Title: **FEMALE GENITAL MUTILATION FGM**

Ref No: 2091
Version 1
Classification: Policy

Directorate: Organisation Wide

Due for Review: 28/10/18

Responsible for review: Jane Wilkinson, Named Nurse for Safeguarding Children

Document Control

Ratified by: Care and Clinical Policies sub-group
Jane Viner, Chief Nurse
Dr Rob Dyer, Medical Director

Applicability: All clinical staff who treat women and children

Contents

1 Purpose

1.1 This Policy aims to pro-actively tackle abuse in the form of Female Genital Mutilation (FGM). It aims to safeguard women and girls from being exposed to FGM, or where exposure has occurred. Once concerns have been raised about FGM, there should also be a consideration of potential risk to other girls in the family and practicing community. Professionals should be alert to the fact that any one of the girl children amongst these groups could be identified as being at risk of FGM and may need to be safeguarded from harm.

2 Introduction

In 2016 the government launched statutory multi-agency guidance on FGM www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

It is clear that FGM is child abuse and a form of violence against women and girls, and therefore should be dealt with as part of existing child and adult safeguarding/ protection structures, policies and procedures

No single agency can adequately meet the multiple needs of someone affected by FGM. This policy encourages the Trust to cooperate and work together with other agencies to protect and support those at risk of, or who have undergone, FGM.

2.1 As FGM is a form of child abuse, professionals have a statutory obligation under national safeguarding protocols (e.g. Working Together to Safeguard Children 2015) to protect girls and women at risk of FGM. Since October 2015 registered professionals in health, social care and teaching also have a statutory duty (known as the Mandatory Reporting duty) to report cases of FGM to the police non-emergency number 101 in cases where a girl under 18 either discloses that she has had FGM or the professional observes physical signs of FGM: **see Appendix 2 and section 3.**

https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

2.2 Female Genital Mutilation can cause extreme lifelong physical and psychological suffering to women and girls. Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. (WHO 2016)

2.3 FGM is known by a number of names, including female genital mutilation, cutting or circumcision. The term female circumcision is anatomically incorrect and gives misleading analogy to male circumcision.

2.4 The names FGM or cut are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms.

2.5 FGM differs from other forms of child abuse in two main ways: Despite severe consequences, parents genuinely believe it is in the best interest of the child to conform to prevailing custom. There is usually no element of repetition- it is a one off act of abuse.

2.6 There are no health benefits to FGM and this act r interferes with natural functions of girls and women's' bodies.

2.7 The majority of cases of FGM are carried out, or originate in some African Countries but it is also practiced among populations in parts of Egypt, Malaysia, Pakistan, Indonesia, the Philippines and Iraq. However in each of those countries the extent of the practice varies. As a result of migration and refugee movement, some ethnic minority populations in the UK are now practicing FGM (Home Office 2014) **see Appendix 1**

3 Roles and Responsibilities of staff

3.1 Working Together:

Working across agencies is essential to effective safeguarding efforts. This is referenced throughout the HM Government Multi-Agency Statutory Guidance on FGM and should be a central consideration whenever safeguarding girls from FGM.

3.2 Reporting FGM:

In April 2015, the Information Standards Board published SCCI2026 Female Genital Mutilation Enhanced Dataset Information Standard and supporting documentation. http://www.hscic.gov.uk/isce/publication/scci2026 This states data should be submitted every time the woman or girl has treatment related to her FGM or gives birth to a baby girl (FGM Enhanced Data set 2015). This data must be reported to the Health and Social Care Information Centre on a monthly basis. This information will be submitted through the data protection team. dataprotection.tsdft@nhs.net using FGM Reporting form **Appendix 3**

See Female Genital Mutilation (FGM), care of a woman with 1646 Guideline. https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G1646.pdf

3.21 Mandatory Reporting Duty for Registered Health Professionals

Since October 2015 registered professionals in health, social care and teaching have a statutory duty (known as the Mandatory Reporting Duty) to report cases of FGM to the police non-emergency number 101 in cases where a girl under 18 either discloses that she has had FGM or the professional observes physical signs of FGM. **See Appendix 2 for further guidance**.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf
However, healthcare professionals are not expected to investigate or make decisions upon whether a case of FGM was a crime or not, under the legislation.
All cases should be dealt with under existing safeguarding processes, which for children under 18 who have undergone FGM would mean a referral to children's social care and the police.
http://www.devonsafeguardingchildren.org/workers-volunteers/safeguarding-hub-the-mash/
Health professionals and organisations can access a range of support materials, including 2-page process guide. These can be found at www.gov.uk/dh/fgm.
Although FGM reporting is a legal requirement for healthcare trusts, professionals working with women need to ensure the information is shared in a sensitive way so that the women are aware of why, how and where the data is stored.
For more information please refer to the FGM Enhanced Information Standard SCCI2026). http://www.hscic.gov.uk/fgm

3.3 The Female Genital Mutilation Act 2003

It is illegal in the UK to subject a child to FGM (The Female Genital Mutilation Act 2003) www.legislation.gov.uk/ukpga/2003/31/contents . It is a crime to assist or arrange for FGM to be carried out in another country by a UK national or a person who is resident in the UK (Serious Crime Act 2015). The Trust and it's staff are bound by law to ensure that any instances identified are dealt with accordingly, which could include informing the relevant authorities such as the police.

3.4 Interpreters

Care must be taken to ensure that an interpreter is available if required in all appointments relating to FGM.
The interpreter should be an authorised accredited interpreter and should not be a family member, not be known to the individual, and not be an individual with influence in the individual's community.

3.5 Recording Information

Any concerns, whether identified through discussion with the patient or family, should be recorded within the patient's records by the healthcare professional who has obtained the information. Further guidance on recording and information sharing can be accessed here;http://www.hscic.gov.uk/media/16781/2026122014spec/pdf/2026122014spec.pdf

Maternity Services

- When FGM or family history of FGM has been identified; prior to, during or after the birth of a baby maternity discharge information sent to General Practitioners and Health Visitors must also include all relevant FGM information, where appropriate,
- Upon issue of the Red Book, it is the responsibility of the midwife to populate the following section, "Are there any other particular illnesses or conditions in the mother's or father's family that you feel are important?" to reflect that FGM has been identified in the mother.
- Where a midwife identifies that there is or are daughters of a woman/girl with FGM, it is the responsibility of the midwife to inform the GP and seek advice from the safeguarding team and consider making a safeguarding referral.
  http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/health_safeguarding_children_team_contacts.aspx

Health Visitors

- When new FGM information is identified, it is the responsibility of the Health Visitor to update the following section within the Red Book: "Are there any other particular illnesses or conditions in the mother's or father's family that you feel are important?"
- Where a Health Visitor identifies that there is or are sisters of a girl with FGM, it is the responsibility of the Health Visitor to inform the GP and seek advice from the safeguarding team and consider making a safeguarding referral. See section 8. http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/health_safeguarding_children_team_contacts.aspx

4. Aim of the Policy

4.1 The aim of this policy is to raise awareness around the practice of FGM and demonstrate the Trusts' commitment to safeguarding, preventing and caring for women and girls affected by FGM.

4.2 The policy also aims to ensure practitioners are aware of where to access local support and ensure local safeguarding procedures are upheld in FGM is suspected and /or confirmed

5 Cultural Issues surrounding FGM

5.1 FGM is a complex issue, despite the harm it causes, many women from practicing communities consider FGM normal to protect their cultural identity. As a result of those belief systems, many women who have undergone FGM believe they appear more attractive than women who haven't been infibulated. In some cultures it is believed that a girl who has not undergone FGM is unclean and not able to handle food and drink.

5.2 Although FGM is practices by secular communities, it is most often claimed to be carried out in accordance with religious beliefs. It should be noted neither the Bible of Koran nor any other religious script advocate for or justify FGM (WHO 2008)

5.3 Parents who support the practice of FGM believe they are acting in the child's best interest. Parents believe it brings status and respect to the girl, preserves a girl's chastity and virginity, is part of being a woman and is a rite of passage.

5.4 In some cultures a girl is only socially accepted by the community after having undergone FGM which has repercussions for a girls marriage prospects.

5.5 Women who have attempted to resist exposing their daughters to FGM report that they and their families were ostracized by their community and told that nobody would want to marry their daughters.

6 Types of FGM (WHO)

WHO definitions http://www.who.int/mediacentre/factsheets/fs241/en/

Female genital mutilation is classified into four major types.

- Type 1: Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Type 2: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- Type 3: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

7 Consequences of FGM

7.1 Many men and women in practising communities can be unaware of the relationship between FGM and its harmful health and welfare consequences as set out below, in particular the longer-term complications affecting sexual intercourse and childbirth. The health professional needs to ensure they raise awareness of the adverse consequences of FGM with practicing communities as required as detailed below:

Short-term consequences following a girl undergoing FGM can include:

- Severe pain
- Emotional and psychological shock (exacerbated by having to reconcile being subjected to the trauma by loving parents, extended family and friends)
- Haemorrhage
- Wound infections, including tetanus and blood borne viruses (including HIV and Hepatitis B and C)
- Urinary retention
- Injury to adjacent tissues
- Fracture or dislocation as a result of restraint
- Damage to other organs
- Death

The long-term health implications of FGM can include:

- Chronic vaginal and pelvic infections
- Difficulties with menstruation
- Difficulties in passing urine and chronic urine infections
- Renal impairment and possible renal failure
- Damage to the reproductive system, including infertility
- Infibulation cysts, neuromas and keloid scar formation
- Obstetric fistula
- Complications in pregnancy and delay in the second stage of childbirth
- Pain during sex and lack of pleasurable sensation
- Psychological damage, including a number of mental health and psychosexual problems such as low libido, depression, anxiety and sexual dysfunction; flashbacks during pregnancy and childbirth; substance misuse and/or self-harm
- Increased risk of HIV and other sexually transmitted infections
- Death of mother and child during childbirth.

The longer-term implications for women who have had FGM Types 1 and 2 are likely to be related to the trauma of the actual procedure, while health problems caused by FGM Type 3 are more severe and long-lasting.
However, all types of FGM are extremely harmful and cause severe damage to health and wellbeing.
World Health Organization research has shown that women who have undergone FGM of all types, but particularly Type 3, are more likely to have complications during childbirth.

8 Safeguarding and when to refer:

8.1 Children and vulnerable adults
Professionals are required to consider the immediacy of the procedure to inform the urgency of response required. Where there is a risk of immediate harm a child protection referral must be made via telephone to the relevant local children services department and followed up in writing within 48hrs or telephone police on 999 for immediate child protection response.
http://www.devonsafeguardingchildren.org/workers-volunteers/safeguarding-hub-the-mash/

- If any child (under 18) discloses to a regulated health professional that they have had FGM, or if a professional observes that she has had FGM, they must report to the police, using the 101 non-emergency number. See section 3 of this policy

- If a vulnerable adult is identified as having had or being at risk of FGM, this should be responded to within the existing safeguarding processes to protect vulnerable adults.
  If an adult discloses to you that a child has had FGM, this is a report of child abuse. You should follow local safeguarding processes. This is because a crime has been committed and a child has suffered physical (and potentially other) abuse. http://www.devonsafeguardingchildren.org/workers-volunteers/safeguarding-hub-the-mash/

- After all referrals to the police or social services, the multi-agency safeguarding response would usually include a referral to a specialist health service, to confirm the girl has had FGM.

- Additionally, when a patient is identified as being at risk of FGM, this information must be shared with the GP and health visitor as part of safeguarding actions

- If you identify that a child (or vulnerable adult) has a family history or details which mean she may be at risk of FGM, but you do not have information to suggest that the risk is imminent, you should follow local safeguarding procedures. This will involve a discussion with your local safeguarding lead, sharing information between professionals, sectors and agencies appropriately and considering early intervention options with colleagues from social care.

- Child or unborn at risk of FGM
  For unborn female infants professionals should consider risk where the mother has undergone FGM or is from a country where FGM is practiced.

Guidance should be sought the safeguarding children team
http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/default.aspx

All cases referred to children services will be considered by the MASH (Multi Agency Safeguarding Hub) including the police.

8.2 Adults

There is no requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police is not required as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. The healthcare professional should support women by offering referral to community groups who can provide support, and for possible clinical intervention or other services as appropriate, for example through an NHS FGM clinic. The wishes of the woman must be respected at all times.

If a woman discloses she has adult daughter(s) over 18 who have already undergone FGM, even if the daughter does not want to take her case to the police, it is important to establish when and where this took place. This should lead to enquiries about other daughters, cousins or girls in the wider family context to assess any risk of FGM to them. Support is available form
Staff can obtain advice and support with these issues from the safeguarding children team
http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/default.aspx

9 Child Protection and Safeguarding Indicators

9.1 Child At Risk of FGM

There are a range of potential indicators that a child is at risk of FGM.

- The family come from a community that is known to practice FGM **see Appendix 1**

- Parents state that they or a relative will take a child out of the country for a prolonged period
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent. This is particularly important to consider over school holidays.
- A child may confide to a professional that she is to have a “special procedure”
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family.

Two or more risks may indicate a high risk for the child however professional judgement should always be used and guidance sought from the safeguarding children team
http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/default.aspx

9.2 Child has been abused though FGM

There are a range of potential indicators that a child has had FGM.

- A child may present to services with urological or gynaecology problems
- Child may have difficulties standing or walking
- Child may spend long periods of time away from the classroom with bladder or menstrual problems
- There may be prolonged absences form school. Professionals may notice a difference in the girls demeanour on return
- Child may disclose
- A child may need to be excused physical exercise lessons without the support of her GP
- A child may ask for help however may not be explicit about the problem due to embarrassment or fear.

Two or more risks may indicate a high risk for the child however professional judgement should always be used and guidance sought from the safeguarding children team
http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/default.aspx

If a child is suspected of having undergone FGM a referral to children services is required and the child should only be examined by a specialist paediatrician following strategy discussion with police and children services.

10 Training and Supervision

The Trust provides specialist training and supervision to clinical staff in maternity and community services and it is incorporated into Level 1 Safeguarding Children Training at Induction.
In addition there is a web based e-learning programme for staff with an iLearn account with Torbay Council
http://torbay.learningpool.com/course/index.php?categoryid=77

11 Monitoring and Auditing

Currently there is no monitoring or auditing of this policy. The reporting will be monitored by the Equality and Diversity Lead

12 References

British Medical Association (2013) Female Genital Mutilation: Caring for patients and safeguarding children. BMA Ethics Health and Social Care Information Centre (2015) Enhanced FGM Dataset [Online] http://www.hscic.gov.uk/fgm

DOH FGM Guidance Flowchart and Poster

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472690/FGM_poster.pdf

The Home office (2014) Multi-agency guidelines Female Genital Mutilation[Online] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

The Home office (2015) 2010-2015 Government Policy Violence against women and girls [Online] https://www.gov.uk/government/publications/2010-to-2015-government-policy-violence-against-women-and-girls/2010-to-2015-government-policy-violence-against-women-and-girls

The Home Office (2015) Introducing Mandatory reporting for Female Genital Mutilation: A summary of responses [Online] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403436/Government_response_to_the_Consultation_on_the_Mandatory_Reporting_of_FGM.pdf

Serious Crime Act 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416323/Fact_sheet_-_FGM_-_Act.pdf

South West Child Protection Procedures (2016) http://www.proceduresonline.com/swcpp/devon/ http://www.proceduresonline.com/swcpp/torbay/index.html

WHO World Health Organisation FGM Female Genital Mutilation http://www.who.int/mediacentre/factsheets/fs241/en/

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525390/FGM_safeguarding_report_A.pdf

13 Equality and Diversity

13.1 This document complies with the Torbay and Southern Devon NHS Foundation Trust Equality and Diversity statements.

14 Further Information

14.1 Links to policies

FEMALE GENITAL MUTILATION, CARE OF A PREGNANT WOMAN
CHILD PROTECTION POLICY 1646

15 Appendices

Appendix 1 – Table FGM practices by country
Appendix 2 – Flowchart – FGM Health Mandatory Reporting – What to do
Appendix 3 – FGM Enhanced Dataset Information Form

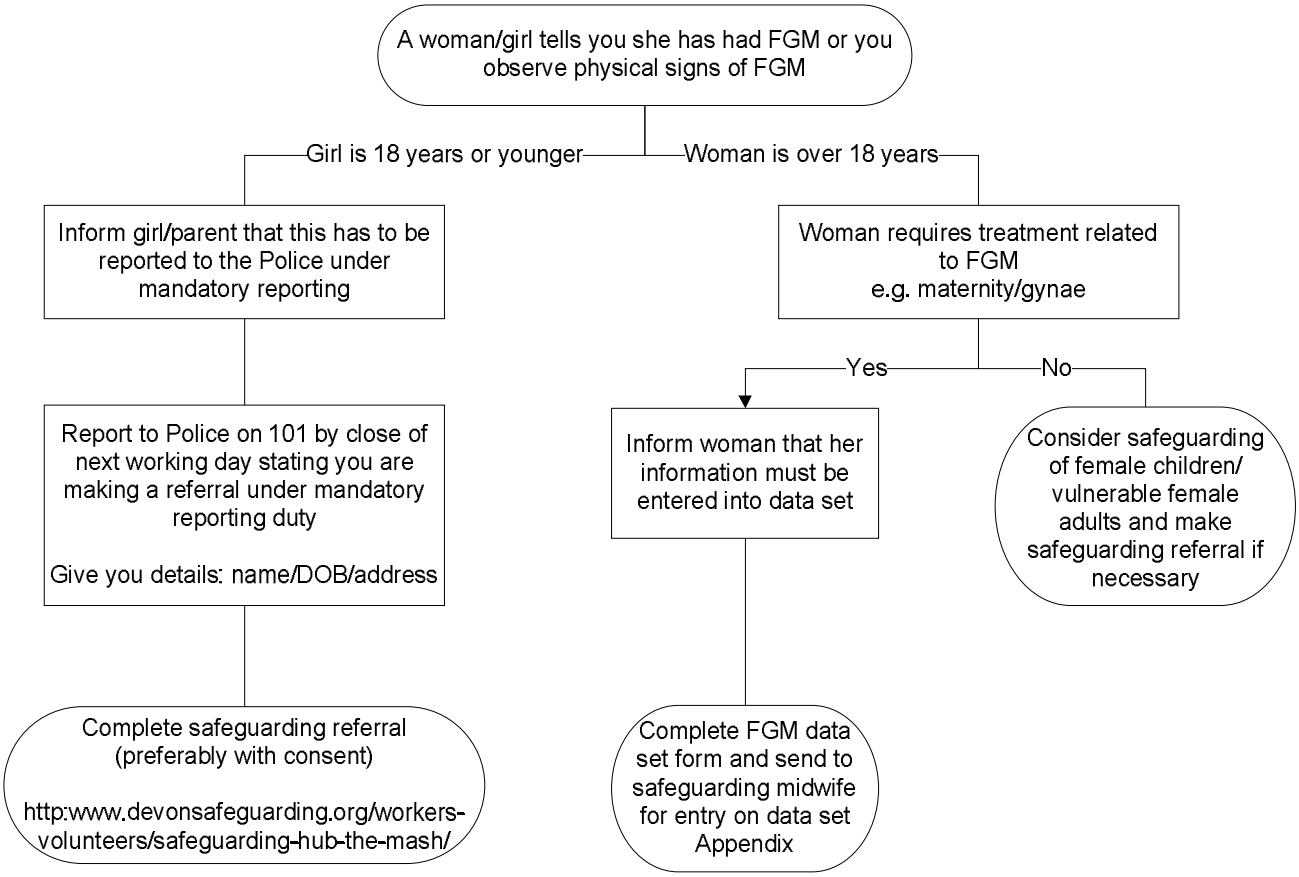
Appendix 1

FGM practices by country		
Country	**Prevalence**	**Type**
Benin	5-50%	Excision
Burkina Faso	Up to 70%	Excision
Cameroon	Local	Clitoridectomy and Excision
Central Africa Republic	45-50%	Clitoridectomy and Excision
Chad	60%	Excision & Infibulation
Cote d'Ivoire	Up to 60%	Excision
Democratic Republic of Congo (Zaire)	Local	Excision
Djibouti	98%	Excision & Infibulation
Egypt	85-95%	Clitoridectomy, excision and infibulation
Eritrea	95%	Clitoridectomy, excision and infibulation
Ethiopia	70-90%	Clitoridectomy, excision and infibulation
Gambia	60-90%	Excision and infibulation
Ghana	15-30%	Excision
Guinea	65-90%	Clitoridectomy, excision and infibulation
Guinea Bissau	Local	Clitoridectomy and excision
Kenya	50%	Clitoridectomy, excision and some infibulation
Liberia	50%	Excision
Mali	94%	Clitoridectomy, excision and infibulation
Mauritania	25%	Clitoridectomy and excision
Niger	Local	Excision
Nigeria	60-90%	Clitoridectomy, excision and some infibulation
Senegal	20%	Excision
Sierra Leone	90%	Excision
Somalia	98%	Infibulation
Sudan	90%	Infibulation and excision
Tanzania	18%	Excision & Infibulation
Togo	12%	Excision
Uganda	5%	Clitoridectomy and excision

Based on statistics from Amnesty International and US Government

Appendix 2

FGM – Health Mandatory Reporting – What to do



Failure to report may result in your professional regulator considering your fitness to practice

Appendix 3

Torbay and South Devon NHS
NHS Foundation Trust

FGM ENHANCED DATASET INFORMATION FORM (FGM enhanced dataset 2015)

Patient Details	
Name of Patient	
Date of Birth	
NHS Number	
Hospital Number	
Organisation that provided care	Torbay & South Devon NHS Foundation Trust
County of Birth	
Country of Origin	
Attendance Details	
Care contact date	
Region of Country of Origin	
How was the FGM identified	
FGM family history	
Number of daughters under 18 years of age	
Advised on the health implications of FGM?	Y/N
Advised on the illegalities of FGM?	
Were any daughters born at this attendance?	
Country of birth of baby's father	
Country of origin of baby's father	
FGM Details	
FGM activity identified	
Deinfibulation undertaken? (re-opening)	
Age range when FGM was undertaken?	
Country where FGM was undertaken?	

Nb: the yellow boxes are mandatory and must be completed

16 Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	2091		
Document title:	Female Genital Mutilation FGM		
Purpose of document:	To inform and educate clinical staff		
Date of issue:	28 October 2016	**Next review date:**	28 October 2019
Version:	1	**Last review date:**	
Author:	Jane Wilkinson, Named Nurse for Safeguarding Children		
Directorate:	Professional Practice		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care and Clinical Policies Group Jane Viner, Chief Nurse Dr Rob Dyer, Medical Director		
Date approved:	26 October 2016		
Links or overlaps with other policies:	All TSDFT Trust Strategies, policies and procedure documents		

	Please select	
	Yes	*No*
Does this document have training implications? *If yes please state:*	☒	☐
Does this document have financial implications? *If yes please state:*	☐	☒
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☒

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
28 October 2016	1	New	Care and Clinical Policies Group Jane Viner, Chief Nurse Dr Rob Dyer, Medical Director

17 The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

18 Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

19

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☒
	General Public	☒	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☒	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process? NO	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☒	Police	☒
	Councils	☒	Carers	☐
	Staff	☒	Other Statutory Agencies	☒
	Details *(please state):*	Maternity Equality and Diversity emergency Care		

South Devon and Torbay Clinical Commissioning Group | Torbay and South Devon NHS Foundation Trust

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	***Female Genital Mutilation Policy***	**Version and Date**	*12.08.2016*
Policy Author	Jane Wilkinson		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)					Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒

If 'Yes', how will you mitigate this risk to ensure fair and equal access?

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☒ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Duty of Mandatory Reporting of FGM and Enhanced Data Set requirements.

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

Children Services Torbay
Midwifery
FGM Champion for the Trust
Torbay Hospital Safeguarding team

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Jane Wilkinson	**Signature**	
Validated by (line manager)	Heather Parker	**Signature**	