Healthcare Improvement Scotland | Evidence
Advice, guidance and intelligence

Domestic Homicide Review

Workshop report
May 2023

NHS SCOTLAND

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May 2023

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Contents

1. Introduction

Background

The Domestic Homicide Review (DHR) Taskforce was established in 2022 to provide national leadership to drive forward change and improvement in the field of domestic homicide. The Taskforce will develop and implement a national DHR model for Scotland. The Taskforce includes partners from COSLA (Convention of Scottish Local Authorities), Police Scotland, social work, third sector organisations including Scottish Women's Aid, NHS boards and victim's representatives.

A key aim of the Taskforce is to create a DHR system for Scotland which will 'help agencies and organisations better identify and respond effectively to the risks associated with abuse and ultimately prevent further deaths'.

The Taskforce, chaired by Anna Donald (Deputy Director, Criminal Justice Division, Scottish Government), first met on 8 December 2022. To establish common ground and identify differences in the group's approach to a Scottish DHR mode, a structured questionnaire was distributed to members.

In total, 13/29 Taskforce members completed the questionnaire (45%). Some respondents suggested a broad definition of scope beyond intimate partner violence (for example to include suicide and/or family violence). Feedback from the questionnaire also noted that inter-agency learning, collaboration and improving understanding of the details of a domestic homicide should be key aims of the review. There was agreement that the memorialisation of victims should be a fundamental component of the Taskforce's work.

A facilitated workshop for members of the DHR Taskforce was held on Monday 20 February 2023. Taskforce members (or their deputies) were invited to the workshop in St Andrew's House in Edinburgh: 27 participants attended. **Appendix 1** lists the participants.

Healthcare Improvement Scotland was asked by the Scottish Government to lead the workshop to provide objective, impartial facilitation of the discussion and summary of feedback. This report includes the outcomes of these activities and presents the feedback as recorded, including photographs of the interactive approaches used throughout the workshop.

Purpose of the workshop

The workshop was designed to further explore the key findings from the questionnaire, to seek consensus and provide reflections to support decision making by the Taskforce. The workshop sought to provide greater clarity on the scope and purpose of the DHR model for Scotland. It provided an opportunity for more detailed discussion on themes and issues relating to the Taskforce's work and remit. The workshop also enabled the Taskforce project

team to provide an update on a range of complementary work that had been undertaken, for example an evidence review (see **Appendix 2**).

The workshop was designed to develop the principles of the DHR model and identify areas of consensus. Participants were asked to identify any gaps in evidence and risks and interdependencies that could impact progress with delivery. Views were invited on how best to memorialise victims and how this could be incorporated into the DHR process. The structure and approaches used in the workshop are presented in **Appendix 3**.

In recognition of the role and responsibilities of the Taskforce, workshop participants were reassured that the workshop was not a decision-making mechanism. Rather, the outputs would be used to inform the Taskforce and to support wider discussion and decision making by the Taskforce. It was also recognised that the process would also inform the development of the DHR model and creation of any subgroups required to underpin Taskforce work.

The discussion summaries and findings from the workshop were presented at the second meeting of the Taskforce on 30 March 2023 as a draft report.

Acknowledgement

Healthcare Improvement Scotland and Scottish Government would like to thank everyone who attended and provided feedback to the workshop sessions.

2. Developing a Scottish Domestic Homicide Review

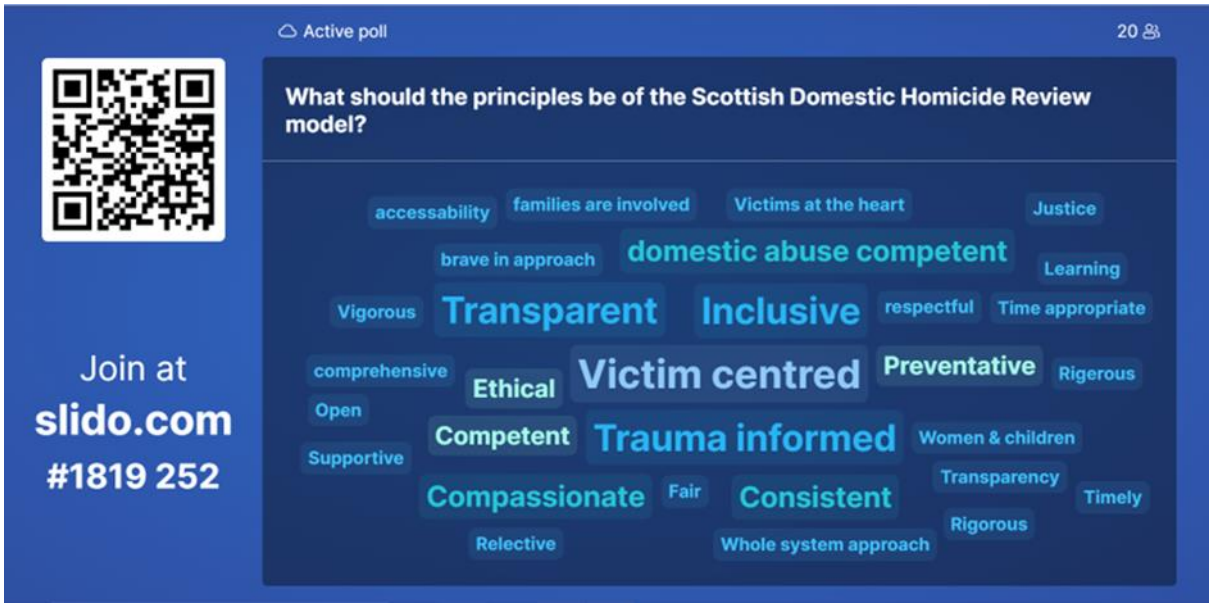
To support the Taskforce's aim of creating a DHR model for Scotland, participants were asked to outline what they thought should be the principles of a DHR and what should be in the scope of its remit.

Principles of a Scottish Domestic Homicide Review

Participants were asked to share their views of the founding principles of a Scottish DHR model via the word cloud app *Slido*. A broad range of potential principles were identified (see Figure 1).

The four principles which received the highest level of support were 'victim centred', 'transparent', 'inclusive' and 'trauma informed'. The principles were revisited at the end of the workshop, to provide an opportunity to reflect on the workshop itself and the validity of the principles.

Figure 1: Suggested principles of the DHR Model (*Slido*)



To support the group to work effectively in the workshop, and help set boundaries, the principles identified for the DHR were also used as principles for the workshop itself. For example, that participants should be transparent, inclusive and respectful in their discussions.

Scoping out a Scottish Domestic Homicide Review

To support the development of the scope of a Scottish DHR, participants worked as individuals and then came together as a group. This interactive session enabled participants to gain a shared understanding of the scope of the model for Scotland and identify where there was consensus and areas of difference amongst participants. Seven themes had been identified as potential areas in scope prior to the workshop, Table 1. Each theme also included a high level definition drawn from a range of DHR research.

Table 1: Potential themes for the scope

Theme	Definition
Intimate partner homicide	A homicide where the perpetrator and victim are, or were, in a relationship with each other.
Suicide	Where a person died by suicide and domestic violence was present.
Homicide-suicide	A homicide where the perpetrator kills their partner/family members and then dies by suicide.
Near death	Assault with life-threatening injuries as a result of domestic violence.
Children	Death of a child (younger than 16 years) that occurs in a domestic violence context.
Bystander death	Homicide that takes place in a domestic/family violence context, but where the deceased was not the primary victim/perpetrator of the abuse. For example a friend, police officer or professional supporting a victim of domestic abuse.
Family homicide	A homicide where the perpetrator and victim were related or lived in the same household, and are 16 years of age or older.

A further sheet was included to enable participants to note other themes which had not been identified in the questionnaire ('gaps').

The outcome of this is presented in the following section with key points and verbatim feedback included against each category. A green post it indicates one person's view that the proposal is definitely in scope, pink = definitely not in scope, orange = not sure or further evidence needed, and yellow = could be in scope in the future.

3. Findings: scope

The seven potential themes for the DHR were reviewed by the group and following discussion agreed by consensus. The group allocated all seven themes to three categories: 'in scope', 'areas for further or later consideration' and 'outwith scope'.

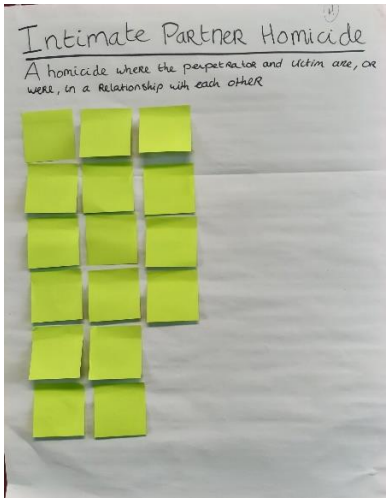
Two themes were agreed as in the scope of the DHR (*intimate partner homicide* and *suicide*). Three themes were noted as requiring further or later consideration (*homicide-suicide, near death* and *children*). Finally, two themes were identified as outwith scope (*bystander death and family homicide*).

Themes to be included in the scope of the Domestic Homicide Review

Following discussion, the group agreed to recommend that the themes of intimate partner homicide and suicide should be included in a DHR.

Intimate partner homicide

There was universal support for *intimate partner homicide* to be included in a DHR.

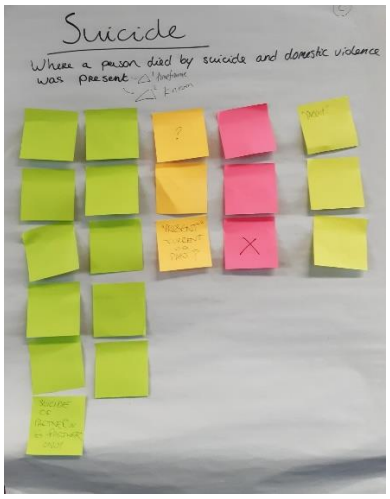


Key points/feedback:

- When we say 'partner' it should always be partner/ex-partner.
- We need to think about adolescent relationships: should they fall under the definition as well? Or would this be determined by age and therefore might be addressed by child safeguarding policies and practice?

Suicide

There was significant support for *suicide* to be part of a DHR, as indicated by the number of green *Post It* notes. The wider group was asked if this was a fair reflection, and it was agreed to recommend that *suicide* should be included in the scope of the DHR.



Key points/feedback:

- It was suggested that this definition should relate to the suicide of a partner or ex-partner only.
- There were comments about timescales: if the relationship was over at the time of the suicide it is not captured as 'domestic violence' within the criminal justice system.
- There may also be issues around the deletion of records after someone completes suicide.

Themes for further or later consideration

Given there was varying support for the themes of *homicide-suicide, near death* and *children* (as indicated by the range of coloured *Post It* notes used), the group agreed to recommend that the three themes should not be currently included in a DHR. It was felt that the Taskforce should revisit this at a later time, or when further evidence was identified and the model has bedded in.

Homicide–suicide

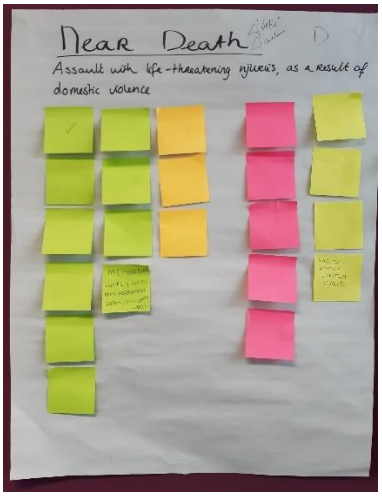
There was a mix of support for *homicide-suicide* to be included in a DHR, with participants split on whether the theme should be included in the initial work of the Taskforce or in a possible second wave of priorities. Following further discussion, it was agreed to recommend that it was currently out of scope, but should be revisited later.

Key points/feedback:

- Those in favour of including thought it should refer only to intimate partner violence.
- The definition should be limited to cover partner and ex-partner (not family members). This would also include 'family wipe-out' or child death as way to control/take revenge on a mother.
- The key is that the killing takes place because of a relationship with a domestic violence dynamic.

Near death

There was a mix of support for *near death* to be included in a DHR, with participants split on whether the theme should be included in the initial work of the Taskforce, or a possible second wave of priorities or outwith scope. Following further discussion, it was agreed to recommend that it was currently out of scope, but should be revisited later.

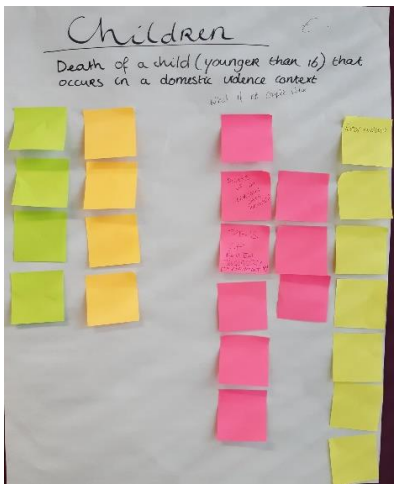


Key points/feedback:

- There is a need for a clear definition here with consideration of timescales. One suggestion was 'an attempted murder where, but for medical intervention, the person would have died as a result of domestic violence'.
- There could be far too many cases to make this practical.
- Including near deaths would enable greater learning from the survivor(s) with the potential to consider preventative measures.
- There were questions about how this would align with/complement Multi-Agency Risk Assessment Conference (MARAC) given that they do not focus on domestic abuse.

Children

There was a mix of support for *children* to be included in a DHR, with a larger proportion of participants indicating that it was outwith scope. Following further discussion, it was agreed to recommend that it was currently out of scope, but should be revisited later.



Key points/feedback:

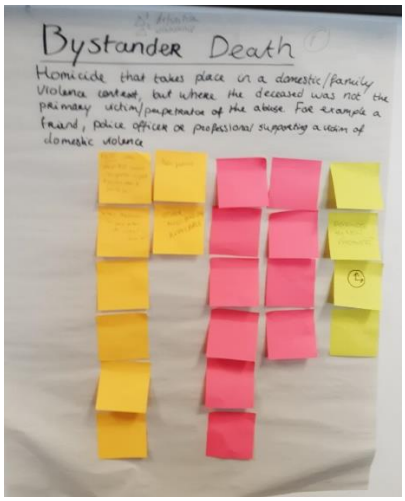
- Children should not be included in scope (or not now) as this was child protection learning review (CPLR) territory. Children could also be picked up in a serious case review.
- Some participants thought that the child protection learning review process was not 'trusted' and that it would be important to understand more about the links between the DHR and CPLRs and whether the latter could be improved.
- Further evidence was needed here.

Themes outwith scope

The group agreed that the themes of *bystander death* and *family homicide* should be recommended as outwith the scope of the DHR Taskforce's work.

Bystander death

There was no support for *bystander death* to be included in a DHR, with a mix of participants noting that it could be an area for revisiting or that that it was outwith scope. Following further discussion, it was agreed to recommend that this was out of scope for the Taskforce.

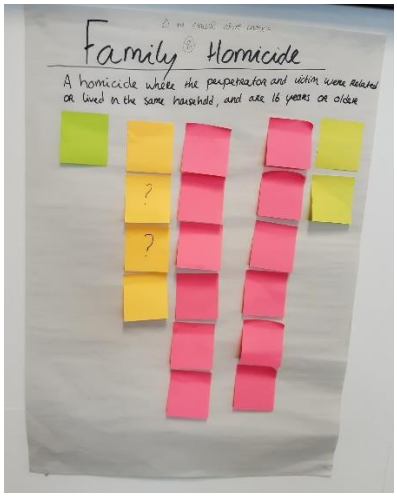


Key points/feedback:

- Some participants felt there was more work needed here especially around establishing a clear and consistent definition.
- Views were expressed that this should be in the context of intimate partner violence. A new partner should be included.
- Might there be other mechanisms to capture this?

Family homicide

There was very little support for *family homicide* to be included in a DHR, with most participants noting that it was outwith scope. Following further discussion, it was agreed that this should be recommended as out of scope for the Taskforce.

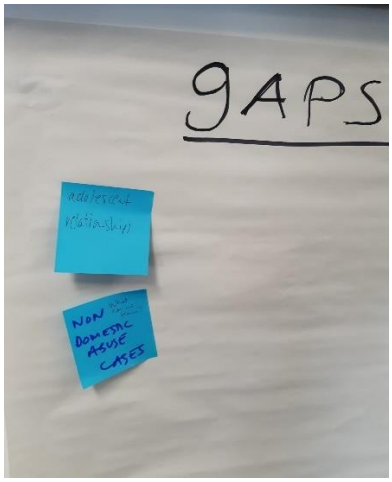


Key points/feedback:

- Some participants thought there was work needed around the definition to place this in the context of domestic abuse.

Gaps

Two areas were identified by the group as potential gaps in the proposed scope: *adolescent relationships* and *non-domestic violence cases*. The group discussed these areas but agreed to recommend that they should not be included as new categories for a DHR.



Key points/feedback:

- It was noted that non-domestic homicide was not the same as violent resistance death.

General points

Participants noted that there needs to be alignment with other reviews that are already in place, for example the child protection learning review system. The DHR needs to be complementary to the legal system and be compliant with the timescales for data retention. Finally, it was suggested that the DHR should consider looking at what is **not** a domestic abuse homicide which would help it to narrow scope and definitions.

4. Findings: purpose of a Scottish Domestic Homicide Review

This session focused on the two broad aims of a DHR which had been identified from the research (which included evidence from UK and international DHR models) and the questionnaire. The agreed aims of the DHR are to contribute to:

- the prevention of deaths, and
- memorialisation of victims.

Prevention of deaths

To support the Taskforce's work around prevention of deaths, two themes were identified for discussion:

- improving knowledge and understanding of the risks and circumstances around homicides, and
- interagency collaboration, information sharing and learning.

Participants were split into small groups and discussed the themes against three main questions:

- what would success look like?
- what will a DHR be able to deliver?
- what is needed to deliver this?

The purpose of this session was exploratory and to capture the broad range of views from participants. The wider group was not asked to seek consensus or identify themes. Discussion points, collated by the facilitator and note taker are presented below. Additional comments and other relevant feedback were recorded on *Post It* notes and added to the '*car park*' board.

Improving knowledge and understanding of risks and circumstances around homicides: discussion notes

What would success look like?

- Reduction in domestic homicides.
- We should be ambitious and aim to have no domestic homicides: drives preventative activity.
- Recognition of the human aspect of the process: tangible impact and the difference made to those affected.
- Supports the family (gives them a voice in the process) as well as system learning.
- National, consistent, transparent process which produces informed learning and reflection.
- National awareness and visibility of domestic abuse and prevention. Media and society would have greater understanding of importance.
- Agencies respond to the reviews.
- Greater sharing with other services/types of review.
- It will be important to share the outcome of the DHR with other (review) systems to increase their understanding of domestic abuse.

What would the DHR be able to deliver?

- The recommendations would prompt tangible and obvious change.
- A DHR will join the dots: it would prompt agencies/systems to 'navel gaze'. Links with other review processes.
- Accountability, by understanding and defining responsibility.
- National visibility.
- Opportunity to publish the DHR report which will enable information sharing and learning.
- Takes into account the longevity of abuse.
- Joins the dots across agencies and other review processes.

What is needed to deliver this?

- Statutory framework underpinned by legislation to ensure recommendations acted on. A small number of participants suggested a Memorandum of Understanding could be used.
- Leadership and accountability.
- Process and information systems (across the civil and criminal system as some may not understand when information can be shared). Linked to this, would a Memorandum of Understanding be needed to improve information sharing? Who would need to be involved in the process – which organisations? We need to understand why people may be reluctant to share information.

- Should sit alongside criminal investigation.
- Resourcing needs (capacity to meet obligations).
- Only lands if the rest of the landscape isn't so busy. Lots of competing priorities (largely from the Scottish Government): importance of a DHR could get 'lost'.
- Need a holistic approach: domestic violence viewed by some as a specialist issue - should be seen as universal interest.
- Agencies need to be curious about understanding the context of domestic abuse.
- Confidentiality and trust are key elements to consider.
- Tie in with monitoring against risk management: MARAC (Multi-Agency Risk Assessment Conference), MATAC (Multi-Agency Tasking and Coordination protocol) and the eight stage homicide timeline. Needs to be all encompassing to create change.
- Need to reframe domestic abuse in the media/society and, is the term 'domestic homicide' right? Better to say 'killing' or 'murder'?
- We need to be realistic: there are gaps.
- Implementation needs close consideration. How do we revisit what we've learnt?
- Where should any recommendations sit within the system?

Inter-agency collaboration, information sharing and learning: discussion notes

What would success look like?

- Information sharing with and learning from other services or types of reviews. Gets everyone round the table.
- Make the final review a public report so that it is available to others for information sharing and learning.
- Accountability for follow-up action which ensures meaningful change.
- Lessons learnt should be shared with all agencies and learnings implemented.
- Outputs should be understandable and actioned: patterns or trends can be understood.
- A healthy system is key – identify the glitches in the system e.g. where is information not getting through/what components need to be in place?
- There should be a focus on victims and stay away from the perpetrator's narrative and views.
- Family need to see the outcome: needs to complement the outcome.
- Widening the MARAC process – taking a holistic approach and consider who else needs to be included.
- DHR is not just about individual review, there is benefit in having multiple reviews, to aggregate data/findings and look for learning across cases.

What would the DHR be able to deliver?

- Allow learning and channel into prevention – some organisations are not looking via a domestic abuse lens.
- Wider public information sharing (as long as it does not prejudice the criminal investigation); bringing agencies and organisations together to act on recommendations.
- Expanding and improving domestic abuse competency.
- Brings consistency to language and support. May allow us to manage expectations and division of responsibilities between agencies. Helps families move forward.
- Would address current lack of accountability as it can be difficult to decide responsibility in an unhealthy system or if services are unwilling to change.
- An independent review would be beneficial which could also tie different elements together e.g. bail decisions.
- Gather research/ratio of perpetrators who have a history of trauma in domestic abuse cases.
- Scotland has a lot of great information on domestic abuse, there is good understanding. The question now is why all this information did not change practice. We know a lot, but how to put this into practice?
- Recommendations/follow-up action can promote change. We will be able to see whether actions have been taken or not. Fewer recommendations would be better.

What is needed to deliver this?

- Essential for everyone to know their role in the review process.
- Need to identify accountability and ensure that outcomes are followed up.
- Technology and systems required to facilitate information sharing.
- Training.
- The DHR should take place alongside any criminal justice investigation (not wait until completion).
- Data protection/gate keeping – information may not be shared due to fear of General Data Protection Regulation (GDPR). Information sharing agreements between agencies suggested with endorsement from the Information Commissioner's Office.
- Would probably need statutory guidance to ensure information sharing.
- Important to be aware of the Lord Advocate's role to review deaths.
- Start with small system change/best practice and test the model in pilot areas.
- Clear framework/process needs to be set from the outset.
- Need to manage expectations of interagency collaboration.
- Getting the right balance between understanding the perpetrator as well as victim to enable learning and preventative measures.

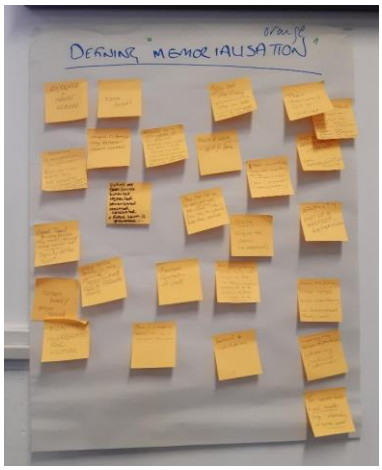
Memorialisation of victims

The second agreed aim of the DHR is to contribute to the memorialisation of victims. Participants were asked to consider two questions:

- what does memorialising victims mean?, and
- how can we implement this as part of the DHR process?

Individual thoughts and reflections were recorded on *Post It* notes and considered by the wider group. Key themes related to ensuring that the process supported victims and their families and that victims were remembered with dignity and respect. The importance of language, and being person centred and trauma informed ran through the discussions. The *Post It* notes and discussion points are presented below.

Defining memorialising



Key points/feedback:

- Recognition of victims: never forgotten, remembered with dignity/respect and are validated.
- Mourned/celebrated, personalise the victim within the DHR. Ensures the victim's experience has led to change with improved responses.
- Must avoid victim blaming. 'Victims are visible'.
- Name the victim: not just for stats - show names and photos 'show the real tragedy behind the numbers'.
- Not everyone wants victims named; can re-traumatise the family.
- Don't focus on the perpetrator.
- Involve family: must be consent based and trauma informed. Take the family views into account depending on sensitivities and culture.
- Need to provide advocacy and support for the family.
- There is a need and benefit in memorialisation but this should sit apart from the DHR. Not every family will be happy with the outcome of a DHR.
- Needs to be media accountability and responsible reporting: address 'invisible women', 'deserving/undeserving'.

Implementing memorialisation

Key points/feedback:

- Need to have consent from family to share personal information.
- Collect up the reviews carried out and name the victim; establish themes, timescales. Periodic review of victims and learning.
- Listen to and respect next of kin views/be guided by them.
- Risk assess each case and consider the impact on families if they are involved. Consider expectations.
- Make funding available to family to choose a memorial. Formally record names of victims and bereaved children.
- Incorporate Karen Ingala Smith 'Comms' model of visibility.
- Must be person-/family-centred approach.
- Publicise lessons to be learnt and organisations need to take responsibility.
- Stop using perpetrator's name: use victim's name the way the case is titled in court. Change in perpetrator descriptions in the media.
- Separate this from the DHR.

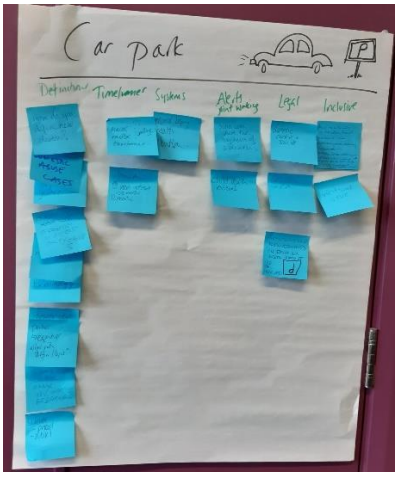
Further points raised in the group discussion:

Four key points were noted:

- It is very personal and different for different families, sometimes depending on cultures.
- We need to be aware that sometimes family members can have feelings of guilt.
- It needs to be consent based.
- The language used needs to be considered.

5. Related work and themes

Throughout the session, participants could leave their comments on related work and themes on the '*car park'* board. At the end of the session, these were reviewed and key themes identified and shared with the wider group.



Key points/feedback:

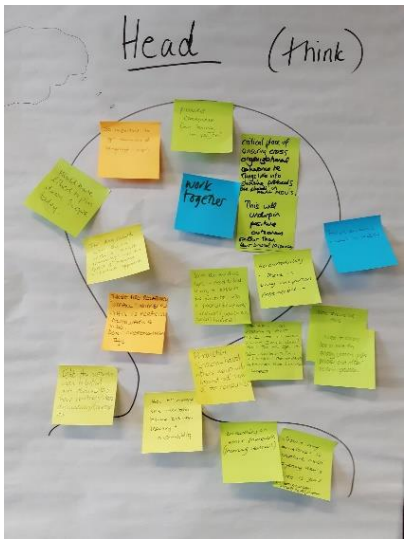
- Definitions (how to define near death, family homicide and homicide suicide; language and terminology were key).
- Timeframes (for MARAC, MATAC, how to define 'recent').
- Systems (record keeping and retention).
- Alerts and joint working (who can alert the system of a death; link DHR to child protection learning reviews; involve statutory violence against women partnerships in each local authority area).
- Inclusivity (how to ensure that seldom heard voices and intersectionality are taken into account especially where stigma can come into this e.g. commercial sexual exploitation; hear the victim's voice).

6. Workshop feedback

At the end of the workshop, each participant was given time to reflect on three aspects of the workshop. The three areas were something that:

- made them think (head)
- made them feel (heart), and
- they will take away (carrier bag).

Head



Key points/feedback:

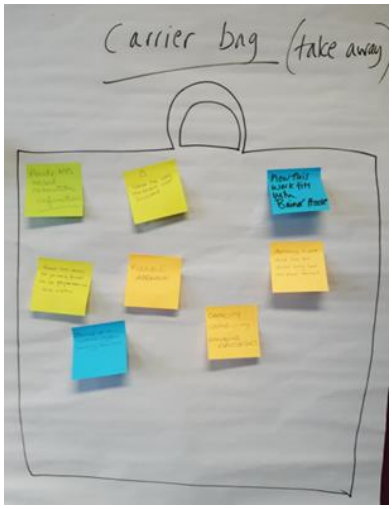
- A number of *Post It* notes highlighted this was a helpful session to hear multiagency ideas/concerns.
- Critical to ensure cross-organisational coherence on things like information sharing protocols/robust MOUs. This will underpin positive outcomes rather than fear-based response.
- Realisation that without accountability the process has limited impact. How to manage the inevitable tension between learning and accountability.
- Focus on aims and what is realistic. Such an emotive topic which way to balance the sensitivities with a practical framework/solutions which are realistic and workable.
- So important to get nuances of language right.
- There are relatively small numbers of domestic homicides: this is perfectly achievable. Don't overengineer this.
- Need to always bear in mind the existing criminal justice process and other review processes. Could encroach on other frameworks (learning reviews).
- The day should have begun with a 'health warning'-in the spirit of a trauma-informed approach.
- Would have liked to have pinned down scope today. Productive being in person.
-

Heart

Key points/feedback:

- Several comments reflecting there was passion and shared commitment to make a difference.
- Overwhelmed.
- Need a focused and safe session for friends/family of victims to inform next steps.
- Fear that a DHR could encroach on other existing work or processes.
- Important to remember that finding someone responsible is the function of the criminal justice process: DHR should be focused on agency responses.

Carrier bag



Key points/feedback:

- Manage person-centred/system learning tensions.
- Flexible approach.
- Capacity, capability, managing expectations.
- Considering in more detail how a DHR may feed into other reviews.
- How does this work fit with Bairns Hoose?
- Provide NHS record retention information.
- Should the DHR be primarily focused on the perpetrator or the victim?
- Liked the way the session was facilitated.

7. Next steps

The discussion summaries and findings from the workshop were presented to the second meeting of the Taskforce on 30 March 2023 as a draft report.

Appendix 1: Workshop participants

Attendees

Name	Organisation
Irma Arts	Scottish Government (Justice Analytical Services)
Natasha Black	Scottish Government (Violence Against Women and Girls)
Katie Brown	COSLA (Convention of Scottish Local Authorities)
Deborah Demick	Crown Office and Procurator Fiscal Service
John Devaney	University of Edinburgh
Anna Donald	Scottish Government (Criminal Justice)
Fiona Drouet	EmilyTest
Gillian Faulds	Police Scotland
Sam Faulds	Police Scotland
Ann Fehilly	ASSIST
Judy Ferguson	Scottish Women's Aid
Jeff Gibbons	Scottish Government (Violence Against Women and Girls)
Lorraine Gillies	Scottish Community Safety Network
Ann Hayne	NHS Lanarkshire
Louise Johnson	Scottish Women's Aid
Michael Luff	Scottish Government (Violence Against Women and Girls)
Karyn McCluskey	Community Justice Scotland
Lucy McDonald	Safe Lives
Emily McLean	Scottish Government (Violence Against Women and Girls)
Fiona McMullen	ASSIST
Alice Nottage	Victim Support Scotland
Moira Price	Crown Office and Procurator Fiscal Service
Stacey Reid	Scottish Government (Violence Against Women and Girls)
Carole Robinson	Scottish Government (Violence Against Women and Girls)
Lynsay Ross	Scottish Government (Violence Against Women and Girls)
Kate Wallace	Victim Support Scotland

Hosts

Name	Organisation
Vicky Carmichael	Scottish Government (Violence Against Women and Girls)
Fiona Wardell	Healthcare Improvement Scotland

Appendix 2: Scottish Government's update on progress: July 2022 to February 2023

- Wide range of engagement with stakeholders across health, justice, social work, academia and victims' organisations in Scotland, to gain insight and understanding.
- Detailed research and analysis including a comprehensive report on DHRs in other jurisdictions.
- Delivery plan and milestones established.
- Ministerial agreement for the creation of a Scottish DHR and establishment of a Taskforce: press release ahead of the first meeting of the Taskforce.
- Taskforce established and held its first meeting.
- Questionnaire issued to Taskforce members to gather views on key elements of a Scottish DHR.
- Regular dialogue with Scottish Government officials and Home Office on related policy development around domestic abuse.
- Workshop to consider principles, scope and purpose of our DHR model with opportunity to highlight gaps/barriers.
- Project planning: consideration of governance structures; subgroups; risks and interdependencies.
- Meeting with Information Commissioner's Office to consider data protection and information governance.
- Meetings with DHR leads in USA, Wales, England, and Northern Ireland.
- Attended Home Office DHR stakeholder session with DHR practitioners.
- Attended stakeholder session with Wales, New Zealand and Australia.
- Abstract submitted to present on the development of the Scottish approach to developing its DHR model, at European Conference on Domestic Violence in September 2023.
- Engagement with a range of internal Scottish Government colleagues and external stakeholders to better understand the range of existing review models and processes in place.
- Discussions around potential Ministerial visits where there would be opportunity to further enhance understanding of international approaches.

Appendix 3: Workshop Methodology

Whole-group and break-out sessions promoted interactive work by individual participants as well as small and wider group discussion. Using this multi-method approach enabled individuals to share their reflections and views, and for consensus to be reached, where appropriate.

Process for identifying the scope

Participants were asked to indicate their support for the seven potential themes for the scope that were identified by the questionnaire using visual tools. To determine support for each theme, participants received four different coloured *Post It* notes. Each *Post It* note colour indicated the participant's decision about whether the theme was in scope. The colour code was:

- green = definitely **in scope**
- pink = definitely **not in scope**
- orange = **not sure or further evidence** needed, and
- yellow = could be in scope in the **future.**

Using this visual approach enabled levels of consensus to be easily determined. The Findings: section above provides photographs of the *Post It* notes with feedback from participants for each theme.

There were three steps in the process for this session.

Step one:

- Participants allocated a specific coloured *Post It* note to each of the seven themes. Each colour indicated the participant's response to the proposed theme.
- Any gaps in scope identified by individual participants were written on blue *Post It* notes and added to the 'gaps' sheet.

Step two

- Each theme was reviewed to determine if there was overall consensus.
- Where there was no consensus, participants were asked to consider if they thought this theme *should be in scope in the future*. Those that agreed, placed a yellow *Post It* note on the relevant sheet.
- This additional option was designed to help identify themes which were not currently considered by some participants as within scope, but which might be in the future (for example a possible second wave of priority) or where more evidence was required to make an informed decision.

Step three

- There was a group discussion to consider the responses for all seven themes. The group was asked to collectively reflect on the 'strength of support' (as determined by the number and range of coloured *Post It* notes) and to review any identified gaps.
- The group reflected on the number and balance of the views noted against each theme.
- The group was asked to identify where there was broad agreement (shown by *Post It* notes) for each theme.
- Each theme was then categorised by the group, by consensus as:
  - should be included in the scope
  - an area that required further evidence or discussion or could be revisited, or
  - out of scope.

Small group discussions

The workshop included small group facilitated discussions which focused on the potential scope themes and aims identified from the questionnaire. The approach included identifying and managing risks and collaborative working. Each of the groups were supported by a facilitator and a note taker. Each facilitator had the same discussion prompts, but were responsive to their group and the flow of the discussion. The facilitators shared the discussion points, on behalf of their group, with the wider group. The discussion summaries are presented above.

Wider group discussions

The wider group discussions provided an opportunity for all the participants to come together to consider issues and themes identified in the individual participation activities and small group discussions This enabled further engagement on the themes of the session at a whole-group level. The group was also asked to determine levels of agreement with themes and proposals, and to identify where there was no agreement or where further discussion or evidence was required.

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