UNIVERSITY OF BIRMINGHAM

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:

Evidence Base to Support the

Impact Assessment

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Summary

This Evidence Base supports the Impact Assessment (produced in a separate document for the Department of Health) that emerged from the feasibility study carried out by HSMC between September 2010 and February 2011. The Impact Assessment proposes that funding and commissioning responsibility for forensic examinations for sexual offences work should transfer from the police to the NHS, with improved quality standards. The Evidence Base is structured in 7 sections followed by detailed annexes.

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GLOSSARY OF ABBREVIATIONS

A&E	Accident & Emergency
ACPO	Association of Chief Police Officers
BME	Black and Ethnic Minority
CC	Custody Care
CJS	Criminal Justice System
CPD	Continuing Professional Development
CPS	Crown Prosecution Service
CPSI	Crown Prosecution Service Inspectorate
CQC	Care Quality Commissioner
DFCASA	Diploma in the Forensic and Clinical Aspects of Sexual Assault
DH	Department of Health
DMJ	Diploma of Medical Jurisprudence
FFLM	Faculty of Forensic and Legal Medicine
FME	Forensic Medical Examiner
FMERSA	Forensic and Medical Examination for Rape & Sexual Assault
FNE	Forensic Nurse Examiner
FP	Forensic Physician
FPSA	Forensic Physician Sexual Assault
FPSO	Forensic Physician for Sexual Offences
FPSOE	Forensic Physicians for Sexual Offence Examinations
FSE	Forensic Services Examiner
GFM	General Forensic Medical
GMC	General Medical Council
GP	General Practitioner
GU	genito-urinary
HMIC	Her Majesty's Inspectorate of Constabulary
HO	Home Office
HSMC	Health Services Management Centre
ISVA	Independent Sexual Violence Advisor
IA	Impact Assessment
ITC	Introductory Training Course
LA	Local Authority
MFFLM	Member of the Faculty of Forensic and Legal Medicine
NST	National Support Team
OSCE	Objective Structured Clinical Examination
PACE	Police and Criminal Evidence
PCT	Primary Care Trust
PTSD	Post Traumatic Stress Disorder
RCPCH	Royal College of Paediatrics and Child Health
SANE	Sexual Assault Nurse Examiner
SARC	Sexual Assault Referral Centre
SO	Sexual Offences
SOE	Sexual Offences Examiner
SOM	Sexual Offence Medicine
STI	Sexually Transmitted Infection
VAWG	Violence against Women and Girls
YP	Young Person

1 OVERVIEW: THE CASE FOR CHANGE

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 2002[1] *The Report on the Joint Inspection into the Investigation and Prosecution of Cases involving Allegations of Rape: A CPSI and HMIC joint thematic inspection* was set up to examine the reasons for the high attrition[2] rate, and to identify good practice and make recommendations to address this. The review 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). Key issues raised in this report included the following:

- 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, before the victim had access to specialist staff;
- police training not conforming to a common minimum standard and resulting in a lack of consistency in approach;
- many Forensic Physicians (FPs) solely reliant on skills developed as part of 'on the job' training;
- a perennial 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 of other agencies, including the Health Service, Social Services and FPs, where facilities for the care of victims were less satisfactory and showed the greatest potential to aggravate levels of attrition.

Five years later, HM Inspectorate of Constabulary and Crown Prosecution Service Inspectorate undertook a departmental review W*ithout 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, specifically noting:

- little consistency was found in the way in which FPs were employed
- shortage of FPs (particularly paediatricians)
- delays in examinations
- varying levels of expertise and wide disparities in levels of service offered to victims

[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.

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

[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

- variability in standards of medical examination facilities
- a growing trend to outsource FP services to private enterprises

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[4], the *Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres, 2009*[5]*; Together We Can End Violence against Women and Girls, 2009; Rape: The Victim Experience, 2009*[6]*; Responding to violence against women and children – the role of the NHS*, March 2010; and the *Stern Review.*[7] (See Annex 1 for further detail).

2 THE CURRENT PROBLEM UNDER CONSIDERATION

The Department of Health set out the background to the study[8] as follows:

- Currently, forensic physicians doing sexual offence examinations largely work in police custody suites, sexual assault referral centres (SARCs) or in other victim examination facilities. The provision of the forensic element of their service is not an "NHS function" and is funded and commissioned by the local police authority, wherever the service is located.
- The adverse effect on the likelihood of rape prosecutions and victim confidence from poor forensic practice continues to be highlighted in Home Office discussions with police services and crown prosecutors, e.g. in relation to making communities safer and building a more effective criminal justice system for victims and the public.
- There are not enough Forensic Physicians to meet the demand for specialist sexual offences investigation and victim care. In addition, although the Faculty of Forensic and Legal Medicine has a specialist curriculum and examination, forensic medicine more generally is not regarded as a recognised medical specialty and currently has no national accreditation.
- Despite an increasing number of doctors working full time and an increased percentage of private providers, the majority of FPs are NHS general practitioners who undertake this work privately in their spare time, contracted directly by local police forces or through forensic service providers.
- Nationally there is a shortage of FPs particularly in rural areas. More specifically there is a lack of female FPs, a preference expressed by the majority of both male and female victims of sexual offences (Chowdhury-Hawkins, 2008).[9]

[4] 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

[5] 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.

[6] Sara Payne (2009) Rape: The Victim Experience: Review, London: Home Office

[7] 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

[8] Source: Invitation to Tender by Department of Health to undertake this forensic feasibility study, February 2010

The DH went on to highlight the need to focus on developing capacity, clinical governance, and a range of health related services to victims of sexual assault:

"… the development of effective and available services for victims of sexual assault relies in no small part on competent healthcare, including forensic medical services, and clinical governance to drive service effectiveness. This will require a commensurate development of commissioning, quality service design and development of the specialist healthcare workforce, especially amongst forensic doctors and nurses. It needs to happen within a national framework of assured professional and service standards underpinned by local commissioning and partnerships. Some work around standards has been initiated by the FFLM. The levers for clinical quality assurance through clinical governance are however, available to NHS-commissioned services only."[10]

The response to these problems was a strategic undertaking by the Department of Health and Home Office to examine the "feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination work to the NHS at the earliest opportunity" (November 2009, *Together We Can End Violence against Women and Girls: A Strategy).*

The Coalition Government has subsequently articulated its ambition to end violence against women and girls through national action where necessary, supporting localism and community social action.[11] It is supportive of the aims of this feasibility study, which had been affirmed in the Department of Health Action Plan *"Improving Services for Women and Child Victims of Violence".*[12]

Introduction to the Feasibility Study

The Department of Health commissioned the Health Services Management Centre (HSMC) at the University of Birmingham to undertake a feasibility study during the six months September 2010 to February 2011. The 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.

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[9] Chowdhury-Hawkins, R., McLean, I., Winterholler, M. & Welch, J. (2008), Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs), Journal of Forensic and Legal Medicine, Vol. 15, No. 6, pp.363-7

[10] Source: Invitation to Tender by Department of Health to undertake this forensic feasibility study, February 2010

[11] The report "*Call to end violence and abuse against women and girls"* was launched by the coalition government on 25 November 2010
http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/

[12] The DH Action Plan was also published on 25th November 2011:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122003

Methodology

The aim of the feasibility study was to generate and test options for inclusion in an Impact Assessment. In order to do this it was necessary to gain a detailed picture of the service through fieldwork with the NHS and police.

The following stages of data collection and analysis activities were carried out:

(i) **Baseline Survey (Quantitative and Qualitative Data).** A baseline survey was designed, piloted, revised and re-piloted before being issued across the England. It was divided into two parts: Survey A and Survey B, separating service provision from commissioning.

- *Survey A - Service Provision.* (Findings reported in Annex 2). This questionnaire collected information on finance, workforce and activity relating to forensic service examinations for sexual assault in England. It was sent out to service providers, including 28[13] Sexual Assault Referral Centres (SARCs) and 15 police force areas without a SARC where forensic examinations took place in custody suites or other locations. The purpose of the survey was to understand: (a) what is currently being provided across the country (SARC and non-SARC), (b) equity between police force areas and (c) resource implications if commissioning responsibility were to move to the NHS. We received responses from 79% of services, covering 85% of England's population. (However, the completeness of data in each return was variable and where information was patchy we have noted the sample size in the evidence base).
- *Survey B – Commissioning and Quality Standards.* (Findings reported in Annex 4). This survey collected information about how police forces currently commission the service and their views about how this might change in the future. It was sent to all 39 police forces in England in September 2010 and 77% of forces responded. The term commissioning was avoided in the questionnaire, being replaced with planning, funding and procuring' in order to reflect terminology in common use within the police.
- *Follow-up.* A small number of telephone interviews were conducted in November and December 2010, with PCT commissioning staff. The purpose of these interviews was to explore views about the possible transfer of commissioning to the NHS.

(ii) **Case study site visits (qualitative data**)**.** (Annex 5). Four case study sites were selected, using primary sampling criteria of (a) SARC and non-SARC provision and (b) rural, mixed and urban provision. The purpose was to gain a greater understanding of local services, with a particular focus on the quality of the service provision and the impact on victims' experiences. The visits were used to follow up lines of enquiry opened by the Baseline Surveys and to triangulate findings.

[13] Some police authority areas have more than one SARC e.g. London, West Midlands, Devon and Cornwall and Northumbria

(iii) **Professional Education.** (Annex 6). The study considered the relationship between service provision, commissioning and professional education. This involved interviews with forensic physicians and professional bodies, e.g. Faculty of Forensic and Legal Medicine (FFLM) within the Royal College of Physicians and the Royal College of Paediatricians.

(iv) **Quality Standards.** (Section 3). A set of quality standards was generated from existing requirements set down by the Home Office, Department of Health and Association of Chief Officers (ACPO)[14], the FFLM, as well as from data about standards of practice outlined by staff in case study sites; these have been used as a benchmark for appraising the costs and benefits of a range of options and were an output of the Baseline Surveys and Case Study visits.

(v) **Data Collection and Analysis.** Data collection proved to be cumbersome due to the highly fragmented pattern of provision. A basic problem is that sexual offence work comprises 2%-15% of the overall workload carried out by general Forensic Physicians. It is low in volume and specialist in nature. Very few forces have a separate contract for this service, with most subsuming it within a larger contract for custody healthcare or a SARC. In many cases, quantitative data was not available to commissioners as it was held by the outsourced private provider companies that supplied forensic services. Nevertheless, we collected detailed data that provides a profile of services in England covering up to 85% of the population. Headlines of the analysis are presented below and further details given in Annexes 2 and 4.

(v) **Define Options and Undertake Impact Assessment.** (Sections 5-7). The Baseline Study provided an Evidence Base which was used to support an option appraisal. The results were taken forward into an Impact Assessment, supplied to the DH in a separate document. The impact of proposals on equality also needed to be addressed (see Annex 8).

Comment on Data Quality in Survey Instruments

The Evidence Base uses data collected through survey instruments, A and B. We aimed for national coverage to gain a full baseline. The response rate in the end was high, approximating to 80% across both surveys. The depth of the response varied between the two surveys:

- Survey A (service provision – mainly quantitative): responses were often incomplete, reducing the sample size for some indices. For example, only 50% of respondents provided both costs and referrals, required to derive unit costs. The major caveat in the

[14] Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres, Department of Health, Home Office, Association of Chief Police Officers; October 2009

analysis is that sexual offences resources are difficult to measure because they are often embedded in the custody care service. The service struggled to provide a coherent data set and we have extracted as much meaning as the data allows. We are explicit throughout the analysis about the scale of the sample and the assumptions used.

- Survey B (commissioning – mainly qualitative): the completeness of responses was high and the quality of data is considered to be good.

Baseline Study A – Profiling the Current Service Provision

The Baseline Study A (reported in Annex 2) supports the case for change by providing evidence of (a) diversity of structure, (b) inequity of resource provision, (c) children and young people's needs, (d) the relationship between quality, gender of doctors and separate sexual offences rotas, and (e) problems of scale, with low volumes of experience to support a critical mass of clinicians.

a) Diversity of Structure

- Over half the rotas in the study sample (17/32) are joint rotas, with doctors covering both general custody care (offenders) and sexual offence (victims) work;
- Workforce models (e.g. combinations of doctors, nurses, paramedics) and employment arrangements involving FPs are becoming increasingly diverse with the growth in outsourcing these services to private providers;
- Independent providers, and some professionals, are pressing the case for extending the role of nurses (Forensic Nurse Practitioners). They point out that the labour market in rural areas makes it easier to recruit high calibre nurses than high calibre doctors, and that sexual health nurses are a good resource for this work[15];
- Forensic examination services are provided in SARCs and Custody suites: SARCs cover 68% of England's population and 56% of the geographical area; custody suites cover 32% of population and 44% of geographical area;
- It follows that custody suites cover more rural areas with an average population density of 735 people per square mile; SARCs cover more urban areas with an average population density of 1,253 people per square mile.

b) Inequity of Resource Provision

The national baseline survey quantified significant variations in workload, workforce, expenditure and unit cost:

- Referral rates per 100,000 – average and median of 28 with lower quartile 18.9 and upper quartile of 36.4;
- There are between 450 and 500 forensic physicians available for sexual offences work in England, with pools ranging from 4 to 24 forensic physicians per police force area rota;

[15] The role of nurses and their scope of practice is an important current issue. See Annex 2 for the FFLM position on this.

- Police expenditure per 1,000 population has a mean of c. £160; the forensic physicians element accounts for 78%;
- The median cost per referral is c. £750 with a lower quartile cost of c. £400 and an upper quartile cost of c. £1,800.

c) Children and Young People's Needs

- There is a pervading sense of anxiety that the forensic examinations of children do not meet a consistent standard for response times, evidence collection and clinical competence[16];
- While children and young people (under 18) account for 21% of the country's population, they represent a third of sexual assault and rape referrals;
- Volumes of forensic examinations are low as many reports relate to historic abuse;
- Where FPs are not paediatrically trained, children under 13 years should generally be examined by a FP and a paediatrician, drawn from local safeguarding services;
- A minority of FPs has paediatric expertise and few paediatricians wish to become involved in this area of work. As a result, the lack of a suitably trained doctor was in places a cause of either (a) delay in undertaking the examination, or (b) lack of confidence about the standards of evidence-taking;
- There are lengthy waiting times for acute paediatric cases, particularly out-of-hours;
- Paediatric cover for forensic examinations is rarely funded by police commissioning and represents a hidden cost to the NHS.

d) Quality, Gender of Doctors and Separate Sexual Offences Rotas

- Joint custody care/sexual offence examination rotas are less costly than separate custody care and SOE rotas, which require two levels of medical cover at any one time[17];
- Joint rotas are predominantly staffed by men (66% male doctors) while separate SOE rotas are mainly staffed by women (95% female doctors);
- Fieldwork indicates that most victims of sexual assault are women (93%) and prefer to be examined by a woman[18]. Lack of a female forensic examiner is a source of delay in response times;
- Joint CC/SOE rotas struggle to recruit women as over 90% of the caseload is linked to custody care work, dealing with offenders rather than victims of crime, which is less attractive to female doctors;
- The fieldwork generated a case for separate sexual offences rotas on the basis that (a) they would be part of a specialist sexual offences service with improved quality standards and (b) they could recruit female doctors;

[16] Annex 7 references recent guidance from RCPCH/FFLM on this

[17] Table at end of Annex 2 indicates that medical cost per 100,000 population is greater for separate SOE rota, at £13,760 per 100,000 population, than for the estimated SOE proportion of a joint rota, at £9,373 per 100,000 population. In addition is the need to run two rotas instead of one. A full costing of separate CC+SOE compared to combined CC/SOE is beyond the scope of this project as comprehensive custody care costs have not been collected.

[18] Supported also by references, e.g. Chowdhury-Hawkins, R., McLean, I., Winterholler, M. & Welch, J. (2008), Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs), Journal of Forensic and Legal Medicine, Vol. 15, No. 6, pp.363-7

- This would require investment and is taken forward into the Impact Assessment;
- In rural areas, where populations and referral volumes are thinly spread over wide areas, the feasibility of providing a separate sexual offences rota may be limited. The development of Forensic Nurse Practitioners could overcome the gender imbalance within a joint custody care/SOE rota. This is not costed into the Impact Assessment as it is a longer term strategic issue.

e) Volume of Experience and Critical Mass

- Forensic medicine is a small sub-specialist area of practice and the volume of reported crime associated with sexual assault is low. The estimated c. 500 doctors involved[19] in England (out of a doctor workforce of 140,000 in the NHS) are often general practitioners providing extra sessions. The Faculty of Forensic and Legal Medicine proposes a threshold of 20 examinations: " the FFLM recommendations for Sexual Offence Medicine is a minimum of 20 forensic examinations per year[20] and for General Forensic Medicine 100 examinations per year but it is recognised that some initial flexibility is desirable to accommodate operational requirements in certain areas[21]". Not all doctors achieve this benchmark. In paediatrics the volumes are very low.
- Critical mass and low volumes of experience in paediatrics lend support to the idea of developing regional services for children. This is a strategic objective that is noted as being desirable but is not quantified in the Impact Assessment.
- Examinations per doctor per year:
    - Adult – mean 27 per doctor per year, with a range from 8 – 40 per doctor per year;
    - Paediatric – mean of 11 referrals per doctor per year (based on a sample of 15 services); examinations were conducted on 55% of referrals, giving a mean of 6 per doctor per year.

Baseline Study B – Profiling Current Commissioning

The Baseline Study B (reported in Annex 4) supports the case for change by providing evidence related to (a) very variable standards of commissioning, (b) clinical governance, (c) joint work with the NHS, (d) significant service challenges and priorities, and (e) future commissioning options. After piloting the questionnaire, the term 'planning, funding and procuring' was used instead of 'commissioning', reflecting the terminology that is in common use within the police.

[19] This estimate is based on the study sample of doctor pools that are involved in rotas that deal with sexual offences. The rotas may be either joint custody suite/sexual offence or dedicated sexual offence rotas

[20] Recommendations for Regional Sexual Assault Referral Centres. Report of a Department of Health Working Group. August 2008.

[21] Source: "Quality Standards In Forensic Medicine, General Forensic (GFM) and Sexual Offence Medicine (SOM)" Faculty Of Forensic & Legal Medicine of the Royal College of Physicians of London, 4th October 2011

a) Very variable standards of commissioning

- Evidence of well developed commissioning was found in no more than 3 forces;
- A significant minority of additional forces is well on the way to specifying services in detail, including meeting victims' healthcare needs and clinical governance arrangements;
- One-third of forces is commissioning to a low standard, with contracts covering only a limited number of basic items, mostly in forces without a SARC;
- The majority of forces (52%) use block contracts; only 12% of forces have separate contracts for this service, with 50% subsuming the service in a much larger custody healthcare contract;
- Performance management of providers is very limited with most providers not reporting against the full set of contract standards; there are a few notable exceptions where performance scorecards monitor performance against a wide range of standards;
- Most forces seek specialist advice (80%) but 30% rely on a local lead FP whose advice is not independent; just over one-third of forces also involved their provider in specifying the service;
- There are poor levels of specification for referrals to other services, and just under half of forces do not specify how victims' healthcare needs should be met. Police cite the ability to influence healthcare services as an advantage of the NHS leading commissioning in the future;
- Some forces are focusing on procurement as a way of driving up standards and resolving clinical governance difficulties; few forces are undertaking needs assessment or consultation with users;
- Most forces have fairly limited staff time available for commissioning the service, and only a small minority provide training for these staff, which focuses on procurement;
- The overall view is that commissioning is not well developed compared with NHS standards of commissioning, with a small number of notable exceptions.

b) Clinical governance

- Clinical governance in contracts was reasonably well specified where forces have a SARC, but less well specified where forces do not have a SARC. Arrangements usually cover clinical lead, clinical governance framework, clinical supervision, training, continuing professional development, and audit and peer review;
- There was limited or no performance data from providers about implementation of clinical governance;
- Nearly half of forces (42%) have faced one or more challenge related to clinical governance in the past 2 years and 10% identify it as one of their top three issues to be tackled in the coming year;
- Police cite clinical governance most frequently as an advantage of the NHS leading commissioning in the future;

- In the 'top nine' forces, where the service is specified in most detail, all forces cover all six core clinical governance items, but there is evidence that these are not always implemented by providers. Only 4 forces commission independently of providers – the remainder rely to some degree on providers, either to provide clinical advice or to provide input to service specifications.

c) Joint work with the NHS

- One-third of forces have no NHS involvement at all in commissioning the service;
- Only 15% of forces worked jointly with the NHS on most aspects of commissioning;
- Multi-agency arrangements to support the commissioning of this service are mostly *ad hoc* or short-term working groups related to SARCs or Rape Steering groups; only 13% of forces had more formal accountability arrangements to the Local Strategic Partnership or the Sexual Health Network.

d) Significant service challenges and priorities

- Large numbers of forces have faced difficulties in securing some of the basic elements of a high quality service for victims, most notably response times (in-hours, 57% of forces; out of hours 60%), availability of suitably trained forensic examiners (67%), and availability of female examiners (70%) and paediatricians (63%).
- The most common priorities for improvement over the coming 12 months were: improve paediatric service and facilities (27%), improve training for FSEs (23%); upgrade facilities (23%).

e) Future commissioning options

- The first choice for most police forces is for the police and the NHS to work jointly in commissioning the service so that both criminal justice and healthcare needs can be met. The second choice is for the NHS to lead.
- There were mixed views from the small number of PCT staff interviewed, with less strong support for NHS involvement (lack of an obvious 'home' for commissioning the service); limited awareness of the police's criminal justice requirements of FPs.

Service Quality

Quality is an important element of the problem under consideration and the case for change in commissioning arrangements. Evidence about the quality of the FP service is drawn primarily from the four case study sites, supplemented by national evidence from police commissioners. (See Section 3). Overall, there are examples from both ends of the spectrum of quality - from well developed FP services which are currently delivered to a high standard and could be seen as exemplars of the proposed quality standards, to services where considerable development and improvement is required. The main quality issues, which apply to many but not all forces, are as follows:

- Many police forces have found that providers have been unable to meet agreed response times in the past 2 years;

- Victims may be kept waiting significant lengths of times (e.g. 8 hours) because FPs are already doing custody work, prioritizing their main clinical role (GP) or may not have clinical cover as a GP to allow them to respond quickly;
- There is limited and uneven access to a female FP, with some forces unable to offer victims a real choice of the gender of the FP;
- A small but significant minority of examinations are taking place in rooms which do not fully meet forensic standards and could therefore be challenged in court;
- There is evidence of inconsistent assessment of need in relation to risk of pregnancy and sexually transmitted infections, including HIV, risk of self harm, mental health, personal safety and/or child protection and wider social support;
- Not all forces specify the need for FPs to provide immediate treatment, including emergency contraception, prophylaxis antibiotics and first aid.

Professions: Education, Accreditation and Training

There is poor availability of suitably trained and competent Forensic Physicians, especially in rural areas where services are located in custody or sympathy suite facilities, and professional isolation is a feature of working life. Consequently there are increasing efforts to improve standards of practice through accreditation and training, e.g.:

- The FFLM has developed a set of training and quality standards (October 2010) which paves the way towards clinical governance in the profession. However, they have found that only 20% of students (many of whom were currently practicing as forensic physicians) passed the GFM examination - examiners found that candidates revealed "a total misunderstanding of the seminal importance of attitude and communication skills. That is what the OSCE tests and that is what many people failed on"[22];
- Development of the Diploma in the Forensic and Clinical Aspects of Sexual Assault (DFCASA), introduced and run by the Society of Apothecaries since 2009[23], has been informed by GMC requirements. DFCASA is being promoted among medical and nurse post-graduates as the national basic standard for all clinicians undertaking sexual offences work and as an entry requirement for further training on advanced practice (which would be conducted via FFLM);
- Within the workplace, training provided for FPs involves a mixture of in-house and national training, such as those run by the Manchester and London SARCs. In-house training could be provided by an independent provider and as part of a joint custody care and sexual offences rota. The length of training for a new doctor varied between 4 days (e.g. 4 days induction training followed by 2 days SO training and

[22] FFLM Board Meeting 26th April 2010 https://fflm.ac.uk/upload/documents/1277211365.pdf
[23] It needs to have produced three completed cohorts before GMC recognition can be sought

mentored examinations) and 6 months (depending on number of cases that came through and prior experience). Staff may be encouraged but not necessarily required to attend national courses. Doctors may be recruited without any formal training in the forensic role. (See Annex 6).

Rationale for Intervention

A more consistent framework is needed for commissioning and monitoring forensic sexual examination work, especially in custody suites and in relation to children, to address the uneven quality (effectiveness and experience) and provision (access and gender choice) that exists across England[24].

The NHS is the organisation most suited to this task. The general perception among police and NHS practitioners is that improvements and standardisation of clinical service is best achieved through the NHS. The benefits of transferring budget and commissioning responsibility to the NHS are considered to be:

- Equity of access;
- Gender choice for the victim of assault;
- Improved experience for victims;
- Application of higher standards;
- Integration of services for children and young people;
- Clinical governance of forensic physicians;
- Movement to a model that would enable recruitment and retention of women forensic physicians;
- Strategic approach to workforce development;

Government intervention is necessary to approve the transfer of responsibility of commissioning from the police to the NHS and the resulting movement of budgets from the Home Office to Department of Health, allowing the NHS (through its new commissioning structures) to commission forensic sexual offences examination work and to apply greater governance to forensic physicians.

Policy Objective

The policy objectives to be met by this intervention are 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.

[24] See Health and Social Care Bill 2011, amending the National Health Service Act 2006, defining the Secretary of State's duty to improve quality and to reduce inequalities. Quality outcomes are categorised as: (a) effectiveness of the services, (b) safety of the services and (c) quality of experience undergone by patients.

3 PROPOSED QUALITY STANDARDS

A set of proposed quality standards has emerged from the study, relating to forensic practitioners for sexual assault in both SARC and non-SARC services. They inform the conclusions since 'quality improvement' is a feature of some of the options defined in Section 5. (Although there may be some overlap, these standards do not map directly to the '10 Minimum Standards' which only apply to SARCs). The table below describes the proposed quality standards. In the right hand column we present quotes and evidence from case study sites and fieldwork surveys that illustrate how the service is performing at the moment.

Proposed Standards : Forensic Practitioners for Sexual Assault	
Service Quality Standards	**Evidence**
Response times	
Victims are seen within 1 hour of expected arrival time for the examination, both in-hours and out-of-hours	Qualitative evidence from case study sites and questionnaires that victims may be kept waiting significant lengths of time, because: • FPs are already doing custody work • FPs prioritise their main clinical role or may not have clinical cover to allow them to respond quickly • female FPs are not always available, especially out-of-hours. Almost half of all police forces have found that providers have been unable to meet agreed response times in the past 2 years. *"We record response times and audit all cases every year – our average is 45 minute response time."* *"There are often delays as the FPs are doing custody work."* *"We have one FME on call at any one time (for the town), and they have both general custody and victim examination duties (general and sexual assault). It's hard to get an on-call FME on Friday and Saturday nights, the custody cells are busy, so there can be a delay, occasionally as long as 8 hours."* *"Two of us (FMEs) are GPs in the same practice. Our practice always comes first, but we can usually cover for each other (when a call comes in), and juggle the home visits."*

Specialist paediatric skills are available for acute cases, within the same response times as adult cases	Evidence suggests lengthy waiting times for acute paediatric cases, particularly out-of-hours, because: • low call out rates make on-call rotas very expensive or not viable unless covering a very large area • relatively few NHS Trusts include this work as part of paediatricians' contracts. The most frequently reported commissioning priority for future improvement was paediatric services and facilities. *"Without the SARC we couldn't get paediatricians involved…we have had problems where we can't get anyone for 24 hours, so the FME has had to do the examination alone. It puts you in a difficult position, but you've got a duty of care… most of our FMEs don't like to see anyone under 16… without a paediatrician there."*
Choice of gender of examiner	
Choice of gender of forensic examiner is always offered by police to all victims, within standard response times. This requires a predominantly, but not exclusively female workforce, and is most likely to be achieved if sexual assault rotas operate separately from custody rotas.	Strong qualitative data from case study sites and questionnaire responses indicate that: • in many areas victims cannot have choice of gender *and* speed of response • some areas emphasize the skills of the FP rather than gender, in order to compensate for poor availability of female FPs • separate rotas may attract female FPs (who may prefer sexual assault work to custody work) • retainer rates need to be high enough to cover out-of-hours childcare costs. 70% police forces are finding it hard to get enough female FPs (this was the commonest commissioning challenge faced by forces in the past 2 years). *"Victims are told it is highly likely that a male doctor will come out. This is hard as some victims want female examiners, but we only have 3 and one of these won't go on a rota to come out after dark. No one has refused a male examiner yet, but if they (the victim) are adamant, we try to get the female doctor from further away to travel here."*

Premises and Equipment	
Examinations take place in forensically approved, cleaned and sealed premises	A small but significant minority of examinations are taking place in rooms which do not meet forensic standards and could therefore be challenged in court, including: • GP consulting rooms • Accident and emergency • Paediatric out-patients • Custody or sympathy suites. *"The sympathy suites are forensically cleaned .. but they are not forensically secure, and half of them aren't locked and are used by other teams."*
Colposcope available along with secure storage of images.	Qualitative data showed evidence of limited access to colposcopes or inadequate training in the use of the equipment. *"There's a good working colposcope here, unlike some hospitals."*
Assessment of need	
Victims needs are assessed fully, including: • **risk of pregnancy and sexually transmitted infections, including HIV** • **risk of self harm** • **mental health** • **personal safety and/or child protection** • **wider social support.**	FPs in some areas expected to focus on the forensic examination only and are not expected to spend additional time assessing and treating victims' wider healthcare needs. *"There are some tick box doctors. Maybe not so rigorous and don't always have the right background and experience."* *"Some of the male FMEs are not particularly interested in sexual assault and it is just one small part of their work. So they treat victims in a fast way – take samples and get away."* *"Sexual assault exams are lengthy – often 3 hours with aftercare. You can't rush it."* *"We use a risk assessment proforma. .. and look at safeguarding, suicide and mental health risk. Acute metal health problems go straight to the mental health team, but other needs eg. self harm, are more difficult to manage…. victims with learning difficulties are not getting the right assessment."* *"You have got to be empathetic, ask the right questions to not offend people and be sensitive. You need the right people with the right attitude and training."* *"Historically, the FMEs have not been confident about assessing for HIV risk."*

Immediate treatment	
Immediate healthcare needs are treated on site: emergency contraception, prophylaxis antibiotics for STIs, and first-aid. This requires FPs to dispense antibiotics and emergency contraception and have access to a first-aid kit.	Evidence suggests that not all forces expect FPs to provide immediate treatment. Victims are instead given information, a prescription or subsequently taken to A&E by the police. The onus is on victims to seek out appropriate treatment, rather than making it easy by providing appropriate treatment on-site. *"Not all the FMEs have emergency contraception to give to people."* *"Sometimes the sympathy suites are not well stocked and the morning after pill isn't there. Sometimes we have to send victims to A&E for HIV prophylaxis treatment."*
Referrals	
Timely referrals are made to additional healthcare services with victims' consent, using local pathways which include rapid access arrangements. Referrals may include: • follow-up STI screening • HIV prophylaxis • pregnancy testing • counselling and mental health services • support from ISVAs and third sector organizations. Local pathways for these services will vary. Victims will also vary in when and how they prefer to access these services, and whether they wish their GP to be informed of any referrals.	Qualitative findings show that, in some areas, FPs provide information only, rather than referring victims to the appropriate range of services. Questionnaire responses indicate police awareness that victims need to be more formally referred onto a range of health and support services. Some forces have good care pathways that enable victims to access wider services quickly. *"There are no formal referrals to other services, it's left up to the victim. The FME may advise the victim to have a check up for STIs."* *"We have issues with…after care and facilitating referrals. They (some FMEs) have no concept of a duty of care and referring patients on."* *"I go over with the victim: the morning after pill, going to the GU clinic, counselling; and the ISVA can help (with this). I don't know if they go to these services, it's the weak part of what we do. It could be better with GU – we aren't sure if there's a fast-track arrangement for victims."* *"The FMEs give advice on where to go, rape crisis, victim support…. we offer to talk to their GP and can make referrals if the victim agrees."* *"We want users to see as few people as possible and to tell their story only once, not be passed from pillar to post. In the daytime, one of the doctors from GU comes down to see victims in the SARC. If they come to the SARC at night, SARC staff ring GU the next day to get them into the most appropriate clinic and then the ISVA lets the victim know."*

Clinical governance	
Clinical leadership	Clinical lead role in place to: • lead clinical governance • provide advice and support on cases to individual FPs • undertake appraisals and assess CPD requirements • ensure cases are reviewed and audits undertaken.
Audit and peer review	Each FP takes part in at least 4 peer review sessions a year
Appraisal	FP role included in annual appraisal
Continuing Professional Development	• Meets FFLM CPD recommendations, including FFLM approved one-day "Best SARC Practice" course at least every 3 years;
User feedback	User feedback and complaints are routinely reviewed to inform practice
Record-keeping	Complete client clinical record within 48 hours of an examination Confidentiality and information governance requirements of both the NHS and police are met
Forensic Practitioners	
Qualifications	Clinician (doctor or nurse) with up to date registration
Training	Meets agreed minimum training requirements e.g. FFLM, DFCASA
Minimum experience	20 adult forensic examinations for sexual assault per year 5 acute paediatric forensic examinations per year
Criminal justice	Able to provide written statements and evidence in court which meets professional body and CPS requirements Meets PACE standards for forensic examinations
Communication skills	Listens and observes effectively Communicates clearly and empathically Demonstrates a non-judgmental attitude to victims

4 SPECIAL ISSUES: PROFESSIONAL STANDARDS, CHILDREN, STAFFING

The fieldwork generated a body of evidence relating to professional standards, children and staffing. This section signposts some of the main findings.

Professional Standards

A study in 2008[25] found that nearly 30% of doctors surveyed, who were working in forensic medicine, had not undertaken any formal training for the forensic role, in the form of Introductory Training Course (ITC). The study also found that these doctors were less likely to be aware of clinical errors: "doctors who have not completed an ITC do not think they have had adverse incidents in relation to patient safety and have not missed forensic evidence", commenting that ''you don't know what you don't know" and asking "In what other branch of medicine would a doctor be allowed to work without appropriate training?" (Annex 6).

Children

There is a deficit in the quality of service provided to children. Standards are uneven and, among experts in the field, there is anxiety about the quality of evidence-collection. The epithet "you don't know what you don't know" is apposite.

The usual model is for a joint examination between a forensic physician and a paediatrician drawn from the local general hospital service. There is a scarcity of paediatricians able and willing to engage in this area of work.

Volumes of forensic examination work are low, averaging perhaps 4-6 per doctor per year. Logic suggests that a regionally-commissioned service would make most sense. Physicians support this.

The box below gives a picture of the current position from the perspective of a forensic physician with a focus on children:

[25] Wall, I.F., (2008) Lack of training in custodial medicine in the UK: A cause for concern?, in Journal of Forensic and Legal Medicine, Volume 15, Issue 6, August 2008, pp 378-381

Notes of Interview with Forensic Physician with Focus on Children

- "the number of paediatric cases being referred to services is reducing (and volumes are low in any case)
- child examinations of cold cases often reveal nothing, i.e. 93% case show no significant clinical indicators ("normal to be normal") even where an offence has been committed (Astrid Heger, 2002[26])
- there are different standards and concern about core competence: forensic competence is a major issue
- NHS services represent a hidden cost of child forensic work
- forensic medical evidence is primarily visual
- there are benefits in having 2 doctors present - paediatrics (top to toe examination) and forensic (gynae)
- low volume coupled with need for daily encounters makes the case for a Regional Service for children very clear
- the UN Rights of the Child (supported by the Council of European Standards) is a touchstone for standards"

Staffing

Forensic examination services for sexual assault are currently provided by doctors. The boundary between medical and nursing roles is currently a subject of hot debate. In our fieldwork (involving interviews and case study visits) we found that the medical profession is keen to raise competence and clinical standards among doctors, arguing that professional isolation (in police stations) and autonomy are challenges that doctors are best placed to deal with. This perspective was articulated by a forensic physician, quoted in the box below.

Notes of Interview with Forensic Physician A

- "isolation is a professional hazard
- nurses work well in settings where supervision is available, but are not necessarily equipped to work alone in a police station
- while nurses are potentially well placed to help in custody, they are not appropriate as a substitute for doctors
- core competence of physicians needs to be established to ensure a clinical lead"

Independent providers, and some doctors, on the other hand, pressed the case for extending the role of nurses to provide Forensic Nurse Examination services. (See box below). They pointed out that the labour market in their rural areas made it easier to recruit high calibre nurses than high calibre doctors.

[26] Astrid Heger, Lynne Ticson, Oralia Velasquez, Raphael Bernier, (2002), "Children Referred for Possible Sexual Abuse: Medical Findings in 2,384 Children", Child Abuse & Neglect Volume:26 Issue:6/7, June 2002, pp:645 to 659, http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=208496

Notes of interview with Forensic Physician B

- " GPs may not have any knowledge of sexual health assessments - not using HIV Pep;
- nurses in sexual health are interested in the role and they can be more experienced than a GP, custody doctors or custody nurses;
- maybe there are some legal problems over court appearance but they would be better than the doctors now. Doctors don't give opinion now in court, they are only witnesses of fact. Police have to pay for an expert in court."

Workforce development and potential substitution between doctors/nurses is noted here as a strategic issue.

Gender has emerged as a quality factor because of the link with separate sexual offences rotas. The logic is rehearsed in several places, namely that:

- in joint custody care/sexual offence rotas, the doctors are mainly male, and the workload is primarily about dealing with offenders;
- Separate sexual offences rotas are mainly staffed by women, who have an interest in dealing with victims of sexual assault, but not general custody care work;
- the examination experience adds to the trauma for the victim where the FP is not competent (according to the FFLM, competence includes attitude and communication);
- separating out sexual offences rotas from custody care rotas would improve the service from both a forensic perspective (on the basis that evidence collection would be improved due to increased focus and competence) and a client or patient perspective (improving the experience and outcome for the victim);
- a separate sexual offences rota would improve the service's chance of recruiting and retaining female physicians.

5 OPTION APPRAISAL

This section describes the options that are considered in the Impact Assessment and how they are appraised through weighting and scoring a set of benefits criteria. The benefits are non-monetised and separate from the costing exercise.

Description of Options

The options are structured according to two questions:

- Who should commission the service?
- What level of quality should prevail?

The two commissioning/quality dimensions result in four options:

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 NHS at current quality standards.

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

The Commissioning Dimension

In terms of the Impact Assessment, which is to explore the feasibility of transferring funding and commissioning responsibility between two government agencies, the commissioning options have been defined as: NHS or police.

These agencies fall within the ambit of the Department of Health and Home Office and the options are consonant with current structures. The context is changing however, with a new Government and changing structures. Potential developments at sub-departmental level, such as transfer of commissioning to points within the NHS Commissioning Board or Public Health England, become a matter for design and implementation beyond the Impact Assessment,

The Quality Dimension

The case for change is built on the need to improve quality, to deal with known deficiencies in the service, particularly in relation to gender choice, children and clinical standards. A detailed set of proposed quality standards was described in the previous section (relating to forensic practitioners and distinct from the 10 Minimum Standards for SARCs). All quality improvements are expected to have a beneficial impact upon the victim/service user. Not all will, however, have a cost implication. One of the main drivers of cost in our quality standards is gender choice. There is evidence to suggest that separate sexual offence rotas, which are more expensive than joint custody suite/SO rotas, are more able to attract female doctors (usually the gender of choice). In rural areas this may be challenging and there may be a trade off between response time (through proximity) and gender choice.

The monetised cost of quality improvement (options 2 and 4) is quantified through (i) a stand-alone sexual offences rota, as a mechanism for attracting women to the service and thereby offering gender choice to victims of sexual assault, which is anticipated to improve (ii) access within 1 hour, since shortage of female physicians contributes to delays, and (iii) training and governance.

Approach to Assessing Non-Monetised Benefits of Options

Non-monetised benefits of options are compared by the following methodology:

- Draw up a set of criteria;
- Weight the criteria, assigning each criterion a percentage that sums to 100%;
- Score the benefits of each option against the criteria, rated 1-10;
- Calculate the total weighted score for each option;
- Rank the weighted scores. The option with the highest weighted score is signalled as the option with the highest non-monetised benefit.

Assignment of weights and scores is a subjective approach that helps to organise the arguments behind the pros and cons of each option.

Criteria for Assessing Options

There are seven sets of criteria, defined as (i) commissioning capability, (ii) quality of health care service, (iii) quality of forensic service, (iv) clinical governance, (v) strategic issues, (vi) operational issues, (vii) acceptability to stakeholders. They are outlined below together with the relative weight which has been assigned to them.

Weight Total=100%	Criteria and Characteristics
40%	**COMMISSIONING CAPABILITY** • Capability to commission a clinical service • Ability to commission high quality clinical governance (with access to independent clinical advice) • Ability to meet the needs of the Criminal Justice System
15%	**QUALITY OF HEALTH CARE SERVICE** • Gender choice, response times, assessment & follow up of consequent health care needs
15%	**QUALITY OF FORENSIC SERVICE** • premises • Integrity of forensic chain of evidence, including collection of evidence & statement • Forensic competence
15%	**CLINICAL GOVERNANCE** • Clinical leadership • Professional supervision and development • Audit and peer review
5%	**STRATEGIC ISSUES** • Aligning policy development and implementation, e.g. workforce development • Future-proofing, e.g. impact of transferring custody health care services to NHS, potential future role of Care Quality Commission (CQC) in approving service provision
5%	**OPERATIONAL ISSUES** • Relationships between healthcare practitioners and police, e.g. accountability, payment and incentive structures, day to day collaborative working • Stability
5%	**ACCEPTABILITY** • Views of stakeholders[27] about pros and cons of police vs. NHS commissioning

[27] Stakeholders refer to individuals and agencies involved in the feasibility study, including SARCs, NHS and police

Discussing the Weighting

The seven criteria are grouped into three categories:

- *Commissioning capability* is the single most important criterion, reflecting the brief of this study. The question 'who should commission forensic examination services?' dominates the criteria through the weighting of 40%.

- *Quality and Governance* has three components: quality of health care service, quality of forensic service, and clinical governance. They reflect the dual role of a forensic practitioner 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. The categories allow for the possibility of tension between healthcare and forensic responsibilities. Each of the three components has a weight of 15%, giving an aggregate of 45%, reflecting the overall importance of the category.

- *Other* includes general strategic (long term) and operational (short term) issues that emerge in discussion of the options, e.g. what model fits best with the direction of travel of other initiatives such as proposed transfer of custody healthcare from police to NHS; how are the long term objectives of workforce development best served? *Other* also includes acceptability, picking up the views of stakeholders about which arm of service should take responsibility for commissioning. The combined weight of this category is 15%, giving it a presence but not outweighing either commissioning or quality criteria.

Discussing the Benefits Scoring

- *Commissioning capability:* the NHS (Options 3 and 4) scores highly on capability to commission healthcare and clinical governance whereas the police (Options 1 and 2) score highly on the ability to meet the needs of the CJS. The net effect is to assign a higher score to NHS commissioning options.

- *Quality and Governance*:
    - Health care quality: attracts a higher score for options which specifically introduce improvements in quality (Options 2 and 4), mainly through resource growth that is quantified in the monetised cost section of the Impact Assessment;
    - Quality of forensic service: the police are intrinsically motivated to ensure that the chain of evidence is sound, leading to an outcome of prosecution and

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personnel, plus professional bodies. Victims groups have not been involved in the study.

conviction. More training and accreditation (higher quality) is needed to ensure that evidence collection standards are consistent across England;

- Clinical governance: one of the drivers of this study has been the clinical governance deficit that exists within current commissioning arrangements (Options 1 and 2), and an expectation that a shift of commissioning to the NHS will be accompanied by strengthened governance. NHS options (3 and 4) attract high scores here.

- *Other:*
  - *Strategic issues:* Strategically, a shift of commissioning from police to the NHS makes good sense. Workforce development, including accreditation and standards for physicians and other practitioners, fits best under the healthcare umbrella. A further argument in favour of transfer of commissioning to healthcare is the proposed shift of responsibility for custody healthcare from police to the NHS.
  - *Impact on day to day operations:* an option of no change (Option 1) will have the least disruptive impact upon day to day operations and so attracts the highest score against this benefits criterion. Even a quality improvement, if it involves structural change (such as a stand-alone SOE physician rota) would introduce some transitional problems. This criterion highlights the benefits of stability versus the risk of change.
  - *Acceptability:* the general view of stakeholders is that the NHS should be the commissioner of this service. The FFLM, for example, notes that: "The faculty is of the opinion that the NHS should commission forensic medical services but they must be adequately funded and have quality standards built in." (See Annex 7). Police forces in England ranked the NHS more highly than the police when asked to choose between NHS and police as lead commissioner[28]. Nevertheless, considerable value was placed on the police's ability to get things done quickly and effectively and, where the police were seen as commissioning a good service, there was no perceived benefit in making a change.

    The pros and cons below reflect stakeholder opinions, informing 'Acceptability':

	Pros (Stakeholder Opinions)	**Cons (Stakeholder Opinions)**
Police	**Police retain control and can make it happen** • Police evidence and forensic needs will be met • Prosecution needs will be met • Directly contracted forensic physicians able to stay in police 'family'	**Lack of clinical understanding and leverage with clinicians** • Hard to influence health services which victims need • Funding burden remains with police • Recruitment problems hard to tackle

[28] 'Joint commissioning' between NHS and police emerged as the favoured option, highlighting the importance of collaboration between the agencies. However, joint commissioning has not been put forward here as an option since the purpose of the study is to test the feasibility of transferring responsibility from police to NHS.

	Pros (Stakeholder Opinions)	Cons (Stakeholder Opinions)
NHS	**Able to commission good quality clinical governance** • Able to influence health services which victims need • Expertise in commissioning quality health services • Similar ethos to the police • Could help with recruitment and retention	**Loss of focus on meeting police's forensic and prosecution needs** • Changes in NHS make it unwise for now • Loss of police expertise • NHS slow, bureaucratic and finds partnership working a challenge • NHS organisations would need to collaborate across a big geographical area • Funding could be threatened or diverted to other services

Weighted Scores

The table below shows the raw scores that have been assigned to each option against each criterion. It is interesting to note that the rank order of the raw scores is the same as the rank order of the weighted scores, indicating that the weighting has not shifted the order of preference (perceived benefit).

		Score Rating				Weighted Score			
	Weight	**Option 1**	**Option 2**	**Option 3**	**Option 4**	**Option 1**	**Option 2**	**Option 3**	**Option 4**
Commissioning Option:		**Police**	**Police**	**NHS**	**NHS**	**Police**	**Police**	**NHS**	**NHS**
Quality (Resources) Option:		**No Change**	**Increase**	**No Change**	**Increase**	**No Change**	**Increase**	**No Change**	**Increase**
CRITERIA:									
Commissioning									
Commissioning	40%	5	5	8	8	200	200	320	320
Quality & Governance									
Quality - health care	15%	4	8	4	8	60	120	60	120
Quality - forensic	15%	6	8	5	7	90	120	75	105
Clinical Governance	15%	3	3	9	9	45	45	135	135
Other									
Strategic	5%	4	4	9	9	20	20	45	45
Impact on day to day operations	5%	9	8	5	4	45	40	25	20
Acceptability	5%	3	3	6	6	15	15	30	30
Total	**100%**	34	39	46	51	**475**	**560**	**690**	**775**

Aggregated Weighted Scores	Option 1	Option 2	Option 3	Option 4
Commissioning	200	200	320	320
Quality & Governance	195	285	270	360
Other	80	75	100	95
Total	**475**	**560**	**690**	**775**

The option that is anticipated to produce the most benefit is *Option 4 – transfer commissioning to NHS with improvement in quality*. *Option 3 – transfer commissioning to NHS at current quality levels*, still ranks above *Option 2 – retain commissioning with police but with improvement in quality*. The *Do Nothing Option 1 – retain commissioning with police at current quality standards*, attracts the lowest score. The conclusion from this rating exercise is that transfer of commissioning from police to the NHS is understood to be 'a good thing', both in the short term and the long term.

6 COSTING THE PREFERRED OPTION

This section describes the baseline position and then goes on to estimate incremental costs of improvement. In costing quality improvements we adopt the following approach:

- Attach a cost to a separate sexual offences rota, linked to gender choice, access and other measures of quality
- Estimate the cost of clinical governance
- Add an administrative burden cost of commissioning

We have not quantified or costed-in resources for:

- Capital development for infrastructure
- Potential workforce developments, e.g. substitution between doctors and nurses
- Paediatrics: children's services in many areas are a hidden cost within NHS provision; we have not factored in resources for additional specialist paediatric input.
- Other quality improvements – we have specifically restricted costed quality improvements to the issue of forensic physician provision.

Baseline Costs

Survey data related to 85% of the population has been extrapolated to the whole of England. We estimate that the current cost of the Forensic Physician service for sexual assault is £6.4 million and that the police contribute a further £1.6 million to SARCs, bringing the total police annual outlay to £8 million.

Baseline Cost

FP for Sexual Offences Examinations	£6.4m
Other police contribution	£1.6 m
Total Baseline	£8.0m

Key Assumptions Relating to Baseline:

- Costs are based on survey data[29];
- Where sexual offences examination work is combined in a joint rota with custody care, providers were asked to give an estimate of the proportion of work related to sexual offences. Estimates ranged from 2%-15%.
- Where local estimates were not provided, sexual offence resources in joint rotas has been apportioned at 10% of the medical staff cost, as the median of the 2%-15% range.

Gender of Forensic Physicians

Gender choice appears to be a major driver of quality and therefore of cost. We describe the current position and explain the rationale of proposing stand-alone sexual offence examiner rotas as a means of offering choice and improving quality. This would involve higher staffing costs.

Current Position

We have data on gender mix of doctors across half the country (covering 24m or 47% of population). The table below shows that:

- Over 60% of rotas in our study are joint custody care and sexual offence examination (CC/SOE) rotas and less than 40% are dedicated SOE rotas;
- There is an apparent shortage of female FPs because joint CC/SOE rotas are not attractive to women (with only 34% of FPs being women) whereas stand-alone SOE rotas are able to recruit female physicians (with 95% FPs being women);

[29] Study Sample Data:

	Cost of Police SOE Medical Staff	Cost of Other Police Input	Total Police	Population
Study Sample	£5,373,723	£1,554,938	£6,928,661	43,560,000
Pro rated to whole population	£6,348,840	£1,837,097	£8,185,936	51,464,400
percentage of police cost	78%	22%	100%	

- Note that up-rating for missing entries probably overstates size of 'other' police input. There is a case for moderating pro rated £1.8m to £1.6m as the sample includes 3 metropolitan SARCs, adding a skew compared to the missing entries which may be less resource intensive;
- On the basis of these calculations, we use a baseline of £6.4m SOE and £1.6m other = £8m.

- These stand-alone rotas are mainly linked to SARCs whereas joint custody care rotas tend to be linked to non-SARC police areas (although some SARCs use them as well);
- There is an urban bias towards SARCs and therefore towards stand alone rotas.

Type of Rota	Female	Male	Total	% Female	Population	Geog. Area (Sq Mile)	Density Pop per Sq Mile	Doctor per Rota
joint	48	95	143	34%	13125800	18801	698	10.2
separate	111	6	117	95%	16316400	4992	3,269	14.6
Total	**159**	**101**	**260**	61%	**29442200**	**23793**	**1,237**	**11.8**

Gender as a Driver of Quality

Access: A major quality target is **Access – 1 hour response time.** We know that this is often not met, especially during the day:

- Where GPs are employed, for example, they may agree to attend after their clinical day has ended;
- Failure to access a female FP leads to delay (due to shortage of female doctors on joint custody suite/sexual offence rotas);
- Failure to access paediatric expertise leads to delay;
- Choice of gender of doctor – this presents a case for separation of general custody suite and sexual offence rota.

Gender Choice: is an important driver of quality. The rationale is:

- Over 90% of victims of sexual assault are women and given a choice they prefer to be examined by a female;
- Lack of female FPs is a source of delay (due to their scarcity);
- Our survey data shows that stand alone specialist sexual offences rotas are likely to be staffed by mainly women whereas joint custody care/SO rotas are more likely to be staffed by men;
- More than 90% of the caseload on CC/SOE rotas relates to custody health care, in which the client is an offender rather than a victim of crime. A minority (less than 10%) of examinations relate to victims of sexual assault, who are mainly female;
- The experience of the complainant in cases of sexual assault is therefore often to encounter a male doctor who is more used to dealing with people accused of crime. Problems occur around: attitude, lack of immediate treatment (e.g. availability of contraception), assessment of health need (e.g. follow on services), communication and empathy;
- Evidence from case study sites indicated that training and supervision linked to specialist SO work provided the conditions for attracting women, so that in some areas there was a waiting list of 20 doctors seeking to become FP in Sexual Offences Medicine;

- It follows that there is a case for promoting stand alone sexual offence services – separate from general custody care – as a means of improving the service.

Driver of Cost

There would be a cost implication in providing stand-alone sexual offence rotas since it would require two separate rotas (CC and SOE) over a given geographical area rather than a single joint CC/SOE. There is currently an urban bias towards stand alone SOE rotas, since they cover small densely populated geographical areas (c. 2000 population per square mile) compared to joint CC/SOE rotas which operate in less densely populated rural areas (c. 700 population per square mile).

Separate SOE rotas may require an even larger geographical reach, to draw in the volume of cases that would be necessary to maintain experience and skills.

A factor in the success of SARC all-women rotas is the high level of remuneration to doctors, who are mainly GPs. Elsewhere less experienced, and therefore cheaper, doctors are frequently employed. The implication is that stand-alone rotas represent a relatively expensive model.

If the stand-alone SOE rota model is unsuitable for some parts of the country, in the longer term it may be desirable to develop the forensic nurse practitioner workforce as part of a joint CC/SOE service as a means of increasing access to female practitioners in rural areas. Medical professionals have ventured opinions against this (e.g. Physician A, Section 4) on the basis of clinical autonomy/isolation, lack of supervision for nurses in custody settings, and requirement to give expert opinion/testimony in judicial cases, plus the need to start with objective standards for clinical leads who are doctors. However, there is some dispute among forensic physicians (e.g. Physician B, Section 4) on these matters. There appears to be a case for developing the role of nurses over time. (The FFLM is to consult on development of standards for non-medical health care professionals – see Annex 7).

Cost Implication

The cost implication may be to increase costs by approximately 25% or £2m (see Annex 3) on the basis that:

a) pro rating the current cost across the whole population, the SOE element of joint rotas cost £1.9m and separate rotas cost £4.5m, giving a total of £6.4m;
b) Separate SOE rotas cost £14.4k per 100,000 population compared to £9.2k per 100,000 for the SOE element of joint SOE/custody care rotas;
c) It would cost an estimated £2.9m to provide separate SOE rotas for the population currently served by join CC/SOE rotas;
d) It is reasonable to suppose that some (but not all) of the SOE component of joint CC/SOE rotas would be pulled out of the joint rota to defray the new rota costs.

Out of the £1.9m we estimate that £0.9m, approximately 50%, would move across, leaving £1m behind in the joint rota.

e) The net increase in medical costs is therefore estimated to be £2m.

Clinical Governance and Training

Investment would be required nationally to develop clinical governance for Forensic Physicians and Clinical Leads. The activities below would be organised in different ways in different areas and may be shared amongst a number of staff or across different forces/providers. For costing purposes, the clinical lead is assumed to need 3 sessions per week. Assuming that approximately one-third of forces are already meeting these requirements, the additional cost of meeting clinical governance is estimated at £1.2m. Assumptions are shown in the box below.

Clinical Governance and Training Costing Assumptions

Forensic Physicians: all take part in at least the following clinical governance activities every year, irrespective of how many sessions they work:

- annual appraisal
- 4 sessions of peer review
- 6 hours of CPD.

Clinical lead: every force funds a clinical lead, to:

- oversee clinical governance
- undertake appraisals
- ensure peer review and audit takes place
- provide guidance and support on cases to individual FPs

These activities will be organised in different ways in different areas and may be shared amongst a number of staff or across different forces/providers. For costing purposes, the clinical lead is assumed to need 3 sessions per week.

Costs

- 500 FPs work across England
- 39 clinical leads (one per force)
- Self-employed FPs and clinical leads : costed using 2010/11 FFLM half-hourly follow-up rate for sexual assault
- NHS employed FPs: add 6 hours of mandatory training per year, otherwise costed as per self-employed FPs
- NHS employed clinical leads: midpoint of consultant payscale with 6 years consultant experience and no clinical excellence award, plus on-costs of 26%
- We assume that suitable arrangements are already in place in one third of services
- The net cost is estimated to be £1.2 million

Administrative Burden

There would be an administrative burden in transferring commissioning from police to the NHS. We have used an assumption of 3% administrative burden (consistent with senior management costs in the NHS which consume approximately 3% of resources). This is equivalent to £6k per police force area.

Summary of Estimated Cost Increase

The incremental cost of proposed quality improvements is estimated to be £3.2m. It is not substantial in relation to the overall healthcare budget, but represents a 40% increase against the current baseline[30].

Baseline Cost	
Forensic Physician for Sexual Offences Examinations	£6.4m
Other police contribution	£1.6 m
Total Baseline	£8.0m
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

Summary of key assumptions/sensitivities/risks:

- Costs are based on survey data;
- Estimates of Sexual Offence resources in joint rotas are mainly apportioned at 10%, reflecting the balance of workload;
- Estimated incremental cost of shift to stand-alone rota is based on top-down assumptions. There may be better ways of estimating these figures;
- Resource pressures will follow from the proposed government funding reduction of 20% to police authority areas;
- Part of the funding baseline (£8m estimate) is based on historic decisions made at the discretion of local police forces, ranging from £0 to £2.2m (by the Met). There may be some sensitivity in transferring these amounts to healthcare and losing them from the police baseline funding.

[30] This baseline excludes current NHS expenditure.

7 THUMBNAIL SKETCH OF EACH OPTION

This section provides a thumbnail sketch of each of the options (set out in Section 5), fleshing out the reality of the current service and the potential impact of change.

Option 1 – Do Nothing

Option 1 represents the status quo or the Do Nothing option. It is formally described as 'police commissioning at current quality standards'. In practice, however, we know that there is no single model on the ground. While the police have statutory responsibility to commission a forensic SOE service, there is a range of practice across the 39 police authority areas.

Advantage of Option 1: Minimum Impact on Day to Day Operations

- This status quo option would be the least disruptive to day to day operations and working relationships

Problem with Option 1: Weak Commissioning – Lack of Independence from Providers

There are many examples of good service provision around England. However, the key question in the Impact Assessment revolves around commissioning of service. On the face of it (based on Survey B) there are 7 police forces that have good commissioning functions, because their contracts include a full range of clinical governance topics. Yet, even among these, there is a lack of independence from providers; the contracts were largely drawn up under guidance from the provider. Only 4 forces sought independent clinical advice and, among these, experience of joint working with the NHS was limited.

On the basis of commissioning capability, therefore, the status quo is weak, suggesting that the police are not best placed to commission a clinically-based service.

Option 2 – Retain Commissioning Responsibility with the police and Improve Quality

Cost-bearing quality improvements include:

- Access within 1 hour – addressing delays caused by lack of female doctor or paediatrician;
- Gender choice – there is evidence to suggest that a stand-alone sexual offences rota (separate for custody work) would promote gender choice by drawing in more women to the workforce;
- Training and clinical governance.

The same investments are loaded into Option 4 (the preferred option) and are discussed in more detail there.

Advantage of Option 2: Police Retain Control

- The link with the Criminal Justice Service would be maintained in this option, ensuring focus on police and prosecution needs

Problem with Option 2: Commissioning, Governance and Funding

- The same commissioning and governance structures would exist as in Option 1, making it difficult for police to exert leverage with clinicians;
- This option would require additional funding which is unlikely to be a priority among police forces. If anything, funding for this service could be at risk since police forces are required to make 20% savings over the next 4 years.

Option 3 – Transfer Commissioning Responsibility to NHS

In this option, there is an assumption of a transfer of commissioning responsibility from police to the NHS at current funding levels.

Advantage of Option 3: NHS Able to Commission Good Quality Clinical Governance

- The case for change is predicated on the need for improvements in the service to victims of sexual assault which the NHS is better equipped to commission;
- Clinical governance, i.e. accountability.

Risk of Option 3: Dominance of Healthcare Concerns and Funding

- In transferring commissioning to the NHS there is a risk that focus on healthcare and clinical governance will displace attention from the need for high quality evidence to assist successful prosecution for rape and sexual assault;
- The NHS is not a perfect organization and there is a fear among stakeholders that loss of police expertise combined with NHS bureaucracy would be detrimental to the service;
- There is also a risk that a service of this small scale will get lost in the funding baseline and will not get the attention or priority it requires.

Option 4 – Transfer Commissioning Responsibility to NHS and Improve Quality

Option 4 emerges as the preferred option as it generates the most benefits, since (a) transfer of commissioning responsibility is anticipated to have a positive impact and (b) quality improvement is both necessary and desirable. Option 4 would also be the most costly.

In summary:

- We argue for a stand-alone sexual offences forensic service, separated from general custody suite work;
- In rural areas there will be pressure to develop the role of forensic nurse examiners if it is not feasible to recruit sufficient female forensic physicians;
- Clinical governance and training costs are factored in;
- Additional capital/infrastructure costs are not factored in.

Advantage of Option 4: Quality Gain through Commissioning Transfer

- This option addresses the problems that have been identified in the case for change.
- Transfer of commissioning responsibility to the NHS gives scope for workforce development that is likely to be required in the future.

Risk of Option 4: Cost

- The feasibility of this option is challenged by the need for investment.

Conclusion

The cost-benefit appraisal ranks Options 3 and 4 above Options 1 and 2. The conclusion of this study is that even at current quality/resource levels, there are advantages in transferring commissioning of forensic sexual examination services from police to the NHS.

The Policy 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.

In 2002[31] *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 attrition[32] rate, and to identify good practice and make recommendations to address this. Key issues raised in this report related to:

- 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;
- There was an inordinate delay, sometimes for some hours, before the victim had access to specialist staff;
- Police training did not conform to a common minimum standard and resulted 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 a perennial 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 of other agencies, including the Health Service, Social Services and FPs, where facilities for the care of victims were less satisfactory and showed the greatest potential to aggravate levels of attrition.

Five years later, HM Inspectorate of Constabulary and Crown Prosecution Service Inspectorate undertook a departmental review (*Without Consent*, 2007), following continued concerns about the attrition of prosecution and conviction rates. They also found considerable problems relating to workforce development and management of forensic medical services by the police, as well as NHS disengagement.

[31] 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.

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

In April 2009[33], Lord Bradley undertook a review of people with mental health problems or learning disabilities in the criminal justice system. He found concerns among healthcare professionals and criminal justice workers that medical care was not always available to police detainees when required and often only within normal working hours. There was also a widely held belief that FPs needed more specialist training in mental health issues in order to cope with the high prevalence of mental health and learning disability problems in custody. In addition, police custody is the only stage in the criminal justice process where primary NHS-commissioned care[34] is not available, breaking the continuity of care and potentially causing difficulty in accessing information from NHS sources. All these issues led the report's recommendations that responsibility for health services in police custody suites should be transferred from the police to the NHS, echoing Baroness Corston's 2007 report[35] into women with particular vulnerabilities in the criminal justice system, and the 2007 Department of Health consultation on developing an Offender Health and Social Care Strategy[36].

In October 2009 SARC guidelines[37] were published which combined the *National Service Guidelines for Developing Sexual Assault Referral Centres,* and *Sexual Assault Referral Centres: Getting Started Guide,* both of which were published in 2005. The aim of SARCs is to promote recovery and health following a rape or sexual assault on victims, whether or not victims wish to report to the police. It is designed to provide integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways. This potentially allows co-ordination with wider healthcare, social care and criminal justice processes to improve health and wellbeing, as well as criminal justice outcomes for adult and child victims of sexual assault as appropriate. Addressing sexual violence is a key element of the Government's wider strategy on *Saving Lives, Reducing Harm*[38] so they have committed to expanding access to the network of SARCs, with a SARC in every police force in England and Wales by 2011. In addition the *Cross-Government Action Plan on Sexual Violence and Abuse*[39] affirms the role of SARCs in providing more accessible healthcare and forensic choices for victims.

[33] 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

[34] The quality of care in custody is therefore not subject to the same governance and performance measures as NHS services.

[35] Home Office (2007) The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system, London: Home Office

[36] Department of Health (2007) Improving Health, Supporting Justice: A strategy for improving health and social care services for people subject to the criminal justice system, A Consultation Document, London: DH

[37] 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.

[38] Home Office (2008). Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence 2008-11.

[39] HM Government (2007). Cross Government Action Plan on Sexual Violence and Abuse. Department of Health (2009). New Health Taskforce.

In November 2009, following one of the largest public consultations and after nearly ten years of work on rape and domestic violence, a cross-government strategy was launched *Together We Can End Violence against Women and Girls (VAWG)* to combat all forms of violence against women and girls and support victims across the three areas of prevention, provision and protection. One of the main priorities recommended was the need to provide end-to-end support for all victims from report to court.

A simultaneous review of victims' experiences[40] was also commissioned in 2009 to ensure that all rape victims receive a consistent, high-quality service. The Victim's Champion Sara Payne, was asked to report. Recommendations included challenging public attitudes and teaching healthy relationships in schools; improving provision of Sexual Assault Referral Centres and Independent Sexual Violence Advisors; improved training for police and the Crown Prosecution Service, and more effective multi-agency working.

Then in March 2010, the Department of Health launched its report by Sir George Alberti[41] as a health response to violence and the need for access to high quality services, recommending that FPs should be employed by the NHS, have better access to high-quality training, be an integrated part of the new NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of victims of rape.

Simultaneously, the Home Office published Baroness Stern's review[42] into how rape complaints are handled from when a rape is first disclosed until the court reaches a verdict. This was because most evidence previously received had been about domestic violence. Key findings from this review included:

- The need to look at rape victims as people who have been harmed, whom society has a positive responsibility to help and to protect, aside from the operations of criminal law. Whether the rape is reported or not, whether the case goes forward or not, whether there is a conviction or not, victims still have a right to services that will help them to recover and rebuild their lives;
- Wholehearted support for the recommendation that the funding and commissioning of forensic medical services should be transferred from the police to the NHS;
- Endorsement of recommendations made by the taskforce led by Sir George Alberti with further recommendations that there should be more appropriate accreditation for FPs to ensure every victim of rape should have the choice of a male or female FP to undertake the examination;
- A recommendation that SARCs be put onto a firm basis as part of mainstream provision and expanded further in the future; (since some police force areas are very large, the need for additional centres should be considered once the initial phase of development is complete);
- The setting up and operation of a Sexual Assault Referral Centre should be shared equally by the police, the NHS and local government.

[40] Sara Payne (2009) Rape: The Victim Experience: Review, London: Home Office

[41] Department of Health (2010) Responding to violence against women and children – the role of the NHS. The Report of the Violence Against Women and Children Taskforce, London: DH

[42] 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

- Suitable arrangements should be put in place, bringing together representatives from the voluntary sector, local authority safeguarding services, the police, the Crown Prosecution Service and Her Majesty's Court Service to focus on rape, to create an effective governance structure for the handling of rape complaints and to enable issues to be brought to a multi-agency forum where action can be taken.
- Every victim who so wishes should be supported by an Independent Sexual Violence Advisor; they need to be seen as an intrinsic part of the way rape complainants are dealt with. Funding should be available in all areas where the demand makes a post viable.

A response to many of the problems highlighted in these reports was a strategic undertaking by the Department of Health and Home Office to examine the feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination work to the NHS.

Service Provision – Survey A

This annex reports on the fieldwork carried out through Survey A. The structure of this annex is:

1. Introduction
2. Participation
3. Facilities
4. Workload: Referrals and Examinations
5. Forensic Physicians: Organisation, Remuneration, Quality and Training
6. Forensic Physicians: Rota, Gender and Workload Volumes
7. Children
8. Current Cost

1 Introduction

Purpose. This survey, Questionnaire A, collected information on finance, workforce and activity relating to forensic service examinations for sexual assault in England. The aim was to gain a picture of current service provision and resource allocation in order to analyse (a) what is being provided now across the country (SARC and non-SARC), (b) equity between police force areas and (c) resource implications if commissioning responsibility were to move to the NHS.

Development. The questionnaire was developed following initial scoping phone calls with stakeholders and a small number of SARC managers and independent FP service providers. The questionnaire was piloted, revised and re-piloted before being sent to all SARCs and police force areas using custody suites rather than a SARC (described as non-SARC areas). The questionnaire contained 21 questions, structured mainly as tables to collect quantitative data. 7 of the questions were narrative asking, for example, about labour market barriers to recruitment and retention of forensic physicians. There was some overlap between this Questionnaire A survey and the separate Questionnaire B which was sent to police leads across 39 police force areas. Tool A focused on provision, which mainly takes place within SARCs, and tool B focused on commissioning undertaken in police force areas.

Process. The study was conducted on a voluntary basis and at least one service indicated that it was unwilling to participate. More commonly, mainly in areas without a SARC, it was difficult to track down the responsible individual and marry up the questionnaire with the person able to complete it. After chasing by telephone, in 20% of cases the questionnaire was sent out again to a different person. It proved challenging to draw up a reliable list of contact names and details across the country. The process highlighted the fragmented and disparate nature of the service and its organisation.

The process involved:

- Send out Questionnaire A on 21st September 2010 from Birmingham University (Project Lead) with return date of 18th October 2010;
- Followed up through telephone and email throughout October/November 2011, concluding in January 2011.

Terminology. Forensic Physician for Sexual Offences (FPSO) is described in local services as Forensic Medical Examiner (FME), Sexual Offence Examiner (SOE), Forensic Physician for Sexual Assault (FPSA). These terms are used interchangeably throughout the analysis. Sexual Assault Nurse Examiner (SANE) and Forensic Nurse Examiner (FNE) apply to nurses, as well as the generic Forensic Services Examiner (FSE) which applies to all clinicians.

Data Quality. The response rate was high, with a return of 79% (n=34/43). Within each questionnaire, however, there were often gaps. Only 20 providers, for example, gave details about their volume of referrals. Only 17 services (covering 50% of the England population) supplied both referral and cost data, allowing us to derive unit costs. We were able to assemble cost data that covers 85% England (by cross-referring with Questionnaire B), but this relied on apportionment assumptions about the percentage of custody care and percentage of sexual offence resources in joint rotas. The analysis is explicit about the assumptions and sample size that underpin it. Our assessment of data quality is that:

- The data has reasonable integrity; (there is an audit trail for each figure);
- It is difficult to get a clear picture of sexual offences resources because in many places it is not a separate service;
- The sample size for particular elements sometimes drops to 50%;
- Data sources are highly fragmented; in one instance 6 departments were involved in completing the questionnaire;
- We have knit different components together, e.g., number of doctors, population, number of referrals, type of rota, cost. We have not had the opportunity to validate the analysis in detail with each service;
- In summary, even though the quality of information is thought to be reasonable, the coverage is patchy in some areas and the data proved difficult to collect and analyse. We have mined a fragile database as exhaustively as possible.

2 Participation

Out of 43 questionnaires originally dispatched[43] we have received responses for 34, giving a participation rate of 79% covering 85% of the England population. (The overall coverage of the study is high, but response rates for individual questions are variable. We show the sample size in each analysis below).

Type	No. Questionnaires Dispatched	No. Respondents	Response Rate
Non-SARC	15	12	80%
SARC	28	22	79%
Grand Total	**43**	**34**	**79%**

Population Served

- We have applied mid-2008 populations to each police force area. Source: Department of Health. These figures are consistent with the local returns.
- We have obtained geographical area data (via Hansard) to estimate population density.
- Population is a key figure as it is used to standardise measures, e.g. staffing and workload, across the country.
- We have looked at different sources of weighted population to adjust for deprivation but were not able to readily access any measure that that could be applied at police force level.
- The implication of the data below is that across England, SARCs cover areas with denser populations (1253 people/sq mile) compared to non-SARCs (735 people/sq mile). The average population density of our respondent and non respondent sample is similar overall (1051/sq mile and 902/sq mile respectively)[44].

Population and Participation

	Non-Respondents	Respondents	England
Non-SARC	3,835,800	12,405,100	16,240,900
SARC	3,996,800	31,226,700	35,223,500
Total	7,832,600	43,631,800	51,464,400

[43] Seven services are covered by 3 questionnaires, so in some respects the study size is n=39. To aid clarity and robustness we map volumes to populations throughout the analysis.

[44] The SARC responders are more urban and non-SARC responders are more rural than their non-respondent counterparts, but the responders are more representative of the national profile than the non-responders.

% Population

	Non-Respondents	Respondents	England
Non-SARC	7%	24%	32%
SARC	8%	61%	68%
Total	15%	85%	100%

Geographical Area Sq Miles

	Non-Respondents	Respondents	England
Non-SARC	3,615	18,479	22,094
SARC	5,071	23,046	28,117
Total	8,686	41,525	50,211

Population Density (Pop per Sq Mile)

	Non-Respondents	Respondents	England
Non-SARC	1,061	671	735
SARC	788	1,355	1,253
Total	902	1,051	1,025

3 Facilities

The data suggests that people have to travel a similar distance to a facility (around an average of 1 facility per 757 square miles) whether it is designated as a SARC or not. The number of rooms available in a SARC tends to be greater, mainly because 1 in 3 SARCs has a designated paediatric examination room.

Values Relating to Survey Responders (Sample n = 28)	Non-SARC	SARC	Total
Sample Population (total resident)	11,095,100	27,506,700	38,601,800
Geographical Area Sq M	16542	14491	31033
Count of Responders	10	18	28
No. facilities	21	20	41
No. rooms - adult	21	22	43
No. room - paed	6	14	20
No. rooms - total	22	28	50
Population per Sq M	671	1898	1244
No. dedicated rooms - paed	1	6	7
No shared adult/paed rooms	5	8	13
Resident Population per facility	528,338	1,375,335	941,507
Resident Population per 1 room - dedicated paediatric	11,095,100	4,584,450	5,514,543
Population per 1 room - total	504,323	982,382	772,036
Square Miles per Facility	788	725	757
Square Miles per Room	752	518	621

4 Workload: Referrals and Examinations

Referral Source

The vast majority of referrals (on average 84%) are made via the police. (If the client reports to the police then the client is taken to the SARC/custody or sympathy suite under escort). 12% of referrals come direct from individuals who have not been to the police. A further 4% of referrals are made via other professionals.

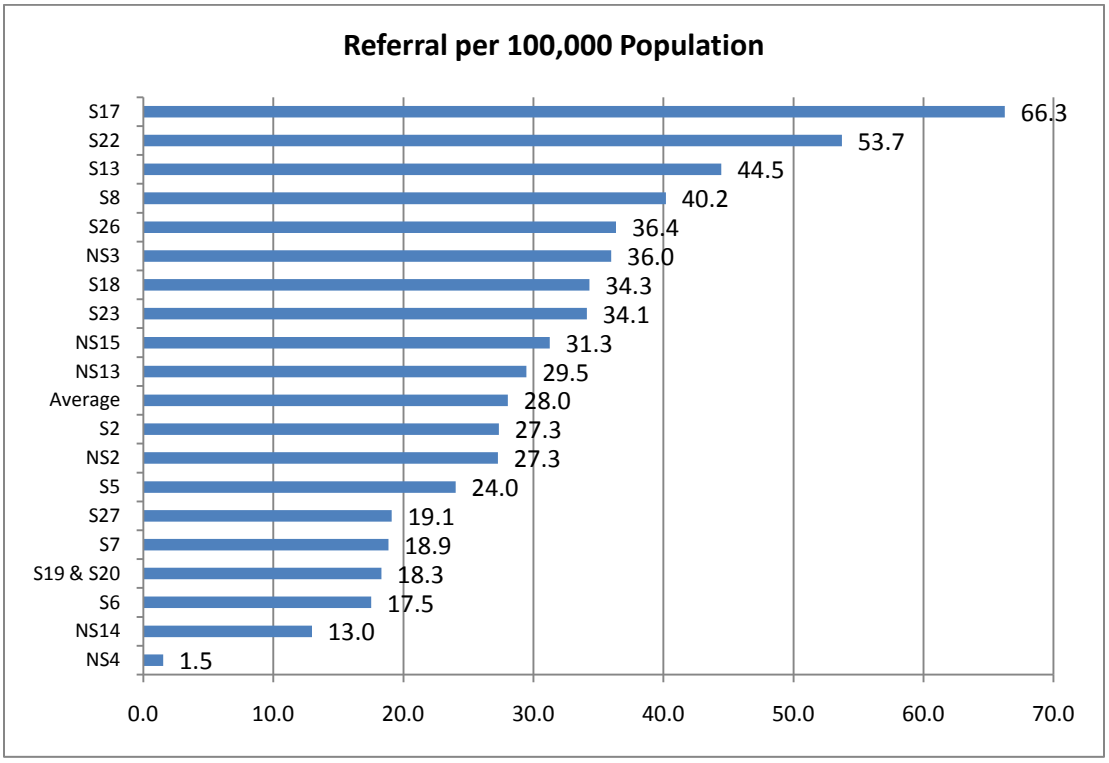
Source of Referral

Code	Total	Police	Self	Other Professional
NS14	100%	100%	0%	0%
NS15	100%	100%	0%	0%
NS2	100%	100%	0%	0%
NS3	100%	99%	1%	0%
S19 & S20	100%	99%	1%	0%
S6	100%	97%	2%	3%
S22	100%	93%	5%	2%
NS4	100%	92%	8%	0%
S17	100%	89%	11%	0%
S23	100%	87%	9%	3%
S3	100%	87%	8%	4%
S1	100%	87%	6%	6%
Average	**100%**	**84%**	**12%**	**4%**
S7	100%	83%	17%	0%
S27	100%	83%	17%	9%
S26	100%	78%	22%	0%
S13	100%	69%	8%	24%
S2	100%	65%	32%	3%
S8	100%	62%	15%	15%

Referral Rate per 100,000 Population

On average there are 27 sexual assault referrals to SARCs and forensic examination services per 100,000 population. The descriptive statistics from the survey are:

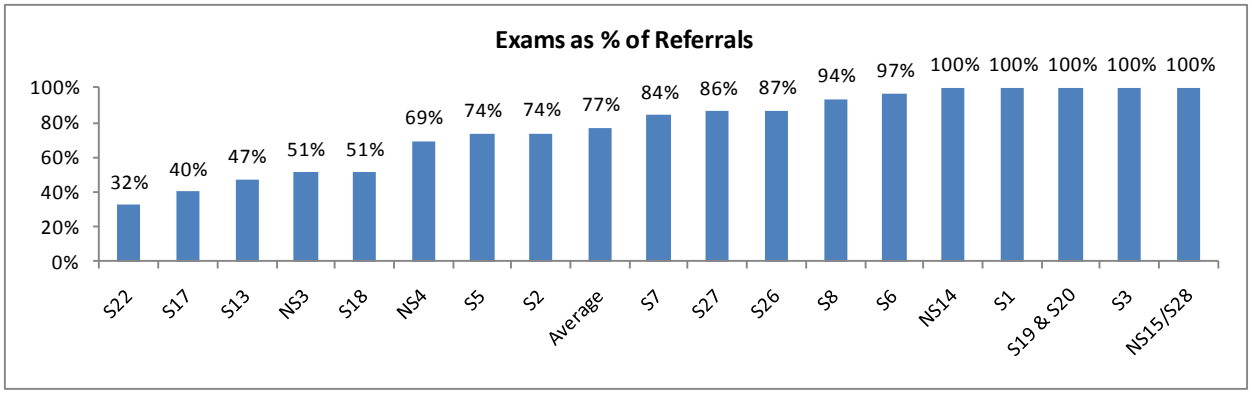
	Referral per 100,000 Population
Number in Sample = 20	
Minimum	1.5
Lower Quartile	18.9
Upper Quartile	36.4
Maximum	66.3
Median	27.3
Average	27.2



Examinations

Not all referrals receive an examination. Elapsed time since the assault is a determining factor. According to one SARC, for example:

- Less than 7 days – a medical examination will take place to collect forensic evidence;
- Between 7 and 10 days – the likelihood of obtaining forensic evidence is low so no FME is involved. The SARC offers support.

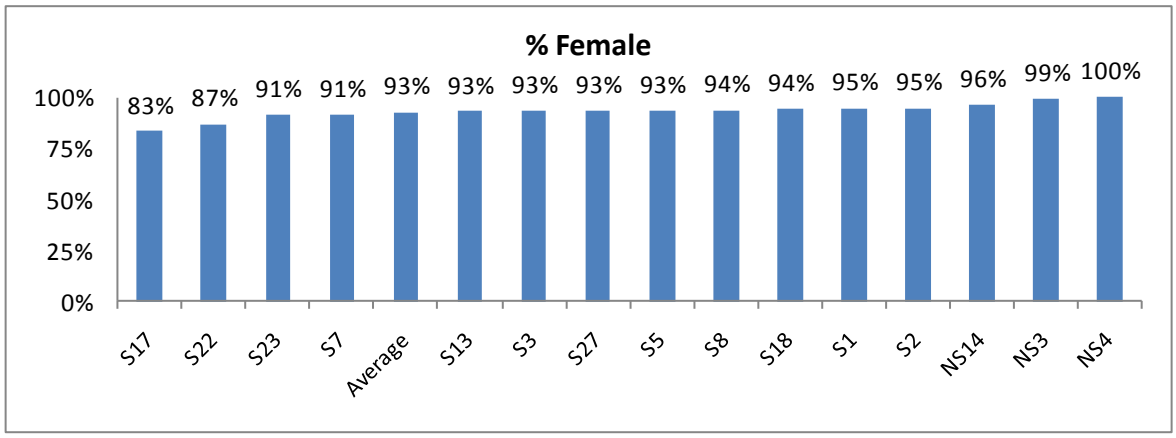


The relationship between examination and referral numbers appears to vary widely across the country. On average forensic physicians undertook examinations upon 77% of referrals. A third of services (5/18) undertook forensic examinations on all referrals and a third (5/18) undertook examinations on 32%-51% of referrals.

Gender of Referrals

The average percentage of referrals is 93% female : 7% male. The ranked sample in the graph below shows that the proportion of reported victims who are male is lowest in areas without a SARC.

S17 has the highest proportion of male referrals, at 17%, and NS4 has the lowest at 0%. It is interesting to note (previous page) that these outliers also have the highest and lowest overall referral rates respectively, suggesting that perhaps there are cross boundary flows between police areas, with S17 importing cases and NS4 exporting cases.

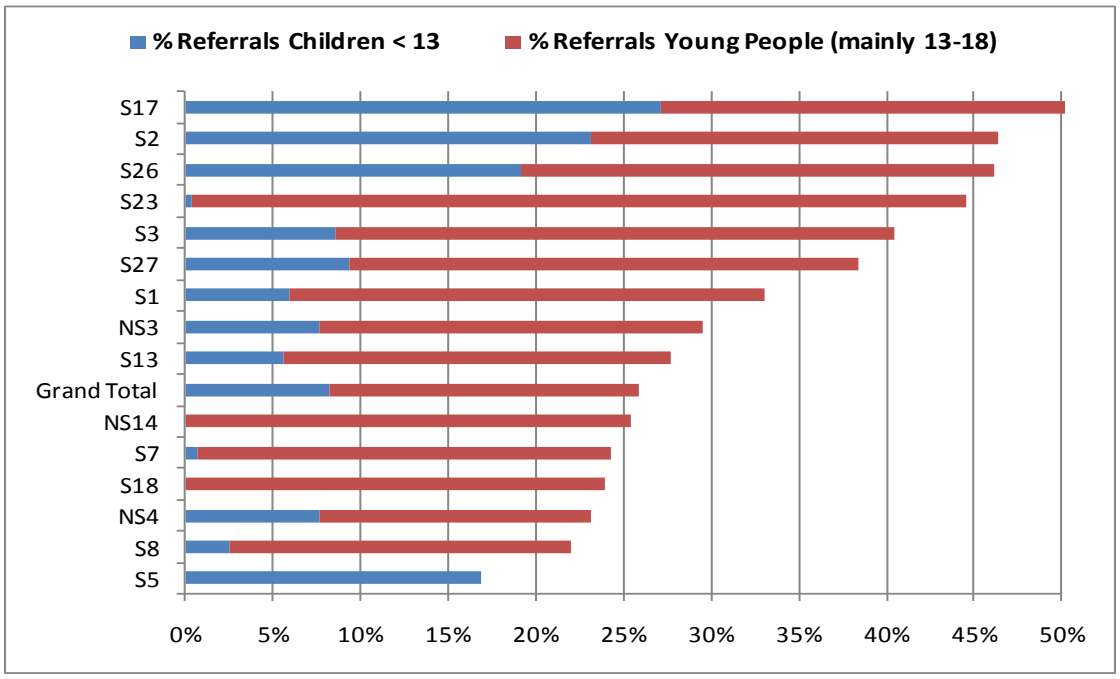


Children and Young People

Children and young people under 18 make up 21% of the national population but on average 31% of sexual assault referrals, showing a high level of concentration of these offences against the young.

On average, where services reported the number of children and young people referred, 31% of all referrals were under 18 , with 8% aged <13 and 22% aged 14-18. The non-SARC services that supplied data all showed relatively low proportions of children and young people (compared to the average). Four SARCs (a quarter of the sample) showed 40%-50% of referrals below the age of 18. There appears to be variability in the age ranges used to defined children and young people. Within this sample (n=15), three noted that their age range for children and young people cut off at aged 16 years.

code	% Referrals Children < 13	% Referrals Young People (mainly 13-18)	Total % of Referrals Under 18
S5	17%	0%	17%
S8	2%	20%	22%
NS4	8%	15%	23%
S18	0%	24%	24%
S7	1%	24%	24%
NS14	0%	25%	25%
S2	3%	23%	27%
S13	6%	22%	28%
NS3	8%	22%	29%
Average	**8%**	**22%**	**31%**
S1	6%	27%	33%
S27	9%	29%	38%
S3	9%	32%	40%
S23	0%	44%	45%
S26	19%	27%	46%
S17	27%	23%	50%



5 Forensic Physicians: Organisation, Remuneration, Quality and Training

Provision and Employment Models

The table below covers the whole of England[45]. It shows that most forensic physician services for sexual offence examinations are contracted out to independent providers, covering 62% of services, 53% of the population and 70% of the land mass of England. This highlights a rural skew towards contracting out and an urban skew towards directly employing doctors. The biggest external provider is G4S, followed by MEDACS, Reliance and Primecare.

Provider	% of SARCs and non-SARC Police Force Areas	% of Population	% of Geographical Area
Not an external provider (FPs contracted directly by either police or NHS)	38%	47%	30%
G4S	25%	18%	32%
MEDACS	10%	8%	17%
Reliance	10%	7%	7%
PRIMECARE	5%	7%	3%
Other External Providers	8%	7%	8%
SERCO	3%	4%	2%
Harmoni	3%	1%	2%
Total	100%	100%	100%

Rotas

The forensic examination service for sexual assault is performed by doctors as part of the evidence collection process in the criminal justice process. Doctors are recruited to participate in a 24/7 rota covering a specific geographical area. Headcount numbers of doctors on a rota does not reflect full time equivalent input as each doctor will be available for a limited number of shifts or sessions in a month.

There is no national record of physicians who are doing forensic sexual examination work. We have obtained numbers of these doctors for services covering 79% of the population. Pro-rating to the whole of England there are likely to be 450-500 doctors doing this work.

The best-resourced services in well-established SARCs recruit GPs and train them as sexual offence examiners. In this model the recruitment is done by the NHS, usually with the involvement of a clinical director, and clinical governance is built into the supervision and

[45] Annex 5 also analyses independent provider provision based on the respondent sample of Survey B. Differences in results are due to differences in sample size.

training regime. These services are more likely to be able to recruit female doctors. They form part of Sexual Offence Examination rotas that are separate from the general custody and forensic work required by the police. In these areas it will be necessary to provide two levels of medical cover: one rota for sexual offence examination and another rota for general custody care work.

An alternative model, which is less costly because it requires only one rota, is to combine sexual offence medicine and general forensic medicine into the same role. The sexual offence element may account for 2%-15% of the workload. The doctors are frequently recruited by independent providers on behalf of the police who fund and commission the service. Many doctors have a primary care background.

The box below contains an account by one Independent Provider. It describes different rota structures and highlights the problems in obtaining doctors of the right calibre and experience, partly driven by cost.

Forensic Examination Service Described by One Independent Provider[46]

Model 1: Joint Custody and Sexual Offences Rota

The contract is for a police-commissioned service with no contribution from the NHS. All doctors cover custody and sexual offences. The independent provider tried to get the police to tender for separate contracts for sexual offences and custody suite. However, they went for the cheapest option which was to have a single rota that provided both custodial and sexual offence services, rather than two separate rotas which would have needed more money and more doctors. A list of FME[47] doctors is maintained, naming people who are available for complex cases/adolescents. This is not funded but is regarded as important by the provider.

Problem – Volume and Experience. A lot of areas have quite small volumes. They cannot be grouped together. Providing 24/7 cover is expensive and provides so little experience that it is difficult to maintain skills.

Model 2: Separate Custody and Sexual Offences Rotas

- Some areas fund separate rotas due to additional funding. They have a clinical director.
- Some doctors work on both the custody and the SO rota. In practice, custody work in this locale is 95% of the workload and SO work is 5% of the workload for a FP.

Background of the Doctors

- Those mainly involved in custody work tend to be people within speciality training programmes who have now reached the end and have not obtained a consultant post. The background tends to be mental health, drugs and alcohol, people with challenging

[46] Source of data: scoping phase in designing and piloting Questionnaire A

[47] 'Forensic Physician' or FP is the term favoured by the profession, but in the field 'Forensic Medical Examiner' or FME is more frequently used.

behaviours, A&E.

- Pure SOE doctors are GPs or community doctors working in GU medicine and family planning. They are quite different to those in custody service work.
- Why GPs are not employed by the independent provider:
    - GPs are expensive. There is insufficient money in the contract to cover the rota with GPs;
    - It is necessary to have a core of in-hours people, and GPs already have a day job
    - Consequently, it is becoming a role for overseas doctors that have not been recruited into a career post;
    - The doctor population is quite fluid. They do the job for 2 or 3 years and then move on. The bulk of the custodial work is conducted by nurses and paramedics.

The Forensic Nurse Examiner Option

- The independent provider is keen to recruit FNEs as they are struggling to recruit clinical staff of adequate quality within the funding available.
- They would like nurses to provide robust cover as part of a Multi-Disciplinary Team for sexual assault (not leading the team).
- FNE can function as a Professional Witness of Facts. This is the required courtroom role, saying what they found, rather than providing an "expert opinion".
- The problem is benchmarking standards, since there is no national benchmark even for doctors.

Model 3: Part-Fund Sexual Assault Rota

In some rural areas the number of call-outs may be small, perhaps 200 cases year. The independent provider is experimenting with a part-funded S.O. rota in which a flat payment of £400 is paid for a call-out, but there is no payment for being on the rota. This is less expensive than the convention of paying for being on a rota plus extra for a call-out.

Remuneration Models

There appear to be three models of remuneration for on-call rotas:

- In most services, doctors receive a fee per service in addition to a retainer (a payment for being on the rota). The fee structure, supplied by five services, is summarised in the table below;
- An alternative approach is fee per shift: "Dependent on the doctor's experience our rates vary from <£30 per hour to >£50 per hour";
- An independent provider (Model 3 in box above) is experimenting with a flat rate for a call-out, with no fee for being on the rota.

SARCs providing a day time follow up service may also employ salaried doctors during the day. This will be in combination with the fee per service structure for out of hours on-call.

Pay Structures Linked to On Call Retained and Fee per Examination

	S2	S27	NS29	S7	NS11	S25
On call retainer	**£6.29**	**£7.50/hr on call rate**	**£3,497 pa**	£435.47	The Service pays three different rates of retainer fees (thus allowing us to retain some FMEs who threaten to leave the service): 7 FME get nationally agreed payments (ca. £3,000 p.a.) FME get retainer fees of £6:50 per hour between 8pm-8am and all weekend 2 FME get £6:50 24/7	The Fee for SOE is £155 per day shift and £205 for nights and weekends. This fixed fee is paid irrespective of call out or not and includes traveling time and expenses, note making and statement writing time. For each additional case attended by the SOE the appropriate fee is paid relevant to the time of call out. This method was selected to reduce bureaucracy and administration costs.
Fee per examination/call out	**yes**	**yes**	**First call out £81.60 (8am – 7pm) or £123.20 (7pm – 8am) second and subsequent call outs £65.30 & £98.00 as above**	**£435.47 (up to 300 medical interventions) £340.00 (Over 300 medical interventions)**		
Charge per first half hour	**£131.51**	**£86 (day) £129 (after 7pm)**	**£20.50 (8am – 7pm) £31.50 (7pm – 8am)**			
Charge per second half hour	**£34.10**	**£23/£34.50**				
Charge per third half hour	**£34.10**					
Charge per incremental half hour	**£34.10**	**£23/£34.50**				
Fee for cancelled services	**£79.44**					
Fee for second call out in a shift	**£105.85**	**As for 1st call**				
Fee for writing a statement	**£80.09**	**£79**	**£36.70**			
Retainer for holding DMJ/FFLM or equivalent		**£2,850**				
Part 1 of DMJ/FFLM		**£1425.50**				

Main Issues in Recruitment and Retention

Out of 16 respondents, 11 indicated that there were recruitment problems. (Where private providers supplied medical services there was a general lack of knowledge by the police lead about recruitment and retention). A quarter of respondents, however, (4/16) said that they had no recruitment problems and in some cases there was a waiting list.

Retention was said to be a problem by half the respondents (8/16) so, while difficult, it was sometimes easier than recruitment since doctors were committed once they joined.

S2: The main issues re doctors recruitment and retention are:

- "A GP earns more money doing a GP locum than doing a SARC session – therefore daytime sessions are not financially attractive enough at the current pay rates
- It is possible to find people to be on the out of hours rota, but hard to fill day time forensic posts.
- It is not a training post: it is a 'dead end' in terms of medical career path – not a specialty, lack of progression/recognition etc. Modernising Medical Careers has made it harder because there is less scope for doctors to step off the career ladder for a while and then step back on.
- We cannot use bank staff – it takes about 3 months to train a doctor
- Fear of going to court – very good doctors can resign after first court case….no matter how much support we offer/provide"

Quality of Service Provided by Forensic Physicians and Relationships with NHS Commissioning

There is a general sense of uneven quality across England in the service provided by FPs, and a view that this can only be ameliorated with improvements in training and clinical governance. The quotation below encapsulates the strength of feeling among service managers about the needs of the victims and how standards might be improved.

S8: **"**The standard of FME provision needs to be a priority for SARCs. At this time the service is ad-hoc and inconsistent. SARC managers have very little control over what is a very traumatic part of the SARC process and has often been described by victims as "as bad as the assault". We need to be able to offer a gender specific service with clinicians that have the appropriate training, interpersonal skills and experience. This should be the minimum standard that victims should receive. Doctors need specialist training, induction and peer support to enable them to perform this role to the best of their ability. Current practice places demands on FMEs' time and performance which can reflect on the service delivered to victims."

We asked respondents to comment on pros and cons of transferring commissioning of FP/SOE services to the NHS. At the service level, there was broad enthusiasm for transfer to the NHS. Quality Assurance emerged as the major factor that managers wanted to see addressed. A quarter of respondents felt strongly that forensic medical examination services for sexual assault belonged with the police as part of a criminal investigation rather

than the NHS. The pro views tended to focus on quality and the experience of victims. The con views emphasized the needs of the criminal justice system and fear of NHS bureaucracy and management:

Pro	• Clinical governance • Properly structured training programme with supervision, peer review and revalidation • Employment of mainly female workforce: "most female FPs do not want to work in a custody setting and were comfortable to work with rape victims as opposed to suspects" • "Splitting sexual assault away from custody rota, so choice of gender of examiner and properly trained SOE to conduct examination rather than poorly trained and disinterested FME" • Terms and conditions: NHS work would be superannuable which would aid recruitment • Scope for strategic commissioning, e.g. taking into account the number of cases in an area and commissioning services on a regional basis • Victim would be mainstreamed into the service • "Forensic recovery is only a very small part of the overall process. Victims regularly are from within vulnerable groups and often have other violent related or mental illness type history. Intervention and correct sign-posting at this stage would give more holistic care to victim and could save the NHS money in the long term. Access to medical records and history, clearer pathways to other services and clear governance, training and assessment of SOEs would all be more robust. There could be an increase in confidence from the victim in relation to reporting incidents and give victims more control of the process." • "makes perfect sense"
Con	• "Will the NHS understand the requirements of the Criminal Justice System?" • "Lack of accountability, lack of forensic cleansing and awareness, availability" • "This work does not sit within Health. The people that we see are here because a crime has been committed and that is their primary reason for attending – NOT for health issues. Due to the sensitive nature of the work it is not appropriate to have Health Interventions except of the most general kind, other than any related to post examination care e.g. STD referral etc. It would be a huge mistake to put this work in the health field – there is not the flexibility, understanding or interest in this work. It has a large Medico Legal part which would cause problems in a health setting" • "bureaucratic and inexperienced management in NHS" • risk of outsourcing to private co. with lower quality standards • "This will not be a priority and all the hard work in getting SARCs developed may well be lost!!!"

Training

Services were asked to describe the current training requirements for Forensic Physicians for sexual offences. Sometimes training was described in terms of accreditation status, e.g. "Training requirements follow Faculty of Forensic and Legal Medicine guidelines and are accredited by the FLLM". In terms of content, training involved a mixture of in –house and national training, such as St Mary's or Havens courses. Staff may be encouraged to attend national courses but they were not always a requirement. In-house training could be provided by an independent provider and as part of a joint custody care and SOE rota. The length of training for a new doctor varied between 4 days (e.g. 4 days induction training followed by 2 days SOE training and mentored examinations) and 6 months (depending on number of cases that came through and prior experience). Examples of SARC and non-SARC training requirements are shown in the boxes below.

Examples of Training in SARCs:

"Attendance at 3 day theoretical course at St Mary's or Havens followed by 1 day in-house training day. Shadow approx. 6 adult cases until acquires forensic competencies and is 'signed off' by Clinical Lead. 2 x Section 9 statements to be completed; further shadowing and theoretical training prior to any child examinations (< 13yrs); attendance at least 4 peer review meetings annually. Must have annual CPR training and Level 3 safeguarding training (child and adult)"

"All FPs complete a national accredited introductory training course (ITC) in Clinical Forensic Medicine and would then complete an advanced course in sexual assault examination and paediatric examination."

- Attend two-day Adult Sexual Assault Examination and Aftercare course
- Attend two-day Paediatric Sexual Assault Examination and Aftercare course
- Attend one-day Courtroom Skills Course
- Safeguarding Children Level 3
- Structured induction to SARC with documentation of completion and professional development plan
- Structured induction to Trust
- Shadowing until deemed competent by senior doctor to carry out examination
- Supervision of examinations until deemed competent by senior doctor to carry out examinations unsupervised or with an experienced paediatrician
- GU skills unless already competent
- Adult and adolescent risk assessment tool (RAI Form 1)
- Basic life support
- Infection control
- Other mandatory training
- Attendance at one-day Staff Update at least once every three years

"A number of our SOE are qualified or working towards the GMC Forensic Medical Examiners qualification and attended the St Mary's course or equivalent. In addition they are mentored by senior SOE for up to 6 months before undertaking examinations on their own. We have ad-hoc seminars and joint training day in house."

"Induction; St. Mary's FMERSA Course; Hold or working towards Dip of Medical Jurisprudence or Dip FCASA. Mentorship; shadowing; annual corporate mandatory training; annual clinical mandatory training; Level 3 child protection"

Examples of training in non-SARC (provided by outsourced company):

There is no national specialization for FME doctors. Doctors are required to attend the following before getting signed off as eligible:

- In-house induction of 2 days
- St Mary's/Haven course in the first 6 months
- Courtroom/statement writing training in the 1st year
- Simulation assessment run in real time, where the doctor conducts an examination (simulated) with police etc present

6 Forensic Physicians: Rota, Gender and Workload Volumes

Key Findings:

- Separate SOE rotas tend to cover urban areas and joint CC/SOE rotas tend to cover rural areas. This is consistent with SOE links to SARCs which also cover more urbanised areas.
- Rotas that are dedicated to sexual offences are mainly staffed by women whereas joint custody care/SOE rotas are mainly staffed by men.

Rota Structures and SARC/Non-SARC Distribution

There are two types of rota in our analysis: a joint rota that covers forensic examinations for both custody care (linked to police stations) and sexual offences. Very few (2/15) separate SOE rotas exist in non-SARC areas; they are linked almost entirely to SARCs. Joint CC/SOE rotas arrangements, on the other hand, are spread across both SARC and non-SARC areas.

	Non-SARC	SARC	Grand Total
Joint CC/SOE Rota	8	9	17
Separate SOE Rota	2	13	15
Grand Total	**10**	**22**	**32**

Rural/Urban Distribution

We obtained data on rota patterns covering 82% of the population and 74% of the land mass. (This suggests that the missing respondents cover rural areas).

Rota Type	No. Respondents	Population Coverage	Geographical Area Sq M	Population per Rota Area[48]	Sq Mile per Rota Area	Density of Pop. Per Sq Mile
Joint Custody Care and Sexual Offence Rota	17	16475400	22243	969,141	1,308	741
Separate Sexual Offence Rota	15	25672000	15050	1,711,467	1,003	1,706
Grand Total	**32**	**42147400**	**37293**	1,317,106	1,165	1,130
Total for England		51,464,400	50,211			
Sample as % of England		82%	74%			

In terms of the sample, the figures (summarised in the table above) show:

- 60% of the population is covered by separate SOE rota and 40% by a joint CC/SOE rota
- 60% of the land area is covered by joint CC/SOE rotas and 40% by separate SOE rotas
- The average population per SOE rota is nearly twice that of a joint CC/SOE rota
- Population density of separate SOE rota areas is more than double that of joint rotas

Gender of Physicians

Access to female doctors is considered to be an important indicator of service quality. The table below (sample n=22) shows that rotas that are dedicated to sexual offences are mainly staffed by women whereas joint custody care/SO rotas are mainly staffed by men.

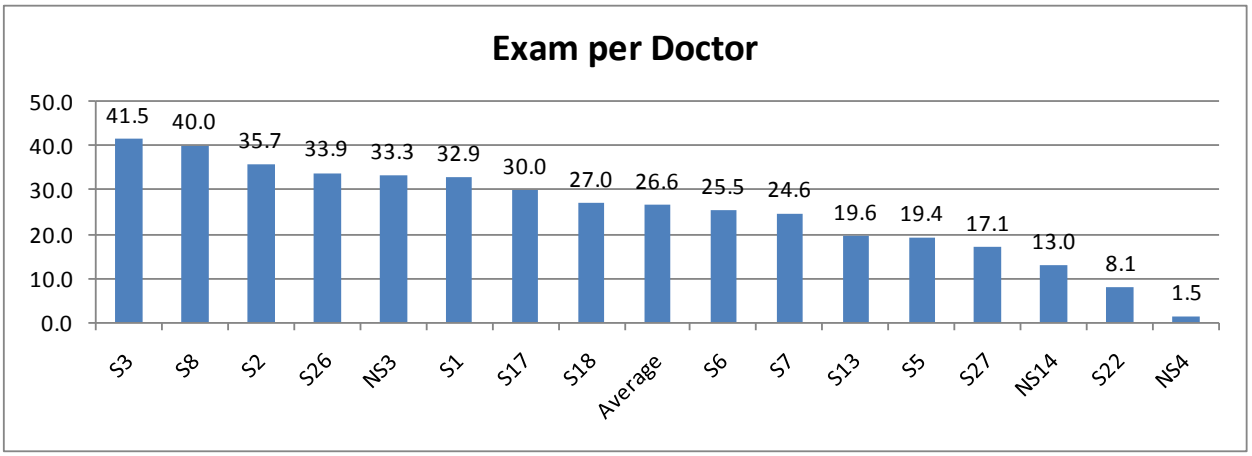
Code	Female	Male	Total	% Female	Type of Rota	Population	Geographical Area Sq miles
NS11	2	11	13	15%	Joint	1186700	2852
NS3	1	5	6	17%	Joint	1083900	632
S16	2	10	12	17%	Joint	695600	2278
S22	2	10	12	17%	Joint	558500	230
NS9	6	18	24	25%	Joint	1066200	1046
S8	4	11	15	27%	Joint	1595200	1843
S18	2	5	7	29%	Joint	1069900	831
NS2	5	8	13	38%	Joint	1705800	1415
NS1	3	4	7	43%	Joint	599400	475
NS5	2	2	4	50%	Joint	710600	1462
S13	4	3	7	57%	Joint	650100	1342
S4	4	3	7	57%	Joint	770400	1307
S7	6	4	10	60%	Separate	1553500	1458
NS4	4	2	6	67%	Joint	847300	2067
S12	7	3	10	70%	Joint	586200	1021
S27	11	2	13	85%	Separate	1350200	248
S2	15	0	15	100%	Separate	2652000	200
S25	7	0	7	100%	Separate	1307200	597
S1	16		16	100%	Separate	2513800	200
S3	15		15	100%	Separate	2502500	200
S26	24	0	24	100%	Separate	2580000	491
S5	17	0	17	100%	Separate	1857200	1598
Total	159	101	260	61%		29442200	23793

[48] Two respondents described two rotas covering the same area. We have not factored this into the table. The effect would be to reduce further the population covered by a joint rota.

Exam per Doctor

The sample suggests an average of 27 examinations relating to sexual assault per physician per year. This is in excess of the professional recommended minimum of 20 per physician per annum. Over one third of services within the sample (n=16) are below this threshold.

This data relates to whole services. We do not have information on individual physicians. We know from interviews that some doctors undertake higher volumes of sexual offence examinations than others.



7 Children

Most children's cases involve historic abuse over a period of time; acute cases of sexual assault on children are rare. General hospital paediatric services provide follow up support that is not costed into this feasibility study, and may be regarded as a hidden cost.

For children aged under thirteen, the most common format is for a forensic physician and a paediatrician to examine the child together. To do this it is usually necessary to call a paediatrician from the neighbouring acute hospital.

The fieldwork identified a high level of anxiety about the safety of services for children. A minority of FPs have paediatric expertise and few paediatricians wish to become involved in this area of work.

- One SARC is instituting a project to train up paediatricians and FPs by working together and engaging in joint peer review sessions, sharing colposcope films and case studies with another SARC by video conferencing.
- In some areas (e.g. S22) all acute cases go to the paediatric team at the local acute hospital.

- NS25: "no paediatrician is available in this county to deliver a service" "the inclusion of a paediatric service would improve the examination process for children"
- S2: "lack of paediatric daytime cover!"

Frequency of Responses to Question About Who Delivers Paediatric Services

What type of doctor (or combination of doctors) examine children?	Under 13 (children)	Aged 13 and over (adolescents)	All children and adolescents
Paediatrician and forensic physician (2 doctors)	**16 services:** S1 S2 S3 S6 S8 S5 S13 S17 S18 S23 S25 S27 NS3 NS4 NS12 NS14	**4 services:** S18 (13-15) S27 (13-15) NS12 NS14	**2 services:** NS9 NS14
Forensically trained paediatrician (1 doctor)	**5 services:** S26 S8 S13 S23 NS12	**3 services:** S26 S13 NS12	**1 service:** S26
Paediatrically trained FP (1 doctor)	**1 service:** S26	**4 services:** S26 S18 NS4 NS12	**1 service:** S26
Forensic Physician (involving paediatrician as deemed necessary)		**11 services:** S1 S2 S3 S6 S7 S5 S13 S17 (S18 16+) S25 NS3	

Data suggests that examinations are conducted on 55% of referrals for children and young people. Only three respondents indicated that they had separate forensic physician cover for children. The median number of referrals aged under 18 amounts to 11.4 per doctor, so the number of examinations would amount to about 6 per doctor. The number of referrals aged < 13 average at 4 per year per paediatric doctor, and much lower per general FP.

Code	Children/YP Referral per Doctor		code	No. Paediatric Doctors	Referral < 13 per Paed
NS4	0.5		S13	5.0	3.2
NS14	3.3		S2	7.0	3.6
S5	4.4		S1	7.0	4.4
S7	7.1		S3	8.0	6.6
S27	7.6		S26	15.0	12.0
S8	9.4				
S1	10.9				
S13	11.4				
S18	12.6				
S2	12.9				
S3	16.8				
S26	18.0				
NS3	19.2				
S23	27.8				
S17	37.7				

As volumes are low, it is difficult to ensure clinical competence. There is a case for regionalising services for children to concentrate cases among a small number of experienced doctors.

8 Current Cost

Current Funding by the Police

Survey data has been extrapolated to the whole of England. We estimate that the current cost of the Forensic Physician service for sexual assault is £6.4 million[49] and that the police contribute a further £1.6 million to SARCs, bringing the total police annual outlay to £8 million. This estimate is carried forward into the Evidence Base that is used to support the Impact Assessment linked to this study.

Baseline Cost

FP for Sexual Offences Examinations	£6.4m
Other police contribution	£1.6 m
Total Baseline	£8.0m

The estimate is for 2009/10 based on 85% of the population (covering 44 million people). We used data from Questionnaire B to supplement gaps in the Questionnaire A response, with some modification to the pro rated estimate[50].

The estimate of £8m relates to police provision only. It does not include the contribution of the NHS or other agencies, where there are partnership arrangements, which are estimated to total £4.5 million, bringing the total cost of this service nationally to £12.5 million. (This

[49] Where services are jointly funded 50:50 by police and NHS, we have used a consistent approach, assuming that FP medical costs are met by police and the balance of the police contribution falls into the 'further contribution' category. The consequence is that, in this analysis, the NHS resource does not cover the FP bill.

[50] **Assumptions – Modifying the Linear Pro Rating.** The table below shows that a linear pro-rating shows £6.4m SOE : £1.8 m Other = Total £8.2m. However, we know there is some bias in the sample since the 85% sample includes the whole metropolitan area and the missing 15% includes services that are significantly less developed or resourced (where both service supply and demand is likely to be lower). This is illustrated by an earlier pro rating based on 67% of the population and including only one third of the metropolitan area where the pro-rated total police spend was £7.7 million. On this basis, £8 million is a reasonable estimate, sitting between £7.7 million and £8.2 million.

Linear Pro-Rating

	Cost of Police SOE Medical Staff	Cost of Other Police Input	Total Police	Population
Study Sample	£5,373,723	£1,554,938	£6,928,661	43,560,000
Pro rated to whole population	£6,348,840	£1,837,097	£8,185,936	51,464,400
percentage of police cost	78%	22%	100%	
per 1000 population	£123	£36	£159	

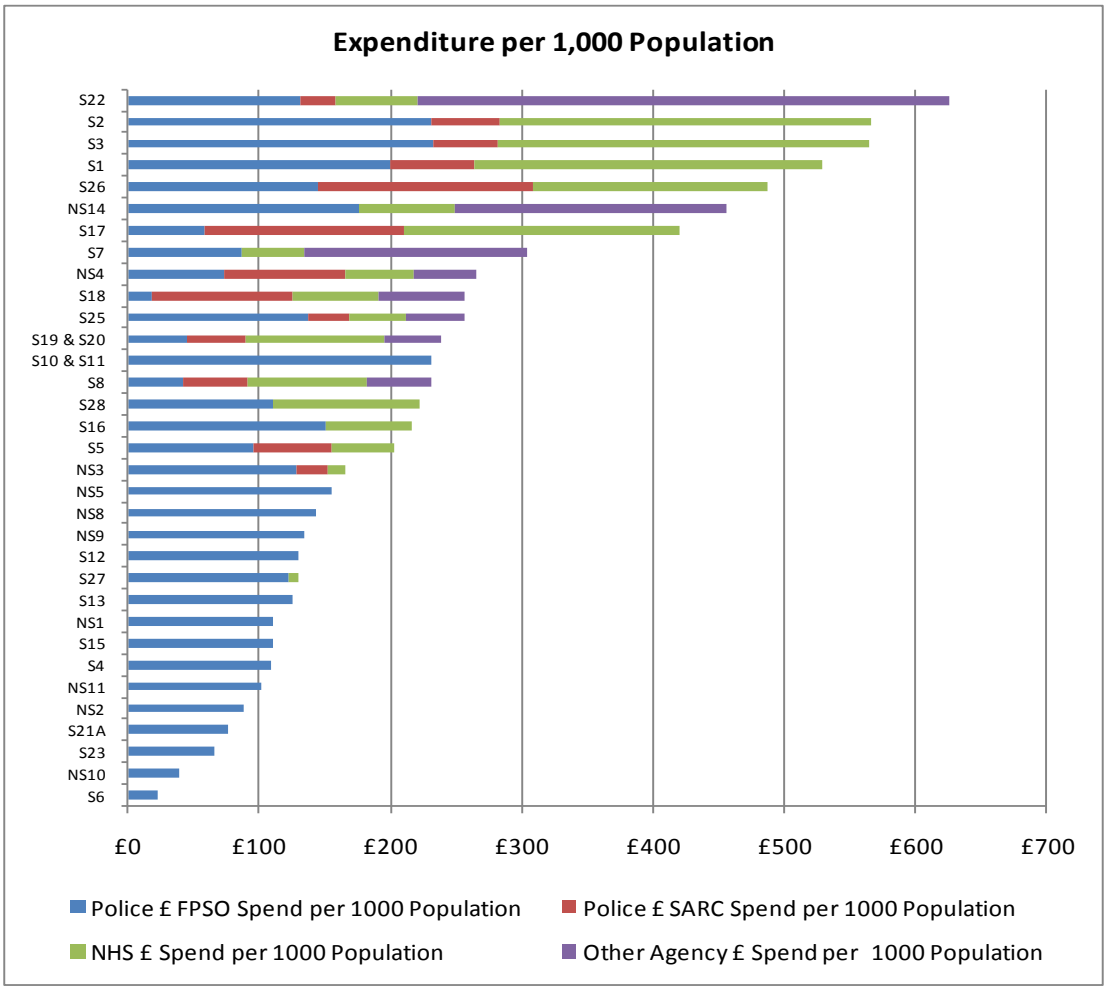
excludes hidden costs currently borne by the NHS, for example, where a paediatrician needs to be present for the forensic clinical examination).

Building Up the Costs – Apportioning Joint Custody Care/SOE funding

The costing data is based on a sample covering 85% of the England population. In spite of the high level of coverage, the data carries a strong health warning because in 17 cases, where the service was provided as part of a joint custody care/sexual offences rota, it was necessary to use an apportionment assumption to determine cost of forensic physicians for sexual offence examinations (FPSOE).

Where local estimates were provided, we used them (e.g. 2%, 4%, 10%, 11%, 15% as SOE percentage of total FP workload). In the absence of local estimates we used an apportionment value of 10% to attribute resources to Sexual Offence Examinations (victims, not suspects) out of a combined custody suite/SOE rota. This is the median value of the 2%-15% range of assumptions supplied to us. (By way of corroboration, a detailed breakdown by one police force area (NS5) showed 11% of FP attendances relating to the victim and 9% to the perpetrators).

Per Capita Spend by Agencies (£ per 1000 population)



The graph above shows the range of spending, standardised against population, for 33 services. Five returns show less than £100 per 1000 population (mainly police spend only) and seven are over £400 per 1000 population (supplemented by NHS and other agency funding). The median of the range is approximately £200 per 1000 population. The following factors contribute to the wide discrepancy:

- 14 authorities show police spend only. Half of these are areas with a SARC. It is possible that the NHS contribution is understated;
- The quality of the data may be weak in some places;
- Nevertheless, the data suggests that there is an underlying inequity of provision across the country.

Unit Cost of Forensic Examination Services for Sexual Assault

This section analyses the overall cost of Forensic Examination Services for Sexual Assault. It goes on to isolate the police element and then, within this, to focus on the police element that pays for forensic physicians for sexual offences (FPSO).

There is a very wide range of unit costs. The table below summarises the findings:

	Minimum	Maximum	Mean	Median
Cost per Referral	£ 133	£ 3,515	**£ 1,031**	£ 746
Cost per Referral Funded by Police	£ 133	£ 1,362	**£ 584**	£422
Unit Cost per Referral Police FPSO Spend (excluding other contribution to SARC)	£ 55	£ 1,362	**£ 439**	£422

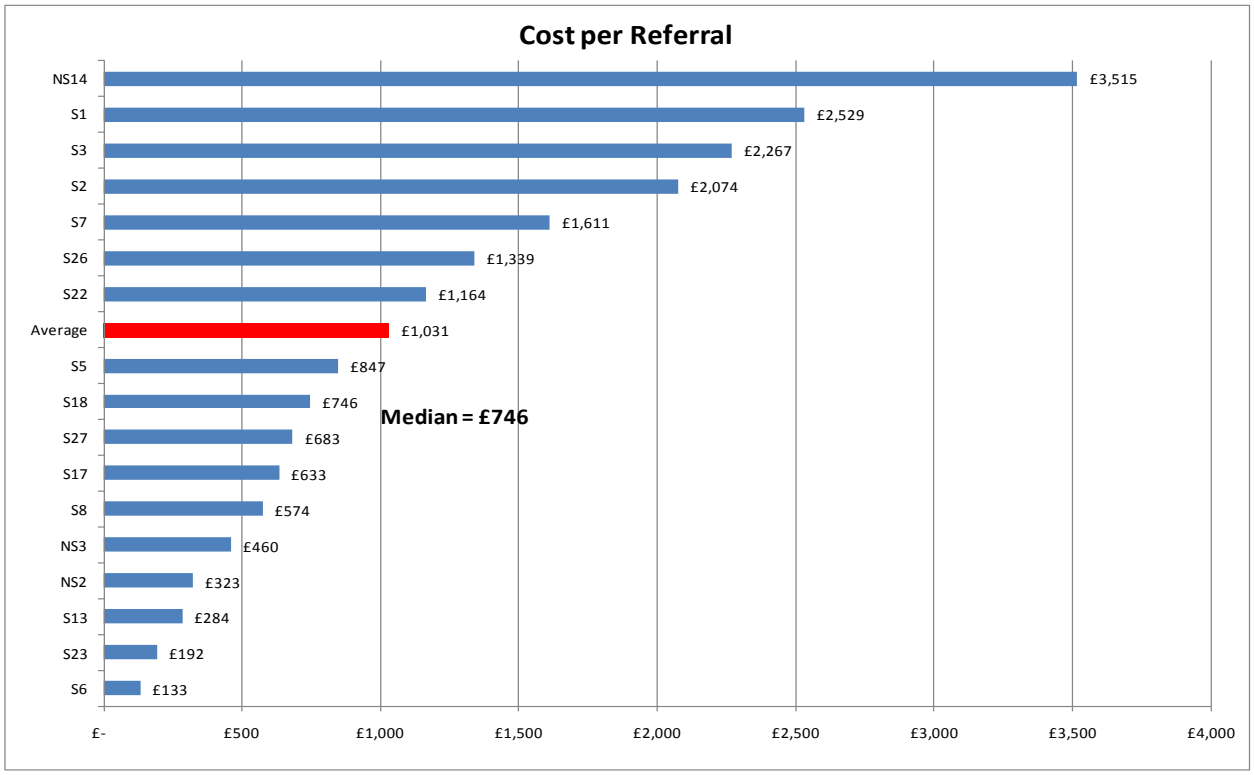
Caveats to bear in mind at this stage are that:

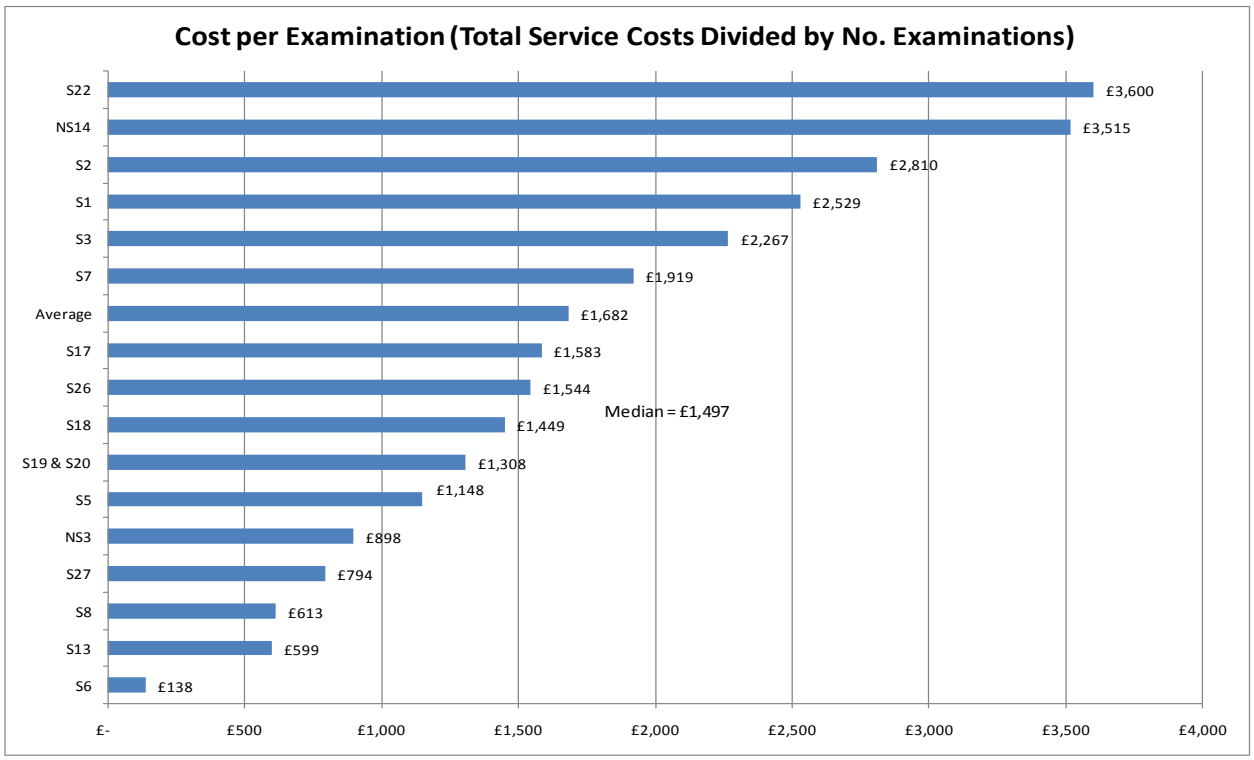
- The sample (n=17) is based services that cover 50% of the England population where we have referrals and cost data that maps to each other.
- Costs include resources for the whole service. It should be noted that the higher cost services include follow up services provided during the day, as well as on-call services for acute cases. The unit cost comparison overstates costs for these services, since referrals or examinations understate the total workload.
- The baseline estimates do not reflect what would be the cost of service if (a) it were to meet a minimum level of quality or equity or (b) the structure of custody suite and sexual offence service were to change, e.g. if all services were to run separate custody suite and sexual offence rotas for forensic physicians.

The average cost per referral (n=17) is £1,031 with a range from £133 per referral to £3,515. The median of the sample is £746 per referral.

The average cost per examination is significantly higher, since in most cases the number of examinations is lower than the number of referrals. The average cost per examination (n=16) is £1,682 with a median of £1,477. Again, it needs to be borne in mind, that for well

developed SARCs, examinations are only a part of the workload. If day time costs of follow up services were stripped out[51] then the cost per examination would be lower for services at the top end.

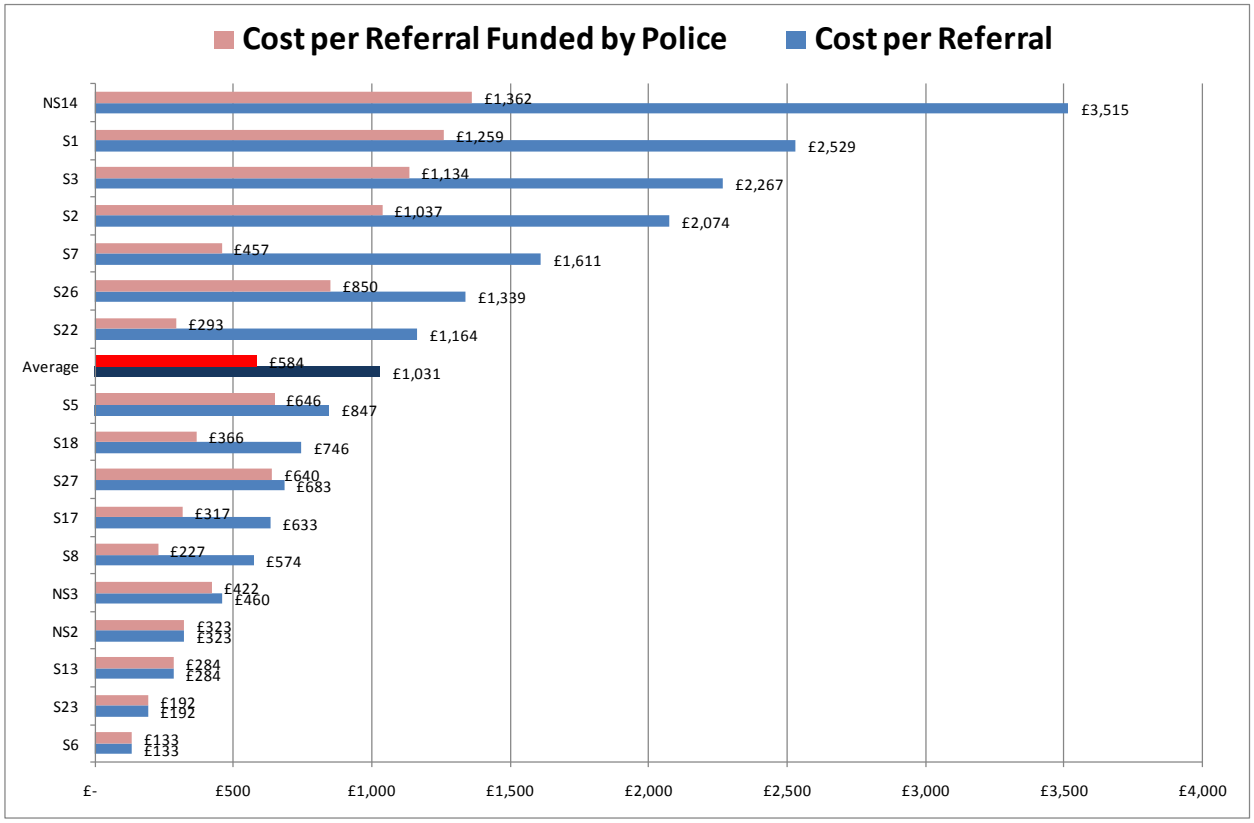




[51] One SARC provided costs that distinguished between on-call and follow-up. However, others with similar services did not make the distinction. For consistency we use whole costs for all services, but note that the content of services covers both cold and acute in some cases.

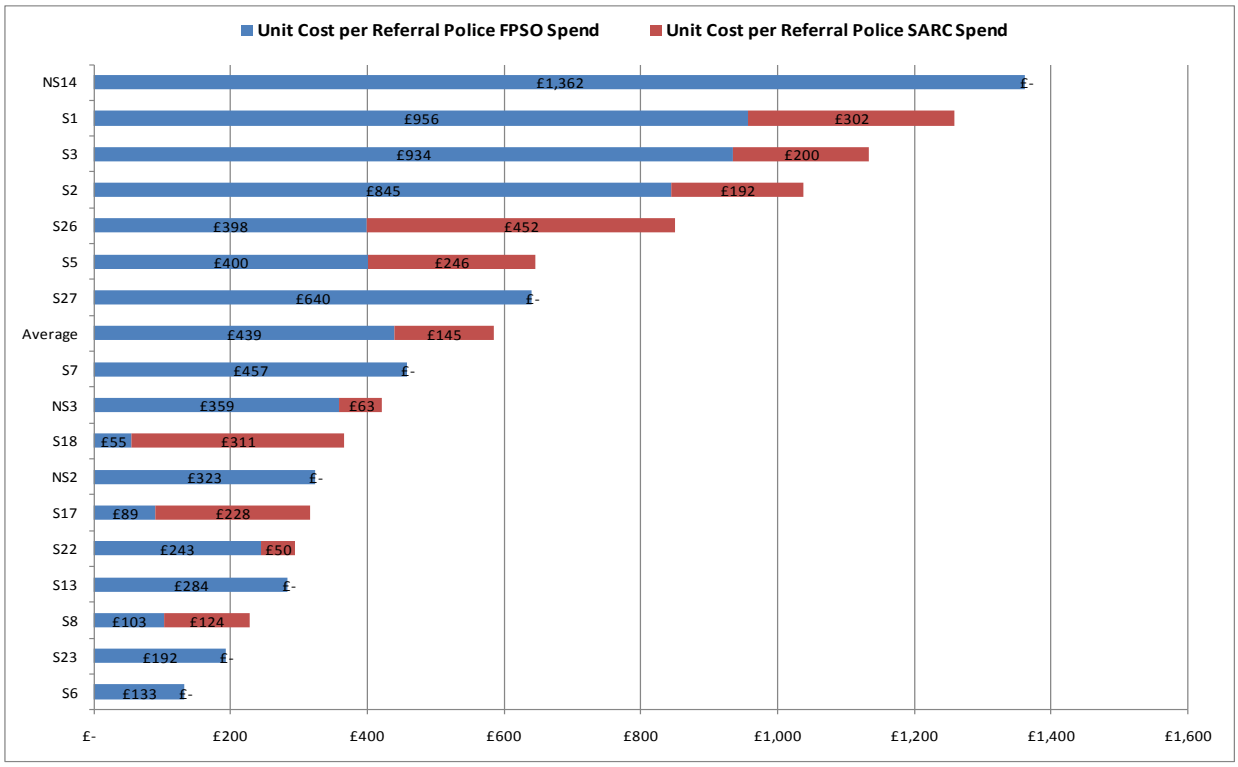
The Police Element

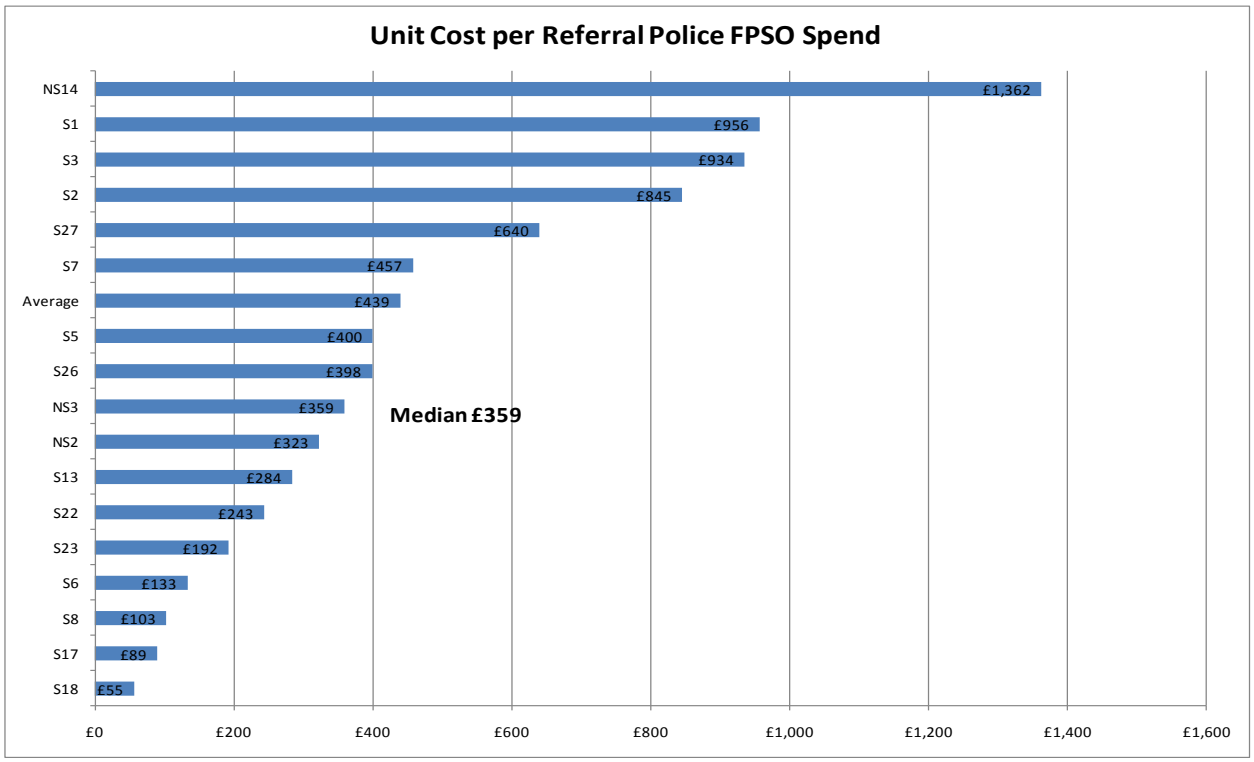
The police element accounts for approximately 50% of funding in the sample being considered here. The graph below (n=17) shows that the average cost per referral, based on police spend, is just under £600.



Breaking Down the Unit Cost to the Police

The average of £584 police spend per referral includes contributions to SARCs that go over and above the Forensic Physician expenditure. In this sample (n=17) there is a 75%:25% split between forensic doctor (FPSO):other, equal to £439:£145 per referral where the £145 contributes to SARC costs such as employment of crisis workers.


Unit Cost per Referral Police FPSO Spend
Unit Cost per Referral Police SARC Spend
NS14 £1,362 £-
S1 £956 £302
S3 £934 £200
S2 £845 £192
S26 £398 £452
S5 £400 £246
S27 £640 £-
Average £439 £145
S7 £457 £-
NS3 £359 £63
S18 £55 £311
NS2 £323 £-
S17 £89 £228
S22 £243 £50
S13 £284 £-
S8 £103 £124
S23 £192 £-
S6 £133 £-
£- £200 £400 £600 £800 £1,000 £1,200 £1,400 £1,600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S13 £284
S22 £243
S23 £192
S6 £133
S8 £103
S17 £89
S18 £55
£0 £200 £400 £600 £800 £1,000 £1,200 £1,400 £1,600

Summary of Medical Costs Standardised Against Population

Type of Rota	Code	Cost of Police SOE Medical Staff	Population	Geographical Area	No. Doctors	Cost per 100,000 population of SOE Medical Staff	Population per Doctor
Joint	**NS1**	£66,300	599,400	475		£11,061	85,629
	NS11	£120,000	1,186,700	2,852	13	£10,112	91,285
	NS2	£150,100	1,705,800	1,415	13	£8,799	131,215
	NS3	£140,000	1,083,900	632	6	£12,916	180,650
	NS4	£61,870	847,300	2,067	6	£7,302	141,217
	NS5	£110,000	710,600	1,462	4	£15,480	177,650
	NS8	£102,200	711,000	1,022		£14,374	
	NS9	£143,055	1,066,200	1,046	24	£13,417	44,425
	S12	£76,600	586,200	1,021	10	£13,067	58,620
	S13	£82,000	650,100	1,342	7	£12,613	92,871
	S15	£108,500	983,400	982		£11,033	
	S16	£104,400	695,600	2,278	12	£15,009	57,967
	S18	£20,339	1,069,900	831	7	£1,901	152,843
	S22	£70,300	558,500	230	12	£12,587	46,542
	S4	£84,000	770,400	1,307	7	£10,903	110,057
	S6	£38,500	1,655,200	1,438	11	£2,326	150,473
	S8	£66,000	1,595,200	1,843	15	£4,137	106,347
J Total		**£1,544,164**	**16,475,400**	**22,243**	**154**	**£9,373**	**106,983**
Sep	**NS14**	£177,000	1,002,900	902	10	£17,649	100,290
	S1	£494,217	2,513,800	200	16	£19,660	157,113
	S17	£40,000	679,200	929	6	£5,889	113,200
	S19 & S20	£119,910	2,622,300	347		£4,573	
	S2	£612,500	2,652,000	200	15	£23,096	176,800
	S21A	£107,000	1,407,000	2,142		£7,605	
	S23	£60,000	914,800	1,354	5	£6,559	182,960
	S25	£180,000	1,307,200	597	7	£13,770	186,743
	S26	£373,763	2,580,000	491	24	£14,487	107,500
	S27	£165,000	1,350,200	248	13	£12,220	103,862
	S3	£567,080	2,502,500	200	15	£22,661	166,833
	S5	£178,400	1,857,200	1,598	17	£9,606	109,247
	S7	£134,000	1,553,500	1,458	10	£8,626	155,350
	S28	£215,000	1,941,000	1,185	8	£11,077	242,625
S Total		**£3,423,870**	**24,883,600**	**11,851**	**146**	**£13,760**	**170,436**
(blank)	**NS10**	£20,689	533,200	761			
	S9, S10 & S11	£385,000	1,667,800	3,949		£23,084	
		£405,689		**10,292**		**£11,327**	
Grand Total		**£5,373,723**	43560000	**44,386**	**300**	**£11,538**	

Converting Current Costs into Projections

The table below takes the fieldwork costs from the previous annex and uses them to estimate the cost of replacing a joint custody care/SOE medical rota with a separate SOE rota.

The cost estimates relate to Option 4 in the Impact Assessment.

COSTS OF MEDICAL STAFF	Rounded to £m for IA	Projection - All Separate Rotas Based on Current Per Capita Cost	Current Pro Rata	Current Costs based on sample	Current Unit Costs per 100,000 population	Population	
				£3,423,870	£13,760	24,883,600	separate
				£1,544,164	£9,373	16,475,400	joint
				£20,689	£3,880	533,200	other joint
				£385,000	£23,084	1,667,800	other separate
current joint	1.9		£1,848,812	£1,564,853	£9,200	17,008,600	sub-total joint
current separate	4.5	£4,500,028	£4,500,028	£3,808,870	£14,345	26,551,400	sub-total separate
	6.4		**£6,348,840**	£5,373,723	£12,336	43,560,000	Total Sample
						31,369,419	pro rata separate
cost of separate rotas to replace joint	2.9	£2,882,679				20,094,981	pro rata joint
Cost of separate rotas	7.4					51,464,400	Total Population
Leave c.50% of existing SOE joint rota resource in place (staying within the joint rota)	1	£924,406					
		£8,382,707					
plus £1.6 million 'other'	1.6	£1,600,000					
Governance	1.2	£1,200,000					
Total	**11.2**	**£11,182,707**					

Commissioning - Survey B

This annex reports on the fieldwork carried out through Survey B. The structure of this annex is:

1. Introduction
2. Participation
3. Current services
4. Contracts and service specifications
5. Commissioning challenges and priorities
6. Commissioning in partnership with the NHS
7. Resourcing commissioning within the police
8. Analysis of the 'top nine' police forces
9. Views about future commissioning
10. Summary of key findings

1 Introduction

Purpose: This survey collected information about how police forces commission the service and their views about how this might change in the future.
Development: The questionnaire was developed following initial scoping with stakeholders and a small number of police staff with commissioning responsibilities. The questionnaire was piloted, revised and re-piloted, before being sent to all 39 police forces in England in September 2010. The questionnaire had 18 questions, which were a mix of closed questions about current arrangements for commissioning and open questions designed to gauge opinions about how well the arrangements work and future options. Telephone interviews were offered in order to assist participants in completing the questionnaire and to allow the research team to follow-up some of the issues highlighted by respondents.

The term commissioning was avoided in the questionnaire, being replaced with 'planning, funding and procuring' in order to reflect terminology in common use within the police. The term Forensic Service Examiner (FSE) was used throughout the questionnaire as an inclusive term to cover medical examinations undertaken by both doctors and forensic nurse practitioners.

Follow-up: A small number of telephone interviews were conducted in November and December 2010, with PCT commissioning staff. The purpose of these interviews was to explore the part played by the NHS currently in commissioning the service, and views about the possible transfer of commissioning to the NHS.

Policy landscape: It is important to note that the national policy landscape for commissioning was subject to considerable change whilst the survey was being developed, piloted and completed in the field. Wherever possible, emerging policy was reflected in the questionnaire, particularly in relation to future commissioning options. However, responses

were potentially influenced by these changes and a sense of uncertainty as the implications of policies started to emerge.

2 Participation

Of the 39 police forces sent a questionnaire, responses were received from 31 forces. One response was excluded because less than one-quarter of the questions were completed, giving an overall response rate of 77%. Two forces declined to take part and one withdrew from the study. The response rate was higher from police forces with a Sexual Assault Referral Centre compared with forces without a SARC.

	Police forces with a SARC	Police forces without a SARC	Total
No. questionnaires sent out	23	16	39
Refusals/withdrawals	1	2	3
No. telephone interviews	14	4	18
% interviewed	64%	29%	46%
Completed questionnaires	20	10	30
Response rate	**87%**	**63%**	**77%**

Data quality: Response rates were very high for a postal survey. This means that the reported results are highly likely to reflect opinion across all forces in England. The majority of respondents completed all questions, although a small minority were unable to provide some of the figures requested. Only one questionnaire was discarded because of significant numbers of blank responses. In retrospect, the only gap in the questionnaire was the omission of police and criminal evidence standards for undertaking a forensic examination from the list of items included in service specifications. Respondents were however provided with space to add any extra service standards which were included in their local specifications. Overall, there is strong evidence for high data quality for this survey.

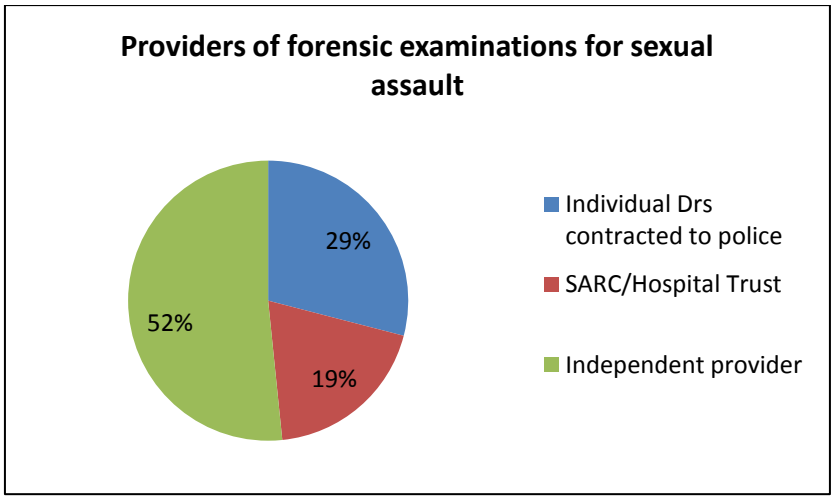
3 Current Services

Providers

Half of the respondents contract with an independent provider for the provision of FSEs[52]. Thirty percent of forces have contracts with individual doctors who work for them sessionally. The remaining 19% are employed directly by SARCs or an NHS Hospital Trust. The only difference between forces with and without a SARC, was that forces without a

[52] The sample is based on the response rate of 77%. Annex 3 results suggest that the majority of non-respondents are likely to contract with independent providers, raising the overall proportion.

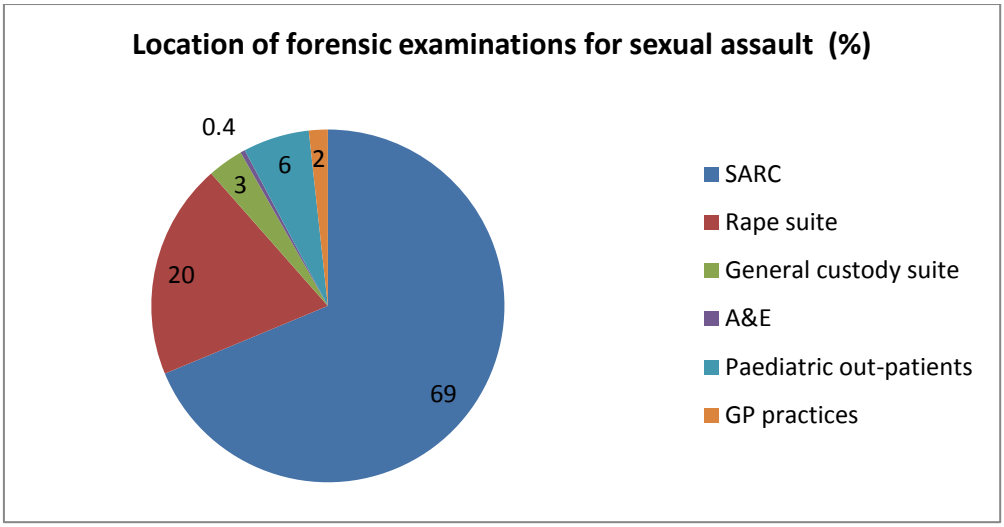
SARC relied more on independent providers whilst forces with a SARC relied more on direct/Hospital Trust employment. The percentage of forces contracting directly with individual Drs was exactly the same for forces with and without SARCs.



Location of forensic examinations

The next chart shows that small numbers of examinations take place in Hospital Accident and Emergency Departments, general purpose custody suites and GP practices. In one force, 45% of forensic examinations were taking place in GP practices. Only 26% of respondents conducted *all* their forensic examinations in SARCs. This is because many forces with SARCs still undertake a small proportion of examinations in rape or sympathy suites due to excessive travel distances to get to a SARC, particularly in rural areas, or because children needed to examined by a paediatrician who was unable to leave the hospital site because of their main clinical duties.

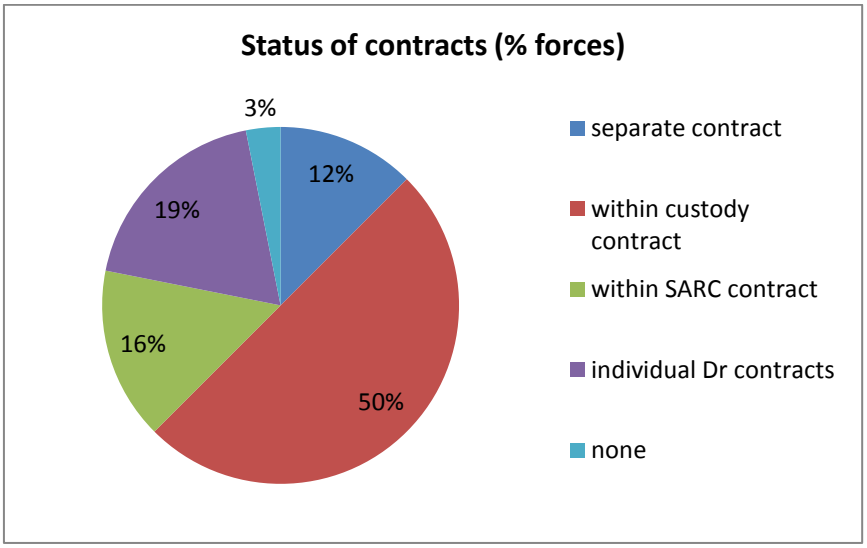
One-third of police forces reported that children are usually examined in hospital paediatric out-patients – this is probably an under-estimate as a number of respondents were not able to provide this information.



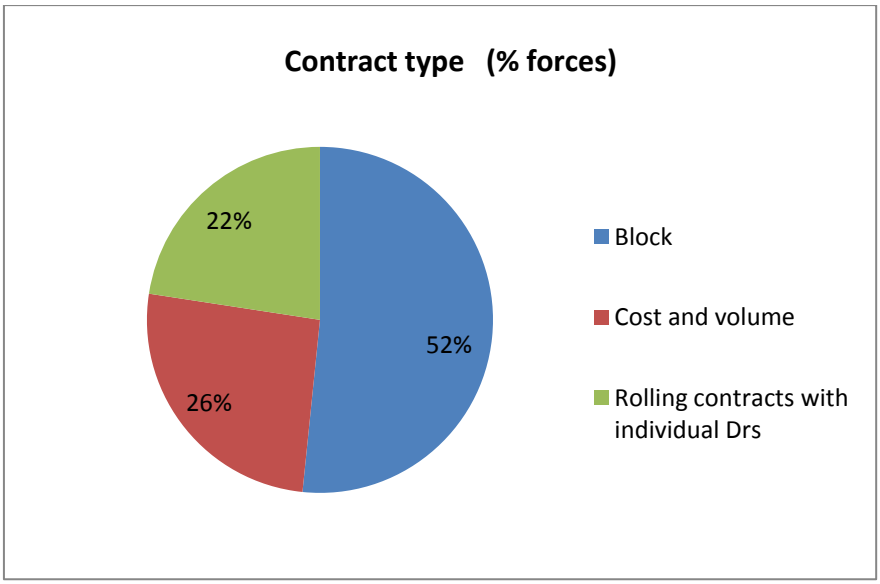
4 Contracts and Service Specifications

Contracts

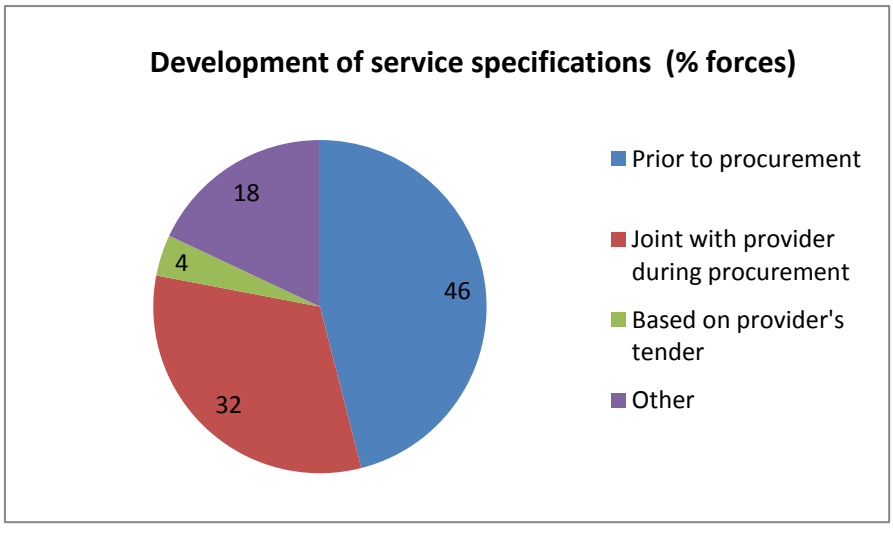
Very few forces have a separate contract for this service, with most subsuming it in a larger contract for custody healthcare or a SARC. There were no differences in the types of contracts used between forces with and without a SARC. Very few respondents could provide accurate information about contract values or spend on the service, particularly where the service was part of a bigger contract.



Just over half the forces had block contracts with providers, with only 26% of forces using cost and volume contracts. Just over a fifth had rolling contracts with individual doctors, which carried on from one year to the next.



Most forces had developed their service specifications and quality standards prior to procurement, although a minority had worked on these jointly with providers during the procurement process.



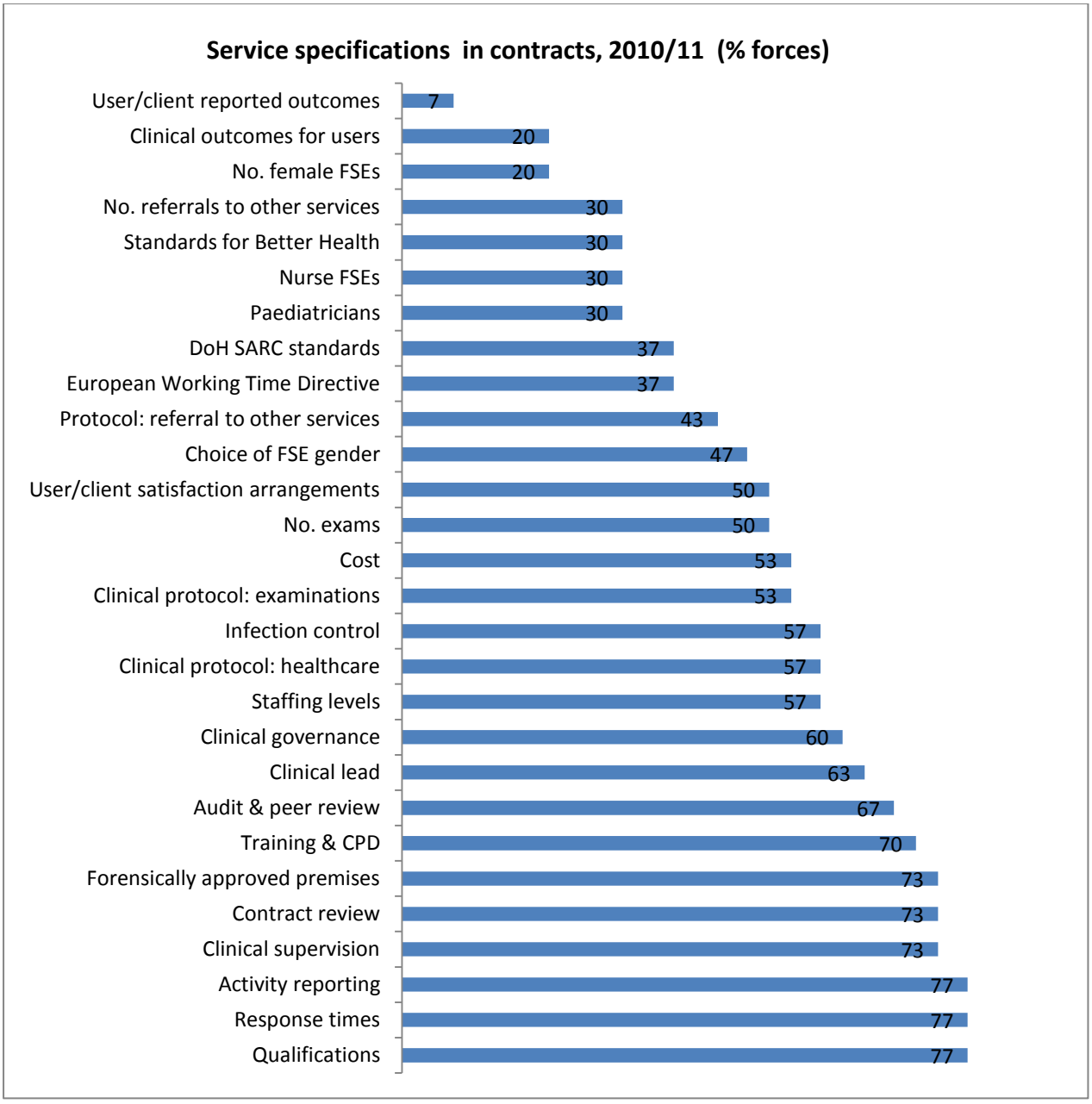
Eighty percent of forces had access to specialist clinical advice to support their commissioning of the service. However, just under a third were taking advice from within the service, via a local lead FME, and did not appear to have access to advice independent of the provider.

Service specifications

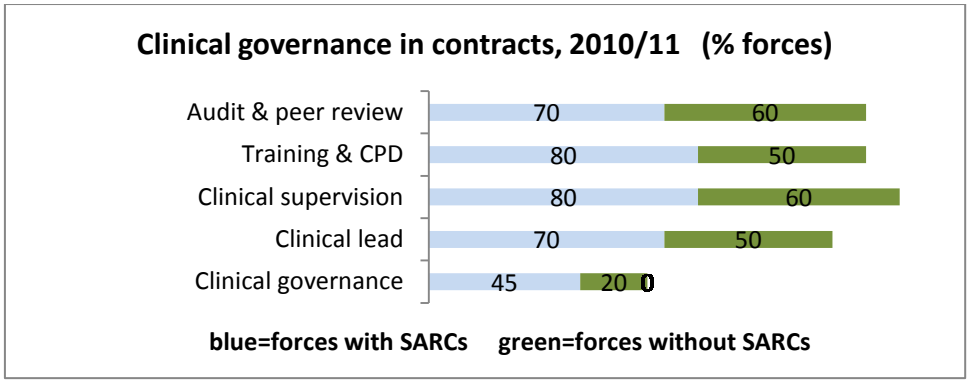
Respondents were asked about whether their contracts contained 28 items related to the quality of the service. This list of 28 items was compiled with reference to NHS guidance for commissioning community services, the relevant core standards for SARCs[12] and feedback from the field during piloting. This approach meant that service specifications were judged against best practice benchmarks for the NHS.

Respondents also had the opportunity to report additional items included in their service specifications. This showed that a minority of forces specify that FSEs should be trained and skilled in providing timely written statements to the police and giving evidence in court.

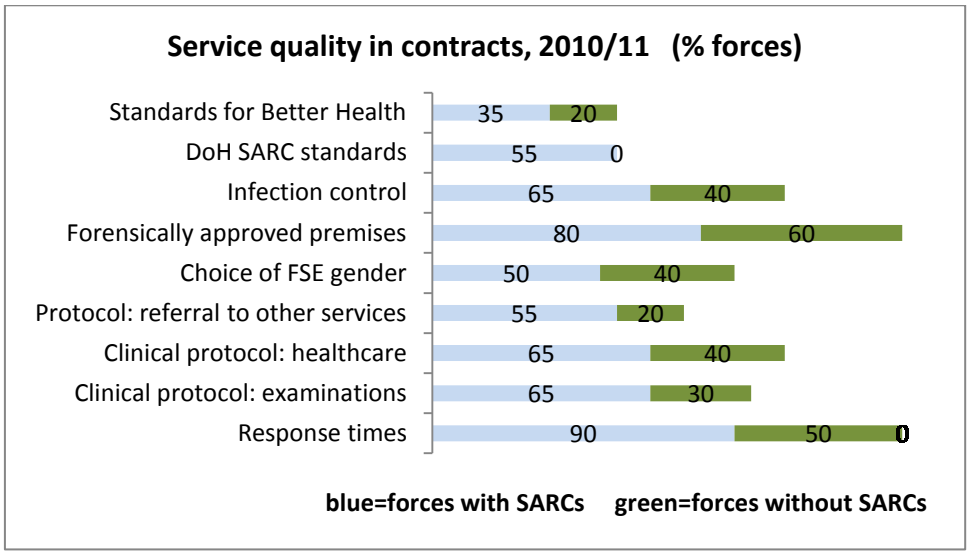
The next chart shows the proportions of forces which include individual quality items in their service specifications.

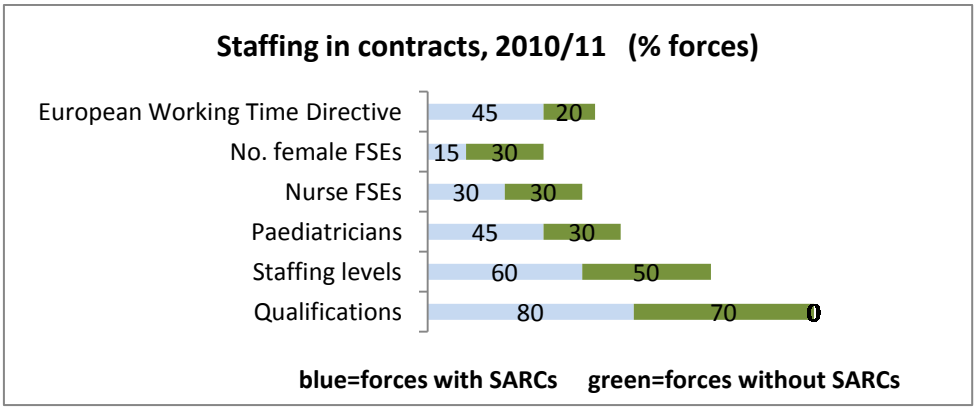


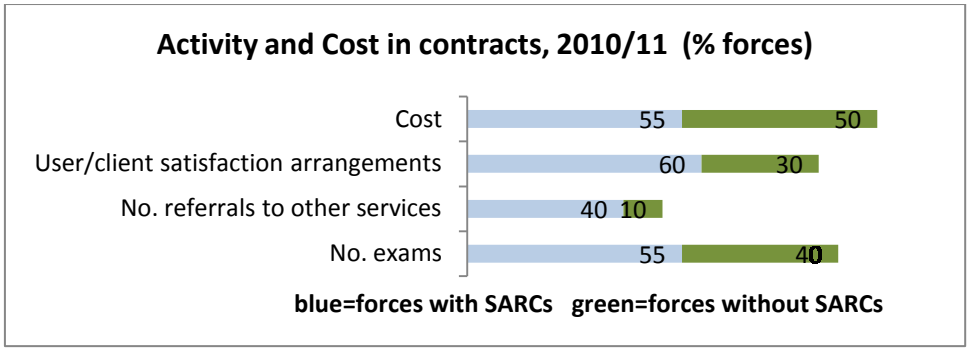
The next set of charts group these items under headings and show how often they are included for forces with and without SARCs. Overall, 26 of the 28 items were included more often by forces with a SARC. This confirms qualitative evidence from telephone interviews that the SARC development process often leads to a more detailed specification of the FSE service.

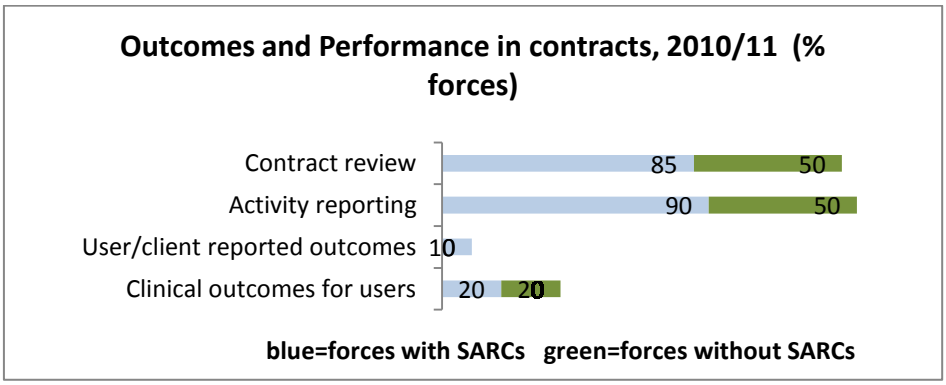


Although the above chart shows a reasonably high level of coverage for clinical governance in contracts, particularly for forces with SARCs, subsequent evidence suggests that clinical governance remains a delivery challenge in many forces (see section on *Commissioning challenges and priorities).*

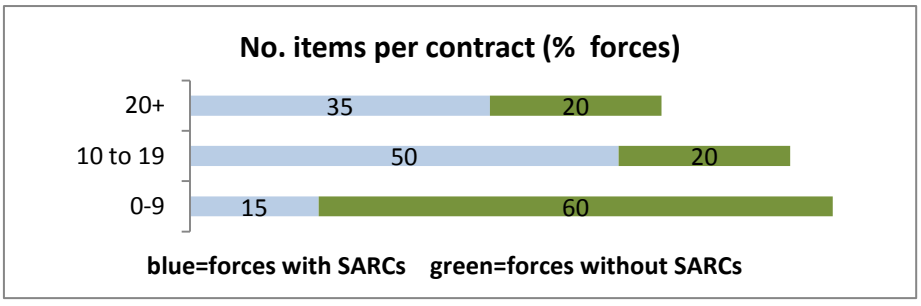








The average number of service quality items included in contracts was 16 for forces with a SARC and 14 for forces without a SARC. However, these averages mask big variations between forces. 60% of forces without a SARC had contracts with less than 10 items, compared with only 15% of forces with SARCs. At the other end of the spectrum, 35% of forces with a SARC had 20+ items in their contracts, compared with 20% for forces without SARCs.



It could be argued that the number of service items specified in a contract is a proxy measure for the quality of commissioning. Although it is not always the case that the service specified in the contract is what is actually delivered in practice, if a commissioner has negotiated detailed quality measures or standards with providers, these are usually reflected in contracts. Use of this as a proxy measure for quality commissioning, suggests

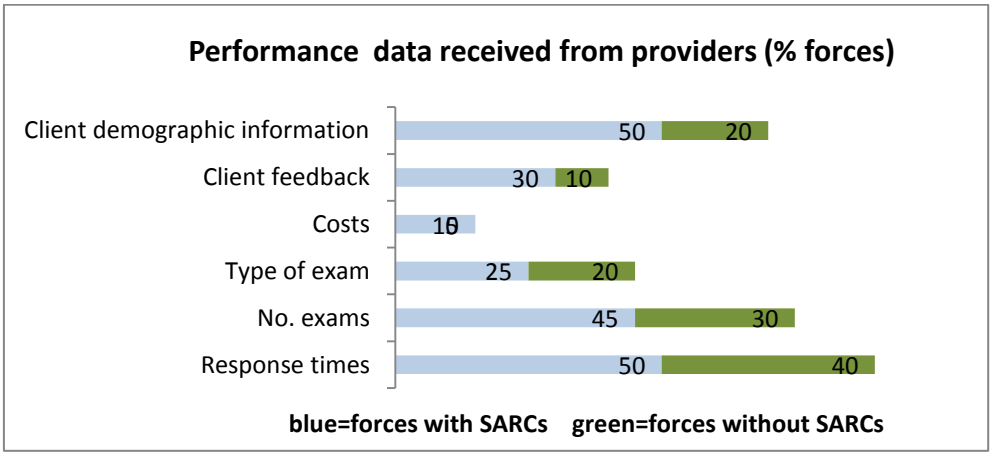
that 30% of forces are commissioning the service well whilst another 30% are commissioning to a low standard. Section 8 provides further analysis of how well the top 30% do across a wider range of commissioning tasks covered in the questionnaire.

Performance management

Respondents were asked to list the performance data that is reported to them by providers, both quarterly and annually. The quality of responses to this question was variable, with 9 respondents appearing to receive no performance data at all (2 forces with SARCs; 7 forces without SARCs). A small minority gave examples of using performance data to drive up quality, with one force recently introducing financial penalties for non-compliance with agreed response times. Key points to note here are:

- performance data was fairly limited and very few forces received data for the full set of standards specified in contracts
- eight forces received no performance data whatsoever from providers
- only a handful of forces received data on clinical governance, and this was mostly related to training provided for FSEs and complaints
- only two forces were monitoring the quality of written statements provided by the FSEs to police
- several forces were introducing or planning to introduce a balanced scorecard approach to reporting and monitoring performance across a large number of measures.

The following chart shows the proportion of forces getting performance data from providers, for the six most frequently reported measures.

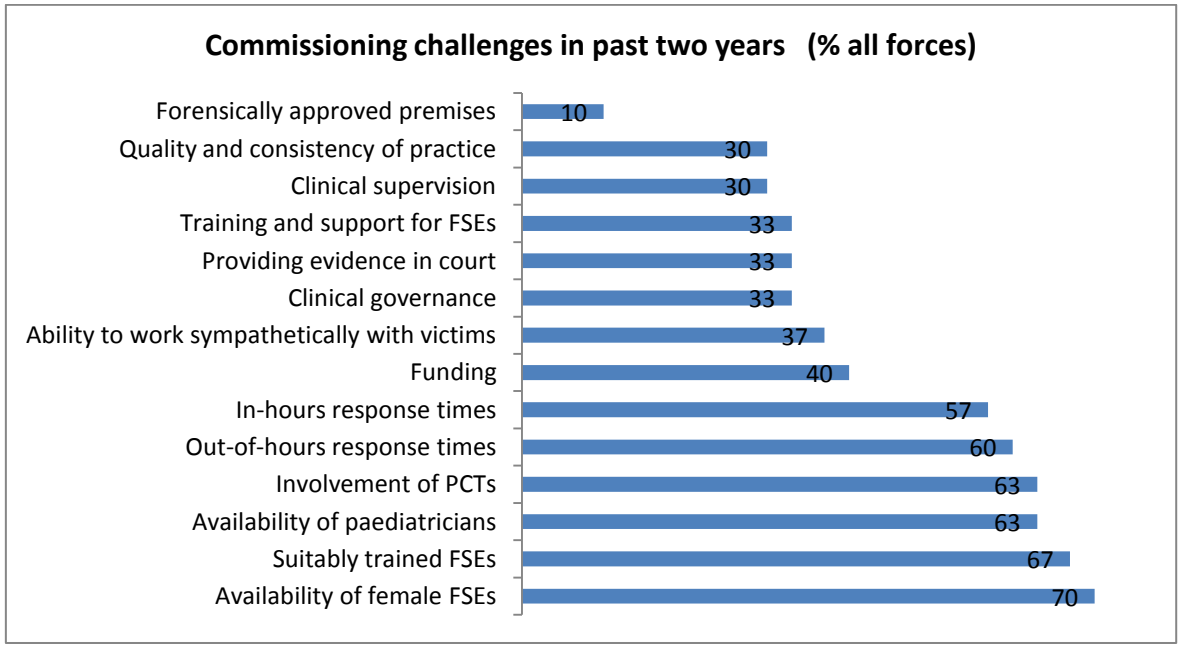


This suggests that although many forces are specifying their services in detail in their contracts, this seems not to be followed through into performance data which demonstrates that a quality service is being delivered. The lack of detailed performance

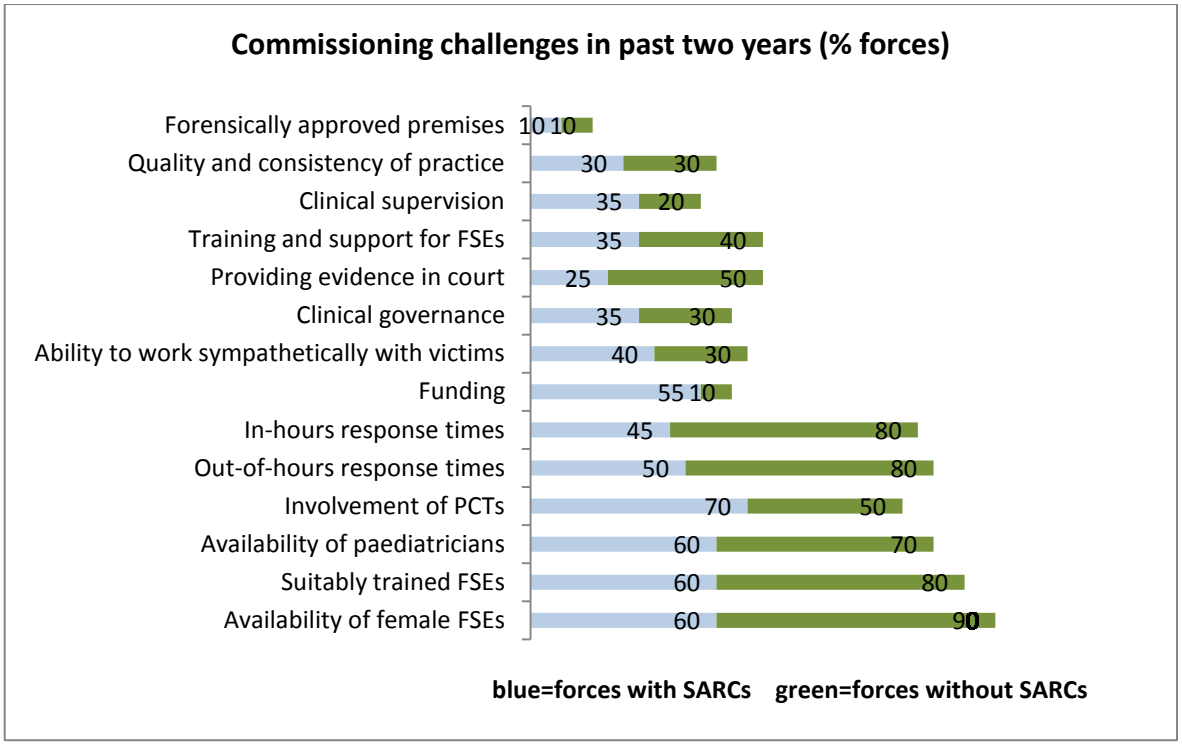
data from providers suggests that although they may be aspiring to provide the quality police forces specify, they are unlikely to be providing this in practice.

5 Commissioning challenges and priorities

Respondents were asked to identify the top three challenges and difficulties faced in planning, funding and procuring a high quality service in their area in the past two years. This provides a useful picture of which elements of the service are proving difficult to improve.



It is worth noting that 42% of forces reported facing difficulties with one or more aspects of clinical governance. The second chart shows that forces without SARCs face a greater level of challenge than forces without SARCs.



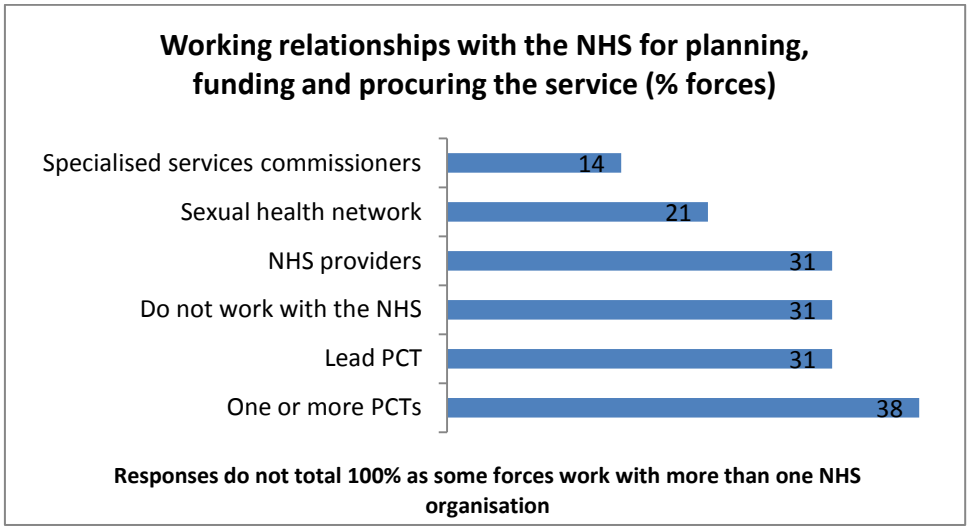
Another take on the same question came from responses to a question about top three priorities for improvement in the next 12 months.

6 Commissioning in partnership working with the NHS

Respondents were asked about:

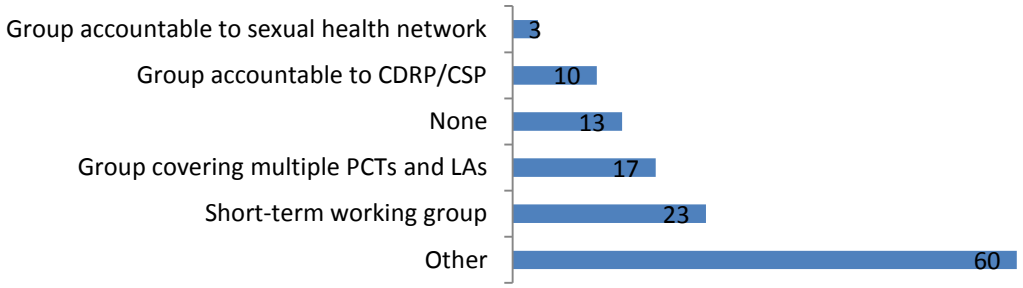
- which parts of the NHS they work with in planning, funding and procuring the service
- accountability arrangements to support this joint working
- which tasks have been led by the police, the NHS or delivered jointly within the last 2 years.

It is notable that one-third of forces reported that they did not work with the NHS at all in commissioning this service. Those that did work with the NHS had most experience of working with Primary Care Trusts (PCTs) or NHS providers.



Where there was joint working between the police and the NHS, this was generally carried out through short-term working groups for the SARC or through Rape Steering groups. Formalised joint accountability arrangements were only in place in 13% of forces, with groups accountable either to the sexual health network or the Local Strategic Partnership (via the Crime and Disorder Reduction Partnership or Community Safety Partnership).

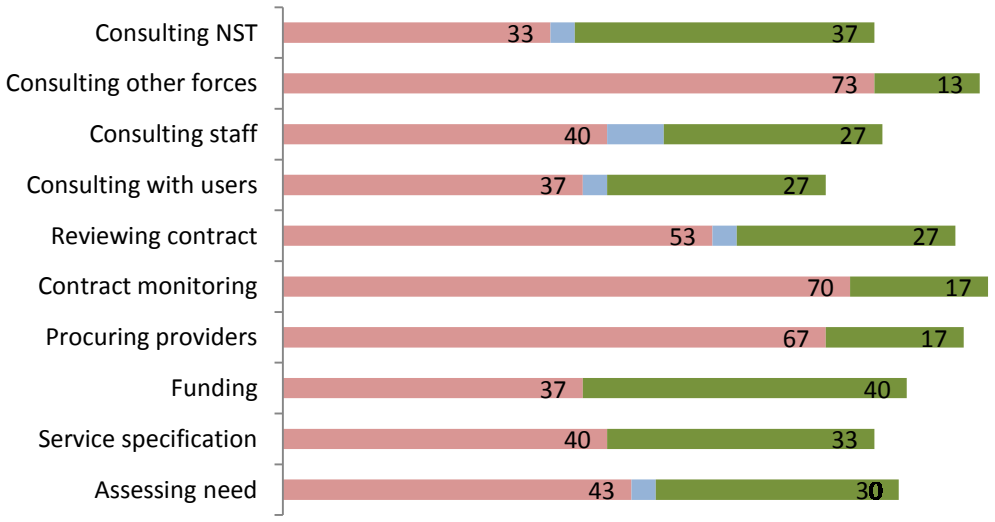
Multi-agency arrangements in place to support commissioning (% all forces)



PCT: Primary Care Trust LA: Local Authority CSP: Community Safety Partnership
CDRP: Crime and Disorder Reduction Partnership
Responses do not total 100% as some forces had multiple arrangements in place

Joint working was in evidence across all the main tasks associated with planning, funding and procuring the service. However, this experience is concentrated in relatively few police forces. 15% of forces worked jointly with the NHS on 9 or 10 of these tasks, whilst 22% had no experience of working with the NHS. A further 41% reported working jointly with the NHS on only 1 or 2 tasks, which were mostly National Support Team (NST) visits and/or consultation.

Key tasks undertaken over past 2 years (% all forces)



red=police led blue=NHS led green=joint police & NHS led
NST : National Support Team

Overall, this suggests that joint working with the NHS is well developed in only a small minority of forces, and is not always embedded into existing joint accountability structures.

7 Resourcing commissioning within the police

Respondents were asked to list all staff within their police force who played a part in commissioning the service, along with details of how much time this took. They were also asked to list all the training staff had received related to planning, funding and procuring the service over the previous two years.

Three forces had a full-time member of staff leading on this service, with the role usually combined with project managing the development or implementation of the SARC. In all other forces, a number of different staff were involved, usually as a relatively small part of their full-time role. The most common of these were:

- the rape champion (strategic issues)
- procurement
- forensic services lead.

In a few forces, the role was aligned with custody services, but more commonly, it was aligned with forensic science services, serious sexual assault, rape or public protection.

The only training provided to police staff involved in commissioning this service was on procurement, which had taken place in 16% of forces over the past 2 years.

8 Analysis of the 'top nine' police forces

Results presented so far have shown how police forces fared in response to individual questions about different aspects of commissioning. This section provides an analysis of how well the 'top nine' forces are doing on the full range of commissioning tasks. The analysis is based on selecting the group of forces which included 20 or more service quality items in their contracts (using this as a proxy measure for high quality commissioning).

The analysis found that, for these forces:

- all had well specified clinical governance frameworks and standards, which were in line with NHS requirements
- 3 of the 9 still had clinical governance issues with providers, despite good specifications of clinical governance in contracts
- all but one used block contracts – although this type of contract is often used for specialised or low volume services, it can make performance harder to manage with providers
- the limited performance and quality data sets reported by providers mean most forces would struggle to actively manage their contracts

- only 4 forces were commissioning independently of providers – the remainder relied to some degree on providers, either to provide clinical advice or to provide input to service specifications
- joint working with the NHS on key commissioning tasks was very limited, with police leading most of the work, and only 2 of these forces collaborating with the NHS on most tasks
- accountability structures were police-led (either SARC development groups or Rape Steering groups)
- all were facing significant challenges in securing a high quality service – including some of the 'basics' such as response times, recruitment and retention, availability of paediatricians and female FMEs.

Overall, this analysis highlights that even in the forces with well developed service specifications, commissioning is not particularly well developed, with the notable exception of 2 or 3 forces. Although this group of 'top 9' forces cover clinical governance arrangements well in their contracts, some still find that providers do not implement these arrangements fully. There is also evidence that most are not commissioning independently of their providers and do not always use commissioning levers to drive up the standard of providers' services to victims.

9 Views about future commissioning

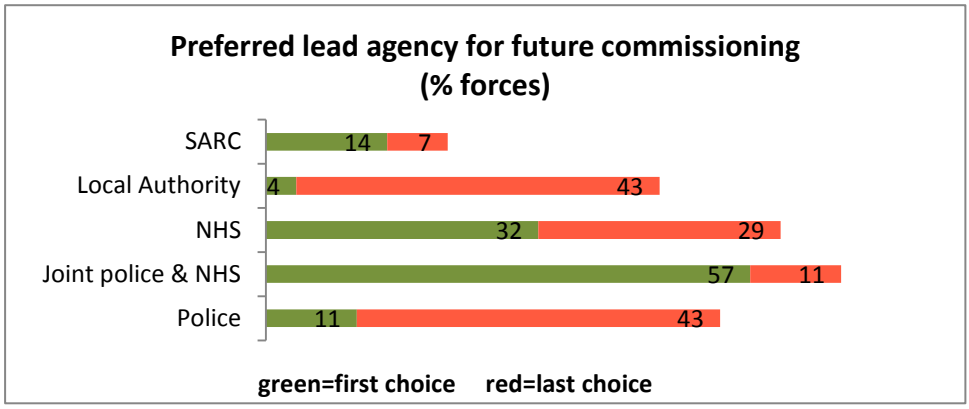
Police views

Respondents were asked to provide their views about the pros and cons of different agencies leading the commissioning of the service in future. They also scored each option on a scale of -3 to +3. The options were as follows:

- Police (as now)
- Joint police and NHS (accountable to a multi-agency group such as the Community Safety Partnership)
- NHS (currently Primary Care Trusts but due to be abolished by 2013)
- Local Authorities (led by public health, following transfer from PCTs)
- SARCs (supported by the NHS and police).

These options were based on the most likely available options as at September 2010, following publication of the NHS White paper in July 2010, but prior to the publication of further guidance later that year. The SARC was included because piloting of the questionnaire raised this as a viable option, even though the SARC is technically a provider service.

The chart below shows the preferred option to be joint commissioning by the NHS and police, followed by the NHS. The least preferred option was the Local Authority followed by the Police. It is interesting to note the lower response rates for two of the options, the SARC and the Local Authority. Some respondents noted that they did not know enough about the Local Authority to offer an opinion on this option, and the responses from others indicated that they were considering the Local Authority in general rather than the public health function.



Scores were also averaged to provide a second analysis of views, as shown in the table below. This shows that forces without SARCs rated four out of five of the options positively. In contrast, forces with SARCs rated only one option positively – the joint police and NHS option. This may reflect their experience of needing to work with the NHS in developing SARCs. However, responses to a separate question about joint working over the past 2 years found limited joint working between the police and the NHS even for forces with SARCs.

Respondents were then asked to consider two additional NHS options, given that PCTs will be abolished:

- GP consortia (groups of practices holding the budget for most of the healthcare needs of their population)
- Specialized services commissioning (specialized and costly services commissioned across large areas on behalf of the NHS Commissioning Board).

Specialized services commissioning was a positively rated option whereas GP consortia attracted the lowest score of all options.

Average preference scores for agencies leading future commissioning (% forces)			
Lead agency	**Forces with SARCs**	**Forces without SARCs**	**All forces**
Police	-0.8	-0.4	**-0.7**
Joint police and NHS	1.7	1.1	**1.5**
NHS	-0.1	0.4	**0.1**
Local Authority	-1.6	0.2	**-1.1**
SARC	-0.1	1	**0.2**
GP consortia	-1.7	-0.8	**-1.4**
NHS Specialized services	1.3	1	**1.2**
Preferences rated from +3 to -3. Positive scores shown in green, negative scores in red.			

The next table summarises respondents' views about the main pros and cons of each agency leading the commissioning of the service in the future.

Most respondents did not provide detailed responses about the Local Authority, GP consortia or NHS Specialized services leading future commissioning. Detailed responses were given for the police, the NHS and the joint police and NHS options.

Pros and cons of different agencies leading commissioning		
	Pros	**Cons**
Police	**Police retain control and can make it happen (16)** Police evidence and forensic needs will be met (12) Prosecution needs met (7) Directly contracted FSEs able to stay in police 'family'	**Lack of clinical understanding and leverage with clinicians (13)** Hard to influence health services which victims need (6) Funding burden remains with police (4) Recruitment problems hard to tackle
NHS	**Able to commission good quality clinical governance (9)** Able to influence health services which victims need (9) Expertise in commissioning quality health services (8) Similar ethos to the police Could help with recruitment and retention	**Loss of focus on meeting police's forensic and prosecution needs (12)** Changes in NHS make it unwise for now (4) Loss of police expertise (3) NHS slow, bureaucratic and find partnership working a challenge NHS organisations would need to collaborate across a big geographical area Funding could be threatened or diverted to other services
Joint police & NHS	**Able to share control and influence over the service (16)** Able to share best practice in both sectors and correct balance between clinical and judicial perspectives (11) Shared funding (5)	**Too complex (7)** Involves too much compromise (7) Overall responsibility and accountability would be unclear (4) No leverage to make it happen Different cultures of police and NHS

Pros and cons of different agencies leading commissioning		
	Pros	**Cons**
Local Authority	More influence over range of other services for victims Possibly cheaper Could link with sexual health (if this transfers to LAs)	**Lack of knowledge about criminal justice system (7)** Needs of police and victims' healthcare needs unlikely to be met Not a core priority Funding could be threatened or diverted to other services
SARC	Used to dealing with lots of different agencies Could develop tailor-made services for victims	No spare capacity No commissioning expertise, procurement expertise limited Too small to have much influence
GP Consortia	Able to tap into local knowledge and wider services for victims Potential conflict of interest where GPs are FSEs Good clinical governance systems	Not suitable for low volume service Would require consortia to collaborate to get geographical coverage – consortia may not agree Low priority compared with more visible and high volume services
Specialized services commissioning	Used to planning and commissioning across large geographical areas Could fit with some specialized services	Low priority as low volume service Large geographical area could result in loss of local focus Detached from police needs
Numbers in brackets indicate number of respondents where this number is 3 or more.		

NHS views

Six telephone interviews were subsequently undertaken with PCT leads for the service during November and December 2010. Nine police forces which had responded to the questionnaires were selected and approached in order to find out who they had worked with in their local PCT(s) on the FSE service. These forces were selected to get a mix based on:

- rural and urban areas
- different parts of the country
- SARCs and no SARCs in place.

The six PCT staff who were interviewed had the following roles:

- sexual health services commissioner, in public health – 3
- joint commissioner for sexual health (NHS and Local Authority) – 1
- SARC project manager – 1
- health protection lead (public health) – 1.

Their expressed preference for the agency to lead future commissioning of the service ranged across the options:

- police – 2
- Local Authority (as part of public health's role in sexual health) – 2
- joint between NHS and police – 1
- Specialized services – 1

The range of pros and cons put forward were similar to those expressed by police respondents to the questionnaire. Key points which came through were as follows:

Police Considerable value was placed on the police's ability to get things done quickly and effectively, and where the police were seen as commissioning a good service, there was no benefit in making a change. Although two interviewees emphasized the importance of meeting police evidence and prosecution needs, this point was missed entirely by the remaining four interviewees, whose responses were dominated by healthcare concerns. This highlights a very significant risk of transferring the commissioning to the NHS. Although this could help address victims' wider healthcare needs and improve clinical governance, there is the potential that NHS commissioning leads to a reduced focus on FSEs providing high quality evidence which assists successful prosecution for rape and sexual assault.

Joint police and NHS Although only one interviewee preferred this option, a number emphasized the importance of good working relationships between the police and the NHS in commissioning this service, irrespective of which agency took the lead. Collaborative commissioning was suggested as an alternative to joint commissioning, with one agency leading and being held to account for delivery. This reflected the mixed experiences of joint working of some of the interviewees, where lack of clarity about accountability can make joint working slow and ineffective.

Local Authority A number of the interviewees expressed the view that the service should "go wherever sexual health goes" (these interviews pre-dated the publication of guidance about the future of public health) although others thought that it was more of a mainstream healthcare service and did not fit well with public health's future role in prevention and health improvement. Loss of buy-in from the NHS was highlighted as a potential risk.

NHS Two key points were that there is no obvious right place for the commissioning of this service in the NHS, and that there could be very real dangers in transferring this responsibility to the NHS at a time of when large-scale change may result in organizational instability and staff role changes.

GP Consortia This option was unanimously rejected, with interviewees emphasizing the expected difficulty of getting GPs to work collaboratively across different consortia, based on their experience of working with GPs. They also noted that it was unlikely to be a priority for GPs, particularly in the next few years, and could therefore become a neglected service.

Overall, these interviews did not raise any new issues, but the emphasis was somewhat different. Whilst many police respondents thought the transfer of commissioning to the NHS would have significant benefits, staff within the NHS were more sanguine about whether these would be realized given the lack of an obvious 'home' for it in the NHS and the forthcoming organizational changes.

10 Summary of key findings

Commissioning for quality Significant numbers of forces appear not to be using commissioning levers to achieve a high quality service for victims, although these aspirations are evident in how they frame the challenges they face and their priorities for the future. A number of forces also seem to be focused on what can only be described as 'the basics', of getting a reliable well-trained workforce which meets acceptable response times and provides victims with choice about the gender of the FME.

Victims' healthcare needs There is clearly an aspiration to work closely with the NHS in order to link victims into a wider set of healthcare services. However, some forces appear to have missed opportunities to specify that FSEs should assess needs holistically, provide immediate treatment and refer victims on to other services. Many forces feel they are not well equipped to influence the NHS to meet victims' wider healthcare needs.

Clinical governance The majority of forces appear not to have commissioned properly resourced clinical governance arrangements, where clinical leads take responsibility for governance, and FSEs 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 FSEs are directly employed by the police, there is qualitative evidence that the police may therefore struggle to hold the FSEs to account, support them adequately or enforce change.

Procurement or commissioning There is some indication that the police focus on procurement of the service rather than commissioning. The latter involves a wider set of activities including needs assessment, consultation and review. There was some evidence that procurement with the independent sector has been seen as a mechanism for driving up standards and resolving difficulties around clinical governance or directly managing doctors.

Provider influenced commissioning There is good evidence that many forces have found it hard to engage the NHS, and PCTs in particular, in order to advise them about clinical standards and governance arrangements which need to be specified with providers. Although some forces have taken advice from elsewhere, others have relied on providers to advise them. This is not ideal as it potentially gives providers undue influence, which could conflict with their interests as providers.

Standard of commissioning The survey findings suggest that there is a high standard of commissioning in only 2 or 3 forces, although a larger minority of forces provided evidence that they are already trying to tackle quality and clinical standards. In contrast, most of the forces without SARCs appear not be commissioning the service at all adequately (with a couple of notable exceptions).

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 FME 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.

Overall, results from the commissioning questionnaire point strongly to a fairly poor standard of commissioning of the FP service for sexual assault, although there is significant variation across the country. At one end of the scale, there are a minority of forces which procure the service on a rolling sessional basis from individual doctors, without specifying standards and clinical governance arrangements. At the other end of the scale, is a small minority of forces where clinical governance appears to be in line with NHS expectations, with the service specified in detail. However, even these forces are faced with significant challenges in securing a consistently high quality service which is fast, offers choice of gender of FSE, with FSEs skilled to meet the full range of victims' healthcare needs as well as meeting police needs for high quality evidence in statements and in court. There is also some evidence that the majority of the forces with a higher standard of commissioning are possibly open to undue influence by providers, as they lack independent clinical advice and most have developed service specifications jointly with their providers.

Case Studies

This section is brief and highlights some themes from case study visits. The case study visits were invaluable to our understanding and appreciation of the service. The knowledge gained from the visits informs the whole of this study, so that the reductive approach here is not a reflection of the full impact of this strand of research.

Sampling Criteria

	Urban	Rural
SARC	Case Study 1	Case Study 2
Non-SARC	Case Study 4	Case Study 3

Approach

For each case study the following steps were covered:

- Issue briefing material
- Exploratory Interview to explore pathway – determining people to interview
- One or two day visit (researcher + assistant)
- Site visit and interviews
- Transcribe interviews
- Summarise findings

Structure of Findings

The case studies provided a wealth of detailed information, giving insight into:

- Pathway from assault to police, forensic examination, follow up health services, and criminal justice system
- Role of practitioners including:
  - police (controller in radio room who handles the call; Force Duty Officer who co-ordinates resources for the whole police authority area and arranges appointment with forensic physician; Specially Trained Officer, formerly known as 'Nightingale' Officer, who is the first point of face to face contact with the victim)
  - Crisis Worker who develops a rapport and acts as an advocate
  - ISVA
  - Adult Forensic Physician who collects evidence and maintains independence from the victim, sharing evidence with police
  - Paediatricians supporting or undertaking forensic examinations
  - Service manager (especially in a SARC)
  - Clinical director

- Physical layout of services, forensically clean areas and equipment used, e.g. colposcope which provides visual photographic evidence (or physical evidence if the light source is attached to a speculum);
- Process of taking and recording evidence – police take and bag clothing; forensic examination needs to be undertaken in forensically clean and secure setting to avoid contamination;
- Dynamics relating to the victim – importance of communication, trust and follow-up;
- Distinction between acute cases (mainly adult) and chronic or historic cases (mainly children);
- Timescales: response times and duration of forensic encounter (1-3 hours);
- Pressures facing forensic physicians, e.g. demand and pressure of custody care workload; isolated working and lack of peer support discourages women from becoming FPs; the prospect of going to court as a source of fear and ' deal breaker' that inhibits recruitment to the specialty
- Distinction between forensic physician role in custody cases and sexual offences (summarised for one case study interview below).

Results of One Interview with FP in a SARC

Custody Work	Sexual Offence Work
• FP is advocate to the detainee • Similar mix of people as in SOE client group, in terms of vulnerability[53] and socio-economic characteristics • FP provides *Statement of Fact* as a professional • FP sees scope for substitution with nurses	• FP is independent (so the Crisis Worker is essential to the role of advocate) • Similar mix of people as in custody care client group • FP provides an expert witness opinion[54] • FP does not see scope for substitution with nurses[55]

- What works well:
    - Use of Crisis Worker and Forensic Physician working together on a case;
    - Supervision for Forensic Physicians and support from a Clinical Director is reassuring: "you know you are backed up";
    - Structured training is important.

[53] See Annex 8, "Impact on Equality"
[54] In another case study it was noted that in practice most FPs are only required to provide a 'statement of fact'
[55] This is an individual and not a universally-held view.

Patterns that Emerged

Case Study 1 – Urban SARC	Case Study 2 (rural and urban) SARC

• **High quality standards:**
  ○ 100% Female physicians
  ○ Dedicated paediatric expertise
  ○ Dedicated facilities
• **FP Recruitment by NHS:**
  ○ GP level, well remunerated
  ○ No recruitment problems (there is a waiting list of GPs who would like to become FPs)
• **Clinical governance:**
  ○ Supervision by clinical director
  ○ Structured training is provided in-house
• Autonomous Forensic Nurse Practitioners piloted but not recommended as a model for the future
• High level of resource
• Successfully integrated with police
 	
<u>Contribution to study:</u> Provides a quality benchmark to allow resource comparison / extrapolation with other parts of the country. Shows good model of governance and joint working.
	• **Variable quality standards**:
	  ○ Dedicated facilities
	  ○ Follow-on treatment and support
	  ○ Integral sexual health pathway
	  ○ Few female FPs
	  ○ Response times variable if female FP wanted/full custody workload
	  ○ Limited paediatric availability OOH
	• **FP Recruitment by private provider:**
	  ○ Problems with recruiting female FPs
	  ○ Some previous FPs spoken and written English and communication skills very poor
	• **Clinical governance:**
	  ○ Weekly review of cases
	  ○ Monthly reporting of quality issues to contracts officer
	  ○ Clinical consultation to FPs by Clinical Director, plus weekly team meetings with SARC staff
	• Reasonable level of resource
	• Successfully integrated with police with joint funding and commissioning
	
	<u>Contribution to study:</u> provides example of jointly funded provision and good clinical governance arrangements.

Case Study 3 – Rural Non-SARC	Case Study 4 – Rural Non-SARC
• **Variable quality standards**: o Few female FPs o Little to no access to paediatricians in or out of hours o No integrated clinical or referral pathways o Little follow-up of treatment or referrals • **Premises and equipment** o 12-14 sympathy suites o All forensically cleaned but not sealed and not checked if properly cleaned o Paediatric facility in hospital potentially used by others after forensic cleaning as door left unlocked • **FP Recruitment by private provider:** o Good quality FP practitioners provided o Problems with recruiting female FPs • **Clinical governance :** o Clinical supervision, training and appraisal of FPs by contractor's Clinical Director o Induction, simulation and additional specialist training provided e.g. on adolescents as key need • Increasingly reduced level of resource • Good integrated work between contractor and police <u>Contribution to study:</u> provides comparable rural example of provision in area where prosecution rates are amongst the lowest in the country over a five year period	• **Variable service standards:** o Few female FPs o Response times variable o Limited paediatric availability out-of-hours o No clinical or referral pathways o Focus on forensic exam to the exclusion of healthcare needs • **Premises and equipment** o Large minority of premises forensically sub-standard o Some good quality premises o Lack of paediatric facilities • **FP recruitment by police** o Flexible and loyal workforce o Occasional recruitment problems o Forensic nurse recruited o Individual FPs hold rolling contracts with the police • **Clinical governance** o No formal system o Some audit & peer review o No clinical lead o No funded on-going training <u>Contribution to study:</u> Provides insight into problems of scale and travel time faced in rural areas.

Professional Education, Accreditation and Structure

Context - Fragmentation and Lack of Training

In 1998, the Audit Commission published its report on the provision of forensic medical services to the police[56] and this led to several police forces beginning a process of outsourcing the service to commercial providers. The Baseline Survey (Annex 2) suggests that by 2010, 62% of services in England have been outsourced.

Forensic physicians were traditionally drawn from General Practitioners with a sub-specialist interest. Outsourcing coincided with a reduction in the number of GPs offering themselves as FPs, due to the advent of GP out of hours co-operatives and new GP contract in 2004. Commercial providers were more likely to use doctors trained outside the United Kingdom who were part-way through their speciality training, working on a full time basis. Service models have also changed, with greater input in general custody care work from paramedics and nurses[57].

A study in 2008[58] found that nearly 30% of doctors surveyed, who were working in forensic medicine, had not undertaken any formal training for the forensic role, in the form of Introductory Training Course (ITC). The study also found that these doctors were less likely to be aware of clinical errors: "doctors who have not completed an ITC do not think they have had adverse incidents in relation to patient safety and have not missed forensic evidence", commenting that ''you don't know what you don't know" and asking "In what other branch of medicine would a doctor be allowed to work without appropriate training?"

Formation of FFLM

While there has been fragmentation in the service, the healthcare professions have tried to introduce standards. The Faculty of Forensic and Legal Medicine was founded in 2006 within the Royal College of Physicians, with a plan to establish a training pathway in Forensic and Legal Medicine and to achieve specialist recognition of the specialty. (FFLM is discussing credentialing with the GMC to enable forensic medicine to be recognized as an area of distinct practice, even though it is not currently formally recognised as a registered specialty).

Accredited courses are being developed, e.g. the St Mary's Course, has been developed by St Mary's Hospital, Manchester as an introductory course for doctors wanting to work as sexual offence examiners which is accredited by the University of Manchester and which is endorsed by the FFLM.

[56] Audit Commission. The doctor's bill, The provision of forensic medical services to the police; 1998.
[57] Payne-James JJ, Anderson WR, Green PG, Johnston A, "Provision of forensic medical services to police custody suites in England and Wales: Current practice", Journal of Forensic and Legal Medicine 16 (2009) 189–195
[58] Wall, I.F. (2008) Lack of training in custodial medicine in the UK: A cause ... Journal of Forensic and Legal Medicine, Volume 15, Issue 6, August 2008, Pages 378-381

FFLM has developed a set of training and quality standards (October 2010) which paves the way towards clinical governance in the profession, e.g. the doctor must attend an FFLM approved ITC before commencing work.

The Baseline Study shows that recruitment of qualified doctors is difficult (within contract funding) and that training patterns are variable, often conducted on the job rather than before the job.

Introduction of DFCASA

The Diploma in the Forensic and Clinical Aspects of Sexual Assault (DFCASA) was introduced in 2009. The Department of Health has funded development 2009-11 to establish it as a basic qualification for doctors, nurses and midwives to improve quality of service to victims of sexual violence. The Diploma is designed and run by the Society of Apothecaries, and has been developed to meet with GMC requirements. It is currently in its second year of development and needs to have produced three completed cohorts before GMC recognition can be sought. DFCASA is being promoted among medical and nurse-post graduates as the national basic standard for all clinicians undertaking sexual offences work and as an entry requirement for further training on advanced practice (which would be conducted via FFLM).

Children

The Royal College of Paediatrics and Child Health (RCPCH) and the Faculty of Forensic and Legal Medicine (FFLM) have developed Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse (where 'a child' is defined as anyone under the age of 16)[59].

"A paediatric forensic examination will be required whenever a child has made a disclosure of sexual abuse, or sexual abuse has been witnessed, or when a referring agency strongly suspects abuse has occurred. It consists of the clinical history and examination, detailed documentation (including the use of line drawings) and photo-documentation, as well as obtaining any relevant forensic samples, writing a report and arranging any necessary aftercare. It is every examiner's responsibility to ensure that there is a therapeutic and supportive environment for the child and carer(s) during the medical examination."

[59] Agreed by the Council and the Standing Committee on Child Protection of the Royal College of Paediatrics and Child Health and the Academic Committee of the Faculty of Forensic and Legal Medicine, October 2007

"**Single or Joint examinations.** A single doctor examination may take place provided the doctor concerned has the necessary knowledge, skills and experience for the particular case. When a single doctor does not have all the necessary knowledge, skills and experience for a particular paediatric forensic examination two doctors with complementary skills should conduct a joint examination. Usually such examinations involve a paediatrician and a forensic physician (forensic medical examiner, police surgeon, forensic medical officer). However, it may be necessary to involve another medical professional such as a genitourinary physician or family planning doctor, if the case demands it."

The fieldwork identified a significant level of anxiety about the safety of services for children. A minority of FPs have paediatric expertise and few paediatricians wish to become involved in this area of work. As a result, lack of a suitably trained doctor was a cause of either (a) delay in undertaking the examination, or (b) lack of confidence about the standards of evidence-taking.

Feasibility Study on Commissioning Forensic Medical Examinations for Sexual Assault

The Faculty of Forensic and Legal Medicine (FFLM) was established in April 2006 and has been founded to achieve the following objectives:

(a) To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine;
(b) To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

The Faculty includes three different professional groups:

- Forensic physicians
- Medically qualified coroners
- Medico-legal advisers to the medical defence organisations.

Forensic physicians include those doctors who provide medical care to complainants of both violent and sexual offences and also to those who are detained in police custody on suspicion of these crimes. We are committed to the development of high standards and, as advised in the recent *Violence Against Women and Children Taskforce Report*[60] along with the Government's interim response[61], it was agreed that the Faculty should set those standards in conjunction with the Forensic Regulator. This we have done; the quality standards have been refined following a public consultation exercise and we have consulted the Forensic Regulator who is supportive of them. We have requested that ACPO and ACPOS distribute them to all police forces.

In addition we have developed a membership examination (MFFLM) as the specialist qualification for doctors that undertake this type of forensic medical work. We also support the Diploma in Forensic and Clinical Aspects of Sexual Assault (DFCASA). This examination is set at a lower level but is appropriate for both doctors and nurses.

[60] Responding to violence against women and children – the role of the NHS. The Report of the Taskforce on the Health Aspects of Violence Against Women and Children. March 2010.
[61] Interim Government Response to the Report of the Taskforce on the Health Aspects of Violence Against Women and Children. March 2010.

We are aware that in some forces nurses are being used to undertake examinations of complainants of sexual assault. Our experience of nurse examinations is mixed - in some areas it appears to be helpful. However in other areas it has not been a success and as a result some forces that have previously used nurses have no plans to use them again. It is not appropriate for nurses to undertake examinations of children as this is contrary to FFLM and Royal College of Paediatrics and Child Health (RCPCH) guidance. What is important is that if nurses are to be used to examine adult complainants they must be appropriately trained, skilled, experienced and qualified. The Faculty is therefore to embark on a public consultation exercise to develop standards for other healthcare professionals both in sexual offence and custodial forensic situations.

The faculty is of the opinion that the NHS should commission forensic medical services but they must be adequately funded and have quality standards built in. They should be commissioned at a high level and not via local commissioning bodies.

Professor Ian Wall

31 December 2010

President

IMPACT ON EQUALITY

This annex contributes to the Equalities Impact Assessment which is required in addition to the general Impact Assessment supplied to the Department of Health. Data is indicative as it is based on small samples collected through a special supplementary exercise.

The conviction rate for rape cases in England and Wales remains alarmingly low at 6.5% of cases reported in 2007/8. The research that is available pertaining to England (Grace et al, 1992[62]; Lees & Gregory, 1993[63]; Harris & Grace, 1999[64]; Lea et al, 2003[65]) found the highest proportion of cases are lost at the earliest stages of the justice process – at policing stage – of which the forensic medical examination is an intrinsic part. It is incredibly important that forensic medical examinations in rape cases are conducted appropriately, firstly, to contribute appropriate evidence to support rape investigations and prosecutions, and secondly, to ensure the victim is not additionally traumatised by the rape investigation process.

As part of this feasibility study, we undertook an equalities impact assessment, to assess whether there were any attitudinal, physical or social barriers that need to be considered as part of the case for change. The areas considered included disability, gender, race, age, sexuality, religion or belief, carers and vulnerability of victims as street workers or as people living in rural areas.

Disability

Prevalence: We gathered data on disability for two areas to provide some indicators of need. In a mixed urban and rural area with a population of around 1.5 m, 9% of victims were recorded as having a disability:

Disability	**%**
Learning disability	2.2
Physical disability	5.6
Physical and Learning disability	1.1
No disability	91.0
Total	**100.0**

[62] Grace, S., Lloyd, C. & Smith, L, (1992) Rape: From Recording to Conviction, Home Office Paper 71, London: Home Office

[63] Lees, S. & Gregory, J. (1993) Rape and Sexual Assault: A Study of Attrition, London: Islington Council Police and Crime Prevention Unit

[64] Harris, J. & Grace, S. (1999) A question of evidence?: Investigating and prosecuting rape in the 1990s, Home Office Research Study 196, London: Home Office

[65] Lea S., Lanvers, U. & Shaw, S. (2003) Attrition in rape cases: developing a profile and identifying relevant factors, British Journal of Criminology 43: 583-599

In an urban area with a population of around 187k, on average 27.6% of victims were recorded as having a disability:

Disability	**%**
Learning disability	5.8
Physical disability	1.6
Mental Health (presenting)	20.2
No disability	72.4
Total	**100.0**

Evidence from this case study site showed that women with mental health problems seemed vulnerable to repeat rape (9% of women with mental health problems). Also, 57.3% were assessed as being vulnerable due to their circumstances

Vulnerability	**%**
Psychiatric History	36.0
Substance Misuse	9.1
Domestic Violence	11.6
Street Work	0.7
Sub-Total	**57.3**

Attitudinal and social barriers: There are two parts to the forensic examination, the first being to take an account of the victim's health and sexual history and make a needs assessment, before the second part involving physical evidence collection. Victims' needs should be fully assessed, taking into account vulnerability - risk of self harm, mental health or disability. Evidence from interviews during the feasibility study shows that a key area of weakness was in the assessment of need during this first part of the process, with some FPs not wishing to spend long with victims, so going through assessment questions expediently:

"Some of the male FPs are not particularly interested in sexual assault and it is just one small part of their work. So they treat victims in a fast way – take samples and get away."

"There are some tick box doctors. Maybe not so rigorous and don't always have the right background and experience."

The psychological trauma of rape for example post traumatic stress disorder (PTSD) is rarely considered in assessments of need during forensic examinations (Lira et al, 1997)[66].

[66] Lira, L. R., Jimenez, R. E., Saltijeral, M. T. & Caballero, M. A. (1997). Mental Health Attention Needed By Violated Women. Salud Mental, 20, 47-54

Access to aftercare is essential in order to treat for possible sexually transmitted infections, including HIV, and provide support and testing for possible pregnancy (Dennis, 2010[67]; Resnick et al, 2000[68]; and Sadler et al, 2000[69]). In rural areas follow-up care may require travel to more than one clinic on several occasions; this is exacerbated where a victim may have a learning disability or mental health problems or be vulnerable due to substance misuse.

Physical barriers: not all facilities had disabled access and toileting facilities.

Workforce issues: the psychological stress among staff induced by working with sexual offences is high, with one area reporting that rape and child sexual abuse accounts for the highest number of referrals to occupational health for police officers. This is likely to be a similar source of stress for Forensic Practitioners, which adds to the case for good clinical supervision of staff involved.

Gender

Prevalence: Across a sample of 15 of the 39 English police authority areas, the average percentage of female victims is 93% while men account for 7% of victims.

Attitudinal and social barriers: No barriers were identified by the research, in relation to gender.

Workforce barriers: A significant barrier related to the composition of the FP workforce. Most victims of sexual assault are women (93%), but research suggests both female and male complainants in rape and sexual assault cases would prefer to be examined by a female doctor, with one-third of women reporting that they would refuse an examination if only a male doctor was available (Chowdhury-Hawkins, 2008)[70]. This is supported by Department of Health, Home Office and Association of Chief Police Officers (ACPO)[71] research which suggests 77% of victims (male and female) would prefer a female examiner and 45% of victims would not agree to clinical examination by male examiners.

[67] Dennis, A. (2010). Assessing Sexual Assault Survivors' Access To Emergency Contraception: Results From A Mixed Methods Study In South Carolina. Womens Health Issues, 20, 248-253

[68] Resnick, H. S., Holmes, M. M., Kilpatrick, D. G., Clum, G., Acierno, R., Best, C. L. & Saunders, B. E. (2000). Predictors Of Post-Rape Medical Care In A National Sample Of Women. American Journal Of Preventive Medicine, 19, 214-219.

[69] Sadler, A. G., Booth, B. M., Nielson, D. & Doebbeling, B. N. (2000). Health-Related Consequences Of Physical And Sexual Violence: Women In The Military. Obstetrics and Gynaecology, 96, 473-480.

[70] Chowdhury-Hawkins, R., McLean, I., Winterholler, M. & Welch, J. (2008), Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs), Journal of Forensic and Legal Medicine, Vol. 15, No. 6, pp.363-7

[71] Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres, Department of Health, Home Office, Association of Chief Police Officers; October 2009

The Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres (SARCs) sets out ten minimum standards including Minimum Element 3: Choice of gender of physician, wherever possible:

- Victims can choose the gender of forensic physician for their clinical examination
- Adequate access to female forensic physicians to meet expected patient choice.

Previous reports articulated a concern about the lack of availability of female medical examiners (HMIC & HMCPS, 2007; Chowdhury-Hawkins, 2008). On this latter issue, the vast majority of forensic medical examiners are male (HMCPS & HMIC, 2002)[72].

Responses to our Baseline Survey A show limited and uneven access to a female FP, with an average of 61%:39% female to male doctors, compared to 93%: 7% female to male reported victims. In some areas fewer than 20% of doctors are female.

Race

Prevalence: The proportion of victims from black and ethnic minority (BME) communities varies between police authority areas. Our sample shows 14% BME in a densely populated urban area and 5% BME in a more rural/ suburban area. It is not known how these prevalences compare to population profiles.

Attitudinal barriers: Sensitivity to victims and cultural competence is important, not least in relation to women and men from BME communities, and those with English as an additional language.

Interview data with health and police staff and Clinical Directors in SARCs, revealed that there can be a poor standard of spoken communication among some FPs, and a lack of empathy:

> "...a young Romanian girl who did not speak English, was examined ... during the examination, there was no demonstrable understanding by Dr. X that different communication skills were needed due to language barriers, and that trauma for both abduction and rape needed to be considered."

[72] HMIC & HMCPS (2007) Without Consent: A Report On The Joint Review Of The Investigation and Prosecution Of Rape Offences, London: HMIC

Age

Visits to case study sites indicated that the majority of victims are between the ages of 16-35, and 'acquaintance rape' is the most common experience found. There are still pockets of professionals who demonstrate an attitude of 'disbelief' towards acquaintance rape (Bell, Kurilof and Lottes, 1994)[73]. A victim is held more likely to be held responsible for what happened when she was acquainted with the rapist (Bridges and McGrail, 1989)[74]. The literature suggests that 'stranger' rape is more 'believable' to society (Costin, 1985)[75].

In addition, women who are raped in a social context are less willing than those raped by a stranger to seek help at the time of the assault, to receive medical attention, or to report the rape to the police (Renner and Wackett, 1987)[76].

Interviews with police on one case study site revealed that young women are less likely to be believed than older women or men reporting rape, where all assaults were classified as acquaintance rape. This was also the case for female street workers.

The percentage of total rapes related to children varied from 12% to 50% across case study sites. Rape and sexual assault services for children and young people have been highlighted as being weak across England. Evidence from interviews, stakeholder event feedback and case study visits suggests lengthy waiting times for acute paediatric cases, particularly out-of-hours. Low volumes of cases make on-call rotas very expensive or not viable unless covering a very large area and few NHS Trusts appear to include this work as part of paediatricians' contracts. Survey B showed that the most frequently reported priority for future improvement was paediatric forensic examinations and facilities.

Sexuality

Prevalence: Male rape accounted for an average of 7% of all reported rapes. Of the 20 police authority areas that responded to Survey A, the highest was 17% male and the lowest was 0% male. Evidence from interviews with police and SARC staff suggested that most male rapes occur between gay men and are not reported. The police authority area where there was a high number of reported male rape cases, also had a good support group for

[73] Bell, S. T., Kuriloff, P. J., & Lottes, I. (1994) Understanding attributions of blame in stranger rape and date rape situations: An examination of gender, race, identification, and students' social perceptions of rape victims. Journal of Applied Social Psychology, 14, 1719-1734;

[74] Bridges, J. S.,& McGrail, C. A. (1989). Attributions of responsibility for date and stranger rape. Sex Roles, 21, 273-287.

[75] Costin, F. (1985) Beliefs about rape and women's social roles, Archives of Sexual Behaviour, Volume 14, No 4: 319-325

[76] Renner, K. E. and Wackett, C. (1987) Sexual Assault: Social and Stranger Rape, in Canadian Journal of Community Mental Health (Revue Canadienne de santé mentale communautaire) Issue: Volume 6, Number 1 / Spring 1987 Pages:49 - 56

gay men, which may have contributed to the high number of referals compared with other areas.

We have data from on police authority:

Sexuality	**%**
Bisexual	1.2
Heterosexual	38.8
Gay	0.2
Lesbian	2.8
Transgender	0.00
Not specified	57.0
Total	**100.0**

Attitudinal and social barriers: There was no evidence in relation to sexuality and forensic examinations; while it might be assumed that the gender of the FP would be important to Lesbians, other data suggests that this might be the case for both male and female victims (Chowdhury-Hawkins, 2008)[77].

Religion or Belief

The only evidence that presented itself during visits was in relation to gender choice of FP, where this was important for women and men from particular faiths which would forbid examination by someone of the opposite sex. Clearly the evidence above in relation to gender therefore also applies here.

Carers

Carers and relatives are usually involved in the reporting of rape and supporting someone when they present to the police or SARC for the first time as well as during the prosecution/conviction stages.

There was good evidence that SARCs took account of this by providing space for carers/relatives to wait and often relied on them where the victim was a child or young person. Acute presentations of children are rare, as the majority of reported rapes are historic; almost always a family member will be present during the examination of a child.

[77] Chowdhury-Hawkins, R., McLean, I., Winterholler, M. & Welch, J. (2008), Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs), Journal of Forensic and Legal Medicine, Vol. 15, No. 6, pp.363-7

In the case of young people, examinations mostly take place during the day so can have some impact on carers/relatives in relation to time of work, as it would later on, if the case went to court.

Other identified groups

There are two other sets of individuals who need to be considered in relation to equality:

- Street workers
- People living in rural areas

Street workers: street workers are often victims of both the trauma of rape and the attitudes of the police, healthcare and CPS staff, which are consistent with societal attitudes. While evidence shows that society and staff are likely to 'believe' stranger rape over acquaintance rape, this is not so for street workers. Amnesty International UK[78] found that:

- A third (34%) of people in the UK believe that a woman is partially or totally responsible for being raped if she has behaved in a flirtatious manner
- More than a quarter (26%) of people think a woman was partially or totally responsible for being raped if she was wearing sexy or revealing clothing
- More than one in five (22%) hold the same view if a woman has many sexual partners
- Around one in 12 people (8%) believe a woman is totally responsible for being raped if she has many sexual partners

People living in rural areas: Our research found that access to secure forensic examinations, timely examinations by a female FP, immediate healthcare and aftercare needs, are neither straightforward nor easily accessed in rural areas.
Where SARCs have been developed, the proximity of some elements of the service is distant from victims' homes, requiring a lengthy journey for the examination. Travelling back and forth to different clinics for aftercare can be difficult where rural transport is poor.

Conclusion

Gender is the main equality factor that is addressed by the proposal to improve service quality, with the aim of increasing choice of doctor gender to victims of sexual assault, who are predominantly female. The issue of poor communication and empathy among FPs has been identified in the Evidence Base and has an impact upon victims presenting as vulnerable and those from BME communities. Attention to equality principles is essential in order to further raise standards across the service as a whole.

[78] AIUK (2007) http://www.amnesty.org.uk/content.asp?CategoryID=10309