OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 17 March 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 17 March 2020

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HEALTH AND SPORT COMMITTEE
7th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Sandy Brindley (Rape Crisis Scotland)
Dr Edward Doyle (Scottish Government)
Gwen Harrison (Rape and Sexual Abuse Service Highland)
Tansy Main (Scottish Government)
Katy Richards (Scottish Government)
Anne Robertson Brown (Angus Violence Against Women Partnership)
Jen Stewart (Rape and Sexual Abuse Centre Perth and Kinross)
Greig Walker (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 17 March 2020

[The Convener opened the meeting at 09:39]

Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill: Stage 1

The Convener (Lewis Macdonald): Welcome to the seventh meeting in 2020 of the Health and Sport Committee. We have received apologies from Miles Briggs. I ask everyone to ensure that mobile phones are off or in silent mode, and not to use them for recording proceedings or for photography.

The first item on the agenda is a panel evidence session on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 1. We have received apologies from the chief medical officer, who is unable to attend because she is required at Cabinet. I look forward to hearing from the witnesses on her behalf and in relation to the bill. The evidence will give us an opportunity to hear about the work of the task force for the improvement of services for adults and children who have experienced rape and sexual assault, and to hear about the bill's provisions.

The CMO is unable to be with us because of the coronavirus. The committee will not discuss the virus today, but we recognise that it is of central importance to us, to Parliament and to our constituents, and it is a matter to which we will return.

I welcome Dr Edward Doyle, who is a senior medical adviser in paediatrics; Greig Walker, who is the bill team leader; Tansy Main, who is unit head of the CMO's rape and sexual assault task force; and Katy Richards, who is a solicitor from the legal directorate of the Scottish Government. Tansy Main will make an opening statement.

Tansy Main (Scottish Government): I am the head of the unit within the CMO directorate of the Scottish Government that has responsibility for the CMO's rape and sexual assault task force and for the Forensic Medical Services (Victims of Sexual Offences) Scotland Bill.

I will not cover the bill itself, but Greig Walker will be happy to answer any questions about the bill process and about what the bill's provisions do. I will provide a brief overview of the strategic context for the work and will then briefly highlight some of the task force's key achievements to date.

I understand that you met survivors last week. The CMO and I have also met survivors and have heard similar, if not identical, accounts. Their experiences were distressing and, frankly, unacceptable. Indeed, it was feedback about the quality and consistency of the services that they received that prompted Her Majesty's Inspectorate of Constabulary in Scotland to undertake a strategic review.

The inspectorate's report, which was published in March 2017, highlighted significant gaps and disparities across Scotland and made 10 recommendations to improve those. In April 2017, the CMO was asked by the then Cabinet Secretary for Health and Sport and the then Cabinet Secretary for Justice to chair a task force to provide national leadership for improvement of those services. The task force vision is for consistent person-centred and trauma-informed services across Scotland. Our ambition is to ensure that the shortcomings of the past are not repeated. The chief executive of Rape Crisis Scotland makes an important contribution to that work and helps to ensure that the voice of lived experience is always front and centre of everything that we do.

In order to deliver against the HMICS recommendations under the remit of the task force, the CMO published in October 2017 a five-year high-level work plan. That set out actions to be taken across a range of issues between now and the end of 2022. The Scottish Government has committed £8.5 million to support that ambitious programme of work.

In December 2018, HMICS published a progress review that recognised the joint strategic leadership across health and justice but highlighted that challenges remained. At the time of that review, the CMO commented that the work of the task force was at a tipping point. Considerable progress has been made since then.

We know that having access to a female doctor is important for anyone who requires a forensic medical examination following a rape or sexual assault. Improving that was an early priority for the task force. Funding has been provided to NHS Education Scotland since 2017 to provide specific training for doctors, with the aim of increasing the number of women available to undertake the work. The training has also been adapted to allow participation by nurses who are involved in providing trauma-informed care for victims of rape and sexual assault.

So far, 118 doctors, 70 per cent of whom are female, and 68 nurses, 97 per cent of whom are female, have been trained. A further 10 doctors and 21 nurses were due to attend the NES training today, but NES decided late last week to postpone

that due to the Covid-19 situation. That training will be rearranged as soon as it is practical to do so.

Baseline workforce data indicates that, now, 61 per cent of sexual offence examiners in Scotland are female. That is an increase of around 30 per cent on the indicative figure in the HMICS report, but we are not complacent. The availability of a female sexual offence examiner is the first quality indicator underpinning the Healthcare Improvement Scotland standards and the work to continuously improve that remains a top priority for the task force and for health boards.

Task force funding has also been provided to recruit more forensically trained nurses to be present throughout an examination and to help to ensure that an individual receives appropriate follow-up healthcare and support. In addition, the task force is supporting a new initiative to develop the role of nurse sexual offence examiner in Scotland. That was a key recommendation in the HMICS report.

09:45

Funding is being provided to train a cohort of community pharmacists to look for indicators of rape or sexual assault and to provide a trauma-informed response to any disclosure. We have also begun work with the Scottish Courts and Tribunals Service to pilot sexual offence examiners giving evidence remotely in rape and sexual assault cases.

Another key HMICS recommendation was that dedicated healthcare facilities should be established across Scotland. Task force funding is being invested in each of the 14 territorial health boards to develop their sexual assault response co-ordination service, in line with a national service specification. Funding is also being provided to develop regional centres of expertise to support those locally delivered services.

All examinations that were previously carried out in a police station are now carried out in an appropriate healthcare setting, and funding has been provided to ensure that all health boards that require a colposcope are able to purchase one. In addition, the fact that a national decontamination protocol has been published and is being implemented by health boards addresses another HMICS recommendation.

A package of resources has been developed to ensure a consistent national approach to the recording, collation and reporting of data in relation to these services. That package includes the final Healthcare Improvement Scotland quality indicators that underpin the standards that were published in 2017, as well as a new national form to consistently capture information that is obtained during a healthcare assessment and forensic medical examination. That form has been agreed by all key partners to ensure that it meets the respective needs of the healthcare and criminal justice systems. The package also includes national data sets to monitor health boards' performance against the quality indicators as they progress through their improvement journey; the first national clinical pathway for adults who present following rape or sexual assault; and a summary clinical pathway for wider healthcare professionals who might be the first to respond to a disclosure of rape or sexual assault.

You will appreciate that we want to ensure that all health boards are appropriately supported to understand how those resources knit together and what their role is in ensuring a successful nationwide roll-out. As such, my team held roadshows in NHS Shetland and NHS Orkney just last week, and four more were scheduled for the remaining health boards over the course of this week and next to explain what the change in practice means for them.

However, in light of the current Covid-19 situation, we are mindful of the unprecedented pressure on the national health service to prioritise its response to the pandemic, so we are considering when it would be appropriate to ask chief executives to implement the new measures. The cabinet secretary will write to the convener about that as soon as the position has been clarified. In the meantime, we can provide copies of all relevant documents, if that would be helpful.

As we announced in the policy memorandum for the bill, a new sub-group of the task force has been established to develop detailed protocols for health boards on the provisions of the bill as they relate to self-referral. The sub-group's work is already well under way.

The task force is now halfway through its five-year plan. Although we still have much more to do, the impact that we are having is tangible, and the bill will be an important anchor that will underpin everything that we plan to achieve.

We would be happy to answer any questions that members might have.

The Convener: Thank you; that was helpful.

The recommendation was made that what was sought was a victim-centred and trauma-informed way of working. I hear what you say about the provision of more female examiners and the carrying out of examinations on health board premises, which are obviously important, but over the piece, how do you think that the work of the task force is contributing to the aim of having a victim-centred and trauma-informed approach?

Tansy Main: As I said, we have a lot more to do, but we have come a long way. Prior to the

existence of the task force, health boards in many areas already delivered such services under the memorandum of understanding, but in many places they were delivered in a police station, and many staff were not trained in trauma-informed care. Colposcopes were not always available.

In the work that we have done over the past few years, our first priority was to ensure that we moved services to an appropriate healthcare setting. I mentioned the national specification document that has been published; it sets out the requirement for age-appropriate person-centred surroundings. Although the procedures take place in a healthcare setting, the emphasis is on ensuring that the setting is as homely and person centred as possible in order to minimise the feeling that it is a clinical environment.

As you will appreciate, the suite for the forensic examination is understandably clinical to an extent, because it has to be decontaminated, but the other rooms and spaces in the suites are being designed to ensure that the environment is as comfortable and supportive as possible for people.

The other key aspect is to ensure that there is a multi-agency approach to the setting. Health colleagues have been working closely with Police Scotland, local rape crisis centres and other key partners to develop that multi-agency approach so that a survivor can have their forensic medical examination, meet their rape crisis advocacy worker and give their recorded interview to the police in the same setting. They can also shower and get fresh and clean clothes—little things that we know from feedback from survivors are really important. Things such as having a cup of tea and something to eat and some time and space to talk to someone before they leave all help to make a big difference.

Health boards are at different stages in that regard but, overall, we have made considerable progress. One of the chief medical officer's first asks of the chief executives was to ensure that all doctors who are involved in providing the care have undertaken the NES training, which was specifically designed around the principles of the trauma training framework. The majority of the doctors and nurses who are involved in providing the care have done that training, which will make a big difference to the person-centred care that is provided.

The Convener: It is clear from what you have said that the views of and feedback from survivors are informing the work of the task force. Is there a formal read-through from the survivors of rape and sexual assault?

Tansy Main: Sandy Brindley, who is the chief executive of Rape Crisis Scotland, is a key member of the task force. We have a survivor reference group, and she has kindly taken a number of issues to survivors in order to talk to them about the task force's work and to get their views and opinions. A recent example concerns the generic name for services in Scotland. You might be aware that, in England, services are called sexual assault referral centres—SARCs. We thought long and hard about what would be an appropriate name in Scotland and, based on feedback from survivors, the agreed name is now sexual assault response co-ordination services, with the emphasis on the response and the co-ordinated, multi-agency aspect of the service that we are trying to provide. We also sought survivors' views on the service specification that I mentioned, which describes the creation of that person-centred environment.

In addition to that formal channel to engage with survivors, Catherine Calderwood has met survivors directly, as I have, and their stories and experiences, which have been invaluable, are our touchstone that we always come back to. In my early days in my post, I met a survivor who had had an appalling experience. She very bravely spoke about that and explained that the process that she was involved with was not person centred or trauma informed at all. We keep coming back to such stories and thinking about how what we are doing will make a difference for people so that those things are not repeated.

Sandra White (Glasgow Kelvin) (SNP): You talked about healthcare settings, but the evidence that we have received suggests that the actual practice does not match what you said is available to people. We have been told about people having to sit in police cars or offices and being unable to change clothes, get a drink of water or even go to the toilet, and all of that is recent. How many of the healthcare settings that you talked about are in place, with the on-going support that you mentioned? Is there a timescale for them? When are they likely to be in place and providing services to survivors?

Tansy Main: We work closely with all 14 territorial health boards. Each board has a dedicated nominated lead whom we liaise with directly, and we also work closely with chief executives.

I will summarise the position by region. In the north region, prior to the creation of the task force, there were no on-island adult services for forensic medical examination. That is no longer the case, because there is a dedicated healthcare suite in the new hospital in Orkney and there is a dedicated suite in Shetland. The Western Isles service was in a general practice surgery but has now moved into a hospital setting, for which we supplied some funding. NHS Grampian has dedicated healthcare facilities in the Aberdeen

community health and care village, which were there before the task force was established. We have provided funding to NHS Tayside to move its suite out of a police station and into NHS premises.

In the south-east, there are dedicated new facilities in NHS Fife and NHS Forth Valley. They were previously located in a police station, but we provided funding to ensure that they were moved into an appropriate healthcare setting. In NHS Lothian, there is a suite in the Astley Ainslie hospital in Edinburgh and another suite in the civic centre in Livingston, which is a multi-agency centre with a dedicated healthcare suite. We recently provided some funding to make improvements there as well. In Edinburgh, we are providing a significant amount of funding for a new regional centre of expertise that will, hopefully, open in the summer. NHS Borders is progressing work for its local facility. Unfortunately, we had word recently that it has had to pause that because it needs the space for patients with Covid-19, which is the priority.

In the west, NHS Greater Glasgow and Clyde has its service at Archway, which is a healthcare facility. We have also provided funding for a new regional centre of expertise in Glasgow that will increase capacity and will be a multi-agency facility with more space so that police can also do their interviews and so on there. I visited the new NHS Lanarkshire suite just a couple of weeks ago and I believe that it is due to open at the end of April. NHS Ayrshire and Arran has a lovely new suite in Prestwick in a dedicated NHS facility, which I visited. The NHS Dumfries and Galloway facility was in a police station, but we provided funding to create a new suite in the Mountainhall treatment centre, which has been open since last June, with locally trained staff providing the service.

I do not know the timescales regarding the experiences of the people Sandra White heard from, but certainly no examinations should take place in a police station any more.

Sandra White: Thank you.

The Convener: Can you tell us what the process of evaluation will be when the task force has completed its work?

Tansy Main: Yes. As I said, we are working very closely at the moment with health board chief executives and we get quarterly returns from each board for performance against HIS standards. Going forward, the package of resources that I mentioned in the opening statement will ensure that data on health board performance against the quality indicators is collected and reported against. Those reports will be published and will be publicly available.

We are also looking to establish a managed clinical network for the services. MCNs exist for children's and young people's services just now, but we want to create one that brings together the adult and sexual abuse element of the child MCN so that we have an overarching body to oversee how services develop, monitor performance against indicators and identify where improvement might be needed. We are working with Healthcare Improvement Scotland to develop that quality assurance process to ensure that issues that arise can be dealt with appropriately. We envisage that that would also be part of the health board annual appraisal process and so on.

The Convener: Thank you.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. We appreciate your being here today.

The "Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill: child rights and welfare impact assessment" states:

> "The Scottish Government considers that the best approach is to align the Bill with the general age of legal capacity (16) and the 'age of consent'".

That means restricting self-referrals to those who are 16 or over. Obviously, rape is the antithesis of consent and there is no connection there. Why was it felt that the age of 16 is appropriate? In particular, if a child or young person aged 13 or 14 who has the mental capacity to understand self-referral is raped by a family member, it might be very difficult for them to find somebody to come with them to report that rape, given that they might be in quite a coercive family relationship to begin with. Will you explain your thinking there?

10:00

Tansy Main: I ask Greig Walker to cover that point from the perspective of the bill.

Greig Walker (Scottish Government): Another relevant factor is that 16 is the age that is applied at the existing self-referral services—the Archway facility in Glasgow and the facility in Tayside.

I will ask Dr Doyle to comment on the paediatric clinical element, the children and young people expert group and the work that he is doing on the future children's pathway. However, it is right to recognise that a range of evidence has been submitted to the committee. Some stakeholders have asked whether the minimum age for accessing self-referral could be lower, although there is no guarantee that anyone who is above the age will always be able to access it. With evidence coming from the National Society for the Prevention of Cruelty to Children and Social Work Scotland, there are also those who are asking whether there is a case for upping the age. It will

be interesting for the Government to see the committee's assessment of that in due course.

The child rights and welfare impact assessment, which Alex Cole-Hamilton mentioned, is where we have set out in the most detail the rationale for the age of 16. Following the 2019 consultation, the key pieces of legislation to be considered seemed to be the Sexual Offences (Scotland) Act 2009 and the Age of Legal Capacity (Scotland) Act 1991. It is also relevant that the mental health and incapacity legislation, including the Adult Support and Protection (Scotland) Act 2007, defines an adult as someone who is 16 or over. That is all the subject of a live review by John Scott QC, of course, and we do not want to pre-empt that.

It is important to focus on section 3 of the bill, which refers to professional judgment. I am not sure that that point has been fully understood by everyone who has read the bill. The reference to professional judgment is there because we recognise that there will be very difficult cases and that clinicians and paediatricians are well placed to work through those. In many ways, the bill does not give rise to new issues, because young people in those difficult situations will be phoning Rape Crisis Scotland, accessing community pharmacies or going to genito-urinary medicine services.

Alex Cole-Hamilton: Before you continue, I have a supplementary question. I am sure that Dr Doyle will have a view on this, as well. I understand all that and I am not saying that I have a problem with it. We are all quite new to this landscape, but many of the acts and thresholds that you mention are about rights and responsibilities and the choices that children make, whereas this is about a service that they can receive. In the current set-up—and the future set-up, if the age remains at 16—what happens if a 15-year-old presents at the Archway? Are they turned away if they have just been raped?

Greig Walker: No. Everyone already has the right to access healthcare under the National Health Service (Scotland) Act) 1978. As I think we may have said in the policy memorandum, no one will be turned away. If people cannot access self-referral for one reason or another, rather than our disempowering them by saying, "We're calling the police, whatever you think", best practice is for their situation to be explained to them.

We now have the rape crisis advocacy project and the trauma-informed workforce. Ideally, young people who are under the cut-off age and vulnerable adults will be put in a situation where they understand their position under the child protection reporting guidance and so on and are empowered to make the decision themselves. Giving people access to healthcare is the function of the bill, as I am sure Tansy Main will agree.

Another relevant factor is that it is quite rare for a young person to access a forensic medical examination, because child sexual abuse is generally disclosed quite some time outside the seven-day forensic window. We have tried in the bill to accommodate a situation where someone seeks forensics but it is not relevant to them. Section 4 has a focus on healthcare needs, which are an absolute priority even if no FME goes ahead. I note again that section 3 is about professional judgment. We are offering legal clarity and underpinning the task force and the health boards, but we do not want to overlegislate and be inflexible.

New voices have come into the debate since the 2019 consultation closed, so it will be interesting to see the committee's assessment. Will there be different options for the bill? The cut-off at 16 could in theory be left to professional judgment, as is the case in relation to vulnerable adults, or a different cut-off age could be introduced. It is interesting that some of the written evidence suggests that the age should be kept at 16 for now and changed in the future. Perhaps a delegated power would be an option in that regard.

As I said, I will be interested to see what the committee makes of that. I believe that you have a panel of children's stakeholders coming up.

The Convener: We do indeed.

Dr Edward Doyle (Scottish Government): There is no intention that anyone who needs healthcare will be turned away. A strong view came through in the work that we did—

Alex Cole-Hamilton: I am sorry to interrupt, but I want to clarify my question, because it is important to get this right. I accept that and I do not expect that anyone who needs healthcare would be turned away. I am really talking about somebody who wants access to justice—someone against whom a crime has been committed, who does not have anyone to support them and does not want to go straight to the police. That is the issue that I am talking about, rather than healthcare.

Edward Doyle: The provision there would be for the professional who sees the young person to make an assessment of risk and vulnerability and, either with the young person's consent or potentially without it, to involve other agencies and invoke the mechanism that we call an interagency referral discussion. That is the key decision point in child protection procedures. The legal situation is that child protection procedures apply to children and young people up to the age of 16. A child or young person who was in that situation would clearly receive healthcare, but the input would not be limited to that. There would be an assessment of risk and vulnerability.

To widen that out a bit, I note that that would always be the situation with other forms of abuse—physical abuse as well as sexual abuse, emotional abuse and neglect. This is core business for many of the professionals that we are talking about. In this case, the detail would be restricted to child sexual abuse, but the concepts are well understood and widely practised, and the responsibilities, as well as being part of the legal framework in Scotland, are embedded in professional responsibilities with the regulatory bodies.

The Convener: How have you sought to ensure that the bill reflects the principles of the barnahus model, which is used in Iceland?

Greig Walker: The aim is that the bill should be barnahus-ready, but barnahus is about much more than forensic medical examination and sexual abuse. The Scottish Parliament information centre briefing acknowledges that it does not necessarily involve having FME done on the premises—in some international barnahus models, it takes place in a separate hospital. It remains to be seen where Scotland is going with that.

I cannot remember it off the top of my head, but there is definitely a stakeholder organisation—it is possibly the Scottish Children's Reporter Administration—that sees the bill as a step towards barnahus, while other stakeholders are unsure. This is not a barnahus bill, but we want to be barnahus-ready. That is very much in the spirit that my colleague talked about. Although the bill legislates for health boards to deliver the legal clarity and underpinning that Her Majesty's Inspectorate of Constabulary in Scotland is looking for, it is intended to work in a multi-agency context where the police and social care have their due roles, the third sector has its role and everything comes together under the national performance framework, which is the glue that binds it all together.

Tansy Main: The service specification that I mentioned refers to the fact that services should be designed to ensure that there is an age-appropriate environment. We have been clear that our facilities that are used by adults, children and young people need to be designed with the principles of barnahus in mind. That approach is about creating a child-centred environment that is appropriate for the age group. Some health boards have their FME facilities for all ages in one place, where there is the space to do that. In other health boards, child examinations will happen in a paediatric environment unit, which is existing practice. However, it is absolutely the case that the services have been designed with barnahus in mind.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I am interested in issues around the sex of the examiner. Tansy Main talked about the need to develop more female forensic medical examiners, and the SPICe briefing mentions that the policy memorandum proposes a nurse sexual offence examiner project so that it would not just be general practitioners who do examinations.

When I visited the Mountainhall centre in Dumfries last Friday, Wendy Copeland, who does a fantastic job, told me a lot about the plan to have a women-led service. It would be interesting to hear more about the proposals to widen access so that we have more women examiners.

Tansy Main: Is your question specifically about nurses or doctors, or is it about both?

Emma Harper: It is about doctors as well. Chaperones are female, and I heard last week that even men who are raped and assaulted choose female examiners. People might not be aware of that.

Tansy Main: In my opening statement, I touched on the work that we have been doing to increase the number of female doctors. As I said, our statistics show a 30 per cent increase since the HMICS report was published. However, it is still not 100 per cent. We recognise that there is a long way to go and we are working hard with health boards to continuously improve that.

We have had feedback on the NES training in relation to remote evidence to courts from female examiners, and particularly GPs who work in the north of Scotland. If they are called to the High Court to give evidence in a trial but they have childcare responsibilities and a clinic to run, that can disincentivise them from being involved in such work, so we are looking at facilitating remote evidence-giving in order to retain the female doctors that we have.

The key to ensuring that people who want a female examiner can have one is the nurse examiner model. That is not new. Sexual offence nurse examiners have existed in England for almost 20 years and they regularly undertake examinations and give evidence in court if they are required to do so. Since the HMICS report, we have done a lot of work to develop detailed proposals on how we can adopt that model in Scotland. We have approval from ministers and the Lord Advocate to undertake a test of change, and we are recruiting this month for two nurse examiners to do that work.

In England, in order to qualify as a nurse examiner, nurses have to undertake a postgraduate qualification in advanced forensic practice for a year, and they have to do a period of on-the-job shadowing before they fly solo. The nurses that we will recruit to the test of change will have the levels of qualifications, experience and

knowledge that are required for the role. At present, only a couple of nurses in Scotland have the qualification, because only Staffordshire University in England offers the course.

In parallel with the test of change, which I will come back to in a moment, we are working with Queen Margaret University to create a new postgraduate qualification in Scotland so that the workforce here can access the training. That course is due to start in September this year and the Government is providing funding for 10 places. Priority will be given to boards in rural and island areas, where it is particularly challenging to have female examiners.

We hope that the test of change will start around June, and it will be hosted at the Archway service in NHS Greater Glasgow and Clyde. We have worked closely with the Crown Office and Police Scotland around that to ensure that they have in place the safeguards and reassurances that they require so that there is no risk to the criminal justice process. We are also working with Rape Crisis Scotland, which will be involved in the evaluation and in getting feedback from survivors on the impact of nurse examiners.

We see the model as being key to creating a multidisciplinary workforce. It will never be the case that it will comprise only nurses or only doctors. We want to increase the pool of people who are available.

A majority of the nurses who are interested in this work are female, which is understandable. There is a lot of appetite from health boards to send nurses for the training, and they are keen to do it. I hope that, when the test of change concludes, the first couple of cohorts will have come through the postgraduate qualification at Queen Margaret University and we will be ready to commence the work. We hope that that will be the landscape for the future.

10:15

Sandra White: Tansy Main said that there are 118 doctors, 70 per cent of whom are female, and 68 nurses, 97 per cent of whom are female. In answers to Emma Harper you mentioned two forensic practice nurses. How many female doctors and nurses are there in Scotland who are capable of doing forensic examinations of the type that we are talking about?

Tansy Main: Bear with me for a wee second while I look through my papers. I have the numbers with me somewhere—

Sandra White: You can send them to us if that is easier.

Tansy Main: I have found the stats: there are 76 forensic examiners in Scotland at the moment, of whom 43, or 61 per cent, are female.

Sandra White: Okay. That is grand. I just wanted to get the numbers, because we are talking about training, too. I am sorry for labouring the point, convener. You mentioned the course at Staffordshire University and the one that is opening at Queen Margaret University. Have there previously been no courses in forensic examination of this type in Scotland? That is what I cannot get my head around.

Tansy Main: There is NHS Education for Scotland training, which all the doctors and nurses who currently deliver the service are required to attend. The doctors undertake a shorter training programme, by virtue of their having a medical qualification, before they are able to do the work. The nurses who attend examinations, to assist doctors and provide trauma support to survivors, are also able to attend the training, so that they can understand and explain the process.

Sandra White: But is that training available in Scotland?

Tansy Main: Yes. The NES training happens in Scotland and has been adapted, so that it is portable and can be delivered in remote and rural locations.

The Queen Margaret University training is specifically for sexual offence nurse examiners. There is a year-long training programme to get that qualification, which is not currently available in Scotland but will be available.

Sandra White: That was my point. If we are pushing for the training, it is important to make the point that it has not previously been available in Scotland.

Tansy Main: Nurse examiner training was not available, but it will be.

Sandra White: We touched on healthcare needs. We heard lots from the witnesses who talked to us in private about their needs and the psychological trauma that they had gone through. Even 10 years later, if they were going for a particular examination, it brought it all back. People had had no support whatever.

You talked a lot about healthcare needs and the terminology in that respect. I have two quick questions—well, they might be quick, depending on how people want to answer them. What does “health care needs” as set out in the bill mean? Will there be guidance on that? Is it anticipated that the two big issues of mental health needs and psychological support will be included under the healthcare needs umbrella?

Tansy Main: Let me give a brief answer and then pass the question to Dr Doyle, who chairs the clinical pathways sub-group for the task force.

The clinical pathway that has been developed is very much about a holistic healthcare response. Forensic medical examination, which, as we know from feedback from survivors, can be the most traumatic part for people, is actually a small part of the services that should be provided. There should be wraparound care involving an assessment of people's psychological and emotional wellbeing, their safeguarding needs and what referrals they may need to other services, such as mental health services or Rape Crisis Scotland services.

Through the task force, the chief medical officer has asked the board chief executives to ensure that they have nurse co-ordinators in place. That may be the same nurse who attends the examination, but in some boards it will be a different role. In some places, the role is embedded in the gender-based violence service or sexual health service. That person's role is to ensure that, after the forensic medical examination, the victim is not left to navigate their own way round the health system, and that they are supported to access the on-going care and support that they need. As I said, some health boards already have that approach in place and others are working towards it. That will make a big difference by ensuring that people have a single point of contact for support as they progress on their recovery journey.

Dr Doyle: We use the term "health care needs" as a broad umbrella term. For example, the situation might start with managing an acute injury, such as control of haemorrhage, and then we would have the actual forensic examination. In the clinical pathway, we have tried to give practitioners a structure to work through. As well as dealing with acute injuries and forensic examination, they are prompted to think about things such as emergency contraception, vaccination for hepatitis B and HIV prophylaxis—there is guidance in the pathway about that. Practitioners are also asked to think about whether the person should be referred to sexual health services and, in the medium term, they might think about drug and alcohol services.

We are also mindful of the need for on-going mental health support in its widest sense. That might not be psychiatry; it might be psychology or counselling. We have done quite a lot of work on how that would look for people after the acute episode, including for children and young people. We are working on some tests of change in the west to inform further developments in that regard. The expert group on children and young people has done an awful lot of work on how we provide consistent and high-quality therapeutic support for young victims across the piece in Scotland. We are mindful of that issue.

All those things come under the umbrella term "health care needs".

Greig Walker: I said earlier that the section that deals with healthcare needs is section 4, but it is actually section 5. I cannot add to what Dr Doyle has said on what the term is intended to mean, but I will pick up on some related points on the bill.

The first is about the way in which we have drafted the bill generally, and specifically the definition of "forensic medical examination". In considering the FME process, we cannot ever entirely disentangle the healthcare and clinical needs from the forensics and justice needs, so we have not attempted to do so. We have tried to find the best interface between wider law and practice in the bill.

Another point that I could usefully pick up on that has been mentioned in a few of the exchanges so far is about the principle of trauma-informed care. In the schedule to the bill, on page 9, we propose to add that principle to the statute book for the first time. That has been welcomed by NHS Education for Scotland, which feels that the approach complements all the good work that it has been doing on guidance and training.

Tansy Main: I have a brief point about the final HIS quality indicators, which have been published. Indicator 4 is on assessing support needs and on-going safety planning, and indicator 5 is on access to immediate sexual health care. Those measures were not previously available, so we risked people slipping through the net and being discharged from the FME service without that on-going safety planning and support in place. The quality indicators will help to focus health boards' minds on the importance of ensuring that that is all provided in a holistic manner.

Sandra White: I am interested in Greig Walker's evidence about the trauma-informed workforce. Tansy Main talked about advising in that regard, but Greig Walker said that the provision on a trauma-informed workforce will be in legislation. This is up to the committee, but I am keen to ensure that, after hearing from others, we can make amendments to the bill on that issue, because it is important. We have talked a lot about clinical and forensic issues, but this is about the victims and their trauma—that is the important part. Thank you for that evidence. I will look at section 5 to see what I can see, and at page 9 of the bill, which I think Greig Walker mentioned.

Greig Walker: If it is at all helpful, the precise legislative reference is part 2 of the schedule, in paragraph 3(5)(b).

Sandra White: I will pick that up from the audio recording.

Greig Walker: The clerks can perhaps help with that. It is on page 9.

Sandra White: Thank you.

Brian Whittle (South Scotland) (Con): Why was it decided that the timescales for retention of samples would not be specified in the bill but would be set out by the Scottish ministers in regulation?

Greig Walker: When we launched the 2019 consultation entitled "Equally Safe—A consultation on legislation to improve forensic medical services for victims of rape and sexual assault", we realised that people would express views about self-referral on a general basis, but we perhaps did not think that they would get into the details of which body holds the samples for how long and what victims' rights are. About a year ago, we had a useful workshop involving Rape Crisis Scotland, health boards, Police Scotland and others at which we fairly easily reached consensus on health boards having to hold samples for the retention period.

One point that came out strongly was that, given that rape and sexual assault completely take away the victim's autonomy and consent, we need to give victims real rights. That is why the bill provides a right to instruct the destruction of samples, a right to instruct transfer to the police and a duty to ensure that victims are informed at the time of examination of what the retention period is and have that explained to them.

Frankly, we did not reach a consensus on the retention period. Tansy Main mentioned that there is now a self-referral sub-group. From considering practice around the United Kingdom, it seems that there is no consistency in any part of it, other than Northern Ireland, which has a single retention period because one facility covers the entire province.

The Faculty of Forensic & Legal Medicine has recommended that the period should be two years, but occasionally it has been put to us that any retention period that ends on an anniversary could be triggering and traumatising. That is very much a live question for the self-referral sub-group. If, during the course of parliamentary proceedings, the committee takes a view or there appears to be a consensus on that issue, an amendment could be made to the bill.

Another reason why the matter has been left to regulations is that services around the UK have changed their retention periods. The FFLM guidance and other guidance could change. We propose that the period should be prescribed by regulations, which would be dealt with under affirmative procedure so that there would be due scrutiny by the committee and Parliament. That approach allows for evolution of medical and forensic science. Another issue is that survivor input will be important before the period is prescribed.

Tansy Main: The self-referral sub-group of the task force is trying to gather best practice from elsewhere in the UK. The group is looking primarily at the SARCs in England, which are well established. As Greig Walker said, there is no real consistency. However, from the evidence that we have gathered so far, it seems that most places have a retention period of around two years; in some places, it is one year. One interesting thing that we have heard from the SARCs is that the majority of survivors who self-refer decide to report to the police fairly soon after the event—within a month or a couple of months. One service in London has reduced its retention period to a year, because it found that the majority of people decide to report fairly quickly. We will look at all the evidence and share it with ministers and the committee to help to inform the debate on that issue.

Brian Whittle: Can you confirm that you will seek views and input from victims on the length of time that they want samples to be retained?

Greig Walker: With any affirmative instrument, the committee will ask us what consultation we have done. We are actively thinking about that.

Tansy Main: The fact that Sandy Brindley, who is the chief executive of Rape Crisis Scotland, is a key member of the task force's self-referral sub-group will ensure that survivors' voices are heard in all our deliberations. Sandy also chairs a group that sits underneath the sub-group, which is looking at how survivors access services. We are very much seeking to ensure that survivors' voices are front and centre in those deliberations.

10:30

The Convener: Emma Harper has a supplementary question.

Emma Harper: When you mention evidence being retained for two years, are you talking about physical evidence such as DNA? Other types of evidence, such as photographic evidence, could last for ever. Does the two-year period relate specifically to physical evidence such as DNA?

Greig Walker: I clarify that that is not Government policy. I was simply pointing out what is in the UK Faculty of Forensic & Legal Medicine guidance. At present, however, that is not fully adhered to across the UK.

The bill proposes that victims will have control of all types of evidence that are provided by them,

including samples, clothing and colposcope images. If they instruct deletion, the evidence will be gone. If they instruct its transfer to the police, it will be seized by the police and become a criminal production. However, the bill recognises that, in addition to the retention period, the nature of what is retained will be open to clinical judgment and subject to what the victim consents to, depending on what they think is best for them. Again, the self-referral sub-group is actively thinking about that.

David Stewart (Highlands and Islands) (Lab): Last week, as the panel will know, we met 10 women survivors, and among the key issues that came up were lack of support and the need for independent advocacy. Was consideration given to those in development of the bill?

Greig Walker: In the policy memorandum, we reference the Rape Crisis Scotland advocacy project. Perhaps you will hear from Sandy Brindley later about how the situation feels to Rape Crisis Scotland, but we would not want Parliament to overlegislate and say that other bodies should do this or that, because the advocacy project already exists and is working quite well. It could have a particularly important role to play in relation to self-referral, which will be a new proposition in most parts of Scotland and is perhaps not in many victims' minds at present. Tansy Main might have something to add.

Tansy Main: I do not have a great deal to add. The funding for the Rape Crisis Scotland national advocacy project comes through our equality and violence against women and girls colleagues. The Government is committed to the project and to ensuring that people can access those advocacy services.

David Stewart: I understand the point about not overlegislating. However, I think that, in the harrowing meeting that we had last week, we were all struck by how nightmarishly horrible the women's experiences were, and I am sure that that is replicated throughout Scotland for other victims. There is clearly demand for advocacy services within rape and sexual abuse services, including in the Highlands, in my region. I am not convinced that I would use the word "overlegislating" in relation to the bill. I believe that there is a huge gap here and that such services are vital. Is anything being done at this late stage to change that?

Greig Walker: That is ultimately a matter for the committee. In relation to what the bill does to dovetail with advocacy services, I note that section 4, which is essentially on victims' rights, says that people must be given information ahead of the examination. I understand that you heard last week that it was not made clear to victims what was going on, why things were being taken or what would happen next. Section 4(2)(b) says that information must be explained, which could be done by the health board's trauma-informed workforce, working in partnership with others.

Another relevant factor is that we are applying the Patient Rights (Scotland) Act 2011 to everything under the bill. That act covers the accessibility of information, and in that spirit we have published an easy-read summary of the bill, which was called for by bodies including People First Scotland.

I think that a lot of good work is going on. I appreciate that the committee heard some pretty terrible things but, as Tansy Main said, we are beginning to turn a corner; people are having better experiences because they are getting positive support from advocates and are having a good experience with the examiner and forensically trained nurse. It no longer feels like a police process; it feels as though their healthcare and recovery is front and centre.

David Stewart: On that point, will the police be encouraged to tell people about the option of self-referral services?

Tansy Main: Yes. The access to services sub-group of the self-referral group that Sandy Brindley chairs is looking at how survivors will access services and what information will be available. Police Scotland and the Scottish Police Authority are part of that work and will ensure that Police Scotland information materials point people to the fact that they do not need to speak to the police first, and that other options are available to them.

David Stewart: Did the Government examine best practice in other parts of the United Kingdom, such as the England, Wales and Northern Ireland victims commissioner project? I declare an interest, because, some years ago, I proposed a bill on that subject. As members of the panel know, the issue is about who stands up for victims. A number of years ago, I took a lot of evidence on that; I met the Victims Commissioner for England and Wales in London and telephoned the Northern Ireland Commission for Victims and Survivors. The Government did not choose that model, and I accept that the legislation is not specifically about that, but there is a huge issue about who stands up for victims. Independent advocacy is one argument; sharing victims' experience so that we can improve the law is another. Have you considered the themes around victims commissioners in other nations in the UK and brought that thinking into this legislation?

Greig Walker: I will pick up a few of those points. We have absolutely considered services in the rest of the UK, because self-referral is well established in other parts of the UK. There have been a number of facility visits, and colleagues around the UK have been generous with their time

and expertise. They produced as much data as they could to help us inform the modelling assumptions in the financial memorandum. We were planning additional visits but they are on hold for the time being.

On the point about victims policy, this is a healthcare bill but it is also a justice bill and a victims bill. Therefore, the task force that you have heard about is complementary to the victims task force, which is under way. It has important survivor liaison; Sandy Brindley is also involved in it and the work is well co-ordinated within Government. It is within the remit of that task force to consider the question of the creation of a victims commissioner but that is a wider justice system measure that is not specific to this bill. We deliberately included the word "victims" in the title of the bill because it is a victims bill.

David Stewart: With joined-up Government, I hope that we are not in silos. Victims on the front line are experiencing the horrors of rape and sexual assault and their needs must be highlighted in the legislation.

Katy Richards (Scottish Government): The committee might find it helpful to note that the bill will also amend the Victims and Witnesses (Scotland) Act 2014, which has a section that allows

"referral to providers of victim support services".

Therefore, that provision will apply also to people who are accessing services under the provisions of the bill.

David Stewart: That is positive. It is also essential not just that the services are there and are developed, but that people know about them. We picked that up from the harrowing evidence that we took last week.

I will move on to capacity and consent to be examined. Convener, I do not think that we have covered it yet but stop me if we have. Particularly in relation to self-referral, what guidance will be issued to health boards in relation to legal capacity and consent?

Greig Walker: To return to something that Dr Doyle and I said earlier, the bill does not give rise to new issues; FME services exist across Scotland and there are some self-referral services. There is extensive guidance from the General Medical Council and the Royal College of Nursing. There are also pieces of Scottish guidance, such as adult support and protection guidance and the current and future child protection guidance. I keep coming back to the point about providing sufficient legal basis and clarity, but guarding against the risks of overlegislating, we felt that, because principles of consent and informed consent are so well embedded in general Scots law and clinical practice, we did not need to replicate them in the bill.

Certainly, the policy is that absolutely everything should be done on the basis of informed consent, with as much survivor input and control as possible. Tansy Main mentioned the adult clinical pathway; what comes out strongly in that is the principle of supported decision making in the United Nations Convention on the Rights of Persons with Disabilities. That relates to adults with learning disabilities, but the general idea is that people should be empowered to make as many decisions as possible for themselves and to know what is going on.

Dr Doyle might want to add something about clinical practice.

Edward Doyle: I do not have anything to add at this stage. All health boards have revised their approach to consent in the wider sense, in the light of a significant medical legal ruling in 2015, in the case of Montgomery v NHS Lanarkshire. There has been a lot of work on that, and the process that we are talking about today is captured in that thinking.

David Stewart: Do we need changes and improvements to examinations, to ensure that people are truly able to give informed consent?

Greig Walker: I would say that that is current best practice and is what is being delivered on the ground.

David Stewart: Thank you.

The Convener: Just before we move on, in response to a question from Brian Whittle about retention, Greig Walker referred to the victim of a sexual offence having control over the evidence. Is the implication of what you said that, once evidence was passed to the police, witnesses did not have control over it?

Greig Walker: The bill legislates for health board responsibilities. It legislates for the interfaces in police referral cases, where a constable brings a victim to a facility. That is the usual model in Scotland, and a sexual offence liaison officer handles the matter; police processes have improved a lot. The bill also picks up on the point that the constable takes the evidence away.

The wider justice process is legislated for separately. Parliament recently passed the Scottish Biometrics Commissioner Bill, which is part of the mix of the law that applies on the criminal justice side. As Katy Richards said, we recognise the important role of the Victims and Witnesses (Scotland) Act 2014, which is partially applied to the bill, where relevant. The Patient Rights (Scotland) Act 2011 is the most relevant rights act in relation to healthcare and is fully applied, including the wording about trauma-

informed provision of healthcare. The victims code for Scotland under the 2014 act applies fully to victims after they have made a police report. There is also the appropriate adult service.

A number of reforms have been made to put in place measures for victims once they are in the justice system, but the bill has to accommodate the possibility that the victim chooses never to go there.

The Convener: But in practical terms, what does that mean for the victim's control over the evidence?

Greig Walker: We know from feedback from survivors that, in a police investigation, more evidence may be taken, such as jewellery and scarves. Under the 2014 act, victims can request to have that back. The process should be smooth, under the guidance, but it was suggested that a few years ago it was not as smooth as it should be. I am certain that the victims task force will look at such issues.

Emma Harper: Some respondents were concerned about the increased costs for health boards, which must implement the provisions of the bill, but it seems that the Scottish Government has provided funding to set up sexual assault centres in healthcare facilities. What concerns have health boards raised about long-term funding and what action has the Scottish Government taken to support boards in that regard?

Tansy Main: As I said, the Scottish Government has committed £8.5 million over three years to support health boards to embed the Healthcare Improvement Scotland standards and prepare for the forthcoming legislation. That has been pump-prime funding, to build workforce capacity, improve the physical environment, procure essential equipment and deliver national projects such as an information technology system.

10:45

Everyone was at different starting points. Some health boards were already delivering services; others were not or had significant improvements to make. Therefore, our aim was to bring everybody up to a similar standard. In order to do that, we asked each health board to do a self-assessment against the HIS standards. That informed a gap analysis; from there, they could identify what funding they would require in order to help them meet the HIS standards. To ensure that the funding was targeted where it was needed most, each health board brought those costed local plans to the task force to bid for funding. At the moment, we are in the process of reviewing their funding needs for this coming financial year. All the funding has been provided on the basis that the health boards commit to sustaining the services that are developed using the task force funding beyond the lifetime of the ring-fenced task force allocation.

A significant amount of the funding has gone into capital developments, such as premises and equipment. As I said, we have also provided funding for pump-prime recruitment of staff, such as forensically trained nurses, to be present during examinations, and to increase the number of female doctors in the Archway service. We are on an improvement journey. With regard to the workforce, come the end of the task force funding, there will be a revenue tail. We are working with health boards to see what that fully costed model would look like beyond 2021-22. As I said, health boards have committed to maintaining the services that are developed utilising that task force funding.

Emma Harper: Are health boards concerned that there will be a big increase in the number of people coming forward? Are they worried that that might impact where we are? We want people to come forward and to feel safe and secure. There needs to be a holistic approach, and any rape or sexual assault needs to be dealt with in a trauma-informed way.

Tansy Main: There is some concern around that. The modelling in the financial memorandum was based on the best available information at the time; that indicates an expected increase of around 10 per cent in demand for self-referrals. Bearing in mind that the police referral model already exists, the increase in demand on health boards will primarily arise from those who choose to access a self-referral instead of a police referral. That 10 per cent is spread between the 14 territorial boards. Understandably, the larger boards will have a greater proportionate share of that demand. The financial memorandum indicates a cost of between £220,000 and £290,000 per year across all 14 boards. Therefore, the cost per board is not significant in the grand scheme of health board funding from the Government.

However, time will tell what the level of demand looks like. Sexual crime is often underreported; as awareness grows of the availability of the service, that demand might gradually increase but, rather than a big surge at the beginning, we expect it to be incremental. From when the bill is implemented, we expect the cost of the increased demand for self-referral to be not too great per board.

Emma Harper: As people find out about the self-referral process, they will get to the right place and the right people. You will track all the data to see whether the numbers are different in rural and urban areas. Is there any additional concern? The modelling says that from a low-demand scenario to medium demand, there is a projected 20 per

cent increase. However, from a low-demand scenario to a high-demand scenario, there is a projected 35 per cent increase. Is that just part of the modelling that has been done to look at how numbers will be projected?

Tansy Main: Yes. As I said, it has been very difficult, because we have not had a consistent means of gathering data on existing demand for services. We asked health boards to trawl through and provide figures for the task force and we understand that, in the previous calendar year, there were 697 police referrals for forensic medical examination and 46 self-referrals. At the moment, the number of self-referrals is low in comparison with the number of police referrals. We now have that baseline and will be able to closely monitor how demand increases over time.

Emma Harper: Thanks.

David Torrance (Kirkcaldy) (SNP): What consideration was given to including a provision in the bill to require monitoring and reporting by health boards?

Greig Walker: I imagine that you are aware that the Law Society of Scotland raised that point.

The package of resources that Tansy Main mentioned in her opening remarks would include consistent national data collection, to allow for modelling assumptions to be replaced with real data, to make it much easier to plan.

An assessment must always be made about what a bill needs to cover and need not cover. There is much good stuff in the task force's work that we felt was adequately covered. For example, we did not feel that the arrangements on the national form, quality assurance and how the information is collated and reported back needed to be statutory. I imagine that the committee will take its own view on that.

David Torrance: How will data collection on forensic medical examinations drive improvement in the service?

Tansy Main: As I said in my opening remarks, the package of resources includes a national form, to ensure that information is recorded consistently. Each health board will provide data to the Information Services Division, to demonstrate its performance against the Healthcare Improvement Scotland quality indicators. That information will be used as part of a quality assurance process that we are developing with HIS, to ensure that the improvement of services is always under consideration, through, for example, the health board annual appraisal process and the managed clinical network that I mentioned.

Brian Whittle: I want to consider the areas that are not in the bill. The memorandum of understanding between Police Scotland and health boards covers more than forensic medical services for victims of sexual assault and rape. Police Scotland pointed out that the wider provision of forensic medical examinations continues to remain outside the legal framework in the bill.

In its submission, the NSPCC said that the examination of children and young people who are alleged to have been involved in sexual assault and abuse is not included in the bill, although

"many children suspected of perpetrating sexual offences are subject to forensic examination in police custody."

The NSPCC went on to say that it would support the bill's provisions being extended to cover the forensic examination of all children, on a statutory basis, and to cover the provision of therapeutic interventions.

How will the arrangements in the MOU that are not in the bill be continued? Will the MOU be revised in light of the bill?

Greig Walker: I will answer the points that I can answer and ask Dr Doyle to talk about the paediatric practice element.

Forensic services is a wide concept, and Scotland has very little legislation on forensics. Even if we narrow it down to forensic medical services, we are still looking at a wide concept, including toxicology, dentistry and all sorts of things. In the 2019 consultation, we asked whether there was a consensus on the need for legislation to deliver the clarity and scope that HMICS was looking for.

Ninety-one per cent of responses endorsed the consultation proposals, which were focused on addressing the HMICS report and the sorts of issue that you have heard about from survivors. I suppose that we made the assessment that we could make relatively quick progress on specific legislation, in the context of the MOU remaining in place for everything else.

It is fair to put on record that the NSPCC and Children 1st also made that point last year. We recognise that. We take the view that, whether someone accesses FME under the bill or under the MOU, there will be no second-tier service. There could be situations in which an FME is accessed on both bases. We have the trauma-informed workforce, the Patient Rights (Scotland) Act 2011 and so on.

In essence, FME for children is rare, because of when things are reported. In the rare instances in which FME is needed in the context of non-sexual child abuse, the basis for that is the MOU; I will ask Dr Doyle to explain how, in essence, the practice is the same.

Dr Doyle: There is very little difference in practical terms between a paediatric forensic examination for suspected sexual abuse and one for abuse. Such examinations tend to be done by the same people, in the same facility.

The bill was not created in a vacuum. There have been standards, guidance and training in paediatric forensic examination for a long time. We have had the three managed clinical networks for child protection in Scotland for some years now; they set standards, gather data and report through their own governance structures.

The fact that non-sexual abuse is not legislated for in the bill will not be detrimental to the service for children and young people in the context of other forms of abuse.

Greig Walker: The barnahus concept encompasses all forms of child abuse. The bill would not limit the approach to FMEs for sex crimes.

Brian Whittle: Has consideration been given to including in the bill children who are alleged to have perpetrated sexual abuse, or do such children sit outside the approach?

Greig Walker: In its report, HMICS made a recommendation about child suspects that was directed to Police Scotland and health boards. The issue is currently being considered through a police care network, so we did not see a need to address it in the bill. However, I understand that the Age of Criminal Responsibility (Scotland) Act 2019 will be the legal basis for alleged perpetrators under the age of 12 providing samples.

Tansy Main: The police care network has been developing standards for the examination of children and young people under the age of 12 who are suspected of sexual crime. The HMICS recommendation was that that does not happen in a police setting, because the suspect is still a child, albeit that they are suspected of a crime. The draft standards that are being considered will embed the principle that an IRD will always take place to determine the most appropriate place for the examination to happen and that that should be a healthcare facility, where at all possible. Protocols will need to be in place between the health board and the police, to ensure that a suspect is not in the same location as the victim at the same time—they must be dealt with separately. The principle of a child who requires an examination being in a healthcare setting rather than a justice environment is very much at the centre of the approach.

The Convener: You referred to an IRD; will you spell that out for us?

Tansy Main: Sorry. It was mentioned earlier; it stands for interagency referral discussion.

The Convener: Serious sexual assault and severe forms of child sexual abuse are sometimes associated with socioeconomic disadvantage. Are the work of the task force and the bill designed to make it easier for victims in such circumstances and those who live in the poorest areas to come forward and seek support?

Greig Walker: We published a number of impact assessments with the bill, including a full fairer Scotland duty assessment, which you can read.

We recognise that there are socioeconomic and other equalities dynamics. The bill talks about people—that is modern drafting practice and you will also see it in the clinical pathways. Everyone is entitled to the same service, but how the boards offer the service from a position of equity is something that they will think about through implementation that is co-ordinated through the task force.

Impact assessments are being done not just for the bill but for the package of supporting documentation that Tansy Main mentioned

Tansy Main: The task force undertook an options appraisal in 2018 to look at the model and configuration of services in Scotland. It was a rigorous process, which involved all our key stakeholders. The preferred model is very much one in which services are delivered as closely as possible to the point of need. That is why we have been developing local services in each of the 14 territorial health boards. Some boards have more than one local service, and there is support from the regional centre.

It is important that people do not have too far to travel to access the service. That is why we focused on there being a local service as far as possible.

The Convener: I thank the bill team and all the witnesses who have given evidence this morning. I am sure that we will talk about these matters again. If witnesses think that it would be helpful to provide further points of information arising from our questions this morning, feel free to do so.

I suspend the meeting for a few minutes, to allow for our round-table evidence session to be set up.

11:01

Meeting suspended.

11:12

On resuming—

The Convener: We resume with our next evidence session as part of our scrutiny of the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 1. We are joined by Sandy Brindley, who is the chief executive of Rape Crisis Scotland; Anne Robertson Brown, who is the vice-chair of Angus violence against women partnership; Gwen Harrison, who is manager of Rape and Sexual Abuse Service Highland; and Jen Stewart, who is centre manager of the Rape and Sexual Abuse Centre Perth and Kinross.

This round-table session will involve members of the committee asking for your views, opinions and experience, but it is more informal than the session that we have just had with the Government witnesses, which you might have watched. Feel free to ask us questions if you think that that will help the dialogue. Do not feel that you have to answer every question—just come in when you have something that you want to add. We are a little spread out, but that is appropriate in the circumstances.

I have a question for any of the witnesses that relates to the discussion that we have had today and informally in the powerful and moving evidence session that we had last week. Which aspects of the examination service are most important for those who have been victims of rape and sexual abuse?

Sandy Brindley (Rape Crisis Scotland): The feedback that we have from survivors is that the most important issue is access to a female doctor. The lack of access to a female doctor is what causes the most trauma.

Another significant issue, which came up at the closed session that we had with survivors last week, is delay. We cannot overstate how much distress is caused by having to wait hours or even days for a forensic examination after being raped or sexually assaulted, which means that victims cannot wash. That can cause huge distress for people. Those are the two key issues.

There are also broader and more general issues. There is a lack of trauma-informed practice. At the closed session last week, one survivor spoke about how the male doctor who examined her did not say a word during the examination. That is clearly not trauma-informed practice. That is a cultural issue, but it is also about how medical staff who are involved in examinations are trained.

11:15

Jen Stewart (Rape and Sexual Abuse Centre Perth and Kinross): I reiterate that the issue of access to a female examiner has come up consistently, as has communication. That comes under the heading of trauma-informed practice. It is important that examiners are clear about what they are doing, when they are doing it and why. Survivors have told us what a difference that makes.

A non-judgmental approach is vital. In Tayside, we have SARN—the sexual assault referral network—which supports survivors and connects them with a rape crisis worker from the beginning. They are met by the worker and a nurse. Follow-up support work has also made a significant difference.

Gwen Harrison (Rape and Sexual Abuse Service Highland): Survivors also tell us that people should be able to pause the process to get the information that they need and take stock before they decide how to proceed. People tell us that that would make a huge difference.

In Highland, there are big concerns about travel and how people access services. We have had instances of people being transferred from one police car to another because it is time for a change of shift, or because they are going from one area to another. That can be retraumatising, as part of that journey.

Anne Robertson Brown (Angus Violence Against Women Partnership): I echo what has been said. Our area is semi-rural, so we have issues with travel, too.

We asked specialist agencies to hold focus groups before we responded. One key idea that came through was about victims being given back some control and being able to pause so that they can say when, how and how fast the process goes ahead.

The Convener: One thing that shocked me in the session that we had last week—because I was not aware of it—was the situation in which somebody who wanted to report a rape on a Sunday night found that the service was so much poorer than it would have been on a Monday morning. Is it important for victims for there to be an out-of-hours or 24/7 service?

Sandy Brindley: Absolutely. No matter when somebody is raped or when they choose to access health or forensic services, they should be able to access the service when they need it. It should not be a two-tier service in which someone who is raped out of hours or at the weekend has to wait overnight, without washing, in the clothes that they were raped in. It is inhumane to expect that of

people in those circumstances. The services should be resourced 24 hours a day.

It is different if the offence is historical and there is no immediate need for a forensic examination or for a health response, but if somebody has just been raped they should not wait days for an examination.

Alex Cole-Hamilton: It is great to see you all here. I reiterate our thanks for the services that you provide. The testimony that we heard last week will stay with me forever.

One thing that struck me in the stories that we heard was that there is sometimes a lack of consent in rape examinations. One example that stuck with me was about a situation in which there was a female healthcare professional, but she said, "We'll just do your smear test now." She did not ask; she just did it. That seemed horrifying. I would like to think that that is the exception rather than the rule, but can you give us an understanding of that?

Jen Stewart: Particularly in the past two years, the feedback on the forensic medical examiners has been very positive. Survivors in our area have fed back that, in their experience, things have been explained and the process has been more trauma informed. Many experiences have been shared with us where that has not been the case, but we have definitely seen progress at local level.

Sandy Brindley: We are seeing progress nationally, too. We have a feedback protocol when we get referrals from Police Scotland. Through the national helpline, we ask people questions, which they can choose to answer, about their experience of the police and the forensic process. That means that we get quick and on-the-ground feedback about what is happening. It is fair to say that, over the past six months in particular, the feedback has started to improve. We are starting to see the impact of the work of the CMO's task force on those issues, which is definitely being reflected in the better feedback that is coming through from survivors who are in contact with us.

However, delays, which cause a lot of distress, continue to come up. The two issues that still come up in the feedback that we get are delays and the lack of female examiners.

The Convener: Is there anything in addition to those two points that you would like to see in guidance to health boards on examinations?

Sandy Brindley: The point about links to advocacy services was well made earlier. Rape Crisis Scotland runs a national advocacy service in partnership with all our local rape crisis centres. The feedback from survivors is that it is a life-saving service, but there are real issues with capacity and funding. Some of our advocacy services have to operate waiting lists, which is not acceptable for services of that nature. We need to consider how to properly fund the health response as well as the services that should go alongside it.

On the issue of resourcing the health response, we should not look only at the number of additional cases through self-referral; we are asking the health service to transform its response to rape and to survivors of rape. Doing that properly will require a significant injection of resources above that which is required for the number of self-referral cases.

For me, the bill has two key functions. One is self-referral and the other, which is just as important, is about making it clear that the health service has a responsibility to respond to the needs of rape survivors. That has not necessarily happened to date, because it has been focused on the old model of provision of the actual forensic examinations rather than the wraparound care. If we are to get the services to a stage where they are not an embarrassment to us as a country, significant investment will be required.

David Stewart: The issue of advocacy has been highlighted. I agree with the points that have been made and echo that the meeting that we had last week was harrowing; the 10 women who came along were extremely brave.

I was certainly struck by the need for independent advocacy. Sandy Brindley was in the room earlier when I raised that point with the bill team. I still feel that the bill should be clearer about advocacy services. It is not enough that they are there; my sense is that they are still patchy and are probably underfunded across the country. Survivors or victims need to know about those services, and clearer emphasis in the bill would help in that regard.

The committee and individual members have a role in relation to amendments, so I would be grateful for the other panellists' views on that. I gave Gwen Harrison's service an advert earlier, so I ask her to respond.

Gwen Harrison: That highlights some of the capacity issues that we have in Highland, especially as a lot of forensic exams will be carried out more locally. If we have two advocacy workers in Highland, it will be really challenging to ensure that they can go to Fort William, Skye or Wick. We expect that the need for our service and for independent advocacy will go up. We are predicting that we will really struggle to continue to deliver the level of service that we provide at the moment.

Sandy Brindley: Advocacy support should be a core part of the clinical pathway that is being put in place and that lies underneath the provisions in

the draft legislation. For that to work, it needs to be resourced properly.

Anne Robertson Brown: I echo some of the things that my colleagues have said. Support and advocacy must be part of the core pathway, but we also need equity across the country. For example, we need to consider issues of travel, rurality and low population density. We face a postcode lottery in the services that women access.

We also need to be mindful that rape can often happen within a relationship. Coercive control presents barriers to women coming forward, including concerns about what will be done with evidence and who will have access to it.

I go back to my point that women should have control over how they report, who they report to and when they go into a police investigation, but we should capture the forensic evidence so that it is there for when they are at that point.

Emma Harper: As an MSP for a rural area, I am interested in how we protect confidentiality in such areas. If we are establishing a standardised approach across health boards, somebody in Stranraer could go to Ayr rather than to Dumfries, for instance. Should there be a process whereby people can self-refer to a place of their choice, rather than being directed to a place within their NHS board catchment area?

Sandy Brindley: Yes, absolutely. Also, somebody might live in one area, but the incident might have taken place in a different area. In my view, where they access the service should be determined by their need and wishes, rather than by what health board area they live in.

Emma Harper is absolutely right to raise anonymity as an issue. Gwen Harrison might be able to say more about that. For example, there were particular issues on Shetland and Orkney before they finally moved to delivering the service locally there, because people were having to travel to the mainland for examinations. People in the community said that, if somebody was getting on a boat or a plane accompanied by police officers, everyone on the island knew that something terrible had happened to them. If that is not a deterrent to reporting rape, I do not know what is.

We need locally delivered services. People should not be travelling significant distances, say from Campbeltown to Glasgow, in the back of a police car. That is unacceptable, so I hope that those days are over as a result of the advent of more locally delivered services. At the same time, people should have some choice about where to go for self-referral. It should be what is comfortable and convenient for them while protecting their anonymity.

Jen Stewart: I echo the point about the challenges due to the geography of our country. If there is an incident in Kinloch Rannoch and the person has to get to Dundee, there are significant problems in supporting access to services. We definitely have a long way to go.

The Convener: So local delivery is important.

Jen Stewart: Yes.

Anne Robertson Brown: I echo what Jen Stewart said.

Angus is part of NHS Tayside, but we are finding that many services are located in Dundee, and that there is a movement back almost to the old regional approach. For women living up in the glens of Angus or rural parts of Perth and Kinross, public transport is horrific, never mind everything else, and everyone knows everyone. So I echo concerns about confidentiality, and I am keen for discussions to take place on what could be offered to protect women's confidentiality, because violence against women knows no boundaries—it happens right across society.

Sandy Brindley: Access to public transport is an important point when it comes to self-referral. With non self-referral, the person is often taken in a police car to where the examination is carried out, whereas, for self-referral, people generally make their own way there, unless they are being supported by, for example, one of our advocacy workers. That is why locally based services that still protect people's confidentiality are important. Somebody should not have to travel on three buses followed by a long walk to get to a service of that nature. Such services must be locally based.

Sandra White: That was an interesting aspect of the topic; I am sure that the committee will discuss it afterwards.

I want to take you back a wee bit, to training for examiners. The evidence that we heard from survivors was horrific. We have just questioned the civil servants, who gave good answers about the bill, and we were absolutely told that there were female doctors. However, one of the horrific things experienced by the survivors who spoke to the committee was when there were no female doctors, and the male doctors had no empathy, were very dismissive and did not speak or anything.

11:30

They are now looking at training, wellbeing and that type of thing. Does the panel consider that the health boards will have appropriate guidance? That is why I was asking about legislation and guidance—I will certainly look up what is in the bill. Funding is also important, to ensure that there is a

well resourced and trained workforce and that people do not have the sort of experience that happened before. Is there enough in the bill to ensure that the examiners will have guidance, that they will adhere to the guidance, and that they will be well resourced and trained?

Gwen Harrison: We have been discussing the need to make sure that, as we move towards more trauma-informed training, people are implementing the training and working in that way. We do not want the training to become a tick-box exercise that people complete without then working in that manner.

A whole team of new forensic nurses started in NHS Highland a few months back and we were asked to train them on the kind of trauma-informed care that we do from day to day. They found that quite powerful, because our training made the approach real. There may be a need for that sort of training, as well as the guidance.

Anne Robertson Brown: I echo some of Gwen Harrison's points. I would love it if in Scotland we stopped talking about trauma-informed care and moved towards trauma-responsive care. We should be delivering trauma-responsive services at the point of need.

There absolutely must be training for the NHS. Why are we not making use of the expertise on the ground? You said that the committee had heard from survivors. They are the experts with the lived experience. How do we get the golden thread of that lived experience pulled through the training? My suggestion is to involve the specialist agencies on the ground in either writing or delivering the training.

Sandy Brindley: The Scottish Parliament information centre briefing refers to a woman who went through the forensic service and, very bravely, took the time to make an audio recording of what was most difficult about the experience for her. We have used that in training forensic service doctors and staff. It is important to make sure that the people who are delivering the services hear directly from survivors about what was difficult and what made things a bit easier, which includes things that people might not even think of.

In the podcast that I am referring to, the survivor talks about how distressing it was to go into the forensics room and see that it was obviously also used for child examinations, because there was a mobile hanging from the ceiling above the examination bed. Trauma-informed or trauma-responsive practice means thinking about the bigger things, but also the smaller things that could be really upsetting to somebody at such a time. That includes making sure that the physical environment is appropriate.

Although it is starting to change, a lot of feedback that we have previously had included a sense that care was not given to people's wellbeing. Somebody might be there for quite a time without being offered a drink or anything to eat. That is not how to get the best evidence from somebody, for a start, but it also conveys a lack of care. In those circumstances, people need a sense that somebody is looking after their wellbeing.

Some of those are broader issues. The bill is one part of a wider package of work, particularly around the clinical pathways and the specification of the services that will be set up across the country. We should be asking not only what the bill can achieve, but what else needs to be put in place and how we can make sure that once it is in place, the work continues and is funded and delivered properly.

Sandra White: Thank you. That raises other questions. I think that Gwen Harrison asked how we will know that the work will continue. We will have to look at the evidence, as people have said, which will mean asking the women and men who go through the service whether it is satisfactory. That type of thing should be put in the guidance. We need to consider that and consider asking you and others who have experience of such work or are survivors, to give the training.

I am talking about giving both information and training. I also want to ask about information for victims, which is a huge issue. We have heard that victims do not really know what they will go through. In particular, I am talking about providing information before an examination.

I have two straightforward questions. Should information be provided to victims prior to and after forensic medical examinations? Section 4 of the bill, which is on "Information to be provided before examination", has been mentioned. Is there anything else that you would like to see in that section?

Those are big questions. I am sure that you can also write to us about them.

Gwen Harrison: There is probably quite a lot of opportunity for independent advocacy in those areas. If an independent advocate is a port of call for people, the options can be laid out and the advocate can ensure that people have all the relevant information. That advice would not be linked to services, and people could decide whether they wanted to report to the police or to self-refer. People would be given information in advance of that.

I agree that, as things come into play, how we ensure that people are aware of them will be crucial. A lot of survivors who come to us have real concerns about speaking to the police, for

example, simply because they have never done that before. Obviously, there will be a lot of changes, and how the messages go out will be really important.

Jen Stewart: All the professionals who are involved in the process need to give consistent messages. The point about reporting is really important. If somebody is spoken to prior to a self-referral, for example, and they are told about being able to make a decision on reporting in their own time, to give them some space, it is very important that every professional who is involved communicates the same messages. People opt for self-referral because it gives them space, and it is quite concerning that there is sometimes feedback that they then feel a certain amount of pressure.

Sandy Brindley: People also need written information. Professionals need to be well informed to talk people through things, but we heard clearly from the survivor session that people were simply not in a place to take in information. That will maybe happen in the hours that immediately follow a rape or sexual assault. A person is likely to be traumatised and in shock, and they will not take in a lot of information.

I go back to the point about feeling that there is some level of control. How can we create some sense of control throughout the process for a person who has had all control taken away? We must ensure that they get enough information in order to give informed consent to a forensic test beforehand, and that should be written information. That is being developed through the work in the CMO's task force. There should also be information that can be taken away on what has happened, what will happen next, and the samples that have been taken. With the best will in the world, a person will not take in the information that they have been told at the time, or they are unlikely to retain it. There must be lots of different leaflets. They will not be able to remember who gave them what or what is going on.

At Rape Crisis Scotland, we are doing work on the Government producing an information booklet that pulls things together for people immediately after a forensic examination. It is really important that people have clear information that has been informed by what survivors have said about what information they needed, and that is written in an accessible way. We can meet information needs through that approach, combined with training for professionals who can talk things through.

Anne Robertson Brown: I absolutely agree with my colleagues, and I will add one thing. We already have an example with the Domestic Abuse (Scotland) Act 2018. Information went out and flow charts were created. Police Scotland put an awful lot of information out there so that people knew the procedures and timelines ahead of requesting a disclosure. I suggest something similar.

We should not wait until a woman has been raped. With regard to the process, the timelines and who would be involved, we should use the KISS principle—keep it simple and straightforward. Social media is a massive influencing platform. We should use all the media possible to make sure that everyone is getting a consistent message about what is involved. That could also be part of an overall communication strategy that includes the content of the training and so on.

Sandra White: Thank you.

David Stewart: I will ask a wider question at this juncture. We know from the statistics and the discussion that we had last week with victims that there are low reporting and conviction rates for sexual offences. I am interested to hear from the panellists whether anything in the bill would affect those factors positively. I appreciate that the bill is a health bill and not a justice bill, but the point that I made earlier was that the Government should apply joined-up thinking across the portfolios, so it would be useful to hear the views of today's panellists on that point.

The Convener: Certainly, although only briefly as we need to discuss other areas. However, it is an important question.

Sandy Brindley: One of the issues, and the reason why we are so behind in our forensic and health response to sexual crime, is that there is a gap between health and justice. The matter has fallen into that gap, so we need to be really careful that that does not happen again. I think that the bill will help, because it will place a clear responsibility on health boards.

The bill has the potential to deal to some degree with the levels of underreporting. Currently, if somebody does not feel able to report to the police, they cannot get a forensic examination, unless it is in the Archway centre in Glasgow, or in the NHS Tayside area. The bill will mean that there is no postcode lottery. People will be able to access a forensic examination anywhere in Scotland without reporting, which means that evidence will not be lost, which in turn may lead to more reporting. I do not think that we are talking about significant numbers—there is a lot of data from many countries that have self-referral about how many of the people who self-refer actually go on to report to the police. We should be realistic about what the bill will achieve; however, even if it involves small numbers in terms of reducing the level of underreporting of rape, the bill is very important, because everybody across the country should have access to self-referral. The bill will also put a clear responsibility on health boards to

co-ordinate responses, which is one of the strongest aspects of the bill.

Anne Robertson Brown: I echo everything that Sandy Brindley has just said. I will put my day hat on for a second. I am here as the chair of Angus violence against women partnership, but my day job is as executive director of Angus Women's Aid. A significant number of women disclose to us, and to every other women's aid service across the country, the level of rape and sexual assault that they experience as part of domestic abuse. The bill will allow such women to self-refer and, as a country, we will get a better idea of the scale of sexual assault and rape.

Like Sandy Brindley, I do not know how many of the self-referrals in Scotland will convert to prosecutions in the short or medium term, but we would have a better idea of the social issues that we need to deal with.

Jen Stewart: I work in an area that has self-referral. It might not be the case that significant numbers of survivors go on to report, but some have gone on to do so and have got justice. It is about giving people choices.

Brian Whittle: I echo my colleagues' sentiments about the evidence that we heard last week, which was harrowing. It was brave of those victims to speak and it was necessary that we heard their evidence.

I also echo what David Stewart said. We are discussing a crime that is underreported and has low levels of conviction, so the importance of getting the bill right cannot be overstated. There are serious health implications for mental and physical health that arise from women's or men's ability to be heard. It is not as simple as separating justice and health—they are intertwined.

I want to ask about people's ability to self-refer when they have additional support needs—I include within that category children, older adults or individuals with mental disorders or an intellectual disability. Are there issues with their ability to self-refer?

11:45

Gwen Harrison: I think that there will be issues, but I also think that we need to consider the definition of a vulnerable adult, because that might be different. Someone who has previously been traumatised by something and has now been retraumatised by an assault will have issues in terms of how they process that, but they might not necessarily be someone who is recognised as being a vulnerable adult. We need to think about that. I do not know how we support such individuals better, but I think that it probably involves ensuring that they have somebody beside them on that journey to make sure that they have truly independent support.

Sandy Brindley: I will deal with children first, because there has been quite a lot of discussion about whether the bill has got it right by setting the minimum age for self-referral at 16. Some people have suggested that it should be 18 while others have said that it should be under 16. I am sympathetic to the arguments about extending it to under-16s, but I think that the bill has got it right by setting the minimum age at 16.

Alex Cole-Hamilton is absolutely right. We are talking about vulnerable people's access to services. Obviously, children are vulnerable and we do not want to exclude them from accessing something that might assist them in these circumstances but, in reality, in almost all circumstances in which somebody under the age of 16 self-refers, the clinicians would decide that they needed to call an interagency discussion, which would mean that the process would not constitute self-referral. I am wary about us offering young people a meaningless right. There is no point giving a right if it is not meaningful, and, as I said, in almost every such case, the clinicians would feel that they had to notify social work, who would notify the police.

Alex Cole-Hamilton: Would you lower the minimum age for self-referral?

Sandy Brindley: On balance, I think that the bill has got it right by setting the minimum age at 16. If clinicians could assure us that they could offer self-referral in a meaningful way to people under the age of 16, that would be different, but, if they cannot do that, there is no point in lowering the minimum age.

We need to think about how we provide services to young people who are experiencing sexual abuse. There is a huge gap in relation to support and advocacy for young people. Our support and advocacy services for children who have been sexually abused work with children over the age of 12, but there is a huge gap for children under that age, particularly with regard to the court process, as well as the process that we are discussing.

A lot of important related work has been done around the barnahus approach, and I know that it has been considered in work that is running alongside the bill. However, the bill has quite a narrow focus: it is about making it clear that the provision of forensic medical services in these circumstances is the responsibility of health boards, and introducing self-referral. Those are my views with regard to the age limit.

On capacity more generally, I think that we should not be restricting access to self-referral unless it is absolutely essential that we do so. We need to be careful not to be paternalistic and not

to make decisions on behalf of people unless they are genuinely unable to consent to a medical procedure. Clinicians are experienced in assessing whether someone has the capacity to consent to medical procedures. That experience is even more important in these circumstances. I think that the role of support agencies can be helpful with regard to helping people to navigate the process—I am thinking about services such as ours, as well as ones such as People First, which works with people with learning disabilities.

Anne Robertson Brown: As I said, I am here today as chair of the Angus violence against women partnership, but we shared our response with the Angus child protection committee for comment. It was in favour of having a stage 2 of the process at which the issue of under 16s could be considered, for some of the reasons that have already been outlined.

One of the things that we are concerned about is the number of young women—those around the ages of 14 or 15—who are disclosing but not reporting rape and other sexual assaults in their relationships. That is why it is our view that there should be a stage 2 to this change of process. At that point, we could look carefully at how to guarantee that what was happening was a self-referral and that child protection guidelines were being followed. We could also bring Gillick competencies into the discussion. We should not do that yet, at stage 1. However, we could possibly do it later, because it might be a ticking time bomb.

The Convener: Am I right to think that you are talking about a second piece of legislation?

Anne Robertson Brown: Yes. A second stage: a follow-up.

The Convener: Okay. That is understood.

Sandy Brindley: It is also important to look at why young people and women in those circumstances are not reporting. I do not know that self-referral alone will fix that, because there is a wider issue about cultural attitudes toward sexual violation, what is happening in schools, the messages that young people are getting and whether certain behaviour is normalised and acceptable.

It is also about whether people have confidence in our justice system. Looking at how people are treated, the conviction rate and how many cases never get to court, we can understand why young people say that going through that process is not for them. That is beyond the scope of this committee. Self-referral is important, but we must also be realistic about what else needs to happen to reduce underreporting. That will not all be dealt with by the bill.

Brian Whittle: The other point that has been raised is about the implications of socioeconomic deprivation. Anne Robertson Brown was right to say that this kind of crime is perpetrated across society. Therefore, we have to be careful that we do not pigeonhole it. However, I want to know whether we should have the ability to target better, based on socioeconomic deprivation.

Sandy Brindley: I am not aware of any evidence that sexual crime is any higher in working-class communities than it is in middle-class or upper-class communities. Therefore, for me, it is about ensuring that the services are available and accessible to everyone.

We should be proactively looking at how we can remove barriers to the service. One way of doing that is to look at the practical barriers to people in general society and to those who are in poverty. For example, if someone has to travel to get to the service, is returning their travel costs or arranging taxis facilitated? Barriers are often financial. However, they might be childcare barriers—what do people do with their kids when they come to get the examination? It is important to think about what we can put in place to ensure that there are no financial barriers to people accessing the services.

Anne Robertson Brown: I echo what Sandy Brindley said, and add that one of my colleagues made a point about confidentiality. We need to ensure that the services are accessible to all women.

Gwen Harrison: I echo that. We must look at how we can remove barriers to people accessing services—we spoke about people sometimes not coming forward because of cultural differences—and at how we can ensure that people are more aware of the service.

I had a chat with some of my colleagues about people whom they have supported previously, including homeless people, who are assaulted regularly but are limited in how they can access services. Often, they do not have a phone, so they cannot phone the service. We need to ensure that there are different access routes for people, and that they are supported through that.

Emma Harper: We have covered wraparound and complete support. I know that the clinic in Dumfries is planning to relocate its sexual health and psychology services next to the sexual assault centre, so that there is a properly engaged wraparound service. There are major challenges in rural areas. We have covered the fact that there needs to be access to psychology and that the service has to be wider. If engagement is better, self-referral rates might improve.

Last week, we heard from some witnesses that it might be useful to record something in the case

notes so that if someone was to have a smear test, there would be a red flag to say whether they were a rape survivor. That would mean that they would not have to retell their story every time. For example, if someone was going for a blood test, the case notes could say that the person was afraid of needles. Has there been further feedback about what needs to be in a person's medical record? Who should access that information? How do we protect confidentiality? In rural areas, everybody knows everybody.

Gwen Harrison: I completely agree. There are real confidentiality issues in relation to rural communities, depending on who can access the information. People who work in the service might know the perpetrator. We should recognise that it is not just about knowing the survivor who has been for the examination; people might also know the perpetrator who has been involved. There needs to be clear consideration of how people access such information and of what information is relevant to be stored. The system would also be much more powerful if people did not have to retell their story every time.

Sandy Brindley: In their feedback, there was an assumption from survivors that their GP would know or that, if they went for a smear test, the nurse would know. It is distressing to think that they would have to retell their story numerous times. It goes back to consent. It would be helpful if, as part of the clinical pathway, we asked somebody clearly, "Would this be helpful? Do you want us to do it?" We should give them the chance to think about that if they are unsure.

I have some anxiety about access to people's medical records, because they have been brought up during rape trials, which is distressing for people. If people knew that that was a possibility, they might not consent to certain things being in their medical records. The NHS could do more to protect the confidentiality of the medical records of people who are going through criminal proceedings. That issue aside, as part of the clinical process and as we co-ordinate that pathway, we should be considering asking survivors whether they would like us to put something on their record, so that they do not need to retell their story. They could then make a choice about whether they want that to be done.

The Convener: I presume that that would be at the point of the examination.

Sandy Brindley: Yes, or it could be part of the immediate follow-up.

Jen Stewart: It would be important to get right exactly what would happen with that information. Would people have the right to retract the information? Earlier, we spoke about what information people get, and that issue is vital.

Emma Harper: Dave Stewart mentioned advocacy. How will the bill support people from ethnic minorities who might have English as a second language or who might face challenges in accessing healthcare? Those challenges might relate to rape or sexual assault, or the fact that a person is going to see a healthcare professional in the first place. There will also be challenges in some of our black and Asian minority groups.

Sandy Brindley: The self-referral sub-group, which I am chairing as part of the CMO's task force, is looking to ensure that any information that is produced is accessible across all our communities. It is important that anything that we produce can be used by any community in the country that might need it.

David Torrance: All the written evidence that the committee has received has highlighted the need to raise awareness and promote self-referral. How should the option of self-referral be publicised? Who should be responsible for the promotion of self-referral services?

Jen Stewart: Responsibility should be shared. In order to promote the services locally, we used social media, posters and GP talks, and we spoke to local hospitals. There has been a shared approach between NHS partners, the rape and sexual abuse centres in Dundee and Perth, Rape Crisis Scotland and the police.

Sandy Brindley: In the self-referral sub-group, we are looking at what information will be needed once we are clear what the routes into the self-referral process will be and how we make sure that people know about that through an awareness-raising campaign.

Part of the difficulty is that people either do not know what to do or are not going to inform themselves about what to do until they are in those circumstances. I think that an awareness-raising campaign is important, but it will probably have a limited impact. The most important thing to do is probably to make sure that the services that people go to straight after being raped—if not the police—know about self-referral and how it is accessed.

12:00

If people do not go to a service such as Rape Crisis Scotland, they will go to somebody such as their GP. One of the most common routes is through front-line healthcare workers, with people presenting either at accident and emergency departments or at GPs. We have to make sure that those staff know how somebody can access self-referral.

We also have to look at online provision. At the moment, if you go on to any health board site or

NHS 24 and type “rape” into the search box, I do not think that anything comes up at all. That is because rape services have not been a core part of health service delivery up until now.

We need to look at online information. The self-referral sub-group is looking at what information people can access online. After somebody is raped, they might go online to find out what they should do and where they should go. We need to make sure that the available information is accurate and quickly points people in the right direction.

The Convener: The risk with online information is that somebody gets bad advice.

Sandy Brindley: Indeed.

The Convener: So having information that is provided and branded by the NHS would clearly be helpful.

David Torrance: How do we engage with public services to make sure that they are all aware what the right self-referral pathway is? As you have said, sometimes they will be the first port of call for anybody who has been raped.

Sandy Brindley: It is for the CMO’s task force to make sure that, through all the health boards, it cascades to front-line workers all the information on what to do if somebody has just been raped.

General practitioners are a common port of call for somebody who has been raped but has not reported it to the police. We have to make sure that GPs not only get information, but get written information that they can give to somebody. I have spoken to people who have said, “I didn’t report, but I saw my GP. I hope he’s kept the samples.”

People in that situation just do not take in what is happening, so we need to make sure that they are given clear written information throughout the forensic pathway and at the first point of contact, which might be their GP.

Emma Harper: I assume that nursing schools are also important for passing on information.

Sandy Brindley: Yes.

Emma Harper: You mentioned the retention of evidence. What is the best way to retain samples? How do we make sure that victims or survivors are informed about their samples? Again, this is about choice, control and allowing people to decide where they want their samples to be. What are the main factors regarding retaining samples and other evidence that would be important to victims? Do any issues need to be addressed?

Sandy Brindley: People definitely need to be given clear written information that they can take away with them that says, “This is what we’ve collected. This is what we’re going to do with it. This is what we’ll tell you. This is when it’s going to be destroyed”.

We need to decide what somebody’s essential care will be. However, let me leave that issue aside for one moment. Somebody will not necessarily have at the forefront of their mind that, if they do not report to the police within two years, the information will be destroyed. Therefore, we really need to look at making sure that, when somebody is giving consent in a very traumatised situation, there needs to be, at the very least, a check-in a little bit further down the line. We do not want to pressure people into reporting, but we need to make sure that they know that their samples have not been tested. Some people assume that, because the samples have been taken, they will be tested and somebody will get back to them if there has been a hit. That is not how it works.

Clear information must be provided so that somebody knows exactly what the situation is. The only way to enable informed choice is to inform people properly at the start about what is happening with their samples. That information needs to be provided verbally and in writing, because people are unlikely to take in and retain that information.

The Convener: Yes, I guess that the point of having written information is that it will be taken away.

Emma Harper: One thing that I learned last Friday is that a person gets a named nurse, who would do the checking-in. That might make it easier not to trigger the one or two-year anniversary of a horrific event. With the development of forensic nurses, might it be a good idea to have a named person, or a named nurse?

Sandy Brindley: Absolutely. The forensic nurse pilot or test of change is important and could transform services across Scotland. The pilot involves nurses actually doing the examination, but even areas that are not participating in it are still involving nurses in forensic examination, often in a supportive and co-ordinating role. Across the country, people should be given a named nurse or named contact who is responsible for their care and who can do the follow-up work. That is done with consent. It is about saying to people that they can come back in a few days, setting out what will happen with the testing and saying that the nurse will check in. The nurse might then phone up in two months to see what the person thinks about the samples. As long as the person is clear about what is happening and they consent to that contact, it will not feel like pressure. That checking in will be important in the circumstances.

Emma Harper: Should the bill determine the length of time for which samples should be

retained? For example, it could be for one year, two years or three years. In the previous evidence session, we heard that there is flexibility in other places.

The Convener: I think that the phrase that was used was that there is no consensus on that.

Jen Stewart: From what we know, survivors ask that the samples are kept for as long as possible. Locally, we tell women that it can be for up to eight years.

The Convener: I take it from the nods of the other witnesses around the table that that is the general view.

Emma Harper: How should victims be advised that their evidence is about to be destroyed by a health board?

Sandy Brindley: They need to know in advance. It is not acceptable for someone to get a call out of the blue saying that everything will be destroyed next week. People need to know and have in their mind what timeframe will be applied in their case, so that they can process what that might mean and make a decision. There will be negotiation at an appropriate point about what people want to happen. Some might say that they do not want to be contacted at all and that the samples should just be destroyed if they have not got in touch. Others might definitely want to be contacted, because they will want support with the decision.

Alongside that, if advocacy workers or rape crisis workers are part of the clinical pathway, we can provide support for people to allow them to reflect on what they feel about the issue in a way that does not feel like pressure.

Gwen, what do you think?

Gwen Harrison: I was just going to say that, if people have an advocacy worker, that can help them to navigate the journey and discuss such issues. If the advocacy worker has been part of the process and is aware of the timescales, they can almost prepare the person to start to think about making that decision.

It all comes back to giving back control to the survivor. They have come through a situation where they have lost all control, so it is important to ensure that they are informed and can give consent and permission on how their information is stored and for how long. If people have an advocacy worker throughout that—or a forensic nurse as a named person—that might provide better support.

Emma Harper: It sounds as though Women's Aid and Rape Crisis Scotland are absolutely essential. We do not want to take away advocacy workers and say that we now have the new forensic nurses, who are the new named nurses. There has to be continued engagement with whichever service people choose to engage with.

Gwen Harrison: As we have said, it is about giving people choice. Somebody might decide that they do not want support from Rape Crisis Scotland or Women's Aid but that they are happy to have contact with the nurse and that is their preferred route. However, if individuals have chosen Rape Crisis Scotland, that could be the route. It is important to give back choice to people.

Anne Robertson Brown: I echo that point about choice. There is also a point about the survivor having a loop back with the contact and having the right to say, "I have reflected and decided that I do not want to report, so destroy my samples now."

The Convener: That is clear.

Brian Whittle: There will obviously be a cost to implementing the bill. The financial memorandum states that

"There are no direct costs to local authorities"

and that third sector organisations will

"play an important part in raising awareness of self-referral",

but that

"costs on the third sector to support the Bill's implementation will be modest."

There are aspects to that that concern me. One aspect is the phrase

"no direct costs to local authorities",

which implies that there will be a cost somewhere or other. The other word that I do not like is "modest".

The third sector is of huge importance to what we are discussing this morning. Given the financial pressures that the sector is already under, what are your comments on the financial memorandum suggesting that the costs to the sector of supporting the implementation of the bill will be "modest"?

Gwen Harrison: RASA Highland does not think that the costs will be "modest". If we have to extend our support to people in more rural communities, our geography alone will mean that there will be increased costs in travel and staff time. They will be much more than modest. We have some real concerns about what the costs will mean for delivery of our service.

Jen Stewart: I agree. I do not necessarily think that the costs will be modest, and I wonder what that would look like.

We have been such close partners in self-referrals so far. We definitely want to keep that

going and be one of the key partners in the future, but we would need additional resources, because our capacity and what we can do are limited. The pilot has been done within existing resources, so it has been a significant challenge.

I think that somebody talked earlier about the importance of people getting a hot drink and access to clean clothes. We can provide those things because we approached one of the local supermarkets and it donated to the service to enable us to do that. We need to be creative about how we resource services.

Anne Robertson Brown: I am very interested in the definition of "modest"—exactly what does that mean? I think that it might be somewhat optimistic. Angus has no dedicated rape crisis service, and that is true of many parts of Scotland. The implication of that is not modest in cost terms.

We have something that I am sure that many other parts of Scotland have. RASAC in Dundee offers a short part-time outreach service to Angus. Women's Aid works closely with that service and gives office space and what have you to reduce costs and so on. I think that the cost implications of the bill are significant as opposed to modest. It is not that I do not think the third sector is up for the challenge, but we cannot tackle the challenge without resources.

Sandy Brindley: It depends on the model of service delivery that we are talking about. If the model is designed to meet the needs of survivors of sexual crime, rape crisis support should be indicated in that model. That is what we are looking to do in Edinburgh. A new multi-agency centre is going to be opened that will respond to people's needs immediately following rape or sexual assault, and an advocacy worker will be based in the centre.

Sometimes people do not care about who is delivering the service; they care that the service that they get is the right service, and it is for us to co-ordinate those services behind the scenes.

What I have mentioned is an urban model; the model would be different in rural and remote communities. However, we should be looking at the delivery of co-ordinated services, and at what the evidence tells us about how we meet the needs of somebody who has just been raped or sexually assaulted.

A video remote interpreting pilot on visual recording of statements to the police is being funded, but that is not being funded through this workstream.

12:15

If we are to create a model that integrates rape crisis support within the service, as we should be doing, and address the gaps in provision—Moray is the only part of Scotland where there is no advocacy worker—the costs will probably be more than "modest". They will be more than modest for the health service, too, if it is to do this properly.

The Convener: What about costs to local authorities? Brian Whittle raised the issue of direct versus indirect costs. I am not sure whether there is expertise at the table from the local authority point of view.

Sandy Brindley: It is probably the health sector, the third sector and the police who will be involved in delivery of services.

Brian Whittle: I should clarify that we are discussing implementation of the bill. Emma Harper talked about the requirement for dedicated health professionals. Integration with the third sector is an issue, too. Resource for the whole system is really what we are talking about.

Anne Robertson Brown: There will perhaps be costs to local authorities to do with training, some of which might be one-off costs.

The Convener: Thank you.

As you perhaps heard, we asked the previous panel of witnesses about monitoring and evaluation of the changes that the bill will introduce, when they are in place. Do the witnesses have views on that? In particular, from the point of view of your organisations and victim support organisations in general, what information about the roll-out and the practical effect of the approach would be useful?

Sandy Brindley: The bill will implement—finally—the provision in previous legislation to allow people to choose the gender or sex of the examiner. That has never been implemented because we have never had enough female doctors and medical staff to do the work. It will be crucial to monitor implementation in that regard. We need to know how many times people are offered a female doctor and how many times they get a female doctor. That is the single most important issue that people raise with us. We will definitely need the data so that we can see whether the approach is working.

On a more general point about the CMO's task force, we will need to know about delays and how long people are waiting for examinations. Monitoring that will be crucial.

We will also need rich information about self-referral. Where is it taking place? What are the timeframes for which people are waiting after making a self-referral? What is the conversion rate—that is, how many cases go on to become reports to the police? What happens to those cases? Is sufficient evidence collected?

The approach is relatively new for us in Scotland—it has been happening in Tayside and Archway, but the numbers have been small. We are introducing the approach nationwide for the first time and we need really rich information. The CMO's task force has done a lot of the work on data collection, to put in place monitoring from the start and ensure that there is a clear review of the effectiveness of implementation.

Emma Harper: Last Friday, I heard that, depending on when events happened, 60 per cent of self-referrals can happen on a Wednesday between lunchtime and 5 o'clock—I thought that that wee nugget of data was surprising. The numbers were very small, though.

It is important that we monitor the data. I agree that there should be 24/7 support, because people might choose to self-refer out of normal hours. It will be interesting to consider when self-referral happens after incidents.

Sandy Brindley: The feedback from survivors at the closed session last week was that there seems to be a particular issue with reporting on a Sunday.

A lot of providers say that there is hardly any demand for an out-of-hours service. That suggests to me that something is going wrong in the system, because survivors are telling us that there is an intolerable wait for services. There is something about the process by which people access services that is not working at the moment.

Gwen Harrison: I wonder whether we need to collect more qualitative data on people's experiences, so that we can make sure that their experiences are similar across the country.

In relation to Highland, the experience in Inverness could be different from the experience in Wick. It is about making sure that there is equity and that people are able to access the same service. Perhaps capturing that softer data would also be useful.

Jen Stewart: We have found it helpful to have regular meetings with the police and the NHS to look at the issue, to speak about people's experiences and to reflect on that feedback.

The Convener: Would you want to continue that under the new arrangements?

Jen Stewart: Yes.

The Convener: Excellent. Thank you. Before we wrap up the session, is there anything that witnesses have not said but are itching to say? We will hear from a lot of people about the legislation as we progress.

Sandy Brindley: I have a comment on a question that was put to the previous panel of witnesses about whether the bill's provisions should be extended to alleged child offenders. Although that is an important issue, my strong feeling is that it is not one for this bill. The bill is about victims of rape and sexual assault. It is important that the guidance on forensic integrity says that, wherever possible, the examination of the victim happens in a separate location and at a separate time from the examination of the alleged perpetrator.

The Convener: I thank our witnesses for their evidence today, which has been informative, helpful and much appreciated.

12:21

Meeting suspended.

12:26

On resuming—

Petition

Community Hospital and Council Care Home Services (PE1710)

The Convener: The next item on the agenda is consideration of petition PE1710, from Edward Archer, which calls on the Scottish Parliament to urge the Scottish Government to review provision of services for elderly and long-term sick people in community and cottage hospitals and in council care homes across Scotland.

The petition clearly relates to the inquiry into social care that we are undertaking. Do members have views on the specific points in the petition?

Emma Harper: It is timely that the petition has come to the committee now, given that we are starting our social care inquiry. We have also heard from the Government about what aspects of social care it is looking at. How do we incorporate the petition into our social care work plan?

The Convener: The petition is certainly relevant.

Brian Whittle: Yes, it is relevant to what we are doing now, although our inquiry is not just about community and cottage hospitals. We are moving from secondary to primary care and we are moving care into the community. The inquiry is about how that impacts on the whole care system. Looking at the petition in isolation would not give us the full picture and answers that we are looking for.

The Convener: That is fair.

David Torrance: I am one of the members of the Public Petitions Committee who referred the petition to the Health and Sport Committee. We considered that this committee could look into the petition in more depth and that the petition could play a vital part in its upcoming inquiry. I am happy that we consider it as part of the inquiry.

The Convener: There seems to be general agreement about that.

We will want to use the evidence that has been provided with the petition to inform our inquiry. For example, it is notable that some integration joint boards use cottage hospitals as a step-down intermediate facility for people who are leaving acute care; others do not. That is relevant to what should happen. Do we agree to take account of the petition as part of our social care inquiry and to inform the petitioner accordingly?

Members *indicated agreement.*

12:28

Meeting continued in private until 12:40.

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