Equality Analysis

Standard template for DH staff
Equality analysis

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Prepared by the Equality and Inclusion Team, Department of Health
Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help Department of Health staff members to comply with the general duty.

Instructions

Please complete the template by following the instructions in each box. Please note that this document have been protected as a form in order to maintain its layout. You may need to unprotect it using the Tools menu in order to work with tracked changes. You will not need a password to unprotect this document.

Should you have any queries or suggestions on this template, please contact the Equality and Inclusion Team on 020 7972 5936 or aie@dh.gsi.gov.uk
Equality analysis

**Title:** Feasibility Study into the Transfer of Commissioning of Forensic Service Examinations for Sexual Offences

**Relevant line in DH Business Plan 2011-2015:**

**What are the intended outcomes of this work?** Include outline of objectives and function aims

- To provide the evidence required to reach a decision on where best to locate responsibility for commissioning forensic examination services for sexual offences work in order to achieve a high quality and cost-effective service which meets the health needs of victims and supports criminal prosecution.
- To provide the evidence required to support required improvements in local service delivery.

**Who will be affected?** *e.g. staff, patients, service users etc*

Women, men and children who are raped or sexually assaulted who consent to a forensic examination

NHS, third sector and police staff involved in supporting victims, assessing the needs of, and gathering forensic evidence from, victims; and police and CPS staff investigating and prosecuting rape and sexual assault.

**Evidence** The Government’s commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.
What evidence have you considered? List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.

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

SOURCES:

In the light of continuing attrition of prosecution and conviction rates of rape and sexual assault, Her majesty’s HM Inspectorate of Constabulary and Her Majesty’s Crown Prosecution Service Inspectorate undertook a departmental review (HMIC & HMCPS 2007), which found considerable problems continuing on workforce development, management of forensic medical services by the police and NHS disengagement, specifically noting:
• shortage of FPs (particularly female FPs and paediatricians)
• delays in examinations (particularly for women and children)
• varying levels of expertise and wide disparities in levels of service offered to victims
• variability in standards of medical examination facilities


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

The feasibility study is based on extensive fieldwork with the NHS and police, which consisted of a detailed scrutiny of current services, providing up-to-date evidence of variation, scarcity and potential solutions. Methods used included two baseline surveys for all Police Authorities and Sexual Assault Referral Centres (SARCs), follow up telephone interviews and four Case Study Site Visits.
Disability

Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.

Prevalence: Data on disability is not collected for all police force areas, but some SARC's collect this data. We gathered data on disability for two areas to provide some indicators of need. In a mixed urban and rural area with a population of around 1.5 m, 9% of victims were recorded as having a disability: (Learning disability 2.2%; Physical disability 5.6%; Physical and Learning disability 1.1%; No disability 91.0%). In an urban area with a population of around 187k, on average 27.6% of victims were recorded as having a disability: (Learning disability 5.8%; Physical disability 1.6%; Mental Health (presenting) 20.2%; No disability 72.4%). Evidence from this urban area showed that women with mental health problems seemed vulnerable to repeat rape (9% of women with mental health problems). Also, 57.3% were assessed as being vulnerable due to their circumstances: (Psychiatric History 36.0%; Substance Misuse 9.1%; Domestic Violence 11.6% and Street Work 0.7%).

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

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

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

The psychological trauma of rape for example post traumatic stress disorder (PTSD) is rarely considered in assessments of need during forensic examinations. Access to aftercare is essential in order to treat for possible sexually transmitted infections, including HIV, and provide support and testing for possible pregnancy. In rural areas follow-up care may require travel to more than one clinic on several occasions; this is exacerbated where a victim may have a learning disability or mental health problems or be vulnerable due to substance misuse.

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

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

• Lira, L. R., Jimenez, R. E., Saltijeral, M. T. & Caballero, M. A. (1997). Mental Health Attention Needed By Violated Women. Salud Mental, 20, 47-54
**Gender** Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).

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

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

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

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

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

Previous reports articulated a concern about the lack of availability of female medical examiners. On this latter issue, the vast majority of forensic medical examiners are male; responses to our Baseline Survey A show limited and uneven access to a female FP, with an average of 61.39% female to male doctors, compared to 93%: 7% female to male reported victims. In some areas fewer than 20% of doctors are female.

Survey data shows that stand alone specialist sexual offences rotas are likely to be staffed by mainly women whereas joint custody care (CC)/SO rotas are more likely to be staffed by men;
- More than 90% of the caseload on CC/SOE rotas relates to custody health care, in which the client is a perpetrator rather than a victim of crime. A minority (less than 10%) of examinations relate to victims of sexual assault, over 90% of whom are female;
- The experience of the complainant in cases of sexual assault is therefore often to encounter a man who is more used to dealing with people accused of crime. Problems occur around: attitude, lack of immediate treatment (e.g. availability of contraception), assessment of health need (e.g. follow on services), communication and empathy.
- Evidence from case study sites indicated that training and supervision linked to specialist SO work provided the conditions for attracting women, so that in some areas there was a waiting list of 20 doctors seeking to become an FP in sexual offences work;
- It follows that there is a case for promoting stand alone sexual offence services – separate from general custody care – as a means of improving the service for women.

- Chowdhury-Hawkins, R., McLean, I., Winterholler, M. & Welch, J. (2008), Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs), Journal of Forensic and Legal Medicine, Vol. 15, No. 6, pp.363-7
**Race** Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.

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

Attitudinal barriers: Sensitivity to victims and cultural competence is important, not least in relation to women and men from BME communities, and those with English as an additional language. Interview data with health and police staff and Clinical Directors in SARC's, revealed that there can be a poor standard of spoken communication among some FPs, and a lack of empathy:

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

Given that victim withdrawal is a significant reason for early loss of cases in the criminal justice system it is of vital importance that the forensic examination does not increase trauma for rape complainants, and as such they need a professional, caring and consistent response that delivers the evidence collection required.

Minutes of the Faculty for Forensic and Legal Medicine Board Meeting 26th April 2010 showed that Examiners found that candidates revealed “a total misunderstanding of the seminal importance of attitude and communication skills. That is what the OSCE tests and that is what many people failed on”

- https://fflm.ac.uk/upload/documents/1277211365.pdf
Age
Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.

Visits to case study sites indicated that the majority of victims are between the ages of 16-35, and 'acquaintance rape' is the most common experience found. There are still pockets of professionals who demonstrate an attitude of 'disbelief' towards acquaintance rape. A victim is held more likely to be held responsible for what happened when she was acquainted with the rapist. The literature suggests that 'stranger' rape is more 'believable' to society. In addition, women who are raped in a social context are less willing than those raped by a stranger to seek help at the time of the assault, to receive medical attention, or to report the rape to the police.

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

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

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

Gender reassignment (including transgender)
Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.

No evidence was available
**Sexual orientation**  Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.

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

We have data from one police authority:

<table>
<thead>
<tr>
<th>Sexuality</th>
<th>%</th>
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<tbody>
<tr>
<td>Bisexual</td>
<td>1.2</td>
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<tr>
<td>Heterosexual</td>
<td>38.8</td>
</tr>
<tr>
<td>Gay</td>
<td>0.2</td>
</tr>
<tr>
<td>Lesbian</td>
<td>2.8</td>
</tr>
<tr>
<td>Not specified</td>
<td>57.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
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</table>

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

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

**Religion or belief**  Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.

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

**Pregnancy and maternity**  Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.

N/A
Carers Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.

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

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

In the case of young people this mostly takes place during the day so can have some impact on carers/relatives in relation to time of work, as it would later on, if the case went to court.
Other identified groups Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.

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

- Street workers
- People living in rural areas

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

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

People living in rural areas: our research found that access to secure forensic examinations, timely examinations by a female FP, immediate healthcare and aftercare needs, are neither straightforward nor easily accessed in rural areas.

Where SARC have been developed, the proximity of some elements of the service is distant from victims’ homes, requiring a lengthy journey for the examination. Travelling back and forth to different clinics for aftercare can be difficult where rural transport is poor; a difficulty that will increase with current local council decisions around cuts.

<table>
<thead>
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<th><strong>Engagement and involvement</strong></th>
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<td><strong>Was this work subject to the requirements of the cross-government Code of Practice on Consultation?</strong></td>
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**How have you engaged stakeholders in gathering evidence or testing the evidence available?**

Consultation with key governmental officers in the Home Office and Department of Health were involved from the beginning. This rolled out to the Police (ACPO Rape Lead and regional Rape Champions) from the second month and continuously thereafter. In addition, the National SARC Steering Group (NSSG) and Regional Sexual Health Leads were involved and asked to influence the design of the study from early on; they distributed information regionally and locally to seek views.

Questionnaires were piloted with Medical Forensic Practitioners (FPs) from different providers (statutory and private) and SARC managers before being sent out.

A stakeholder event was established once data had mostly been collected to feedback interim results and impressions to generate further discussion and critique in relation to the data, and to receive feedback on any areas stakeholders felt needed highlighting.

**How have you engaged stakeholders in testing the policy or programme proposals?**

Findings were presented to a stakeholder event and feedback given (see above for who the stakeholders were). Also the draft evidence base was circulated to key stakeholders for detailed comments, eg. Home Office, Police and Department of Health.

**For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:**

see above
Summary of Analysis  Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

It is incredibly important that forensic medical examinations in rape cases are conducted appropriately, firstly, to contribute appropriate evidence to support rape investigations and prosecutions, and secondly, to ensure the victim is not additionally traumatised by the rape investigation process and to improve the victim experience. Her Majesty’s HM Inspectorate of Constabulary and Her Majesty’s Crown Prosecution Service Inspectorate found considerable problems relating to forensic examinations of adults and children who had been raped including:

• a shortage of FPs (particularly female FPs and paediatricians)
• delays in examinations (particularly for women and children)
• varying levels of expertise and wide disparities in levels of service offered to victims
• variability in standards of medical examination facilities

The impact of this work will seek to improve the quality of victims’ experiences of services by:

1) Providing separate rotas for forensic examinations for rape and sexual assault. This will ensure that there is:
   a. Swifter accessibility to forensic examinations for adult and child victims;
   b. Time for full assessment of needs for example for vulnerable and disabled victims;
   c. Gender choice for women, men and people of religious faiths, within specified service timescales;
   d. Forensic Practitioners who are appropriately trained and focussed on working with victims as opposed to perpetrators.

2) Improving clinical governance, training and supervision of Forensic Practitioners which will:
   a. Ensure that good clinical and professional standards are set for forensic examinations including assessment of need, forensic samples, and conduct;
   b. Ensure Forensic Practitioners convey an empathic and sensitive attitude and effectively communicate with victims, thereby providing a more conducive environment for young women, street workers, victims from black and ethnic minority communities and victims who are vulnerable and traumatised;
   c. Provide integrated and accessible specialist paediatric and safeguarding expertise for child victims;
   d. Ensure that forensically cleaned and secured premises and equipment are available and in good working condition so that victims may feel confident that ‘evidence’ is not contaminated.

3) Assessing health care needs to ensure that:
   a. Vulnerability risks and disabilities (learning disability, physical disability, mental health problems, self-harm, repeat rape) are picked up at the earliest opportunity;
   b. Immediate healthcare needs are treated e.g. pregnancy testing, sexually transmitted infections and HIV, risk of self harm;
   c. Aftercare follow up is offered where victims (or their families in the case of children and young people) give consent.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.
### Eliminate discrimination, harassment and victimisation
Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

There is no specific discrimination against groups. Gender is the main equality factor that is addressed by the proposal to improve service quality, with the aim of increasing choice of doctor gender to victims of sexual assault, who are predominantly female. The issue of poor communication and empathy among FPs has been identified in the Evidence Base and has an impact upon victims presenting as vulnerable and those from BME communities. Attention to equality principles is essential in order to further raise standards across the service as a whole.

### Advance equality of opportunity
Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Findings from the feasibility study clearly points to a preferred option of transferring the budget and commissioning of Forensics Examinations from the police to the NHS with an additional requirement to improve the quality required through improved commission and performance management and a clear service specification.

Where these improved standards in clinical governance and quality are implemented this will provide for a greater equality of opportunity for adult and child victims of rape and sexual assault as detailed in the summary above.

### Promote good relations between groups
Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

There is no evidence of any aggravation of relationships with any specific group or community, or with victim’s groups.

There is evidence of positive and productive working relationships between the police and the NHS in some police authority areas, while in others this is less so. The primary relationship that will be enhanced through implementing the preferred option for change will be to properly address the healthcare and criminal justice needs of victims, by having both the NHS and the Police involved in determining the specification of services locally. In turn this will mean an improved service for victims, and can lead to better healthcare outcomes (physical and psychologically), while criminal justice outcomes are often dependent on juries, the quality of the forensic evidence will also be improved through improved clinical governance, supervision and training.
What is the overall impact? Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?

The overall impact of recommended changes is that there will be better evidence for prosecution (clinical governance) and improved standards of service for adults and children who have been raped or sexually assaulted:

1) Improvement in service quality (aided by training and governance) would (a) improve the experience for the victim and so potentially raise reporting rates, and (b) improve the quality of forensic evidence, potentially raising conviction rates.

2) The NHS can exert greater control over clinical governance, driving up standards;

3) There are long term and strategic gains to be made through workforce development and recruitment/retention of practitioners. Development of nurse-led services in some areas (especially rural) might be an effective way to promote gender choice and overcome recruitment and retention problems.

4) The professions (medical and nursing) will be better enabled to drive up standards through education and development of sound career pathways.

Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.

All issues that need to be addressed are highlighted in the feasibility study and guidance will be issued in due course to the NHS/Police by the Department of Health and the Home Office.

Action planning for improvement Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Further work needs to be undertaken to fill the evidence gaps, in particular in relation to race and disability needs of victims; this needs to be taken forward by the Home Office/Department of Health in consultation with key stakeholders across the system.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment
- Plans already under way or in development to address the challenges and priorities identified.
- Arrangements for continued engagement of stakeholders.
- Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses).
- Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies.
- Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results.
- Arrangements for making information accessible to staff, patients, service users and the public.
- Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.

Joint discussions between Department of Health and Home Office
Links to other areas of work to ensure consistency e.g. wider custody care work
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<tr>
<td>Name of person who carried out this assessment:</td>
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<tr>
<td><strong>Date assessment completed:</strong> 30 March 2011</td>
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<tr>
<td><strong>Name of responsible Director/Director General:</strong></td>
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<td><strong>Date assessment was signed:</strong></td>
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## Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

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<th>Actions</th>
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<td>Transparency (including publication)</td>
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