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Health Services Management
Centre (HSMC)

School of Public Policy

Feasibility of Transferring Budget and
Commissioning Responsibility for
Forensic Sexual Offences Examination
Work from the Police to the NHS

Executive Summary

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Summary

The Department of Health commissioned HSMC between September 2010 and February 2011 to review the feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination work from the police to the NHS. The study concludes that commissioning should be transferred to the NHS and that quality should be improved. Specifically, there is a case for separating sexual offences examination work from the general custody care work of forensic physicians. The study found that, even without this development, there would be net benefits in transferring commissioning responsibility to the NHS.

The baseline cost of the services to be transferred was estimated to be £8 million in England. Quality improvements were estimated to cost a further £3.2 million, covering (a) introduction of a separate sexual offences rota, and (b) improved clinical governance, peer review and training.

The Context

Since the early 2000s, there have been a number of reports, commissioned by both the Department of Health and the Home Office, analysing and assessing the quality of the response, forensic examination, investigation, decision-making and prosecution of allegations of rape. This was due to the marked decline in the percentage of successful prosecutions for rape offences and continuing poor standards of service delivery.

In 2002¹ *The Report on the Joint Inspection into the Investigation and Prosecution of Cases involving Allegations of Rape: A CPSI and HMIC joint thematic inspection* found that the rate of conviction for rape, after trial, had decreased from one in three cases reported (33%) in 1977 to one in 13 (7.5%) in 1999. Furthermore, only one in five (20%) reported cases at that time was reaching trial stage (p1). The joint inspection was set up to examine the reasons for the high attrition² rate, and to identify good practice and make recommendations to address this.

Key issues raised in this report were that: the training of staff to receive rape victims was problematic across the service; the environment into which a victim was taken was not always conducive to securing the confidence of the victim; inordinate delays, sometimes for some hours, occurred before the victim had access to specialist staff; police training did not conform to a common minimum standard, resulting in a lack of consistency in approach; many Forensic physicians (FPs) were solely reliant on skills developed as part of 'on the job' training; there was continued difficulty in the recruitment and retention of FPs, particularly female doctors, which limited the choice for victims of the gender of the examining doctor; and a number of forces worked in isolation from other agencies, including the Health Service, Social Services and FPs, as a result of which facilities for the care of victims were less satisfactory and showed the greatest potential to aggravate levels of attrition.

¹ HM Crown Prosecution Service Inspectorate/HM Inspectorate of Constabulary (2002) *The Report on the Joint Inspection into the Investigation and Prosecution of Cases involving Allegations of Rape: A CPSI and HMIC joint thematic inspection*.

²Attrition is the process by which a number of the cases of rape initially reported do not proceed.

Five years later, HM Inspectorate of Constabulary and Crown Prosecution Service Inspectorate undertook a departmental review *Without Consent* (2007)³ following concerns about the continuing attrition of prosecution and conviction rates. They found considerable problems continuing on workforce development, management of forensic medical services by the police and NHS disengagement.⁴ Since then there have been six further reports each highlighting particular aspects of service responses to rape and sexual assault including the *Bradley Report, 2009*⁵, the *Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres, 2009*⁶; *Together We Can End Violence against Women and Girls, 2009*; *Rape: The Victim Experience, 2009*⁷; *Responding to violence against women and children – the role of the NHS, March 2010*; and the *Stern Review*⁸

The Brief

Forensic physicians doing sexual offence examinations carry out their duties in police custody suites, sexual assault referral centres (SARCs) or other victim examination facilities. They are organised into rotas, providing either stand-alone sexual offence examination services or joint custody care/SOE services. The provision of the forensic element of their service is not an NHS function. It is funded and commissioned by the local police authority, wherever the service is located.

The brief for this study carried out by HSMC was to assess the feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination (SOE) work from the police to the NHS. The term 'commissioning' here means 'planning, funding and procuring' the service.

The study objectives were:

- To provide the evidence required to reach a decision on where best to locate responsibility for commissioning forensic examination services for sexual offences work in order to achieve a high quality and cost-effective service which meets the health needs of victims and supports criminal prosecution.
- To provide the evidence required to support required improvements in local service delivery.

³ HM Crown Prosecution Service Inspectorate (2007) *Without consent: A report on the joint review of the investigation and prosecution of rape offences*. London: HMCPSI

⁴ *Without Consent - Joint HMIC/HMCPSI Report: 2007*, <http://www.hmcp.si.gov.uk/index.php?id=47&docID=258>

⁵ Department of Health (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*, London: DH

⁶ Department of Health, Home Office and Association of Chief Police Officers (2009) *Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres*. London: Department of Health.

⁷ Sara Payne (2009) *Rape: The Victim Experience: Review*, London: Home Office

⁸ Home Office (2010) *The Stern Review: A Report By Baroness Vivien Stern CBE Of An Independent Review Into How Rape Complaints Are Handled By Public Authorities In England And Wales*, London: Home Office

The policy objectives were to:

- Improve the quality of services to victims of rape and sexual assault, especially children;
- Improve the experience of victims of rape and sexual assault;
- Deliver equity of access to resources across England;
- Ensure forensic competence of practitioners through improved clinical governance, peer review and accredited training; and
- Optimise the potential to raise prosecution rates in cases of rape and sexual assault.

Outputs

The study produced separate documents which have been submitted to the Department of Health:

- Impact Assessment – considering costs and benefits of options for change, including status quo;
- Evidence Base – the Impact Assessment was supported by an Evidence Base that collated fieldwork, including:
 - Report of ‘Survey A’ Fieldwork on Service Provision - a questionnaire was sent to all service providers, (managers of SARCS and police leads of services located in custody suites, i.e. non-SARC areas), collecting information on finance, workforce and activity. The response rate was 79% (34/43), covering 85% of England’s population, but for individual questions within the survey the participation rate was often much lower. Quantitative data was found to be fragmented and difficult to access;
 - Report of ‘Survey B’ Fieldwork on Commissioning and Quality Standards – the survey was sent to police leads, eliciting a 77% response rate (30/39), with a high standard of completion;
 - Case Studies – 4 case study sites were visited, providing data about service structure and quality;
 - Status of professional education and a statement from the FFLM.
- Equalities Impact Assessment – considering the relationship between forensic services for sexual assault and gender, disability, race, and religion.

The Current Service and Case for Change

The fieldwork identified variations in the quantity and quality of service provision and commissioning which underlined the need for improvement:

- **Diversity of Structure** - in England there is a mixture of: SARC and custody suite provision; joint custody care/sexual offence examination forensic physician rota and separate SOE rota; recruitment of forensic physicians by independent providers and direct engagement by police or NHS; rural and urban skews (measured by density of population) with more joint rotas and custody suite provision in rural areas and more SARCS and dedicated SOE rotas in urban areas.

- **Inequity of resource provision** - there are significant variations in expenditure (police + NHS + other agency spend)⁹ with five areas (n=33) spending less than £100 per 1000 population and four spending over £500, around a median of £200 per 1000 population. The unit cost per referral (n=17) varies between a lower quartile cost of c. £400 and upper quartile of c. £1,800, with a median cost around £750.
- **Children and Young People** - there was particular concern about lack of consistency and availability of forensic services for children. The low volume of cases, averaging 4-6 examinations per doctor per year, suggests that there is a strong case for commissioning the service on a regional basis.
- **Quality** - Variable quality was found relating to response times, premises and equipment, gender choice, assessment of need and follow up of consequent health care requirements, e.g. screening for sexually transmitted infection.
- **Gender, Access and Choice** - 93% of reported victims of sexual assault (in our survey) are women. Fieldwork suggests that most prefer to be examined by a female physician and that lack of female forensic examiners is a source of delay. Joint custody care/SOE rotas are predominantly staffed by men (66% male on average) while separate SOE rotas are mainly staffed by women (95% female doctors). The nature of the work makes it difficult to recruit women to joint custody care/SOE rotas, where the sexual offence element is around 10% of the workload and 90% relates to custody care and offenders. There is a case for separating out SOE physician rotas from custody care.
- **Volume, Experience, Critical Mass and Competence** - Forensic sexual offence examination work is a low volume, specialist area of practice, which is not recognised as an accredited training specialty. The majority of FPs are traditionally NHS general practitioners who undertake this work as a special interest, contracted directly by local police forces or through forensic service providers. Commercial providers are increasingly using doctors trained outside the UK who are part-way through their speciality training, working on a full time basis. Not all services achieve a throughput of 20 examinations per physician per year, which is the threshold for competent practice recommended by the Faculty of Forensic and Legal Medicine (FFLM) for adult services.
- **Professional Development** – Doctors may be recruited without any formal training in the forensic role, relying on on-the-job training. The FFLM has recently developed a set of training and quality standards (October 2010) that paves the way towards clinical governance. The Diploma in the Forensic and Clinical Aspects of Sexual Assault (DFCASA), started in 2009 under the auspices of the Society of Apothecaries, is being promoted nationally among medical and nurse post-graduates as the national basic standard for all clinicians undertaking sexual offences work.

⁹ We asked for police, NHS and other agency spend and were able to report it, noting also that paediatric provision by NHS services is not explicit and so represents a hidden cost. The baseline cost of £8m quoted as the resource implication of transferring budgets from police to NHS relates to current police expenditure only and does not include NHS spend.

- **Strategic Workforce Development** - The average referral rate (sample n=19) is 28 per 100,000 resident population, with a lower quartile of 18.9 and upper quartile of 36.4. A population of 1 million in the lower quartile, which may cover large rural areas with low population density, would generate less than 200 referrals per year across a pool of, say, 10 doctors. Rural services in particular may struggle to provide a 24/7 SOE rota separate from custody care, even though the study concludes that this would on balance raise quality standards. There is often poor availability of suitably trained and competent FPs and difficulty in the recruitment and retention of female FPs. Consequently, there is currently strong debate in the field about the scope for developing Forensic Nurse Examiners to undertake forensic physician roles. There is pressure to change workforce roles and this study has identified workforce development as a strategic issue for the future.
- **Commissioning** - The study suggests that there is a high standard of commissioning in no more than 3 forces. One third of forces is commissioning to a low standard, with contracts covering only a limited number of basic items. Although significant numbers of forces appear not to be using commissioning levers to achieve a high quality service for victims, these aspirations are evident in how they frame the challenges they face and their priorities for the future. Even among better performing police forces, the majority lacked independence from providers in their commissioning and relied on providers for their clinical advice.
- **Clinical governance** - The majority of forces appear not to have commissioned adequately resourced clinical governance arrangements, where clinical leads take responsibility for governance, and FPs are trained, keep up to date, peer review their practice, are supported and have their performance appraised in ways which are no different from the rest of their clinical practice. Where FPs are directly employed by the police, there is qualitative evidence that the police may therefore struggle to hold the FPs to account, support them adequately or enforce change.
- **Future commissioning options** - Both the police and NHS staff highlighted the need for the police and NHS to work together in order to secure an FP service which meets victims' healthcare needs as well as the police's needs related to evidence and subsequent prosecution. It was also recognized that one agency would need to take the lead and be accountable for commissioning the service. This could be summed up as a collaborative (rather than a joint) commissioning arrangement. Police forces expressed a very strong preference for this kind of arrangement for future commissioning.

Conducting an Option Appraisal to Support the Impact Assessment

The study asked two questions:

- who should commission the service: police or NHS?
- what level of quality should prevail: current or improved?

A cost-benefit analysis was used to assess four options that emerged from these commissioning/quality dimensions:

Option 1. Do Nothing. Police fund and commission FP services for sexual offences work at current quality standards.

Option 2. Police fund and commission FP services for sexual offences work with improvements to quality standards.

Option 3. Transfer responsibility for funding and commissioning of FP services for sexual offences work to the Department of Health at current quality standards.

Option 4. Transfer responsibility for funding and commissioning of FP services for sexual offences work to the Department of Health, with improved quality standards.

Quality Improvement

A set of quality standards relating to forensic physicians was proposed. Many had no direct cost consequence, e.g. greater consistency in referral practice into mainstream healthcare. In terms of costed quality improvements, the study supported two developments. The first was movement towards a model where sexual offence examination services were separate from general custody care work, because it would foster:

- competence through greater focus on sexual offence (rather than general custody) work;
- recruitment and retention of female forensic physicians;
- gender choice for the victim of assault.

The second costed quality improvement consisted of time for improved clinical governance, peer review and training.

Benefits

Non-monetised benefits of options were assessed against seven criteria grouped into three categories:

- *Commissioning capability* was the single most important criterion, reflecting the brief of this study.
- *Quality and Governance* had three components: quality of health care service, quality of forensic service, and clinical governance. They reflect the dual role of a forensic physician service which is to ensure health and well being of the victim and also to link with the criminal justice system (CJS), with the objective of pursuing a criminal investigation. Clinical governance describes the infrastructure that is supposed to maintain quality standards.

- *Other included general* strategic (long term) and operational (short term) issues that emerged in discussion of the options, e.g. how are the long term objectives of workforce development best served?

The benefits appraisal ranked Option 4 highest, followed by Option 3, then Option 2, with Option 1 attracting the lowest score. The ranking suggests that transfer of commissioning from police to NHS would be beneficial, even without the costed quality development.

Costs

Survey data relating to 85% of the population was extrapolated to the whole of England. We estimated that the current cost of the forensic physician service for sexual assault is £6.4 million (at 2009/10 prices) and that the police contribute a further £1.6 million to SARCs, bringing the total police annual outlay to £8 million.

Cost Implication at Steady State - transfer of funding and commissioning of FP services to the NHS implies a transfer (or reprovision) of the current baseline which is £8 million.

Summary of Estimated Cost Increase - the incremental cost of proposed quality improvements is estimated to be £3.2m, due to quality improvements gained by (a) stand alone rota for sexual offences and (b) training and clinical governance. It is not substantial in relation to the overall healthcare budget, but represents a 40% increase against the current baseline¹⁰.

Baseline Cost	
Forensic Physicians for Sexual Offences	£6.4m
Other police contribution	£1.6 m
Total Baseline	£8.0m
Incremental Cost	
Stand Alone Rota	+£2m
Governance	+£1.2m
Total Estimated Cost of Option 4	£11.2m
Administrative Burden (3%, or £6k per police force area)	£0.25m

¹⁰ This baseline excludes current NHS expenditure.