Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services.

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Document Status

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Contents

Equality statement

Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- *Reduce health inequalities in access and outcomes of healthcare services integrate services where this might reduce health inequalities*
- *Eliminate discrimination, harassment and victimisation*
- *Advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.*

Introduction

NHS England commissions public health services as per the NHS public health functions 2015-16 agreement made under section 7A of the National Health Service Act 2006.

One of these responsibilities is the co-commissioning of sexual assault referral centres (SARCs) with police forces as defined in the core Service Specification 30 for Sexual Assault Services.

This document is primarily for commissioners of SARC services and aims to summarise the key deliverables for sexual assault services that all stakeholders and partners including NHS England are encouraged to deliver across the care pathway.

NHS England Teams will also need to work in partnership with police forces, Clinical Commissioning Groups (CCGs), local authorities, social care, education and the voluntary sector plus other stake holders to ensure that services meet the needs of the individual who has been sexually assaulted or raped to improve quality and outcomes for that individual, be they adults or children and young people.

The content of this document is divided into two parts 1) a framework for adult services 2) a framework for paediatric services. This approach has been adopted to facilitate commissioning, since some commissioners may wish to develop an all age service in one or several locations, whereas other commissioners, whose levels of demand may be different may prefer regional dedicated hubs for paediatric provision.

NHS England commissioners may wish to use these frameworks to develop local contracts schedules with providers, subject to available resources.

Definitions

Sexual offences are governed by the Sexual Offences Act 2003 (England and Wales).

A rape occurs when someone 'intentionally penetrates the vagina, anus or mouth of another person with his penis', that the other person does not consent to the penetration, and the perpetrator 'does not reasonably believe that the other person consents'. There is also a separate offence of assault by penetration when someone 'intentionally penetrates the vagina or anus of another person with a part of his body or anything else'.

Sexual activity with a child under 16, causing or inciting a child to engage in sexual activity, engaging in sexual activity in the presence of a child, and causing a child to watch a sexual act, are offences irrespective of whether the child consents or not.[1] .

In this document, sexual assault, sexual violence and sexual abuse are used interchangeably and not necessarily in their technical or legal definitions. While accounting for less than 1% of all recorded crime, the levels of under-reporting mean that the scale of sexual violence and abuse is significant. The latest police recorded crime figures showed an increase of 9% in all sexual offences for the year ending June 2013 compared with the previous year (up from 51,252 to 55,812). Sexual offences include rape and other sexual offences, both of which also increased by 9%.[2] Whilst, sexual violence and sexual abuse disproportionately affect women and girls, men and boys face additional barriers in disclosing and seeking help following sexual assault.

Context - legislation and research

Under the Children Act 1989 (s17) every local authority has a duty to safeguard and promote the welfare of children within their area. The local authority must provide services to ensure that local children are able to achieve and maintain a reasonable standard of health and development to
ensure that individual children's health is not impaired, or further impaired. The Children Act 2004 extends this duty to safeguard and promote children's welfare to the Local Authority's partners, including Health, the Police, Probation and Youth Offending, and Education services, by requiring them to co-operate to improve local children's well-being (s10). Furthermore, the Children Act 2004 requires these individual Local Authority partner agencies to make arrangements for ensuring that the need to safeguard and promote the welfare of children is embedded within the daily functioning of their service (s11). This includes both services which are provided, and those that are commissioned. This legislation is very important in considering how forensic health services and follow up services should best be commissioned and delivered to children and young people. Agencies and practitioners must think in terms of the actual needs of the child and not simply in terms of areas of responsibility or job descriptions.

[1] Sexual Offences Act 2003 Part 1

[2] http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/period-ending-june-2013/info-sexual-offenses.html

The Cross-Government Action Plan on Sexual Violence and Abuse, *Call to End Violence Against Women and Girls* brought together all the work in hand to address all aspects of sexual violence and set out the roles and responsibilities of key agencies, including the NHS. It focused on the further value that Government could add on preventing violence and challenging attitudes and behaviours; providing support for those who have experienced sexual violence; working in partnership with public bodies and community groups; reducing the risk to women and girls and bringing perpetrators to justice. The Plan affirmed the role of SARCs provided locally, in making healthcare, including forensic examination choices and the criminal justice system more accessible to those who have experienced sexual violence.

In March 2010, the Department of Health (DH) launched the NHS Taskforce report by Sir George Alberti, "Responding to violence against women and children - The Role of the NHS".[3] This noted the need for access to high quality services. It recommended that Forensic Physicians should be employed by the NHS with better access to high-quality training, be an integrated part of the new NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of victims of rape.

Simultaneously, the Home Office published Baroness Stern's "Independent Review of How Rape Complaints are Handled in England and Wales" which covers when a rape is first disclosed until the court reaches a verdict.[4] This supported victims of rape having a right to services to help them recover and rebuild their lives. It also endorsed the recommendations from Sir George Alberti's Taskforce report; that funding and commissioning of forensic medical services should be transferred from the police to the NHS; the setting up of and operation of SARCs should be shared equally by the police, the NHS and Local Government and include the setting up of effective governance structure and multi-agency for a to take action and improve services. In addition it recommended victims of rape should have a choice of gender of Forensic Physicians and if they wish be supported by an Independent Sexual Violence Advisor (ISVA).

In 2013 as a result of the Health and Social Care Act NHS England and Public Health England were established. NHS England received the delegated authority to commission a range of public health functions under s7A of the act, which include sexual assault referral centres. It was decided that these needed to be co-commissioned with police forces and their respective police and crime commissioners, local authorities and clinical commissioning groups.

In 2015 the Dame Elish Angionlini review of how the Metropolitan Police Service (MPS) and Crown Prosecution Service (CPS) investigate and prosecute rape cases was published. The review contains 46 recommendations on how partners can improve the reporting, care, support and conviction rate in relation to sexual abuse. Commissioners in both the London area and across England will need to work with partners to take account of this review in their local commissioning plans.

[3] Department of Health (2010) Responding to violence against women and children- the role of the NHS. The Report of the Violence Against Women and Children Taskforce, London: DH

[4] Home Office (2010) The Stern Review: A Report By Baroness Vivien Stern CBE Of An Independent Review Into How Rape Complaints Are Handled By Public Authorities In England And Wales, London: Home Office

SARCs contribute to achieving a range of local and national priorities and policies to improve health and wellbeing, tackle violence and abuse, reduce inequalities and tackle discrimination.

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.

SARCs have to assure effective implementation of The Equality Act 2010 as women and girls are the major group of sexually assaulted people.[5]. Furthermore there is a significant cohort of boys who are at risk of child sexual abuse.

The statistics

Data from ONS for 2014, for England and Wales show that sexual offences rose by 32% to 26703 rapes and 53559 serious sexual assaults which is the highest level of crime since records began in 2002. As well as improvements in recording, this is also thought to reflect a greater willingness of victims to come forward to report such crimes. In 2011/12, the police recorded a total of 53,665 sexual offences across England and Wales.

Data also reflects that females were much more likely than males to have reported being a victim of a sexual offence; this was the case across all sexual offence categories. Overall 2.5 per cent of females and 0.4 per cent of males had reported experiencing some form of sexual offence in the last 12 months. For both sexes, the vast majority of incidents are accounted for by “other sexual offences”, which include offences relating to indecent exposure, sexual threats and unwanted touching.

Focusing on the most serious sexual offences (including attempts), 0.5 per cent of female respondents had reported being a victim in the last year. Of these, the majority had been a victim of rape and two fifths a victim of assault by penetration. Males were much less likely than females to report being a victim of a most serious sexual offence (0.1 per cent). To put these figures into context, over the same period, 2.2 per cent of adults had been a victim of a violent crime resulting in injury in the last 12 months.

Based on these prevalence rates, it is estimated that there were between 430,000 and 517,000 adult victims of sexual offences per annum. Of these, it is estimated that there were between 366,000 and 442,000 female victims and between 54,000 and 90,000 male victims. With regard to the most serious sexual offences, the

[5] The British Crime Survey 2010/11. http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/

survey estimated the number of females who were victims ranged between 68,000 and 103,000 and male victims between 5,000 and 19,000 per year.[6]

Sexual violence and abuse can cause severe and long-lasting harm to individuals across a range of health, social and economic factors. It can worsen the impact of inequalities which mostly affect women, the vulnerable and the disadvantaged, and are often linked to domestic violence. Long-term effects can include depression, anxiety, post-traumatic stress disorder, psychosis, drug and substance misuse, self-harm and suicide, of which a higher prevalence is documented amongst young people who have experienced sexual assault.

Providers of SARCs should be informed of anticipated demand on service by the commissioner.

Whole System Relationships

The SARC will be commissioned by NHS England in partnership with the police, local authorities and clinical commissioning groups and will promote all agencies to work together in the best interests of clients accessing the SARC service.

The SARC service cannot work in isolation and must work with partners to deliver safe, effective clear pathways of care. Partners will include:

- The Police Service
- The Police and Crime Commissioner
- The Lead Health Commissioner/s
- The Local Authorities
- NHS England, Clinical Commissioning Groups
- Public Health England
- Local Paediatric Services
- Child and Adolescent Mental Health services
- Adult Mental Health services
- The Crown Prosecution Service
- Forensic Science Service Providers
- Third Sector Organisations
- Sexual Health Services
- Social Care Agencies
- Other stakeholders including Ministry of Justice (MoJ) and Home Office who provide grant support to SARCs and third sector therapeutic support.

Stakeholders and interdependencies may vary from those identified above and the importance of the interface with other services cannot be overstated. Access to and support from such services should always be as open and available as circumstances allow.

It is recommended that Information sharing agreements between these services are in place. These agreements must support the sharing of information, by describing the legal framework, the framework for decision making and the processes to follow

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214970/sexual-offending-overview-jan-2013.pdf

to ensure client receive appropriate and co-ordinated support. These information sharing agreements will support case-by-case (or ad hoc) information sharing are a useful tool to support staff and organisations. Information Sharing Agreements are not a requirement for the appropriate and necessary sharing of information. Such sharing can appropriately take place in the absence of an agreement.

The Third Sector

Third Sector organisations, including Victim Support, Rape Crisis, The Survivors Trust, and Respond are important providers of specialist services to adults and children who have experienced sexual assault and abuse. They are major providers of specialist advocacy, counselling, pre-trial therapy and support services and see recent victims as well as survivors, sometimes targeting specific client groups. Their services are pivotal to supporting client well-being, recovery and independence. Some of these agencies do this through an Independent Sexual Violence Adviser (ISVA) who can provide support whether or not clients choose to go through with the criminal justice process.

Provision is across a wide choice of environments from one-to-one work to groups. Clients can be supported with advocacy for agencies such as housing, the NHS and Mental Health and the Criminal Justice System. Clients often express their wish to access follow on services in non-clinical settings (Survivors' Journeys, Survivors' Voices, The Survivors Trust and Rape Crisis England and Wales, 2015).

Organisations in the sector can play an integral role in:

- Supporting clients to access SARCs in the immediate aftermath of sexual violence or abuse.
- Providing services such as support, counselling, pre-trial therapy and advocacy, one-to-one and in groups.
- Frequently providing the long-term support and advocacy which may be needed to help clients to recover their confidence.
- Sign-posting clients to additional services.
- Supporting clients who approach services long after the abuse has taken place.
- Supporting the carers of child victims, which in turn leads to greater support for the children that may minimise the impact of any sexual violence on them.

These benefits were first evidenced in the 2004 Home Office Commissioned study by Lovett et al 'Sexual Assault Referral Centres: Developing Good practice and Maximising Potentials. It is expected that the SARC will develop and maintain referral pathways and working relationships with relevant third sector services.

Part 1

Aims and Objectives of the service

This framework details the commissioners' requirements for providers to deliver a SARC service.

The provider will deliver the following services through the SARC whilst ensuring safe and appropriate staffing capacity at all times. This includes responsibility for co-ordinating the smooth running of the SARC service and liaising with partner organisations to ensure the profile of the service is maintained.

Service Aim

The delivery aim of the SARC is to provide clients with:

1. Acute healthcare and support in age-appropriate settings;
2. Comprehensive forensic medical examination;
3. Follow up services which address the client's medical, psychosocial and on-going needs;
4. Direct access or referral to Independent Sexual Assault Advisor (ISVA).

The provision of quality sexual assault services supports Domains 1, 3, 4 and 5 as shown in the NHS Outcomes Framework below.

Domain	Indicator	
Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

Commissioner aims

The commissioners' aims are for the provider to deliver a SARC service which ensures that each individual client receives the most appropriate care to meet their assessed needs. This will take place in a timely manner, give support the client through their recovery, assist the investigative process if they wish to pursue a criminal justice outcome, and ultimately to reduce the amount of long term care needed and future demands on the NHS.

Provider objectives

The provider must deliver a SARC service which meets the standards set out by the Faculty for Forensic and Legal Medicines *Operational procedures and equipment for medical facilities in victim examination suites or Sexual Assault Referral Centres (SARCs) (2012)*.[7] Detailed outcomes are set out within the performance framework:

- Twenty-four hours access to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure and age appropriate venue.
- Appropriately trained crisis workers to provide immediate support to the client and significant others where relevant.
- Choice of gender of physician, wherever possible.
- Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offence examinations for adults and children.
- Dedicated forensically approved premises (preferably for sole use)
- Have decontamination protocols in place such that it can ensure high quality forensic integrity and a robust chain of evidence in keeping with Faculty of Forensic & Legal Medicine (FFLM) guidelines.
- The medical consultation includes immediate health assessment including assessment of injuries from a medical viewpoint. It will risk assess for self-harm, vulnerability and sexual health; there will be immediate access to emergency contraception, post-exposure prophylaxis after sexual exposure (PEPSE) or other acute, mental health or other health services and follow-up as needed.
- Access or referral to support, advocacy and follow-up through a counselling service, including support through the criminal justice process (should the client choose that route). There should be an offer of counselling from specialists trained in pre-court age appropriate counselling.
- Well-co-ordinated interagency arrangements will be in place, involving local third sector service organisations supporting victims and survivors, Local Safeguarding Children Boards (LSCBs), Boards for Vulnerable Adults and Health and Well Being Boards (H&WBB). These arrangements must be reviewed regularly to support the SARC in delivering to agreed care pathways and standards.
- The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive.
- Minimum dataset and appropriate data collection procedures.

And in particular, as highlighted in the University of Birmingham Study[8]:

- Clients are seen in a timely manner. In acute cases this should be within one hour of referral time, both in-hours and out-of-hours.
- Appropriate paediatric skills are available for paediatric cases, within the same time responses as adults.
- Choice of gender of forensic medical examiner is offered to all victims.

[7] http://fflm.ac.uk/upload/documents/1348663369.pdf

[8] Crilly, T, Combes, G, Davidson, D, Joyner, O and Doidge, S. Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS. University of Birmingham. 2011 http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2011/forensic-sexual-offences-report.pdf

The SARC will work toward compliance with the above standards.

The provider will offer a referral to every client to an ISVA or child advocates to meet their support needs

Performance Management and Activity Reporting

Providers will be required to demonstrate:

- Equitable and consistent standard and delivery of SARC services to clients.
- A high level of choice of client access provided through police, anonymous and self-referral processes.
- Improved sexual health outcomes, in accordance with British Society for Sexual Health and HIV (BASHH), British HIV Association (BHIVA) and Faculty Sexual and Reproductive Health (FRSH) guidelines for clients, as well as reducing longer-term demands on the NHS through early intervention.
- Improved mental health outcomes through early support of clients' needs, by having access to counselling and pre-trial therapy.
- Support to criminal justice outcomes through close working relationships with the police, achieving a high standard of forensic evidence (retrieval of trace evidence, injuries, including the absence of injuries), maintaining client confidence in the criminal justice system and information sharing.
- Development of excellence and expertise to provide advice, training, and support to health professionals, relevant third sector organisations, Police and Crown Prosecution Service.
- Delivery of wider client support through strong third sector relationships.

The SARC must provide activity reports in line with the SARCs management information stipulated template, Sexual Assault Referral Centres Indicators of Performance (SARCIP) at least quarterly to inform national commissioning assurance and any regional, sub regional assurance.

Service Description

The provider will deliver the following healthcare service through the SARC whilst ensuring safe and appropriate staffing capacity at all times.

A SARC will:

- Assess and deliver the healthcare and support needs of the client and, where appropriate, offer and provide a forensic medical examination.
- Where clients are unsure as to whether they wish to take up a criminal justice action, provide the opportunity for clients to agree to evidence being stored in case they decide to report to the police at a later date, as well as to provide information anonymously and to request that their samples are tested anonymously.
- Provide secure storage of medical records and where appropriate forensic samples (see FFLM guidance, ref [9]). Length of storage is to be agreed with local providers.

[9] http://fflm.ac.uk/upload/documents/1348663369.pdf

- Provide immediate attention, in a timely fashion, to the client as seeing someone as soon as possible enhances the chances of good criminal justice and health outcomes. This needs to be balanced with other factors such as the client's wishes and time since assault.
- Where possible, allow clients choice of gender of physician – most clients prefer to be seen by a female clinician.
- Address safeguarding, care and support issues for all clients.
- Ensure clients are given information about independent counselling and advocacy services
- Where there are no overriding safeguarding concerns about someone else, give clients who are competent adults the choice of whether or not to involve the police.
- Aim for high levels of client satisfaction.

Care pathways

The care pathways illustrate how clients access the service and the various agencies engaged in delivering the SARC service. Please refer to Appendix 1:

Service Delivery

Service model

The provider is required to ensure that the SARC meets all key national requirements including:

- Recommendations for the Collection of Forensic Specimens from Complainants and Suspects' published by FFLM, which are reviewed and updated every 6 months (January & July).
- Joint publication by the Department of Health, Home Office and Association of Chief police Officers *Revised national Service Guide. A Resource for Developing Sexual Assault referral Centres* (2009).
- Forensic and legal medicine guidelines and standards e.g. those produced by the FFLM, RCPCH, BASHH and FSRH guidelines and standards on sexual and reproductive health service provision
- National Service Framework for Children, Families and Maternity Services; and Standards for Better Health.
- Clinical governance frameworks which assist services in achieving Standards for Better Health.
- Public Health Outcomes Framework

The service must actively pursue compliance with national healthcare standards, including clinical governance and risk management in line with provider policies.

Days/ hours of operation

The SARC service must be available 24 hours a day, 7 days a week, including public holidays, to provide advice to police and clients, and deliver acute medical and forensic examination. Provision of SARC follow-up services are only required during office hours of 9am to 5pm. The provider must ensure that the police and clients can communicate with the SARC through the most efficient manner possible.

Response times and prioritisation

Response times will need to be detailed by commissioners based upon consultation, Health Needs Assessment (HNA) and demand profiles for services.

Referral Criteria and routes

The service must be made accessible to clients who are victims of rape or serious sexual assault. Access must be provided to any client who contacts the SARC be that through police referrals, or through self or anonymous referrals.

Police referral route

The provider must ensure that the police can communicate with a forensic medical examiner at all times in order that an early evaluation of the need for a client's forensic examination can be made. An assessment of immediate health needs such as self-harm risk assessment, emergency contraception, blood-borne virus prophylaxis including HIV post-exposure prophylaxis and hepatitis B must also be provided. If an urgent forensic examination is needed, the client will attend an appointment to be seen. This appointment will be within 60 minutes of referral, both in and out-of hours. Commissioners recognise that delays may take place e.g. if another client is already at the SARC. This timescale only applies where the client wishes to attend within the 60 minute period. Commissioners and providers must also identify and act upon safeguarding issues.

Non-police referral route

The service should be accessible to all. The provider must ensure that clients can be seen even if they choose not to go through the police referral route.. Accordingly clients must be able to communicate with a crisis worker at any time, who will advise the client regarding the importance of risk assessment for emergency contraception, blood-borne viruses including HIV post-exposure prophylaxis. This must be done in a timely manner both in and out of hours. If a forensic examination is needed, the client will attend an appointment time to be seen. As with the police referral route, commissioners recognise that delays may take place if another client is already at the SARC.

The SARC must provide the client with options - whether to have their forensic samples stored until they have made a decision whether or not to proceed (see FFLM guidance[10]), or to have their samples submitted for forensic testing once they have reported to the police (which can be facilitated through the SARC). The provider will ensure that the SARC staff comply with the Any Anonymous Referral Standard Operating Procedure' so that communication between the SARC and the police, regarding the management of the client's forensic samples, is effective.

Paediatric Referrals

Please refer to Part 2 and Appendix 2

[10] http://fflm.ac.uk/upload/documents/1348663369.pdf

Delivery of Forensic Services

Forensic medical examiners

The provider will provide forensic physicians (or forensic nurse examiners as appropriate) to undertake the forensic medical examination. The client will be offered a choice of gender of forensic physician wherever possible. An assessment of a client's need for a forensic medical examination will consider a variety of issues, such as potential medical needs, forensic issues such as possible injuries. This assessment will not be constrained by whether or not the client is outside the "forensic window" in terms of forensic samples. This decision will be made by the forensic medical examiner in consultation with the police and where necessary other SARC healthcare professionals.

The provider will comply with any local 'Standard Operating Procedure' which sets out how medical photography and colposcopy should be used to capture external and sensitive images of injuries. Highly sensitive images taken during a forensic examination need to be stored securely and only disclosed in line with FFLM guidance.

Every client must be offered administration of emergency medical/sexual health treatments by the forensic medical physician where appropriate, or referral on to appropriate services as currently recommended by BASHH and FSRH. This includes access to emergency contraception and PEPSE. If these services are not directly available at the SARC and a referral onwards is made, the pathway must be such that any delay to receive treatment is kept to a minimum reflecting the decreasing effectiveness of treatment with delay.

Each case must have a risk assessment for safeguarding issues and also risk of imminent self-harm including suicide.

Provision of Evidence

The provider must ensure, upon request and where appropriate consent has been obtained, that SARC staff provide forensic examination exhibits and witness evidence to the police, and engage with the criminal justice system. This requirement is usually associated with staff who undertake forensic examinations.

Evidential needs will be reviewed on a case by case basis by the investigating officer and the forensic medical examiners, bearing in mind the latest FFLM recommendations.[11]

Child Cases

Refer to Part 2

Crisis Workers

The provider must provide a broad range of support to clients through the provision of crisis workers who will deliver confidential, emotional and practical support to

[11] http://fflm.ac.uk/upload/documents/1348663369.pdf

clients throughout their time within the SARC in close co-ordination with the police and other healthcare professionals. This will need to be informed by particular standard operating procedures for crisis workers in SARCs.

Discharge processes- Transfer of and Discharge from Care Obligations

Clients accessing the SARC will be assessed prior to the conclusion of their appointment by a crisis worker or nurse, depending on the referral route through which the client presented, to evaluate on-going risks to the client.

All clients, and carers that present with clients, must be offered a referral to a counsellor, based on need and must be offered written information on aftercare for their physical, medical and emotional needs.

Delivery of Follow-up Services

The provider will ensure the delivery of follow-up services.

Sexual and Reproductive Health

Follow-up medical services may be provided on site or other locations depending on the model to be used and will include access or referral to sexual and reproductive health screening, treatment and care, HIV testing, follow-up care for clients prescribed PEPSE and access to choice of contraceptive methods including emergency contraception as required. Any client receiving positive sexually transmitted infection (STI) results will be offered treatment, including assistance with partner notification in line with Society of Sexual Health Advisor's guidelines, and referred to the local genitourinary medicine (GUM) clinic where appropriate.

Every client attending for a forensic examination will be offered a choice of follow up care which includes medical and psychosocial services. This may be delivered in the SARC or through a pathway to other community or other voluntary sector services.

Mental Health

The SARC will ensure the provision of appropriate psychosocial support according to the clients' needs. When clients' mental health needs exceed the remit, i.e. needs are greater than Improving Access to Psychological Therapies (IAPT) level 3 support, the SARC will refer them to local community mental health services or acute services as appropriate. Referrals should be with consent or, in the case of adults without capacity, in their best interests.

Clients aged under 18 will be referred to their local safeguarding team. Provision for further paediatric services such as medical care and psychosocial support must be available.

Criminal justice

The provider must ensure that all clients are given an opportunity to engage with the police. Clients who have not reported the offence to the police must be offered an appointment with the police officer or other appropriately trained staff to discuss the possibility of reporting or giving intelligence anonymously. Adults with mental

capacity should normally be left to make their own decisions about reporting sexual assaults against them to the police. However, it will usually be in the public interest (in relation to prevention of crime) to report suspected sexual assaults against adults who have capacity but who may be unable to protect themselves from further abuse. Suspected sexual offences against children or adults without capacity should always be reported to the police unless there are compelling reasons not to do so.

Promotion

The provider must ensure that the SARC is adequately promoted so that the service is as accessible as possible including hard to reach groups.

Relevant networks and screening programmes

The service will participate in relevant sexual health networks as well as relevant national SARC bodies and police meetings.

Training/ education/ research activities

Training of SARC staff and development should be assured to meet appropriate national and local standards including Quality Standards in Forensic Medicine, published by the Faculty of Forensic and Legal Medicine.[12]

Any acceptance and exclusion criteria and thresholds

Geographic coverage/ boundaries

It is anticipated that nearly all clients will either reside in the area, or the offense will have occurred in the area where the SARC is commissioned. However, there should be no geographical bar to the service. There may be an entry requirement based on age, but this should only occur where there is appropriate provision elsewhere in the area for those clients who are under that age for entry.

Applicable Service Standards

Improving Access

It is expected that numbers of individuals reporting sexual assault will increase over time by on-going awareness campaigns to promote accessibility of the service. Commissioners will work providers to market the service to increase awareness. To inform this, SARC providers will keep information on ethnicity and diversity which will be collected by the SARC, which they will analyse quarterly to monitor access from hard to reach and vulnerable groups. This process is in line with performance management and activity reporting through Sexual Assault Referral Centre Indicators of Performance (SARCIP).

[12] http://fflm.ac.uk/upload/documents/1348663369.pdf

Governance

Any complaints received will be managed according to the provider's policy.[13]

Information Sharing

Safeguarding referrals including domestic violence will be made in accordance with local child and vulnerable adult safeguarding policies.

The SARC will work with the police and partners to standardise and improve information sharing in order to meet the needs and best interests of the client. It is recommended that Information sharing agreements between these services are in place. These agreements must support the sharing of information, by describing the legal framework, the framework for decision making and the processes to follow to ensure patients receive appropriate and co-ordinated support. These information sharing agreements will support case-by-case (or ad hoc) information sharing are a useful tool to support staff and organisations. Information Sharing Agreements are not a requirement for the appropriate and necessary sharing of information. Such sharing can[must] appropriately take place in the absence of an agreement".

Staff should be properly trained and supported in confidentiality, consent, mental capacity and acting in the public interest. This includes appropriate decision making and record keeping.

The National Ugly Mugs Scheme, funded by the Home Office and supported by ACPO, is a third party reporting system which allows sex workers to report crimes against them if they do not feel confident in making full reports to the police. Information from the reports will be used to produce alerts to warn other sex workers and will also be fed anonymously into police intelligence databases, including the Serious Crimes Analysis Section. SARCs are encouraged to become members of the scheme allowing them to report incidents and receive alerts to disseminate amongst their service users. They should also encourage sex workers who use their services to become individual members of the scheme.

Capital assets

Equipment

The provider is responsible for its equipment and assets and will ensure that a maintenance schedule exists. Age appropriate equipment and surroundings will be available. Each SARC will obtain its drugs and other consumables through the provider's ordering system.

Accessibility/acceptability

The SARC must be accessible to all clients. The SARC must be an open access service for any client who has been a victim of rape or serious sexual assault. Clients can be referred as per the detail in Appendices 1 and 2, which demonstrate that the service will be accessible to clients who are brought to the SARC by police, or to those who wish to contact the SARC directly. . The range of services and

[13] Provider should INSERT CLINICAL GOVERNANCE AND INFORMATION GOVERNANCE ARRANGEMENTS.

options that the SARC provides will be of an acceptable quality to meet clients' needs.

Safeguarding issues for children and vulnerable adults must be addressed. The provider must conduct an annual Equality Impact Assessment of the SARC service and ensure an action plan is produced to review the accessibility of the service. The provider will work with commissioners to trial basing a Sexual Offences Investigative Trained (SOIT) officer in a separate hospital room near to the SARC. The aim is for police to bring clients directly to a SOIT so that the client's pathway is streamlined and early access to medical advice and forensic examination is available.

Capacity Review

Where a capacity review has been undertaken the findings and recommendations should be included in contracting documentation, such as the service specification.

Infection Control

The SARC will ensure high standards of infection control as required by any national and/or local provider policies as well as ensure high standards of forensic integrity based on national or local provider policies in order to safeguard the quality of evidential specimens.

The provider will maintain the forensic integrity of the SARC by complying with relevant standards.

Service User Experience

To continually improve service provision every client will be given a service user questionnaire to complete. Returned questionnaires will be reviewed regularly with an action plan drawn up and reviewed monthly. An evaluation report will be written annually.

Improving Productivity

To ensure timeliness, statements requested by the police from a forensic physician will be completed within 10 working days.

The SARC will be required to support the commissioners' work plan objective of evaluating the quality of the whole service including timeliness of forensic medical examinations.

This evaluation will enable development of a best practice model which, in turn, will enhance productivity.

Care Management

Forensic clients who have requested follow up care must be offered an appointment at the time of initial examination or contacted within three working days.

SARC staff will carry out a risk assessment on all clients. Safeguarding referrals will be made within one working day for non-urgent referrals and immediately for urgent referrals. All non-police referrals will be offered an appointment with the sexual offences trained officer or other appropriately trained staff to discuss the possibility of reporting and giving intelligence anonymously.

Quality requirements

Commissioners should refer to schedule 4 parts A-D of the NHS contract for political quality standards. Locally quality standards should be agreed between commissioners and providers.

Part 2

Commissioning Framework for Paediatric Sexual Assault Referral Centres (SARC) Services.

Executive summary

Sexual violence and child sexual abuse including child exploitation can cause severe and long-lasting harm. The definition for child sexual abuse is described below[14]:

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

NHS England is responsible for co-commissioning SARC services for children and young people, with police forces and a range of other local partners. Children and young people are not 'mini adults' and require specific services to meet their needs.

Sexual assault and rape are under-reported, but the 2010/11 British Crime Survey reported records of 17,727 sexual crimes against children (England and Wales). [15] Up to 15-30% of children and young people may have experienced sexual violence. There are both immediate and long term health consequences of sexual assault, requiring co-ordinated responses in the short, medium and long term, more commonly in children, but also starting and continuing into adolescence. As in the definition above, abuse takes all forms and often starts with grooming for some time before continuing to more physical forms of sexual abuse. The child may present late or may never present until adulthood, or when their child suffers sexual abuse. These victims will be outside the forensic window and need different management pathway as this is not considered urgent.

Specific consideration of capacity and consent is required for children and young people. Confidentiality and autonomy can require careful negotiation between the child or young person, family and safeguarding requirements.

The service model recommended is of a SARC "hub" serving a number of authorities (possibly over a wide geographical area), linked through clear referral pathways and

[14] https://www.gov.uk/government/publications/working-together-to-safeguard-children
[15] http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/period-ending-june-2014/stb-crime-stats--year-ending-june-2014.html

managed clinical networks to a range of “spoke” local services. The model and pathways need to reflect local needs assessments and encompass both immediate and longer term assessment, treatment and support. Paediatric SARCs have an important educational role, promoting awareness of the signs and symptoms of sexual assault and of the services available. Important dimensions of quality include patient experience as well as the timely availability of appropriate expertise. They must work closely with their colleagues in health, social care, education and the third sector.

The Children Acts 1989 and 2004 offer an important legislative framework, together with a range of guidance specific to sexual assault services, including those for children and young people. Safeguarding policy includes guidance on information sharing and system wide assurance. Other relevant legislation includes the Sexual Offences Act 2003, related Crown Prosecution Service legal guidance. and the Home Office response to their consultation on Introducing mandatory reporting for female genital mutilation (2015).[16]

There are quality standards agreed or in draft for doctors and nurses. Workforce planning needs to take account of the range of skills required and ensure appropriate provision for supervision and mentoring.

[16] Home Office. *Introducing mandatory reporting for female genital mutilation consultation- summary of responses.* February 2015.

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Purpose and scope

This part of the framework outlines key issues in the commissioning of paediatric SARC services for all children and young people who have experienced sexual assault, rape or sexual abuse. A child or young person is defined by the Children Act 1989 as being a person who has not yet reached their 18th birthday.

NHS England Teams are asked to use this summary of key issues to develop service specifications for commissioning.

Context for services for children and young people

Key points

- Sexual violence and abuse can cause severe and long-lasting harm.
- NHS England is responsible for co-commissioning SARC services for children and young people, with police forces and a range of other local partners.
- Children and young people are not 'mini adults' and require specific services to meet their needs.

NHS England is responsible for co-commissioning SARC services with police forces. The operating framework is outlined in 'Securing Excellence in Commissioning Sexual Assault Services for People who Experience Sexual Violence'[17]. There needs to be robust joint commissioning along the whole care pathway so that the needs of children and young people are met from the SARC through to community paediatric and other related services. NHS England Teams will need to work with police forces, Clinical Commissioning Groups (CCGs), local authorities and other commissioners to ensure that services meet the needs of the child or young person who has been sexually assaulted or raped.

Sexual violence and abuse, including child sexual exploitation, can cause severe and long-lasting harm to individuals across a range of health, social and economic factors. Victims may present acutely or more often in intra-familial abuse many years afterwards. It can worsen the impact of inequalities that are often linked to domestic violence and mostly affect women,vulnerable and disadvantaged people. Long-term effects can include depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide, of which a higher prevalence is documented amongst young people who have experienced sexual assault.

Services to meet the needs of children and young people who are raped or sexually abused need to take account of the differences between adults and children. Children and young people are not 'mini-adults'. It is not uncommon for children and young people who are vulnerable (for example, who have long term medical conditions, other psychosocial needs, are in care of the local authority and/or have complex past and family histories) to have been subjected to more than one type of abuse. They may be from families where there are many complex needs and this requires a holistic approach and, usually, multiagency involvement. The welfare of

[17] NHS England (2013) *Securing Excellence in commissioning sexual assault services for people who experience sexual violence* http://www.england.nhs.uk/2013/06/13/commis-sex-assault-serv/

the child or young person is paramount. The services that are commissioned will need to allow for individual plans, taking into consideration the needs of that particular child or young person.

Evidence of needs: prevalence

Key points

- Sexual assault and rape are under-reported, but the 2010/11 British Crime Survey reported records of 17,727 sexual crimes against children (England and Wales).
- 15-30% of children and young people may have experienced sexual violence.
- There are both immediate and long term health consequences of sexual assault, requiring co-ordinated responses in the short, medium and long term.

It is estimated that between 5 and 10% of girls and 5% of boys have experienced penetrative sexual abuse before the age of 18, and up to three times this number may have experienced other forms of sexual violence and inappropriate sexual activity – see definition of child sexual abuse[18]

The NSPCC's 2011 report[19] indicated that:

- 0.6% of under 11s and 9.4% of 11–17s had experienced sexual abuse including non-contact offences in the past year.
- 65.9% of the contact sexual abuse reported by children and young people (0-17s) was perpetrated by other children and young people under the age of 18.
- Teenage girls aged between 15 and 17 reported the highest past-year rates of sexual abuse.

Data from individual SARCs suggest that between 22% and 50% of clients seen are young people under 18 years old (NHS England, 2013, op. cit.).

The 2010/11 British Crime Survey (BCS) reported that 17,727 sexual crimes against children were recorded by the police in England and Wales in 2010/11, including:

- 5,115 offences of rape of a female child under 16.
- 918 offences of rape of a male child under 16.
- 4,301 offences of sexual assault on a female child under 13.
- 1,125 offences of sexual assault on a male child under 13.
- 5,806 offences of sexual activity involving a child under 16.
- 152 offences of abuse of children through prostitution and pornography.
- 310 offences of sexual grooming.
- 146 offences of abuse of a position of trust involving a child under 18.

It is important to note that cases of sexual assault and rape tend to be under-reported, so it is likely that the true prevalence is substantially higher than currently indicated.

[18] http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/
[19] NSPCC (2011). *Child abuse and neglect in the UK today report*. London: NSPCC

Risk factors for child maltreatment include[20]:

- Parental or carer drug or alcohol abuse.
- Parental or carer mental ill health.
- Intra-familial violence or history of violent offending.
- Parent with learning difficulties.
- Previous child maltreatment in members of the family.
- Known maltreatment of animals by the parent or carer.
- Vulnerable and unsupported parents or carers.
- Pre-existing disability in the child, including learning disability.

The health needs of children and young people experiencing sexual assault include (NHS England, 2013, op. cit.):

- The physical health consequences of sexual violence.
- For rape, a risk of pregnancy in 5% of cases.
- Contraction of sexually transmitted infections and HIV.
- For all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services.
- Psychological consequences linked to profound long-term health issues, with one-third of rape survivors going on to develop post-traumatic stress disorder.
- Relationship problems and longer term psychological needs or mental illness.
- An increased risk of suicide for abused children when they reach their mid-twenties.

Young victims of sexual assault have often experienced other co-morbidities, including mental ill health[21]. Just under 50% of women using mental health services have been subject to sexual abuse in childhood[22]. Findings from a review of the first 21 clients aged 0 - 12 seen at one of the 3 London SARCs between 01January and 01 October 2008 (Havens, 2014)[23], showed that a third of the children and young people had learning disabilities. Other co-vulnerabilities included domestic violence, mental health problems and self harm.

Many of those coming to the SARC will be victims of sexual exploitation. This is often a hidden situation for the young person: see reports from the Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG) 2012-2013[24]. Paediatric SARC services must have:

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20 National Institute for Health and Care Excellence (NICE) (2013). *When to suspect child maltreatment*. London: NICE

21 Muram, D., Hostetler, B.R., Jones, C.E. and Speck, P.M. (1995) Adolescent victims of sexual assault. *Journal of Adolescent Health*,17, pp 372-375
Sacks, R.J., Cybulska, B.A., Forster, G.E. (2008) Referrals of young people attending a sexual assault referral centre to mental health services. *International Journal of STD & AIDS*,19, pp 557-558

22 Department of Health (2008). *Refocusing the Care Programme Approach Policy and Positive Practice Guidance*. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083647

23 Havens (2014). *Case review of first 21 clients seen at one of the 3 London Sexual Assault Referral Centres (SARCs) between 1st January and 1st October 2008.* Unpublished

24 http://www.childrenscommissioner.gov.uk/info/csegg1

- The awareness to detect such cases, including knowledge of risk factors individual to both the child and the circumstances (see Appendix 3)
- The capacity to provide appropriate support for the victims.
- Robust inter agency networks to help devise solutions and assist with prevention.

The commissioning of paediatric services, including SARCs, where children and young people are seen, need to take account of projected population changes (including population age profiles), which will differ from area to area. For example, projections for London are shown as an example in Table 1.

Table 1: Example of population projection - Greater London population (thousands)

	Total		Age 0 to 15		Age 16-64		Age 65+	
Year	SHLAA	Trend	SHLAA	Trend	SHLAA	Trend	SHLAA	Trend
2013	8,400	8,432	1,668	1,671	5,781	5,802	952	958
2014	8,498	8,543	1,690	1,696	5,842	5,871	966	977
2015	8,597	8650	1,713	1,720	5,904	5,936	980	994
2016	8,696	8,755	1,737	1,745	5,966	5,999	993	1,011
2017	8,766	8,855	1,758	1,769	6,013	6,057	1,005	1,028
2018	8,857	8,951	1,780	1,795	6,058	6,111	1,019	1,046
2019	8,939	9,044	1,799	1,817	6,105	6,163	1,034	1,064
2020	9,020	9,134	1,817	1,837	6,153	6,214	1,050	1,083
2021	9,102	9,221	1,832	1,853	6,202	6,263	1,069	1,105
2022	9,166	9,305	1,839	1,866	6,239	6,312	1,087	1,128

Source: GLA 2012 round projections

Service responses: specific considerations

Key points

- Specific consideration of capacity and consent is required for children and young people.
- Confidentiality and autonomy can require careful negotiation between the child or young person, family and safeguarding requirements.
- Their safety is of paramount importance

Mental capacity and consent

All victims of sexual assault or abuse must be assessed with regard to their competency to consent to an examination. Assessment of a young person's capacity to consent is made in accordance with the relevant legal principles and recorded in their health record. See Department of Health 'Reference Guide to Consent for Examination or Treatment'.[25] Please note that capacity can and will vary over time and is not a one-off judgement.

[25] Department of Health. *Reference guide to consent for examination or treatment.* 4 August 2009. https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

The Reference Guide also sets out that the Mental Capacity Act 2005 (England and Wales) applies only when a young person aged 16 and 17 lacks capacity to consent because of an impairment of, or a disturbance in the functioning of, the mind.[26] Otherwise young people, including those under 16 years old can give consent, but only if the young person has the maturity and understanding to make a reasonable assessment of the advantages and disadvantages of what is proposed.[27] When a young person under the age of 16 is assessed to have capacity and does not want to involve parents/carers the 'Fraser guidelines' set out in the case of Gillick should be applied.[28]

Where young people are not able to give consent, their views must be ascertained as far as possible and taken into account, and the legal basis for the examination or proposed treatment must be recorded. Where a young person lacks the capacity to make decisions for her/himself, someone with parental responsibility should, make the decision on the young person's behalf.[29]

The consent process will take into account all relevant aspects, such as the forensic examination (including photo-documentation of the ano-genital examination where necessary) in accordance with guidelines from the Royal College of Paediatrics and Child Health (RCPCH) and the Faculty of Forensic and Legal Medicine (FFLM)[30], on-going support, sharing of information, report writing, witness evidence, etc.

Confidentiality, choice and control

Unless there are exceptional circumstances, decisions on the care of children and young people about sexual matters should be made by those with parental responsibility for them, unless they have capacity and the Fraser guidelines determine they should make the decision themselves (often with the advice of practitioners and agencies). In exceptional circumstances the wishes of parents and children can be overridden in the public interest, in particular, in this context, to safeguard the child or others.

It is usual for parents to be told about and be involved in anything affecting their child's health, so any question about whether information should be withheld from parents (for example, in relation to the incident or the alleged perpetrator) must be considered carefully and the decision recorded. Furthermore, safeguarding referrals may need to be made irrespective of consent to share information (see p35). When a child is looked after by a local authority on a full care order, the local authority has overriding responsibility and will need to be consulted about the process. Competent adults usually make their own choice to reveal sexual assault and determine whether to proceed via the police or as a self-referral. Whilst a person under 18 can make a self-referral, the duties of child safeguarding mean that suspected sexual offences against them will be reported to the police unless there are compelling reasons not to do so.

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[26] See *Mental Capacity Act 2005 Code of Practice*, HMG, 2005, 12.13
[27] *Gillick v West Norfolk* [1986] 1AC 112
[28] As above; *R (Axon) v Secretary of State for Health* [2006] EWHC 37; and see http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/
[29] Children Act 1989 section 3
[30] RCPCH/FFLM (2012) *Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse* http://fflm.ac.uk/libraryby/date/#Y2012

Plans for further treatment and care of the child or young person must take account of their family circumstances and their educational needs.

Service model, care pathway and quality issues

Key points

- The service model recommended is of a SARC “hub” serving a number of authorities, linked through clear referral pathways and managed clinical networks to a range of local “spoke" services.
- The model and pathways need to reflect local needs assessments and encompass both immediate and longer term assessment, treatment and support and liaison with other agencies.
- Paediatric SARCs have an important educational role, promoting awareness of the signs and symptoms of sexual assault and of the services available and how others can refer in as victims can present in many settings.
- Important dimensions of quality include patient experience as well as the timely availability of appropriate expertise.

Service model

The recommended service model for meeting the needs of the child or young person who has been sexually assaulted, raped or abused is to deliver through a managed clinical network. This will have the acute forensic examination and care delivered at a SARC "hub" with referral pathways in place to local paediatric services for support and follow-up care where these are needed. The acute forensic examination needs to identify any forensic issues, safeguarding and provide immediate access to emergency contraception, post-exposure prophylaxis after sexual exposure (PEPSE), first aid or other acute mental health or sexual health services where indicated. Either during the initial presentation or at follow up appointment, the medical consultation may identify unmet health needs or further safeguarding issues. These needs include a risk assessment of harm/self-harm, together with an assessment of vulnerability, safeguarding and sexual health needs; and further follow-up may be required to address these issues. The service model is more than the medical examination: it includes access to crisis workers (support staff) trained to work with children, Child Advocates (or advocates/independent sexual violence advisors trained to work with children), and later support which may include counselling and/or practical support for the child and/or their carers. The importance of liaison with other health providers, social care and education and some local third sector providers of practical support and resilience-building cannot be overestimated. Availability of this range of support, delivered in a seamless manner, is vital.

It is important to take account of the guidance from the RCPCH and FFLM[31]:

> “Who should conduct a paediatric forensic examination?
> Any doctor (paediatrician or forensic physician) who undertakes a forensic assessment of a child who may have been subjected to sexual abuse must have particular skills. The child or young person must be assessed fully but

[31] RCPCH/FFLM (2012) *Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse* http://fflm.ac.uk/libraryby/date/#Y2012

appropriately dependent on the age and gender of the child, and the suspected nature and timing of the possible abuse."

A single doctor examination may take place provided the doctor concerned has the necessary knowledge, skills and experience for the particular case. When a single doctor does not have all the necessary knowledge, skills and experience for a particular paediatric forensic examination two doctors with complementary skills should conduct a joint examination. Usually such examinations involve a paediatrician and a forensic physician. However, it may be necessary to involve another medical professional, such as a genitourinary physician or family planning doctor, if the case demands it.

There are numerous advantages to service delivery via a managed clinical network[32]. This includes ensuring that RCPCH standards are met, that services are cost effective, that there is critical mass to provide paediatric facilities and maintain paediatric and forensic skills, and that there are processes in place to ensure on-going training and peer review and psychological supervision for staff.

Commissioners will take account of the findings of local needs assessments to develop managed clinical networks. Currently in most areas the numbers of children and young people seen by SARCs are low compared to the number of adults. Commissioners must be aware that these low figures are likely to be masking unmet need, partly due to lack of services. Numbers are likely to rise when more services become available. A substantial number of child cases will present non acutely (se paragraph below for definition). This is because children who suffer intra-familial abuse are groomed and abused often over long periods and the literature tells us that most present non-acutely. However, if they are victims of stranger abuse, they are more likely to disclose early. Non-acute referrals will still need assessment, but during the day and in a planned way, often after an Achieving Best Evidence (ABE) interview and a social care strategy meeting

There is no nationally agreed definition of acute and non-acute, but for the purposes of this document acute is anything less than three weeks since the last assault (so that acute and resolving physical injuries can be detected before healing occurs) and non-acute is after three weeks or more. The timing of assessment of cases needs to be addressed case by case, balancing any need for urgency of forensic and medical care against the gathering of information and approaching the assessment in a planned, co-ordinated fashion that always has the best needs of the child at the centre rather than the convenience of services. Best evidence is obtained and health care provided as soon as possible after an assault. Forensic sampling can last up to 7 days. Both PEPSE and emergency contraception are best given as soon as possible with PEPSE having to be given within 72 hours and emergency contraception within 5 days. Signs of healing may rarely last up to 3 weeks.

Commissioners may wish to collaborate on developing paediatric managed clinical networks to serve larger areas. A population-based service model is recommended based on a SARC paediatric "hub" serving a wide geographical area and linked to more local "spokes" of community paediatric services. For example, St Mary's in

[32] RCPCH (2012) *Bringing Networks to Life – An RCPCH guide to implementing Clinical Networks* http://www.rcpch.ac.uk/child-health/standards-care/service-configuration/networks-childrens-health-services/networks-childr

Manchester carries out forensic examinations of children and young people referred from Cheshire, Yorkshire, and Derbyshire. Another hub for non-acute victims is at University College London Hospital, which regularly receives referrals from at least eight London Boroughs. The hub refers to local paediatric and other services for on-going care and support. A needs assessment that informed the review of the Havens (London SARCs)[33] highlighted the need for:

- A resilient and specialist paediatrics service across London for both acute and non-acute referrals.
- 24/7 advice from paediatricians or forensic physicians trained in assessing child sexual abuse as per Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine guidance.
- Clearer pathways and protocols between SARC and community paediatricians/specialists/to determine need for forensic medical examination.
- Models of provision to meet individual need.

University College London Hospital 'Safeguarding Clinic'[34] surveyed the 32 boroughs in London to map how complex child abuse cases (including sexual abuse) were managed within each borough. Ten boroughs responded; half had a local clinic. Eight out of ten felt that a pan-London network would be useful and nine out of ten felt that a pan-London telephone advice service would be useful.

Experience from Manchester suggests that awareness of the availability of a co-ordinated service for children and young people uncovers substantial unmet need, resulting in a significant increase in referrals. Of the Manchester hub's referrals, 40% are now children, 71% of whom were acute referrals (nearly half the children were under 13 and 60% of those were acute) (2013 data; personal communication from the Clinical Director).

Care pathway

Children and young people who have been raped, sexually assaulted or abused may need a wider and different range of care pathways than adults.

Care pathways arising from medical consultation may need to include any of the following specialties: social care, sexual health, genito-urinary medicine, gynaecological health (e.g. regarding female genital mutilation) and age appropriate psychological support (Child Health ISVA) which does not reach thresholds for CAHMS, and also where a CAMHS referral may be needed. All will require safeguarding referrals and in some cases the safeguarding issues may be very complex, including trafficking and child sexual exploitation. Consideration will also be required of long term complex health needs (e.g. involving child and adolescent mental health services) and the need for links with local services, given vulnerability (e.g. education, social care). Care pathways should also ensure long-term follow up

[33] Davies, H., Reardon, S. and Stuart, A. (2012). *Sexual Violence in London. A Needs Assessment to Inform the Review of the London Havens Sexual Assault Referral Centres.* Commissioned by the NHS London Sexual Health Programme and the Metropolitan Police. London: MBARC

[34] Hodes, D. (2012) Review of UCLH study on child sexual abuse clinics.

in relation to specific co-morbidities. (Note: some services operate different age criteria; this will need to be taken into account when agreeing local pathways.)

It is important to ensure that paediatric SARC services have an outreach and training component and that they promote awareness of their services and referral pathways to health and social care professionals. SARC services should be designed to take an active role in promoting awareness of the signs and symptoms of child sexual abuse, including child sexual exploitation, as part of an early detection system, working closely with other organisations. Capacity needs to be built into the service in order to develop partnership working.

For example, a review[35] by the London SARCs (Havens) described the patchiness of links with local community services:

> "Those Boroughs where the links are strongest tend to be those either geographically close to the Havens and/or those where Haven Paediatricians are based in their substantive role. An audit of 44 cases in East London between 01/04/2009 and 31/03/2011 identified that only 11 (25%) were followed up by a local borough paediatrician."

Rates of further examination, intervention and referral were low for these followed up cases. Cases of child sexual exploitation in council areas also emphasise the need for appropriate interagency working through Local Safeguarding Children's Boards and in services working together to responsively to meet the needs of the young people affected through clearly shared care pathways and understanding.[36]

The SARC care pathway to be commissioned is shown in Appendix 2. Workforce development plans need to support the commissioning of the pathway to ensure that there is a full complement of appropriately trained staff to offer the best for the children and young people. There is now a greater recognition of this and more training is available.

Quality

The service should be delivered in locations that are safe, fit for purpose and have the necessary facilities to meet the child and young person's needs.

The service provider will ensure that children aged under 16 are examined in line with the RCPCH and FFLM Guidelines (2012) (op.cit.):

> "A single doctor examination may take place provided the doctor concerned has the necessary knowledge, skills and experience for the particular case. When a single doctor does not have all the necessary knowledge, skills and experience for a particular paediatric forensic examination, two doctors with complementary skills should conduct a joint examination".

Please note that a child or young person is defined by the Children Act 1989 as being a person who has not yet reached their 18th birthday.

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[35] Cordon, S. (2013). *Haven Transition Project Report and Recommendations to Commissioners, January 2013 Paediatric Service Sub Group Work stream. Review of service and options appraisal on implementation of a single paediatric rota.* London: The Havens

All cases should be subjected to a strategy discussion and triaged to establish an appropriate and timely response, taking into account all the facts relating to recovery of evidence and the holistic needs and best interest of the child. It is desirable that the child should be seen as soon as is practicable and if possible within 60 minutes of referral where this supports the aim above. Most paediatrics cases are not seen within the target time of 60 minutes and many wait unacceptably long times – over 24 hours (from time of report to police, not from time of police referral to SARC). These are complex cases requiring co-ordinated responses from a range of professionals, and some delays are appropriate and will be partly due to a reflection of the best interests of the child and the complexity of the case. As noted above, in some cases it will be appropriate for a paediatrician and the forensic physician to carry out forensic medical examinations jointly.

The point is for the right people, in the right place, to see the child at the right time. A timely response to acute presentations is important, as:

- Trace evidence may be lost rapidly (within hours).
- Injuries can change/heal rapidly and so need urgent assessment.
- Responses to health needs such as injuries, emergency contraception and PEPSE are most effective when dealt with as soon as possible.

These issues must be balanced with the social/developmental needs of the child and the need to have a strategic, considered approach to a situation.

Non-acute child cases should be seen in a timely manner that takes account of the emotional wellbeing of the child and carer and allows multiagency work to take place, which includes ABE and strategy meetings. Such patients will be seen in different settings depending on local arrangements. Some will be seen in the community clinic with the consultant with a special interest and this clinic maybe in the hospital or part of the local SARC that sees historic cases. For example, some SARCs aim to see a child within three working days. Others will wait until the child can come to the next dedicated clinic (usually within 2 weeks) accompanied by the social worker or police allocated to that child and the paediatrician with the necessary background information in order to undertake a holistic assessment and write a useful report. It must be remembered that children who have been victims of sexual abuse may present with other maltreatment physical, emotional abuse and neglect and so will not necessarily present to specialist SARC settings. As such child sexual abuse needs to be considered in all child protection assessments through a sensitive approach to enquiring.

Young people aged under 18 will be referred to their local safeguarding team. Safeguarding referral will be considered for those aged 18 and over according to local adult safeguarding procedures. Referral pathways to paediatric services such as medical care, psychosocial support or CAMHS must be available.

Monitoring and key performance indicator examples for SARCS are suggested in Appendices 4, 5 and 6 to support local discussions between commissioners and providers.

Law, guidance and standards

Key points

- The Children Acts (1989 and 2004) offer an important legislative framework, together with a range of guidance specific to sexual assault services, including those for children and young people.
- Safeguarding policy includes guidance on information sharing and system wide assurance.

The Children Acts 1989 and 2004

Under the Children Act 1989 (s17) every local authority has a duty to safeguard and promote the welfare of children within their area. The local authority must provide services to ensure that local children are able to achieve and maintain a reasonable standard of health and development and to ensure that individual children's health or development is not significantly impaired, or further impaired. The Children Act 2004 extends this duty to safeguard and promote children's welfare to the local authority's partners, including health, the police, probation, youth offending and education services, by requiring them to co-operate to improve local children's well-being (s10). Furthermore, the Children Act 2004 requires these individual local authority partner agencies to make arrangements for ensuring that the need to safeguard and promote the welfare of children is embedded within the daily functioning of their services (s11). This includes both services that are directly provided and those that are commissioned. This legislation is very important in considering how forensic health services and follow up services should best be commissioned and delivered to children and young people. Agencies and practitioners must think in terms of the actual needs of the child and not simply in terms of areas of responsibility or job descriptions.

The needs of a child or young person can depend upon a range of issues. These include whether the child is pre-pubertal or has additional complex health needs such as mental health problems or learning disabilities. It will also be important to ascertain who has parental responsibility for the child or young person, as they may be a Looked After Child in the care of the local authority.

Safeguarding

Policy is set out in 'Working Together to Safeguard Children' (HM Government, 2013)[37] and NHS England's 2013 Accountability and Assurance Framework. Within the framework of the NHS Mandate[38], these policy documents set out a clear leadership role for NHS England to discharge their safeguarding responsibilities by establishing Health Area Forums, to provide system wide assurance. Local commissioning should comply with this guidance, informed by local Joint Strategic Needs Assessments.

[37] https://www.gov.uk/government/publications/working-together-to-safeguard-children
[38] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

'Working Together to Safeguard Children' (op. cit.) offers further guidance on information sharing (p 15/16):

> "Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:
>
> - All organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the Local Safeguarding Children Board (LSCB).
> - No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care.
>
> "Information Sharing: Guidance for Practitioners and Managers' (Department for Education, 2008)[39] supports frontline practitioners, working in child or adult services, who have to make decisions about sharing personal information on a case by case basis. The guidance can be used to supplement local guidance and encourage good practice in information sharing."

This approach is supported by General Medical Council (GMC) guidance on sharing information[40]

Further guidance on health care roles and competences in relation to safeguarding children and young people is set out in the 2010 Intercollegiate Document[41].

The Home Office response to their consultation on "Introducing Mandatory Reporting for Female Genital Mutilation" (February 2015) needs to be taken into account. The guidance focused on the specifics of the response to FGM and will complement other relevant guidance on child abuse, such as "Working Together to Safeguard Children".

Other relevant law, guidance and standards

A list of other relevant publications is given at Appendix 7.

Workforce

Key points

- There are quality standards agreed or in draft for doctors and nurses.
- Workforce planning needs to take account of the range of skills required and

[39] https://www.gov.uk/government/publications/information-sharing-for-practitioners-and-managers
[40] http://www.gmc-uk.org/Child_protection_guidance.pdf_52579216.pdf
[41] *Safeguarding Children and Young people: roles and competences for health care staff*. Intercollegiate document published by RCPCH on behalf of the contributing organisations (2010) http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Safeguarding%20Children%20and%20Young%20people%202010.pdf

ensure appropriate provision for supervision and mentoring.

As noted previously, the SARC needs to be supported by a range of staff, including doctors, crisis workers, child advocates and counsellors. The service needs to be equipped to respond to the needs of the family as well as the child/young person.

There are not yet national standards for recruitment or training for all staff, nor nationally agreed measures of performance. There are Quality Standards for Doctors Undertaking Paediatric Sexual Offence Medicine (PSOM) (FFLM, 2014)[42]. The Quality Standards for Nurses - Sexual Offence Medicine[43] include requirements for nurses practising with children and young people.

Vicarious trauma can be a serious issue for staff. Workforce plans and job planning should take account of the need for regular supervision (psychological) and mentoring for ALL staff as a way of reducing the risk, in addition to peer review and clinical supervision. This will be cost effective in the long term.

Who Pays: Responsible Commissioner?

The responsible commissioner for forensic examination is the police and for healthcare is NHS England. Support for children and young people to enter and engage in the justice system should be a shared responsibility. The SARC and care pathway should be co-commissioned between NHS England (for the sexual assault public health element), local police forces/police and crime commissioners (for the forensic medical, criminal justice and local rape support element); CCGs (for other health services and CAMHS aspects) and local authorities (for children and family services and preventive public health).

Given the additional needs and complex issues to be commissioned for children, it is likely that the cost per case for a child is similar to that of a complex adult care pathway. An independent costing project has been funded by NHS England to validate this assumption, the summary results and action plan to support this will be available in Q3 2015.

Service Specification

Commissioners are asked to use this summary of key issues with their stakeholders to develop service specifications to improve quality and outcomes for children and young people.

Conclusion

[42] http://fflm.ac.uk/upload/documents/1393326841.pdf
[43] The United Kingdom Association of Forensic Nurses and FFLM (2014) *Quality Standards for Nurses - Sexual Offence Medicine (SOM)* http://fflm.ac.uk/libraryby/date/#Y2014

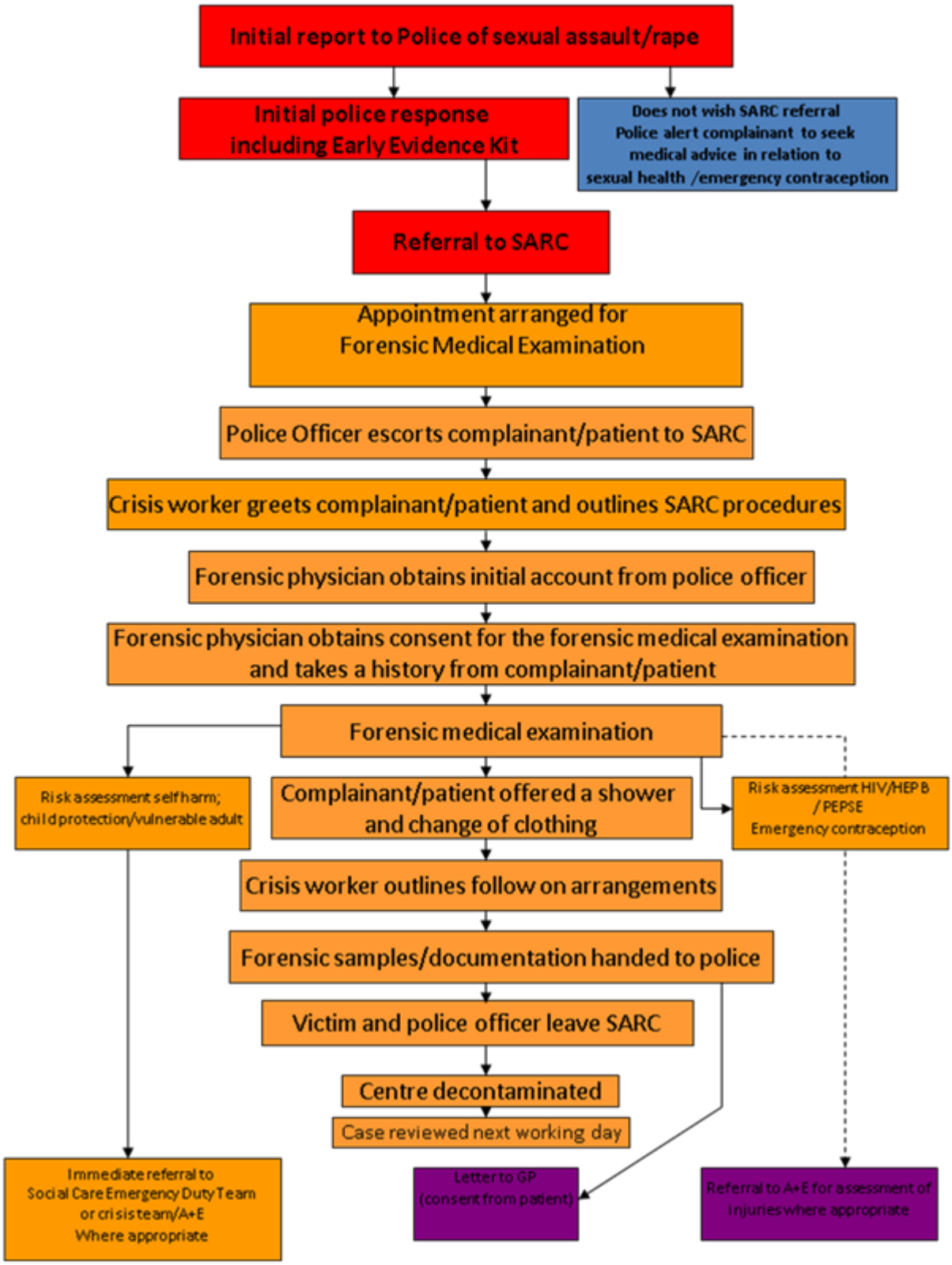
This document summarises key issues in commissioning paediatric SARC services. Given that the number of children and young people raped or sexually assaulted is smaller than the number of adults, and that the expertise required is relatively specialist, commissioners may wish to commission these services on a regional basis.

Appendix 1. Adult Pathways

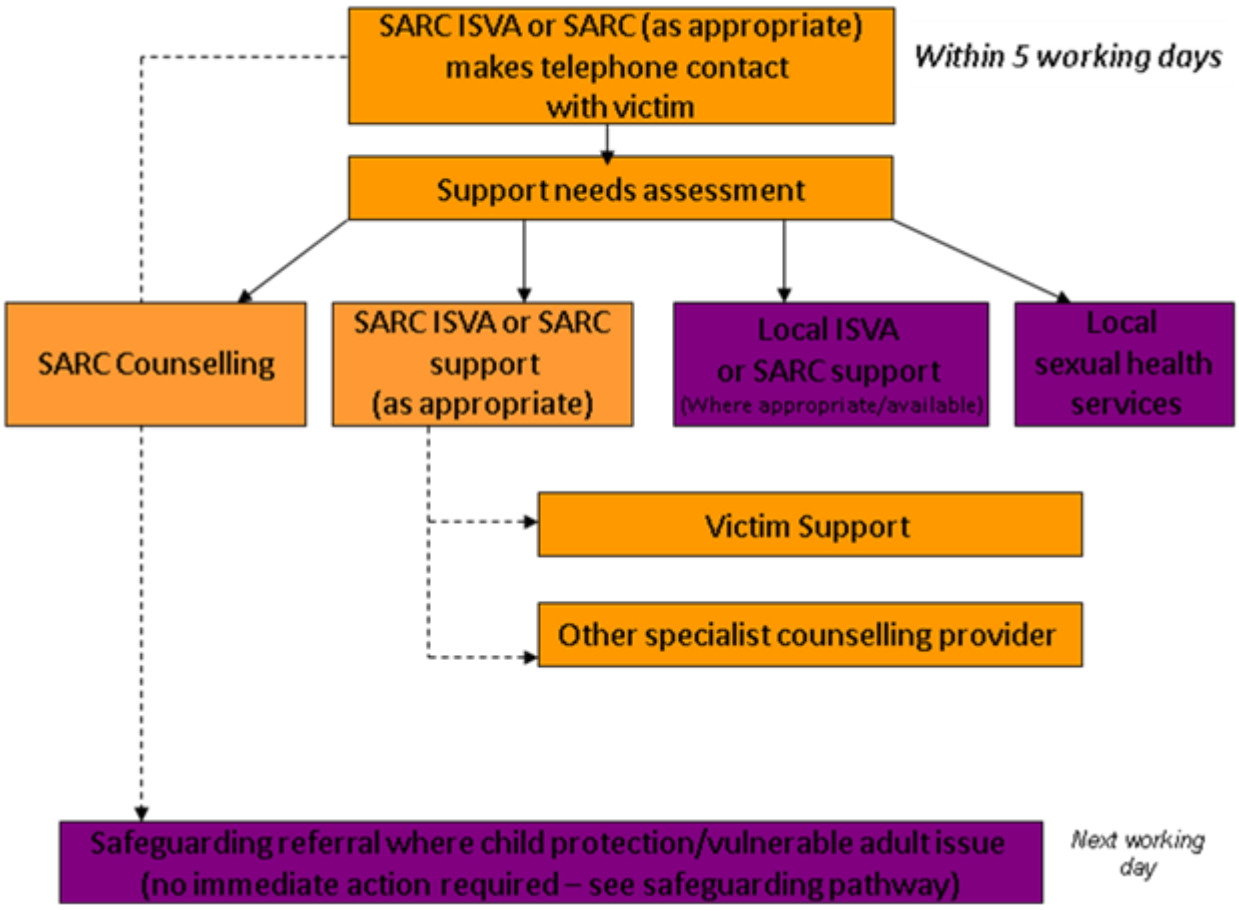
***These are from National Framework Specification and the Service improvement will develop pathways in 2013-14**

- SARC Adult Care Pathway (police case): Initial attendance at SARC
- SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)
- SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)- range of support services
- SARC Follow-up Adult Care Pathway (police case): Counselling services
- SARC Adult Care Pathway (self referral): Initial attendance at SARC
- SARC Follow-up Adult Care Pathway (self referral): SARC ISVA or SARC (as appropriate)
- SARC Follow-up Adult Care Pathway (self referral): SARC ISVA or SARC (as appropriate)- range of support services
- SARC Follow-up Adult Care Pathway (self referral): Counselling services

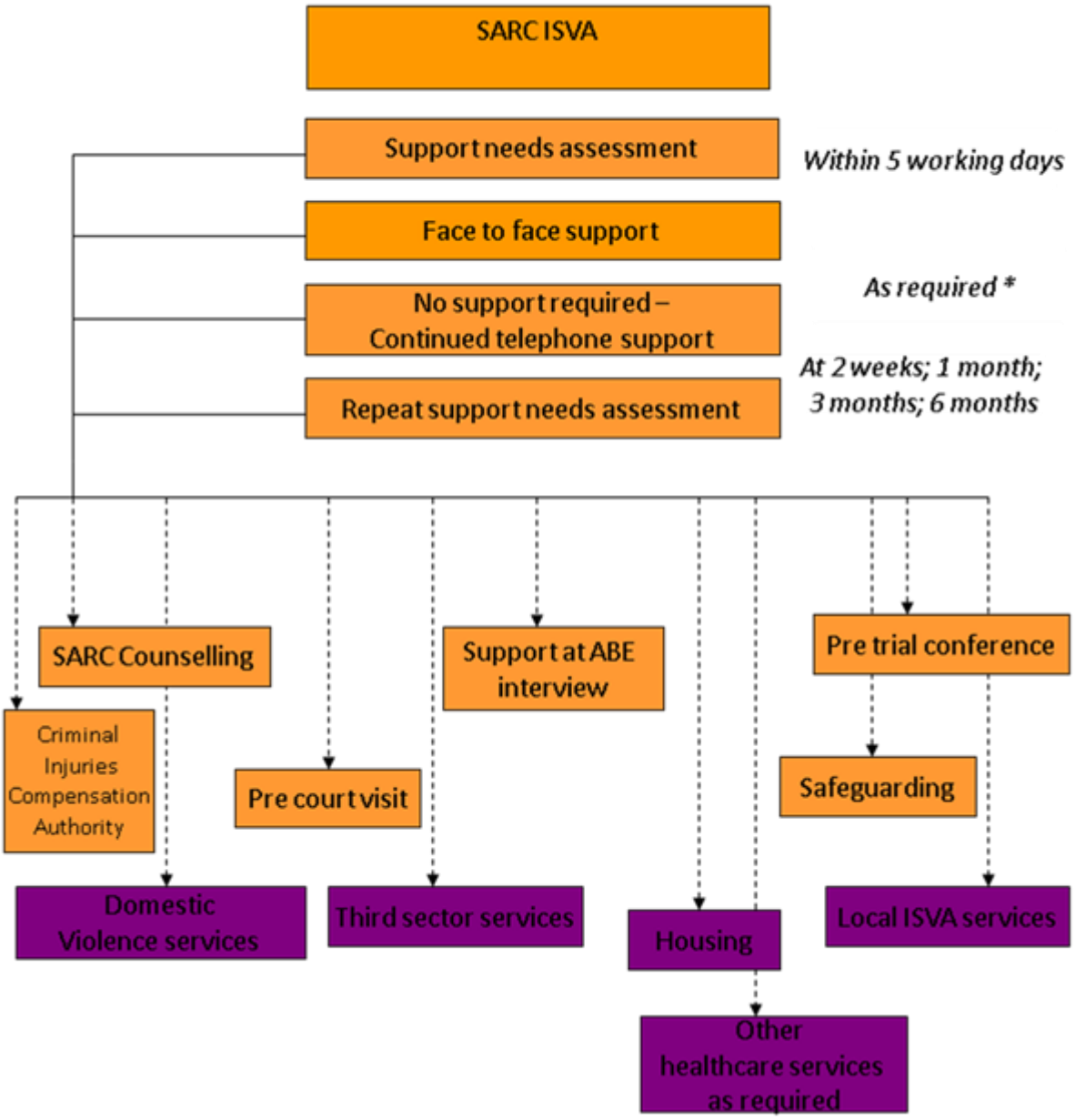
SARC Adult Care Pathway (police case): Initial attendance at SARC



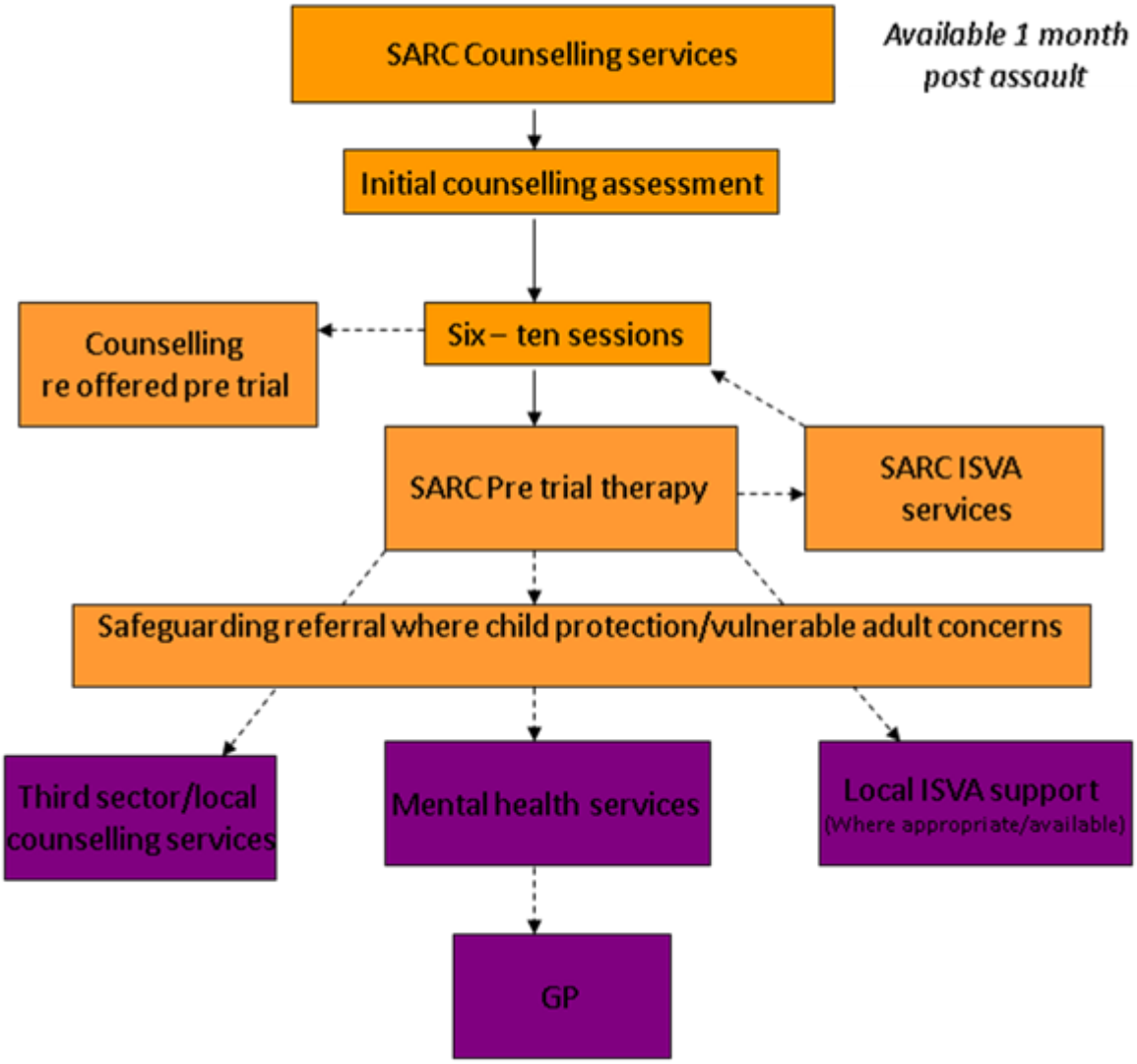
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)



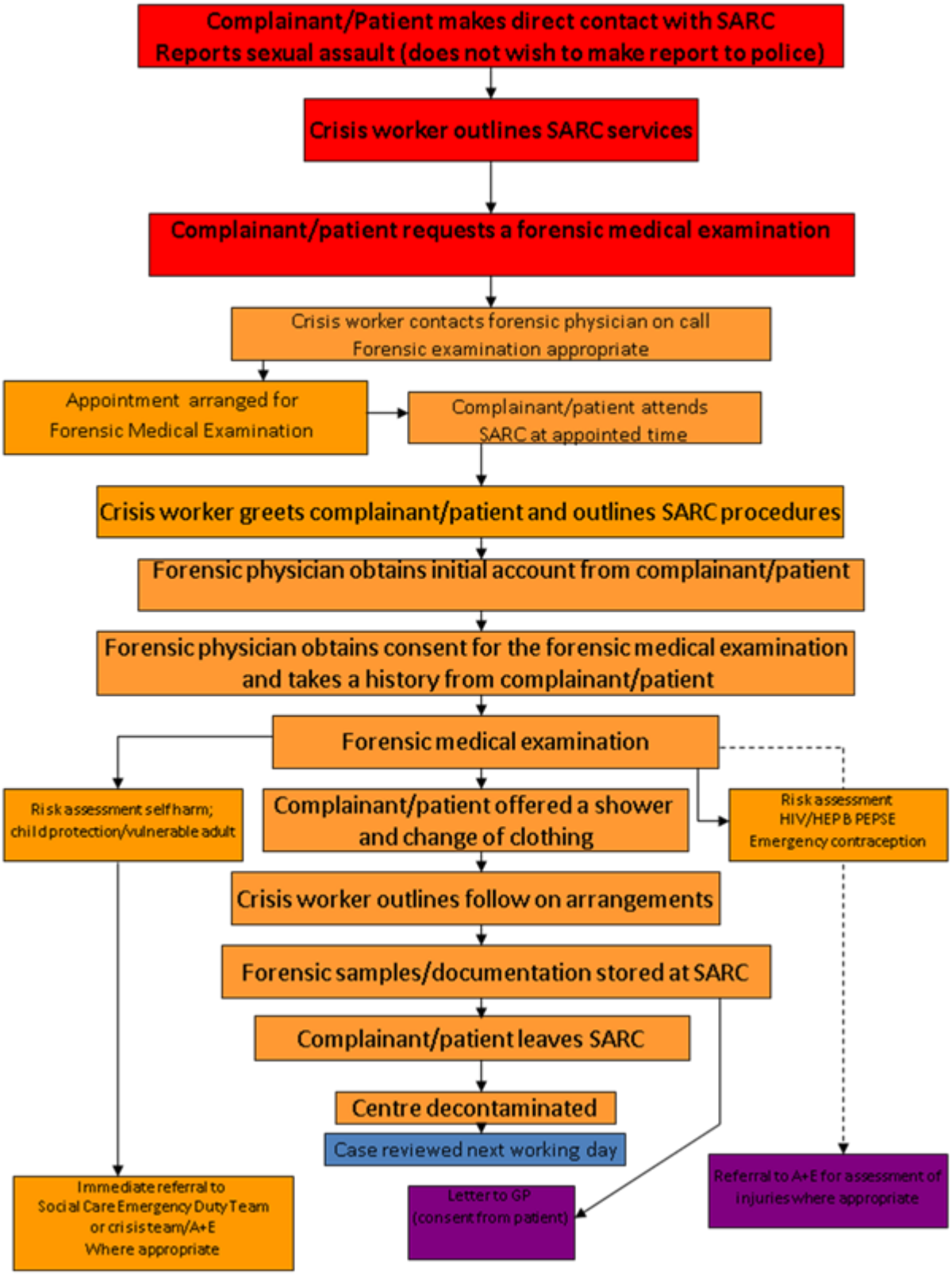
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate range of support services



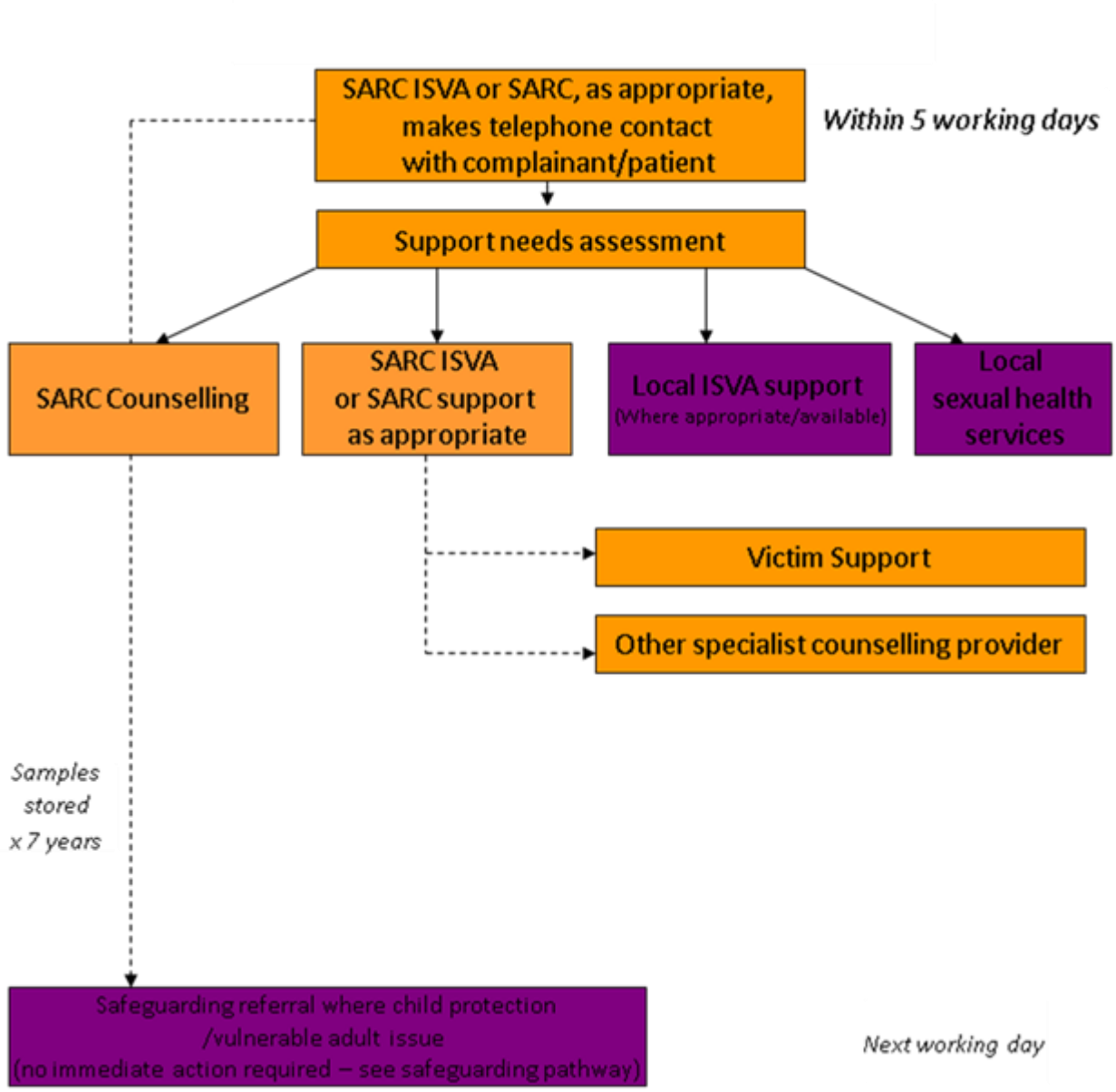
SARC Follow-up Adult Care Pathway (police case): Counselling services



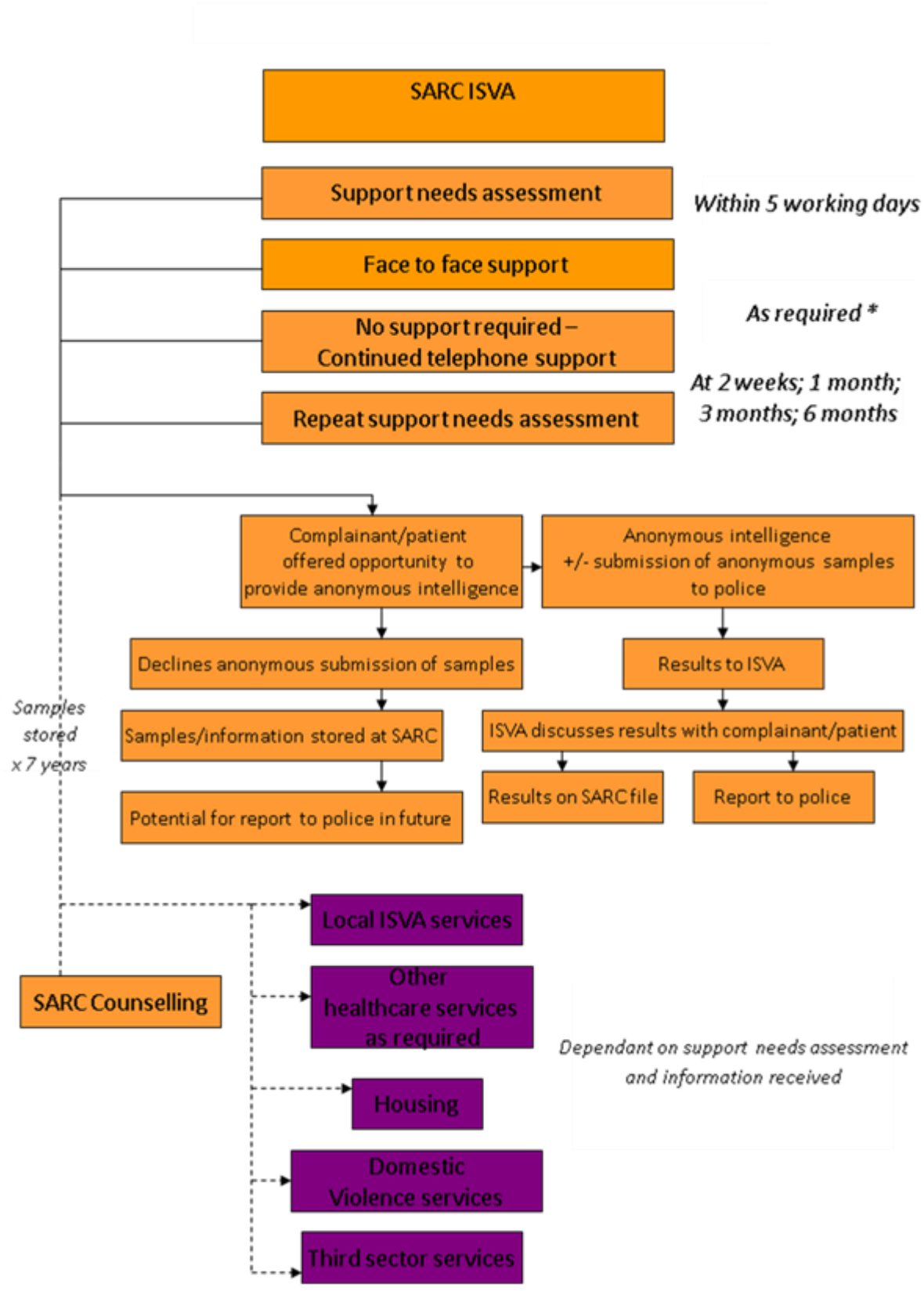
SARC Adult Care Pathway (self referral): Initial attendance at SARC



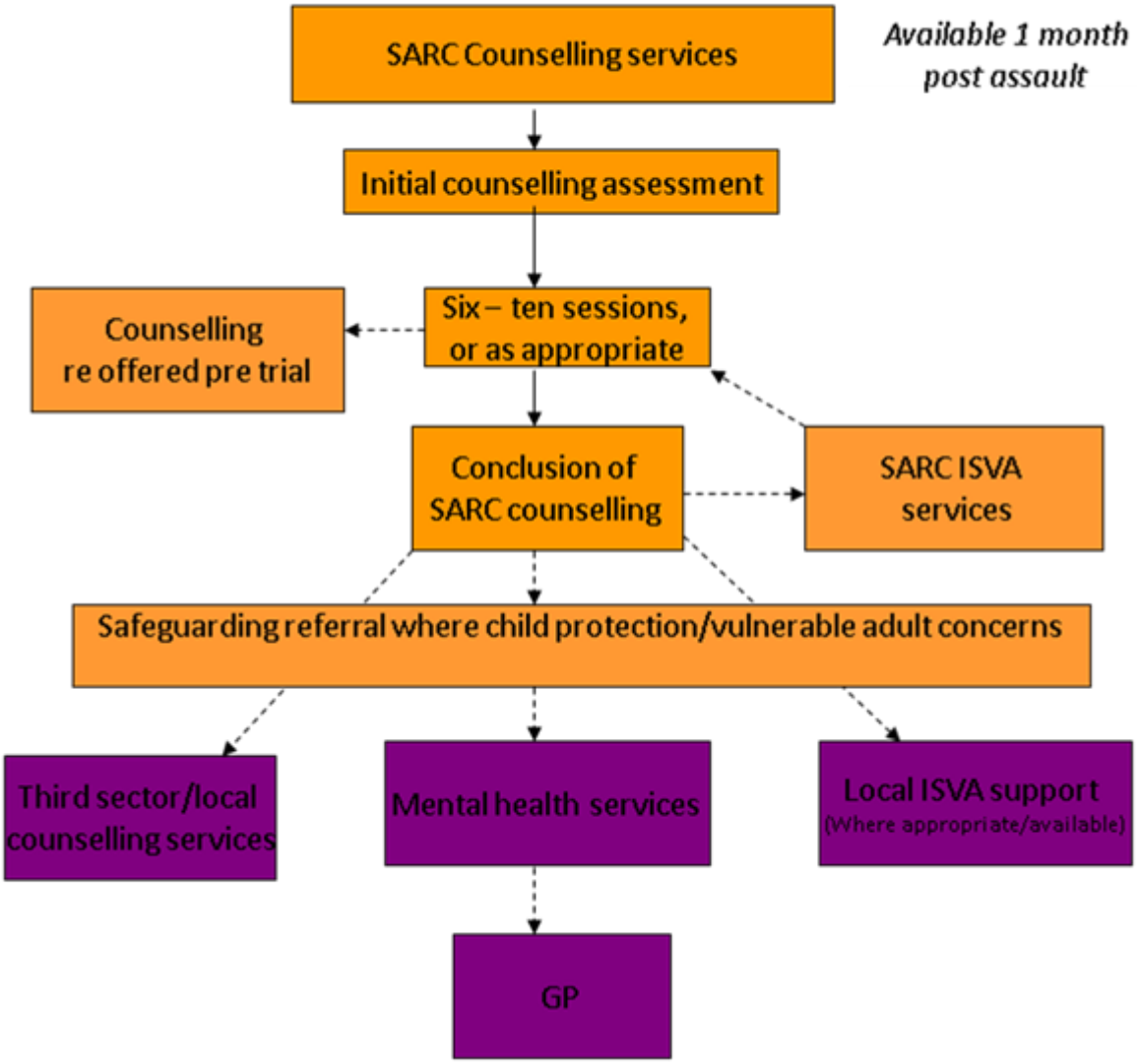
SARC Follow-up Adult Care Pathway (self referral): SARC ISVA or SARC (as appropriate)



SARC Follow-up Adult Care Pathway (self referral): SARC ISVA or SARC (as appropriate)- range of support services

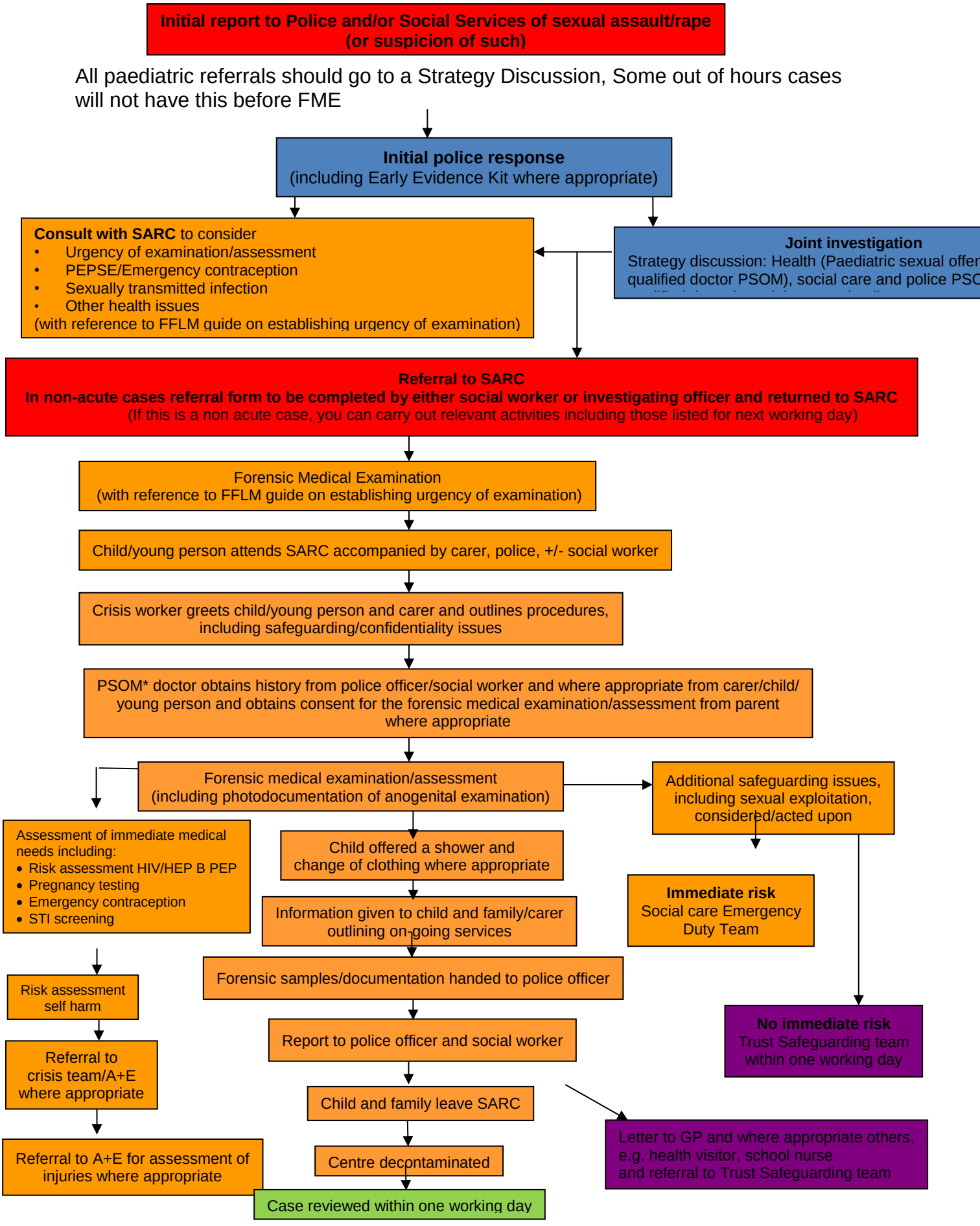


SARC Follow-up Adult Care Pathway (self referral): Counselling services

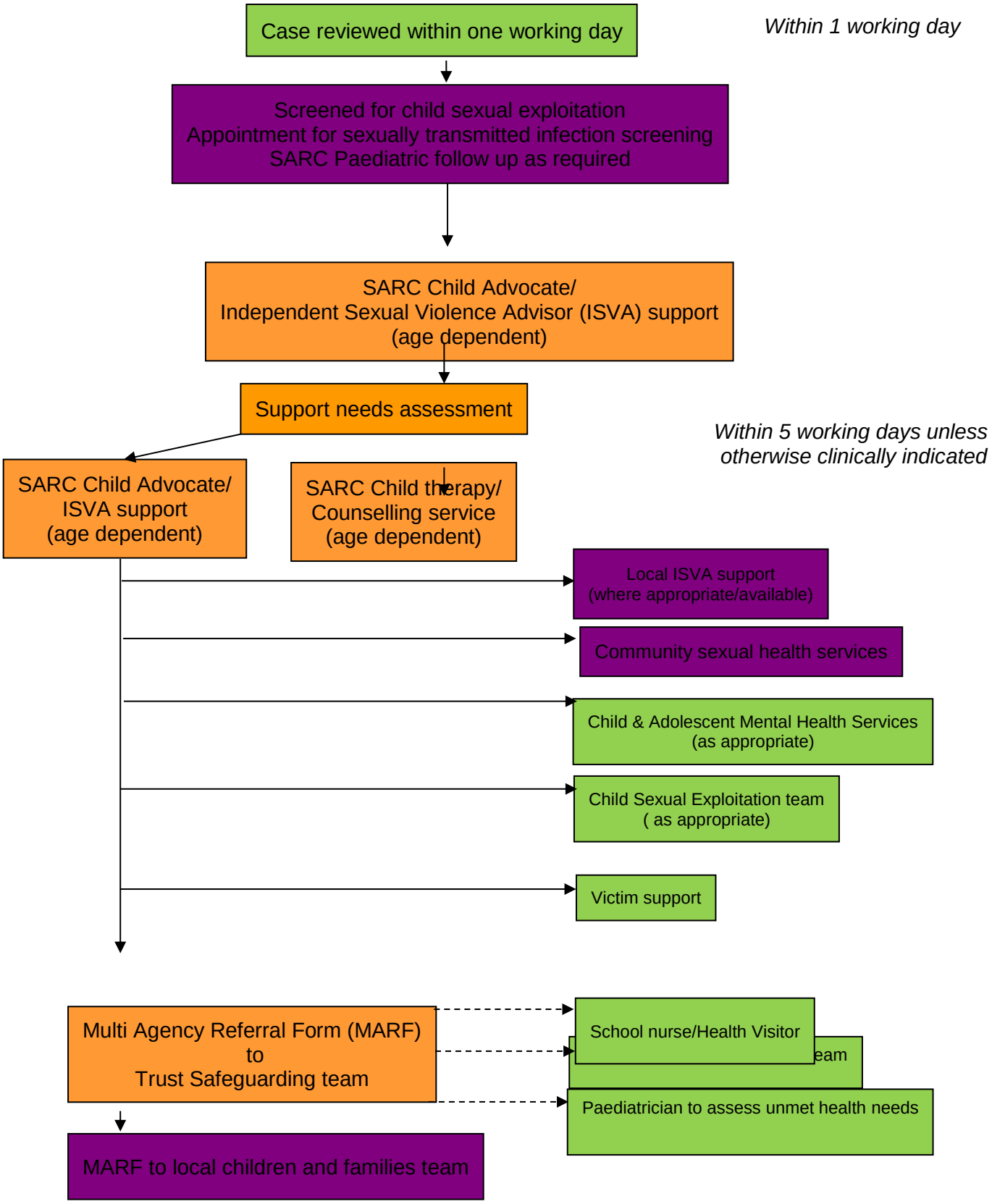


Appendix 2
SARC Children and Young People Care Pathway

Note: self referrals are also included as an entry point



SARC Children and Young People Care Pathway, continued



** Paediatric Sexual Offence Medicine (Quality Standards for Doctors Undertaking Paediatric Sexual Offence Medicine (2014): http://fflm.ac.uk/upload/documents/1393326841.pdf)*

*** Age appropriate*

Appendix 3

Child sexual exploitation: warning signs and vulnerabilities[44]

The following are typical vulnerabilities in children prior to abuse.

- Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, and parental criminality).
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect)
- Recent bereavement or loss.
- Gang-association either through relatives, peers or intimate relationships (in cases of gang‑associated CSE only).
- Attending school with children and young people who are already sexually exploited.
- Learning disabilities.
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families.
- Friends with young people who are sexually exploited.
- Homeless.
- Lacking friends from the same age group.
- Living in a gang neighbourhood.
- Living in residential care.
- Living in hostel, bed and breakfast accommodation or a foyer.
- Low self-esteem or self-confidence.
- Young carer.

The following signs and behaviour are generally seen in children who are already being sexually exploited.

- Missing from home or care.
- Physical injuries.
- Drug or alcohol misuse.
- Involvement in offending.
- Repeat sexually-transmitted infections, pregnancy and terminations.
- Absent from school.
- Change in physical appearance.
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites.
- Estranged from their family.
- Receipt of gifts from unknown sources.
- Recruiting others into exploitative situations.
- Poor mental health.
- Self-harm.
- Thoughts of or attempts at suicide.

[44] Taken from Appendix 3 of “If only someone had listened” Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups – Final Report (2013) http://www.childrenscommissioner.gov.uk/content/publications/content_743

Appendix 4

Annual self-assessment of the key elements of SARCs in the Department of Health, Home Office and Association of Chief police Officers Revised National Service Guide (2009): Data monitoring[45]

National Service Guidance: key Minimum Elements	Self-assessment of how SARCs meet the Minimum Element. Please rate 1, 2 or 3 1=does not meet the minimum element, 2=on the way to meeting the minimum element 3=meets the minimum element
1:Twenty-four hour access to crisis support, first aid, safeguarding, specialist clinical and forensic care.	***Need to state the 1, 2 and 3 measures for each key element in order to undertake assessment***
2: Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant.	
3: Choice of gender of doctor, wherever possible.	
4: Access to forensic doctor and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for children including safeguarding.	
5: Dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high quality forensic integrity and a robust chain of evidence.	
6: The medical consultation includes risk assessment of harm/self-harm, together with appropriate forensic assessment and an assessment of vulnerability and immediate health needs including access to emergency contraception, post-exposure prophylaxis (PEP) or other acute, Child and Adolescent Mental Health Service (CAMHS) or sexual health services and follow-up as needed.	
7: Access to support, advocacy,	

[45] Department of Health, Home Office, Association of Chief Police Officers (2009) *Revised National Service Guide: A resource for developing Sexual Assault Referral Centres* http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570

National Service Guidance: key Minimum Elements	**Self-assessment of how SARCs meet the Minimum Element. Please rate 1, 2 or 3 1=does not meet the minimum element, 2=on the way to meeting the minimum element 3=meets the minimum element**
counselling and follow-up through the service, including support throughout the criminal justice process, should the victim choose that route.	

National Service Guidance: key Minimum Elements	**Self-assessment of how SARCs meet the Minimum Element. Please rate 1, 2 or 3 1=does not meet the minimum element, 2=on the way to meeting the minimum element 3=meets the minimum element**
8: Well co-ordinated interagency arrangements are in place, involving local Third Sector service organisations supporting victims, Local Safeguarding Children Boards (LSCBs) where services are reviewed regularly to support the SARC in delivering to agreed care pathways and standards.	
9: The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive.	
10: Minimum dataset and appropriate data collection procedures in each SARC.	
11:Extent to which your SARC is integrated with local support services for victims.	
12: Strengthening the sustainability of your SARC through joint commissioning and local strategic partnerships, including the Third Sector.	

Appendix 5 – Sexual Assault Referral Centres Indicators of Performance (SARCIPs)

Key:

● NHSE performance schedule

◇ Annual audit

	Key Performance Indicator/Information Measure	KPI Description	Monitored via:
Complaints/Victim Voice	Complaints Initial Response	100% of complaints receive an initial response within 3 working days	●
	Complaints Full Response	100% of complaints receive a detailed response within 25 days. If further action is required beyond the timescale then a subsequent date will be agreed with the complainant	●
	Quarterly Patient Survey	Quarterly patient survey conducted with an action plan drawn up and reviewed monthly	◇

Clinical Suitability/ Supervision	Choice of SoE Examiner (Gender)	Clients offered choice of gender of forensic medical practitioner	◇
	Completion of SOM	% of SOE's who have completed >= 20 hours SOM within the past 6 months	◇
	PDR Agreement	% of SARC Staff who have an agreed PDR for the preceding 12 months	◇
	Peer Review	% of SoE's who have had >= 4 peer review meetings in the previous 12 months	◇
	Mentorship	% of Examiners who have a named mentor	◇
STI/BBV Testing	HIV Testing	% of victims tested for HIV	●
	Sexual Infection Testing	% of victims tested for a sexual infection	●
	Hepatitis B Testing	% of victims tested for Hepatitis B	●
	Hepatitis C Testing	% of victims tested for Hepatitis C	●
PEPSE	Availability of PEPSE	% of victims who were assessed for PEPSE	●

	Uptake of PEPSE	% of victims who received PEPSE within 72 hours	●
	Completion of PEPSE	% of victims who received PEPSE who completed the recommended course	●
Sexual Health	Emergency Contraception	% of victims who received Emergency Contraception	●
	Referral to Sexual Health	% of victims who were referred to sexual health services	●
Response Times	Contact on First Call Out of Hours	% of SoE who respond to first call out of hours	●
	Urban Area Response Times	% of victims seen by a SoE within agreed contract times in urban areas	●
	Rural Area Response Times	% of victims seen by a SoE within agreed contract times in Rural areas	●

Counselling	Counselling Waiting Times	% of patients who waited <= 4 weeks for first counselling appointment	●
	Counselling	% of victims provided counselling with14 days	●
Criminal Justice	Statements	% of Statements received within 14 days of Sexual Offence Examination.	●
	ISVA	% of victims engaging the services of a named ISVA	●
	Assault Reported to Police	% of victims who report incident to the police	●

Sexual Assault Service - Minimum Data Set

Attendance	Male Victims	●
	Female Victims	●
	Attendances in hours	●
	Attendances out of hours	●
Assault Type	Rape	●
	Sexual Assault (Non Rape)	●
	Historic Abuse	●
	Child Abuse	●
	Grooming	●
Contact Type	Forensic Client	●

	Non Forensic Client	●
	Forensic Client Follow Up	●
	ISVA Follow Up	●
	Counselling Follow Up	●

Source of Referral	Police – SOLO	●
	Police – CID	●
	Police – Control Room	●
	Police – Other	●
	Voluntary Sector	●
	Social Services	●
	School	●
	GUM/CASH Clinic	●
	GP	●
	Family/Friends	●
	A&E	●

BME Status	White-British	●
	White-Irish	●
	White-Other	●
	White & Black Caribbean	●
	White & Black African	●
	White & Asian	●
	Indian	●
	Pakistani	●
	Bangladeshi	●
	Asian-Other	●
	Black-Caribbean	●
	Black-African	●
	Black-British	●
	Black-Other	●
	Chinese	●
	Not Known	●

	Not Given	●

Age	<=12	●
	13-15	●
	16-17	●
	18-24	●
	25-34	●
	35-44	●
	45-54	●
	55-64	●
	65 +	●

Definitions

Complaints / Victim Voice

Complaints Initial Response	
100% of complaints receive an initial response within 3 working days	
Numerator	The number of complaints that receive an initial response with 3 working days
Denominator	The total number of complaints received within the reporting period

Complaints Full Response	
100% of complaints receive a detailed response within 25 days. If further action is required beyond the timescales then a subsequent date will be agreed with the complainant	
Numerator	The number of complaints that receive a detailed response within 25 days
Denominator	The total number of complaints received within the reporting period

STI/BBV Testing

HIV Testing	
The % of victims tested for HIV	
Numerator	The number of victims tested for HIV
Denominator	The number of referrals into the SARC during the reporting period

Sexual Infection Testing	
The % of victims tested for a Sexual Transmitted Infection	
Numerator	The number of victims tested for a Sexual Transmitted Infection
Denominator	The number of referrals into the SARC during the reporting period

Hepatitis B Testing	
The % of victims tested for Hepatitis B	
Numerator	The number of victims tested for Hepatitis B
Denominator	The number of referrals into the SARC during the reporting period

Hepatitis C Testing	
The % of victims tested for Hepatitis C	
Numerator	The number of victims tested for Hepatitis C

Denominator	The number of referrals into the SARC during the reporting period

PEPSE

Availability of PEPSE	
The % of victims who were assessed for PEPSE	
Numerator	The number of victims who were assessed for PEPSE
Denominator	The number of referrals into the SARC during the reporting period

Uptake of PEPSE	
The % of victims who received PEPSE within 72 hours	
Numerator	The number of victims that received PEPSE within 72 hours
Denominator	The number of victims that were assessed for PEPSE within the reporting period

Completion of PEPSE	
The % of victims who received PEPSE who completed the recommended course	
Numerator	The number of victims that competed the recommended course
Denominator	The number of victims that received PEPSE

Sexual Health

Emergency Contraception	
The % of victims who received Emergency Contraception	
Numerator	The number of victims who received Emergency Contraception
Denominator	The number of referrals into the SARC during the reporting period

Referral to Sexual Health	
The % of victims who were referred to Sexual Health Services	
Numerator	The number of victims who were referred to Sexual Health Services
Denominator	The number of referrals into the SARC during the reporting period

Response Times

Contact on Frist Call Out of Hours
The % of SoE's who respond to first call out of hours

Numerator	The number of SoE's who responds to first call out of hours
Denominator	The number of out of hours calls

Urban Area Response Times	
% of victims seen by a SoE within agreed contract times in urban areas	
Numerator	The number of victims seen by a SoE within agreed contract times in Urban Areas
Denominator	The number of victims from urban areas

Rural Area Response Times	
The % of victims seen by a SoE within agreed contract times in Rural areas	
Numerator	The number of victims seen by a SoE within agreed contract times in Rural areas
Denominator	The number of victims from Rural areas

Counselling

Counselling Wait Times	
The % of victims who waited <= 4 weeks for first counselling appointment	
Numerator	The number of victims that waited <= 4 weeks for first counselling appointment
Denominator	The number of victims referred for counselling

Counselling	
The % of victims provided counselling within 14 days	
Numerator	The number of victims provided counselling within 14-days
Denominator	The number of victims referred for counselling

Criminal Justice

Statements	
The % of Statements received within 14-days of Sexual Offence Examination	
Numerator	The number of forensic examination statements received within 14 days of a Sexual Offence Examination
Denominator	The number of referrals into the SARC during the reporting period

ISVA

The % of victims engaging the services of a names ISVA	
Numerator	The number of victims engaging with ISVAs services
Denominator	The number of referrals into the SARC during the reporting period

Assault Reported to Police	
The % of victims who report incident to the police	
Numerator	The number of victims who report incident to the police
Denominator	The number of referrals into the SARC during the reporting period

Appendix 6 - Other relevant law and guidance

British Association for Sexual Health and HIV (2011) *UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011*. Updated 2012 http://www.bashh.org/documents/4450.pdf

Care Quality Commission (2009) *Safeguarding children: A review of arrangements in the NHS for safeguarding children* http://webarchive.nationalarchives.gov.uk/20100813162719/http://www.cqc.org.uk/guidanceforprofessionals/nhstrusts/specialreviews/2008/09/safeguardingchildren.cfm Includes introduction of registration system, with legally enforceable powers

Care Quality Commission (2010) *Making a difference to people's lives through modern healthcare and social regulation* http://www.cqc.org.uk/about-us

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Department of Health (2004) *National service framework: children, young people and maternity services* https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services

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- Article 19 – protection from being hurt, violence, abuse and neglect
- Article 34 – protection from sexual abuse
- Article 39 – help for hurt, neglect, abuse, exploitation, torture, Inhuman or degrading treatment or punishment

Appendix 7 Cost of Service by commissioners

Total Cost of Service (NB: IF ONLY A PART OF THE SPECIFICATION IS TO BE COMMISSIONED, PLEASE A) IDENTIFY THE SERVICE AND COSTS AND B) NOTE WHO WILL COMMISSION THE REST OF THE COMMISSIONING TEMPLATE , ESTIMATED COSTS AND REFERRAL PATHWAYS (IF APPROPRIATE).	Baseline carried forward to 2014-15	Revised 2-14-15 baseline Contract				

Appendix 8 Quality and Performance Standards

Quality and Performance Standards - The provider will achieve the quality indicators as outlined in the main NHS Contract for Community Services.			
Quality Performance Indicator	***Threshold***	***Method of Measurement***	***Report Due at Contract Performance Meeting***
Infection control	100%	6 monthly de-contamination check/swabs sent to Forensic Science Service. DNA environmental monitoring sampling should be conducted every two months by the MPS DNA Unit will undertake the sampling.	Quarter 2 & 4
Service User Experience	100%	Recording that client are offered a service user feedback form and if they haven't documented why they haven't. Analysis of information received.	Quarter 2 & 4
Improving Productivity	Trajectory Set	Number of statements requested; numbers of % completed within 10 to 15 working days in accordance to new trajectory set.	Quarter 1, 2, 3 & 4
Care Management	100%	Clients requesting contact by follow-up within 72 hours; Clients referred will have an assessment of suitability for Forensic examination. Report split by MDT; monthly breakdown.	Quarter 1, 2, 3 & 4
Access	90-95%	Total number of FME callouts and % where FME arrived within 1.5 hr of call. Exceptions reporting for non-achievement of either target.	Quarter 1, 2, 3 & 4
Information Governance	100%	Provision of data by all service providers will comply with national and local data reporting requirements	Quarter 1, 2, 3 & 4
Clinical Assessment	100%	All staff who have direct access to clients will have completed competency-based training, according to their scope of practice and fulfilled relevant update requirements and reviews.	Quarter 1, 2, 3 & 4
Reducing Inequalities and improving client outcomes	90 -100%	Supplementary testing to the reference laboratory preliminary reports issued within 7 days and final reports received by clinician within 14 working days (100%) Clients informed of their results and relevant follow-up organised is within 14 days. Clients being offered relevant pharmacological preventions and treatments. (100%) Care Pathways linking all providers to other services which support forensic assault all referrals to be acknowledged within 14 days (90%)	Quarter 1, 2, 3 & 4
Clinical Governance	100%	The service demonstrates compliance with national healthcare standards, including Clinical Governance and Risk management in line with Trust policies	Quarter 1, 2, 3 & 4
Audit	dependent on specific target	Activity will be measured within a comprehensive performance framework that will reflect outcomes, outputs and indicators.	Quarter 1, 2, 3 & 4
Complaints	85%	To respond to all complaints in accordance to Trust policies. Explore and analyse trends of complaints, near misses, AI, and QSR.	Quarter 1, 2, 3 & 4