professionals and practitioners from other agencies carrying out health service functions that would otherwise be carried out by the NHS.

Health Act 1999

Section 27 of the Health Act replaces section 22 of the NHS Act 1977. Section 27 states that NHS bodies and local authorities shall cooperate with one another (this allows for practitioners to share information) in order to secure the health and welfare of people.

Health and Social care Act 2012

The Health and Social Care Act 2012 underpins wide ranging reforms of the NHS since it was founded in 1948. Changes include the establishment of a National Health Service Commissioning Board and Clinical Commissioning Groups, as well as Health and Wellbeing Boards. The changes became operational on 1st April 2013. The Act sets out provision relating to public health in the United Kingdom; public involvement in health and social care matters; scrutiny of health matters by local authorities and co-operation between local authorities and commissioners of health care services. The Act establishes a National Institute for Health and Care Excellence, and establishes the provision for health and social care. The clinical commissioning organisations established by the Act must have a secure legal basis for every specific purpose for which they wish to use identifiable patient data. Where there is no such statutory legal basis either the consent of the patient is required to process personal confidential data or the data must be fully pseudonymised.

The Adoption and Children Act 2002

For further information about the Adoption and Children Act 2002 and Regulations see www.education.gov.uk/childrenandyoungpeople/families/adoption

3. BERKSHIRE DATA AND INFORMATION SHARING AGREEMENT

Partners to this Agreement

This Information Sharing Agreement has been approved by all partner members of the six Berkshire Local Safeguarding Children Boards.

Purpose

The aim of this agreement is to facilitate the lawful exchange of personal and sensitive data in any form, within and between organisations for notified and defined purposes, respecting the rights of individuals set out in legal acts and common law. When the records of deceased people are required by their relatives or other parties, ethical and confidentiality issues will be safeguarded in the same way as if the person was living.

The public expects and the Data Protection Act 1998 requires that personal information held by statutory agencies will be properly protected. However, there is also a public expectation that there will be an appropriate sharing of information in working in partnerships for specific pieces of work with statutory obligations.

The purpose of sharing information between partner organisations is to:

- Ensure the provision of appropriate services for children and young people in need or at risk or likely to be at risk of suffering significant harm: sections 17 (10) and 47 (1) of the Children Act 1989 - or who otherwise are considered to be at risk of social or educational exclusion.
- Obtain the assistance for the local authority from other local authorities, in order for the local authority to perform its functions of providing services to children, young people and families under Part 111, Section 27, Children's Act 1989.Promote or improve the economic, social or environmental well being of children, young people and families in need in Bracknell Forest. This will include the provision of improvements to health and/or educational opportunity as well as the reduction or elimination of risk factors for children and young people within the city.
- Prevent or reduce crime and identify and apprehend offenders or suspected offenders Section 115, Crime and Disorder Act 1998.
- Ensure that children and young people who are missing education or at risk of going missing from education, are identified and supported.
- Provide information to assist in the planning and development of services for children and young people.
- Provide information for statistical analysis.

By sharing information, partner organisations will be able to identify children and young people considered to be in need or at risk of social or educational exclusion at an early stage of concern and provide effective multi-agency intervention in order to promote their health and well-being. Nominated representatives from organisations which are signatories to this agreement will be engaging in regular, multi-agency discussions in order to secure services for identified children, young people and their families.

The type and extent of information to be shared

Routine information sharing:

The information shared will be the minimum amount necessary; it will be relevant and only used for the purposes of this agreement. This is necessary to ensure compliance with the second and third principles of the Data Protection Act 1998:

Principle 2: "Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes".

Principle 3:" Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed."

Anonymised information: Whenever possible data should be anonymised, if large volumes of data is provided for Management Information (MI), research and/or planning by partner organisations, as a matter of courtesy the outcome of that research/planning should be provided to the organisation(s) supplying the data.

Data Sharing Categories

Aggregated/Statistical Information - aggregate and management information to plan and monitor progress of the service. This information can be shared without client consent.

De-Personalised/Anonymous Information - Individual level information may be depersonalised/ anonymised by the removal of any client identifiable information (such as name, address, unique identifiers, etc) and therefore outside the ambit of the Data Protection Act 1998, then shared by organisations within the context of this protocol. This information can be shared without client consent.

Personal Non Confidential/Non Sensitive Information - Information needed to identify and maintain contact with all clients in order to provide an effective service, such as Name, Address and Date of Birth. This information may be shared with the Informed Consent of the client.

Personal Confidential/Sensitive Information - Information needed to provide comprehensive support to clients and can be subdivided into broad categories:

Confidential - This information deemed to be 'professionally' sensitive, such as client characteristics (e.g. homeless, substance misuse, etc), assessment data or opinions.

Sensitive - This is information defined within the Data Protection Act 1998 as sensitive such as ethnicity, religious beliefs, criminal procedures or health related issues.

Confidential and/or sensitive information cannot be shared unless the client has given their Explicit Consent. There is other overriding legislation and exceptional circumstances.

Data Quality

Information held must be accurate and kept up to date. Steps must be taken to validate information, such as checking with the person who originally provided the information, if there is any doubt as to its accuracy. Sharing inaccurate information can lead to decisions being made on false information. Data owners will ensure they amend any incorrect details and inform partners of the correct information. Information discovered to be inaccurate, out-of-date or inadequate for the purpose should be notified to the Data Controller who will be responsible for correcting the data and notifying all other recipients of the information who must ensure the correction is made.

Designated Officer

In order to ensure compliance with the Data Protection Act, participants to this Agreement shall nominate a Designated Officer to whom all requests and from whom all disclosures of personal information will be made. Disclosure requests, disclosure decisions and the details of personal information that has been disclosed will be in writing and the designated officer will maintain a record. The identity of the data owner must also be recorded against the relevant data. No secondary use or other use may be made unless the consent of the disclosing party to that secondary use is sought and obtained.

Information discovered to be inaccurate or inadequate for the purpose will be notified to the data owner who will be responsible for correcting the data. The data owner will then notify all other recipients of that data, who must ensure that the correction is applied. Decisions on disclosures reached at meetings must be minuted.

The designated officer will ensure that appropriate security arrangements are in place within their respective organisations to prevent unauthorised access to and disclosure of personal data. A list of designated officers will assume responsibility for data protection, security and confidentiality issues and compliance with legislation within their respective organisations will be made available to partner organisations as a matter of routine.

Disclosures and Transfer of Information

Where information is shared, disclosed or exchanged requests for information will be specific to the purpose, recorded and made on a need to know basis. When disclosing personal information, many of the data protection issues surrounding disclosure can be avoided if the consent of the individual concerned has been sought and obtained. The organisation that originally discloses personal information to another party to this Agreement always retains ownership of the data (the data owner), each organisation must therefore decide the propriety of any particular disclosure. The identity of the

data owner must always be recorded against that data.

A recipient of personal information must obtain the consent of the data owner before making a secondary disclosure to another party to this Agreement. For the purpose of this requirement, each council department will be treated as a separate organisation.

Partner organisations will have appropriate information systems and records about information transfers. These records should cover when information has been given, when it has been refused and what medium has been used, including paper, electronic and conversational. The records should also cover the disposal and amendment of information. Where information is exchanged on a case by case basis, it should be ensured that requests are specific and recorded. Disclosure of information should be authorised by the appropriate personnel and should be provided on a need to know basis only. This "need to know" principle is a fundamental part of ensuring information is shared appropriately and is in compliance with the Data Protection Act 1998.

Data retention, review and disposal

Partner organisations will apply relevant regulations and timescales to the retention, review and disposal of information, (electronic and paper based), only keeping information for as long as is necessary in relation to the original purpose

Appropriate Security

General

The partners to this agreement acknowledge the security requirements of the Data Protection Act 1998 applicable to the processing of the information subject to this agreement. Each partner will make sure they take appropriate technical and organisational measures against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data. In particular, each partner must make sure they have procedures in place to do everything reasonable to:

- Make accidental compromise or damage unlikely during storage, handling, use, processing transmission or transport.
- Deter deliberate compromise or opportunist attack.
- Dispose of or destroy the data in a way that makes reconstruction unlikely.
- Promote discretion to avoid unauthorised access.

Access to information subject to this agreement will only be granted to those professionals who 'need to know' to effectively discharge their duties.

Additional arrangements

To determine what security measures are appropriate in any given case, partners must consider the type of data and the harm that would arise from a breach of security. Information obtained in confidence may be regarded as requiring a higher level of security. In particular, they must consider:

- Where the information is stored.
- The security measures programmed into the relevant equipment.
- The reliability of employees having access to the information.

Complaints and breaches

All complaints or breaches relative to this agreement will be notified to the designated Data Protection Manager of the relevant organisation in accordance with their respective policy and procedures. Partner organisations will need to have appropriate arrangements to:

- Tackle any breach of agreement.
- Handle internal discipline.
- Monitor security incidents.
- Deal with malfunctions.

Indemnity

In return for the provision of any information by a partner organisation to another (the Receiving Partner) under the terms of this Agreement, the Receiving Partner undertakes to indemnify the Partner that provided the information in respect of all claims and liabilities arising from the use of the information by the Receiving Partner or it's failure to comply with its obligations under the Agreement.

Subject Access Requests

All Subject Access Requests must be made in writing to the relevant data controller and the subsequent actions taken must be fully recorded within the organisation's system. Information obtained from a partner organisation without the prior consent of the data subject cannot be disclosed to that individual without the agreement of the originating organisation. This does not prevent the individual making a separate Subject Access Request to the originating partner organisation. Agencies must make sure that data will be received by the requester no later than 40 days from receipt of request.

Children under 12 years of age

When a child does not have the capacity to understand the request, a parent/ guardian/carer can make a Subject Access Request in respect of their child. Information on consent and Fraser competence guidelines are attached as annex 1 of this document.

Parent/guardian/carer

Parents/guardians/carers of individuals with sufficient understanding of their rights have no automatic rights of access to the subject's data (in accordance with Data Protection Act 1998) It is considered good practice to ensure that the parent/guardian/carer of those under 16 years old is informed that the gathering, recording and possible sharing of information is taking place.

Parents/guardians/carers will normally only be able to access an individual's data (if they are deemed competent) with the signed consent of the subject. All parent/guardian/carer requests to access data must be referred to the designated manager within the relevant organisation. Access may be granted in cases where the designated manager is satisfied that an individual is not capable of representing themselves and that the parent/guardian/carer constitutes the client's legitimate representative. Where a Subject Access Request has been granted to the parent/guardian/carer the reasons for doing so must be fully recorded and clearly referenced to the evidence and information on which the decision is made

Freedom of Information Act considerations

If a party receives a request for information under the Freedom of Information Act 2000 and the information requested is identified as belonging to another signatory party, it will be the responsibility of the receiving agency to contact that party to determine whether the latter wishes to rely on any statutory exemption under the provisions of the Freedom of Information Act 2000 and to identify any perceived harm.

General operational guidance

Partner organisations must consider the staff time and resource implications that are involved for the Data Controller extracting the data. If a request is made and then the data is no longer required there should be a process for withdrawing the request. Partner organisations to this agreement will need to identify:

- A named individual to lead on the Agreement
- How they will champion training on the Agreement.

Partners will work within the accompanying Operational Agreement and Arrangements governing the collection, transfer, storage and disposal of information.

Review Arrangements

This Information Sharing Agreement will be formally reviewed annually unless legislation or government guidance necessitates an earlier review. Any of the signatories to the Agreement can request an extraordinary review at any time where a joint discussion or decision is necessary to

address local service developments.

Closure/termination of agreement

Any partner organisation can suspend the Information Sharing Agreement for 30 days, if they feel that security has been seriously breached. This should be done in writing and evidence provided. Any suspension will be subject to a risk assessment and resolution meeting, comprising of the signatories of this agreement or their nominated representative. This meeting will take place within 14 days of any suspension.

Signatories to this Agreement:

The Agreement was signed off by the six Berkshire LSCBs on the following dates:

LSCB Area	Date
Bracknell Forest	25th November 2016
Reading	26th May 2016
Royal Borough of Windsor and Maidenhead	7th December 2016
Slough	10th November 2016
West Berkshire	September 2016
Wokingham	26th October 2016

PART 2

Template for developing an Information Sharing Agreement on specific areas of work

SERVICE / PROJECT SPECIFIC INFORMATION SHARING AGREEMENT

(Put in here description of service of subject of agreement :)

PURPOSE OF THE AGREEMENT

The purpose of this agreement is to provide the framework to enable lawful exchange of personal and sensitive data in any form, within and between the specified organisations. This is an agreement between XXX and XXX. It is made under the auspices of the Berkshire Local Safeguarding Children Boards Data and Information Sharing Protocol for Agencies Working with children and Young People.

The Data Protection Act 1998 requires that personal information held by statutory agencies will be properly protected.

PARTIES TO THE AGREEMENT

The parties to this agreement are:

INFORMATION ABOUT THE SERVICE

(In this section the lead manager should provide details about the project / service and include: A clear statement of why there is a need to share information between the organisations party to this Information Sharing Agreement.)

DATA ITEMS TO BE SHARED

In this section specify:

- What data / information will be shared?
- How will the data / information be shared?
- How will the information be stored / secured?
- How will consent be gained (if appropriate) and how will this be recorded?
- If consent is not gained need to say why and record clearly.

Data Sharing Requests

(The service will have an agreed set of data that it will routinely share with the parties to this agreement in order to provide evidence of performance management linked to the service objectives / targets). (Where data is being requested of the service which is in addition to the data agreed by all parties a data request form will be completed and returned to xxxxxxxxxxxxx).

A data request form is attached as annex 3

A decision will be made about the data request by the lead manager and will then be processed accordingly.

BASIS FOR SHARING INFORMATION

The Data Protection Act 1998 governs the obtaining, holding and processing of personal information while some Acts of Parliament give public bodies express statutory powers to share information.
For the purpose of this framework the key legislation informing the work of the XXX includes:

- *Insert here the key legislation that underpins the service being provided*.

ACCESS AND INDIVIDUALS RIGHTS

(Lead manager to determine who will have access to the information within the parties signed up to the agreement). (Where a project is hosted by one agency/authority the service will operate under the policies and procedures of the host agency/authority.)

Freedom of Information Requests

The parties in this agreement are subject to legal duties under the Freedom of Information Act and any other applicable legislation governing access to information. Each party in the agreement will assist the others to enable compliance with the obligations. All parties in the agreement are entitled to any and all information relating to the performance of the agreement.

INFORMATION GOVERNANCE

Governance of the service will be the responsibility of the Lead Manager/Management Board who will be responsible for the agreement of service delivery outputs and outcomes and for monitoring all aspects of the service. *The following areas will need to be considered for this section:*

- Agreement about what datasets will be shared to ensure it is reasonable/and not too excessive.
- Looking at ways to ensure the quality of the data, and the accuracy of the data.

- Ensuring consistency of data recording and ensuring compliance with the data sharing agreement and policies and procedures.
- Agree the retention and destruction processes of shared items and a process for dealing with potential challenges if there is disagreement.
- Agree the security and storage arrangements and a process for dealing with any breaches.
- Agree a process for dealing with FOI and data requests.
- Agree a process for keeping data and information sharing under review.
- Agree timescales for review of agreement

INFORMATION SECURITY

The parties to this agreement acknowledge the security requirements of the Data Protection Act 1998 applicable to the processing of the information subject to this agreement. Each partner will make sure that they take appropriate technical and organisational measures against unauthorised or unlawful processing around personal data and against accidental loss or destruction of, or damage to, personal data. In particular each partner must ensure they have procedures in place to ensure that all reasonable steps are taken to:

- Make accidental compromise or damage unlikely during storage, handling, processing transmission or transport.
- Deter deliberate or opportunist attack.
- Dispose of or destroy the data in a way that makes reconstruction unlikely.
- Promote discretion to avoid unauthorised access.

Access to information subject to this agreement will only be granted to those professionals who "need to know" to effectively discharge their duties. To determine what security measures are appropriate in any given case, the parties to this agreement must consider the type of data and what risk /harm there would be in the event of a security breach. Key to the process is considering:

- Where the information will be stored
- The appropriate level of security measures within the ICT equipment
- The training of all staff in information security and data protection.

REVIEW ARRANGEMENTS

This Information Sharing Agreement will be reviewed by xxx at least annually and more frequently where there are significant changes to the service.

Information Sharing Agreement Signed

Name	Role	Organisation
Date Signed:		
First Review Date:		
Second Review Date:		

Part 3: Annex Information

Annex 1: Consent and Fraser Competence Guidelines

In many instances, you will seek consent to share information from the parent/ carer. This is particularly the case in work with younger children and in any interventions which include support work with the family. However in some cases the child/young person will be able to give consent without referral to their parent/carer. This is possible if they are judged to be Fraser Competent. Children under 16 should always be encouraged to involve their parent/carer unless to do so could put them at risk of harm. Particular care should be taken with children with a disability, who are sometimes wrongly assumed not to be able to give consent. The term, 'Fraser competent', arises from the case in the 1980s when Victoria Gillick attempted to set a legal precedent which would have meant that medical practitioners could not give young people under the age of 16 treatment or contraceptive services without parental permission. (Gillick vs West Norfolk and Wisbech Area Health Authority, 1985). The ruling was initially successful but then the House of Lords ruled that young people who are under 16 are competent to give valid consent to a particular intervention if they have sufficient understanding and intelligence to enable them to understand fully what is proposed and are capable of expressing their own wishes. Lord Fraser was the leading Law Lord for the review. Although the ruling was initially in regard to medical consent, it is now generally felt that the ruling applies to consent for other services.

Annex 2: Caldicott Principles

Caldicott Report 1997 – And the Caldicott 2 Review 2013

In December 2011 the Government announced that it wanted to allow patients' records and other NHS data to be shared with private life science companies, to make it easier for them to develop and test new drugs and treatments. Concerns were raised about what that might mean for patient confidentiality. This and other issues prompted the instigation of Caldicott 2, in which Dame Fiona was asked to review information issues across the health and social care system. Dame Fiona first investigated issues surrounding confidentiality when she chaired a similar review in 1996-7 on the use of patient data in the NHS. That review recommended that the NHS adopt six principles (see below) for the protection of confidentiality, which became known as the "Caldicott principles". The review also recommended that NHS organisations appoint someone to take responsibility for ensuring the security of confidential information. These people became known as "Caldicott Guardians". The reach of Caldicott 2 is far wider than the 1997 report. Its recommendations affect all organisations working in the health and social care sector – including local authorities. Its

recommendations, if adopted, will have a significant impact on the way that local authorities operate.

1. Justify the purpose(s) for using confidential information - Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.
2. Only transfer/use patient-identifiable information when absolutely necessary - Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose.
3. Use the minimum identifiable information that is required - Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.
4. Access should be on a strict need to know basis - Only those individuals who need access to patient-identifiable information should have access to it. They should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.
5. Everyone with access to identifiable information must understand his or her responsibilities - Action should be taken to ensure that those handling patient-identifiable information, both clinical and non-clinical staff, are made fully aware of their responsibilities and obligations to respect an individual's confidentiality.
6. Understand and comply with the law - Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

The new Caldicott principle

The duty to share personal confidential data can be as important as the duty to respect service user confidentiality. Registered social workers working with a patient should be considered to be part of the patient's care team. This means that the patient is taken as having given their implied consent to relevant information being shared with the social worker for the purpose of their care. Only the NHS and Social Care are required to apply these principles and to nominate a senior person to act as a Caldicott Guardian responsible for safeguarding the confidentiality of patient information.

Annex 3: Data Request Form in relation to xxx service / project

In requesting information and signing this request you are agreeing to comply with the principles of the Data Protection Act 1998. The Data Protection Act is not a barrier to sharing information, but provides a framework to ensure that personal information is shared appropriately and securely. All requests for information / data will be assessed against the rules for information sharing, and against relevant legislation and guidance, and where relevant legal advice will be sought before a decision is made to share.

Name of requester: ***(NB this is the person to whom the data/information will actually be sent)***	
Job Title:	
Organisation:	
Date request submitted:	
Deadline/date required: ***(NB Please be as realistic as possible or put 'to be discussed'. If you write 'asap' we will contact you anyway to discuss)***	
Tel:	
e-mail (if external): *(***Please note all information will be sent via electronic means through either GCSX or through an encrypted email, information will not be sent if it is considered insecure to do so)**	
Details of data/information required: ***(Please be as specific as possible about breakdown (e.g child/school/Borough level) and format (e.g spreadsheet map/chart etc) If spreadsheet ideally please supply a list of the headings you need or a template in Excel)***	
Frequency that data is required *(***Please specify if this is a one off request or**	

if this is a regular requirement, and note that this will be kept under review to ensure ongoing data protection compliance)	
Purpose data will be used for: ***(this will not only enable us to prioritise requests but also help us understand and***	
Confidentiality /Data Protection? ***(Is the information likely to lead to anyone being identifiable? Where will it be stored once it is sent to you?)***	
Any additional information? ***(e.g is this for an FOI request? Is it a statutory requirement? Is the request a one-off or a regular requirement?)***	

Please submit your data request to:

Xxxxxxxx

Email address:

Annex 4: Useful Information Links

HM Government: Information Sharing: Advice for Practitioners providing safeguarding services to children, young people, parents and carers.	**https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice**
Information Commissioners Office (ICO)	**https://ico.org.uk/**
NHS: Inter-agency information sharing protocol	**http://www.this.nhs.uk/fileadmin/IG/interagency-information-sharing-protocol.pdf**

Royal Berkshire NHS
NHS Foundation Trust

Female Genital Mutilation (circumcision) guideline (GL837)

Approval

Approval Group	Job Title, Chair of Committee	Date
Maternity & Children's Services Clinical Governance Committee	Chair, Maternity Clinical Governance Committee	13th November 2015

Change History

Version	Date	Author, job title	Reason
1.0	2004	Jill Ablett (Consultant Obstetrician), Marianne Flynn (Midwife)	Trust requirement
2.0	Oct 2007	Jill Ablett (Consultant Obstetrician)	Reviewed
3.0	Nov 2010	Jill Ablett (Consultant Obstetrician)	Reviewed
4.0	Dec 2012	Jill Ablett (Consultant Obstetrician)	Reviewed
5.0	February 2014	D Parris, Specialist Midwife for Domestic Abuse & Social Inclusion	Change to process and documentation required
6.0	Oct 2014	Jill Ablett (Consultant Obstetrician), Leila Rushamba (SAS Obstetrics & Gynaecology)	Reviewed in line with National guidance
6.1	Oct 2015	Leila Rushamba (SAS Obstetrics & Gynaecology)	Reviewed in line with new National guidance and Legislation

***Overview**: Female genital mutilation can have profound effects on childbirth. Sensitive management is essential.*

What is Female Genital Mutilation?

Female Genital Mutilation, (FGM), is the intentional alteration or injury to the female genital organs for non-medical reasons. This can be divided into four different types;

Type 1 – Removal of all or part of the clitoris (a small, sensitive and erectile part of the female genitals), sometimes removing the skin fold around the clitoris

Type 2 – Removal of the clitoris with all or part of the inner labia (lips), with or without cutting of the outer labia of the female genitals. .

Type 3 – (Infibulation) Narrowing of the vaginal opening through the creation of a covering seal by cutting and repositioning the inner and outer labia with or without removal of the clitoris

Type 4 – all other harmful procedures for non- medical reasons, including pricking, piercing, incising, scraping and cauterising the genital area.

Law in the UK

1. FGM is illegal unless it is a surgical operation on a girl or woman irrespective of her age:
    a. which is necessary for her physical or mental health; or
    b. she is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.
2. It is illegal to arrange, or assist in arranging, for a UK national or UK resident to be taken overseas for the purpose of FGM.
3. It is an offence for those with parental responsibility to fail to protect a girl from the risk of FGM.

Antenatal care

Legal responsibility of the health professional once a woman with FGM is identified:

1. Mandatory Data Recording

- FGM and FGM type (if known or genital examination was performed) must be clearly documented in the medical records.
- Genital piercings should be classified as type 4 FGM in accordance with the WHO FGM classification.

- Use the FGM recording tool (Appendix 1) to record further details in accordance with the HSCIC FGM Enhanced Dataset. This information will be used by the reporting lead to report to the Department of Health.
- Explain to the woman that her personal data will be transmitted to the HSCIC for the purpose of FGM prevalence monitoring and that the data will be anonymised at the time of publication. Explicit patient consent is not required however FGM patient information leaflet MUST be given.

- If a patient raises an objection at time of discussion, the responsible clinician must inform the FGM team. This must be noted on the FGM recording tool.

- If the objection is not raised at this point, and the patient's information is submitted, the patient must be advised to contact HSCIC to raise an objection at the following website:

http://www.hscic.gov.uk/media/14700/Preventing-the-use-of-yourinformation-for-health-andor-social-care-purposes-other-than-directcare/pdf/Preventing_Use_of_Your_Information_Form.pdf

This will automatically remove her information from the dataset.

NB: Reporting to the Department of Health is mandatory with each encounter not only at first attendance.

2. Mandatory Reporting Duty

- If the woman is under 18, urgent referral to the police as soon as possible after a case is discovered. The best practice is to reports by the close of the next working day. A maximum timeframe of one month from when the discovery is made applies in cases where further advice from safeguarding team is required.
- Report by **calling 101**, the single non-emergency number. Explain that you are making a report under the FGM mandatory reporting duty
- The individual professional who becomes aware of the case MUST make the report; the responsibility CANNOT be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.
- If the unborn child, or any other child in the family, is considered to be at risk of FGM then reporting to social services or the police must occur.

3. Refer to Miss Ablett ANC for review as may need booking for consultant care, FGM leaflet to be given at booking. If seen in different clinic please inform member of the FGM team or Miss Ablett's secretary for data collection locally and nationally.

- If the woman has achieved successful vaginal deliveries prior to this referral, she may not need consultant clinic review and can be contacted by Stephanie Dickens, Specialist Midwife to discuss issues.
- If primiparous - assess the extent of FGM (appendix 2) and document in the notes. If able to visualise the urethra, defibulation (reversal) is not required. If the FGM is more extensive than this, elective defibulation should be offered and with consent, be performed within the second trimester of pregnancy.
- If Type 2 or 3 manage as high obstetric risk (increased risk of haemorrhage, perineal trauma and caesarean section.
- Support and counselling must be provided concerning the law in this country / the effects of FGM within pregnancy and childbirth / health consequences of FGM / the woman's future after defibulation has been performed / child protection issues. Discuss and clearly document agreed plan of care in the green page.
- Offer screening for hepatitis C in addition to routine screening for hepatitis B, HIV and syphilis

4. Safeguarding

- It is the responsibility of the attending clinician to report to the police and/or social services (see above). All women should be referred to the Reading Multi Agency Safeguarding Hub or Children's Social Care Services in West Berkshire and Wokingham for further assessment regarding child protection. Please reassure the woman not to be alarmed by this.
- FGM safeguarding risk assessment form (appendix 3) must be completed at the clinic by the assessor or during telephone conversation by the midwife. A copy of this form together with Child protection referral form must be sent by secure fax or email to the local children's social care services.
- All women should be referred to Poppy team and Child protection midwife
- Letter to GP copied to Health visitor.
- Provide details about of NSPCC helpline, Health passport and support groups

Copies of Health passport can be obtained here:

https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation

- Ensure all women have FGM information leaflet

.

Intrapartum care

- If defibulation has been performed before or during pregnancy, treat as normal.

- If the woman remains infibulated, offer reversal early in the labour to aid vaginal examinations and catheterisation. This could be carried out by an appropriately trained midwife or registrar.
- If the woman prefers reversal in the 2nd stage of labour, perform as the fetal head distends the vulva.
- For defibulation, draw up 5-10mls of 1% Lidocaine using a syringe and orange needle and inject along the line of the fused labia. Once the Lidocaine is effective, place your fingers under the skin of the fused labia for guidance and use straight scissors to perform an anterior midline episiotomy (cut upwards), stopping the incision once the urethra is exposed. Use gauze to soak up blood and apply pressure. (An RML episiotomy does not need to be routinely performed).
- By British law, it is illegal to re-infibulate the woman. Thus, if the labial edges are bleeding, they may need suturing, but the edges should not be sutured together (re-infibulation). Any suturing performed must not impede future intercourse and childbirth and the urethra must be exposed.

Postnatal care

- Perineal care as normal, stressing the importance of personal hygiene to aid healing.
- Continued support and counselling of the effects of FGM, the physiological and psychological changes from defibulation and the future of the woman and her family.
- Effective communication between all health professionals in being aware of any child at risk of FGM.
- If identified postnatally – See above – legal responsibility of health professionals. Notify the designated child protection midwife or other member of the FGM team.
- **<u>If the sex of the neonate is female or has female sibling</u>**:
    - Fill in the FGM assessment form, If not filled during antenatal follow up.
    - Refer to Child Protection midwife for referral to Multi Agency Safeguarding Hub regardless of type of FGM or history of defibulation.
    - Enter FGM onto CMIS
    - Document maternal history of FGM in the personal child health record (‘Red Book’) prior to postnatal discharge
    - Share information in postnatal booklet SBAR tool
    - Provide details about of NSPCC helpline, Health passport and support groups

- Document FGM on discharge summary to HV and GP in postnatal booklet, state referral for Child protection.

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

References

1. House of Commons (2003) Female Genital Mutilation Bill: A Bill to restate and amend the law relating to female genital mutilation; and for connected purposes. 11th Dec: House of Commons: London
2. The Children's act (1989) section 47 (1).
3. Ministry of Justice, Home Office. Serious Crime Act 2015.
4. HM Government, Multi-Agency Practice Guidelines: Female genital Mutilation, 2014 Ch 6. Pg 32-34.
5. Royal College of Obstetricians and Gynaecologists (2015) Green-top Guideline No. 53 – Female Genital Mutilation and its Management
6. Royal College of Midwives (2011) Female Genital Mutilation, Guidance for Midwives.
7. 'Female Genital Mutilation Enhanced Dataset – Information Governance Statement', http://www.hscic.gov.uk/media/18125/FGM-Enhanced-Dataset-IGStatement/pdf/FGM_Enhanced_Dataset_IG_Statement.pdf
8. FGM Prevention Programme-DoH - Understanding the FGM Enhanced dataset – updated guidance and clarification to support implementation. Sept. 2015

   FGM Prevention Programme: requirement for NHS staff (PDF, 319kb)
9. DH Safeguarding against FGM Guidance for professionals. 2015

   https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-riskof-fgm

Author/s: Marianne Flynn (Midwife), Jill Ablett (Consultant Obstetrician) 2004

Reviewed: October 2007 (Jill Ablett), November 2010, December 2012, February 2014, October 2014 (Leila Rushamba, Catherine Hiskett and Jill Ablett), October 2015 Leila Rushamba (SAS Obs & Gynae)

Review: November 2017

Author:	Leila Rushamba	Date:	November 2015
Job Title:	SAS Obstetrics and gynaecology	Review Date:	November 2017
Policy Lead:	Group Director Urgent Care	Version:	6.1 ratified 13th Nov 2015 Mat CG mtg
Location:	Policy hub/ Clinical/ Maternity / Medical conditions & complications / GL837		

FGM RECORDING TOOL

PATIENT DETAILS

(place sticker with full address please)

Date……

Country of birth			
Country of Origin & Region			
GP (Practice name)			
Department where patient was seen			
Referred from			
Is she Pregnant? Yes No EDD:……..	If yes, referral to Miss Ablett ANC	Yes	No
Is she under 18 years old? Yes No	If yes, referral to police	Yes	No
Any daughter/granddaughter under 18? Yes NO	If yes, Referral to Children social services (follow child protection procedures)	Yes	No

FGM Information

How was FGM identified		Self reported	
		During examination	
Type of FGM if known			
Age range when FGM was performed			
Country were FGM was undertaken			
Any other family members with FGM (list)			
Any Physical or Mental effect?		Yes	No
Advice given	Health implications of FGM?	Yes	No
	FGM specialist clinic	Yes	No
	Support groups	Yes	No
	Illegalities of FGM in the UK	Yes	No
	NSPCC helpline	Yes	No
	Child line	Yes	No
	Health Passport	Yes	No
Informed of the FGM enhanced dataset		Yes	No
Any objection to FGM enhanced dataset		Yes	No
Letter to GP		Yes	No
FGM PIL given		Yes	No

FGM team Informed : Yes Name of the FGM team: ..... Date:…..

Appendix 2 – Type classification of FGM

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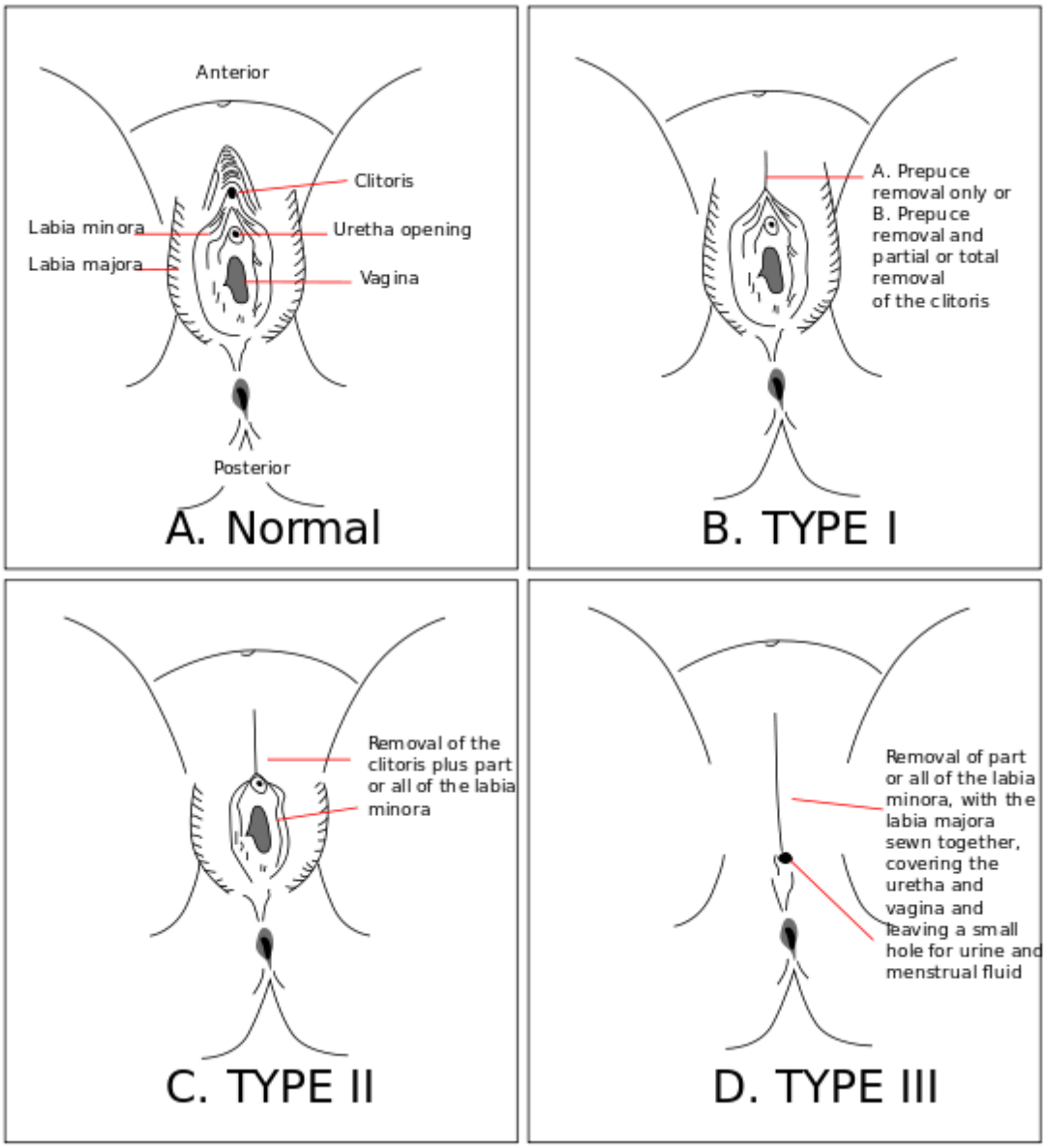

Appendix 3: Pregnant woman

(This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM).

Completed by:.....

Date:.....

Initial / on-going assessment *(please circle)*

Patient's details

Indicator	***Yes***	***No***	***Details***
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting re-infibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION: *If the risk of harm is **imminent,** contact* Social Services/CAIT team/ Police - 999/MASH ***URGENTLY***.

Appendix 4 – Decision making & action flowchart for Maternity Staff

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Decision Making and Action Flowchart for Maternity Staff when the risk of FGM is identified

(place in front of buff on blue paper notes tick when action has been completed)

ANTENATAL

Referral made to specialist Consultant Jill Ablett

- ❑ **Refer to Reading Multi Agency Safeguarding Hub(MASH) or Childrens Social Care Services in West Berkshire and Wokingham**
- ❑ Refer to poppy team and Child protection midwife

- ❑ Document consultant plan on cons care green sheet.
- ❑ Fill in FGM assessment form
- ❑ Liaison letter to GP
- ❑ Copy to Child Protection midwife
- ❑ Inform named health visitor
- ❑ Provide information about health consequences and the UK law
- ❑ Give details of NSPCC helpline & support groups
- ❑ Discuss services for any psychological needs
- ❑ Give RBH FGM leaflet

INTRAPARTUM

Read and discuss with women Consultants plan of care in labour documented on green paper at front of buff notes

POSTNATAL

Sex of neonate

Male

- ❑ No further action required

Female

- ❑ Enter FGM status of mother onto CMIS

- ❑ **Refer to MASH or Local Childrens Social Care Services in West Berkshire and Workinham.**
- ❑ Refer to poppy team and CP midwife
- ❑ Enter FGM onto CMIS
- ❑ Share information in postnatal booklet SBAR tool
- ❑ Document FGM on discharge summary to HV and GP in postnatal booklet

J Ablett, L Rushamba, C Hiskett (Oct 2014)

Page 1 of 1

Royal Berkshire NHS
NHS Foundation Trust

Guideline for the Management Female Genital Mutilation outside the Maternity Department
GL993

Approval and Authorisation

Approved by	Job Title	Date
Policy Approval Group	Chair, Policy Approval Group	January 2016

Change History

Version	Date	Author	Reason
Version 1.0	November 2015	Ann Gordon, Leila Rushamba	New Guidance.

Author:	Dr Gordon,Dr Leila Rushamba	Date:	January 2016
Job Title:	Named Doctor Child Protection,Speciality Dr in Obstetrics and Gynaecology	Review Date:	January 2018
Policy Lead:	Director of Nursing	Version:	Version 1.0
Location:	Corporate Governance shared drive – GL993		

Contents

1.0 Purpose

The purpose of this document is to provide advice on how to manage cases where Female Genital Mutilation is identified. It is applicable to all departments except Maternity who currently have their own guideline.

2.0 The Function of Policy

The function of the policy is to ensure that all departments manage cases of Female Genital Mutilation appropriately ensuring that the needs of the woman, any child protection issues and all legal requirements are addressed.

3.0 Female Genital Mutilation (FGM) and UK Legislation

FGM is illegal in the UK. Under the Female Genital mutilation Act 2003 and The Serious Crime Act 2015 it is an offence to

- Perform FGM in England, Wales or Northern Ireland.
- Assist a girl to carry out FGM on herself in England Wales or Northern Ireland
- UK nationals or ANY UK residents to carry out aid or abet counsel or procure the carrying out of FGM abroad. (this is intended to cover taking a girl abroad to be subjected to FGM).
- There is the offence of failing to protect a girl from FGM.
- Any person found guilty of an offence under the FGM Act 2003 is liable to a maximum penalty of 14 years imprisonment or a fine or both.

In addition FGM is CHILD ABUSE and should be dealt with as such under the Children Act 1989 and Child Protection Procedures for Berkshire Local Safeguarding Children Boards (http:/berks.proceduresonline.com/index.htm). The SAFETY OF THE CHILD IS PARAMOUNT and all professionals have a duty to SAFEGUARD girls at risk.

It is mandatory for the Royal Berkshire NHS Trust (RBHNHST) to submit data to the Department of Health FGM Enhanced Dataset hosted by HSCIC.

It is mandatory for health professionals to report all cases of FGM in those **under 18** to the Police – this should be done as soon as possible normally by the end of the next working day. The number to phone is 101 the police non-emergency crime number. It must be reported by the person identifying/ receiving the disclosure of FGM and **cannot be delegated**. Please discuss any cases with the Safeguarding Team.

4.0 Background to Female Genital Mutilation

Female Genital Mutilation (FGM) comprises all procedures involving partial or complete removal of the external female genitalia or other injury to the female genital organs for non medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls and women's bodies. The practice causes severe pain and has several immediate and long term consequences, including difficulties in child birth and also dangers to the child (see Appendix 1). **IT IS A FORM OF CHILD ABUSE.**

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and parts of the Middle East and Asia but has also been documented in communities in Iraq, Israel, Oman, the UAE, the Occupied Palestinian Territories, India, Indonesia, Malaysia and Pakistan. (**Appendix 1**).

FGM may be carried out in the newborn period, during childhood, adolescence, just before marriage or during first pregnancy. However it is thought that most cases occur between 5 and 8 years old and so girls in this age group are at higher risk.

FGM is often seen as a natural and beneficial practice carried out by a loving family who believe that it is in the girl's or woman's best interests and this may inhibit a girl in coming forward to discuss concerns or talk openly about FGM. It may be seen as a requirement for marriage in some communities and part of their cultural identity. Religion is sometimes given as a justification for FGM however FGM predates Christianity, Islam and Judaism and the Bible, Koran, Torah and other religious texts do not advocate or justify FGM. It is a form child abuse and violence against women and serves as a complex form of social control of women's sexual and reproductive rights.

FGM carries many short and long term health risks for girls and women; pain, bleeding, infection, urinary problems, chronic pelvic infections and pain, menstrual difficulties, pain during sex and loss of pleasurable sensation, infertility, complications during pregnancy and delivery of the baby and psychological and mental health issues.

FGM may be known by many different terms, including cutting, female genital cutting, circumcision, initiation. The names FGM or 'cut' are increasingly used at community level but may not always be understood by individuals in practising communities (**Appendix 2).**

5.0 Types of FGM

Four types of FGM are recognised and some in particular Type 4 may be difficult to recognise unless the practitioner is an expert in this area (**Appendix 3**)

- Type 1 – Clitoridectomy: partial or total removal of the clitoris or rarely the prepuce.

- Type 2 - Excision: partial or complete removal of the clitoris and labia minora with or without the removal of the labia majora.

- Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a seal.

- Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes, eg pricking, piercing, incising, scraping or cauterising. These cases should be reported to the FGM Enhanced data base as Type 4 FGM as per WHO definition.

6.0 General Principles

- FGM is child abuse and professionals have a duty to safeguard girls at risk. It should be seen as no different from any other kind of abuse and referred as such.
- Get accurate information about the urgency of the situation.
- Adult patients where there is **no risk** to female children have a right to confidentiality and no referrals should be made without their consent.
- The RBH must record data for the 'FGM Enhanced Data set' and we must inform the woman of this and give her the information leaflet 'More Information on FGM 2015'
- Talking about FGM should be non judgemental but clear on the illegality and health risks of the act but not blaming the girl/woman.
- Every effort should be made to provide a female professional to discuss FGM if a girl or woman would prefer this.
- Interpreters should not be a family member or someone known to the individual and should not be someone with influence in their community.
- Professionals should deal with FGM in a professional manner and avoid expressing horror or suggesting that an individual is 'abnormal' as a result of having undergone the procedure.
- Document all information clearly and contemporaneously.

7.0 Factors for Identifying Women and Girls at Risk

There are a range of potential indicators that suggest a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators are present this could signal a risk to the child or young person. It is believed that FGM happens to British girls in the UK as well as overseas.

Indicators of heightened risk

- The girl comes from a community where FGM is known to be practised.
- Any girl born to a woman who has been subjected to FGM also any other female children in the extended family.
- Any girl who has a sister who has already undergone FGM must be considered to be at risk of FGM also any female children in the extended family.
- Any girl who is withdrawn from PHSE at school may be at risk as a result of her parents wishing to keep her uninformed of her body and rights.

Indicators of Imminent Risk

- Families may practise FGM when an elderly female relative from the country of origin is visiting.
- A girl is heard talking about it.
- A girls is heard talking about a special procedure/attend a special occasion to become a woman
- A girl may request help.
- A girl is taken out of the country by a relative or parents for a prolonged period.
- A girl may talk of a long holiday to a country where FGM is prevalent.
- Parents seek to with draw their daughter from learning about FGM.

Indications that FGM may have already taken place

- Difficulty in walking/sitting/standing**.**
- A girl may spend longer in the toilet.
- A girl may have menstrual/urinary problems or urinary tract infections.
- There may be prolonged absences from school or college.
- A girl or woman may be particularly reluctant to undergo normal medical examination.
- A girl of woman may confide in a professional.

8.0 Notifying Cases of FGM

- The Royal Berkshire Hospital has a duty to notify all cases of FGM to the Health and Social Care Information Centre (HSCIC) to provide input to the Enhanced Data Set on FGM. This is mandatory.

- Women should be informed that their information will be submitted to the HSCIC and given the information that they can apply to have their data removed and how to go about doing this. The purpose of this data collection is to improve the NHS response to FGM and help in commissioning services to support women who have undergone the procedure. No personal details will be passed on to the police or social care from this and will not trigger individual criminal investigations.

- **All women MUST be given the patient information leaflet 'More Information about FGM' (2015) which gives full information about the data collection and how to have their data removed. Down load from** http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/2903740%20DH%20FGM%20Leaflet%20Acessible%20-%20English.pdf **.Giving the leaflet makes the RBH compliant with 'fair processing' and Data Protection. Hard copies are available in gynaecology emergency clinic, Paediatric ED and from the Safeguarding team.**

- All cases are referred by either Dr Leila Rushamba (obstetric and gynaecological cases) or Named Nurse for Child Protection Jo Horsburgh (all other cases). They must be informed of patient's details of all cases identified in any areas.

- The attending clinician is responsible for collecting the necessary information for the Enhanced Data Set. The Trust FGM recording tool (**appendix 4**) is available on the Trust FGM website and covers all required information.

- A girl/woman will only undergo a clinical examination if it is medically necessary for her care. **There is no place for examining a girl/woman simply to confirm FGM or its type for reporting purposes**.

- Cases should be reported **every time** contact is made with RBH not just on first presentation. It includes contacts which are not due to FGM related problems.

Contacts

- Dr Leila Rushamba (Speciality Doctor, Obsterics and Gynaecology) – for maternity and non pregnant gynaecology patients. Leila.Rushamba@royalberkshire.nhs.uk / bleep 612

- Joanne Horsburgh (Named Nurse for Child Protection) – for all other women and girls identified in other departments. Joanne.Horsburgh@royalberkshire.nhs.uk and 0118 322 8046

9.0 Where to find things

Document/Form	Found at
Information leaflet on FGM and enhanced data set 'More Information about FGM' (2015)	. http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/2903740%20DH%20FGM%20Leaflet%20Acessible%20-%20English.pdf
RBH FGM recording tool	RBH FGM website
Risk Assessment Form Non Pregnant Women	RBH FGM website
Risk Assessment Form Pregnant Women	RBH FGM website
Risk Assessment Forms Child Young Adult under 18	RBH FGM website
Female Genital Mutilation (circumcision) Guideline (GL837) for use in the Obsteric Department.	RBH Policy Hub
Generic Referral form to Children's Social Care	RBH Intranet Clinical Care under Child Protection page.
Multiple useful/interesting documents relating to FGM	RBH FGM website.

The RBH FGM website is found at RBH Intranet - Clinical Care - Child Protection
FGM is highlighted in a green bar which links through to the website.

http://nww.intranet.royalberkshire.nhs.uk/clinical_care/s/safeguarding.aspx

Useful Names and Numbers

Joanne Horsburgh	-	Named Nurse for Child Protection	0118 3228046
Elizabeth Porter	-	Lead Nurse Adult Safeguarding	01183227482
Catherine Hiskett	-	Named Midwife for child protection	07768752529
Jessica Higson	-	Senior Nurse for Children and Safeguarding	01183226998
Ann Gordon	-	Named Dr for Child Protection via switchboard mobile or page	

Social Care

Reading MASH	01189 373 641
West Berkshire CAAS	01635 503 090
Wokingham Triage	01189 088 002
Bracknell Forest Access and Assessment	01344 352 000
Emergency Duty Team (out of hours referrals)	01344786543

Police

Non-emergency referral line 101 (to refer new cases of FGM in girls under 18)

Support Service

NSPCC FGM helpline: 0800 028 3550 or fgmhelp@nspcc.org.uk

9.0 Actions to be taken in different scenarios

Pregnant Woman with FGM

Assess are there symptoms related to FGM which require urgent medical intervention?

YES carry it out/refer to Gynaecology/Obstetrics registrar as appropriate (bleep 602/555)

NO Is she already booked with the Obstetric team and known to the FGM Obstetric team?

YES - then further assessment and management will be in hand, check that she has an appointment and knows where to go. Collect information necessary for the dataset. Inform Dr Rushamba of her attendance for notification to Data Set.

NO - Refer to Miss Ablett in Antenatal Clinic where the FGM team (midwife or obstetrician) will make an individual risk assessment. Make the referral by ringing the Maternity Co-ordinator on delivery suite.
Any child considered at risk (unborn or other) will then be referred to social care. Ensure that the woman knows that she must attend antenatal clinic. Make sure that any need for an interpreter is indicated at the time of referral.

Inform the woman that FGM is illegal in this country and that it cannot be carried out on any female children that she may have.

Inform her that social care will be involved in assessing any risk to any female children already in the family and any future children if they are female.

Inform her that the RBH must notify her details to the FGM Enhanced Data set and give her the leaflet 'More Information on FGM' and 'RBH – Maternity - FGM Patient information leaflet' from intranet.

Collect Data for Data set and inform Dr Rushamba of her attendance for notification to data set.

Carry out risk assessment (**appendix 5**) and refer to social care.

Sign Post to Support Groups if wanted
NSPCC FGM Helpline (National) 0800 028 3550

Document all discussions, actions and referrals clearly in the notes. Inform the GP.

There is a Female Genital Mutilation (circumcision) Guideline (GL837) under Maternity on the RBH Hub to more fully cover this.

Action - Non Pregnant Female over 18 with FGM

Asess are there symptoms related to FGM or a gynaecological condition which require urgent intervention.

YES - carry it out/refer to Gynaecology registrar on call as appropriate (bleep 602).

If treatment requires admission then the actions below become the responsibility of the gynaecology consultant who may delegate as appropriate. If no admission is required the actions remain the responsibility of the referring team.

NO – Assess Family Circumstances

Are there children and if so how many, how old and what sex are they?

CHILDREN AT HOME
• Assess the risk of FGM in female children using the risk assessment tool. **(Appendix 6)**
• If risk is urgent involve the Named Doctor and Nurse urgently (in their absence the paediatric consultant on call) and make referral urgently to social care.
• Discuss/refer to social care as appropriate in other cases.
• Inform the woman of the involvement of social care and what they plan.

FOR ALL WOMEN
• Explain procedure is illegal in the UK and give information leaflet.
• If does not require immediate intervention, **respect patient wishes** / if wishes clinic appointment to discuss non urgent symptoms GP to refer to Gynaecology Outpatients for the attention of Dr. Leila Rushamba who will see and assess whether treatment locally or onward referral to a centre specialising in FGM is more appropriate.
• Sign Post to Support groups • NSPCC FGM Help Line 0800 328 0550
• Referral to Mental Health Team if needed Inpatient – PMS • Outpatient CPE on 0300 365 0300
• Inform woman that RBH must notify her details to national data set and give her the information leaflet. Collect Data for Data set and inform Named Nurse Jo Horsburgh for notification to data set.
• Document that she has had FGM in the medical notes.
• Document referrals made and information given. Inform GP by sending copy of assessment tool.

During working hours the Named Nurse/Dr may be able to come to assist in the assessment of risk and are available for advice.

Action - girl 16 or under identified with FGM (or Discloses FGM) while in the RBH

Assess are there symptoms related to FGM which require urgent medical intervention?

Yes – refer to the paediatric consultant on call (paediatric registrar if unavailable) gynaecology registrar (bleep 602) who will involve the gynaecology consultant. and to the paediatric consultant on call.

No - Refer to the paediatric consultant on call (as per Child Protection) who may wish to discuss with the Named Professionals during working hours.

Paediatric consultant to see parent and child together to obtain history and family details (as per child protection medical).

If the child has no current symptoms and has made a disclosure then there is no need to examine the genitalia as a forensic examination will be organised as part of the Child Protection investigation.

If the referral is made based on FGM being identified by another health professional and there is no disclosure from the child then the paediatric consultant needs to make a professional decision over whether to examine the genitalia either alone or with a colleague to rule out other medical conditions.
If an examination is to be carried out, arrange for an appropriate chaperone to attend.

Inform the parent/s and child that FGM is illegal in the UK and is managed as child abuse. You have a duty to refer any case to Social care and the police.

Refer to Children's Social Care as a **child protection referral**. Social care should then be able to organise an appropriate medical assessment at an appropriate time. This will be done via the Sexual Abuse Referral Centre (SARC).
Refer the case to the police using the non emergency number 101.

Inform child and parents of the referral to social care and the police.

Collect information for the Data Set and inform Named Nurse Jo Horsburgh of the case for submission of data to the data set. Give information leaflet - More Information on FGM (2015)

Consider referral to CAMHS/Psychologist if there are signs of emotional trauma.

Sign Post Parent and child to support groups
NSPCC 0800 028 3550 fgmhelp@nspcc.org.uk

Arrange follow up appointment to discuss any FGM related chronic health problems, and arrange referral to specialist centre for surgical reversal if required. The centre to refer to is currently under exploration. There is a NHS list of specialist centres on the FGM website.

Document all discussions, actions and referrals clearly in the notes. Inform the GP

Action - young woman 17- 18 identified with FGM or discloses FGM. (this group are defined a child for Social Care and Police)

Assess - Are there symptoms related to FGM which need urgent medical intervention?

Yes – refer to gynaecology registrar (bleep 602) who will involve the consultant.

The Gynaecology Consultant will then assume responsibility for all the actions listed below. They may wish to delegate this but ultimate responsibility for ensuring all are completed will rest with them. They may wish to discuss with the Named Professionals during working hours (or the paediatric consultant out of hours).

NO – If there are no acute symptoms related to FGM the responsible consultant will then assume responsibility for all the actions below. They may wish to delegate this but ultimate responsibility for ensuring all are completed will rest with them. They may wish to discuss with the Named Professionals during working hours (or the paediatric consultant out of hours).
The consultant or their delegate will see the young woman (with or without parent present) to obtain history, and family details. There is no need to examine the genitalia as a forensic examination will be organised as part of the Child Protection investigation.

If there aresymptoms related to FGM but no urgent intervention is required, advise the GP to refer to Gynaecology Outpatients for the attention of Dr. Leila Rushamba who will see and assess whether treatment locally or onward referral to a centre specialising in FGM is more appropriate.

If the referral is made based on FGM being identified by another health professional and there is no disclosure from the young woman then the responsible consultant needs to make a professional decision over whether to examine the woman's genitalia either alone or with a colleague to rule out other medical conditions.

If an examination is to be carried out then an appropriate chaperone should be in attendance.

Inform the young woman (parents if present) that FGM is illegal in the UK and is managed as child abuse. You have a duty to refer any case to social care and the police.

Refer to Children's Social Care as a **child protection referral**. Social care should then be able to organise an appropriate medical assessment at an appropriate time. This will be done via the SARC as there are currently no Paediatricians performing this work at the RBH.

Refer the case to the police using the non emergency number 101

Inform child and parents of the referral to social care and the police.

Collect information for the Data Set and inform Named Nurse Jo Horsburgh of the case for submission of data to the data set. Give the leaflet More Information on FGM (2015).

Consider referral to CAMHS/Psychologist if there are signs of emotional trauma.

Sign Post young woman to support groups
NSPCC 0800 028 3550 fgmhelp@nspcc.org.uk

Document that the girl has had FGM in the medical notes and document all other actions taken and referrals made. Share information with the GP.

Action - there are concerns identified at the RBH that a young person less than 18 years is at risk of FGM or has had FGM performed.

This may be an emergency if the child or young woman is about to be taken abroad for the procedure or have it performed in the UK imminently. The police and social care can use emergency protection procedures to prevent this.

Use the risk assessment tool to gather information to either support or reduce concern about risk. (**appendix 7/8**).

Discuss with Named Professionals in working hours. Discuss with Paediatric Consultant if child 16 years or less or supervising speciality consultant if young person 17-18 years and out of hours.

Discuss with girl/young woman/parents that FGM is illegal in UK and give 'More Information about FGM (2015)' leaflet.

Decide if **Significant** or **Immediate risk** requiring **urgent referral to social care** for the child's protection and **make referral if** required.

If no significant or immediate risk consider whether there is sufficient concern to merit referral or discussion with Social Care and who is best placed to do this. This is probably best done in working hours by a senior professional after discussion with the named professionals.

Sign Post girl/ young woman/parents to support group.
NSPCC 0800 028 3550 fgmhelp@nspcc.org.uk

Document all assessments, actions and discussions in the notes.

Share information of any identified risk with the Patient's GP.

10.0 References

- Female Genital Mutilation Risk and Safeguarding – Guidance for Professionals. DOH March 2015

- FGM Prevention Programme – Understanding the FGM Enhanced dataset-updated guidance and clarification to support implementation. DOH/hscic September 2015

- Mandatory Reporting of FGM A new professional duty. DOH/NHS England 2015

- Female Genital Mutilation The Facts, Home Office.

- More Information about FGM (2015) DOH

- Multi-Agency Practice Guidelines: Female Genital Mutilation, HM Government.

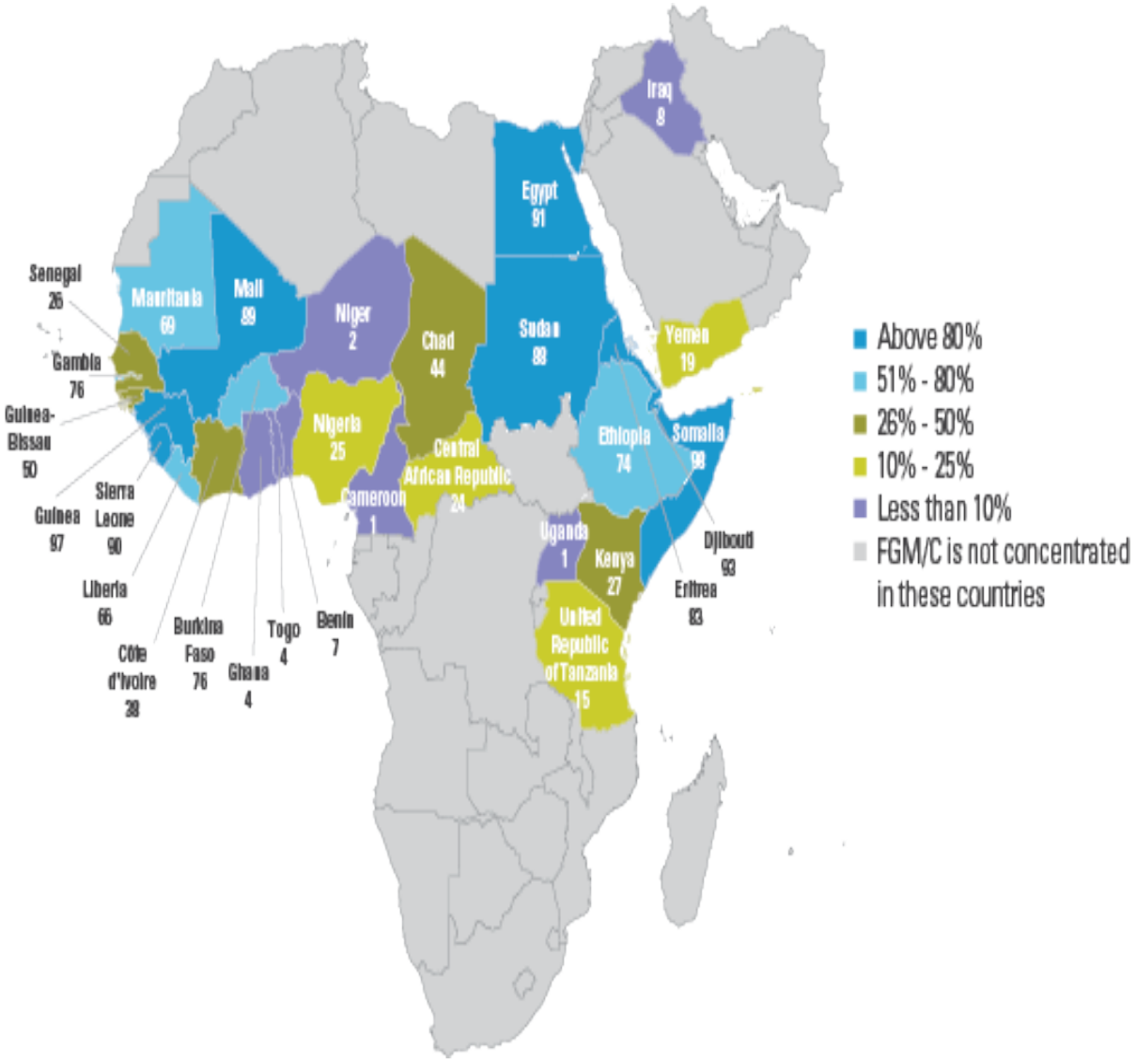
- Tackling FGM in the UK, Intercollegiate recommendations for identifying and reporting 2013.

- Working Together to Safeguard Children 2015

- Berkshire LSCB Child Protection Procedures 2.11 Female Genital Mutilation.

Most of the above are available on the RBH FGM website.
There is a RED Folder in Dr Gordon's office labelled FGM where there are hard copies for reference.

Appendix 1: Countries that practice FGM



FGM has also been documented in communities including: •Iraq •Israel •Oman •the United Arab Emirates •the Occupied Palestinian Territories •India •Indonesia •Malaysia •Pakistan

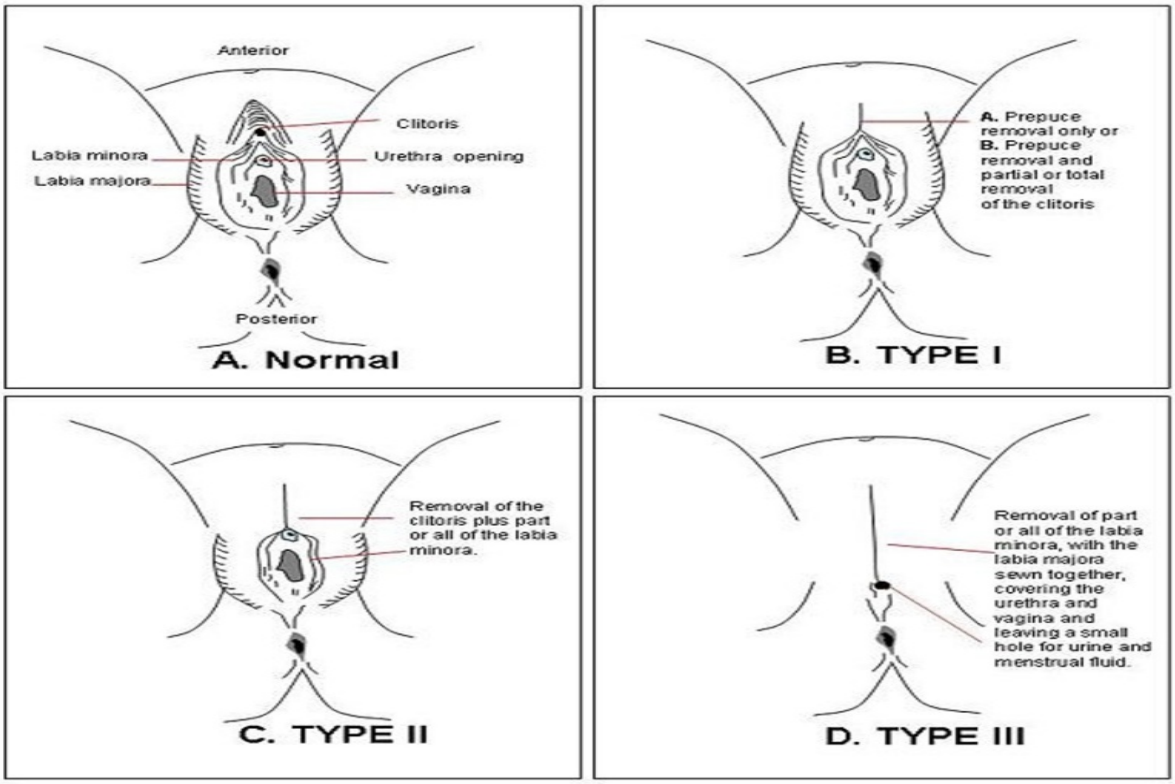
(Percentage of girls and women aged 15 to 49 years who have undergone FGM/C)

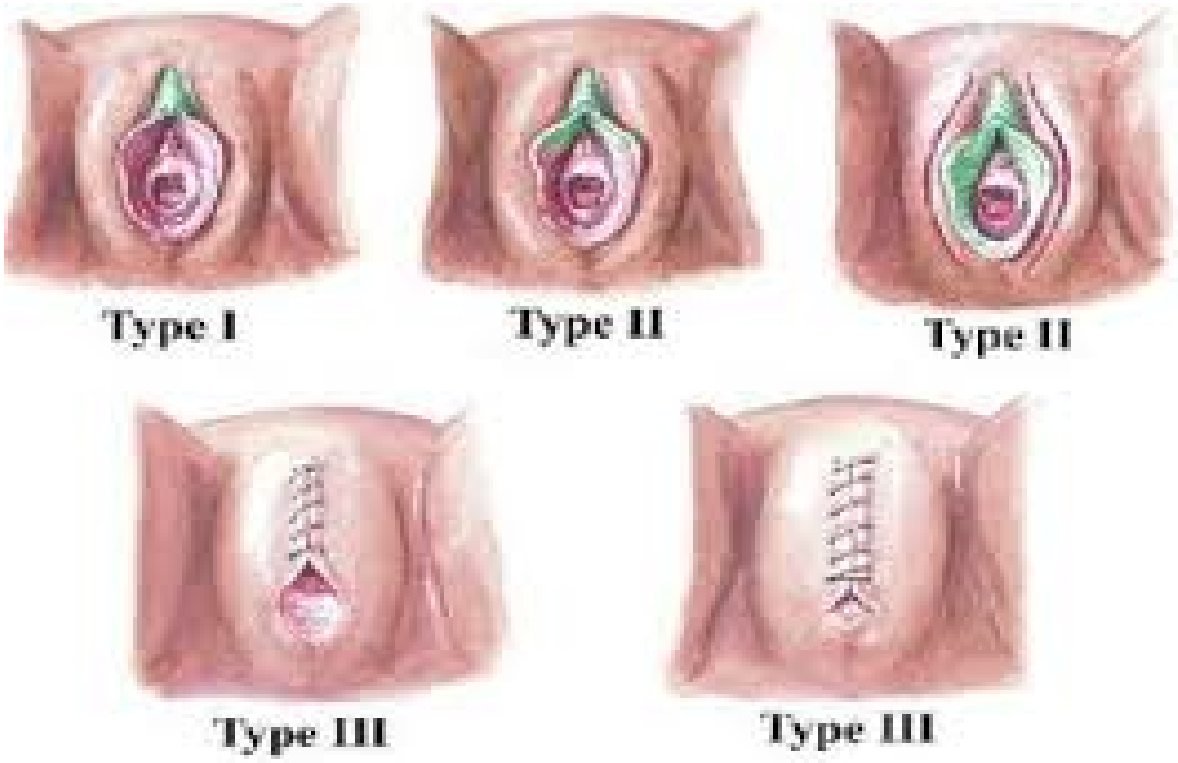
Source. http://www.data.unicef.org/child-protection/fgmc

Appendix 2: Traditional and local terms for FGM

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi wasichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation – for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition/obligation – for Muslim
	Bondo	Temenee/ Mandingo/Limba	Integral part of an initiation rite into adulthood – for non-Muslims
	Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non-Muslims
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' ie. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis

Appendix 3 Types of FGM





Author:	Dr Gordon,Dr Leila Rushamba	Date:	January 2016
Job Title:	Named Doctor Child Protection,Speciality Dr in Obstetrics and Gynaecology	Review Date:	January 2018
Policy Lead:	Director of Nursing	Version:	Version 1.0
Location:	Corporate Governance shared drive – GL993		

Appendix 4; FGM Data Recording Tool

FGM RECORDING TOOL

PATIENT DETAILS

(place sticker with full address please)

Date……

Country of birth			
Country of Origin & Region			
GP			
Department where patient was seen			
Referred from			
Is she Pregnant? Yes No	If yes, referal to Miss Ablett ANC	Yes	No
Is she under 18 years old? Yes No	If yes, referral to police	Yes	No
Any daughter/ granddaughter under 18 ? Yes NO	If yes, Referral to Children social services (follow child protection procedures)	Yes	No

FGM Information

How was FGM identified		Self reported	
		During examination	
Type of FGM if known			
Age range when FGM was performed			
Country were FGM was undertaken			
Any other family members with FGM (list)			
Any Physical or Mental effect?		Yes	No
Advice given	Health implications of FGM?	Yes	No
	FGM specialist clinic	Yes	No
	Support groups	Yes	No
	Illegalities of FGM in the UK	Yes	No
	NSPCC helpline	Yes	No
	Child line	Yes	No
	Health Passport	Yes	No
Informed of the FGM enhanced dataset		Yes	No
Letter to GP		Yes	No
More Information on FGM leaflet given.		Yes	No

Appendix 5: Pregnant woman (This is to help the social services make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM).

Patient's details

Date:..... Completed by:.....
Initial/on-going assessment

Indicator	*Yes*	*No*	*Details*
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman			
Woman is reluctant to undergo genital examination			
SIGNIFICANT OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION: If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.
If the risk of harm is ***imminent,*** *contact* Social Services/CAIT team/ Police/MASH ***URGENTLY****.*
In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

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Location:	Corporate Governance shared drive – GL993		

Appendix 6: Non-Pregnant woman (This is to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM).

Patient's details

Date:..... Completed by:.....

Initial/on-going assessment

Indicator	*Yes*	*No*	*Details*
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FG			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/ no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:– if they are under 18 years you have a professional duty of care to refer to social care			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

ACTION: If one or more indicators are identified, refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

If the risk of harm is ***imminent,*** *contact* Social Services/CAIT team/ Police/MASH ***URGENTLY***

In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

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Appendix 7: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required.

Patient's details

Date:..... Completed by:.....

Initial/on-going assessment

Indicator	***Yes***	***No***	***Details***
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FG			
Father comes from a community known to practice FG			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the Always check whether family are already known to social care			

SIGNIFICANT OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

ACTION: If one or more indicators are identified, refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.
If the risk of harm is ***imminent,*** *contact* Social Services/CAIT team/ Police/MASH ***URGENTLY***
In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

Appendix 8: CHILD/YOUNG ADULT (under 18 years old) (This is to help when considering whether a child HAS HAD FGM)

Patient's details

Date:..... Completed by:.....

Initial/on-going assessment

Indicator	***Yes***	***No***	***Details***
CONSIDER RISK			
CHILD/YOUNG ADULT (under 18 years old)			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A & E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs eg withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Girl spends a long time in the bathroom/toilet/long periods of time away from the classroom			
Girl talks about pain or discomfort between her legs			
SIGNIFICANT OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social service			

ACTION: If one or more indicators are identified, refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

*If the risk of harm is **imminent,** contact* Social Services/CAIT team/ Police/MASH ***URGENTLY***

In all cases:– •Share information of any identified risk with the patient's GP •Document in notes •Discuss the health complications of FGM and the law in the UK

Royal Berkshire NHS
NHS Foundation Trust

Safeguarding Children

Information Sharing Guidance: Child Sexual Exploitation (CSE)

This document has been developed to provide guidance to RBH frontline professionals involved in information sharing discussions at multi agency locality CSE operational meetings.

The guidance aims to provide:

- confidence that CSE cases continue to be dealt with in line with established child protection procedures
- a consistent approach to information sharing
- clarity for front line staff

Introduction

In order to ensure safeguarding, information sharing is an important part of frontline practitioners' job when working with children and young people. This guidance gives a practical overview of sharing information relating to Child Sexual Exploitation, to enable practitioners to feel confident in sharing information whilst also building and maintaining therapeutic relationships.

Professor Munro's[1] review of child protection recommended greater trust in, and responsibility on, skilled practitioners at the frontline. It emphasized the move away from a less central prescription and interference. Lord Laming[2] highlighted that the safety and welfare of children is paramount and practitioners should feel confident about how to deal with the complexities of information sharing.

In relation to children being sexually exploited, practitioners need to adopt an open and inquiring mind to any reasons for a change in behaviour for all children. If practitioners have a concern about a child's welfare, or believe they are at risk of harm, that information should be shared with the Local Authority, considering the security of sharing and being proportionate (Refer to Child Protection Protocol CG074).

[1] Munro. E. (2011) The Munro Review of Child Protection: final report. Accessed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf 7/8/15

[2] The Lord Laming (2009) The Protection of Children in England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/328117/The_Protection_of_Children_in_England.pdf accessed 7/8/15

Many cases of CSE will pass a threshold for intervention under Section 17 or 47 of the Children's Act 1989 which makes information sharing straightforward. However, some cases fall short of the threshold. These cases are no less important because there still may be identified risk. In these cases, information may be shared in the public interest, to protect children and potentially prevent and detect crime.

This guidance is provided to ensure that practitioners feel confident about when and how to share information.

Consent/Informing Young People about Sharing Information

In line with Child Protection guidance, wherever possible, the young person will be informed that information will be shared.

In practice, however, for most cases consent will not be sought from the young person. However, it is still possible to share personal information without consent in order to protect an individual from significant risk or if the child/ young person is suffering or likely to suffer significant harm.

Key message: a young person deemed to be at risk of child sexual exploitation is a child / young person at risk of significant harm.

When to share information

1. Is there a clear and legitimate purpose for sharing information?
   - Yes – see next question
   - No – do not share
2. Does the information enable an individual to be identified?
   - Yes – see next question
   - No – you can share but should consider how
3. Is the information confidential?
   - Yes – see next question
   - No – you can share but should consider how
4. Do you have consent?
   - Yes – you can share but should consider how
   - No – see next question
5. Is there another reason to share information such as to fulfil a public function or to protect the vital interests of the information subject?
   - Yes – you can share but should consider how
   - No – do not share

In considering the questions above, it is important to note that the CSE operational groups have a "clear and legitimate purpose for information sharing" i.e. to safeguard and protect young people.

The flow chart in Appendix 1 identifies when and how to share information.

RBFT information sharing recommendations (in line with Appendix 1)

Guidance	Agreement
Identify how much information to share	The key consideration is proportionality. If the child / young person is known to be on Child Protection plan, is a Looked After Child, or is known to be a level 1, 2 or 3 CSE risk the following information is likely to be proportionate: 1) Known / not known to service 2) Engaged / not engaged with sexual health services 3) Admissions/attendances for "high risk" indicators such as drug and alcohol use and self harm. 4) Confirmation that the RBFT Trust Sexual Health CSE safeguarding indicator tool has been completed and outcome: • No risk identified – no further action • Risk identified - CP referral made following established CP procedures **NB – if information is sought over that set out above, the requester should be asked to justify that request, setting out what further information is required and why.** **Further sensitive information will then be shared with the allocated social worker.** <u>Points for consideration in relation to proportionate sharing</u> - Does the encounter with Health Services at the RBFT add to a bigger picture about the child / young person? - Does the requester have any further information about risk that would justify further disclosure? - Could sharing information about the child / young person compromise their engagement with services and/or potentially lead to increased risk? If there is any doubt about the level of information to be shared or whether sharing will increase the risk to the child, discuss with departmental senior staff, safeguarding and legal team to confirm detail to be shared.

Distinguish fact from opinion	As per CP guidance
Ensure you are giving the right information to the right individual	As per CP guidance
Ensure information is shared securely	• No paper copies of meeting notes to be carried to operational meetings • NHS.net used for all correspondence • Confidentiality at all ops meetings acknowledged
Inform the individual that info has been shared unless it will create or increase risk	As per CP guidance

Recording the information sharing decision

The information sharing decision should be recorded in the medical records of the service user. The record should detail:

- The origin and basis for the information request
- The information shared and the reasons behind it
- Any outcome of the information sharing
- Whether the service user's consent was sought

The service user (and potentially their parents) will be entitled to access the medical records. Following such a request, consideration should be given as to whether the entries relating to CSE information sharing should be redacted on the basis that they may cause harm to the service user or others (or whether any other exemption applies to subject access). This decision should be made in line with the principles which govern whether the consent of the patient was sought at the time of information sharing.

Persons of Interest

In the event that, following CSE information sharing, the Police request information in relation to a Person of Interest, they should be asked to make this request through the formal Trust procedures. This can be made through the RBFT legal team.

Information sharing in response to audit requests

Area profile audits - percentages to be supplied rather than comment made on individual cases.

Appendix 1: Flowchart of when and how to share information relating to Child Sexual Exploitation