OFFICIAL REPORT
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 12 May 2020**

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 12 May 2020

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## HEALTH AND SPORT COMMITTEE
**11th 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:**

Dr Anne McLellan (NHS Lanarkshire)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

Virtual Meeting

# Scottish Parliament

## Health and Sport Committee

*Tuesday 12 May 2020*

*[The Convener opened the meeting at 10:00]*

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

**The Convener (Lewis Macdonald):** Good morning and welcome to the 11th meeting in 2020 of the Health and Sport Committee. I thank members for their attendance in these unusual circumstances and thank our parliamentary staff, particularly the broadcasting office, for their hard work in setting up this remote formal meeting. We recognise the challenging times in which we are living and pay tribute to all the organisations in the health and care sectors for their continued dedicated service and hard work. I ask that all members ensure that their mobile phones are on silent.

Agenda item 1 is our second evidence session on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 1. Scrutiny began in February and was subsequently delayed due to the pandemic. We will now take evidence during May and June, with the intention that stage 1 of the bill will be completed in the Scottish Parliament in autumn 2020, if it is approved.

Today's session is to discuss a range of issues with national health service boards. I welcome Dr Anne McLellan, who is a consultant in sexual and reproductive health at NHS Lanarkshire. Thank you for joining us.

Due to the challenges of managing a virtual meeting such as this, we will take questions in a pre-arranged order. I will ask the first questions and then invite others to ask theirs in turn. I ask for succinct questions and answers. I ask those who speak to give broadcasting staff a few moments to operate their microphone before asking a question or providing an answer. I also ask members to indicate when they are on their final question, so that the broadcasting staff will be ready to move on to the next member.

Dr McLellan, we have heard a lot of evidence about examinations and how important an appropriate examination place is for those involved. Are appropriate facilities in place, or would they need to be put into place in order to implement the bill successfully?

**Dr Anne McLellan (NHS Lanarkshire):** Boards have done a lot of work on establishing capital projects that will enable them to have suitable premises. Importantly, most of those will move the examination site out of police custody into healthcare facilities or into sites that are near to healthcare. In Lanarkshire, we are almost ready to open a facility in the grounds of, but not in, University hospital Wishaw, which I hope will be more user friendly.

I know that good work has been done in Larbert. I am not sure about the other boards, but most of them are moving to improve premises, which is a welcome step forward.

**The Convener:** You think that the boards are on board and are progressing plans on premises. What about the workforce? Are workforce plans in place? Is the workforce already there? What is the prognosis for development on that side?

**Dr McLellan:** The workforce is a challenge, particularly with regard to the gender of the examiner. That is going to be a challenge in the next year or two. However, the west of Scotland is making big steps to improve the workforce and increase the number of female forensic examiners. There has also been a good training programme nationally to encourage female forensic examiners to come together. The bill is a welcome improvement to the care of victims and survivors, but it would be good to have a network for female forensic examiners throughout Scotland.

Although the workforce is a challenge, there are ways that it can be facilitated. What I mean by that is that there are sexual health staff in every health board at the moment who are used to seeing patients who have experienced sexual assault but have not involved the police. There is a body of staff there who can be tapped into with the appropriate training. I think that that is the way forward.

In some of the quieter or more rural boards, it will still be challenging to maintain skills and provide a 24/7 service of high quality, but it is doable with a network and with remote training. In Lanarkshire, I anticipate that some of the staff whom we have put forward as eminently suitable to be forensic examiners may be working at a different site and not in the centre of excellence. However, they will be linking in with the centre of excellence for updates, or to do virtual training to keep them all skilled and to ensure a consistent approach. There are challenges, but I think that we can address them.

**The Convener:** If I understand you rightly, you are saying, essentially, that networking is the way to deliver a 24/7 service. Clearly, it would make a huge difference to those involved.

I think that you mentioned work that is being done at west of Scotland level. Do I take it from that that the north, west and east are already working on a regional basis to identify female forensic examiners and create the kind of network that you are talking about?

**Dr McLellan:** Yes. Most of my experience is in the west of Scotland, but there has been national training, and boards in other areas are linking in.

I am not worried about the rural issue. Obviously, forensic examiners do not see so many cases per year in a rural area, and there will be a mandate that someone needs to see so many cases to keep their skills up, but there is so much of a move now to remote and virtual working, partly because of the coronavirus, that people will become very familiar with remote consultations or remote supervision. There are ways in which we can get round the rural issue.

**The Convener:** That is very interesting—I am sure that it is something that we will follow up with the three regions. I am also interested to hear how the changes resulting from the coronavirus are already creating new possibilities for training and so on. That is very encouraging.

**Sandra White (Glasgow Kelvin) (SNP):** Good morning, Dr McLellan. Among the many issues that have been raised is the retention—the recording and storage—of evidence and the cost of that to health boards. I think that your health board has raised that issue. How do you think that the retention service should operate?

**Dr McLellan:** We have to be sensible here. I am sure that, as a result of the bill, more people will come forward; more people may also self-refer. The problem will be the storage of large items such as a duvet or clothing. It is unrealistic to take all of that on board for an indefinite period. However, at the moment, the retention of samples from self-referrals is of swabs only. There is a compromise here. The timescale for retention is up for debate, but after three or six months—whatever is decided—the evidence can be destroyed.

The other thing is that we could opt to say that clothing, or large items such as duvets, should not be stored beyond a certain time, whatever happens, but that we would keep the forensic swabs, because the swabs are smaller. The swabs also require to be in a freezer. Freezer storage capacity will be needed.

The issue of sample ownership may be challenging but, again, I think that it can be worked through. We can agree that, if samples are taken on health board premises, they are health samples until they are destroyed. That will need to be managed properly. If a self-referral went down the police route, the samples would need to be transferred to Police Scotland, or to the Scottish Police Authority. I think that that is workable.

From a practical point of view, we cannot store loads of stuff for years, and certainly not indefinitely. We could limit storage to swabs only, and limit the time period.

It may be different for children or adolescents. I am not a paediatrician, but I can say that, although we keep sexual health records for most of the population for only eight years, we keep young people's records until they are 25 in case something comes out later, so we may have to think about how long we store material that relates to the young people who come in. That would be for the paediatricians to decide, with the police—I am not a child forensic medical examiner; I do not examine people who are under 13.

Does that make sense?

**Sandra White:** Thank you—it does, and it opens up another avenue. You might call it a two-track approach to retention: swabs would be kept for longer, albeit not indefinitely, and bigger items would be kept for just a couple of months. That is interesting.

The issue of ownership is delicate, and includes the storage of data. It has been suggested by the Information Commissioner's Office that perhaps we should look at a data protection impact assessment. Would that be a good way to go forward?

**Dr McLellan:** I find it a bit confusing myself, but I understand that the concern is that the swabs of another person would be retained without their knowledge. Advice on that would need to be taken from the Information Commissioner.

One solution for the larger items would be to photograph them, so that there would be at least some evidence. We would not have the DNA analysis, but the items could be photographed before being discarded. Once they were—

**Sandra White:** Thank you—

**Dr McLellan:** Sorry—

**Sandra White:** Not at all. I am interested in what you have said, and you have answered the questions that I wanted to ask. That was my last question. Thank you so much.

**David Torrance (Kirkcaldy) (SNP):** It is hoped that the bill will address service variation across Scotland by standardising forensic medical examination services in urban and rural communities. What is needed to ensure that a consistent service can be delivered across Scotland?

**Dr McLellan:** There is an appetite and a will among the female workforce in Scotland to deliver

that. I attended the update training with NHS Education for Scotland. A lot of good female doctors are willing to work in, or are already working in, these services.

As I have said, we should have a network with national updates, each done once for Scotland. We should be providing consistent services. I do not see big challenges in that, apart from some people not seeing the appropriate volume of cases, and there is potential to bring those people into the bigger centres, for example for a week a year, or to enable them to do virtual consultations, for which they would have mentoring.

We need to try to get an equitable service across all health boards. Putting premises near patients is good, but we need the same, or similar, very clear pathways, with the same level of commitment from clinicians, police and the voluntary sector, so that, wherever someone presents in Scotland, they will get a quality service, with a seamless provision of high-quality care.

10:15

**David Torrance:** Is there a risk that health boards will implement the legislation in different ways, leading to variation in service provision across Scotland?

**Dr McLellan:** Yes, that is a risk. If the bill goes through, there will perhaps have to be an agreement, for example among the lead clinicians for sexual health. Every single board in Scotland has a lead clinician for sexual health. They are employed by the health board and they need to drive forward implementation to make sure that we do not do things differently, and that we come up with a minimum that must be delivered, as a benchmark.

To be fair, we are getting better data now, and a sub-group of the task force is looking at data. There must be an on-going quality assurance process. We must look at how many people are seen within three hours, and, by looking at the indicators, how many can choose the gender of their examiner, how many were not able to be seen because the suite was in use, and so on.

There needs to be a stepwise implementation of the legislation. If we have a new bill that encourages self-referral across Scotland, with loads of awareness raising, it could be a huge project and we could be totally inundated. However, I do not think that that will happen if we do it in a logical, stepwise fashion.

We must keep the smaller health boards on board with everything that is happening—it cannot just be a Glasgow and Edinburgh project. I think that we will get there, and the Healthcare Improvement Scotland standards will help.

**George Adam (Paisley) (SNP):** On that point, you said that the west of Scotland is ahead in this area. If we are talking about consistency of service across Scotland, what is the difference between services in the west of Scotland and those in certain rural areas, or maybe even those in some rural areas in the west of Scotland?

**Dr McLellan:** The only reason why the west of Scotland is ahead is that it has traditionally had the Archway service, which was really the first functioning sexual assault referral centre in Scotland. Actually, in the west of Scotland there have been huge problems with recruitment and service provision, so it has not all gone smoothly there.

In the model that is proposed by the task force, which involves a centre of excellence and a hub-and-spoke model, it will be necessary to identify centres of excellence that support the smaller boards. I am quite clear about that. There are other things that could be done that are not in the bill. For sexual health, there were HIS standards that said that we had to provide 12 hours of clinical care in every settlement of 150,000 people. Therefore, we would expect patients to be seen within X hours, X per cent of the time, or we would expect a person from a rural area not to have to travel further than X miles. With regard to clinical service provision, there are things that we can do that are outwith the bill, if the clinicians get behind them, which they hopefully will if they are given direction by the health boards.

**George Adam:** Is there any guidance that you would you like to see from the Scottish Government on the examination and retention service?

**Dr McLellan:** It has to be consistent, and there has to be regulation of the training, so that all forensic examiners are of a certain standard, doing a certain number of cases and linking into a centre of excellence. On retention, to be honest, I think that the length of time that we keep samples might become a problem.

Obviously, somebody can report a sexual assault any time in their life but we cannot keep samples indefinitely for people who self-refer but who might or might not report. Even if we allow samples to be stored, I am not sure that it would be realistic to store big items for life for the whole population. That would be difficult. It would be good in a way, because we would have that DNA evidence for 30 years, and we have seen cold cases being settled 30 years later, but if the large items are discarded and there are still swabs, we will still have that DNA.

The only question, which is not in the bill or in anybody's mind, is whether there should be an anonymous DNA database. That would be a whole piece of work on its own. In other words, should DNA samples be taken, analysed, and stored in an anonymous database? That might be useful if the same DNA appeared four or five times, even if a crime has not been reported.

**The Convener:** Thank you. Emma Harper has a brief supplementary question.

**Emma Harper (South Scotland) (SNP):** I just want to pick up on what Dr McLellan said about the ability to do an examination within three hours. Early data from the self-referral service in Dumfries and Galloway shows a peak of self-referrals on a Wednesday, which does not relate to the person having been assaulted on a Saturday, Sunday, Monday or Tuesday. Will that factor be gathered during any data collection?

**Dr McLellan:** The three hours is an arbitrary standard that patients—[*Temporary loss of sound*]. If there was only one examining room in Dumfries, it would be unfortunate if three people were to present at the same time; it would not be possible to hit the target.

We should aim to examine people within three hours because they cannot shower or wash until they have been examined. However, in reporting on the three-hour target, we would have to say, for example, that two patients had not been examined within three hours because the suite was already in use, so one had waited six hours and the other had waited nine hours.

Alternatively, we could give the patient the option to travel elsewhere, if that meant that they would be examined sooner. I think that it is possible to get to the Lanarkshire suite from Dumfries in under six hours, so if the Lanarkshire suite was free a person could go to that suite rather than waiting six hours. One of the other two patients could go, which would mean that nobody would have to wait for nine hours. Does that make sense?

**Emma Harper:** Yes.

**Dr McLellan:** We have seen some long waits, even in Glasgow. In the past year or two, when staffing has been a major issue, we have seen patients having to wait overnight or over weekends without having a shower. Many people will just not do that, but will instead decide that they will not pursue their case. Most people who had been sexually assaulted would not want to wait 48 hours to have a shower.

**David Stewart (Highlands and Islands) (Lab):** I will move on to discuss the role of professional judgment. The explanatory notes confirm that the bill

"does not confer on individuals a right to have a forensic medical examination".

Examinations will be carried out only based on the professional judgment of the healthcare professional. Please expand on that. What would it mean in practice?

**Dr McLellan:** I am with you on that. I think that what it means is that, for example, for someone who presents nine days post assault, there is no point in a forensic examination to capture DNA. The person could demand a forensic examination, but it would be inappropriate because it would not capture DNA, so they could not have a forensic examination for DNA at that stage.

If a patient were to demand that they be looked at, and was bruised, our professional judgment would be that we would look at the bruise and document the injury, but we would not do the full swabs because they would not get DNA. That might change as DNA tests get better; some DNA tests pick up DNA up to 10 days afterwards. However, we are not quite there yet: throughout Scotland at least, it is seven days for DNA.

**David Stewart:** Thank you. That was very clear. You have given a good example of a clinical aspect of professional judgment. However, there are also non-clinical factors. Could you give me an example? For example, would you consider the age or maturity of the individual before making a decision to go ahead?

**Dr McLellan:** Yes. I was trying to think of scenarios in which we would not do a forensic examination despite the patient being really keen to have one. The issue is not about consent; it might be inappropriate to do forensics on someone who was acutely psychotic, for example, although that is probably also a clinical factor.

However, there are workarounds in such situations. We might be able to do an examination of a psychotic person if the matter was serious—for example, if the patient was badly injured. In such a case, we might feel that the person needed to be examined, even if not for forensics—although we would capture the forensics at the same time. To be honest, we would probably need to take legal advice—possibly from the Medical Defence Union—and we would obviously take advice from a psychiatrist. I am thinking also about the issue of fluctuating capacity: it would be unusual for someone who was acutely psychotic to demand a forensic examination and not need one, although that could happen.

**David Stewart:** You mentioned legal advice, which takes me nicely on to my next question. How important is the guidance from the Faculty of Forensic & Legal Medicine? I presume that Scotland-wide consistency is very important.

**Dr McLellan:** Yes, it is. As you know, unfortunately the laws in England and in Scotland sometimes differ. For guidance on retention of samples and on clinical matters, the Faculty of Forensic & Legal Medicine is useful. However, it has come into its own only in the past few years, and the training has changed a lot. It is better that people train through the faculty; however, five or 10 years ago, that was not mandatory. It can be difficult for us when the legal situations in England and Scotland differ. The training in Scotland has to reflect the legal process in Scotland, which the doctors in Scotland have to work to. Does that make sense?

**David Stewart:** It does.

Is there a wider philosophical issue in this about patient rights versus professional judgment? I am thinking about the European convention on human rights. This might not be your area of expertise, but do you see any dilemma in terms of the legislation around human rights?

**Dr McLellan:** There could be a dilemma for adolescents. There are two points to make: all people have the right to good clinical care and all people have the right to have forensics captured, if doing so is indicated. What I find challenging is the human rights position when an alleged perpetrator's DNA has been captured and stored, and there is the question whether it should be destroyed. I am not sure about that aspect of human rights.

I think that there would be very few, if any, situations in which the human rights of a patient would be overruled by a doctor in a forensic setting. I would be very surprised if that were to happen. Most doctors are empathetic and sensible. If the doctor had any doubt, or was in a dilemma about a human rights matter or other challenging issue, such as someone's capacity, or if they were not in tune with what the patient wanted, they could take advice from more senior people or from the Medical Defence Union.

There are, in Scotland, channels through which such matters can be sorted out sensibly, without their going in front of a court. Some cases might need to go in front of a sheriff, but we would hope that most of the time in Scotland, through good working, having multidisciplinary teams and taking the right advice from the relevant professionals, we would not go in front of a sheriff unless we needed clarity.

10:30

**The Convener:** Thank you. I am sure that we will come back to those issues in a future meeting, when we hear from witnesses about legal rights and the justice system.

**Alex Cole-Hamilton (Edinburgh Western) (LD):** Thank you for your evidence so far, Dr McLellan. Should self-referral be available only to people who are over 16, and if so, on what basis do you think that?

**Dr McLellan:** That is one of the most difficult areas. To be honest, we should encourage self-referral in 13 to 15-year-olds, because 40 per cent of last year's 13,000 sexual assaults were on under-18s.

We see a lot of adolescents. One in four under-16s in Scotland is sexually active. There are a lot of challenging scenarios and it is not easy when an adolescent comes in but then refuses police involvement—that is the big challenge. We need to encourage those young people to come forward for clinical care. They should be supported by an advocacy worker—maybe a youth specialist.

Obviously, if there is a clear child-protection barn door, we have to involve the police. However, certain scenarios are difficult. For example, two 14-year-olds go to a party, they get drunk and go into the bushes, something happens and one of them wakes up with all their clothes on inside out and feeling sore down below. If we say that the police must be involved in all cases that involve under-16s, with no consideration of different circumstances, we will miss an opportunity to get adolescents to come forward.

**Alex Cole-Hamilton:** I share your concern about restricting self-referral to over-16s—not least, because if sexual abuse or assault happens at home, perhaps at the hands of an older family member, it will be much harder for the person to find an appropriate adult to come with them, or to talk to someone in their social network.

What happens at the moment if a 14-year-old who has been assaulted or raped appears at the Archway? What is the protocol when children try to self-refer?

**Dr McLellan:** There is no capacity for under-16s to self-refer in Archway at the moment. [*Temporary loss of sound*.] If the person comes in to our sexual health service outwith the seven-day period, we cannot do the forensics anyway.

Let us forget about Archway—if an under-16 comes to any sexual health service at the moment, they will get clinical care. A risk assessment is performed for all under-16s who come to sexual health services, whether or not they have been sexually assaulted. We look at the age of the partner. Was there coercion? Was there grooming? Where did they meet the person? Did they meet them online? That happens routinely for under-16s in sexual health services. There are robust systems in place—[*Interruption*.] If there is definitely sexual assault or statutory rape, we will open up the matter to police and social work.

**Alex Cole-Hamilton:** I will ask this question, if I may, very briefly. If a 14-year-old girl came in and said, "I've just been raped and I want you to examine me, because I want to press charges", and she understood the landscape in that regard, would you proceed? Would the Archway or an equivalent clinic proceed with the medical examination and take samples?

**Dr McLellan:** Yes, it definitely would. If a 14-year-old came in within seven days of the sexual assault, forensic samples would be taken. A paediatrician or forensic examiner—or both—would examine her properly to get all the evidence that they need.

The challenge for self-referrals among under-16s is when under-16s come in and do not want police involvement. Obviously, if it is barn-door clear that there has been sexual assault by an older partner, family member or neighbour, that is easy, but there are difficult scenarios. We operate for 13 to 15-year-olds on the basis of the age of legal capacity; we allow them to have contraception and we allow them to have a termination, provided that they understand all the risks and benefits. It is hard to say, across the board, that all under-16s must have police involvement and cannot self-refer.

That is a challenge. However, I am confident that we can put things in place to mitigate the challenges. We encourage police reporting, of course, and we look at the risks of reporting or not reporting.

The main thing, for us, is to keep such kids engaged. If we become too intrusive, dictatorial and black and white, they just go underground. We do not want that. We link with social work and schools, and in NHS Lanarkshire we have two lifestyle nurses, who work with very vulnerable and chaotic adolescents. A lot is going on behind the scenes. I am confident that we can put things in place to make the system robust.

However, limiting self-referral to over-16s would be a missed opportunity.

**Alex Cole-Hamilton:** That is helpful.

**The Convener:** I remind members not to talk across witnesses; it makes it hard to hear what people say. Do you want to come back in, Alex?

**Alex Cole-Hamilton:** No, that is it from me. Thank you, convener.

**Emma Harper:** I agree that the bill offers the correct way to move towards a more holistic and person-centred health approach. I have a couple of questions about the financial implications for health boards. In its submission, NHS Lanarkshire expresses concern that the bill will create additional resource requirements for health boards in the longer term, to ensure that there is, for example, adequate staffing, "on-going training" and "Psychological support ... for workforce". The board also talked about resources for storage facilities, suitable premises, family support and equipment. The bill's financial implications are therefore very broad. Do you have concerns about the long-term funding for the approach in the bill?

**Dr McLellan:** Yes, I have concerns about the long-term funding. At the moment, following-up of patients who have been sexually assaulted can involve several visits back to the health service. The person might need to come back after one or two weeks for a sexual health screen and at three weeks for vaccination, and they might be put on post-exposure prophylaxis and have a month of anti-HIV drugs. Follow-up after a sexual assault can involve six appointments.

In self-referral, when the bill is passed the clinical workload will go up and the amount of follow-up work will go up. I suspect that the awareness raising that follows the bill and promotion of self-referral will also mean that the numbers will go up. The number of sexual assaults has gone up; there has been an 8 per cent rise in Scotland in the past two years.

It is difficult to cost all that. There will be a need for mental health services, child and adolescent mental health services, alcohol and drugs services and so on. The package of care will not be small, and that alone will require increased resources. Storage facilities—freezers—are also needed, which will have cost implications. Buildings will require to be maintained. Victims' travel will have cost implications.

I am confident that we can tap into the nursing workforce, who can help. Sexual health nurses are working across services and can be used, but that will mean transferring resources from the things that those nurses are currently doing. We can transfer resources maximally, but there will still be financial pressures on boards to deliver the new approach, and resource will have to be redistributed if there is no additional resource—if that makes sense.

**Emma Harper:** It is good to hear about that wide range of issues. It is interesting that we are transferring some skills and services to the nursing workforce. Today is international nurses day, so it is good to hear that we are widening the workforce's ability to support the forensics service.

Has sufficient consideration been given to the increased costs? You mentioned the increase in assaults; we are hearing about an increase in assaults during the coronavirus lockdown. Given all those issues, does further consideration need to be given to the financial implications?

**Dr McLellan:** Yes, absolutely—the financial modelling really must be thrashed out, because

we do not want to open up a service that is not sustainable and that goes backwards. The cost modelling in the financial memorandum uses three predicted levels for the number of people coming in for self-referral. I think that you will have to go for the high one, which is an additional 90 cases per year.

The number of patients who might come forward if the bill is passed probably needs to be reconsidered. For example, just as an indicator, I have a report from 2019, which I am holding up. I do not know whether members can see it—you probably cannot. I can send it electronically. It gives data on how many sexual assault cases were seen at Archway last year. There were 66 from Lanarkshire, 61 of which were police referrals and only five of which were self-referrals. However, I think that people who might self-refer are not so willing to travel to Glasgow, so the figure will go up once services are delivered locally. Therefore, the financial memorandum needs to cost self-referrals at the highest level.

Only 66 people from Lanarkshire were seen at Archway last year. Yesterday, we ran a report quickly from our electronic records in Lanarkshire. My information technology person, who is shielding, did a quick snapshot and found that, in the past 12 months, of about 29,000 patients in Lanarkshire, 118 had said that they had experienced a forced sexual assault. I do not know whether those 118 include the people who attended Archway—we will need to look at that—but our records suggest a much higher number of people than are coming forward to Archway. The big risk with the financial modelling is that the number of cases could be much higher than the number that has been costed for.

Another issue is that the financial memorandum does not anticipate NHS Lanarkshire requiring to see any more patients because we already have self-referral to Archway. However, on a practical level, patients are not self-referring to Archway.

Also, Archway has been very understaffed for the past couple of years. The year before last, when it was using COMS—Custody & Offender Medical Services—for its out-of-hours service, there was no capacity for self-referrals after 5 o'clock, because COMS is employed by the police.

We have to be cautious—the figure for self-referrals might be an underestimate. For the financial modelling, we should err on the side of assuming that larger numbers will come forward. The trade-off is that not all those people will go down the court route. It is good that the costings are quite high for the justice process, but not all self-referrals will go down that route. More people might come forward who need forensic examination, but the knock-on effect might not be that 100 per cent go to court.

**The Convener:** Thank you very much. I will briefly go back to the questions that I asked at the outset. If a health board puts in place the facilities that it needs, and staffing is made available for 24/7 operation, how big a difference will it make to the costs whether there are 90 self-referrals, or a different number?

10:45

**Dr McLellan:** Do you mean 90 additional self-referrals per year?

**The Convener:** Some of the costs will be necessary in order to implement the bill, regardless of the numbers who come forward. How much of the extra costs that you have described will have to be incurred anyway, regardless of the level of future demand?

**Dr McLellan:** I am not sure how to answer that—I am sorry. My understanding is that the unit cost per patient is in the financial model, although I am not sure where the figures came from: they were, for example £3,000, £3,600, and £5,000, and the figure was £12,000 for Shetland.

If we were operating 24/7, we would need to look at staggering our patients, if that makes sense. I cannot answer the question, to be honest. That is partly because we have not had a fully staffed service, so we have not looked at that. We will, once we have a fully staffed service running.

I can, however, say that Archway is now doing much better, and that there are more in-house examiners, who operate until midnight. That is definitely helping. I think it will happen stepwise, but I cannot yet give you a figure for costs.

**The Convener:** The fact that that figure is not readily available is important, and is something that we will pursue with other witnesses.

**Miles Briggs (Lothian) (Con):** Good morning, Dr McLellan. Thank you for joining us this morning.

What is your view on there being a public awareness campaign for self-referral, and how should it be co-ordinated?

**Dr McLellan:** A public campaign on self-referral would need to be pushed at people aged 16 and over. We could then look at how that went. I do not think that we should do a campaign on self-referral by 13-year-olds—we should focus on people aged 16 and over using a wide public awareness campaign. That could be done through the usual media—the police, television and an app. We would use health promotion teams around the country, which are well versed in delivering such messages. There is a specialist health promotion team in every health board, and a lead national

group of health promotion specialists. It would not be a problem for them to deliver such a campaign.

**Miles Briggs:** Thank you.

From your experience, how could health boards, in implementing the legislation, take into account inequalities and ensure that it improves equity in access to services?

**Dr McLellan:** As you know, we have high deprivation in Lanarkshire, so we are familiar with targeting services at areas of deprivation. We are always looking at postcode data and data from the Scottish index of multiple deprivation. We should be capturing who is already coming to services; perhaps the data group is already doing that. If they are not, we could do that.

In Lanarkshire, we look at the postcodes of people who come to our young persons' services. If, for example, we found a high number of people from Airdrie going to a service elsewhere, we would put more resources into Airdrie. Alternatively, if we found that nobody was coming in from Airdrie, we would address that. I think the situation would be similar; we would look at the data for postcodes and at data from the Scottish index of multiple deprivation.

We would also need to take advice from third sector organisations about where they would want services to be targeted. That is not just about where people live; we might, for example, want to promote the service through domestic abuse organisations.

I would take advice from our health promotion people, who usually have relevant data and can give us intelligence. Postcode data and the Scottish index of multiple deprivation are quite good. There might be, within a board's area, a cluster that will have a higher rate. We would expect North Lanarkshire to have a higher rate than South Lanarkshire, so we would target more support at North Lanarkshire. We usually target more support for deprivation there: we use such intelligence.

**Miles Briggs:** What should be done, through the bill, for people from ethnic minorities and people who experience language barriers? How should we provide services and reduce inequalities for black and minority ethnic communities?

**Dr McLellan:** We would go to Hina Sheikh, who gives us intelligence on that matter. We have done a lot of work on blood-borne viruses through faith groups—with mosques, for example—and workers for Waverley Care are tapping into the Chinese community. We can use intelligence and advice from them. We also obviously need interpretation services. We would get the message out there similarly to how we did it for blood-borne virus testing: hepatitis B, for example, is a problem in the Chinese community. We would look at what is out there already and use it.

Interpreters are fine unless people are using a language that is not very well known or a dialect that is not commonly used. Sometimes there is a problem in that because there are not many interpreters, the patient might know the interpreter. We could address that by using someone from the board. Telephone interpretation in cases of sexual assault is not ideal; the telephone interpretation service is not ideal for a lot of people.

Google Translate is excellent. I have done consultations with a North Korean woman on the phone when that was necessary—although it was not about sexual assault, but about coil fitting. I knew, at least, that they were reading what I was telling them and that there was no one else involved. That was possible in a busy clinic. There are ways round things. It would not hold up for forensic work, but at least we could use Google Translate to tell people, "We need to sort this out. Hang on." It is common sense.

**The Convener:** Another mechanism for remote working rears up in front of us.

**Dr McLellan:** Exactly.

**Brian Whittle (South Scotland) (Con):** Evidence to the committee has highlighted the importance of psychological and mental health support, and the role that supported decision making and advocacy play in sexual assault and rape victims' recovery. Should the bill give victims a right to advocacy services? What importance would you place on that?

**Dr McLellan:** Advocacy and the psychological aspect are very important. They are not outwith my control, but they are areas in which we need to be backed up. Even with a good clinical and forensic examination, we need advocacy so that the woman has support through the court process—preferably from the same person throughout. It is important that it starts from the moment of engagement; the emphasis should be on getting advocacy and the clinical care in early. The forensics and the police are not secondary, but advocacy and clinical care are paramount at the start of the process. If they are done well, there are better outcomes for everybody.

Psychological support is extremely important. Mental health services are under huge strain and will be under even more strain after the coronavirus outbreak settles, however long that takes.

When people come in for a forensic examination, part of the package of care is a psychosocial assessment. It is quite brief, but it is included. We want to know whether people are

safe, so we ask about their mental health issues, and there is a brief suicide assessment and self-harm assessment.

In Rape Crisis Scotland and in Archway, support from advocacy workers is crucial. It is they who keep in touch with the person once they have gone home. We can refer people to general practitioners and to mental health services, but the advocacy work is crucial. The psychological impact often comes later—it does not come in the first 24 hours. An early assessment might be made, but the issue is on-going support.

In the west of Scotland, we have been considering a clinical pathway. We previously discussed the point that, sometimes, even with the best psychological support, people have pulled back by the time the court process starts. However, an advocacy worker can keep things going and can link the person with services that they need when the court trial starts or at times in the future when the person might be more vulnerable.

Ideally, the advocacy person should be engaged from the start and should see the person through the whole process. That is an essential component.

**Brian Whittle:** You are indicating that, to an extent, NHS boards are providing immediate and on-going psychological support to victims of sexual assault and rape. For me, the key point that you are highlighting is that there should be a continuing advocacy service, from start to finish. Where do things currently stand in that regard? How much do we need to upskill, and how well is the system prepared for handling the requirements?

**Dr McLellan:** The rape crisis centres are keen to help. People might be allocated at the start of the process, but it would be overwhelming if they had to see 20 people constantly for a year and a half. It might be possible to step in and out and to touch base with each person at three months, six months and nine months, for example.

From a psychological point of view, the general practitioner can be a good link for those who are linked into mental health services. There are differences: advocacy workers take people through the court process and provide support, and formal counselling services are separate. We do not have the arrangements for that clearly thrashed out, to be honest, but there is a need for both those services.

**Brian Whittle:** Another question springs to mind, on the impact of the third sector and how we utilise that sector and bring it into the fold. Where are we with that, and how important will it be to utilise the third sector?

**Dr McLellan:** The third sector is very important. We have good links, although they have been haphazard in the past. However, there is now a chance to create a more consistent service for everyone. We are working on a pathways approach in the west of Scotland. Rape Crisis Scotland is with us at the table and is keen to be involved.

It would be ideal if voluntary sector organisations such as Rape Crisis could be involved from the very start, when a person hits the service. What tends to happen is that a patient is seen and gets their forensic package. They will then go away, having been given information about rape crisis services. It would be better if they were linked in right at the start of the process for a face-to-face discussion. That is what we want to provide, although not everybody will want that.

**The Convener:** Thank you. That was very helpful.

You made a number of comments related to recruitment and staffing. You mentioned delays in Glasgow because of staffing over the past year, and difficulties in recruiting to Archway. We know about such things and have heard about them from other witnesses.

You mentioned networking and you talked about resources. What is the single most important thing that could come with the bill in order to make all that a reality? It is great to have legislation that strengthens the system, but it will clearly only be as good as the system can be made in practice. You have identified some existing practical challenges. What should the Government do to back up the legislation once it is in force?

11:00

**Dr McLellan:** We will need a strong clinical network that links with the police and brings in the voluntary sector, so that everyone, wherever they are, has the same care pathway. Networks are key, so that we know who the local police are and so that they know what is happening.

There is no time to train a batch of new young female doctors in time for the legislation. However, such training is happening anyway, and there are already a lot of female examiners who could be brought into the network. We should be bringing nurses into the training, too.

There has to be a network that people can link into. There also needs to be a multi-agency policy document on how to progress the legislation, with implementation being driven by lead people in sexual health services and the police.

I had not realised that, sometimes, people are signposted back to the 101 telephone number to report a rape, because not every police area has a

dedicated team that deals with rape in that area. If we have information about the police's teams, we will be better able to work together. Multidisciplinary working and improving the service need to be the focus, following the legislation.

**The Convener:** Thank you very much for taking part. It has been a very helpful meeting, and I know that all members have appreciated your answers. We might come back to you on one or two points; we will certainly be seeking comments from others on issues that you have highlighted.

That concludes the public part of the meeting. Our next meeting is provisionally scheduled for Wednesday 20 May. Notification will be given in the *Business Bulletin* and via the committee's social media, as usual.

11:02

*Meeting continued in private until 11:25.*

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