



Department  
for Education

# **An Evaluation of the Second Phase of the Female Genital Mutilation Early Intervention Model**

**Research report**

**January 2017**

**Katie McCracken, Ana FitzSimons,  
Sarah Priest – Opcit Research**

**Children's Social Care Innovation Programme Evaluation Report**

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# Executive summary

## The project

The Female Genital Mutilation Early Intervention Model (FGM EIM) pilot was established to implement and refine an effective strategy to prevent new cases of FGM among women and girls, while supporting those affected by FGM. To achieve these aims, the pilot brings statutory health and social services together with community members and organisations to co-construct an effective and sustainable intervention delivering support to women who have undergone FGM and safeguarding those at risk of FGM. The pilot is delivered across 3 local authority areas within London (the Tri-Borough, Tower Hamlets, and Waltham Forest), each of which has a high estimated rate of prevalence of FGM, relative to the average for England.

Given variations in local circumstances, the pilot is delivered in different ways across the 3 areas. A core component of the pilot in all 3 areas is the provision of FGM clinics. All clinics are staffed by specialist FGM Practitioners, midwives, and community mediators drawn from community organisations. One clinic is also staffed by a therapist. Advice on the law around FGM and safeguarding children, as well as more general support with accessing services, is provided to families by the FGM Practitioners, who also assessed the level of risk to any girls in the families. The role of the specialist FGM midwives is to provide advice on the type of FGM women have, the health issues women may face (including during pregnancy and labour) as a result of their FGM, and deinfibulation. Community mediators provide support and advocacy to the women seen in clinic, and feedback on families' experiences to other pilot staff.

Alongside work in the FGM clinics, FGM Practitioners conduct risk assessments and provide support to families not seen in clinic. Pilot staff also undertake work to develop new, FGM-specific assessment and intervention tools and protocols; deliver training and events to relevant professionals; engage with members of potentially affected communities to identify local needs, strengthen efforts to raise awareness of FGM-related issues, and promote understanding of services and legislation; and engage with schools to raise awareness about FGM among pupils, parents, teachers and governors.

## The evaluation

The evaluation of the first phase of the pilot focused on assessing the impact of the pilot on services and members of potentially affected communities. The evaluation of the second phase continued to assess this impact, while focusing more closely on lessons for best practice in the social care/children's services response to FGM, and for collaboration between services and communities. A review of monitoring data on clinic

attendance and risk assessment was conducted to understand the scale and outcomes of support and safeguarding. Interviews were also conducted with 13 key professionals involved in the development and delivery of the pilot across the 3 local authority sites. Interviews with 4 women who had been supported by the project were conducted across 2 pilot sites to improve understanding of their experiences and views of the pilot. The husband of one of these women was also interviewed. While considerable efforts to interview further women were made by the evaluation team, major obstacles (outlined in the methodology section of this report) were encountered at 2 pilot sites.

## Findings and recommendations

A total of 80 women were seen at FGM clinics and risk assessments were completed for 68 families during the second phase of the pilot. No children were identified as facing a high risk of FGM.

Pilot staff delivered FGM training to professionals, as well as outreach and awareness-raising sessions in school and community settings. Across the pilot sites, 34 training sessions were delivered to professionals working within social care/children's services, health, education and the police, 7 sessions were delivered to school pupils and 4 to pupils' parents, and 21 events were delivered within communities.

Interviews with pilot staff identified several lessons for best practice in the social care/children's services response to cases of FGM, including lessons for collaboration with communities.

- One family's experiences can have an impact on the willingness to engage with services of much wider sections of communities: it is important to get each interaction (including, importantly, home visits) right. Negative experiences can result in families feeling alienated from and less willing to engage openly with services, thereby reducing the ability of social care/children's services to deliver effective safeguarding.
- Risk assessment should reflect the reasons for which families are referred for assessment. For families assessed because the mother has undergone FGM (and has therefore been a victim of child abuse), and where there are no further specific concerns about the safety and wellbeing of the children, risk assessment should have a relatively narrow focus on the risk to children of FGM. Offers of more general support should also be made, but practitioners should be aware that a more full and formal needs assessment (for example, following each section of the standard assessment framework) may constitute an inappropriate level of intrusion into families' lives.

- While appropriate levels of training on FGM should be provided to all relevant social care/children's services professionals, effective assessment to identify risk of FGM requires specialist knowledge and skill. It should be delivered by dedicated social care/children's services practitioners with advanced training and specialist expertise in FGM casework.
- The Community Mediator role was crucial to the effective functioning of the pilot: social care/children's services should continue to promote collaboration and co-construction of services with members of potentially affected communities. Having a channel for communication and mediation between services and potentially affected communities, provided by Community Mediators drawn from those communities and trusted by their members to represent their interests, enabled social care/children's services to learn – from mistakes as well as successes – about 'what works', and improve the efficacy of their approach to safeguarding. Families also benefitted from the support and advocacy they received from Community Mediators. This often functioned to improve experiences of social care/children's services intervention by ensuring good understanding of the process and purpose of assessments.
- Social care/children's services should recognise that the benefits of community mediation are valuable but precarious. Successful advocacy and mediation depends on the ability of Community Mediators to work alongside services while maintaining families' trust. This, in turn, relies on services agreeing to make reasonable adjustments to improve the efficacy of systems and practice in response to constructive feedback from members of potentially affected communities.

# The project

## Literature review

A review of relevant literature was undertaken for the evaluation of the first phase of the FGM EIM pilot and is published in full in the report for that evaluation. The most relevant key findings of the literature review are reproduced below.

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

As set out in the 'key findings' section below, this evaluation of the FGM EIM provides further evidence of the importance of meaningful dialogue between services and potentially affected communities; appropriately sensitive practice; specialist services; wider workforce training; and multi-agency collaboration. The report also sets out concrete proposals for how these can be achieved, based on analysis of project implementation across the pilot sites.

## Local context

Research funded by the Home Office and Trust for London and conducted by City University London and Equality Now provides estimates of FGM prevalence in local

authorities across England and Wales.<sup>1</sup> This research suggests each of the pilot sites has relatively high FGM prevalence rates compared to the average across England and Wales of 4.8 cases per 1,000 population.

The estimated total number of cases of FGM in Tower Hamlets is 2,401, representing a prevalence rate of 19.5 cases per 1,000 population. In the Tri-Borough, it is estimated that 7,246 women have undergone FGM, which represents a prevalence rate of 25.5 cases per 1,000 population. In Waltham Forest, the estimated total number of women who have undergone FGM is 2,273, representing a prevalence rate of 17.6 cases per 1,000 population.

## Project aims and activities

The Female Genital Mutilation Early Intervention Model (FGM EIM) pilot was established to implement and refine an effective strategy to prevent new cases of FGM among women and girls, while supporting those affected by FGM. To achieve these aims, the pilot brings statutory health and social services together with community members and organisations to co-construct an effective and sustainable intervention delivering support to women who have undergone FGM and safeguarding those at risk of FGM. The pilot is delivered across 3 local authority areas within London (the Tri-Borough, Tower Hamlets, and Waltham Forest), each of which has a high estimated rate of prevalence of FGM, relative to the average for England.

Given variations in local circumstances, the pilot is delivered in different ways across the 3 areas. These differences are set out in detail below. The core components of the pilot in all 3 areas include the provision of FGM clinics. Referral pathways to the clinics vary across the boroughs, but, in general, women identified by health and other professionals as having undergone FGM – and, in particular, pregnant women identified by midwives – are referred by those professionals to pilot staff for support and safeguarding services.

All clinics are staffed by FGM Practitioners drawn from social care or children's services, midwives, and Community Mediators drawn from community organisations.<sup>2</sup> One clinic is also staffed by a therapist. Advice on the law around FGM and safeguarding children, as well as more general support with accessing services, is provided to families by the FGM Practitioners, who also assess the level of risk to any girls in the families seen in clinic.

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<sup>1</sup> Macfarlane, A. J. & Dorkenoo, E. (2015) *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*, London: City University London in association with Equality Now

<sup>2</sup> While the specific job titles of staff in these roles vary across the pilot sites, these titles are used throughout this report for the sake of clarity.



The role of the specialist FGM midwives is to provide advice on the type of FGM women have, the health issues women may face (including during pregnancy and labour) as a result of their FGM, and deinfibulation.

The model of the clinics is underpinned by a recognition that midwives are often best-placed to identify women who have undergone FGM, while social workers have the most highly developed expertise in safeguarding and direct work with families. The model aims to bring together the skills and expertise located within these professions in order to offer a high quality intervention that is co-designed with, and effectively facilitated by, community advocates.

Alongside work in the FGM clinics, pilot staff undertake work to develop new, FGM-specific assessment and intervention tools and protocols; deliver training and events to relevant professionals; engage with members of potentially affected communities to identify local needs and strengthen efforts to raise awareness of FGM-related issues; and engage with local schools to raise awareness about FGM among pupils, parents, and staff.

## **Variations in the delivery of the model**

### **Clinics**

There is one monthly hospital-based pilot clinic at Site A. (A further FGM clinic is based in another hospital in the borough, but is not part of the pilot.) Community midwives may refer pregnant women to the specialist FGM Midwife, who may then refer the case to children's social care via the FGM Practitioner, and forward a copy of the referral to the Community Advocates. The FGM Practitioner may also receive referrals through the Multi-Agency Safeguarding Hub (MASH). The pilot clinic is attended by the (pilot-funded) FGM Practitioner and either the (pilot-funded) Community Coordinator or other community volunteers, and also by the specialist FGM Midwife and, when possible, a Sexual and Reproductive Health Consultant (whose roles are not funded by the pilot). During the second phase of the pilot, the FGM Practitioner took on the additional role of Acting Project Lead, as the original Lead had left the post.

At Site B, there is one weekly and one fortnightly clinic, each held at a different hospital in the borough. (A further FGM clinic is based in a community setting in the borough, but is not part of the pilot). Professionals may refer women directly to the FGM clinics and women may also self-refer by telephoning to ask for an appointment. Referrals are particularly encouraged from midwifery staff. At each clinic, there is a different specialist FGM midwife based at that hospital (who is not funded by the pilot). The (pilot-funded) FGM Practitioner and Community Mediators attend both clinics. The (pilot-funded) therapist attends one clinic and is also available to women seen in the other clinic if they

want counselling or therapeutic support. There is also a Local Authority Project Lead at this pilot site, who is not funded by the pilot.

At Site C, there is one monthly FGM clinic held within a hospital maternity unit in the borough. Midwives and other professionals may refer women who have undergone FGM to the MASH. The MASH screens all FGM referrals to determine whether a referral to social care or Early Help is appropriate. If Early Help is appropriate, the MASH refers the case on to the FGM Practitioner. (If a referral to social care is required, the FGM Practitioner is also copied in to provide support to the social worker allocated to the case.) Antenatal midwives referring pregnant women to the MASH simultaneously make a referral directly to the FGM clinic via the clinic midwife. Clinics are attended by the FGM Practitioner (who, unlike the other FGM Practitioners in the pilot, is based in Early Help, rather than statutory social care) and the Community Mediator (both of whom are funded by the pilot), and the clinic Midwife and a member of Obstetric medical staff (not funded by the pilot). Site C also has a Local Authority Project Lead, whose role is not funded by the pilot.

## **Social care/children's services**

At Site A, with regard to women referred to the clinic through the midwifery route, the FGM Practitioner talks with women in clinic to ensure they understand the law and to give advice on safeguarding. The FGM Practitioner also assesses any risk using the Department of Health FGM risk assessment tools, generally completing the risk assessment in clinic. (There is one tool each for pregnant women, women who are not pregnant, girls under 18 who have undergone FGM, and girls under 18 who have not undergone FGM). Where the FGM Practitioner receives a referral for a woman who will not be seen in clinic (because, for example, the referral has come through the MASH route and no health needs have been identified), but has daughters, the FGM Practitioner may conduct a home visit to complete a risk assessment. Where no risk is identified, the case is closed to social care. Where risk is identified, a referral is made to the relevant social care team to conduct further assessment and progress the case within social care.

At Site B, the FGM Practitioner has an initial talk with women in clinic to ensure they understand the law and to give advice on safeguarding. An initial assessment of risk is also made. Where women are pregnant with a girl or have young daughters, the case is referred to the social care contact and assessment team. A home visit is conducted by a member of the assessment team and a full FGM risk assessment is made using the standard children's social care 'assessment framework'. Home visits are usually booked with families by either the FGM Practitioner or a Community Mediator, to ensure the purpose of the visit is understood and the timing is convenient, and a Community Mediator usually also attends the visit. The FGM Practitioner may also, when appropriate, attend with or go instead of the assessment team social worker, although

this has happened less frequently in the second phase, as assessment team staff have gained more training and experience.

At Site C, for maternity referrals to the clinic, the (Early Help) FGM Practitioner either conducts an assessment of risk at the clinic or, if there are girls under 18 in the family, arranges a home visit to complete the risk assessment. As at Site A, Department of Health FGM risk assessment tools are used for this process. For other referrals from the MASH, the FGM Practitioner telephones the family to attempt to arrange a home visit, in order to conduct a risk assessment, or, if the family cannot be reached, books the appointment and sends a letter to inform the family about the visit. Based on the outcome of the risk assessment, the case may be closed, an offer of a further Early Help assessment may be made, or the case may be referred on to other departments and services as appropriate. The FGM Practitioner at this site also acts as Practice Educator for two student social workers during the pilot, delivering ongoing training and shadowing on FGM casework.

At all 3 sites, FGM Practitioners provide FGM training, consultancy, advice and guidance to social care and other professionals, as well as taking part in community and schools events to engage in dialogue around FGM and discuss other community issues.

## **Community engagement**

At Site A, the pilot-funded community role is the Community Coordinator, who organises and trains volunteers (of whom there are currently 8) to attend clinic and engage in community outreach and awareness-raising events. The Community Coordinator also sometimes attends clinic, though this has happened less frequently in the second phase of the pilot as the focus has shifted to training more volunteers.

The Community Coordinator and volunteers at Site A, and the Community Mediators at Site B, facilitate clinic attendance in a similar way, by calling women in advance to explain and provide reassurance about the purpose and process of the clinic. They also advocate for families, and mediate between families and staff, at the clinic to ensure mutual understanding and a positive experience. Where possible, they provide ad hoc translation (although they are not a specialist translation service). They also conduct follow-up telephone calls with women to gain feedback about their experiences of the clinic.

In cases where home visits are required, at Site A, the Community Coordinator accompanies the FGM Practitioner to ensure the experience is as smooth and constructive as possible. At Site B, Community Mediators liaise with the contact and assessment team to arrange a convenient time for the visit, and also accompany the social worker to ensure the experience is constructive. At both sites, these staff also speak to families after visits about their experiences.

Importantly, the community roles provide a channel for feedback to pilot and social care staff about what has and has not worked in direct work with families, and for mediation to resolve any issues when problems occur.

A large part of the community roles at both sites is the organisation and delivery of FGM outreach and awareness-raising events in community and school settings. The roles have been filled by members of a local charity and a local grassroots community organisation. Those in the community roles have held regular community events to open up conversations about FGM; raise awareness of the case against FGM; empower community members to advocate against it and seek help if they need to; and broker better relationships between communities and services.

The Community Mediator role at Site C is very much focused on the organisation and delivery of outreach and awareness-raising events, as well as on the provision of FGM training to a range of professionals. Different sessions are tailored to participants' needs. Events have taken place in community settings – such as community centres and people's homes – as well as in schools, where awareness-raising sessions have been tailored to school governors, teachers, pupils and parents. Several events have garnered significant media attention. In addition, the Community Mediator attends the monthly clinic, sitting in with women during their discussion with the FGM Practitioner to provide advocacy, support and information.

Sites A and C also have a Male Worker, whose role is focused on outreach and awareness-raising events with men in the community. This role is funded from the original funding for the first phase of the pilot. Site B originally had a pilot-funded Male Worker, but ended this post during the second phase of the pilot.

## Therapy

During the first phase of the pilot, Sites A and C funded a dedicated therapeutic service for women who had undergone FGM. This was provided by a local charity, located in a community setting, with expertise in delivering therapy to BME communities and vulnerable communities, and in harmful practices and violence against women and girls. This service received few requests for support from women seen by pilot staff and funding was discontinued for the second phase of the pilot. The charity did, however, take steps to reach out through other local charities and community organisations, and was thereby able to provide courses of therapy to women who had undergone FGM. For the second phase of the pilot, therapeutic services in these sites were 'mainstreamed', through an agreement that Improving Access to Psychological Therapies (IAPT) would accept referrals from pilot staff.

The protocol at Site B is to offer all women seen in the 2 pilot clinics counselling or therapeutic support, and there is a dedicated therapist situated 'in-clinic' at one of the

clinics. Another therapist had been situated within the other clinic during the first phase of the pilot, but the role did not continue into the second phase. Unless women in the clinic where the therapist is based opt out, the therapist conducts a brief initial mental health assessment. This identifies any needs, such as depression, for which a referral may be made to the hospital's antenatal psychiatrist. The therapist also discusses post-natal depression and how women can access support if they are affected by this in future. The brief initial assessment also enables the therapist to identify potential signs of trauma. If signs of trauma are identified, women may be invited to clinic again for a further assessment. Where need is identified, women may then be referred on to relevant services, or offered ongoing trauma therapy with the clinic therapist. Where trauma therapy is inappropriate or declined, but women want to, for example, learn about relaxation techniques to help them during labour, one-off therapeutic sessions are also provided by the therapist.

In some cases, the therapist has supported women during their deinfibulation procedure. In recognition of the psychological challenges women can face after deinfibulation, the therapist generally telephones women post-procedure to ensure any mental health needs are identified and addressed.

The therapist is also active in 'skilling up' other clinic staff to improve their ability to identify signs of discomfort, anxiety, depression and trauma. More broadly, the therapist has provided FGM training to health and other professionals, and has taken part in several community events discussing FGM and other community issues.

A significant piece of work conducted by the therapist at Site B is the development of specialist FGM mental health protocols. These protocols have been developed in collaboration with experts in FGM and psychological therapies (who are external to the pilot), and are to be launched in 2017. It is intended that these will fill the gap in clinical guidelines on pre-assessment, assessment, and the different kinds of therapy that may be useful for women who have undergone FGM.

## The evaluation

The evaluation of the first phase of the FGM EIM pilot examined two central questions:

- What impact does the project have on service delivery, and on the working practices of professionals working to prevent new cases of FGM and support women who have undergone FGM?
- What impact does the project have on women who have undergone FGM and members of potentially affected communities, including those who are at risk of FGM?<sup>3</sup>

The evaluation of the second phase of the pilot has refined answers to these questions, while focusing in more detail on best practice in the social care/children's services response to FGM, and in collaboration between services and communities. The central evaluation questions were:

- What lessons have been learned during the pilot for the social care/children's services response to FGM, in terms of both systems and professional practice?
- What lessons have been learned during the pilot for collaboration between social care/children's services and communities?

In order to answer these questions, a range of methods were undertaken.

A review of monitoring data on case management was conducted to understand the scale and outcomes of casework. In-depth, one-to-one, semi-structured interviews were conducted with key professionals involved in the development and delivery of the pilot in each of the 3 local authority sites. These included interviews with the 3 Project Leads (including one FGM Practitioner who took on the additional role of Project Lead in the second phase of the pilot), the 3 FGM Practitioners, 2 Therapists, 4 Community Mediators, and 2 trainee social workers. The interviews identified how the pilot has been implemented in the different sites and key lessons from the pilot, including the main enablers of, and barriers to, success.

In-depth, semi-structured interviews with 4 women who have been supported by the project were conducted across 2 pilot sites to improve understanding of their experiences and views of the pilot. The husband of one of these women was also interviewed. Significant obstacles to interviewing women were encountered in 2 of the pilot sites, and the number of these interviews is therefore lower than originally anticipated. Access to client interviewees was dependent on pilot staff, who held records of the women seen by

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<sup>3</sup> The Mayor's Office for Policing and Crime Female Genital Mutilation Early Intervention Model: An Evaluation (2017) <https://www.gov.uk/government/publications/female-genital-mutilation-early-intervention-model-evaluation>

pilot staff, and were therefore necessarily 'gatekeepers' between the evaluation team and clients. Staff in 2 pilot sites expressed the concern that the timing of the evaluation might be inconvenient for clients, given that women seen in clinic tended either to be pregnant or to have recently given birth. In the other pilot site, Community Mediators were instrumental in facilitating interviews with clients.

# Key findings

## Performance figures

### Clinic attendance and risk assessment

At Site A, 16 women were seen in clinic between July and December 2016. During that time, risk assessments were completed by the FGM Practitioner for 28 families. All risk assessments resulted in the risk being assessed as low, and no Child Protection or Child In Need plans were required.

At Site B, between July and December 2016, 47 women were seen across the 2 FGM clinics. 18 cases were referred to children's social care for further risk assessment. 8 cases of pregnant women were being tracked at the time of writing, which will be followed up to ascertain the gender of the baby (in order to make a referral to children's social care if a baby girl is born). Of the risk assessments that were completed, 1 identified that a child had been privately fostered and the child was therefore designated a Child In Need and given a private fostering assessment. A further 3 remained open to social care due to the mother being identified as vulnerable. Other cases were assessed as low risk and had their cases closed to children's social care. No Child Protection Plans have resulted from the risk assessments.

At Site C, between July and December 2016, 17 pregnant women were seen in clinic, all of whom were referred to the clinic by maternity or antenatal clinic midwives. A further 5 women were referred to the FGM Practitioner via the MASH. Two of these referrals came from Health Visitor, 2 from the police and 1 from a GP. None of the referrals screened by MASH required social care involvement. Risk assessments were carried out for 22 families. Of those cases for which no risk assessment was completed or planned, 3 had moved out of the Borough, 2 had refused the assessment, and 1 had demonstrated low risk without the need for a formal assessment. All cases for which a risk assessment was completed were assessed as low risk, including the 2 referred by the police after their families had been stopped at airports under Operation Limelight.

The total numbers of women seen in clinic and risk assessments completed across the 3 pilot sites during the second phase of the pilot are given in the table below.

**Table 1: Clinic attendance and risk assessments**

	Site A	Site B	Site C	Total
Women seen in clinic	16	47	17	80
Families with risk assessments completed	28	18	22	68



## Training and events

Pilot staff have delivered FGM training to professionals, as well as outreach and awareness-raising sessions in school and community settings. The numbers of sessions and events delivered are given in the table below. (Complete data on numbers of attendees were unavailable.) Across the pilot sites, 34 training sessions were delivered to professionals working within social care/children’s services, health, education and the police, 7 sessions were delivered to school pupils and 4 to pupils’ parents, and 21 events were delivered within communities. The numbers participating in these sessions varied, but several (and particularly the schools-based sessions) garnered audiences in the low hundreds.

**Table 2: Sessions and events**

	Site A	Site B	Site C	Total
Training – social care/children’s services	8	3	1	12
Training – health	6		1	7
Training – education (schools and nurseries)	3	1	10	14
Training – police			1	1
Sessions with school pupils	2		5	7
Sessions with parents of school pupils		3	1	4
Community events	5	7	9	21
Media appearances			3	3
Conference for professionals	1		1	2
Total	25	14	32	71

## Psychological services

During the first phase of the pilot, 12 women at Sites A and C received psychological support (in courses ranging from a few weeks to several months) from the pilot-funded, community-based therapist. Two women were referred from the FGM clinics and a further 10 were engaged by reaching out through other community organisations. Since the discontinuation of funding for that service and the mainstreaming of psychological support to IAPT, no referrals to psychological services have been made through the pilot.

At Site B, the therapist reported having conducted initial psychological assessments with the majority of women attending the clinic. Five women accepted the offer of further assessment and referral to NHS psychological services, while 1 engaged with a long-term course of trauma therapy with the clinic therapist. A further 4 received one-off therapy sessions.

None of the women interviewed for the evaluation had felt the need to take up psychological support. Therapists and other pilot staff reported the view that take-up was

low because many women were well able to deal with the psychological consequences of their FGM. Further, all staff considered that accessing NHS-based mental health services often has considerable stigma attached to it. Some also reported that far less stigma was likely to be attached to a community-based therapeutic service provided by a local organisation, such as that funded during the first phase of the pilot. While this did not receive many referrals from health or children's services professionals, that it garnered clients through community-based outreach indicates that community-level therapeutic services may represent a comparatively more successful route toward more widespread provision of therapeutic support to women who have psychological needs resulting from their FGM.

## **Lessons for the social care/children's services response to FGM**

While much progress was made toward an appropriate social care/children's services response to FGM cases, the pilot also faced some significant obstacles to the achievement of this goal. As a result, much was learned by pilot staff regarding the factors that enable and hinder such progress. The clear implication of the findings presented below is that, for social work in FGM cases to be successful in supporting women and safeguarding children, social care cannot operate on a business-as-usual model. Casework, including risk assessment, in FGM cases should be conducted by dedicated specialist FGM practitioners with advanced training and expertise in FGM, in close collaboration with members of potentially affected communities.

### **Background context**

Two aspects of the background context of social work practice in FGM cases were repeatedly highlighted in interviews with Project Leads, FGM Practitioners, and Community Mediators. These constitute significant challenges in themselves and are related to further challenges that pilot staff sought to address.

First, pilot staff reported that, on the basis of the risk assessments completed during the pilot, they were confident that children within many families wherein a woman has undergone FGM are well-loved and cared for by their parents. That is, the kind of abuse and neglect that would standardly invite intervention is not a factor in most FGM cases seen during the pilot. These staff also reported that, nonetheless, the systems, protocols and practice of social care interventions typically reflect and are suited to fulfilling the requirement to identify and address abuse and neglect. In the context of the social care systemic response to FGM cases, then, the general tendencies of the statutory social care system (notwithstanding changes implemented during the pilot) were characterised as often ill-suited to constructive, impactful work with individuals, families, and communities affected by FGM. This general tension was identified as a key aspect of the

background context not only of the work of the pilot, but of standard statutory social work in FGM cases more generally.

Another aspect of the circumstances in which the pilot took place concerns the (dynamic) reputation of, and attitudes toward, children's social care. Two of the women we interviewed reported having started their engagement with the pilot believing that the service exists solely 'to take children away from their families', and wanting 'nothing to do with it'. Community Mediators also reported that, at least at the start of the pilot, many members of the communities from which they were drawn held similarly narrow and negative views of children's social care. There is, however, evidence that this perception is being successfully addressed: both women had a more positive perception of children's social care at the time of their interviews, which they directly attributed to the pilot. Further, Community Mediators consistently emphasised that changes in the attitudes of local community members to the service, though gradual, are being achieved as the pilot continues. This was attributed in part to their community outreach work, including events that brought together members of communities with social care staff to explain the work of the pilot in the context of UK legislation. It was also attributed to word about families' direct experiences of the work of the pilot spreading within communities. In particular, the view of social care as existing to remove children was being dispelled as home visits occurred, assessments were completed, and cases were closed.

## **Arranging home visits**

At the start of the first phase of the pilot, some sites sent families a letter to inform them of the time of their home visit. By the second phase of the pilot, FGM Practitioners or Community Mediators at all sites generally telephoned families in advance of home visits in order to explain and provide reassurance about the purpose and process of the visit, and to book it at a convenient time. Pilot staff reported families' feedback to Community Mediators suggested this provision of a full explanation to families (where possible, in their own language) had worked well to reduce most families' anxieties both before and after visits, and facilitate positive engagement. Interviews with families supported this finding.

## **Risk assessment tools**

Risk assessment at pilot sites was completed using different assessment tools. FGM Practitioners reported that none of the tools was ideally suited to the assessment of risk in FGM cases. The specific problems they identified, as well as suggestions for improved risk assessment practice, are outlined below.

At one site, social workers used the standard social care risk assessment framework. Using this standard framework, social workers assess children's 'developmental needs' (including in health, education, emotional and behavioural development, identity, family

and social relationships, social presentation, and self-care skills), parenting capacity (including in basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries, and stability), and family and environmental factors (including family history and functioning, wider family, housing, employment, social integration, and community resources).

A key piece of consistent feedback from families at this site, reported by FGM Practitioners, Community Mediators, and client respondents, was that this assessment is not well-suited to the purpose of identifying and addressing risk in families wherein a woman has undergone FGM, and has in practice often led to counterproductive results. These participants reported that discussion between social workers and families should remain focused on the issue: FGM. Where risk assessment has focused solely on the risk of FGM (rather than extending to an assessment of the risk other forms of abuse, or neglect), and where families have been informed about the law and good safeguarding practice, and asked if there is any further support they require, home visits have tended to go relatively smoothly. Families have expressed to Community Mediators their appreciation of the information and support they received from the service. Where far more wide-ranging discussions have taken place, in which social workers have, for example, asked parents directly about the ways in which they discipline their children, or sought to inspect children's bedrooms, families have tended to report to Community Mediators that the experience felt intrusive, accusatory, and disrespectful.

All pilot staff emphasised that these negative experiences were often discussed widely within local communities, and that, as such, each negative experience may have an impact not only on the family in question, but on the willingness of a far greater number of people to engage with social care. As willingness to engage (and, in particular, to openly disclose potential risks and comply with requests) is key to safeguarding, unless there are specific concerns about additional needs unrelated to FGM, full use of each section of the standard social care assessment framework is therefore likely to be counterproductive to the aims of the pilot.

Risk assessments at the other sites were completed using the 4 Department of Health FGM risk assessment tools for women who are pregnant, women who are not pregnant, girls who have undergone FGM, and girls who have not undergone FGM. While certainly more focused on the risk of FGM than the standard assessment framework, the tick-box format of this tool was criticised by both FGM Practitioners who used it. Again, the FGM Practitioners at these sites reported that not all questions are appropriate for all families, and that the formulaic structure of the tool does not lend itself to the kind of open, exploratory discussion that in their view enables the most reliable assessment risk.

Two of the FGM Practitioners reported that they were each developing their own guidance for FGM risk assessment. While acknowledging the reassurance that very formulaic tools can provide to social workers, and especially those with less relevant

experience or expertise, both reported that their guidance would advise social workers on the kinds of conversation they should have with families, rather than listing fixed criteria to be applied in each case. It was emphasised that practitioners assessing risk should be sufficiently knowledgeable and experienced as to feel confident exercising their professional judgement regarding what – and what not – to discuss: not all questions or areas for discussion suggested by tools are necessary or helpful to broach with all families.

## **Good practice and interpersonal skills**

In addition to using an appropriate tool and method to assess risk, social care staff emphasised the importance of good interpersonal skills and of taking the right approach to their direct interactions with families. They reported highlighting in training provided to social care/children's services staff that, in all families referred to social care for FGM risk assessment, there is a woman who has been the victim of child abuse. Moreover, while safeguarding children must always be their first priority, given outcomes of completed risk assessments, it is likely that in many more families there will be very low risk identified. This should be reflected in practice, in order that the overall impression families gain of social care is not one of an agency that suspects them of intent to commit a crime. An overly 'heavy-handed' or 'draconian' approach to interaction is not only unnecessary, but potentially counterproductive, given the potential for negative experiences to have damaging impact on families' and communities' willingness to engage, and therefore social care's ability to safeguard.

This was corroborated in interviews with families. Where it was felt social workers had been friendly and open, families had been reassured by the visit. Where it was felt practice had been more brusque and focused on getting answers to set questions, families reported having been left feeling anxious and fearful of the service.

Community Mediators warned, however, that feedback from clients indicated the need for social workers to display the right level of sensitivity. This topic also featured in training delivered to social care/children's services staff. On the one hand, there are reasons to be highly sensitive in discussions of FGM: it is often viewed by women as a deeply personal and private issue. In some cases, it may be associated with trauma or other difficulties. On the other hand, Community Mediators reported that many women who have undergone FGM do not identify as traumatised victims and may feel patronised by overly sensitive practice or practice that appears to them as pitying. There is a balance to be struck here in practice.

## **The specialist FGM practitioner model**

As outlined above, risk was assessed in different ways at the different sites. Findings from pilot staff and client interviews indicate that effective risk assessment and support

for families is best delivered by dedicated practitioners with extensive training and expertise in FGM casework.

### **Evidence of the benefit of expertise**

A student social worker receiving Master's level training in FGM casework at Site C discussed the importance of specialist expertise in FGM to successful practice in these cases. She described a case (seen during the pilot's first phase) in which a pregnant woman's referral notes had stated that she had declined deinfibulation. This was interpreted as a potential indicator of support for FGM. However, explaining her decision in a discussion with the student social worker, the woman described her very considerable fear of 'going under the knife again'. The student social worker affirmed the choice was hers to make, but offered further information about the benefits of deinfibulation, particularly for pregnant women, in order that she was fully informed. Two days later, the woman requested the procedure. Both deinfibulation and community-based psychological support was arranged for her. The student social worker explained:

'Our conversation helped her, because that's when she was able to say, 'Okay, it affected me'. But if I myself had not been informed on how to support and talk to the lady, and on deinfibulation, how would I have been able to support her? Every social worker in contact with these women needs to have this knowledge, because it might be their conversation that leads to, for example, a decision to have deinfibulation. They need to know the right approach. It's a very sensitive topic for many women. If I had just been a social worker going there to just fill in my form, I would not have understood what she could be going through. I might not have been that empathetic. But because I was informed, I used the right approach. And that really helped. So we need to be empathetic, sensitive, and knowledgeable. With all this together, you can make a big difference to people's lives.'

At Sites A and C, the FGM Practitioners generally conducted the risk assessments. These professionals reported that they had developed their understanding and skills throughout the pilot, and significantly improved their practice as a result. Community Mediators also reported that FGM Practitioners' practice had improved and that feedback from families had become increasingly positive as they gained experience. The clear benefit of having dedicated FGM Practitioners to conduct these assessments were that, by the second phase of the pilot, practitioners had developed considerable (and continually expanding) expertise regarding the health and legal implications of FGM, the various forms of support that may be appropriate, and the considerable cultural, religious, familial and individual diversity among potentially affected communities. This enabled them to deliver effective risk assessment and support.

At Site B – the largest of the 3 Local Authorities – the FGM Practitioner did not have the capacity to conduct all risk assessments and social workers from the local contact and assessment team therefore generally conducted this function. A significant part of the FGM Practitioner’s role during the first phase of the pilot was to provide training in FGM casework to the 20 to 25 social workers in each team and also, during both phases, to speak to them about each of their allocated cases to ensure they were appropriately informed before conducting the home visit. In some cases, where the FGM Practitioner judged the case to be particularly complex or sensitive, she accompanied or went instead of the social worker on the home visit.

The normal process of arranging home visits within the assessment team is to send a letter informing families of when the appointment will take place, which clinic staff found had resulted in significant anxiety within some families. To reduce this anxiety, an arrangement with the assessment team was made, whereby Community Mediators, or sometimes the FGM Practitioner, would mediate between the team and the family to arrange a convenient time for the visit.

Cases were initially allocated within the assessment team according to capacity. However, pilot staff reported that this process had not worked well. A small number of home visits conducted by the assessment team had the effect of risking the good reputation pilot staff were working to cultivate for the pilot, and for social care and services more generally. Unhelpful practice identified in these cases included approaching risk assessment ‘like a tick-box exercise’, and interaction that had an overbearing, accusatory or insensitive tone. In these cases, families had been left upset, and word had spread through their communities about their negative experiences. The FGM Practitioner and Project Lead at this site both noted that part of the cause of the problems was that, while training had been provided to the team by the FGM Practitioner, the level of staff turnover was extremely high. While the benefits of training social workers who subsequently left the team would, it was hoped, be felt in other areas, they were lost from the pilot site. New social workers with relatively limited training and experience in FGM were being allocated cases for assessment.

The response at that site was to shift further toward a ‘specialist FGM practitioner’ model. Currently, intensive training is being focused on 3 members of the assessment team, to which FGM cases will be allocated. Thus, an important lesson identified by pilot staff is that practitioners conducting assessment of risk of FGM and providing support to women who have undergone FGM should have specialist expertise in this area. While appropriate levels of training on FGM should be provided to all relevant social care and children’s services professionals, direct work with families (including assessment) should, where possible, be conducted by dedicated staff with advanced specialist training.



## Responding to community feedback

Another lesson for the social care response to FGM cases is that having a channel for, first, feedback from communities and, second, mediation of problems when they arise, was crucial to the delivery of effective interventions. All social care staff interviewed reported that, while the pilot started in the context of a broader social care system that was not designed for safeguarding against the risk of FGM, and aimed to introduce a model that was better suited to safeguarding within potentially affected communities, they initially had limited experience of 'what works'. The model needed to be reflexive and responsive to local circumstances, and so to include a mechanism that would enable continual learning about how the pilot was being experienced and perceived in local communities. Community Mediators are drawn from – and well-known and trusted by many members of – local potentially affected communities, while also being firmly committed to the principles of safeguarding. Through holding conversations with families that are often, they reported, more open than they would be if a health or social care professional were in their place, they were able to identify 'what works', and what was not working well, locally. Their feedback thereby enabled the continuous refinement of the model. The Community Mediators were therefore consistently identified by pilot staff as a crucial element of the Early Intervention Model: without the channel for feedback they created, lessons for good practice in assessing risk and supporting families may have been missed.

Community Mediators also facilitated the resolution of tensions that arose during the pilot between local communities and children's social care. In several cases, Community Mediators were able to mediate to resolve families' unofficial complaints about children's social care before they were formally escalated (see the case study below). Often, resolutions were achieved through improving each party's understanding of the other's position. Part of the message Community Mediators communicated to women, families and communities about children's social care is that its purpose as a system is to safeguard children and that social workers are now in a position where they must formally assess risk of FGM to any daughters of women who have undergone FGM by discussing certain issues with families. Part of the message they communicated to children's social care is that if this process unnecessarily makes families feel under suspicion of intent to commit criminal abuse of their children, it risks alienating communities and creating barriers between families and services that need to be bridged if effective safeguarding is to take place. Pilot staff reported that, rather than reacting defensively, local social care staff generally responded in a constructive manner, acting in good faith to address families' concerns about systems and practice.



## Working with community organisations

As outlined above, Community Mediators provided advocacy and mediation for individuals and families, a channel for clear communication between communities and services, and community outreach events to discuss FGM and promote understanding of services and legislation.

A majority of pilot staff interviewed emphasised that, in order to perform this function successfully, Community Mediators must occupy a distinctive bridging position between communities and services. In order to do this successfully, they reported, individuals and the organisations from which they are drawn need to be trusted by members of communities and clearly distinguishable from ‘the authorities’: they must be – and be seen to be – ‘on the side of the community’. Simultaneously, they need to be fully committed to safeguarding responsibilities and able to navigate social care and other statutory systems that can sometimes be ‘labrynthine’ or ‘clunky’. They also need the strength and conviction to be able to respond to the disappointments and frustrations of members of communities that are often directed at them, as key stakeholders. As with the FGM Practitioner role, those fulfilling the community role benefitted from training and support in balancing these requirements.

One Community Mediator emphasised the inherent precarity of her and her organisation’s position. If they are viewed as apologists for a service that is imposing on communities without providing valuable support or addressing valid concerns, they will lose the trust and openness that enables them to perform their function. This introduces a sense of urgency for social care to get it right, and of the limits to how many cases can go badly before the community role becomes untenable. Systems in social care and children’s services that were, standardly, set up to address families experiencing abuse or neglect need to be able to work effectively with families where no abuse or neglect is present. Again, having a specialist FGM practitioner to assess risk while also empowering families by providing them with full information and support was seen as key to ensuring the most effective social care/children’s services response to FGM. The Community Mediator explained:

‘Sometimes when I’m explaining the work we do, I feel like I’m walking a thin line. I could fall this side or this side. If I fall on the side of children’s services, I’m going to cut off my community connections. If I fall the side of my community, I’m going to cut off everything to do with children’s services. So there has to be good understanding, because the last thing I want is to become estranged from my own community. Because that’s the whole purpose, that’s the whole aim of the organisation, to be honest. There needs to be a change in how children’s services approach FGM. Because if they don’t do that, I don’t know how far we can go. We can do so much to make the community integrated, to develop the community. But on the other side, they have to do the same thing. We need to meet in the middle. We can’t go all the way from where we stand to family and

children's services, because then we'd become estranged with our own community. And if we become estranged, we won't be able to exist. We'd rather leave and continue what we do. Or we have to meet at a middle point of understanding each other. The longer this is not resolved the more difficult it will be for communities to accept family and children's services' support. There will be no negotiation. There will be no coming together and working together. There will be more vulnerability. There will be more 'hard to reach' communities. There are issues that make communities 'hard to reach', that need to be resolved. And the way we resolve them is to understand them, and come to a midpoint.'

## Case study

Pilot staff at Site B facilitated an interview with a family who had experienced a home visit that had gone badly. The case is illustrative of the importance of 2 central elements of the implementation of the early intervention model at that site: client advocacy by Community Mediators, and skilled risk assessment informed by the FGM Practitioner's experience. The problems arose in this case largely because, for various reasons, those central elements were not in place.

Due to a combination of annual leave and sick leave, one clinic was held with only the midwife present and without Community Mediators having telephoned women in advance. The midwife provided information and health advice to a woman who attended, and also told her she would get a call in a few weeks about a social care home visit. The woman reported in interview having not fully understood the purpose of the home visit and having, as a consequence, felt extremely anxious about it. On returning from leave, the Community Mediator telephoned to explain the purpose of the home visit and book it for a convenient time. She then accompanied the assessment team social worker. At that stage of the pilot, neither had yet gained very extensive experience of home visits for FGM risk assessments. The woman reported her experience:

'Once the social worker came on the home visit, everything changed for me. At the beginning, I thought she was coming for FGM, that she would ask specifically about FGM. But, although she asked a few questions about FGM, she asked about the whole family, deep questions about the children. She said 'I want to speak to the children, I want to see them separately, I want to contact their school, I want to contact your GP'. So we began to get really worried, you know? We thought 'Why have you come here? You came here because of me, because I had FGM. You've done something good which is to explain to me all the information about the health complications and the law around FGM, all the details. I've told you how I feel about FGM. But what I don't understand is: why do you have to involve the school and the GP? Why do you have to speak to my children separately?' All this became really upsetting. It made me really worried. I felt, where they are coming from, they don't understand me. They should have more understanding, more connection with me and with where I'm coming from, why I'm really wary, why I'd be

really concerned about social services contacting the school or GP about my family. I didn't feel that was there.'

Following the visit, a Community Mediator telephoned the family to discuss their experience. The woman's husband explained their reaction to her. The Community Mediator reported:

'The father, when I called him to make another appointment, was really upset. He said, 'I am gathering members of the community together to complain about what I've been through. We welcomed the social worker into our home, and the whole issue diverted to something else that was not necessary. I don't understand why my children were asked certain questions. I don't understand why all these things are happening, when we're against FGM, and we're actually trying to cooperate, and we're welcoming people into our home.' So he was really upset.'

The Community Mediator fed back to pilot and assessment team staff the details of what had gone wrong. She explained:

'I went back to social services and said, 'This is really not the way we expected the community to be treated. The whole family felt like there was so many intrusions in their private life. They've been cooperating but things have been escalating in a different direction. We want you to come back and to explain to them the reason why you are doing this.' So I had to get involved. After we had discussed what happened, the social worker went back to the family, explained everything, and apologised. The case is about to close now. This is not the way it should be. We should treat the community in better ways.'

Through skilled mediation, drawing on years of experience of brokering better relationships between the local community and local services, Community Mediators were able in this case to facilitate better understanding on each side about what had happened and why. The problem was resolved and the family reported feeling much better about the experience. The women reported:

'We felt very happy about how the complaint was dealt with. We felt like the community was behind us and they supported us as soon as we complained. We feel like the problem has been resolved. The social worker understands the mistakes she made at the beginning. And things are really much better for us because we feel like we are supported. We are not fearful anymore.'

The Community Mediator emphasised that, in her judgement, the tensions in this case might have been avoided had the clinic operated on the pilot model:

'What frustrates me, is that month of frustration she went through. If she'd had the initial attachment with the Community Mediator and FGM Practitioner at the clinic, she would not have been so fearful. I think her case is really unfortunate.'

## Limitations

Significant obstacles to interviewing women were encountered in 2 of the pilot sites, and the number of these interviews is therefore lower than originally anticipated. Access to client interviewees was dependent on pilot staff, who held records of the women seen by pilot staff, and were therefore necessarily 'gatekeepers' between the evaluation team and clients. Staff in 2 pilot sites expressed the concern that the timing of the evaluation might be inconvenient for clients, given that women seen in clinic tended either to be pregnant or to have recently given birth. In the other pilot site, Community Mediators were instrumental in facilitating interviews with clients.

Online 'learning logs' were designed and distributed to staff involved in the delivery of the pilot. These asked about professional knowledge and practice in cases of FGM. However, participation rates in this evaluation method were not sufficiently high for analysis of learning log responses to be included in the evaluation report.

The evaluation of the first phase of the pilot focused more broadly on the general features of the FGM Early Intervention Model, and on the factors that enabled and hindered constructive collaboration between health services, social care/children's services and communities. This evaluation of the second phase of the pilot focuses more narrowly on the impact of the pilot of social care/children's services systems and practice, including collaboration between those services and members of potentially affected communities. The evaluation sets out in greater detail the variations in the implementation of the model at the different pilot sites, directing analysis toward the lessons learned by social care/children's services regarding what works best for supporting families and safeguarding children. For further information on other aspects of the FGM Early Intervention Model, please see the evaluation report for the first phase.

## Implications and recommendations

The findings of this evaluation suggest several lessons for best practice in the social care/children's services response to cases of FGM, including lessons for collaboration with communities.

- One family's experiences can have an impact on the willingness to engage with services of much wider sections of communities: it is important to get each interaction (including, importantly, home visits) right. Negative experiences can result in families feeling alienated from and less willing to engage openly services, thereby reducing the ability of social care/children's services to deliver effective safeguarding.
- Risk assessment should reflect the reasons for which families are referred for assessment. For families assessed because the mother has undergone FGM (and has therefore been a victim of child abuse), and where there are no further specific concerns about the safety and wellbeing of the children, risk assessment should have a relatively narrow focus on the risk to children of FGM. Offers of more general support should also be made, but practitioners should be aware that a more full and formal needs assessment (for example, following each section of the standard assessment framework) may constitute an inappropriate level of intrusion into families' lives.
- While appropriate levels of training on FGM should be provided to all relevant social care/children's services professionals, effective assessment to identify risk of FGM requires specialist knowledge and skill. It should be delivered by dedicated social care/children's services practitioners with advanced training and specialist expertise in FGM casework.
- The Community Mediator role was crucial to the effective functioning of the pilot: social care/children's services should continue to promote collaboration and co-construction of services with members of potentially affected communities. Having a channel for communication and mediation between services and potentially affected communities, provided by Community Mediators drawn from those communities and trusted by their members to represent their interests, enabled social care/children's services to learn – from mistakes as well as successes – about 'what works', and improve the efficacy of their approach to safeguarding. Families also benefitted from the support and advocacy they received from Community Mediators. This often functioned to improve experiences of social care/children's services intervention by ensuring good understanding of the process and purpose of assessments.
- Social care/children's services should recognise that the benefits of community mediation are valuable but precarious. Successful advocacy and mediation

depends on the ability of Community Mediators to work alongside services while maintaining families' trust. This, in turn, relies on services agreeing to make reasonable adjustments to improve the efficacy of systems and practice in response to constructive feedback from members of potentially affected communities.



Department  
for Education

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**Reference: DFE- RR number**

**ISBN:**

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Any enquiries regarding this publication should be sent to us at:

[richard.white@education.gsi.gov.uk](mailto:richard.white@education.gsi.gov.uk) or [www.education.gov.uk/contactus](http://www.education.gov.uk/contactus)

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