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Dear Colleague

**RE: GUIDANCE FOR SERVICE SPECIFICATION AND STANDARDS FOR HEALTHCARE TO PREVENT FEMALE GENITAL MUTILATION (FGM) AND RESPOND TO THE NEEDS OF THE SURVIVORS**

**Purpose**

1. This letter provides guidance for the healthcare services required:

- ***To support women and girls when FGM is disclosed or identified; and***
- ***To prevent FGM and protect those at risk of FGM.***

**Background**

2. A Scottish Government Short Life Working Group (SLWG) has produced Scotland's National Action Plan to Prevent and Eradicate FGM. A Multi-Agency guidance to support an integrated response for the cessation of FGM in Scotland will be available in Spring 2016. Both documents can be accessed through the link below.

<http://onescotland.org/equality-themes/gender-equality/female-genital-mutilation-fgm/>

**Next Steps**

3. An Implementation Group is being set up by Scottish Government to monitor the progress of the activities and outcomes in the Action Plan.

4. The guidance in this letter is to enable NHS Boards to deliver the actions expected from them as described in the Scotland's National Action Plan to Prevent and Eradicate FGM (2016-2020).

**From the Chief Medical Officer  
Dr Catherine Calderwood MA  
FRCOG FRCP(Edin)**

**Chief Nursing Officer  
Professor Fiona McQueen**

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18 February 2016

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SGHD/CMO(2016)5

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**Addresses**

For action

Chief Executives of NHS Boards  
and Special Health Boards

For information

Chairs of NHS Boards and Special  
Health Boards  
Medical Directors – to cascade to  
hospital doctors and GPs  
Directors of Nursing – to cascade to  
nurses, midwives and health visitors  
AHP Directors  
Directors of Public Health  
NHS Board Primary Care Leads  
BMA  
MDDUS  
MPS  
MDU  
Private hospitals  
Academy of Medical Royal Colleges  
and Faculties in Scotland  
RCN  
RCM  
Directors of Social Work  
Police Scotland  
COPFS

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**Further Enquiries**

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**Policy**

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This includes:

- ***Guidance for Service Specification for Healthcare to prevent Female Genital Mutilation (FGM); and Healthcare to respond to the needs of survivors of FGM (See Annex A); and***
- ***Service Standards to consider (See Annex B).***

5. NHS Boards should implement a pathway which includes local, regional and national services, to address the varying needs of the survivors of FGM and those at risk of FGM e.g. complex surgery could be agreed to be provided at a national level. Performance and outcome indicators for the services should be agreed at regional and national levels as appropriate.

6. Communities who may be affected by FGM should be involved in the discussions regarding service delivery and outcome indicators.

7. We recognise that some areas can be more challenging than others e.g. providing appropriate support to individuals for their communication needs, and on-going education and training of staff to develop competencies. This will enable them to handle sensitively any disclosure, appropriately assess and protect individuals at risk, and provide relevant and acceptable support.

8. Some NHS Boards may not perceive the need for pathways and processes for services in this area due to their belief of a lack of prevalence of FGM and communities who practise FGM in their areas, and therefore a lack of a need for related services. However, research undertaken by Scottish Refugee Council (SRC) (see link below) explains that survivors of FGM, and practicing communities and individuals, are present in varying numbers in all Health Board areas in Scotland, although they may not yet be apparent to healthcare services.

[The Scottish Refugee Council \(SRC\) report - Tackling Female Genital Mutilation in Scotland - A Scottish Model of Intervention](#)

9. We are also concerned about the lack of recorded national data about FGM across NHSScotland and note that this is now available in other UK countries. A short life working group, led by ISD, to review the current data collection landscape for Scotland, has concluded that the most appropriate approach would be to strengthen the recording of FGM in existing data systems in Scotland. We therefore ask you to implement processes for the recording of FGM within your Board, so that we can have more robust information about the prevalence and incidence of FGM in Scotland. Further details are contained within **Annex B** which updates the codes in the previous CMO/CNO letter - [http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)19.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)19.pdf). Importantly, the ISD led short life working group has noted the dependency on clinical staff for the recording of FGM in the correct part of the clinical records e.g. in hospital discharge summaries and GP practice clinical records.

10. Other information on information governance, resources and legislation are available in the **Annex D**.

### **Action**

11. We would be grateful if you could disseminate this information to appropriate staff and ensure that they are aware of their responsibilities in relation to FGM, including:

- raising awareness of FGM and how to handle disclosure and assess risk of FGM;

- agreeing service pathways in the Health Board to prevent and protect girls from FGM and supporting survivors of FGM. Information about such pathways should be widely disseminated to all relevant staff and the community;
- recording of data in existing data collection systems, as noted in **Annex C**; and
- contributing and actively participating in the Scottish Government Implementation Group as required.

Thank you for your invaluable support in protecting girls at risk from this illegal practice, and supporting women who are survivors of FGM.

Yours sincerely

*Catherine Calderwood*

**Dr Catherine Calderwood MA FRCOG FRCP(Edin)  
Chief Medical Officer**

*Fiona McQueen*

**Professor Fiona McQueen  
Chief Nursing Officer**

**Guidance for Service Specification for  
Healthcare to prevent Female Genital Mutilation (FGM); and  
Healthcare to respond to the needs of survivors of FGM**

This guidance includes:

- Key components of the service response;
- Access to services;
- Key Issues to consider;
- Service delivery arrangements
- Sustainability of services and

**Key components of the service response for:**

- **the prevention of FGM; and**
- **support of the survivors of FGM**

Services should be able to identify and respond to the needs of survivors of FGM, and to protect those at risk of FGM, to prevent FGM. These needs can be wide ranging and overlapping and statutory services, in partnership with non-statutory services, should be available to meet these needs.

The services will mainly address 2 major aspects:

- Services which are required when FGM is disclosed or identified. This would include information, advice, psychological and other support; interventions such as de-infibulation; and assessment of other associated female members in the family/community at risk.
- Services required to prevent FGM and protect those at risk

Healthcare responses to FGM, including consideration of other relevant forms of Gender Based Violence (GBV), should be culturally sensitive, person centred services which consider the health and well-being needs of the patient, and cover the 6 areas highlighted below. These needs are likely to be multiple, varied and overlapping and should be informed by a good understanding of any previous experiences of discrimination, inequalities and trauma the patient or their family may have had. ***Forensic medical examinations may be required only for those people who are in the care of the police.***

The needs include:

- Information (such as about services, legal issues, health impact);
- Physical health needs;
- Mental health needs;
- Sexual health needs;
- Emotional or practical support needs (such as relationship support and arranging a place of safety); and
- Risk assessments for the woman/girl, and children of the patient, and consideration of other children within the family unit.

**Some Key Issues to Consider:**

- ***Staff should be aware that FGM has been illegal in Scotland since 1985.***
- All services should be aware of the potential mental health, emotional and psychological impacts of being an FGM survivor, including the emotional impact of disclosure and the aftermath of disclosure e.g. revealing the condition and being

questioned about it, being physically examined, and the family and individuals going through a risk assessment with a potential of child protection referral process. Health Boards should be able to refer on to specialist services to respond to these needs.

- Safety and welfare of the child is paramount.
- It is sometimes difficult to differentiate the appearances of FGM from normal congenital appearances. It is important to refer the women and girls to specialists before undertaking any interventions or commencing child protection procedures.
- Professional practice involves asking questions in sensitive areas. A professional's personal fears of being thought "racist" or "discriminatory" should not compromise the duty to provide effective support and protection.
- All relevant staff involved in the delivery of services should have access to education and training regarding the management of survivors of FGM, recording of the type of FGM and any surgical interventions undertaken, as well as child protection risk assessment procedures of other female children in the family.
- All services should be person centred in considering and addressing the health and well-being needs of the individual.
- Consideration should be given to the individual woman or girl's choice of the gender of the clinician wherever possible.
- Appropriate interventions will depend on the type of FGM which presents with symptoms and whether the woman is pregnant or not. FGM is often identified during antenatal care, but sometimes not until delivery.
- Women with gynaecological symptoms such as pelvic or genital pain, incontinence or prolapse, and menstrual dysfunction may need referral to gynaecological services such as general gynaecology and urogynaecology, or some Health Boards may choose to respond via a one stop clinic approach.
- An assessment check list should be used to ensure consistency and that critical aspects are appropriately identified and addressed. This will be provided in the Multi-Agency Guidance for Scotland, which can be accessed from the link below from Spring 2016.  
<http://onescotland.org/equality-themes/gender-equality/female-genital-mutilation-fgm/>
- To prevent duplication and confusion, clear local referral pathways should be developed and be appropriately publicised. Consideration should be given to extending existing pathways and established services for other forms of GBV to include FGM.
- The contact details of a named FGM Clinical Lead in each Health Board such as a senior clinician, with a named deputy to cover for absences, should be known to the community and other professionals. The Clinical Lead should have links to the GBV Lead, Child Protection Lead, Adult Protection Lead, and relevant others. If the Clinical Lead is from the mental health services, then they should liaise with other clinical services and vice versa.
- The Clinical Lead will be responsible for ensuring that appropriate service response is available in their area to address the needs of FGM survivors and to prevent FGM being undertaken in others. The Clinical Lead will liaise with other Leads, such as for Child Protection and GBV, to develop and agree local pathways to ensure an integrated response, which minimises distress to individuals. The Clinical Lead will also be responsible for publicising widely the management of survivors of FGM and protection of others from undergoing FGM. This should include referral pathways, with the accompanying referral criteria and keep them up to date.
- The contact details, of the Child Protection Lead, GBV Lead and Adult Protection Lead, should also be known to all health professionals (including those working in the community such as GPs and Health Visitors).

- Referrals to specialist care should be documented in the clinical records and the GP practice informed of any interventions, transfer of care, outpatient follow up and discharge as appropriate.
- Clear referral criteria and discharge criteria should be agreed, with aims and outcomes measures that are expected to be met prior to discharge from specialist care.
- A discharge plan should be prepared offering support and facilities required for providing care at home. To deliver their duty of care, the healthcare professional should ensure that they take the permission of the patient/legal guardian to inform the GP and other relevant services.
- These needs are likely to be multiple, varied and overlapping in the context of previous experiences of discrimination, inequalities and trauma.
- An interpreter of a specified sex (female or male) may be preferred and the woman may not accept someone from their own community (even if they do not know them personally or have any possible connections with them). It may sometimes be very difficult to get the husband/relative to leave the room and the woman may wish or be pressurised to have them there. Private time with the woman could enable enquiry, disclosure and any follow up agreed. Clinicians should seek guidance from the Clinical Lead or other senior colleagues on when they should insist on seeing a woman alone.
- Staff should be aware that culturally sensitive services need to be balanced with gender sensitive services which support the rights of women, as they may occasionally conflict.
- It must also be borne in mind that some women may strongly resist any surgical procedure that she believes “reverses” the FGM. Sometimes from pressure from their husband/family, the woman may refuse any interventions as she may be unable to go against the husband/family’s wishes. Such circumstances will pose a challenge to protect the woman’s rights.
- Staff should be aware of and consider the clinical implications for transgender and lesbian individuals who are survivors of FGM. Local clinical guidance should include relevant information about the management of such individuals.

## **Access to Services**

There will be multiple points of access to services e.g.

- Self-Referral;
- Referral from GP practices;
- Referral from obstetrics and midwifery or other acute and community services (e.g. A&E/ED, sexual health services, family planning and genito-urinary (GU) clinics, urology, cervical smear screening, travel clinics, paediatrics, gynaecology, health visitors, school nurses, social services, mental health, out of hours primary care services, Scottish Ambulance Service and GP practices);
- Referral from third sector organisations; and
- Referral from legal agencies e.g. to support asylum claims.

## **Service delivery arrangements**

To deliver the services, different models of service delivery will be adopted by Health Boards e.g. where local needs analysis suggests low demand, specific FGM regular clinics may not be required. In such circumstances, it would be reasonable to identify and involve clinicians with expertise on FGM, who would see women in their existing antenatal/gynaecology or other clinics (including dermatology, mental health services and genito-urinary medicine) where survivors of FGM are most likely to present. An example of a practical model could

be where Consultants, midwives and others who manage survivors of GBV, could also manage patients with, or at threat of undergoing FGM, given the similar skills/experience and knowledge required, including referral for other specialist input as needed e.g. mental health services, psychological trauma services, and others. FGM is often associated with Honour Based Violence (HBV) and Child and Early Forced Marriage (CEFM).

It is unrealistic for one clinician to offer all the potential interventions as the needs are usually variable.

While most of the required services are expected to be delivered locally by Health Boards or with mutual arrangements with other Health Boards, some highly specialised services such as complex surgical interventions, where there are associated clinical complications, may require national arrangements, with clear nationally agreed referral and eligibility criteria for such services.

Clitoral reconstruction should not be performed in the UK as advised by The Royal College of Obstetricians and Gynaecologists (RCOG) in its Green-top Guideline No. 53, on the management of FGM. The current medical evidence suggests that such surgery may result in further damage to the clitoral nerves and blood vessels without conclusive benefit - *Female Genital Mutilation and its Management (Green-top)*.

It is also important that other relevant healthcare staff should have the knowledge and skills to ensure identification and appropriate timely interventions and know how to take action on prevention of FGM when required e.g. FGM is part of the core training for cervical screening in NHS Glasgow and Clyde and sensitive enquiry about FGM is routine as part of booking for maternity services.

GMC has published an information bulletin to the medical profession on FGM which can be accessed from the link below.

[http://www.gmc-uk.org/guidance/27723.asp?dm\\_i=OUY,3NFX,JWQ6LB,D4L9E,1](http://www.gmc-uk.org/guidance/27723.asp?dm_i=OUY,3NFX,JWQ6LB,D4L9E,1)

Appropriate, timely and sensitive intervention may lead to a quicker recovery and prevent further trauma leading to re-victimisation.

Effective support and communication from managers to staff at all levels about the clear recording and reporting protocols will be important to staff.

Health Boards should develop appropriate services in consultation with local patient groups, schools and community groups.

Health Boards should consider at all stages, how to incorporate the help and support of patient, community and third sector groups, as well as any on-going role for such groups, once the service is established.

Health Boards should also publicise their services and referral pathways widely, including to GP Practices and other professionals working in the community, keeping any contact lists/numbers up to date.

Robust performance and outcome indicators for the services need to be developed and agreed regionally and nationally, which will reliably measure the impact of the service, including whether the service meets the needs of this population.

For example, Health Boards should provide or enable access to services, with clear protocols, such as:

- Appropriate interpreting and communication services i.e. trained interpreter not known to the patient.
- Clinical Psychology services (including for Post-Traumatic Stress Disorder), Psychosexual services (including counselling) and Psychiatrist services, child psychologist/psychotherapist (for family issues and children). One example of such a service is the NHS Greater Glasgow and Clyde (CGC) Psychological Trauma Service.
- Maternity services with relevant expertise in the management of FGM.
- Gynaecology services including general gynaecology and urogynaecology to address the urogynaecological issues related to FGM.
- Advocacy/patient support by female individuals aware of FGM.
- Child Protection services.
- Access to de-infibulation as in-patient and/or out-patient and appropriate surgical intervention where clinically indicated.

### **Sustainability of services**

It is possible that more people may access services for care and support if they become aware of the services and have confidence in them. In addition, changes in migration patterns and population movement could increase or reduce the need for the services.

Consideration must be given to an effective and sustainable structure for the future, including succession planning of the relevant workforce and the on-going training of staff delivering these services. Services for FGM should be embedded in or linked to service responses to GBV wherever possible, as a similar skill set is required for both conditions e.g. managing trauma, awareness of safety of the women, her children and other female siblings, negotiating and empowering women to make choices regarding their health such as cervical screening, contraception/fertility/pregnancy planning, and other areas.

In the interest of sustainability of services, effective responses to FGM within Boards should not be dependent on a single clinician. Instead the expertise should be embedded within teams delivering key services, linked with appropriate succession planning.

The affected community and third sector organisations not only provide valuable input into the development of services, but also contribute to the training of staff e.g. improve cultural competency. They should be encouraged to focus on education and provision of accurate information within the communities, such as the effects of FGM and the legal issues, and support/facilitate the empowerment of communities to stop/prevent the practice of FGM. Some examples are provided in the link below.

<http://www.womenssupportproject.co.uk/vawtraining/content/femalegenitalmutilation/277,234>

It is important to periodically reassess the health care and support needs locally. All Health Boards should contribute to the national data gathering and reporting requested by ISD from hospitals, community services and GP practices as explained in the link to the CMO/CNO letter below.

[http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)19.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)19.pdf)



**Service Standards to consider**

Below are some service delivery standards to consider and agree on a national, regional and local basis, as appropriate.

1. All consultations must include a discussion about the legal status of FGM as GBV, and this must be documented in the notes.
2. All services should be designed following consultation with patient groups and local community groups. Where possible, on-going involvement should be built into the service quality improvement to ensure it remains fit for purpose.
3. Written information should be available to all in the Health Board area. This should contain:
  - Basic information about harmful effects of FGM and the health risks (e.g. problems with sex, urinary infections, vaginal infections, pelvic or genital pain, incontinence or prolapse, and menstrual dysfunction, difficult childbirth, etc.), and the legal status of FGM.
  - Information about the potential impact of FGM, including mental, psychological, emotional and relationship difficulties, with clear guidance about how help can be sought with these issues.
  - Information to the public and staff about the services available and how these will be provided e.g. a choice of the gender, of the healthcare staff where possible, free and confidential advice, etc.
  - Information about de-infibulation and appropriate surgical intervention to address complications should be available for women undergoing this procedure. Diagrams of the types of FGM should be available for clinical staff, as they may assist in explanation of the appearances.
  - Contact details for the Health Board Child Protection Lead, GBV Lead, FGM Clinical Lead and Adult Protection Lead must be available in the clinics, GP Practices and other relevant community based staff.
  - Contact details should be offered of any local community groups as well as national groups for peer support and advocacy, including the NSPCC helpline.
  - Flow charts for staff about different pathways depending on the point of access and the presenting issue e.g. those used in NHS Highland and Glasgow's pathway for maternity services (see **Appendix 1**).
4. Independent interpreting services, other communication support and support for other additional needs should be available for all women, if required. Staff should sensitively try to secure "private" time with the individual if she appears to be being pressurised by others in her family/community.
5. As the majority of girls and women will require a genital assessment a female chaperone will be required. The reason for the examination, by whom, and the reason for the presence of the chaperone and any other issues related to the examination, should be explained in a sensitive manner, before the woman undresses.
6. Access to psychology and psychosexual input should be available. Although this may not be available in a particular clinic, a clear referral pathway to a clinical psychologist or counsellor familiar with FGM should be in place. It is important to distinguish between

support, counselling and specific psychological interventions as inappropriate interventions and referrals can lead to unhelpful or harmful responses.

7. All Health Boards should have access to a de-infibulation service. If not provided by the Health Board then a clear referral pathway for de-infibulation should be in place.

8. De-infibulation may not be appropriate in every case and detailed discussions regarding the indications for surgical interventions should be held with the patient, including a realistic presentation of the benefits and risks.

9. The majority of de-infibulations is expected to be performed under local anaesthetic in an outpatient setting. Some women with extensive genital scarring or psychological distress during examination will require de-infibulation under an anaesthetic (general or spinal). This will usually require a day case hospital admission.

10. Health Boards also need to ensure that their staff have the appropriate competencies and training to handle disclosures of FGM and child protection issues sensitively, as well as have the training and competencies for appropriate clinical management. Staff should have access to existing resources (some examples below) and other reliable resources as they are developed.

<http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/maternity-care/about-us/current-projects/compassionate-connections.aspx>

<http://www.gov.scot/Topics/People/Equality/violence-women/FGM/Letter><http://www.gov.scot/Resource/0044/00446674.pdf>

11. All relevant staff involved such as in the hospital and community clinics, general practices, community pharmacies and community nursing should be familiar with the Multi-Agency Guidance for Scotland, which can be accessed from the link below from Spring 2016 <http://onescotland.org/equality-themes/gender-equality/female-genital-mutilation-fgm/> They should have also had awareness training and confidence in how to manage disclosure.

12. Health Boards must have an agreed multi-agency response to people who have had FGM. This may be within the wider Child Protection and GBV processes.

13. All clinical staff should be familiar with the implications for Child Protection and FGM.

**Responding to Female Genital Mutilation in Highland**



Final Responding to  
Female Genital Mutilat

**NHSGGC Care Pathway for Revision of Female Genital Mutilation (FGM)**



NHSGGC FGM  
Revision Pathway 20:

**RECORDING OF FEMALE GENITAL MUTILATION**

A short-life working group (SLWG), led by Information Services Division (ISD) of NHS National Services Scotland, was convened during 2015 to review the current data collection landscape for FGM in Scotland, and consider whether any new, specific, data collection is required.

The Scottish FGM Data SLWG reviewed developments in England, whereby the Health and Social Care Information Centre (HSCIC) have recently introduced an experimental data collection specifically relating to FGM, following legislation in England where the recording of FGM is mandatory. However, information published in England from this new collection notes that *“caution is advised in interpreting these findings because data completeness is often low and may vary by region and submitter”*. The Scottish FGM Data SLWG concluded that a separate data collection in Scotland could run into similar data completeness issues, particularly because the legislative position in Scotland is different (i.e. recording of FGM is not mandatory) and that an alternative approach would be to **strengthen the recording of FGM in existing data collections in Scotland**. The introduction of a new International Classification of Diseases (ICD10) code for FGM in April 2016 allows more accurate recording of FGM in secondary care settings (see section 1 below). Recording of FGM in primary care should continue to use Read codes (see section 2) – data could be extracted, with appropriate approvals, using the new Scottish Primary Care Information Resource (SPIRE) which is due to be introduced across Scotland during 2016/17. The FGM Data SLWG has also recommended that recording of FGM could be strengthened through the Child Health System Programme (see section 3).

Critical to the success of monitoring of FGM in Scotland will be the recording of FGM by clinical staff in the patients’ medical records, particularly in the discharge sheets and in communications with GP practices. This ensures that adequate information is available to specialist clinical coding staff and hence appropriate codes are reliably applied to electronic medical records.

ISD will monitor the recording of FGM throughout 2016/17.

**1. Recording within Secondary Care settings**

The recording of FGM within secondary care through the Scottish Morbidity Returns (SMRs) should utilise codes available within the International Classification of Diseases Volume 10 (ICD10) and the OPCS Classification of Interventions and Procedures Volume 4 (OPCS4).

**1.1 International Classification of Diseases (ICD10)**

In a change to the guidance issued in 2014, a new ICD10 code (personal history of female genital mutilation) will be made available for episodes of care on or after April 1<sup>st</sup> 2016. Within Scotland, this coding will also be able to specify the type of FGM (I, II, III, or IV – see definition below).

<b>Clinical staff should record ‘FGM’ followed by the FGM type (either I, II, III or IV) to allow coders to apply the appropriate ICD10 codes.</b>
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**Classification of FGM (2008) – [The WHO/UNICEF/UNFPA joint statement](#)** classified FGM into four types.

**Type I – Clitoridectomy:** partial or total removal of the clitoris and/or the prepuce.

**Type II – Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

**Type III – Infibulation:** narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.

**Type IV – Other:** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

Type IV comprises a large variety of procedures which does not remove tissue from the genitals. They are generally less associated with harm or risk than Types I, II, III, where genital tissue is removed.

**The associated ICD10 codes are:**

	<b>ICD10 code</b>
Personal History of Female Genital Mutilation – Type 1	Z91.71
Personal History of Female Genital Mutilation – Type 2	Z91.72
Personal History of Female Genital Mutilation – Type 3	Z91.73
Personal History of Female Genital Mutilation – Type 4	Z91.74
Personal History of Female Genital Mutilation – Type unspecified	Z91.79

## **1.2 Office of Population & Censuses & Surveys Volume 4 (OPCS4)**

There are two codes in OPCS4.7 which are used to record the initial corrective procedure for certain cases of FGM. The codes are unchanged since the 2014 guidance.

**P07.2** Deinfibulation of vulva

**R27.2** Deinfibulation of vulva to facilitate delivery

R27.2 – This is a specific code for obstetrics and would therefore be restricted to use in obstetric care and would typically be recorded on ISD's SMR02 (Obstetric) records in Scotland

P07.2 – This is a more general code which would be typically used on the other SMRs, i.e. SMR00 (outpatients), SMR01 (inpatients and day cases) and SMR04 (mental illness).

## **2. Recording within Primary Care (including Out of Hours)**

Staff recording FGM and type information in clinical systems that deploy Read clinical terms and codes (e.g. Primary Care, Out of Hours) should select the appropriate codes

from the list below (including the type of FGM). Note this is an expanded list from that issued in the 2014 guidance.

	<b>Read v2</b>
Family history of Female Genital Mutilation	12b..
History of Female Genital Mutilation	15K..
H/O Female genital mutilation type 3	15K0.
H/O Female genital mutilation under 1 year of age	15K1.
H/O Female genital mutilation between 1 and under 5 years of age	15K2.
H/O Female genital mutilation between 5 and under 10 years of age	15K3.
H/O Female genital mutilation between 10 and under 15 years of age	15K4.
H/O Female genital mutilation between 15 and under 18 years of age	15K5.
H/O Female genital mutilation at 18 years of age or over	15K6.
Female Genital Mutilation	K578.
Female Genital Mutilation Type I	K5780
Female Genital Mutilation Type II	K5781
Female Genital Mutilation Type III	K5782
Female Genital Mutilation Type IV	K5783
At risk of female genital mutilation	13VY.
Deinfibulation of vulva	7D045
Deinfibulation of vulva to facilitate delivery	7F1B5

### **3. Child Health Systems Programme (CHSP Pre-School and School)**

The CHSP Pre-School and School systems support the delivery of the child health programme by facilitating the automated call and recall of children for the agreed schedule of child health reviews for pre-school and school children. Child health reviews incorporate assessment of children's health, development, and wider wellbeing alongside provision of health promotion advice and parenting support. The CHSP systems also allow consistent recording of the findings and outcomes of child health reviews.

All CHSP forms offer Health Visitors and School Nurses the opportunity to record a summary list of issues relevant to a child's on-going health, development or wellbeing at the end of a review. The issues listed are then input into the child's CHSP record by administrative/coding staff as an appropriate Read code. National guidance on common and/or important conditions affecting children and their associated recommended Read codes is available to support this process (see <http://www.isdscotland.org/Health-Topics/Child-Health/Child-Health-Programme/Child-Health-Systems-Programme-Pre-School.asp>). The FGM Data SLWG has recommended that the following FGM codes are added to the national guidance as important conditions affecting children and to support consistent recording of FGM:

History of Female Genital Mutilation	15K..
At risk of female genital mutilation	13VY.

**The Resources and Information to Help Tackle FGM in Scotland**

- FGM has been unlawful in Scotland since 1985. The Female Genital Mutilation (Scotland) Act 2005 re-enacted the Prohibition of Female Circumcision Act 1985 and extended protection by making it a criminal offence to have FGM carried out either in Scotland or abroad by giving those offences extra-territorial powers. The Act also increased the penalty on conviction on indictment from 5 to 14 years' imprisonment. Legislation has been strengthened to extend the reach of the extra-territorial offences in that Act to habitual (as well as permanent) UK residents. <http://www.legislation.gov.uk/asp/2005/8/contents>
- The Scottish Government has funded the Women's Support Project to develop a range of training materials and information materials on FGM. These include:
  - a Scottish DVD outlining the law, child protection, prevention work in communities and services for women and girls who have experienced FGM;
  - information leaflets for practitioners highlighting key points, good practice, resources and services, and a standardised training package and risk assessment tool and
  - an FGM statement that sets out the law in relation to FGM in Scotland and (signed by Cabinet Secretary for Social Justice, Cabinet Secretary for Education, Cabinet Secretary for Justice, Lord Advocate and Minister for Children and Young People). The purpose of this statement is to allow a person who may be at risk to show it to family friends and or relatives when travelling abroad to remind them that FGM is a serious offence in Scotland and the UK and that there are severe penalties (up to 14 years in prison) for anyone found guilty of the offence.
- These resources can be found at: <http://www.fgmaware.org/>
- The Scottish Government has also provided useful information and links to support organisations at:  
<http://onescotland.org/equality-themes/gender-equality/female-genital-mutilation-fgm/>  
<http://ww.gov.scot/Topics/People/Equality/violence-women/forcedmarriage>
- NSPCC helpline staff have been trained by FGM health experts so that NHS staff and the public can receive support from a 24/7 team of advisors who can discuss the often complex circumstances surrounding cases of FGM. The helpline number is **0800 028 3550** or at [fgmhelp@nspcc.org.uk](mailto:fgmhelp@nspcc.org.uk)
- **Petals**: Is a web app for young people, both girls and boys living in the UK who want to find out more about Female Genital Mutilation (FGM).
- The Scottish Government has printed copies and an electronic version of a 'Statement Opposing FGM' leaflet (a wallet-sized document sometimes known as the "health passport") for families travelling abroad who may be pressured to allow girls to undergo FGM. Electronic copies are available to download at [http://www.fgmaware.org/uploads/4/6/7/9/46792493/fgm\\_gov\\_info.pdf](http://www.fgmaware.org/uploads/4/6/7/9/46792493/fgm_gov_info.pdf)

Hard copy can be obtained by contacting Scottish Government Equality Team at 3HS, Victoria Quay, Edinburgh, EH66QQ. Telephone number 0131 244 7097/41834

## Patient Information and Leaflet

- *More information about FGM* – There is useful information and a link to a leaflet that can be given to patients identified with FGM. It defines the different types of FGM, explains the health consequences and the help and support available, and provides information on the FGM data being collected in the NHS. Available in English and ten other languages from the NHS Choice website at [www.nhs.uk/fgm](http://www.nhs.uk/fgm)

## Training

- FGM e-learning training modules: *Raising awareness of female genital mutilation*. The five e-learning modules are free of charge to all NHS staff via the 'e-learning for health' platform and cover a range of issues in relation to FGM at all stages of a girl or woman's life including:
  - Introduction to FGM;
  - Adult women both pregnant and non-pregnant;
  - Children and young women;
  - Communication skills for staff;
  - Legal and safeguarding issues.
- These e-learning modules have been developed by Health Education England and are available at:  
[www.e-lfh.org.uk/programmes/female-genital-mutilation](http://www.e-lfh.org.uk/programmes/female-genital-mutilation)

## Information Governance

- Collecting and sharing information appropriately is essential to provide safe and effective healthcare.
- *The NHSScotland Code of Practice – Protecting Patient Confidentiality, second edition, 2010* (link provided below) should be read with the healthcare professional's regulatory organisation's guidance on confidentiality such as those given below. If healthcare professionals are unsure about the law or their responsibilities relating to protecting personal identifiable information, senior colleagues, the individual's regulatory or professional body or the defence organisation may be able to help. The local information governance expert for NHS Boards is the Caldicott Guardian or the Data Protection Officer.  
<http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4069835/3619da45-b41c-4c2b-bb75-10cd7ff091bb.pdf>
- The General Medical Council's (GMC) *0-18 years: guidance for all doctors* sets out the duties and principles for doctors related to children from 0-18 (particularly paragraphs 42-52 in the link below). In it, the GMC explains that "it is guidance, not a statutory code, so you must use your judgment to apply the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions."  
[http://www.gmc-uk.org/guidance/ethical\\_guidance/children\\_guidance\\_index.asp](http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp)



- GMC's guidance on *Confidentiality* (2009) sets out the principles of confidentiality and respect for patients' privacy that doctors are expected to understand and follow. See link below. This is expected to be updated shortly.  
[http://www.gmc-uk.org/guidance/ethical\\_guidance/confidentiality.asp](http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp)

## Current Legislation and Resources in Scotland

- A new mandatory reporting duty for FGM was introduced in England, Wales and Northern Ireland in Part 5 Section 74 (5) (b) of the [Serious Crime Act 2015](#) on 31 October 2015. The duty requires regulated health and social care professionals and teachers in England, Wales and Northern Ireland to report known cases of FGM in under 18-year-olds to the police.
- Currently, there is no “mandatory reporting” in Scotland and the duty to notify above does not apply to Scotland. This does not mean that concerns in relation to FGM should not be reported, acted upon appropriately, with the help of available guidance (some of which are mentioned below).
- The National Child Protection guidance provides a national framework within which agencies and practitioners at local level – individually and jointly – can understand and agree processes for working together to support, promote and safeguard the wellbeing of all children. It sets out expectations for strategic planning of services to protect children and young people and highlights key responsibilities for services and organisations, both individual and shared.
- The revised National Guidance for Child Protection in Scotland, published in May 2014, provides a clear definition of what abuse is. It sets out our expectations for all individuals working with children and young people to identify and act on child protection concerns. The revised guidance contains a strengthened section on FGM.
- CMO/CNO letters have been provided to Health Boards for guidance:  
[http://www.sehd.scot.nhs.uk/cmo/CMO\(2014\)19.pdf](http://www.sehd.scot.nhs.uk/cmo/CMO(2014)19.pdf)  
<http://www.gov.scot/Topics/People/Equality/violence-women/FGM/Letter>
- The Scottish Government has used a multi-agency approach involving relevant agencies, professionals and communities to support children and women who are affected and to counteract the continued practice of FGM. A variety of interventions based on the “Getting it Right For Every Child (GIRFEC)” principles has been used e. g. a letter was sent by the Cabinet Secretary for Education and Lifelong Learning and Minister for Commonwealth Games and Sport (now Cabinet Secretary for Commonwealth Games, Sport, Equalities and Pensioners’ Rights) on 28 April 2014 to Head Teachers to highlight the issues related to FGM in the context of schools and the local communities. A link to the letter is attached below.  
<http://www.scotland.gov.uk/Resource/0044/00446674.pdf>
- A National Action Plan to Prevent and Eradicate FGM (2016-2020) was published on 4 February 2016, and a Multi-Agency writing group is developing for publication by Spring 2016. The Multi-Agency national practice guidance aims to support frontline staff and their organisations to address female genital mutilation (FGM) in Scotland. It will provide advice on good practice for individual practitioners and agencies within the statutory and third sector on identifying and responding to FGM, but, given the imperative of collaborative work to meet the often complex needs of women and girls affected, it will also set out a multi-agency response to support such co-operation.

- Background

The duty to report is one of six provisions relating to FGM in the Serious Crime Act 2015, only one of which applies to Scotland, as below.

- Part 5 Section 70 applies to Scotland - Offence of Female Genital Mutilation: extra-territorial acts. The Scottish Government collaborated with the Westminster Government to close a loophole in the law in the Prohibition of Female Genital Mutilation (Scotland) Act 2015 (by means of an LCM) to extend the reach of the extra-territorial offences in that Act to habitual (as well as permanent) UK residents. *This provision commenced in Scotland on 03 May 2015.*

The others below apply only to England, Wales and Northern Ireland (Not Scotland)

- Anonymity for victims of Female Genital Mutilation – Part 5 Section 71 4a
- Offence of failing to protect girl from risk of genital mutilation – Part 5 Section 72 3a
- Female Genital Mutilation protection orders – Part 5 Section 73 5a
- Duty to notify police of Female Genital Mutilation – Part 5 Section 74 5b
- Mandatory Guidance about Female Genital Mutilation – Part 5 Section 75 5c

With specific regard to provisions (listed as 2 to 6) above, the Scottish Government is funding, a community based organisation to consult with a cross-section of potentially affected communities to ascertain their views on the legislative provisions (2 to 6 above) introduced in March 2015 in England, Wales and Northern Ireland relating to FGM. Consultation will ensure that any new legislation for Scotland will meet the needs of Scottish communities potentially affected by FGM and ensure that protection is as robust as it can be. This work is being carried out with on-going liaison with Scottish Government officials and will produce a final research summary report by March 2016. We will also take account of the impact of the legislation in England, Wales and Northern Ireland.