Healthcare Improvement Scotland

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Lewis Macdonald
Convener, Health and Sport Committee
The Scottish Parliament
Edinburgh
EH99 1SP

Dear Convener,

Health and Sport Committee consideration of the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill

Thank you for inviting Healthcare Improvement Scotland to comment on the evidence submitted so far in the Committee Stage for the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill. We appreciate the Committee's commitment to this piece of legislation and its flexibility in continuing the parliamentary process during the current pandemic.

As requested, we have reviewed the questions put to Dr McLellan and our thoughts on the topics raised and the subsequent discussions are attached. We have also responded to the questions addressed specifically to Healthcare Improvement Scotland.

Yours sincerely

Safia Qureshi

Dr Safia Qureshi

Director of Evidence

Healthcare Improvement Scotland

NHS SCOTLAND

Healthcare Improvement Scotland response to questions from the Health and Sport Committee, as requested on 14 May 2020

Supplementary information relating to questions asked at the session

Over the last three years Healthcare Improvement Scotland (HIS) has worked closed with the CMO Taskforce for victims of rape and sexual assault. HIS is a member of the Taskforce and additionally has supported the work of the following CMO Taskforce subgroups:

- Clinical Pathways subgroup (subsequently merged with the Children and Young People's Expert group)
- Quality Improvement subgroup
- Workforce and Training subgroup
- Information Governance Delivery Group

Since January 2019, HIS has worked in partnership with the Care Inspectorate to develop a set of standards for a Barnahus[1] response for children who have experienced or witnessed violence. This work is closely aligned to the work of the CMO Taskforce.

Standards provide a blueprint for national consistency in quality and governance whilst recognising that local services may be best placed to determine how to ensure equity of access in their area. Throughout our involvement in this work, HIS has reiterated the principles which underpin the 2017 Healthcare and Forensic Medical Services standards for people who have experienced rape, sexual assault or child sexual abuse. The standards outline a service which is person-centred, trauma informed, and offers quality and access to all people who have experienced rape, sexual assault or child sexual abuse.

In her evidence to the Committee, Dr McLellan stated that 'for sexual health, there were HIS standards that said that we had to provide 12 hours of clinical care in every settlement of 150,000 people'.

To clarify, Standard 1 of the 2008 sexual health standards (withdrawn while under review) stated that 'a comprehensive range of specialist sexual health services is provided locally and individuals with the greatest need are treated as priority'. This is reiterated in Standard 1.2 which says that 'there is a minimum of 2 full days per week of integrated local specialist sexual health provision available within 30 minutes travel from each settlement over 10,000 people'. HIS recognises that local services may have operational detail relating to the provision of clinical care and appropriately determined staffing levels and we also note that the 2008 sexual health standards are currently in review.

[1] Barnahus, or Child's House, is a multi-agency and child-focused response for victims and witnesses of violence. Across Europe, the model is characterised by intensive, multi-agency and ongoing support in a child-friendly setting and a single forensic interview, which prevents children and young people from having to attend court. Each Barnahus is built on Further information about the work to develop Barnahus standards is available from: http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/barnahus_standards.aspx

Operational details on facilities, sample retention, guidance, and terms such as 'professional judgement' should be underpinned by the principles outlined in the standards with the aim of improving services for victims and ensuring national equity of access and quality for all victims.

From our engagement activities to support the work of the Taskforce (detailed below), HIS received significant feedback that advocacy, mental health support, and a trauma-informed response is felt to be integral to high quality services.

Additional questions for Healthcare Improvement Scotland

22. What involvement have victims had in the development of the standards and indicators?

HIS develops standards and indicators using a methodology which consists of four phases: scoping, development, consultation, and finalisation. A development group, supported by a HIS project team, is responsible for the content of the standards or indicators. Direct engagement with users at each stage is integral to the development of all our standards. In this circumstance, the HIS project team were advised by Rape Crisis Scotland that indirect representation was a trauma-informed approach. Consequently, we invited Rape Crisis Scotland to represent victims on the standards development group. Rape Crisis Scotland was also an active member of the both the interim indicators development group and the final indicators development group.

During the consultation period for the 2017 standards the project team developed a facilitator pack for support workers to use with victims. The pack enabled Rape Crisis Scotland to capture feedback from their clients which supported their consultation submission. In addition to this, victims were provided with an opportunity to meet directly with the HIS project team, to share their experiences: this opportunity was taken up by two people who were interviewed in their own homes, with their support worker present. In order to gather a wide a perspective as possible, a public survey seeking feedback on the draft standards was also circulated using third sector networks and social media. The HIS project team received 657 comments using the online survey tool, many of which were from local victim support organisations and Rape Crisis centres.

During the consultation period for the interim indicators and the final indicators, the HIS project team conducted an extensive engagement exercise. The exercise included an invitation to join peer support groups for adults who had experienced sexual abuse as children to discuss the indicators and what was important. In addition, a user-led service design group, also consisting of adults who had experienced abuse as children, gave face-to-face feedback on the content of the standards. The HIS project team visited advocacy and support workers from Scottish Women's Aid and Rape Crisis Scotland on the Shetland Islands to help to capture as many perspectives as possible.

In supporting the work of the Taskforce, HIS has led on national public consultations on the adult and children's clinical pathways. On the advice of third sector organisations, the HIS project team engaged with victims including young people indirectly through support workers and representatives. This included engagement sessions with the workers from the Rape Crisis Scotland helpline, the local Rape Crisis Centre on the Orkney Islands, Violence Against Women Partnerships across Scotland and local and national children's charities and campaigners. This extensive engagement was undertaken by the same HIS project team working on the development of the indicators, enabling a sharing of learning.

23. To what extent do the indicators encompass qualitative data on the experience of victims?

The HIS indicators do not directly measure qualitative data, largely due to the need for a nationally consistent dataset to benchmark quality improvement. The indicators are linked to the 2017 standards which do highlight the essential need for local qualitative improvement data, including direct feedback from service users, to inform and shape good leadership and governance.

Standard 1.4 (f) notes that 'for the co-ordination of healthcare and forensic medical services, each NHS board can demonstrate collection, monitoring, and review of data, and action taken as a result'. Additionally, Standard 1. 4 (g) notes that 'for the co-ordination of healthcare and forensic medical services, each NHS board can demonstrate ongoing quality improvement (including offering people the opportunity to feedback on their experience)'. This is reiterated in Standard 1 'Practical examples of evidence of achievement' which states that 'Feedback (anonymised) from people who use services' as best practice. The standards note throughout that services should ascertain people's preferences and needs, document these, and demonstrate that they have been actioned. This is expected to form part of the 'collection, monitoring and review of data' as outlined in Standard 1.4.

Further direction is provided in the introduction to the final indicators (February 2020) which notes that 'services should continue to review their data, as part of internal governance mechanisms, to improve the care and support that they provide. All services are expected to meet the criteria outlined in the 2017 standards regardless of whether a corresponding indicator exists.'

In addition to the indicators, HIS is providing support to the CMO Taskforce to develop national quality assurance mechanisms.