Report for distribution prepared for ACC on behalf of the three SAATS Funders

Review of the Sexual Abuse Assessment and Treatment Services (SAATS) and the Organisation of Doctors for Sexual Abuse Care

Jo Esplin, Jo Smith, Gary Blick, and David Moore

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Wellington	**Auckland**	
Level 9, 1 Willeston St PO Box 587 Wellington 6140 Ph: +64 4 915 7590 Fax: +64 4 915 7596	Level 8, 203 Queen St PO Box 2475 Auckland 1140 Ph: +64 9 909 5810 Fax: +64 9 909 5828	
Sydney	**Canberra**	**Melbourne**
Level 14, 68 Pitt St GPO Box 220 NSW 2001 Ph: +61 2 9234 0200 Fax: +61 2 9234 0201	Unit 3, 97 Northbourne Ave Turner ACT 2612 GPO Box 252 Canberra City, ACT 2601 Ph: +61 2 6267 2700 Fax: +61 2 6267 2710	Level 2, 65 Southbank Boulevard GPO Box 3179 Melbourne, VIC 3001 Ph: +61 3 9626 4333 Fax: +61 3 9626 4231

For information on this report please contact:

Name: Jo Esplin

Telephone: +64 9 360 1773

Mobile: +64 27 233 4010

Email: jesplin@srgexpert.com

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Executive summary

This report

This is an edited version of the full Sexual Abuse Assessment and Treatment Services (SAATS) and Doctors for Sexual Abuse Care (DSAC) review report. The intent is to make it available for wide distribution to stakeholders as part of a feedback loop. It wholly reflects the content of the original report with the exception that commercially sensitive financial modelling and information has been removed. The rest of the report has been edited, for ease of reading without changing any findings or recommendations.

Background

(SAATS) deliver medical and forensic services to victims of sexual abuse of all ages (child, adolescent and adult) for acute, historic, forensic and non-forensic presentations. The services include both first presentation and follow up appointments, where needed. The funders are ACC (lead funder on behalf of the three funders), New Zealand Police and the Ministry of Health. The majority of the workforce is doctors and nurses working in either District Health Boards (DHBs) or other community based and primary health care services with a few Police Medical Officers (PMOs) on the rosters as well. DHBs hold the contracts with ACC, with some of them sub-contracting to other services, for example, accident and medical centres.

Prior to 2006 – 2008, there were no national SAATS services or funders, other than some ad hoc funding arrangements for parts of the service. Services were undertaken by individuals who invoiced the NZ Police on a fee for service basis for their time, or by PMOs. The impetus for development of SAATS services was that DSAC had written to Ministers and funders alerting them of the fragility of existing services across the country.

There are 15 service contracts between ACC and the DHBs[1]. Most paediatric services are provided within the DHB, albeit these are very variable, with many gaps. Adult services vary in where they are provided and by whom, based on local arrangements.

In line with international good practice, it is intended that at the local level there is a tripartite approach to SAATS including health, NZ Police and crisis support agencies. Currently there are many gaps in crisis supports and some gaps in paediatric services.

Importance of the SAATS service

Sexual abuse can result in significant and lifelong personal, social, health, and economic costs to victims, their families, and the wider community and economy. The SAATS service is very important for individuals who suffer assault or abuse to avoid or help prevent long term effects, ongoing distress and wellbeing issues. In addition, quality SAATS services are important for effective collection of forensic evidence, where required.

[1] 14 services are being provided with MidCentral currently providing the service for Whanganui.

The SAATS services are a vital part of the health system; however, they are difficult to maintain due to relatively low and variable volumes, across the geography of New Zealand. They need to be nurtured and supported to be sustainable, especially with the expected and desired growth over time[2].

This review was about sustainability

This review of SAATS was undertaken to look at the current delivery and sustainability of SAATS. Sapere Research Group (Sapere) was engaged by the funders to undertake several site visits, a rolling literature scan and other stakeholder interviews. ACC undertook a clinical audit of six sites and produced a report that Sapere then considered for this report.

In addition, Sapere was asked to consider the role and sustainability of the DSAC organisation and a proposed (by DSAC to the funders) new National SAATS Clinical Network (SAATS network).

117 stakeholders were interviewed, including SAATS services (clinical staff and management, one administrator), funders, three international experts, and DSAC. An e-survey for the SAATS workforce was run and received 95 responses. Financial payment data was sourced from two databases in ACC and several individual services gave some information on their actual costs and budgets.

Between the ACC Clinical Team and Sapere, nine vendor contract holders were visited and interviewed. Three other sites were interviewed by telephone and two further sites responded in written form. In addition, a variety of additional email responses were received.

A rolling international literature scan was undertaken to identify good practice features for sexual abuse medical and forensic services. These were then considered in the New Zealand context (i.e. volumes, workforce, and geography), against the current SAATS contractual service specification and information gathered in the qualitative interviews.

Based on expected incidence data there is significant under-reporting/access at present, and funders wish to address this. Therefore, there is a need to incrementally grow the workforce and improve service accessibility and sustainability, to ensure that over time, all those who choose to access SAATS can access them.

Key review findings

Service volumes are growing

The number of first consultations (acute and historic) for 2014/2015 was 1,753, which was a 13% growth on the previous year. Of those, one in three adults goes on to have a follow-up consultation, while one in four children and adolescents do. The volumes and rate of growth differs significantly across regions.

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[2] It is noted there is under reporting of sexual abuse, that the funders would like to see addressed as much as is practicable.

Good practice features show opportunities for an improved service

SAATS adult services are reportedly significantly better than they were before the introduction of the SAATS service specification and contracts, in the mid-2000s. However, the paediatric services are not currently as robust or sustainable as the adult services. Where services for adolescents are delivered, by what age bracket and by whom, varies between paediatric and adult services, depending on local individual practitioner preferences, criteria and availability. While tailoring to local circumstances is appropriate, there is an opportunity to streamline this nationally. For example, in the future this could include national criteria as to when an adolescent is seen in a child or adult service[3].

The key concerns and opportunities for improvements for SAATS services in New Zealand, when measured alongside international good practice criteria are:

- Improve rates and timeliness of access.
- Address gaps in crisis support.
- Address gaps in paediatric coverage and sole paediatricians covering 24/7 services in some places.
- Improve appropriate services for youth and adolescents.
- Address accessibility and appropriateness of services for Māori and Pacific people.
- Address accessibility and appropriateness for other vulnerable groups e.g. transgender, sex workers, disabled people and recent migrants.
- Support and grow the sustainability of the workforce and services, including funding.
- Grow multi-disciplinary team approaches including professional support of staff, e.g. professional supervision, peer review.
- Provide strategic policy ownership and leadership from central government.
- Create national oversight and quality control of a national service not 15 individual services.
- Improve data collection and analysis, with feedback loops to services developing a national overview of SAATS services and workforce.

Governance, management and staffing models vary

The service models of how SAATS are arranged and delivered locally vary. This is based on local resources including workforce preferences, DHB management style and priorities, as well as pragmatic local configurations. Local solutions are not a service issue per se. However where DHBs don't assign a manager or portfolio that proactively oversees the service, this can cause issues for the workforce and the service. This is particularly the case for paediatric services, as most sit within DHBs.

3 Note: this is not intended to be age based but a series of client centered criteria.

SAATS and DSAC are inextricably linked to provide a quality medical assessment and forensic service

The workforce and operations of SAATS are inextricably linked to the work DSAC does with training and other, what DSAC terms as, "SAATS enhancing services." Together, and with the proposed National SAATS Network, this creates a national service system for enhanced quality and sustainability.

SAATS service and workforce sustainability is a concern

Overall, sustainability of SAATS services is a concern for the following reasons:

- Workforce burnout, availability and number, especially paediatrics and more experienced adult service doctors.
- Lack of workforce development and recognition pathways for the work.
- Change in workforce demographics and expectations, meaning less likely willingness for participating in after-hours rosters and pro bono work going forward.
- Funding levels of some cost components of the current contract.
- Gaps in funding some components of the service.

In addition:

- Sustainability of DSAC and what they can do within current funding envelopes.
- Role of the new SAATS network and how it might be funded, including local SAATS staff being paid for participating in on line or virtual peer review and training/learning.

Workforce e-survey findings

A web-based survey was sent to the workforce in SAATS services. 95 responses were received. It must be noted that this may be a skewed sample as it was likely that more "engaged"[4] clinicians responded as it was sent out via the DSAC network. The response did represent all geographic areas and covered doctors and nurses. Of those that responded, many doctors were DSAC accredited and 51% said they were doing some unpaid SAATS work. For example, 29 (30.5%) people said they do up to half a day per month unpaid.

Respondents said the personal motivation for working in SAATS included that it is important and rewarding work and identified the importance of having a supportive team.

People reported that there are several functions of SAATS services not being done that should be. 23 people said the services needed improved funding and resources to undertake the total service, e.g. follow up, marketing, education. Eight said more administration was required; seven thought more training and support for new people was needed.

[4] To SAATS and DSAC specifically.

A proposed SAATS network

64% of the e-survey respondents said they saw a role for a national SAATS network. The majority of interviewees thought it was a new and important role for quality development and controls, particularly focussing on peer support and expert advice. A clear theme from survey respondents wanted it to be representative of the services so to continue to shift from a doctor-dominated representation to wider representation such as nurse, administration and (service) management. *Note: this is already underway with the recent DSAC changes to governance.*

Financials and funding a SAATS network

A key impetus for the review was a concern that the SAATS services may not be sustainable from either a financial or workforce perspective. We reviewed the current funding model and developed scenarios for potential change in demand. Specifically, we have looked at the funding of the SAATS services, DSAC as an organisation, and the potential development of a SAATS network. The latter is financially inextricably linked with the current and future functions and roles of DSAC, as DSAC is with the training and support of SAATS.

SAATS volume growth projections

If basic demographic growth is assumed, it is projected that services could grow 8% per annum. However, if we consider latent demand growth (i.e. those that have not reported to date but might as a historic presentation), then there could be three times the growth of demand.

Key recommendations

SAATS recommendations

In general, most of the SAATS adult services are meeting most, but not all, critical aspects of the service specification and contract. However, there is more variation and significant service gaps for paediatric services.

The following recommendations are suggested to improve the quality and sustainability of the SAATS services.

1. Adopt the proposed SAATS service principles (in this report)
2. The Ministry of Health to take a strategic policy and leadership role for SAATS, based on the workforce being a health workforce.
3. Revise the service specification alongside good practice and pragmatic New Zealand approaches including an updated funding model, consideration of some day time models over time, improved reporting requirements, alongside considering a longer term contract to allow for service and workforce planning.
4. Prioritise paediatric services to address workforce and service gaps, this initiative to be led by ACC (as lead funder) working with and involving the Paediatric Society and College, DSAC and the Ministry of Health.
5. Develop criteria for a person-centred approach to determining where adolescent services are delivered is undertaken, to ensure best patient-centric approaches.

6. Identify local solutions to organisational location and management of SAATS services based on the best pragmatic local solutions and supports, harnessing existing workforce and management commitment as much as possible.
7. Require contract holders with ACC to report on their contracts for SAATS services.
8. ACC to clarify with DSAC and SAATS services regarding lodging an ACC45 claim for patients and how the system can be patient-focussed.
9. Continue to have a doctor and nurse team for acute assessment and treatments.
10. Grow the services incrementally via workforce development, advertising and marketing, education and service profiling and develop a workforce development pathway.
11. Create a three tiered expert workforce model to provide a recognition pathway to incentivise the workforce.
12. Review the SAATS services on a regular basis e.g. biennially to ensure all is proceeding as expected.

DSAC recommendations

13. Further refine the Medical Expert Review Group (MERG) process including clarifying when to use it for paediatric cases and looking at ways for further national moderation.
14. Building on the recent governance enhancements, merge the ideas and approaches for the future of DSAC and the proposed SAATS network, create synergies and further develop an integrated approach to clinical services and service sustainability.
15. Consider how consumer/patient input, especially from hard to reach and vulnerable populations may be more included in the future.

Workforce and training recommendations

16. Over time, make DSAC training and accreditation mandatory via the partnership with DSAC and the new SAATS network to ensure appropriate quality results and outcomes. *Note: Until the paediatric work is undertaken this recommendation may not apply to all paediatricians.*
17. Increase the amount of training, education and peer support opportunities per annum the workforce can access, via the proposed SAATS Network.
18. Funders to consider paying for all DSAC training and membership for doctors and nurses (when accreditation is developed for nurses) including:
    (a) Training;
    (b) Accreditation; and
    (c) Re-accreditation.

Proposed SAATS Network recommendations

19. Fund the proposed SAATS network, to be reviewed over time.

20. The three funders to work with relevant Government agencies and crisis support representatives for national improvement in access to and consistency of crisis support for patients.

21. Prioritise initial activity including working with the funders to develop data and reporting management, and the development of peer support and review services.

Recommendation on monitoring and evaluation of SAATS

22. Funders to adopt a national agreed framework for monitoring and evaluation of SAATS that include outcomes-based meaningful reporting.

23. Funders to implement a system for proactive and systematic national-level monitoring and analysis of trends in service volumes and patient profiles.

24. ACC, as lead funder, to provide regular feedback to service providers on the quality of their individual reporting and on the findings and implications of national-level monitoring and analysis.

25. Instigate regular reviews e.g. biennially, of the SAATS volume growth and pricing.

Funding recommendations

26. Note the total estimates of additional cost including the SAATS services current service specification, unfunded aspects of the SAATS service, DSAC and the new SAATS network. *[Note: these financial figures have been removed for this shorter report version]*.

1. Background

1.1 Background to the review

Sapere Research Group (Sapere) was contracted by ACC on behalf of the three funding agencies (ACC, the Ministry of Health, and NZ Police) of Sexual Abuse Assessment and Treatment Services (SAATS) to undertake a review and make comment on:

- SAATS.
- The organisation of Doctors for Sexual Abuse Care (DSAC).
- A proposed new national clinical network for SAATS (SAATS network).

Note that SAATS includes:

- All ages: child (paediatric), adolescent and adult.
- Acute medical and forensic assessment and treatment services.
- Historic (non-acute) medical assessment and treatment services.
- First presentations and follow-up where required.

We noted that some stakeholders may use these terms interchangeably depending on local circumstances, solutions, preferences and configurations.

In most instances the paediatric and adult services are managed and run separately with the responsibility for adolescents varying between the two, depending on local arrangements and workforce. Similar to other international jurisdictions, there is no consistent definition of adolescent in New Zealand. Where available, SAATS services link with crisis support for the patient and they also work closely with the local NZ Police District(s).

The funders wished to complete the review to have a clearer understanding on how the SAATS service is operating nationwide, and whether the current structure and funding model is supporting consistent and quality service delivery.

The review ran over the period of September 2015 to March 2016.

1.2 Scope

1.2.1 Included

Included in the review scope were: SAATS, DSAC, a potential new national SAATS network and a rolling literature scan.

So that the following could occur:

- Stakeholder engagement.
- Service and financial model development.
- Service mapping.
- Purchasing model (procurement) development.

- Effective use of funds/cost effectiveness.
- Clear identification of current service and sustainability gaps.

1.2.2 Excluded

Out of scope was:

- Patient contact/interviews.
- A review of clinical records related to service provision.
- A revision of the service specifications.
- Full pricing of a new service specification.
- Systematic literature review on clinical best practice.
- A clinical audit.

1.3 Evaluation objectives and questions

1.3.1 Objectives

The evaluation objectives were:

- Quality Services: identify good practice models for the paediatric, adolescent and adult services.
- Develop an Outcomes Framework[5] for performance measurement and monitoring.
- Workforce: how best to ensure a quality sustainable workforce for SAATS.
- Funding: inform the development of a sustainable funding model for national service provision which includes a scoping for the need for a clinical (and administrative) network of all SAAT Services that are linked to sustainable funding for DSAC.

1.3.2 Evaluation questions

The evaluation questions Sapere was contracted to address were:

- What is the current clinical service model and is this 'good practice'?
- What is SAATS current service provision?
- Does it meet contracting requirements?
- Does it meet best practice standards?
- Is there a gap between current service provision and good practice, and how can this gap be reduced or removed?
- What are some options/recommendations for an evidence-based quality service?

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[5] See Section: A Framework for Monitoring and Evaluation of SAATS.

- What is the current funding/pricing model and how is it being utilised by different SAATS sites?
- What additional funding sources, including cross subsidisation, in addition to the letter of agreement with ACC, Ministry of Health, and NZ Police, are currently being utilised in order to enable service delivery?
- What are some good practice options for a funding/pricing model?
- What are some recommendations for monitoring and auditing, including quality assurance and outcome measures?

1.4 Methodology

A mixed methods approach was used, comprising a rolling scan of good practice literature, interviews with key stakeholders and international experts (including site visits to nine contract holders and telephone interviews with three and written responses from one other), analysis and modelling of service volumes and costs and an e-survey of the SAATS workforce. A clinical review was undertaken by ACC of six sites, the findings of which have been considered for this evaluation report.

1.4.1 Site visits and interviews

In total, there are 15 SAATS contracts, between ACC as lead funder (on behalf of Health and NZ Police) and the District Health Boards (DHBs). 14 are delivering the service (to varying degrees) with one being covered by another DHB.

Nine contract holders (there were more than nine actual sites within this group) were visited and interviews undertaken with key stakeholders and staff. Three contract holders were visited by the ACC Clinical Team (ACC), three by Sapere, and three by both ACC and Sapere together. Three other services were interviewed by Sapere via telephone and two supplied written responses. Note: although each contract holder was contacted initially, it was up to them to decide and determine who the interviewees were, based on local knowledge and configurations.

The number of contract holders and sites to visit was driven by budget considerations. The prioritisation of sites to visit was advised by DSAC. A mix of rural, provincial, and urban sites was chosen, as well as the paediatric and adult services within each. They were (with interview leads in brackets):

- Northland (Sapere).
- Auckland – which covers Waitemata, Auckland, and Counties Manukau DHB districts (ACC and Sapere).
- Waikato (Sapere).
- Hawke's Bay (Sapere).
- Tairawhiti (ACC).
- MidCentral DHB – which covers Whanganui DHB (ACC).
- Nelson Marlborough (ACC and Sapere).
- Canterbury – which covers West Coast DHB (ACC and Sapere).

- Southern (ACC).

In addition others were interviewed by phone and/or sent written responses to the interview questions.

Stakeholder mix and numbers were arranged by local managers and varied between sites. The majority of interviews or focus groups were held with mixed groups of:

- The DHB manager/contract holder.
- DHB portfolio manager.
- Service manager.
- Lead adult and paediatrician clinicians.
- Other key nurses and doctors.
- Administrators.
- Local District Police.
- Crisis support (where available).

Other stakeholder interviews were held with:

- DSAC.
- Funders (ACC, NZ Police, and the Ministry of Health).
- Ministry of Social Development.
- The National Tripartite Meeting in Auckland (February 2016).
- Three international experts in the field (Australia -forensic expert, United Kingdom – adult and child services expert, and United States – child expert).
- Ex NZ Police[6] manager of SAATS.

In addition, Sapere and ACC representatives attended selected non-clinical sessions of the DSAC Update Conference, held in Wellington in late 2015.

With a combination of site interviews, interviews with other stakeholders, and the workforce survey, there were 117 stakeholders interviewed and 95 respondents to the workforce survey.

Note: The 95 e-survey respondents cannot be directly added to the stakeholder interviews, as some may have been the same people who chose to respond. The findings from the interviews, site visits, and e-survey were triangulated for the qualitative analysis.

1.4.2 Workforce survey

As a key consideration for the review is the sustainability of the workforce, a workforce e-survey was also undertaken to gain further input from the workforce. The web link for this was distributed via DSAC's membership list and via the ACC SAATS contract holders. People could distribute it more widely, if they chose. 95 responses were received between December 2015 and January 2016.

[6] No longer representing NZ Police.

Responses had representation from DHB districts that hold SAATS contracts, doctors and nurses, paediatric, adolescent and adult workforce, and one administrator. It should be noted that as it was sent out via DSAC's web links it is likely to have a skewed response.

1.4.3 Financial analysis

Financial sustainability was also a key consideration of the review. SAATS contract payment and ACC45 lodgement data was sourced from ACC to model current and historic volume claim and growth trends in payments, and then modelled to show potential growth rates if additional growth rates of presentations are experienced.

Financial data was received from four services. This was in varying forms and at varying levels of detail.

The workforce e-survey sought information on rates of paid and unpaid time working in SAATS.

2. History of SAATS

2.1 Development of SAATS

SAATS services provide the medical care and forensic examinations[7] which are available to all people in New Zealand (the patients) who require them, regardless of age. Those who might require this level of specialist service are a subset of those who experience sexual assault or abuse. This service is for all people, even if they do not wish to report to the NZ Police.

Prior to the establishment of a SAATS service in 2006–2008, the examinations and medical treatment were undertaken by a range of doctors often working in isolation, including Police Medical Officers (PMOs). The doctors individually invoiced NZ Police for these exams. From 2001, ACC had a contract with DSAC trained doctors to pay for non-forensic medical assessments[8].

In 2006, DSAC alerted Ministers and ACC, Ministry of Health, and NZ Police that these services were in a very fragile state across New Zealand. A working group was established to develop a sustainable service model and funding. For the first time, national service specifications and contracts were developed. This was a tripartite approach which, at that time, the Ministry of Social Development declined to be involved in.

2.2 Development of DSAC

> *"DSAC is a national organisation of doctors and nurses formed to develop and maintain standards of best practice in the delivery of medical and forensic services in New Zealand in the area of sexual assault/abuse. (…) the purpose of the organisation is to provide accessible education, training and support of clinicians (…) including the medico-legal process.*
>
> *DSAC was formed in 1988 by a group of doctors who recognised the need for a specialised medical service to address the complex and varied needs of people who disclose a history of recent or historic sexual assault or abuse."*[9]

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7 For the purposes of this report, it is the gathering of evidence for a potential Court process.

8 DSAC. Proposal for a Sustainable Medical Service for Sexual Abuse Care and Treatment Services: Phase One. January 2014.

9 DSAC. Proposal for a Sustainable Medical Service for Sexual Abuse Care and Treatment Services: Phase One. January 2014.

2.3 How SAATS services are configured now

2.3.1 Funding

The contract for SAATS is administered by ACC on behalf of the three funders (Health, ACC, and NZ Police). There are multiple additional funding streams and cross subsidisation from the DHBs, and at times, other services topping up some of these services (e.g. via population-based funding formulas via DHBs, staff time being paid for via other services, management time and pro bono/volunteer time). There is a national pricing schedule for NZ Police for payment of some aspects of SAATS, e.g. some training costs, funding the Medical Expert Review Group (MERG) time. How the schedule is used and interpreted varies between Police Districts as it allows for negotiation of what is funded.

2.3.2 Size of the service

There are 15 ACC SAATS vendors, all of whom are DHBs, of which seven subcontract out to other providers. Examples of other providers include general practice, an A&M clinic, a Trust, a private hospital, and a family planning clinic. Where a DHB does not hold a contract, their populations are covered by a neighbouring DHB contract.

Some DHBs run their services over more than one site, depending on geography (e.g. Southern has sites in Dunedin, Invercargill and Queenstown) and/or delivering paediatric and adult services separately or together.

2.3.3 Access and delivery is variable

Referral pathways and options are variable with some services allowing referral from any source 24/7, including self-referral. Others have a range of time of day referral differences with some adult services having referrals only or mainly via the NZ Police. Especially for after-hours, several services' referrals can only be done via the NZ Police. Paediatric services reported that the majority of referrals are from NZ Police or CYF.

In summary the full service specification as it is currently, is not generally being met. However for adult services it appeared the critical acute and forensic services were being delivered, albeit some had to travel to get to them, and by far the majority only in after-hours time (as the workforce have regular daytime jobs such as being a GP, a Practice Nurse, sexual health staff, etc.). By contrast, paediatric services appear to have far more geographic and/or time of day variations and gaps.

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3. SAATS Review Findings

3.1 Principles

In reviewing the SAATS services, it became clear that a set of principles would be useful to guide options and recommendations in this review as well as future clinical and service considerations. The following principles are proposed:

1. Services are patient-centric.[10]
2. Good quality consistent clinical practices and standards including:
   (a) Enhanced peer review and support.
   (b) Quality training and professional development.
   (c) Ensuring workforce wellbeing, including supervision.
3. Clinical time is not used for non-clinical work that can be more efficiently done by others.
4. Clinical time for core activity is funded and staff are paid for time worked, e.g. interagency meetings, education, peer/case review.
5. Improve access and grow the services and the workforce, in an incremental sustainable manner.
6. Adopt a pragmatic approach to a national and regional view of service design in the first instance and review this as the expected volumes grow.
7. Avoid duplication wherever possible: develop once (e.g. nationally), adjust and implement locally.

3.2 Good practice features

Sapere was asked to look at international good practice features for SAATS type services and supporting infrastructure, e.g. training, and make comparison against what is currently occurring or being delivered in New Zealand.

A top line observation is that New Zealand needs to be pragmatic about how it continues to develop and deliver SAATS services and to grow and develop over time. The size of the population, numbers seeking or requiring SAATS, and geography means we cannot seek to replicate larger overseas models, e.g. the UK hub and spoke model, and the UK SARC[11]

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[10] Sapere took advice from DSAC that people who use the services are referred to as patients, rather than clients or victims, as it is a medical service.

[11] http://www.solacesarc.org.uk

model. However, we can learn from these models, and the stakeholders, including the international experts, who were interviewed for this review.

3.2.1 International and literature good practice features

The rolling literature scan and interviews with three international experts identified 24 features of good practice that need to be considered for a robust SAATS type service. These are:

Referral pathways and accessibility

1. Information provision and raising awareness.
2. Victim access points and referral pathways.
3. Accessibility and coverage.

Service requirements

4. Triage and initial response.
5. Medical assessment and treatment.
6. Forensic assessment.
7. Follow up.
8. Support services (crisis).
9. Being victim/patient centred.
10. Service quality and appropriateness.
11. Clinical peer review and supervision.
12. Administration support.

Workforce

13. Training and professional development.
14. Rosters.
15. Workforce wellbeing/supervision and support.
16. Sustainability.

Physical facilities and infrastructure

17. Facilities, equipment and consumables.
18. Forensic examination room.
19. Diagnostic and testing equipment.
20. Co-location and integration (MDT approach).

21. Infrastructure (IT, secure storage, etc.).

Collaboration and governance in service provision

22. Whole of Government policy.

23. Medico-legal services.

Monitoring and reporting

24. Reporting and monitoring (including data collection).

3.2.2 Good practice in the New Zealand context

Overview comment: build on recent years' developments

Overall, stakeholders reported that the sexual abuse assessment and treatment services are much improved (for patients and workforce) than they were before the introduction of the national SAATS contract, in 2006 – 2008, albeit less so for paediatric services at this stage. They were mainly pleased that this current review was underway so the successes could be built on and any new or remaining issues be addressed. Key reported challenges for adult services are funding and for some, workforce. There are significant issues with paediatric services and workforce coverage.

A "traffic light" summary shows the hot spots of issues

In summary, the following "traffic light" table provides a quick general overview where we see the biggest variances to good practice currently. We have split paediatric and adult, as some of the issues are significantly different. We need to acknowledge that there are also pockets of variance within individual locations and / or services which could not be reflected at every detailed local level.

3.2.3 Summary of gap analysis: Current status of service delivery against elements of good practice

Table 1 Key for Table 2

Colour	Meaning
(green)	Largely being met (may be some variability).
(amber)	Some notable gaps/concerns and/or material variability in some services or areas of good practice.
(red)	Significant gaps/concerns.

Table 2 Summary of paediatric and adult services

Area of good practice	Current status			Comment
	Paediatric	Adolescent	Adult	
Referral pathways and accessibility				
Information provision and awareness raising				Some services not proactively advertising at all; some others hard to locate, e.g. no web presence. Lack of advertising to diverse groups, including linguistic diversity.
Victim/survivor access points and referral pathways				Availability of self-referral and non-Police channels a gap in many areas. Reportedly major issue with CYF referral practices, e.g. not recognising need for medical examination and/or treatment.
Accessibility and coverage				Gaps in 24/7 coverage (day time and afterhours). Gaps in regional availability. Availability of paediatric services a critical issue. Transport and linguistic diversity also barriers to access.
Service requirements				
Triage and initial response				Triage generally OK. Initial response varies based on time of day, day of week (i.e. weekend or not), and workforce.
Medical assessment and treatment				Low access, particularly for paediatrics, due to low numbers on rosters.
Forensic assessment				Many paediatrics have to travel at times to get forensic acute assessment.

Follow-up				High rate of Do Not Attends. Some services not offering this.
Support services				Availability of crisis support a critical gap. Quality/variability of some crisis-support for individuals is an issue. Increasing difficulty in accessing this service.
Victim/patient-centred				Variable somewhat dependant on resources (e.g. approaches to replacement clothing, refreshments, availability of waiting rooms for family/whanau). Needs of vulnerable groups variably met, e.g. Māori, recent migrants, ethnic minorities, people with disabilities, sex workers, transgender not expressly met. Access/referral pathways hard to find.
Service quality and appropriateness				Not all doctors and nurses specifically trained Variable appropriateness for many parts of the population an issue
Clinical peer review and supervision				Variable.
Administration support				Most services reported not enough administration time and so clinicians undertaking administration work.
Workforce				
Training and professional development				Paediatrics a critical issue in SAATS services, though DSAC paediatric training internationally recognised. Recruitment and retention an issue in some services. Lack of workforce development pathway, for doctors and nurses.

Rosters				Paediatrics a key gap. No clear national pathway for adolescents, and therefore rosters vary and some gaps reported.
Workforce well-being – supervision, support and safety				Risk of workforce burnout, trauma, stress.
Sustainability				An issue, particularly in the context of an ageing workforce, and changing work-life expectations. Key person risk (reliance on one person) in many areas.
Physical facilities and infrastructure				
Facilities, equipment and consumables				Generally speaking people had appropriate facilities but not at the level specified in the current service specification e.g. not all have colposcopy, medical photography
Forensic examination room				Lack of dedicated facility in some services; but cleaning protocols in place. No issues reported by Police Adolescent-appropriate facilities a gap.
Diagnostic testing and equipment				Colposcopes and photography not in all areas. No evidence that access to labs and pharms an issue.
Co-location / integration				Not recommending hub and spoke model for NZ, so an overall mix of models across NZ now.
Infrastructure				Varies based on local situations.
Collaboration in governance and service provision				
Policy				Lack of strategic policy leadership and oversight from central government.

Multi-disciplinary collaboration, co-provision and response				Raising awareness and education across referral agencies can be a gap (gap in crisis support services noted above).
Governance				Need for MDT in local and national governance.
Medico-legal				NZ Police report no issues. Paediatricians especially report this makes for a barrier to them providing this service.
Monitoring and reporting				
Data collection				Inconsistent practices, data gaps. No national coordination of data, trend analysis. Local collection varies.
Reporting requirements				Only one service reporting to ACC regularly.
Funding				
Funding				Cross-subsidisation in most services. Reliant on pro-bono work in many areas (unsustainable). Gaps and underfunding in some components of contract, e.g. administration. New funding lines being recommended e.g. for the SAATS network.

3.2.4 Summary of the top concerns and opportunities regarding New Zealand good practice

In summary, the top good practice gaps are:

- Access: both referral process (particularly from CYF) and entry points (including non-Police and self-referral channels), as well as low volumes (for acute, acute forensic, and historic).
- Availability and variability of crisis support.
- Paediatric service gaps and workforce challenges.
- Accessibility and service appropriateness for adolescents.
- Accessibility and service appropriateness for vulnerable groups.
- Support of workforce, wellbeing and development pathways; various causes/barriers.
- Service sustainability: funding – varied issues, real or perceived gaps, e.g. administration.
- Co-location/MDT approaches vary, including education and relationships with local MDT/tripartite members in some instances.
- Strategic policy leadership from central government, as well as national-level service oversight and quality control, plus consistency issues.

3.3 SAATS services findings

3.3.1 Some SAATS services have improved measurably and it is time to build on this

Each service has various local solutions to make the service work in their own context and location, attracting and utilising the workforce as best they can. The majority of stakeholders interviewed, including NZ Police at both national and district levels, indicated that the SAATS services are far better since the introduction of SAATS than previously. This is so even for paediatrics, even though there is still significant need for service development for paediatric and adolescent services.

3.3.2 There are many examples of what works well, but not consistent across or within all services

Services vary in each location in terms of how they are configured, where they sit within the health service continuum, and exactly what service components are delivered. There is no national overview of service policy, development, and delivery.

All services are providing some form of acute, and acute forensic medical assessment and treatment, albeit most can only do this outside of normal business hours. The lack of day service is because the workforce is already working a full day roster in their regular jobs, e.g. as a GP, specialist or a nurse. The only full weekday rosters are in the Auckland adult and paediatric services.

Examples given by stakeholders of things that support the SAATS service to work well are below. Note: not all of these features are evident in every service; and less so in paediatric services.

National/regional approaches

- The DSAC training and annual updates.
- The DSAC MERG service.[12]
- Access to other expert SAATS staff for peer support and review, particularly for isolated staff.[13]

Local approaches

- Sufficient administration support.
- Regular tripartite meetings with NZ Police and crisis support agencies, driven by a current Local Level Agreement (LLA).
- Having highly skilled nurses.
- Working as a team, with the nurse and doctor undertaking acute and forensic examinations together.
- Active support of the workforce including supervision, joint meetings and pay rates.
- Realistic rostering both for caseload (critical mass of caseload and also not over-burdening) and on-call roster burden.
- Paid time for other work such as interagency meetings, rostering, and peer review.
- Paid time for "marketing" and education awareness raising, e.g. in schools, GPs, CYF, and emergency services.
- Good contract holder support, e.g. DHB.
- Additional funding.

3.3.3 Access and volumes

Experts in sexual abuse assessment and treatment critical

For both paediatric and adult services, they are each typically provided after-hours, once the doctor and nurse have finished their "day job". For example, a patient may present to police in the morning and not be able to be seen till after hours, e.g. at 6pm. Police report that it can be difficult to keep the person at the Police station all day. Some stakeholders voiced concern that there is a significant risk to loss of quality or crucial forensic evidence. However, in speaking with the overseas experts, they were clear that New Zealand needs to take a pragmatic approach to how the workforce is utilised, particularly considering our

[12] Medical Expert Review Group, to assist with reports getting to Court quality. This is funded via NZ Police.

[13] The Medical Consultation Liaison Service is not generally recognised as such, or utilised. This type of support needs to be more formalised in the future for senior peer and case review. We recommend that this role, as well as its funding, be subsumed into the proposed SAATS Network.

relatively low volumes. One international expert was particularly clear that, in reality, the potential loss of forensic evidence is relatively small compared to the risk of loss of evidence if the medical assessment and examination is undertaken by people who are not expert in sexual abuse assessment and treatment. An additional supporting option is that others e.g. NZ Police or Emergency Department staff, can be taught how to take an initial early mouth swab.

Minimal public profiling or marketing of SAATS services

The majority of services are not educating local communities nor marketing their services. The reason is that they are fearful of capacity issues and/or don't have the administration support or funds to do it.

Access and volumes is a complex equation involving caseload volumes for quality and sustainability of the service, funding models, and workforce resources (i.e. who, and the number of workforce willing to work in these services). International evidence quotes an annual caseload of 20 to maintain skills and expertise. For most in New Zealand, as evidenced by volume analysis and also the workforce survey results, they would not see 20 cases per annum.

Not all groups access services equitably

According to our qualitative analysis and international evidence, there is a current gap in more "vulnerable" groups accessing these services. There is likely to be a myriad of reasons for this, many not related to the SAATS services themselves. Specific groups reported to us were male, transgender, people with an intellectual disability, those with a brain injury, cultural groups, particularly Māori and Pacific and migrants.

3.3.4 Paediatric SAATS services are the biggest challenge that needs addressing

Paediatric workforce challenges

The biggest challenge for service delivery is reliable and sustainable coverage of most paediatric services. It was reported to us that many paediatricians choose not to undertake sexual abuse work, even though they are generally doing child and adolescent physical abuse work. Several interviewees believed that assessment and treatment for physical and sexual abuse for children should not be separated. Several sites visited only had one or two paediatricians willing to do SAATS work and we believe this creates a non-sustainable roster burden for them. When paediatricians are on annual or sick leave, NZ Police reported that at times they have to transport the patient to a neighbouring DHB or Starship Children's Hospital in Auckland.

The most frequently cited reasons, as evidenced in local and international stakeholder interviews, why many general paediatricians do not choose to do this work include:

- Fear of medico-legal issues.
- Not wanting to do wrong on behalf of the child, e.g. misdiagnosis resulting in a child being wrongfully removed from their family, or conversely being mistakenly sent back to an unsafe environment.

- Some not wanting to deal with females of menstruating age and/or who may be sexually active by choice.

Conversely, some services do have a robust and full paediatric roster and SAATS work is required to be a part of their role by their employer as part of their employment.

Addressing the paediatric workforce issue is seen to be broader than the review of SAATS but is raised as a significant issue. It is recommended that ACC as lead funder, in conjunction with the new SAATS Network, in partnership with other key stakeholders such as DSAC, MoH, Paediatric Society and College, and NZ Police consider this as a priority issue to address.

3.3.5 Adolescent and youth services are variable and should be improved

As with all health services in New Zealand, there are variable considerations and approaches to determining what criteria determines an adolescent and when an adolescent is referred to a paediatric service or an adult service. For SAATS, there is no one "age" and there are variable "criteria" that seem to be largely based on local historic and / or individual practice. From the international interviews and literature, it appears this is the same for other jurisdictions.

Some stakeholders were very vocal about the need for New Zealand to develop a better service for adolescents, which considered and addressed specific youth needs. Another priority for the new SAATS Network will be to consider how to improve services for youth and adolescents.

3.3.6 Governance and management models vary

How the services are governed and managed varies across sites and DHBs. This is based on local resources, practicalities (e.g. availability of appropriate facilities) and management preferences. There is no one right way and it is important to have locally tailored solutions.

Services for children are all within paediatric services in the DHBs. As already mentioned however, cover and therefore access is highly variable. Volumes in many areas are very low, e.g. two acute presentations in one year. Consideration needs to be given as to how to support and develop paediatric SAATS services, support the workforce and improve access/reporting rates.

Examples of how adult services are configured and managed include:

- Stand alone: either within a DHB facility or a community provider.
- Within or alongside DHB sexual health services.

- Afterhours from an emergency department (ED) wider premises (note this is a standalone service within an ED delivered by DSAC trained staff; and not subject to the typical ED triaging timeframes or use of their staff, etc.).[14]
- Primary care, e.g. a GP practice, an accident and medical (A&M) centre.

3.3.7 DHB knowledge and management of the services varies and impacts on the service

Although there is a range of governance and management models, this does not appear to impact on the services as much as the "status", profile, and priority of the SAATS service within DHB management. There are examples where the DHB is highly proactive and supportive of the service. These examples are mainly with regards to the adult services, although some DHBs demonstrated full support of their paediatric service. Examples of this support included:

- Regular inclusive management meetings with the service, ability to problem solve together.
- Additional funding from the population based funding pool (PBFF).
- Additional funding for specific activity such as clothes or training.
- Ample and appropriate facilities.
- Any range of additional resources such as rent, other overhead, administration, consumables, telephone.
- Ability to utilise parts of other services, e.g. sexual health, to work together with the SAATS service.

Where this type of support was in place, particularly management support, services reported things worked well and they felt supported and valued to undertake the SAATS service.

Conversely, where this was not in place, there were examples of services and individuals believing that they were being undermined, and close to burnout. In many of these instances, particularly paediatrics, the SAATS service is often reliant on one person and, in our opinion, is not a sustainable service overall.[15]

3.3.8 Some cross subsidisation of services occurring

In most of the services, there was evidence of cross-subsidisation occurring. As per the previous section this was either from utilisation of staff resources being paid for from another service or budget, management time, facilities usage and/or direct additional funding.

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[14] *Note*: Good practice suggests that SAATS type services should only be provided in an ED if there are fast track access procedures. In this example, there are as it is the SAATS provider delivering it, not the mainstream ED.

[15] This statement relates to the overall service, not the quality of the individual staff person or medical assessment.

In considering this, we debated whether cross-subsidisation is an issue, as for many services in health they are not purely stand alone. However, the level of cross-subsidisation could become a risk for sustainability if, for example, a DHB manager changed and stopped that line of funding and/or the service subsidising the SAATS service itself came under a budget squeeze or review. This consideration should be part of ongoing SAATS reviews.

3.3.9 SAATS and DSAC are inextricably linked to provide a quality medical assessment and forensic service

DSAC provides a range of training, advisory, membership and education, and advocacy services that they call SAATS enabling services. Without these services, there would not be training, a growing body of expertise, peer review options, Medical Forensic Expert Review Group (MERG), and a professional workforce to deliver SAATS. DSAC has two managers and one full-time administrator. Occasionally, it is supported by short term contactors. Clinical work, with reportedly approximately 300 to 600 hours per annum, is undertaken on a voluntary / pro bono basis. With the changing workforce and generation, it is reported that this is not likely to be sustainable in to the future.

DSAC and SAATS are funded separately. DSAC funding comes from a range of sources, and some of DSAC funding is one-off or time limited fees. DSAC believes the current funding model and amounts are not sustainable for the activity they believe necessary, currently or in to the future. This will be exacerbated if DSAC are required to administer, support and/or participate in the additional functions and activities of the proposed SAATS network.

3.3.10 The SAATS workforce needs to be supported and developed

The clinical workforce is made up of a range of staff such as paediatricians, GPs, specialists (e.g. obstetrics and gynaecology, emergency department, sexual health physicians, PMOs) and nurses. The qualitative interviews and international literature shows the invaluable role skilled and experienced nurses play in these services. In some instances, the nurse is the "SAATS expert" and guides the doctor in the collection of forensic evidence. This is especially so where there is a relatively low volume of acute forensic presentations and the nurse works across paediatric, adolescent and adult services in their District (and hence has a higher caseload). New Zealand has a "gold standard" in having a nurse and a doctor at every acute and forensic examination. This must continue for a patient centric approach, quality, safety, and medico-legal reasons.

In most of the qualitative site interviews, the workforce was seeking a range of more support including:

- Access to expert SAATS advice.
- Peer support and peer review.
- Paid time to network, build relationships, and provide education.
- Management support.
- Case review.
- Medico-legal support.

In addition, added administration support was required by most sites.

3.3.11 Workforce needs more support, incentives and a development pathway

Based on the workforce survey, the workforce that is currently delivering SAATS is clearly incentivised by doing a good job and the right thing for the victims of sexual abuse in New Zealand. However, stakeholder interviews (national and international) clearly indicated that the incoming generation of workforce will not be so amenable to afterhours work and/or voluntary (pro bono) work than those who are currently working in SAATS.

Currently, there is no formal development pathway for the SAATS workforce in New Zealand. A variety of options have been expressed by stakeholders for creating a pathway and recognition including:

- Create a tiered structure (e.g. three tiers) so people can aspire and be rewarded for experience and expertise. Three tiers being varying levels of expertise that are recognised for and people can aspire to.[16]
- Acknowledge the value and importance of this type of work, and give accolades for achievements.
- Ensure supervision and enable peer support so that vicarious traumatisation does not occur.
- Improve the peer review and case review process in New Zealand, and thereby the confidence of clinicians to work in a SAATS service.

3.3.12 Financial sustainability is a concern for the majority

Financial sustainability under the current contract is a concern for the majority of services, but not all. The factors that appear to be of the main consideration for the financial challenges are:

- Provincial and large services.
- Daytime service versus effectively afterhours only.
- Administration.
- How the DHB funds, locates and manages the service, particularly paediatric SAATS services.
- The split and pricing of fee for service claims and fixed price components.
- Cross-subsidisation, i.e. some services having support and resources from other services, e.g. sexual health nurses.
- Employment practices and costs.

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[16] Note: Parts of Australia have a five tier structure from no specific training but supported remotely by experts e.g. outback ED, through to highly skilled and recognised in the field of sexual abuse care.

3.3.13 Crisis support variably available

Access to crisis support services for patients is highly variable across New Zealand. The variability includes access to, coverage and quality of crisis support workers. International evidence shows that effective crisis support is essential for most, in their recovery and for therapeutic effects.

The two key funders that fund crisis workers are:

- Ministry of Social Development for specifically trained sexual abuse workers such as Rape Crisis; and
- Department of Justice for general Victim Support (not specific to Sexual Abuse).

In addition, for those people who register a claim with ACC (an ACC 45 form), ACC provides funding for ongoing counselling, but this is not usually an acute crisis response. There have been examples cited by interviewees where there are long waiting times, in some examples given it was months, to access ACC Counselling.

Appropriate funding to grow national coverage and quality of crisis support is vital. These services are an integral part of a tripartite response to peoples' needs. At times, if these services are not available locally, then the SAATS service will try and undertake additional follow ups to cover the patient's needs. If the desire to address low rates of access to SAATS is achieved this will create an even greater demand on crisis support.

3.3.14 Administration support needs boosting

The majority of services noted that they had little or no administration support. However, what is evident is that there is a lot of health professional (doctor and nurse) time being used to undertake administrative duties e.g. filing, paperwork, photocopying, and coordination of some roster duties.

This is inefficient and detracts scarce clinical skills from clinical duties. As the SAATS services grow and develop, e.g. with the proposed SAATS network, and improved marketing and education, there is a need to ensure sufficient and efficient administration time. This will also allow for reduction in clinical time being used for non-clinical work, and some unpaid clinical time, e.g. we found many examples of clinical people developing resources in their own time.

3.3.15 Health, clinical policy and leadership

There are three funders for SAATS. However, the SAATS workforce is by far the majority part of the New Zealand health services. This is both within the public system of DHBs and the primary health care system of GPs and primary care nurses. There are a few PMOs who also participate on the roster in a few SAATS services. Currently, the SAATS services run independently of each other and there is no national oversight or coordination. It is proposed that the new SAATS Network will help address this. However this will not create a national central government or policy overview.

Recent restructures in the Ministry of Health, and changes of portfolios, have given more profile for the SAATS service in Health. We believe there is a need for more policy direction, national service oversight and coordination, and leadership for SAATS from the Ministry of

Health, alongside the two other funders. When the proposed SAATS Network proceeds, this will provide a ready avenue for Health to participate in and gain feedback on policy.

3.3.16 National data management, analysis and reporting should be improved

There is no one current database of SAATS volumes, services and/or issues or trends across New Zealand. ACC, as the lead funder, has two data sets. One set is based on SAATS claims (the Oracle database), and the other is based on clients who lodge an ACC 45 ("InFact" database) and make a SAATS payment claim. Currently, this does not provide for any simple national-level or regular analysis of the data.

Providers are meant to report annually to ACC; however, we only evidenced one provider who is reporting regularly currently. Feedback from stakeholders was that they did not feel the right measures were being asked for and that no one read their reports, so they stopped reporting. Some asked for a feedback loop in the future.

There is also variable local SAATS services data collection. It would be advantageous, for comparative reasons, for the SAATS network to work with the funders on what might be the most useful to record and collect, that could then be entered nationally.

Note there was much discussion on the ACC45 and the process for that. Some services lodge the ACC45 for most claims and some for none or very few. The two key issues we heard with lodging the ACC45 are:

- Patient privacy as ACC has to be in contact with the person. However there are potential ways around that e.g. the letter gets sent to the SAATS service not to the patient's home.
- The process the ISSC unit uses if an ACC45 is submitted then it is assumed an ACC mandatory time focussed process needs to take place, even if the patient doesn't want it activated at this time. This may cause ACC contact with the person they do not want. Some services appear to manage that on behalf of the patient and others don't feel they have the resources to do that.

3.3.17 Follow up services

Follow up sessions are part of the international good practice. There were many reports from services of issues in undertaking follow ups, for both acute and historic. The three key concerns were:

- Do not attends (DNA) and the high cost of arranging the follow up, getting staff to be there but no patient arriving.
- Amount of time chasing people on the telephone to arrange a follow up.
- Travel distance and cost a major barrier for many people.

Some SAATS services said they do no follow ups as they have no capacity, but on the continuum one service said they do up to three and sometimes more. The service specification notes up to two follow ups. Follow ups are important for some patients but not all; however, when they are important, they cover a range of things such as, but not limited to:

- Medical care/ advice.
- Injury care/advice.
- Sexual health and/or contraception care/ advice.
- Referrals to other services.
- Therapeutic continuation including if no crisis support is available.

If the patient has been referred back to their GP (where appropriate or the service doesn't deliver follow ups) and the right crisis supports are in place to support the person with psychosocial supports and access to other services they might need (e.g. Work and Income) then follow-up by the SAATS service may not be required.

3.3.18 Role of nurses in SAATS

Both the qualitative interviews and the international views (literature and interviews) demonstrated the high importance of the skilled nurse role in SAATS services. New Zealand does not yet have a development pathway for nurses, however DSAC / the SAATS network is considering how this can occur as an area of special practice.

3.4 Workforce survey results support site visit findings

Below is a summary of the key findings from the survey.

3.4.1 Methodology

A web-based survey live-link was sent to the DSAC membership list via DSAC, and the ACC SAATS contract holders via Sapere, on 22nd December 2015. This closed on 19th January 2016. We received 95 responses. It is not possible to derive a response rate, as the link may well have been passed to other interested parties. We received responses from all but two DHB districts. The two DHB districts who did not reply do not have a contract for SAATS, as they are serviced by other SAATS-contracted providers.

Responses were analysed and some were compared against paediatric and adult responses, geography, and other features.

Note: as it was sent via the DSAC network it is likely to be a skewed sample based on all who work in SAATS.

3.4.2 Key e-survey findings

Where people work

Of the 95 respondents, 93% are currently working in SAATS services. About 70% were doctors, and less than 30% were nurses.

Of the doctors, 25% work in paediatric services, 60% in adolescent services, and 77% in adult services (note this means many work in at least two areas/services). All nurses work in adult services, with 60% also working in adolescent services and 12% in paediatrics.

DSAC Accreditation and memberships

Two thirds of doctors are DSAC accredited. The cost of their accreditation is met from a range of sources for different people, some having multiple sources including employers, SAATS services, self, and NZ Police. Three said they sourced from CME/CPD funding.

Over 90% of doctors who responded are members of DSAC, as well as 64% of nurses (two thirds have full membership and one third has associate membership).

For the doctors, the most common reason for not being a member was they had not got around to it (but intend to). One nurse considered membership to be of limited value given they only do on-call work in SAATS and have other memberships more relevant to their [main] role.

The DSAC membership fees are mainly half met by employers (53% for doctors and 57% for nurses) or the person themselves. The remainder are met from SAATS services or doctors own CME allowances.

How many assessment and treatment services people do per annum

The results of this question show the majority do fewer than 10 per year. The key exception is for nurses, as 52% of them do between 11 and 20 acute forensic cases a year.

Table 3 Volume of assessment and treatment services per year

Number of respondents

	First consultation – acute forensic	First consultation – acute non-forensic	First consultation - historic	Follow-up (in person or telephone)
Doctors				
Fewer than 10	31	35	23	26
11-20	19	6	13	12
More than 20	8	3	6	8
Nurses				
Fewer than 10	9	14	11	7
11-20	13	2	1	-
More than 20	3	-	1	4

Not surprisingly, the results also show those in the larger centres are doing more cases per annum. The results were similar when analysed across paediatric and adult services.

Unpaid work for SAATS or paid from another service

Not all people responded to this question; 84 did. 51% of the 84 said they do some unpaid work. Of those, doctors report doing more unpaid work as do those who work in adult services.

Of those who responded to this question, 29 (34%) said they do up to half a day per month, eight (9%) up to a day, two up to two days, and four people more than two days per month.

Respondents who provided comment on this question said that unpaid time was spent doing tasks such as providing telephone advice, paperwork for reaccreditation, preparing a formal statement for Court, (beyond the maximum paid hours), mentoring/peer review, ongoing professional education (keeping up with the literature), training of new doctors and patient follow-up/handover.

Nearly one third of people reported doing SAATS work paid for by another service/budget, e.g. a DHB sexual health service. Tasks undertaken in this type of role include follow-up administration, advice to other doctors, responding to phone calls, and receiving disclosures/identifying victims during other clinics (school clinics, sexual health).

Respondents were asked to estimate how much time they spend doing SAATS work while being paid for another role. Sixteen (61%) said up to half a day a month, two said up to a day, two up to two days, and one more than two days. Five (19%) do more than four hours a month.

People work in SAATS for a variety of reasons

Important and rewarding work

The top reason given was that people find this important work for victims and rewarding work. People feel that victims deserve a voice and the best possible care. The word *"passionate"* was used by many.

Having a supportive team

Another strong theme was that the SAATS teams are very supportive; therefore, this is a highly valued and key motivator to work in the service. Working in multi-disciplinary teams was also satisfying.

Five people said the money was helpful as relatively well paid. One said payment for mileage should be paid.

Four people responded to the disincentive question

Four respondents (all doctors) stated that they previously worked in a SAATS service, and we asked them why they stopped. The reasons given varied:

- Insufficient time given other roles.
- Losing motivation and near retirement.
- Moved away from the district.
- Funding arrangement did not work well for a salaried paediatrician unwilling to be on additional roster.

- Burnout.

We asked these people what would motivate them to work in a SAAT service again in the future. Two said if the service was being integrated into the paediatric/child health service at the DHB, with one adding that this requires a sufficient number of adequately trained staff. Two cited personal reasons for not wishing to re-join the service.

Potential improvements and what is not being done that should be

The strongest theme (23 people) said improved resourcing and funding, including recognition of unpaid work, and funding for transport/mileage, DSAC accreditation and membership fees, ongoing professional development/CME, follow ups (including nursing time), telephone work, being on-call, and do not attends (DNAs).

The next theme (8 people) was to improve the administration resource, and secondly to have more staff on roster. Next (7 people) people thought that there needed to be improved training and support for new clinicians. A few people (e.g. four each theme) each then said:

- Better social supports for victims.
- Better follow up services.
- Better facilities.
- More peer support.
- Recognition of paediatrics and adult services being different/improving paediatric services.
- Improved interagency relationships and awareness raising/education.

Two people said a clinical network is needed, and one said the on-call rate needs to be addressed.

Only 16 people responded to the question of what should be done that is not done currently.[17] There were a wide range of things mentioned, but a small number of the 16 for each theme. A summary is provided below:

- A collaborative model between SAATS and ACC for seamless service for patients/better victim support.
- Improve services for children.
- Improve awareness, visibility of service, better access (e.g. for historic services).
- Need service providers literate in Kaupapa Māori and Tikanga Māori.
- Improved forensic practice and facilities.
- Improved multi-disciplinary team service.
- Improved funding to attend DSAC meetings, supervision and de-brief time.
- Develop / improve the career pathway.
- Consider how to maintain expertise, e.g. diminishing caseloads in paediatrics.

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[17] Note: this question was added to the survey part way though on the advice of DSAC.

- Review protocols and forms.

Two thirds see a role for a national clinical network

64% saw a role for a national network, while 34% said they did not or were unsure. Several respondents commented that they did not know what it might do and/or how it would differ from DSAC (were concerned about the potential for duplication).

Several said the management of a network should have representatives from all regions and a mix of doctors and nurses. The need for funding and a dedicated resource for this was highlighted.

Respondents were asked what the purpose and functions of a clinical network might be. Suggestions made by at least two respondents (per idea) included:

- Information sharing/sharing of experience/advice especially around cases (particularly for those working in isolated areas), and also going to Court.
- Peer support and mentoring.
- Improved consistency/standardisation including of forms, policies, procedures.
- Quality improvement/clinical excellence.
- Reduce duplication (avoiding 'reinventing the wheel').
- Data/trend analysis and research.
- Education and training.
- Better coordination with other services (such as crisis support).
- Awareness raising including in the wider community.
- Additional suggestions from one respondent included facilitating patient transfer between services, and a place for a consumer voice.

4. DSAC and the proposed national SAATS network

4.1 DSAC: A highly committed national body with an emphasis on training and quality

Since incepted, SAATS services have developed and improved in how they are configured and delivered, yet there are opportunities to develop and grow them even further. In addition, opportunities to support and grow the workforce are currently being further developed by DSAC and this is supported by the review.

Current key DSAC activities include:

- Training.
- Accreditation system.
- Advocacy and advice.
- Expert medical advisors relating to SAATS.
- Peer review.
- MERG[18].
- Annual Update Conference.
- Ensuring the DSAC Manual is kept in line with best international practice.
- Education e.g. for NZ Police, local health providers, referrers and others.
- Arranging and hosting visiting speakers.

4.2 Building on the successes to date there are opportunities for development underway

There was a lot of feedback on the significant work and achievements of DSAC, with some reports of opportunities for change. There is recognition by many that without DSAC the SAATS services would not be where they are now in terms of trained staff and quality service delivery. There have been several papers from DSAC to the funders detailing why DSAC is not sustainable in the current funding and service delivery model it has. There has been additional funding given to ensure sustainability while this review has been underway. After undertaking an extensive review of their organisation (refer the 2014 sustainability papers) DSAC has made changes and advancements in their governance structure, to include, as one part of the change, non-clinical experts, e.g. financial and marketing experts.

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18 Medical Expert Revie Group: Expert review of formal statements that are likely to go to Court.

They have also initiated work on designing and developing a new national network (called SAATS-Link) to support SAATS services and the workforce.

DSAC have participated fully and openly in this review and have been highly responsive in their approach.

Conversely, there was some comment by a smaller number of stakeholders on the previous and current approach of DSAC – namely, that until recently nurses were not able to sit on the Executive. This has changed with the recent changes to the governance structure, and although nurse representation is not yet in equal ratio to doctors DSAC will continue to work with the SAATS Network to engage the nursing profession further.

Some stakeholders felt that DSAC needs to expand more representationally to actively demonstrate a culture of full inclusiveness, for example cultural representation and that for vulnerable populations such as Māori, Pacific and migrants. DSAC report they are aware of this and is progressing with their new Strategic Action plan. An additional consideration over time might be to also involve patient (i.e. consumer) representation.

Many commented that the MERG process was excellent and that they couldn't do their job without it. A few did also reflect that it could be improved by having an enhanced moderation and educational approach, for some practitioners, so they could learn more from the process.

4.3 The proposed national SAATS network is supported

Increasing quality and advancing consistency will cost more, but be beneficial in terms of sustainability of workforce and services overall. In the November 2014 DSAC Sustainability report, there is a proposal to develop a national SAATS Clinical Network. This section comments on that.

Overall, stakeholders and Sapere agree a national SAATS network is positive in terms of supporting the services, creating a national focus, quality developments and a pathway that supports the development of clinical staff, and can also support other staff, e.g. SAATS administrators and managers[19]. It is acknowledged that this would require funding to support this level of development, both in the SAATS network, including clinical and administration time, and also in SAATS services to pay staff to participate.

Key functions and activities of the network would be, at least in the first instance:

1. Patient portal, with a map of services and links to other important agencies.
2. National web site for Network members with links to local services and a map (navigation and information functions).
3. Information for wider SAATS providers and workforce.

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[19] There was some feedback that administrators and managers can be isolated in these services, and that there is an opportunity to learn from each other, and provide support.

4. Frequently asked questions (FAQ) for SAATS staff.
5. Nationally available, locally adaptable policies and procedures; guidelines.
6. Support for staff such as:
   (a) Education and training, e.g. video clips, online learning modules.
   (b) Virtual peer review.
   (c) Enabling and supporting contemporary peer review of active/recent cases.
   (d) Availability of senior staff for Q&A; expert advice.
   (e) Medical examination reviews.
   (f) Enabling and enhancing (i.e. simplifying) the current accreditation process, including developing an accreditation process for nurses, over time.

In addition as the SAATS network develops and progresses other opportunities are:

- Active webinars and taking a more proactive expert support role that proactively reaches out to SAATS staff.
- Further develop a workforce recognition pathway, which recognises levels of experience.
- Proactive management of the membership alongside the DSAC functions, e.g. analyse membership and activity coverage, identify gaps and areas of opportunity.
- Increase via the developing Network, support for new doctors (for paediatrics and adults) in the Court process.
- Sharing and learning on a range of service topics such as sharing of local solutions that others may learn from, supplies procurement, contractual and employment options, use of and options for the LLA, and the opportunity for SAATS-Link members to engage in on line discussion forums.

We recommend that the current Medical Consultation Liaison role and funding be absorbed into the functions of the SAATS Network.

We also note the DSAC Strategic Agenda is to develop and operationalise the SAATS network under the DSAC structure. We believe some positioning to profile and highlight the SAATS network in conjunction with or aligned to, but not absorbed into DSAC, would be preferable. This would give it a SAATS service and operational profile (as differentiated from DSAC) and therefore might have the potential to attract those in the wider workforce who might not otherwise be as ready to participate; especially in the short to medium term.

We recognise that there is currently a limited workforce available to contribute expert input to the development and implementation of this work. We therefore suggest that a phased approach is taken – starting with the practical steps currently under development, but with a view to more ambitious development over the longer term.

5. Financial volume analysis

5.1 Key points

- The volume of first consultations has increased by 18% in 2013/14 and 13% in 2014/15. In total, 1,753 first consultations were delivered across adult, adolescent and paediatric services in 2014/15. These increases have been faster than population growth – suggesting other factors, such as increased victim disclosure and improved service accessibility.
- Material variation in the rate of service take-up across districts suggests differences in awareness of, and access to, the service. For example, for adult cases, average rate of first consultations in 2014/15 was 26 per 100,000 adults. Several vendor districts had a much higher rate, with the highest being 92 consultations per 100,000. Conversely, the lowest rate was 8 consultations per 100,000 adults.
- If districts with lower rates of service take-up were to have the same level of take-up as the districts with the highest rate for adult, adolescent and paediatric client groups, then the cost of the service could, plausibly, be three times as high in future as it has been.
- Under this forecast scenario, the national volume of first consultations would increase from an average of 48 per week in 2014/15 to 133 first consultations per week in 2024/25 – representing an increase of 85 first consultations per week.
- High variation in the extent to which providers submit ACC 45 forms (sensitive claims) suggests some are aware or not liking the ACC process for patients once it is submitted offer their patients the choice, whereas the data points to other districts having very low or no ACC 45s submitted.
- We believe the current SAATS services require additional funding [numbers deleted]. This includes addressing both some costs already in the service schedule and some that are not, e.g. such as clothing, medical consumables, and networking and education
- We also have modelled and believe that DSAC requires additional funding to put it on a sustainable footing. This is in addition for funding for the time for the SAATS workforce to have ongoing participation in the proposed national SAATs network.

5.2 Approach to our financial analysis

Our approach to understand the patterns and cost of service delivery and to modelling plausible future scenarios has been built around the following high-level steps:

- Analyse fee-for-service payments by service code over the four years to 2014/15.
- Analyse expenditure incurred under current service specification.
- Analyse information about provider cost structures and considered the extent to which there are any material and systematic gap between pricing and underlying costs.
- Project future demand under different assumptions about service take-up.

- Project future costs, given alternate demand scenarios, and under current and alternate service pricing scenarios.

We have also looked at variation among the districts in terms for service delivery and payment claiming behaviour. In keeping with ACC's condition of use around the data extracts, suppliers and districts have not been identified in this report.

5.3 Service delivery

5.3.1 Consultation volumes

The volume of first consultations has increased from 1,426 in 2011/12 to 1,753 in 2014/15 – representing an increase of 327 or 23% over this period. This rise is higher than population growth over this period (4%) – suggesting other factors, such as increased victim disclosure and improved service accessibility. This growth in consultations occurred across the latter two years with annual increases of 18% in 2013/14 and 13% in 2014/15, as Table 4 shows.

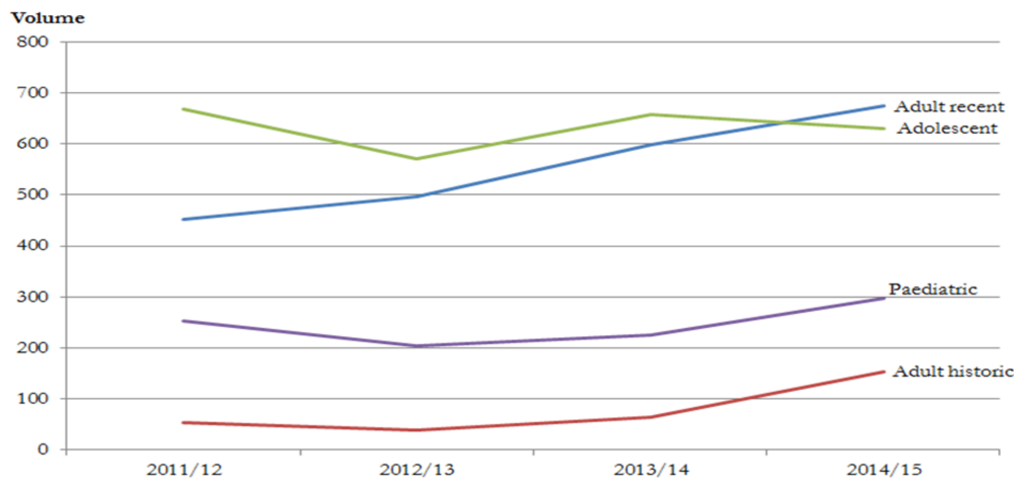
Table 4 Volumes of first consultations, 2011/12 – 2014/15

Measure	2011/12	2012/13	2013/14	2014/15
First consultations	1,426	1,311	1,548	1,753
Annual change		-115	238	205
Annual change (%)		-8%	18%	13%

Source: ACC, InFact and Oracle data extracts; Sapere analysis

Figure 1 shows these volumes differentiated by broad client groupings. First consultations for adults (recent cases) comprised the largest group in 2014/15 and increased strongly each year. Adolescent first consultations also account for a large volume and tended to fluctuate over time. Paediatric and adult (historic) first consultations increased strongly in 2014/15.

Figure 1: Volume of first consultations by client group, 2011/12 – 2014/15



Source: ACC, InFact and Oracle data extracts; Sapere analysis

We separated out these first consultations into the service codes outlined in the service specification. Adult, adolescent and paediatric first consultations are differentiated by forensic and non-forensic examinations; adult non-forensic examinations are further differentiated into recent and historic cases. Points of note include:

- The most commonly used service codes are those for first consultations with a forensic examination for adults and for adolescents.
- The volume within most service codes has increased across the latter two years of 2013/14 and 2014/15, with strong growth in among adult clients in particular The exceptions are adolescent forensic and paediatric forensic cases.
- Consultations with forensic examinations form the majority of first consultations for adult and adolescent clients, but conversely, among paediatric first consultations, non-forensic cases outweigh those with a forensic examination.

The service specification also provides for follow-up consultations with clients. Follow-up consultations for adults are distinguished between first and subsequent follow-ups as well as telephone consultations for adults. Follow-up consultations for adolescent and paediatric clients are classified under the same codes, differentiated by first and subsequent follow-ups. **Error! Reference source not found.** presents the volume of follow-up consultations over the four-year period of 2011/12 to 2014/15.

- Among adult clients, there has been an increase in first follow-up consultations, consistent with the increase in first consultations in 2013/14 and 2014/15, in particular. Telephone consultations comprise the largest volume of follow-ups with adult clients.
- Among adolescent and paediatric clients, volumes of first follow-up consultations have fluctuated although there has been some growth in subsequent follow-ups.

Looking at the frequency of first follow-up consultations alongside first consultations suggests that the majority of clients will experience a single in-person consultation.

- The ratio of adult follow-ups to adult first consultations in 2014/15 was 1: 0.30 – equivalent to 30% or approximately one-in-three first consultations resulting in a follow-up consultation.
- The ratio of adolescent / paediatric follow-ups to adolescent / paediatric first consultations in 2014/15 was 1: 0.24. This is equivalent to 24% or one-in four first consultations leading to a follow-up consultation.

5.3.2 Geographic variation in service uptake

Converting first consultation volumes to a rate per 100,000 of population allows service uptake to be compared among the 15 vendor districts. The rates were calculated as follows.

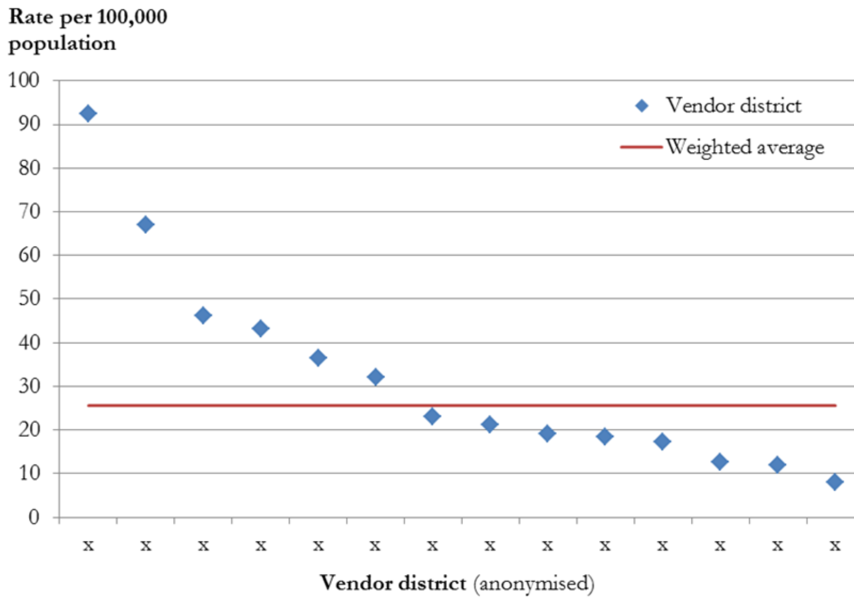
- Vendor districts were defined; these mainly correspond to the DHBs with exceptions where providers within one DHB cover the population of a neighbouring DHB[20].
- First consultations, both forensic and non-forensic, are grouped into adult, adolescent and paediatric clients according to the service code included with the payment claim.
- The population counts for the vendor districts were obtained from Statistics New Zealand's population estimates. As there is no consistent definition of adolescent age, for the purposes of analysis the paediatric population we defined as 0-13 years, with the adolescent population being 14-20 years, and adults being 21 years and over.

The key finding is that there is material variation in service uptake among districts. While geographic difference in the incidence of sexual abuse is possible, it seems more likely this variation in uptake is driven by awareness of and accessibility to the service.

Figure 2 shows rate of first consultations per 100,000 adults for 2014/15. The weighted average rate was 26 consultations per 100,000 adults. Several vendor districts had a much higher rate, with the highest being 92 consultations per 100,000. Conversely, the lowest rate was 8 consultations per 100,000 adults.

[20] Auckland covers Waitemata and Counties Manukau; MidCentral covers Whanganui; Capital & Coast covers Hutt; Canterbury covers West Coast.

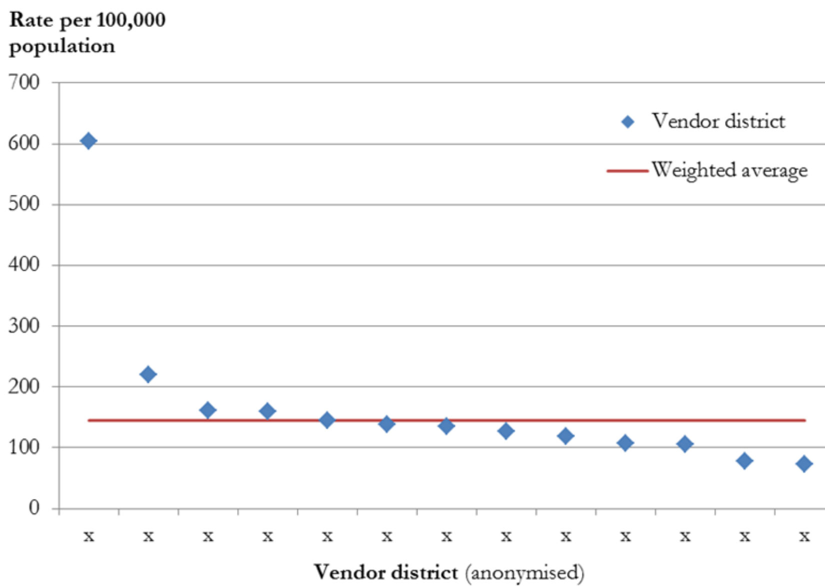
Figure 2: Rate of first consultations for adult clients by vendor district, 2014/15



Source: ACC, InFact and Oracle data extracts; Sapere analysis

Figure 3 shows the shows rate of first consultations per 100,000 adolescents in 2014/15. The weighted average was 144 consultations per 100,000 adolescents aged 14-20 years. Seven of the vendor districts (i.e. 50%) had consultation rates within ± 25% of the weighted average (i.e. 108-180 consultations per 100,000). Again, there was an outlier at the higher end, with the highest rate being 605 consultations per 100,000 adolescents.

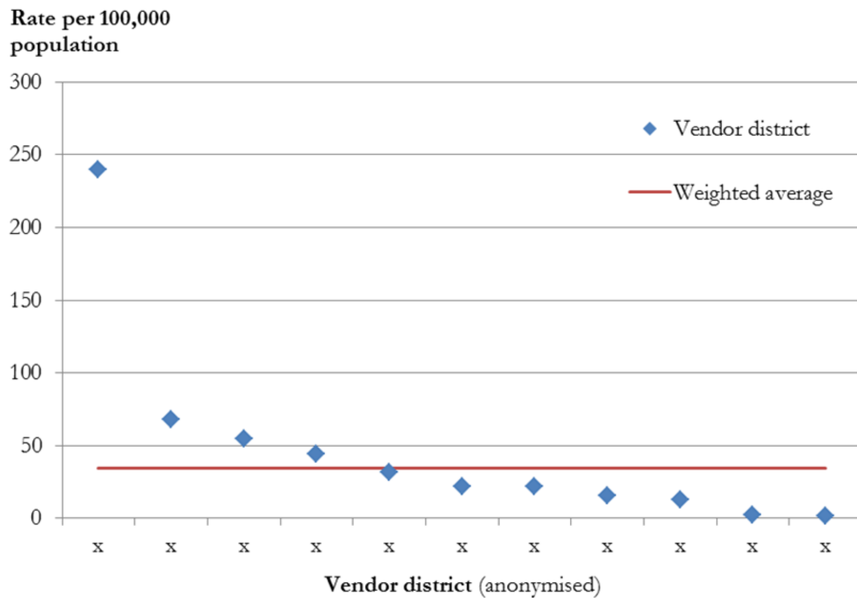
Figure 3: Rate of first consultations for adolescent clients by vendor district, 2014/15



Source: ACC, InFact and Oracle data extracts; Sapere analysis

Figure 4 presents the rate of first consultations per 100,000 children in 2014/15. The weighted average was 35 consultations per 100,000 with the highest rate being an outlier at 240 consultations per 100,000. Notably, two districts had very low rates (<0.5 per 100,000).

Figure 4: Rate of first consultations for paediatric clients by vendor district, 2014/15



Source: ACC, InFact and Oracle data extracts; Sapere analysis

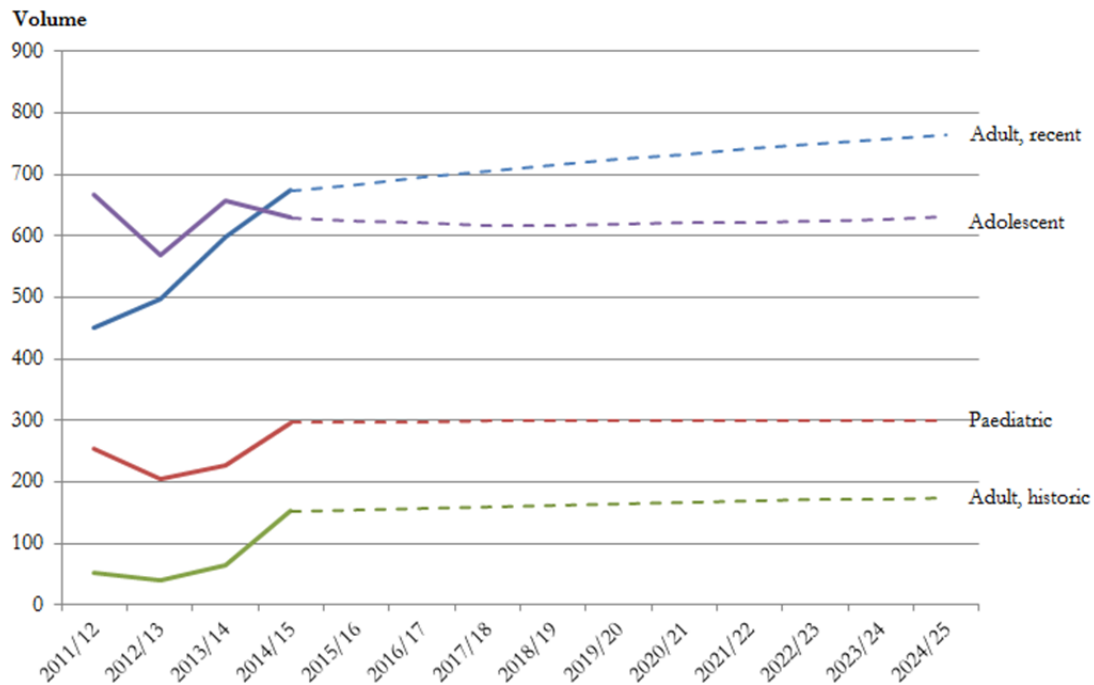
5.3.3 Lodgement of sensitive claims

Providers may complete a sensitive claim (i.e. using an ACC45 form) with the client during their first consultation and lodge the claim with ACC. Digging deeper we saw that there was a distinct variation in providers who lodge an ACC45. Some are completing them for 100% of clients and many not for any.

5.4 Projecting demand under two scenarios

As a starting point for considering future service demand, we project first consultations for adult, adolescent and paediatric clients by holding constant the consultation rates observed in 2014/15. This **demographic growth scenario** allows the national population projections, produced by Statistics New Zealand, to drive demand for these service volumes. The results are shown in Figure 5 and broadly reflect the projected ageing of the population with demand being fairly flat for adolescent and paediatric groups. This approach assumes that the underlying incidence of sexual abuse and patterns of access to the service remain similar.

Figure 5: Projection of first consultation volumes – demographic growth scenario



Source: ACC, InFact and Oracle data extracts; Sapere projection

Going further, we produce a scenario with higher demand that assumes the country as a whole eventually matches the highest rate of service uptake identified among vendor districts. This **latent demand scenario** assumes that demand due to an awareness raising campaign and improved service access. The key assumptions are that:

- Demand for first consultations steadily increases for four years as awareness is raised and service access is improved.
- After four years the national consultation rates match the highest observed among vendor districts in 2014/15.
- The ratio of follow-up consultations to first consultations remains constant (i.e. the ratio observed in 2014/15).
- Demand for adult historic cases eases after five years as a backlog is worked through.
- Prices for consultations and for fixed costs remain similar, increasing by 2.0% each year (consistent with the midpoint of the inflation band pursued by the Reserve Bank).

6. A framework for monitoring and evaluation of SAATS

6.1 Current monitoring and reporting requirements

The current reporting requirements for SAATS providers are set out in Section 12 of the Service Schedule.

Section 12.1 Client reporting

(i) Where a client wishes to notify ACC of the sexual abuse/assault for the purpose of accessing support or where a personal injury has occurred, an ACC45 should be submitted.

(ii) Where a client chooses not to notify ACC of the event but the client received a medical and/or forensic service under this contract the vendor shall submit the SAATS Supplier Report to ACC.

Section 12.2 Vendor reporting

Report on service delivery issues (for example, staff turnover, staff training, staff qualifications, undelivered services, gaps in roster cover), contingencies, emerging trends or innovative approaches taken will be required annually

ACC requires vendors of Medical Consultation Liaison to provide 1 month of audit data annually.

In addition to the patient information provided by way of the ACC45 form, SAATS providers are required to submit an annual narrative report on service delivery issues. The annual reporting requirements is not currently being enforced by ACC and few services provide these reports (we were told that just one service regularly submits them). The ones that are provided are not reviewed or actively used by ACC, and ACC has not provided feedback to services on the quality or usefulness of the information provided.

Some of the original reporting fields were felt to be meaningless and were removed, e.g. time from referral to being seen, as there are many variables that may be outside of the services' control which may impact on that, including victim choice.

6.2 Rationale for collecting data

Data can be collected for a number of purposes, as summarised in the following Table 5. This report focuses on the key information that should be reported by individual SAATS services to the funders. The purpose of this data is to inform strategic policy making by providing information on the effectiveness and value for money of SAATS services. In particular, information on the volume and profile of people accessing the services is vital to understanding the need/demand for services, and forecasting future volumes, and hence funding requirements.

We also provide some suggestions for the types of information that services may wish to collect, to help inform their on-going monitoring and self-assessment of service delivery (in particular the profile of patients accessing their services, and thereby which groups may be under-represented), and the peer support and professional development provided for their own workforce. Advice from the good practice literature and our discussions with international experts emphasised the importance of monitoring and analysing the profile of service users, to help understand which groups may be under-represented in presentations, as well as any changes in trends that may be important to inform planning and continuous service improvement.

In addition to these two tiers of reporting, ACC will need to continue to monitor ACC45 lodgements and the information provided through these claim forms.

Table 5 A hierarchy of monitoring and reporting

Level	Form/Medium	Purpose
Strategic policy	• Annual reporting by services to funders	• Decision-making • Trend analysis
Organisational performance	• Clinical audits of services	• Accountability and feedback loops • Sharing of cross service information
Service delivery	• ACC45 forms. • Services' own data recording and monitoring systems • National SAATS Network	• Learning for improvement (service design and quality, and workforce development)

6.3 Core measures

6.3.1 An example from the UK to build from

The service guide for SARCs in the UK sets out some principles for a minimum dataset and data collection procedures, which include:

- Information policies clearly outlining the responsibilities of all staff across agencies regarding data collection, sharing and confidentiality.
- Agreed standards and protocols for data collection and frequency within the service, between agencies… and across pathways.
- Service data includes demographic data and incident details on all service users, where possible (including age, gender, sexual orientation, disability, ethnicity, religion or belief) and other good practice requirements.

- A promotion plan on how and when information can be used to support service development (e.g. positive information about SARCs may encourage other victims to seek help)[21].

The minimum dataset covers:

- Attendance (male/female, in/outside of hours).
- Assault type.
- Contact type (non/forensic etc.).
- Source of referral.
- Ethnicity.
- Age.

And the performance measures for SARCs cover:

- Complaints/victim voice (initial response time, full response time and quarterly patient survey).
- Clinical suitability/supervision (including patients offered choice of gender of clinician, and rates of peer review, mentoring etc.).
- Sexually Transmitted disease / Blood Bourne Viruses testing.
- Sexual health (including emergency contraception).
- Response times (for assessment).
- Counselling (waiting/access times).
- Criminal justice (including reporting to Police).

In addition, the UK guidance provides a template for annual self-assessment by SARCs, which includes a self-assessed rating against key service elements (such as providing 24-hour access, access to appropriately qualified and supported clinicians, and well-coordinated inter-agency arrangements).

6.3.2 A core national minimum dataset

With respect to a core minimum dataset, our recommendations are based on the UK requirements. We have included some additional fields to capture other elements of service accessibility that we consider important to be monitoring, based on the New Zealand evidence regarding prevalence and the vulnerability of particular groups (disability and language/interpreter). We suggest that assault type is optional at this stage (as it may be difficult to assess). It will be important for ACC to communicate to providers why this information is being sought, what will be done with it, and to provide feedback to providers both on the quality of reporting and the findings of national-level trend analysis.

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[21] UK Department of Health, Home Office and the Association of Chief Police Officers (2009) *Revised National Services Guide: a resource for developing Sexual Assault Referral Centres.*

Table 6 Recommended minimum dataset for SAATS services

Dimension	Field
Number of patients seen	• Age (year) by the contract child, adolescent and adult. • Gender. • Ethnicity. • Acute forensic/acute non-forensic/historic (length of time since assault). • Disability (specify). • Interpreter requested/provided. • Number reporting via Police. • Number proceeding to Court. • Number who had Crisis Support/declined Crisis Support.
Referral pathway	• Self-referred. • Police. • Crisis support. • ED. • GP. • CYF. • Other (specify) e.g. Schools.

6.4 Service-level monitoring

In terms of service-level performance measures, we consider these should be aligned to the New Zealand service specification and can be met through a combination of regular cycles (e.g. every three years), as well as any issues based triggered audit (by ACC) and workforce monitoring. In our view, the type of narrative information on workforce trends and pressures that is required by the current SAATS service specification would be more appropriately captured and monitored by the new SAATS Network as opposed to the funders.

The UK performance indicators require services to undertake a quarterly patient survey, with an action plan drawn up and reviewed monthly. We suggest that this concept could be considered further by the new SAATS Network, to explore the value, ethics, and practicality of such a survey. A survey could focus on ascertaining patients' needs, and the extent to which services/how well they were met. The results would provide additional information about who is accessing the service and ways in which service delivery could be improved over time, with a focus on continuous improvement in service design and quality. It could cover aspects such as:

- Knowledge/awareness of the services (how they found out about it).
- Needs such as cultural appropriateness, interpreter, wheelchair and other facility access issues, replacement clothing, toiletries and refreshments; suitability of waiting area, transport/travel.

A number of ethical and survey design issues would need to be worked through and assessed, including the risk of re-victimisation, the survey medium (e.g. paper, online, telephone, and translation into other languages) and at what point in the process patients are invited to complete it. Consistency of survey form and data entry across services would be helpful in identifying widespread issues and trends, as well as learnings and areas of success that could be shared nationally.

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