Honouring the Lived Experience

Chief Medical Officer's Taskforce to Improve Services for Victims of Rape and Sexual Assault

Option Appraisal Report

October 2018

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1. Executive Summary

In 2012, a Memorandum of Understanding was agreed between the NHS and the Police which set out the partnership arrangements for custody healthcare and forensic medical services. The transfer of responsibility for delivery of these services (from the Police to the NHS) took place in April 2014. Responsibility for health care in police custody is a function and responsibility of Health Boards under the Health Service (Scotland) Act 1978.

Forensic medical services (which cover the examination and collection of forensic samples from alleged perpetrators and victims of crime (including children) - are currently delivered by health boards but remain a function and responsibility of the Scottish Police Authority under section 31 of the Police and Fire Reform (Scotland) Act 2012.

In March 2017, the Chief Medical Officer (CMO) for Scotland, Dr Catherine Calderwood, was asked by the Cabinet Secretary for Health and Sport and the Cabinet Secretary for Justice, to chair a new Taskforce to set the vision and provide the national leadership required to support Health Boards to deliver consistent, person centred, trauma informed healthcare and forensic medical services and access to recovery for anyone who has experienced rape and sexual assault in Scotland, as close as possible to the point of need.

In October 2017, the CMO published a high level work plan which sets out a clear vision of how the Taskforce and its five sub groups wish to drive forward improvements over the next five years. The design and delivery of services sub group was tasked with making a recommendation to the Taskforce to ensure person centred, trauma informed, sustainable and accessible services across Scotland.

That work has now led to this formal options appraisal of the service model and service configuration. The scope for the option appraisal process was to include services for children, young people and adults.

In May 2018, at a meeting of the Taskforce it was agreed that a rigorous improvement approach was required to develop and appraise new service options for service delivery and give consideration to the service locations to ensure this criteria is met and progresses the vision for the taskforce outputs.

The Taskforce agreed to the appointment of an independent options appraisal lead, Kate Bell, NHS Lanarkshire to work closely with a sub-group of the taskforce as a short life working group (SLWG) chaired by Professor Elizabeth Ireland. Tansy Main, Rape and Sexual Assault Taskforce Lead and Jana Sweeney, Rape and Sexual Assault Taskforce have made a significant contribution to the planning, delivery and analysis of the option appraisal process.

This report delivers the remit set out by the Taskforce (May, 2018) to engage with a wide range of stakeholders in order to carry out a robust option appraisal process reflective of survivors of sexual assault & rape across Scotland.

The Option Appraisal event took the stakeholder group through a rigorous decision making process with recommended outcomes for the a multi-agency approach to service delivery that will ensure all those working in the field of forensic medical examination, social work and third sector organisations can deliver the highest quality of care, treatment and support to survivors. The event also recommended a service configuration model which features both a strong locally commissioned service with ongoing support for recovery within a model that will see centres of excellence developed across Scotland to meet the volume of need and ensure the best utilisation of staff required to meet the necessary standards and guidelines.

On June 27th, 2018 the all stakeholder engagement option appraisal process took place and arrived at the following recommendations:-

The service change proposals for forensic medical and healthcare services for approval by the CMO Taskforce (7th August, 2018) are:

- The recommended option for service delivery is:

Option 4 –Multi-Agency Centre/co-ordinated services for adults, children and young people who have experienced sexual assault and rape (acute and historic).

- The recommended configuration model for service delivery is:

Model D – Local services which meet the HIS standards, delivered as close as possible to the point of need and supported by a centre of excellence.

PLEASE NOTE: Centres and/or co-ordinated services will be developed as close as possible to the point of need owned, funded and delivered by the relevant Health Board (s) and Integrated Joint Boards. Island services as well as rural and remote mainland communities to be supported by centres of excellence[1].“Multi agency centres” and “centres of excellence” do not have to be a physical location. These terms can describe a collection of services delivered out with a physical space. The taskforce will explore in more detail how the option will meet in particular, the needs of children.

Model D has been re-worded to reflect the participants’ unanimous views shared at the option appraisal stakeholder event that the primary emphasis should be on locally delivered services, supported as appropriate by a centre of excellence. See page 13 for original wording.

[1]For a more detailed description of the centre (s) of excellence see page 21

2. Context

2.1 Purpose of the report

The purpose of this report is to enable the CMO Taskforce to approve and endorse the recommendations from the option appraisal stakeholder process. The report provides a detailed description of the work carried out during the option appraisal pre-work, development and decision making process culminating in the recommendations arrived at during the stakeholder engagement event held 27th June, 2018.

The recommendations from the option appraisal process will support the Taskforce in the delivery of its vision for people who have experienced sexual assault & rape in Scotland.

2.2 Taskforce Vision for Victims of sexual assault & rape

In March 2017, the Chief Medical Officer (CMO) for Scotland, Dr Catherine Calderwood, was asked by the Cabinet Secretary for Health and Sport and the Cabinet Secretary for Justice, to chair a new Taskforce to set the vision and provide the national leadership required to support Health Boards to deliver consistent, person centred, trauma informed healthcare and forensic medical services and access to recovery for anyone who has experienced sexual assault and rape in Scotland, as close as possible to the point of need.

The work of the Taskforce contributes to fulfilling the aims of the Scottish Government's Equally Safe[2] strategy which provides a framework to eradicate violence against women and girls in Scotland.

In October 2017, the CMO published a high level work plan which sets out a clear vision of how the Taskforce and its five sub groups wish to drive forward improvements over the next five years. The design and delivery of services sub group was tasked with making a recommendation to the Taskforce to ensure person centred, trauma informed, sustainable and accessible services across Scotland.

That work has now led to this formal options appraisal of the service model and service configuration. The scope for the option appraisal process was to include services for children, young people and adults. The Taskforce Vision is set out below.

The Task Force vision, as set out in the work plan is to deliver 'consistent, person centred, trauma informed healthcare and forensic medical services and access to recovery, for anyone who has experienced rape or sexual assault in Scotland'.

[2] http://www.gov.scot/Resource/0045/00454152.pdf

3. Short Life Working Group

In May 2018 at a meeting of the Taskforce held 15th May, 2018 it was agreed that a rigorous improvement approach was required to develop and appraise new service options for service delivery and give consideration to the service locations to ensure the criterion is met.

The Taskforce agreed to the appointment of an independent options appraisal lead, Kate Bell, NHS Lanarkshire, Head of Service Change & Transformation to work closely with a sub-group of the taskforce as a short life working group (SLWG) chaired by Professor Elizabeth Ireland. Tansy Main, Rape and Sexual Assault Taskforce Lead and Jana Sweeney, Rape and Sexual Assault Taskforce have made a significant contribution to the planning, delivery and analysis of the option appraisal process.

The short life working group membership was drawn from Taskforce members. The Terms of Reference for the short life working group were agreed as follows:

- Work with option appraisal lead to develop all relevant materials to inform the decision making at the event
- Work together to ensure the event and decision making reflects the needs of people with lived experience
- Further develop the current options for a service model (care, treatment, support) for people who have experienced sexual assault & rape.
- Develop models for the service configuration of the above model (service provision/where and how many).
- Establish the definitions of the quality attributes, benefits criteria, influencing factors to support decision making
- Agree the rankings and weightings of each of the options
- Agree who will present the service options and configuration models and agree how these will be described for the options appraisal event
- Attend the event as a key informant and if appropriate participate in the scoring of the models
- Review the event report as an accurate reflection of the process and support the chair of the SLWG to present the option appraisal recommendations to the taskforce at its meeting, 7th August, 2018.

An open, transparent and inclusive methodology was agreed to ensure that decisions about future service delivery and configuration would be informed by the views of people with lived experience and those who work in the services.

The approach included:

a) Building on work to date to develop options for the service model and service configuration in collaboration with key stakeholders, including those with lived experience.

b) Working up all aspects of the option appraisal approach through the SLWG to ensure an evidenced based approach to both the topic and service change methodology.
c) Ensuring inclusion of the work with Health Boards to undertake a guided self-assessment and gap analysis against the existing Healthcare Improvement Scotland standards (2017).
d) When the preferred service option and service configuration model are agreed, NHS Boards will act on this information together with the output from the HIS Standards self-assessment exercise, to help inform the development of a local, (costed) improvement and implementation plan for 2018-2020, to deliver the standards in the context of the agreed models.

4. Case for Change

As highlighted by the HMICS report, there is currently disparity in the quality and accessibility of services across Scotland.

Rape, sexual assault and all forms of gender based violence are a serious public health issue which is recognised as a violation of the most fundamental human rights. It can have short- and long-term consequences on women's physical, mental, sexual and reproductive health. Whether sexual violence occurs in the context of an intimate partnership, within the larger family or community structure, or during times of conflict, it is a deeply violating and painful experience for the survivor.'

The service model may vary according to the demographic or geographic nature of an area; however the resources and key elements of the current services try to ensure consistency of provision for service users nationally, with access to advice and information available 24/7.

The Taskforce and its sub groups are already progressing many different strands of work which will help NHS Boards and multi-agency partners to deliver the preferred model of service (the what) as well as the configuration of the service (the where/how many).

A Forensic Medical Examination (FME) of a victim of sexual crime has a dual purpose of addressing the clinical and health needs of the victim - at a time of significant trauma - as well as to collect forensic samples in support of a potential criminal investigation. However, delivery of these services has primarily been viewed through a justice, rather than a health and care lens. We know through feedback from people with lived experience of rape and sexual assault, that some individuals have received a health care response which has not been trauma informed or person centred. This can have a significant impact on their immediate and long term physical and psychological recovery.

These issues were highlighted in a HM Inspectorate of Constabulary in Scotland (HMICS) report published in March 2017 (A strategic overview of the provision of forensic medical and health care services to victims of sexual crime). The review

highlighted significant gaps and disparity across the country and made a number of recommendations to improve this.

The HMICS report stated:

“The evidence in this review confirms the need for national standards, and highlights wider issues affecting the quality of service delivered to victims of sexual crime. The review shows that significant disparity in the services currently provided, and supports the need for further investment in healthcare professionals, premises, and equipment. The priority for forensic medical examinations should be to address the immediate health needs and future recovery of patients, with the contribution to potential criminal justice proceedings being an important but not the sole consideration.”

At the moment, there are many different ways in which people can access a forensic medical examination and associated healthcare services following a rape or sexual assault. Adults who choose to report the crime can access these services through the Police. Some adults choose not to report to the police and self-refer to these services (where they are available). Others may contact Rape Crisis Scotland, their GP, their local sexual health clinic, NHS 24 (111 number) or the Breathing Space helpline for information.

An inter-agency referral discussion will take place between police and health and social work partners to determine the most appropriate course of action for a child or young person who discloses a rape or sexual assault. This may include referral for a forensic medical examination if appropriate. For children and young people, this would normally take place within a hospital setting by a Paediatrician and Forensic Medical Examiner.

The compelling Case for Change was set out in full as stand-alone document shared as pre reading material with all participants of the option appraisal event.

The recommendations of the options appraisal exercise is intended to help inform lasting and meaningful change for people who have experienced the trauma of sexual assault or rape. There is no doubt that they should be afforded the best possible healthcare response that the NHS (together with multi-agency partners) can provide and that is what we are striving to deliver.

5. Option Appraisal Stages

5.1 Stages of Option Appraisal

The standard option appraisal process is relatively straight forward and comprises five key stages.

Stage 1; Rationale for Intervention

- Research and understand the current position – business as usual
- Establish rationale for change
- Identify objectives (outcomes and outputs) to support the need for change

Stage 2; fully describe each option which can deliver the model

It is a requirement to also include a 'do nothing/do minimum' option at this stage for comparative and reference purposes only. Develop a long list and appraise this to reach a short list of viable options for multi-criteria decision making appraisal.

Stage 3; identify the benefits criteria

These are the measurable outcomes of the project which will allow the level of compliance of each option to be determined objectively and presented as a numerical score. It is a requirement to apply a weighting to each Benefit Criteria in order to reflect relative importance.

Stage 4; Option Appraisal process and assessment of non-financial benefits

A process where each option is considered against the agreed benefits criteria and a score allocated against the multi criteria with agreed weightings. The conclusion of this stage is to provide a tabulation of the relative scores which in turn identifies the relevant ranking of the non-financial benefits for each of the options.

Stage 5; Formal appraisal of the financial benefits

The financial appraisal stage sits out with the formal group decision making process and is carried out on the viable, deliverable options as recommended through the stakeholder engagement and scoring process.

Once the preferred service model and configuration are approved by the Taskforce, Health Boards will be expected to work with their multi-agency partners to develop costed plans for implementation, which will need to look at the aspects of the service to be planned and delivered on a local as well as a regional basis.

5.2 Event Approach and Methodology

The aim of the event was to measure all options, including the status quo against the agreed benefits criteria and scoring process to reach viable, feasible and deliverable service options and service configuration models.

5.3 Scoring Process and Methodology

All new policies, programmes and projects, whether revenue, capital or regulatory, should be subject to comprehensive but proportionate assessment, wherever it is practicable, so as best to promote the public interest. Core guidance is contained in the Green Book[3].

The option appraisal approach taken utilises best practice from decision making frameworks applied in major service change. The approach has at its heart the best interests of the service user whilst also ensuring the right service elements and crucially the right workforce model is in place to deliver the highest quality services across the range of disciplines.

5.4 Long List of Options

Table 1- Long List of Options (service delivery for adults, children and young people)

Number	Title
Option 1	Status quo (current service and considering the consequences of inaction)
Option 2	Improvement of existing services (Do minimum)
Option 3	Health Board specific approach with some elements of regional collaboration.
Option 4	Sexual Assault & Referral Centre (SARC)
Option 5	Multi-Agency Centre for adults, children and young people who have experienced rape and sexual assault
Option 6	Integrated Gender Based Violence Services
Option 7	Private Sector/Out Sourcing the service delivery

The short life working group conducted a fit for purpose analysis of the long and short-list using multi-criteria decision analysis techniques to assess benefits, costs and risks.

The list was filtered down by assessing how well they meet the quality criteria and the following critical success factors;

- **Strategic fit** – how well does the option meet agreed objective and fit with the wider organisational or public-sector objectives?
- **Service user requirements** - how well does the option meet the requirements of the service users?
- **Potential affordability** – how will the option be financed and is it affordable with existing budgets?
- **Potential achievability** – how likely is it that an option can be achieved given organisational capacity, capability and skills (workforce) available?

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/685903/The_Green_Book.pdf

Other factors may be relevant to assess the long-list and affect which options are feasible:

- **Constraints** – such as legality and ethics
- **Dependencies** – such as infrastructure
- **Risk** – there is a risk that the option will take too long making it undeliverable within a reasonable timeframe for the project requirements.

Options discussed and ruled out at that stage: out-sourcing service provision to private sector (not palatable/inconsistent with delivery of public services in Scotland); integrated gender based violence services incorporating domestic violence services for adults and wider (non-sexual) child neglect and abuse (out with scope of the Taskforce / ability to manage demand).

It was agreed that the Taskforce remit and the options appraisal exercise excludes services for perpetrators in police custody (custody healthcare services).

5.5 Short-list of Options

On the basis of the above assessment of the long-list options (by critical success factors), the following short-listed options were selected for final appraisal to reach a preferred option.

Table 2 Short List of Options (service delivery for adults, children and young people)

Number	Title / summary
Option 1	Status quo or do nothing (retained as a baseline comparator) This option would mean that existing services largely remain as they are (good practice in places but inconsistent and fragmented picture across the country).
Option 2	Status Quo Plus: Implementation of HIS Standards for children young people and adults. This option would mean that Health Boards focus on improving the existing model of service delivery, in order to provide national consistency in the quality of forensic medical and health care services (as set out in the published HIS standards).
Option 3	Sexual Assault Referral Centre (SARC) – for Forensic Medical and Health Care Services (acute and historic) for adults and adolescents. This option would mean that a specialist, age appropriate forensic medical and health care service is provided by an appropriately trained mix of staff. It would provide equitable access to an individually tailored care package based on a comprehensive needs assessment, with a choice of action at every stage of care (whether clinical or non-clinical).

Option 4	Multi-Agency Centre/Co-ordinated services for adults, children and young people who have experienced rape and sexual assault (acute and historic). This option would provide the opportunity to co-locate those health services with other agencies and partners to help deliver a holistic, smooth pathway. For example, social work, criminal justice, advocacy and third sector services for the individual and their family all under the one roof.

The above service options were subject to option appraisal assessment at the stakeholder event on 27th June 2018.
The Benefits Criteria are set out at Appendix 1.

5.6 Ranking and Weighting the Criteria

The **'weighting and scoring'** method, is a form of multi-attribute or multi-criterion analysis. This involved identification of all the non-monetary factors (or "attributes") that are relevant to the service change process; the ranking and **allocation of weights** to each attribute to reflect their relative importance; as it relates to the service change. This is then used at the event to **allocate scores** to each option to reflect how it performs in relation to each of the benefit criterion.

- The SLWG (07 June 2018) confirmed the list of benefit attributes.
- The SLWG developed the options and assessed the relative importance of the benefits criteria
- The group of subject matter experts met on the 15th June, 2018 to agree the ranking and weighting of the benefits criteria.
- Those present reported this to be a transparent, rigorous and robust process of exploring the case for change and the rationale behind each criterion as it applied to the service change and the aims of the Option Appraisal process.
- The meeting was chaired by an objective service change facilitator (Kate Bell).

5.7 Final Ranking and Weighting

This process was split into two stages:

- The sub-group of the SLWG ranked the benefits criterion in order of importance.
- The SLWG gave a weighting to each of the benefit attributes in line with the ranking.

Table 3 – Ranking and Weighting

Benefits Criteria 'Attributes'	Final Ranking	Final Weighting
Person-Centred	1	2.0
Safe	2	0.8
Effective	3	0.6
Equitable	4	0.4
Timely	5	0.2
Efficient	6	0.1

5.8 Service Configuration Models

The SLWG developed the list of service configuration options and the essential, desirable and important factors to guide the decision making process as part of the option appraisal event. The participants score sheet for the afternoon session includes all 23 factors.

Service Configuration Models for consideration were:

MODEL A – Status Quo - services remain in existing geographic locations with some regional collaboration

MODEL B – Status Quo Plus – services remain in existing geographic locations with enhanced regional collaboration

MODEL C – Regional service / centre of excellence with supported island services.

MODEL D - Regional service / centre of excellence with supported island, as well as rural/remote and mainland services which are owned and driven by the relevant Health Board (s).

6 Option Appraisal Event

6.1 Pre – Work

As part of the pre-work for the event a set of event briefing papers were distributed 7 days in advance of the event to all participants.

All stakeholders were identified through the taskforce and short life working group and invited to the event with 6 week notice period. All attendees were allocated to one of seven groups pre-event to ensure equal representation. This ensured a mixed representation of expertise and knowledge across all groups. The participants remained in the same groups for both the morning and afternoon session. All groups were supported by a Taskforce member and a dedicated facilitator for the groupwork process. This enabled each proposed option and service configuration model to be discussed in turn in each of the seven mixed stakeholder groups at a suitable pace.

An explanation of the decision-making methodology and scoring process was presented at the event by the option appraisal lead.

6.2 Stakeholder event

Participants were welcomed to the event by Kate who described the process of development to date and expressed her thanks for the commitment of the SLWG members who had given their time in meetings and over the past 6 weeks to develop the options and the models as well as all of the materials for the event.

Kate described the stakeholder event as an opportunity to:

1) Consider the service delivery options with a view to appraising and recommending a preferred option.
2) Consider the service configuration model (scale - where and how many) and recommend a fit for purpose locations for the future service model.

The option appraisal event was attended by members of all agencies. In total there were 51scorers in the morning and 51 in the afternoon session.

6.3 Presentations

The participants listened to presentations from:

- Professor Elizabeth Ireland describing why change was required (as set out by the CMO Taskforce),
- Dr Deborah Wardle, Consultant, Sandyford Sexual Health Service/NHS Education Scotland presented the service delivery options as developed by the SLWG and Pauline McGough, Clinical Director at Sandyford Clinic.
- George Laird, Manager West Of Scotland Sexual Health MCN & Child Protection MCN, presented how the options reflected on Children's services.
- Sandy Brindley, Chief Executive of Rape Crisis Scotland provided the survivors' perspective.
- Kate Bell, Head of Service Change & Transformation NHS Lanarkshire, described the option appraisal process including the scoring and voting approaches being utilised. Kate sign-posted participants' to the contents of pre reading pack which included a full options appraisal pack, the case for change and the event programme. The scoring ranking, weighting and process were described for the service delivery options. This was also repeated in the afternoon to describe the influencing factors methodology as a decision making technique to agree the service configuration model.

6.4 Honouring the Experience

It was explained that actual attendance by those with lived experience was pursued but was always going to be extremely challenging. To ensure the voices of people with lived experience could form part of the option appraisal and influence the decision making process a 10 minute audio recording was played, recorded by a person with lived experience and included in the presentation delivered by Sandy Brindley to represent survivors' views. The audio can be accessed via Sandy Brindley.

The participants' feedback noted the impact that this had on them and agreed this was representative of the variation in current Forensic Medical Services across Scotland.

As the lived experience was critical to the event and the future service options and locations, Sandy and members of the SLWG also developed and analysed a questionnaire for survivors and staff to share as part of the presentation.

6.5 Question and Answer session

The programme included a question and answer session am and pm to enable opportunities for the participants to raise questions for points of clarity with all presenters.

7. Scoring Process and Methodology

7.1 Scoring the service delivery options

The morning session gave an opportunity for further interrogation of the options as they related to the benefits criterion - quality dimensions as well as the benefits, risks and opportunities for improvement in the speakers' presentations.

Each group were asked to consider the options for change applying the information obtained from the pre briefing pack and also from the presentations to add to their own professional judgement and perspective.

PLEASE NOTE: As a default the groups were asked to consider the following as a question throughout the process.

- Does the option being considered meet the needs of those with lived experience?
- How will the option meet the needs of children?
- How will the option/model make the best use of skills & expertise available across the agencies across Scotland charged with delivering the future service model?

The facilitators invited the group to:

- Consider the information contained within the pre briefing pack, the presentations by the subject matter experts and proceed to discuss the risks and benefits of the service options for the delivery of services to those who have experienced sexual assault & rape in Scotland.
- Go through the Quality Dimensions (Criteria) to ensure everyone knows how to apply each of the dimensions and definitions as they relate to the service options.
- Ask all group members if they fully understand the process of scoring.
- Ensure sufficient dialogue, questions, explanation are given an airing.
- Ask individuals to score each dimensions on a scale of 0-5 for all options. Each individual to apply a score.
- This process must be repeated for all options and models

All participants completed an individual scoring sheet to represent the value of each of the benefits criterion as it applied to the options. (See Appendix 3)

7.2 Scoring the service configurations

The afternoon session concentrated on assessing the service configuration models using information and materials presented and detailed groupwork discussions. Participants went into previously allocated groups for a facilitated groupwork discussion around all of the service configuration models.

The decision making approach utilised in the afternoon session required the short life working group to suggest some factors they consider to be either 'essential' or 'important' or 'desirable' for the location of the centre/services for people who have experienced sexual assault & rape in Scotland.

For example, an essential factor would likely be 'adequate and fit for purpose accommodation. An important factor might be 'increases the recruitment and retention of staff'. A desirable factor might be opportunities exist for further service development without the need for refer on or hand off to other agencies.

The analysis of the method works as follows:

(Step 1) First consider if a clear preference emerges after consideration of the feedback on essential factors. If yes, then we have a preferred model! If not, move to Step 2.

(Step 2) Consider if a clear preference emerges after consideration of the feedback on important factors. If yes, then we have a preferred model! If not, move to Step 3.

(Step 3) Consider if a clear preference emerges after consideration of the feedback on desirable factors. If yes, then we have a preferred model!

The facilitators took the group through the process to ensure all key questions were answered or explained. Each participant completed individual score sheets across the agreed essential, desirable and important factors for future delivery of the future service location. (See appendix 4)

8. Scoring Analysis

8.1 Participant Coding

Participant coding is as follows for both morning and afternoon sessions.

	Makeup of scorers	
	AM	**PM**
Number of "1 - Service User (survivor)	5	5
Number of "2 - Police Scotland	5	5
Number of "3 - Social Work (government and non-governmental)	2	2
Number of "4 – NHS Staff (clinicians)	17	17
Number of "5 - NHS Staff (non-clinicians)	15	15
Number of "6 - Voluntary Organisations	2	2
Number of "7 – NHS Scotland National Board	1	1
Number of "8 – COPFS (Non-scorer AM)	0	1
Number of "9 - Scottish Government	2	2
Number of "10 - Local Authority	2	2
Total	**51**	**52**

8.2 Number of scorers for each session

There were a total of 51 scorers in the morning and 52 in the afternoon session. There may be minimal discrepancies in representative analyses as two separate scoring sheets were used. One participant left and anther joined for the afternoon session. Some participants brought previous versions from emailed information and did not use the final versions in the pack provided on the day. There was no impact on the overall scoring for the sessions.

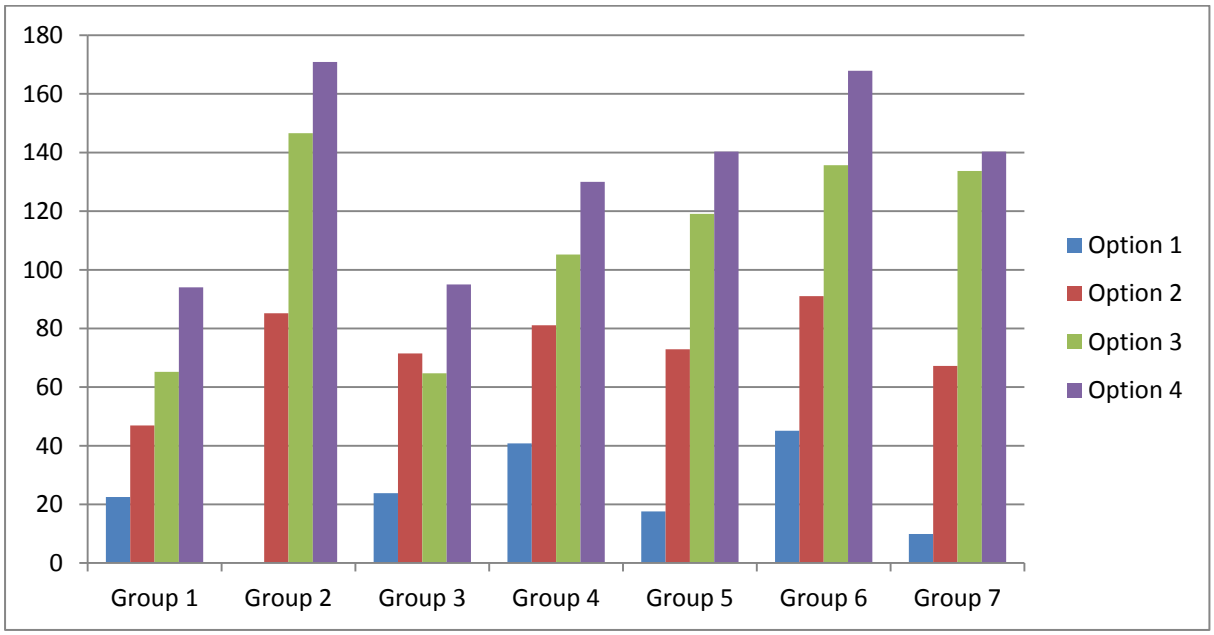
8.3 Scoring – Service Options

Table 4 – Unweighted Scores for all Options by Groups

Score:	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Totals:	%	Ranking
Option 1	34	0	38	55	22	65	18	**232**	**7%**	**4**
Option 2	68	122	99	109	115	133	99	**745**	**21%**	**3**
Option 3	98	217	95	153	171	203	196	**1133**	**33%**	**2**
Option 4	**135**	**243**	**132**	**187**	**204**	**240**	**205**	**1346**	**39%**	**1**
Totals	335	582	364	504	512	641	518	**3456**	**100%**	

Table 5- Weighted Scores All Options, all Groups

Score:	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Totals:	%	Ranking
Option 1	22.5	0	23.8	40.8	17.6	45.1	9.9	**159.7**	**7%**	**4**
Option 2	46.9	85.2	71.5	81.1	72.9	91	67.2	**515.8**	**21%**	**3**
Option 3	65.2	146.6	64.7	105.2	119.1	135.7	133.7	**770.2**	**33%**	**2**
Option 4	**94**	**170.9**	**95**	**130**	**140.3**	**167.9**	**140.3**	**938.4**	**39%**	**1**
Totals	**228.6**	**402.7**	**255**	**357.1**	**349.9**	**439.7**	**351.1**	**2384.1**	**100%**	



Graph 1: The histogram graph above reflects the data in table 5 above.

The function of including the Status Quo ‘do nothing’ model is to provide a benchmark so that the value of the alternative 'do something' models may be judged by reference to current service provision.

All groups scored Option 4 as the highest scoring. 72% of the scoring was applied to options 3 and 4. Although each of the groups scored the status quo low, Group 2 reached a group decision to score the status quo as a zero which reflected the guidance given by the option appraisal lead that a zero score had been included to reflect the view that the current service adds no value going forward.

Table 6 - All groups summary by Quality Dimension – Service Delivery Options

Option 1		**Total**	**Weighting**	**Weighted total**	**Rank**
1	Person-centredness	41	*2.0*	82	
2	Effective	36	*0.8*	29	
3	Safe	39	*0.6*	23	
4	Equitable	33	*0.4*	13	
5	Timely	41	*0.2*	8	
6	Efficient	41	*0.1*	4	
			Total for Option 1 =	**160**	**4**
Option 2					
1	Person-centredness	126	*2.0*	252	
2	Effective	124	*0.8*	99	
3	Safe	139	*0.6*	83	
4	Equitable	114	*0.4*	46	
5	Timely	114	*0.2*	23	
6	Efficient	128	*0.1*	13	
			Total for Option 2 =	**516**	**3**
Option 3					
1	Person-centredness	185	*2.0*	370	
2	Effective	191	*0.8*	153	
3	Safe	199	*0.6*	119	
4	Equitable	180	*0.4*	72	
5	Timely	182	*0.2*	36	
6	Efficient	196	*0.1*	20	
			Total for Option 3 =	**770**	**2**
Option 4					
1	Person-centredness	232	*2.0*	464	
2	Effective	233	*0.8*	186	
3	Safe	233	*0.6*	140	
4	Equitable	206	*0.4*	82	
5	Timely	216	*0.2*	43	
6	Efficient	226	*0.1*	23	
			Total for Option 4 =	**938**	**1**

Table 6 above covers all groups across the 6 quality dimensions. Before weighting options 2, 3 and 4 have scored Safe highest with option 1 showing equal scores for person-centredness, equitable and efficient. When the scores are weighted all participant scores show person centred to be the most important. In both weighted and unweighted scoring the ranking of the options remains the same with the same percentage proportions across all groups.

8.4 Service Option Scoring Outcome

As a result of the morning scores the option deemed viable and deliverable in accordance with service options criterion is described below

Option 4 Multi-Agency Centre for adults, children and young people who have experienced rape and sexual assault (acute and historic).

8.5. Scoring Analysis – Service Configuration

Table 7 – Score for all Groups – Service Configuration

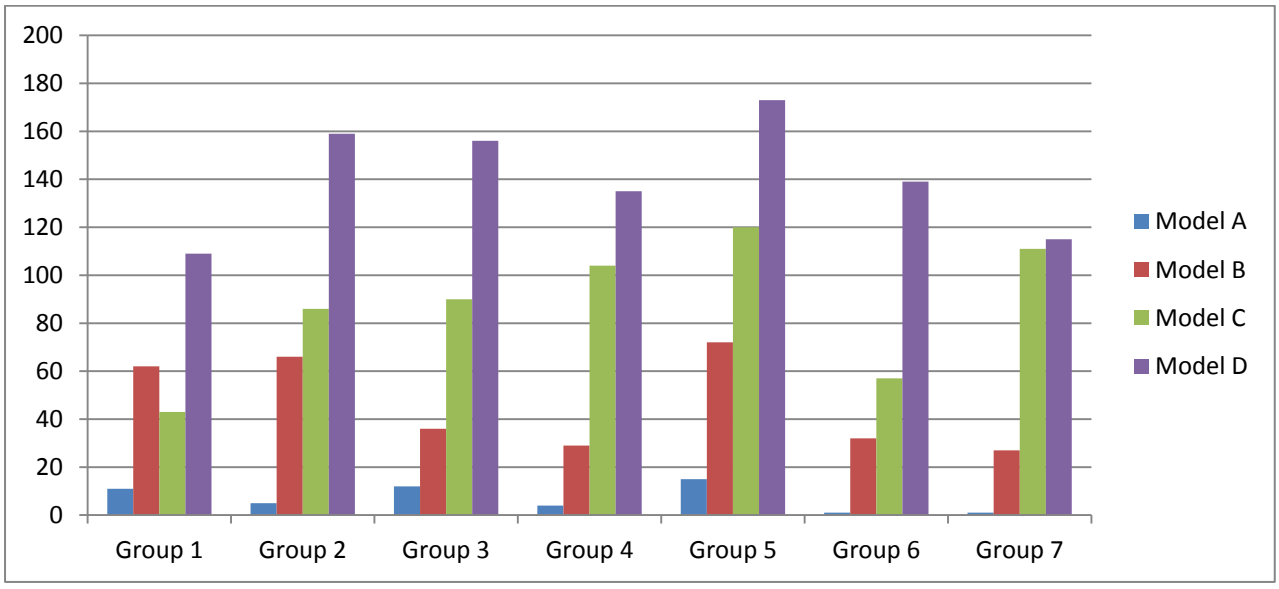
	Model A	Model B	Model C	Model D
Group 1	11	62	43	109
Group 2	5	66	86	159
Group 3	12	36	90	156
Group 4	4	29	104	135
Group 5	15	72	120	173
Group 6	1	32	57	139
Group 7	1	27	111	115
Total	**49**	**324**	**611**	**986**
%	**3%**	**16%**	**31%**	**50%**

Table 7 above is a record of the scores across all groups in relation to the Essential, important and desirable factors to design and deliver a person centred, safe, effective service configuration for people who experience sexual assault & rape in Scotland.

The total scores illustrate that overall all 7 groups voted Model D as the preferred model for implementation. The percentage of the vote split by option shows Model D represented 50% of the participants' votes.

The graph represents all group scores across all models.

Graph 2 – The histogram below represents the distribution of all participant votes across all models.



8.6 Service Configuration Model Outcome

Model D was voted the highest service configuration model across all groups with the narrowest margin recorded between option 3 and 4 in group 7.

Model D – Local services which meet the HIS standards, delivered as close as possible to the point of need and supported by a centre of excellence.

Model D was subject to detailed discussion and by consensus with all participants it was agreed that this needed to be amended to describe a service configuration with locally delivered services at the heart, supported by a centre of excellence.

The participants felt strongly that the model should not just describe a 'centre' (i.e. the physical building) but should capture the key elements of the service to be provided (which may be delivered out with that physical space).

The centre (s) of excellence (CoE) would be a dedicated specialist team, a shared facility or an entity that provides the following: - resources, guidance, leadership, best practices, co-ordination of services, research, support and/or education, training and development. This would be provided for staff working to support people locally who have been sexually assaulted or raped. A CoE could provide core services, when necessary outreach to local areas when required. The centre and services would support appropriately trained qualified staff to undertake a forensic medical examination. As a multidisciplinary team approach is central to the model, a holistic and seamless service could be provided to meet the needs of people and address a range of demands from clinical requirements to support and recovery in a coordinated manner.

This model is based on delivering the vision of how services could be best designed to deliver high quality care, treatment and support for recovery for survivors. This multi-agency option would provide clarity regarding a route/s for self-referral, enable services to be accessed locally; consolidate relationships with a crisis/advocacy support worker; and co-ordinate ongoing support and recovery services.

In early work within the taskforce (May, 2017) it was agreed that a clear point of access into services should be national, staffed over 24 hours and enable people to get to the right place, with support from a multi-agency team in a location as close as possible to them as quickly as possible.

This service configuration model requires a lot more work to agree the detail; however the model enables better equity of access to the right person in the right place first time. This could be through a centre or services for all in Scotland and with the access to a 24 hour number.

At this stage it is not known how many of the specialist centres/services there will be in Scotland. However it needs to be understood that the principle is that services will firstly be accessed locally in a facility equipped to provide the highest quality of service to meet the agreed standards.

The Taskforce will consider the most appropriate way to reflect this in the final name of the agreed model. Participants also felt that whilst this was the preferred model for adults and young people, that the existing service provision for children (under 12) was working well (although there was a clear commitment to improvement and in particular trauma & recovery services). There was an appetite to look at how future developments in relation to how the Barnahus concept could build on this, taking cognisance of social work policy, responsibilities and guidelines in relation to child protection as well as those of other partner agencies.

The event noted the Barnahus concept in England for response to child sexual abuse had worked well and posed the question as to whether a similar model would also work in Scotland.

8.6 Further Analyses

In order to test the robustness of the results of the option appraisal an assessment of the sensitivity of the ranking of the scores to key variables and assumptions was carried out.

Graph 3 - below recorded the outcome of the morning scoring exercise for each individual group (by group), by combination and what the outcome/ranking would have been.

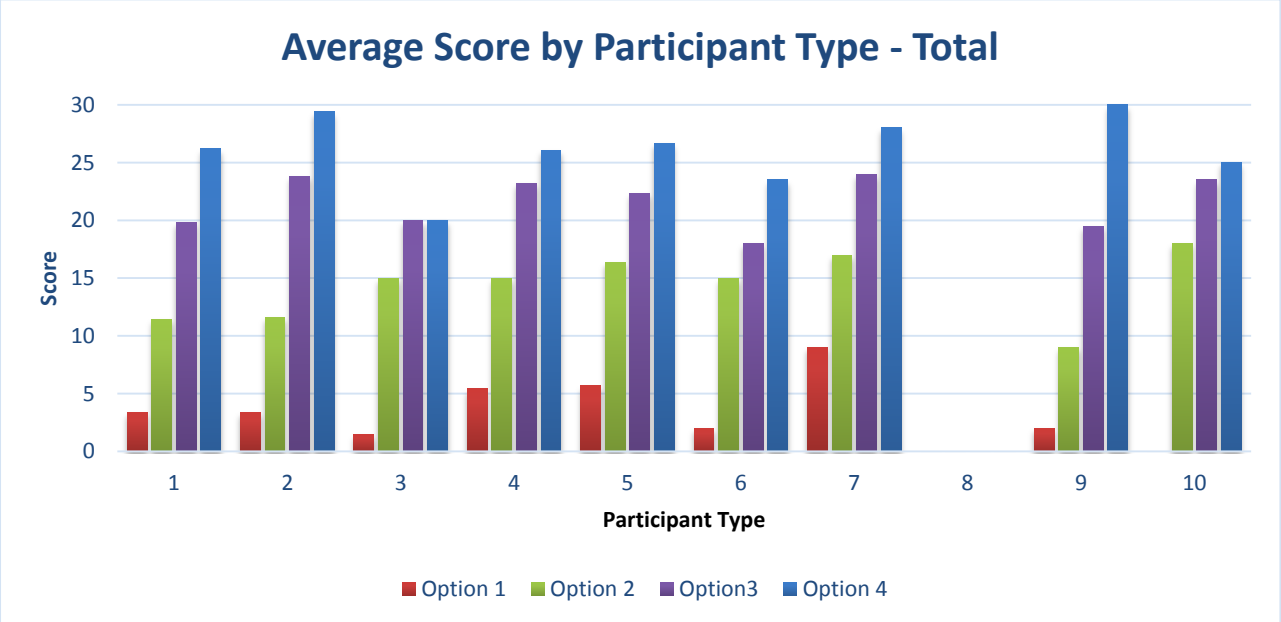
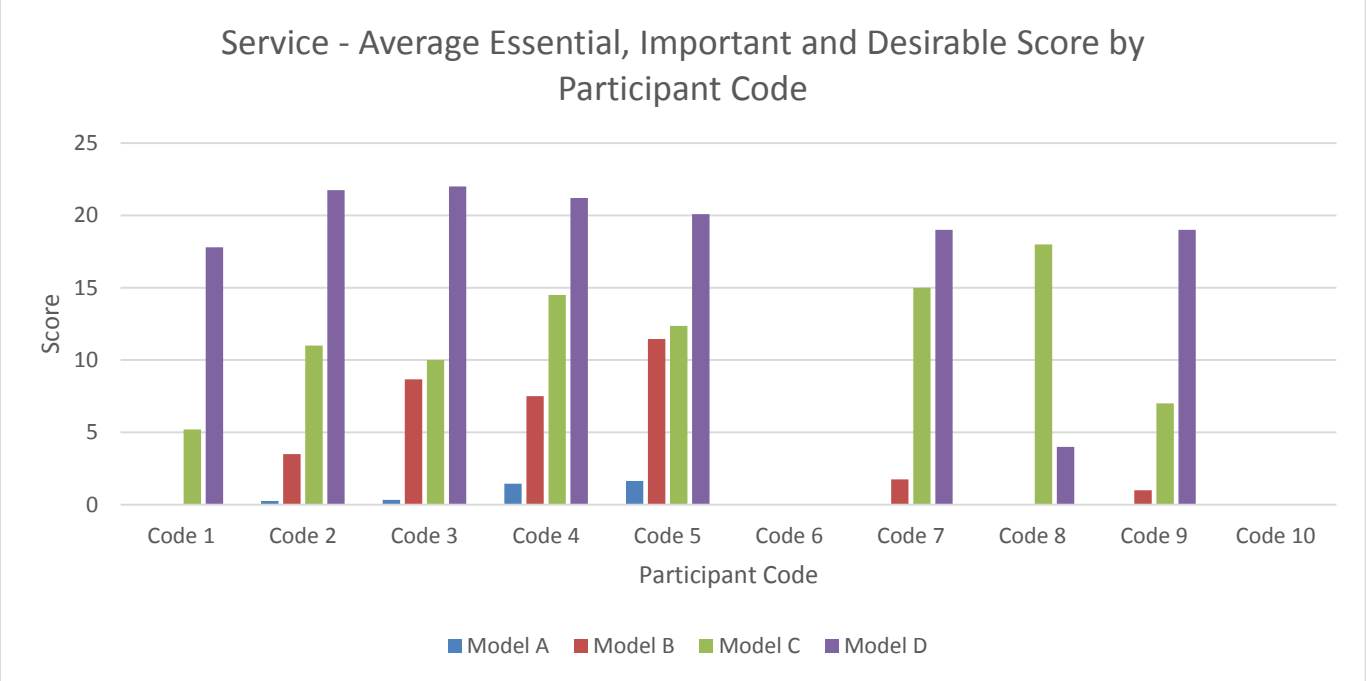


Table 7 below represents an average score across all factors and participant score for the afternoon session.

	Model A	Model B	Model C	Model D
Number of "1 - Service User (survivor)	0	0	5	18
Number of "2 - Police Scotland	0	4	11	22
Number of "3 - Social Work (government and non-governmental)	0	9	10	22
Number of "4 – NHS Staff (clinicians)	1	8	15	21
Number of "5 - NHS Staff (non-clinicians)	2	11	12	20
Number of "6 - Voluntary Organisations	nil	nil	nil	nil
Number of "7 – NHS Scotland National Board	0	2	15	19
Number of "8 – COPFS (Non-scorer AM)	0	0	18	4
Number of "9 - Scottish Government	0	1	7	19
Number of "10 - Local Authority	nil	nil	nil	nil



Graph 4 above represents the votes for all models across all participants coding. For the purpose of clarity the coding of participants may differ from am and pm sessions due to accuracy of the template used. Some participants used the previous emailed version which was re-coded for the final version in the packs on the day. This did not compromise the outcome as shown in the analysis.

9. Plenary Session

Following on from the groupwork scoring process in the afternoon we opened up a plenary session for feedback from each of the groups. The groups were encouraged to explore anything that had not been in scope for the process and event so far to enable attendees to feed into the next steps for the work.

Services

- There needs to be crystal clear accountability and governance. This is easier to do with local delivery of services (with co-ordinated service/centre to support local delivery at regional level). This is a service not necessarily bricks and mortar
- The services should be age appropriate.
- Services in Orkney would benefit from the support of a centre of expertise
- Local services need adequate funding to ensure no variation in quality.
- There needs to be consistent decent pathways of care so that patients and staff know what to expect. The additional bit of the pathway around the justice side can be traumatic, criminal justice needs improvement (that's not for today)

Children

- There was a discussion around children and the legal age vs. age of consent.
- Need to link this work with developments around Barnahus model.
- Request that the child age in brought into line with International Definition.
- Local services for children – importance of secure and trusting relationships between child and professional (s) involved in their care (Children's 1st)
- How does the advocacy support for children fit in with existing children's services and MCNs? Suggestion to migrate from managed clinical networks to managed care networks for child protection (more multi-agency).
- Reassurance required that whatever is recommended would not unpick the work going on around children. We need to be very aware of the risk around children and make sure that any decisions don't undermine the work that has gone over the past decade.
- A plea that any option going forward for consideration will sit with the wider child protection sphere, it's not just the crown but can also be called to a child protection hearing. We're meant to be protecting children.
- Reassurance that models put forward won't dissemble, be detrimental to any current structures for children, will only build on them.

Training

- Need to tie in with work that NHS Education Scotland (NES) has done on trauma informed services (NB: this is now weaved through the 2 day NES introduction to Sexual Offence Examinations course but could feature more predominately in detailed service specifications as they are developed).

Workforce

- Regarding female workforce, there is overwhelming evidence for female doctors but there are some exceptions.
- Need to give victims a choice (men and boys) –
- Advocacy worker not the only model. What about developments around healthcare co-ordinators?
- We need to ensure that the justice side is remembered. Need to gather admissible, reliable evidence. Whatever the system we need to have well-trained and experienced FMEs so they can give expert opinion in court. The challenge of local delivery and maintained expertise, if they are only required to do one or two examinations a year it could lose expertise. Frequency = expertise.

Configuration

- Regional centres not suitable for Police Scotland
- Regional model too wide for the North
- How much of care pathway is regional and local. Immediate support local, facilitated discussions about next steps (FME etc.), follow on care and support local. Travel for FME – if need be.
- Barnahus model in Denmark – centres of excellence supporting 90+ inhabited island communities.
- The group felt that multiple centres for excellence were a good idea, but suggested more than 3 are necessary.

General

- Trauma informed – 5 principles: safe/trustworthy/rapport/collaboration/empowering.
- Suggestion that the Quality Criteria Safe could be both physical and emotional
- Archway grab bag model could be looked at for hard to reach areas
- Moving forward, the group have hope that the CMO taskforce team will be able to reassure them that this new option won't be funded locally using existing budgets.

10. Evaluation

The option appraisal process has been set out with a structured and disciplined approach to ensure we capture and collect high quality information on the current service context and the findings of the communications and engagement process to date. Analyses of the data and information have enabled the SLWG to set out the challenges/expose issues or opportunities; and present informed options to stakeholders involved in supporting the service improvement process. This will ensure the Taskforce and Scottish Government is well placed to respond to the immediate, emergent and future challenges in the provision of services to people who have experience sexual assault & rape in Scotland.

The Option Appraisal event was attended by a total of 52 stakeholders including representation from the Scottish Government; NHS Clinicians, Managers and Staff, Health & Social Care Partnership; Police Scotland; Social Work; Forensic Services and Voluntary Organisations.

- Of the 52 attendees 42 (81%) returned evaluation forms were received.

- The venue for the event, the *Deacon Suite, Royal College of Surgeons, Nicolson Street, Edinburgh*, rated overall as a good/very good venue.

Venue	**Very Good**	**Good**	**Poor**	**Very Poor**
Location & Access	34	8	0	0
Refreshments	20	19	6	1
Acoustic (sound)	13	22	6	1
Comfort	18	23	1	0

10.1 Presentations

Participant feedback on the presentations was very positive with everyone (42) rating the content and quality as very good and good. The ‘use of plain English’ was rated as good and very good by all with the exception of one participant who rated it poor.

The explanation of technical terms was rated over all as very good and good 39 (92%) and 3 (8%) returns rating the use of technical language as poor.

In relation to the openness and responsiveness to answering ongoing questions as required by the attendees, returns rated the active engagement of participants through pre-reading material, clear presentations and breakdown of options and models and informed discussion throughout lead to respondents rating this aspect of the process as very good or good by all 42 (100%) respondents.

One return rated ‘keeping to time’ as poor with all others 41 (98%) returning a rating of good and very good.

10.2 Group Work

Feedback in relation to the group work sessions included positive 'yes' responses regarding being encouraged to take part (40) and being supported (39) and listened to (41) with (40) responding 'yes' to having had been able to ask questions, (36) said 'yes' to having had questioned answered with (38) returning that it had been okay to just listen.

There was a return of (41) saying 'yes' that the task of the group work had been clearly explained by the facilitator with (40) returning that the facilitator had kept the control of the group and (41) saying that the facilitator had kept to time.

The 'yes' score for the remainder of the questions have been listed below:

- Use of plain English was encouraged (34)
- Technical, scientific or medical terms were explained (34)
- I enjoyed taking part (40)
- Overall this was a good use of my time (40)

10.3 General Feedback

- 33 people said they had received enough notice ahead of the event with 9 responding that they had not that they had not
- 39 people said they had received an invite with three responding that they had not
- 38 said they had been provided with enough information ahead of the event with 4 responding that they had not
- 40 said that access to the venue had been easy with 2 saying that it had not
- 4 said that they had been able to easily park at the venue,15 returned 'not applicable' with 23 giving no response
- 31 said that they were welcomed at reception with 8 saying no, 3 gave no response
- said they had been advised of the fire exit plan, 32 said they had not, 4 left it blank
- 13 said that the location of the toilets had been clearly explained, 28 said it had not, 1 left blank

10.4 Comments regarding the venue and event overall:

"Far too much material in the packs on the table"

"Very good pack in advance. Insufficient info on Models of Delivery. Very important Option Appraisal."

"RCS late to tell of the event"

“More detailed information about proposed Model of Service Delivery for children and young people. – or at least how their very different need should be addressed to would have been really helpful.”

“Make sure links to other Scottish Government work. Explore what has worked/hasn’t or Archway journey. No detriment to existing Child Protection processes and consideration of this under role.”

“Overall good; venue cold until late afternoon; refreshments poor; lunch disappointing.”

“Very good event” “Good session; interesting discussion/debate, very engaging”

“I am left wondering about children and young people in this system. It felt very adult focussed.”

“Speaker on podium difficult to hear”

“Did I have an invitation – no? But original planners and event heads all assumed I had – so just came anyway.

“I didn’t get a chance to see you at the end to say well done. That was a very impressive feat pulling that off in such a short timescale. Thanks for all your help” Sandy Brindley, Rape Crisis Scotland.

“Thank you so much for all the immense input to make today the success it has been!” Professor Elizabeth Ireland

“I was very taken with your revised approach of ‘locally delivered with regional expert support’. I think this will be best configured (certainly in the North) as a network approach. I left the session feeling very confident that we will, as Scotland, develop an appropriate, high quality model for this care”. Adam Coldwells, Chief Officer, Aberdeenshire Health and Social Care Partnership

“Thank you to all of you for being here today and investing in a very crucial area of work for Scotland. This is a complex area and I am pleased to see a robust and rigorous process has been completed by all of you here. As we progress the implementation of this work you can all look back and say I played a part in making things better for people who experience sexual assault & rape”
Dr Catherine Calderwood, Chief Medical Officer

11. Conclusions

The option appraisal methodology, the criteria and approach applied has proved to be robust and mitigated any form of bias or strategic scoring/voting. The scoring/voting analysis supports that participants have adhered to the request to make decisions based on the needs of people with lived experience and also to align scoring/voting to the needs of all service users (survivors/victims be they children, young people or adults across Scotland) in the preferred outcomes for service delivery options and service configuration models. The recommendations and outcomes of the process are true to the decision making tools applied.

Unequivocally there is recognition of the list of challenges of similar importance across the landscape of public sector corporate objectives and imperatives. However this programme of work as stated by the Chief Medical Officer has a sense of value like no other. We must do better to honour the lived experience of people who have experienced sexual assault and rape in Scotland and view this programme of work to have a worthiness and priority that requires immediate progress and a rigorous implementation plan and successful delivery over the coming 1-3-5 years.

It is worthy of note that complex programmes of work such as this require adequate resourcing such as programme direction and project management capability within a programme approach. A programme approach will provide specialist knowledge skills, apply innovation, shorten programme delivery and provide certainty of a change that is improvement based on the mandate and vision.

Report author:

Kate Bell, Head of Service Change & Transformation, NHS Lanarkshire

Date completed: 08th August, 2018

Benefits Criteria – Service Option **Appendix 1**

Quality	Key Features
	*Reduced Clinical Risk and avoiding harm to patients from care that is intended to help them.* A **safe** service for sexual assault and rape victims would therefore provide: • The right mix of workforce, medical, non-medical, social work, third sector • A multi-disciplinary team approach to service delivery – right expertise and streaming to the right person/first time • Clinical environment (age appropriate) and equipment that meets the needs of the person • Meets the National Standards (HIS, 2017) • Appropriate pathways for efficient uptake of services for safe and improved outcomes
	*Providing services based on scientific knowledge and best clinical standards and improved quality of Care and outcomes* An **effective** service for sexual assault and rape victims would therefore provide: • Sufficient staff working together in teams to ensure a responsive and flexible service • The range of staff with the right skills available to meet all expected clinical conditions • A 'fit for purpose' clinical environment to deliver evidence based care • Training opportunities are available for the multi-skilled workforce • Access to assessment/medication/ treatment (where indicated) • Structures and mechanisms in place to utilise and deploy staff and resources effectively. • Essential links between with health, social work and police Scotland. • Greater opportunities for joint working, peer support within the workplace • A sustainable and deliverable model that enables ongoing recruitment & retention opportunities for all staff groups
	*Care is responsive and appropriate to patients needs and patient is included in clinical decisions.* A **person-centred** service for sexual assault and rape victims would therefore provide: • People are listened to and treated with respect and dignity with confidentiality where possible • People are treated by the right staff (professional/competence/values), with expertise (knowledgeable of needs, skilled) and supports (recovery supports for as long as required)

	• Local services remain available at each of the local hospitals 'spokes' • Support provided through availability of transport where clinical need is established • Care is delivered within the timeframe as per waiting times standards • Will improve the experience of people, families and service users • People are seen by the right person in the right place within the right timeframe
	*Avoidance of waste including energy, supplies, equipment, resources including staff and ensuring a seamless journey through services* An **efficient** service for sexual assault and rape victims would therefore provide: • A service configured to meet evidence based demand • Better utilisation of local services where required. (increased access) • The available workforce has a range of knowledge and skills responsive to the needs of the client/service user groups • Informed deployment of the workforce and resources to allow faster access to assessment, care and treatment. • Efficient deployment of skills and knowledge 24/7 • The service is well resourced, financially viable and deliverable
	Providing care that does not vary in quality because of geography, location or socio-economic status. All patients have access to a range of service provision An **equitable** service for sexual assault and rape victims would therefore provide: • Equitable access to the centre of excellence for all who need to access the service • Access to a workforce who are suitably qualified, competent and trained to meet the support, care and treatment needs and can reduce any risk of harm and manage the care and treatment sensitively and effectively • Access to interpretation services where required to ensure meaningful communication with all service users
	Reduction of harmful delays for those who give and receive care A **timely** service for sexual assault and rape victims would ensure: • Sufficient workforce available to ensure timely access to the right person first time. • Sufficient infrastructure in place to provide a comprehensive service • Pursue 'best in class' (benchmarked nationally) performance to deliver the highest quality of care and ensure ease of access to support.

OPTION APPRAISAL PROCESS **Appendix 2**

Participants Briefing Paper for Option Appraisal

A. Purpose of this briefing

This briefing sets out information on the process for Option Appraisal of services to people who have experienced sexual assault & rape across Scotland.

B. How are we planning to do this?

The Scottish Government sets out very clearly the process for Informing, Engaging and Consulting People in Developing Health and Community Care Services[4], which this process has followed.

The SLWG confirmed the list of benefit attributes (07th June, 2018).

- A sub-group of the Taskforce have **ranked** the attributes in order of importance which will be shared with the participants at the event. (07th June 2018)

- The same sub-group of the Review Board have given a **weighting** to each benefit attributes in line with the ranking. (15th June, 2018)

We have:

1. Agreed the key features according to the vision for future services to victims attached to each of the **benefit attributes** to be used as a guide for participants to score each option accordingly
2. **Ranked** the criteria in order of importance (subject matter experts)
3. **Weighted** the criteria (subject matter experts)

3.1 The **benefit attributes** are based on the six dimensions of healthcare quality and include key features relevant to the delivery of future services attached to each. A paper giving more detail can be found in the information pack.

The group of key informants discussed the “ranking” and “weighting” of the attributes or “what is most important to this service change” prior to the event.

C. Weighted Scoring Method explained

The weighted scoring method is a form of multi-criteria analysis. It involves identification of all the non-monetary factors (or "attributes") that are relevant to the service change project; the allocation of weights to each of them to reflect their relative importance; and the allocation of scores to each option to reflect how it performs in relation to each attribute. The result is a single weighted score for each option, which may be used to indicate and compare the overall performance of the options in non-monetary terms.

[4] Informing, Engaging and Consulting People in Developing Health and Community Care Services CEL 4 2010

This process necessarily assigns numeric values to judgements. These judgements should not be arbitrary or subjective, but should reflect expert and service user/lay representatives' views, and should be supported by objective information.

To achieve meaningful results which decision-makers (NHS Lanarkshire and key partners) can rely on, it is important that all stakeholders are represented and that:

1. the exercise is not left to the 'experts', but is undertaken by a group of people who represent all of the interested parties, including, for example, those who are directly affected by the project, and those who are responsible for its delivery;
2. the group possesses the relevant knowledge and expertise required to make credible measurements and judgments of how the options will impact upon the attributes;
3. the group is led by an objective person to steer the process, probe opinions, promote consensus and avoid prejudice; and
4. the justification for the group's chosen weights and scores is fully explained

D. Benefit Attributes

The criteria ranking is in order of their importance (1 – 6) where 1 is the most important, 2 is a little less important and so forth until all 6 are ranked. The weightings are applied across the ranking to reach a total of 60.

Benefits Criteria 'Attributes'	Final Ranking	Final Weighting
Person-Centred	1	2.0
Effective	2	0.8
Safe	3	0.6
Equitable	4	0.4
Timely	5	0.2
Efficient	6	0.1

The event will:

- Assess the potential benefits of different options against the information presented
- Assess options as **objectively** using agreed benefits criteria

The outcome of this exercise utilising individual participant scores will be used at the stakeholder event to score the improvement options against the above ranked/weighted attributes.

E. What am I expected to do at the Option Appraisal Meeting?

Note - This exercise will be led by NHS Lanarkshire facilitators who will support and guide the group through every step of the process.

You are required to do the following:

- *On the 27th June you will be expected to:*

Morning session:

- *You will consider the six benefit criteria headings and the key features of each as they relate to the services and the proposed improvement models.*
- *There will then be group discussion of the options where additional information and detail can be further discussed using all information shared with experience and knowledge of key informants present. There may be one or more groups involved in discussion.*
- *You will then fill in an individual score sheet. These sheets will be added together to produce a recommendation from the group.*

Afternoon session:

- *The second groupwork session will ask you to make use of the information presented and score the proposed models and combinations against the stated criteria (Influencing factors) to support the assessment of the right location or locations for the future delivery of the services in Scotland.*
- *These scores will be collated for each group and for all attendees and reported after the workshop in a full report of the event.*
- *The report will be circulated within a four week period of the event to al attendees.*

You will be invited to complete an evaluation form on the day and a report capturing the outcome of the day will be sent to you after the event. Outputs from the workshop will be reported to the Taskforce being shared with the Scottish Government.

Event Programme Delivered **Appendix 3**

Time	Description	Lead
09.00-09.30	Registration & Tea/Coffee	
09.30-09.35	Introduction to the event	Kate Bell, Head of Service Change & Transformation, NHS Lanarkshire
09.35-09.45	Why Change is Required?	Dr Elizabeth Ireland, Chair of National Services Scotland (Executive Sponsor for SLWG)
09.45- 10.05	Description of Options (Service Delivery)	Dr Deb Wardle, Clinical Lead for Archway, member of faculty forensic & legal medicine, Associate Deans at NHS Education Scotland
10.05 - 10.20	Children's Perspective	George Laird, Manager WOS Sexual Health MCN & Child Protection MCN
10.20-10.45	Lived Experience	Sandy Brindley, Rape Crisis Scotland
10.45-11.00	Questions & Answer	Kate Bell, Head of Service Change & Transformation, NHS Lanarkshire
11.00-11.15	Comfort Break	
11.15-11.30	Description of scoring process	Kate Bell, Head of Service Change & Transformation, NHS Lanarkshire
11.30- 12.30	Non-financial Option Appraisal & Scoring	Groupwork facilitated
12.30-1.15	Lunch	
12.30-1.00	Analysis of the am scoring – produce recommended service model	
1.15- 1.45	Description of sites/configuration Models	Dr Elizabeth Ireland, Chair of National Services Scotland (Executive Sponsor for SLWG)
1.45 –2.00	Questions and Answer	Kate Bell, Head of Service Change & Transformation, NHS Lanarkshire
2.00 –2.15	Description of Voting process	
2.15-2.30	Comfort Break	
2.30-3.30	Appraisal of Service Configuration Models	Groupwork - facilitated
3.30- 4.00	Plenary	Feedback from table facilitators
4.00- 4.05	Reflections and Update	Dr Catherine Calderwood, Chief Medical Officer
4.00 – 4.15	Next Steps & Close	Dr Elizabeth Ireland, Chair of National Services Scotland (Executive Sponsor for SLWG)

Individual score sheet – service delivery options session **APPENDIX 4**

Each INDIVIDUAL should make use of all the information available (presentations, benefits/risks group work), discuss the models in relation to the factors listed, consider to what extent each model supports these and SCORE APPROPRIATELY (0– 5).

NAME..... DESIGNATION.....

GROUP.....

Factors		**Institute of Medicines Dimensions of quality**	**Descriptions provided by subject matter experts with regard to each quality dimension and its relevance to the future service delivery.**		**Service Delivery Options**		
				Option 1	**Option 2**	**Option 3**	**Option 4**
1	**Safe**	Avoiding injuries to patients from healthcare that is intended to help them	A **safe** service for sexual assault and rape victims would therefore provide: • The right mix of workforce, medical and non-medical • A multi-disciplinary team approach to service delivery – right expertise and streaming, right person/first time • Clinical environment (age appropriate) and equipment that meets the needs of the person and national clinical quality indicators. • Appropriate clinical pathways for efficient uptake of services for safe and improved outcomes				
2	**Effective**	Providing services based on scientific knowledge	An **effective** service for sexual assault and rape victims would therefore provide: • Sufficient staff working together in teams to ensure a responsive and flexible service • The range of staff with the right skills available to meet all expected clinical conditions • A 'fit for purpose' clinical environment to deliver evidence based care • Training opportunities are available for the multi-skilled workforce				

			• Access to assessment/medication/ treatment (where indicated) • Structures and mechanisms in place to utilise and deploy staff and resources effectively. • Improved linkage with health, social work and justice teams. • Greater opportunities for joint working, peer support within the workplace • A sustainable and deliverable model				
3	**Patient Centeredness**	Providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions	A **person-centred** service for sexual assault and rape victims would therefore provide: • People are listened to and treated with respect and dignity with confidentiality where possible • People are treated in a centre of excellence (Hub) with the right staff, with expertise and supports • Local services remain available at each of the local hospitals 'spokes' • Support provided through availability of transport where clinical need is established • Care is delivered within the timeframe as per waiting times standards • Will improve the experience of people, families and service users • People are seen by the right person in the right place within the right timeframe				
4	**Efficient**	Avoiding waste, including waste of equipment, supplies, ideas, and energy	An **efficient** service for sexual assault and rape victims would therefore provide: • A service configured to meet evidence based demand • Better utilisation of local services where required. (increased access) • The available workforce has a range of knowledge and skills responsive to the needs of the client/service user groups				

			• Informed deployment of the workforce and resources to allow faster access to assessment, care and treatment. • Efficient deployment of skills and knowledge 24/7 • The service is well resourced, financially viable and deliverable				
5	**Equitable**	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status	An **equitable** service for sexual assault and rape victims would therefore provide: • Equitable access to the centre of excellence for all who need to access the service • Access to a workforce who are suitably qualified, competent and trained to meet the support, care and treatment needs and can reduce any risk of harm and manage the care and treatment sensitively and effectively • Access to interpretation services where required to ensure meaningful communication with all service users				
6	**Timely**	Reducing waits and sometimes harmful delays for both those who receive care and those who give care.	• A **timely** service for sexual assault and rape victims would ensure: • Sufficient workforce available to ensure timely access to the right person first time. • Sufficient infrastructure in place to provide a comprehensive service • Pursue 'best in class' (benchmarked nationally) performance to deliver the highest quality of care and ensure ease of access to support.				

Please tick one as appropriate

[ ] Service User (Survivors) [ ] Service users Representatives [ ] Member of the public
[ ] Police Scotland [ ] NHS staff (clinician) [ ] NHS Scotland (National Board)
[ ] Social Work staff [ ] Local voluntary organisation/Charity [ ] Scottish Government
[ ] National voluntary organisation/Charity Other *(Please specify)*.....

Individual score sheet Service Configuration Models **APPENDIX 5**

Consider each **essential** factor in turn. Place an X in those 'option' boxes that you consider can deliver that factor. Repeat this process for each i**mportant** factor and then for each **desirable** factor

	Service Configuration Models			
	MODEL A	**MODEL B**	**MODEL C**	**MODEL D**
	Status quo i.e. health board delivered services with limited regional collaboration	Health Board delivered services with enhanced / more-co-ordinated regional collaboration across Scotland	Regional service / centre of excellence	Centres of excellence with supported local services in [each] Health Board area
1. The optimum opportunity for service delivery within non-police setting				
2. A safe place to be examined by specialist staff that meets the highest standards for the provision of forensic examination of victims of sexual crime.				
3. Enables Multi-disciplinary working (NHS led)				
4. A responsive, modern and respectful environment for services users				
5. Will provide sufficient accommodation to meet the service specification				
6. Optimum environment to deliver of the HIS Standards				
7. Delivers person centred, safe and effective services 24/7 service				
8. Access 24/7 service (even if virtual team available to support local remotes out of hours)				
9. Greater flexibility for HBs to share resources and risk.				
10. Greater flexibility for staff to work across geographical boundaries				
11. Access to services 24/7 even if not in same place by same people.				
12. End of two tier service - (replacement of existing SLA arrangements between boards and between boards and private sector (for out of hours services).				
13. Access to a specialist workforce (gender of examiner)				
14. Access to age appropriate services, with modern accommodation, properly specification of equipment, adequately trained support, victim treated with respect and dignity				

15. More digitally enabled services				
16. Access to Sexual Violence Advisors (Care Co-ordinators)				
17. Access to Trauma, recovery services				
Important – it is important the model provides:				
1. Minimum impact of legal process (Disruption and ongoing knock on effects to victims)				
2. An educational, teaching & learning environment				
3. Enables Peer Support for staff				
Desirable – It would be desirable if the model could provide:				
1. Improved access to information within all public sector organisations				
2. Opportunities for co-location with relevant services				
3. Opportunity for further service development without the need for refer on or hand off to other agencies				

[ ] Service User (Survivors)
[ ] Police Scotland
[ ] Social Work staff
[ ] Service users Representatives
[ ] NHS staff (clinician)
[ ] Local voluntary organisation/Charity
[ ] Member of the public
[ ] NHS Scotland (National Board)
[ ] Scottish Government

[ ] National voluntary organisation/Charity

Other *(Please specify)*.....

List of Participants **Appendix 6**

1	Sandra Aitken	Child Protection Team Leader	Scottish Government
2	Faye Allan	Advocacy worker for the National Advocacy Project	Rape Crisis Scotland/ Edinburgh Rape Crisis Centre
3	Anne Armstrong	Nurse Director - North Lanarkshire Health & Social	NHS Lanarkshire
4	Sandie Barton	National Co-ordinator	Rape Crisis Scotland
5	Heather Bett	Clinical Service Manager	NHS Fife
6	Lesley Boal	Detective Chief Superintendent, Head of Public Protection	Police Scotland
7	Sandy Brindley	National Co-ordinator	Rape Crisis Scotland
8	Dr Catherine Calderwood	Chief Medical Officer for Scotland (Chair)	Scottish Government
9	Gaby Coia	Specialist Sexual Health Nurse Archway	Greater Glasgow and Clyde
10	Adam Coldwells	Chief Officer	Aberdeenshire Health and Social Care Partnership
11	Katie Cosgrove	Gender Based Violence Programme Lead	NHS Health Scotland
12	Linda Creaney	Support & Advocacy Worker	Lanarkshire Rape Crisis Centre
13	Robbie Cumming	Forensic Medical Examiner/GP/Police Custody and Offender Medical Services	NHS Ayrshire and Arran
14	Angela Cunningham	Service Manger	NHS Tayside
15	Dr Edward Doyle	Senior Medical Officer	Scottish Government
16	Gillian Galloway	Head of Prison Healthcare, Out of Hours & Forensic Medical Service	NHS Tayside
17	Andrew Gillies		Social Work Scotland
18	Bruce Henderson	Forensic Medical Examiner	NHS Ayrshire and Arran
19	Ruth Henry	Manager Archway	NHS Greater Glasgow and Clyde
20	George Laird	Paediatric/ Manager	WoS Sexual Health
21	Jamie Lipton	Procurator Fiscal Depute	Crown Office and Procurator Fiscal Service
22	Jane MacDonnell	Consultant Paediatrician	NHS Fife
23	Hilary MacPherson	O&G Consultant	NHS Orkney
24	Iain McAuley	Service Manager	North Lanarkshire Health and Social Care Partnership
25	Belinda McEwan	Children and Families Lead	Social Work Scotland
26	Dr Pauline McGough	Clinical Director Sandyford	NHS Greater Glasgow and Clyde
27	Tracey McKigen	General Manager	NHS Lothian

28	Barry Muirhead	Clinical Nurse Manager, People in Police Care	NHS Lothian
29	Anne Neilson	Director of Public Protection	NHS Lothian
30	Tom Nelson	Director of Forensic Services	Scottish Police Authority
31	Fiona Noble	Planning and Performance Manager Sandyford	NHS Greater Glasgow and Clyde
32	Alasdair Quinney	Health Board Executive Lead	NHS24
33	Karen Ritchie	Deputy Director of Evidence	Healthcare Improvement Scotland
34	Carol Rodgers	National Lead Forensic Scientist, Sexual Offences	Scottish Police Authority
35	Dr Jennifer Schofield	Adult Service Manager Sandyford Sexual Health Service	NHS Greater Glasgow and Clyde
36	Derek Scrimger	SPA Forensic Services	SPA Forensic Services
37	Cliff Sharp	Health Board Executive Lead	NHS Borders
38	Lindsay Thomson	Medical Director	State Hospitals Board for Scotland
39	Melanie Wade	Detective Inspector, SD National Rape Task Force	Taskforce Police Scotland
40	Alison Wales	Policy Officer	NSPCC
41	Deb Wardie	Consultant Sandyford	NHS Greater Glasgow and Clyde
42	Sally Wielding	Consultant in Sexual Health	NHS Borders

Event Management, Planning, Facilitation and Support

43	Leanne Baxter	(Group Facilitator)	Healthcare Improvement Scotland
44	Kate Bell	Head of Service Change and Transformation (Option Appraisal Lead)	NHS Lanarkshire
45	Prof Elizabeth Ireland	Chair of NHS National Services Scotland - representing NHS Chairs Group (Optional Appraisal Exec Lead)	NHS National Services Scotland
46	Tansy Main	Rape and Sexual Assault Taskforce Lead (Group Facilitator)	Scottish Government
47	Graham Milne	Programme Manager, Forensic Examination Services for Victims of Rape and Sexual Assault, NSS (Group Facilitator)	NHS National Services Scotland
48	Paula O'Brien	(Group Facilitator)	Healthcare Improvement Scotland
49	Donald Reece	Procurement Programme Manager (Group Facilitator)	NHS National Services Scotland
50	David Steele	Programme Director, National Services Division (Group Facilitator)	NHS National Services Scotland

51	Jana Sweeney	Rape and Sexual Assault Taskforce Policy Manager (Group Facilitator)	Scottish Government

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Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

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