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National Service Specification for Sexual Assault Referral Centres

Incorporating NHS public health functions agreement 2023-24

Version 1, 26 June 2023

Contents

1. The Purpose of Specification 30

This document is primarily for commissioners and providers of Sexual Assault Referral Centres (SARC) and aims to summarise the key deliverables that NHS England are required to support across the care pathway. It replaces both the Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centre Services (2015) and the NHS public health functions agreement 2019-20 Service Specification No. 30 Sexual Assault Referral Centres.

SARCs are commissioned with contracts for provision held across seven NHS England regional teams which includes London, South East, East of England, Midlands, North East and Yorkshire, South West and North West.

NHS England regional teams are expected to work collaboratively with our Police and Police and Crime Commissioners to deliver SARC services whilst also considering a whole system approach to sexual assault and abuse by working with colleagues including, but not limited to, Integrated Care Systems, education, the specialist sexual violence and sexual abuse voluntary sector and any other stakeholders such as the Care Quality Commission and the Forensic Science Regulator. This is to ensure that SARCs meet the needs of individuals who have been raped, sexually assaulted and/or sexually abused to improve the quality of life and outcomes for that individual, be they adults or children and young people.

This document also outlines the public health functions to be exercised by NHS England in regard to the commissioning of SARCs as well as ensuring that service parity is achieved across England, through specifying what core services need to be in place as well as providing regional population-based considerations.

Whilst NHS England is specifically responsible for commissioning the public health elements of SARC services, this document will consider the entirety of the role and scope of SARCs as it's important to highlight the areas of co-commissioning to ensure a unified approach across the delivery of both SARCs and wider sexual assault and abuse services that are in place.

1.1 The NHS Public Health Functions Agreement

NHS England works closely with UK Health Security Agency and the Department of Health and Social Care to provide and commission a range of public health services.

The NHS public health functions agreements set out the arrangements under which the Secretary of State delegates responsibility to NHS England for certain public health services known as Section 7A services in accordance with the National Health Service Act 2006. This delegation authority remains with the introduction of the Health and Social Care Act 2022.

Underpinning the agreement is the expectation that NHS England commission programmes relating to immunisation, population screening and other services which include public health services for children and adults in secure and detained settings as well as sexual

assault referral centres. Service Specification No. 30 outlines the public health functions to be exercised by NHS England in regard to the commissioning of SARCs. This Service Specification covers the period from 2023-24.

These public health functions within SARCs include[1]

- Screening for sexually transmitted infections such as HIV.
- Applying public health sciences to the planning, commissioning and provision of services.
- The promotion of all types of healthcare.
- The provision of training in public health with due regard to any standards and requirements set by other national bodies.
- Supporting SARCs to understand and utilise population health data, including understanding the existing health inequalities and the evidence base for improving population health and reducing inequalities.
- The development of population health policies and strategies and their implementation.

NHS England, as stipulated above, is responsible for the commissioning of the public health element within SARCs. The responsible commissioner for forensic examination is the Police and/or Police and Crime Commissioners.

1.2 Definitions of sexual assault and/or sexual abuse and risk factors.

A sexual assault is any sexual act that a person did not consent to or is forced into against their will. It is a form of sexual violence and includes rape (an assault involving penetration by a penis, of the vagina, anus or mouth), or other sexual offences, such as groping, forced kissing, child sexual abuse or the torture of a person in a sexual manner.[2]

The Sexual Offences Act 2003[3] provides further legal definitions of the various forms of sexual violence and abuse inclusive of rape, causing sexual activity without consent and child sexual offences.

Sexual assault and/or sexual abuse can happen to anyone; men, women and children; at any age, and may be a one-off event or happen repeatedly. In some cases, abuse can involve the use of technology, such as the internet or social media, which may be associated with sexual grooming, online sexual harassment and trolling.

[1] https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2021-to-2022/nhs-public-health-functions-section-7a-agreement-2021-to-2022-letter-from-dhsc-to-nhse
[2] https://www.nhs.uk/live-well/sexual-health/help-after-rape-and-sexual-assault/
[3] Sexual Offences Act 2003 (legislation.gov.uk)

Whilst sexual abuse can happen to anyone there is a collective evidence base, built up over a number of years, which shows profiles of populations where sexual assault is more prevalent and/or more likely to occur. This includes[4]

- Women are more likely than men to be victims of sexual assault.
- Full-time students are more likely to experience sexual assault than those in any other occupational group.
- Women with disabilities.
- Single adults.
- Unemployed adults.
- Younger age groups.
- Black, Asian and minority ethnic groups.
- Individuals with poor mental health.
- People with diagnosed or non-diagnosed learning disabilities.
- Those with substance misuse problems (including binge drinking).
- Sex workers.

In addition, historical studies also suggest that only around 15% of those who experience sexual violence report to the police and approximately 90% of those who are raped know the perpetrator prior to the offence[5]. This is not necessarily solely in partner relationships that are in domestic settings, though rapes do occur in intimate partner relationships Victims/survivors may also know the perpetrators as a consequence of work, religious affiliations, family affiliations, being associated with student and educational establishments, institutional establishments related to social care as well as prisons, to name a few.

Sexual violence in domestic settings does occur. The definition of "domestic abuse[6]" states behaviour of a person towards another person is domestic abuse if both are aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is abusive if it consists of any physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, psychological, emotional or other abuse and it does not matter whether the behaviour consists of a single incident or a course of conduct.

Section 70 Domestic Abuse Act 2021 introduced the offences of non-fatal strangulation and non-fatal suffocation. The offences came into force on 7 June 2022 and are not retrospective.

Laws and policies also further define child sexual abuse such as the 2018 HM Government report, 'Working together to safeguard children', which states:

[4] Sexual offences victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk)
[5] https://webarchive.nationalarchives.gov.uk/20160106113426/http://www.ons.gov.uk/ons/rel/crime-stats/an-overview-of-sexual-offending-in-england---wales/december-2012/index.html
[6] Domestic Abuse Act 2021 (legislation.gov.uk)

"…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."

Child sexual exploitation is also a form of child sexual abuse. The same statutory guidance, 'Working together to safeguard children', defines "child sexual exploitation" as:

"…where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology".

Services to meet the needs of children and young people who have or may have been raped or sexually abused must be provided in ways that take account of the differences between adults and children and young people. Paediatric services should be considered for children and young people until their 18th birthday. However, some young people between the ages of 16-17 years may prefer to attend an adult service. In these cases, children's safeguarding procedures will still apply.

Children and young people who have, or may have, been sexually abused often experience more than one type of abuse and they may be from families where there are many complex needs. 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 domains[7]. Victims may present acutely, but victims of intra-familial abuse may present many years afterwards. Sexual abuse can worsen the impact of inequalities that are often linked to domestic violence and mostly affect women and vulnerable and disadvantaged people. Long-term effects can include depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide. A higher prevalence is documented amongst children and young people who have experienced sexual assault.

Risk Factors to consider for healthcare professionals providing support interventions include[8]:

- Parental or carer drug or alcohol abuse.
- Parental or carer mental ill health.
- Intra-familial violence or history of violent offending.

[7] https://www.iicsa.org.uk/reports-recommendations/publications/inquiry/final-report/i-victims-and-survivors-voices/part-g-impact-child-sexual-abuse.html
[8] National Institute for Health and Care Excellence (NICE) (2017). When to suspect child maltreatment. NICE.

- Parent with learning difficulties.
- Previous child maltreatment of or by 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.
- Those exhibiting sexually harmful behaviours.
- Conflict-related sexual violence.

There are also many understandable reasons[9] individuals do not report sexual violence, including:

- Inadequate support systems.
- Shame.
- Fear of retaliation.
- Fear of being blamed.
- Fear of not being believed.
- Fear of being mistreated and/or socially ostracized.

Modern slavery which also encompasses human trafficking can also give rise to exploitation such as forced labour, slavery, servitude, forced criminality, removal of organs and sexual exploitation. In most cases involving human trafficking for the purpose of sexual exploitation, the victim is female; however, there are also male victims. The majority of female victims of trafficking identified in the UK are exploited through being forced into sex working. Many are beaten, raped and abused.[10] The forcible or deceptive recruitment of women and girls for forced sex working or sexual exploitation is another form of gender-related violence.[11]

Male victims of sexual exploitation may have additional barriers to disclosure. There is currently a limited research base to assess the exact extent of adult male sexual exploitation. Detailed guidance exists for children that are sexually exploited.[12]

There is no typical experience of people who have been trafficked for sexual exploitation. Some are held captive, assaulted and violated. Others are less abused physically, but are psychologically tormented, and live in fear of harm to themselves and their family members.

Additional areas to consider where sexual assault and/or sexual abuse may occur is county lines which is defined in the Serious Violence Strategy and states: ‘County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move

[9] WHO_RHR_12.37_eng.pdf
[10] modern slavery statutory guidance, non statutory guidance v2.11 (publishing.service.gov.uk)
[11] https://www.gov.uk/crime-justice-and-law/violence-against-women-and-girl
[12] Department for Education (publishing.service.gov.uk)

[and store] the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

Evidence suggests that those that experience sexual violence, irrespective of gender, may experience similar mental health, behavioural and social consequences[13] [14][15]. However, women and girls bear an increased burden of injury and disease from sexual violence and coercion[16]. This is due to women and girls being the largest cohort of sufferers of sexual violence and also because they are vulnerable to sexual and reproductive health consequences such as unwanted pregnancy, unsafe abortion and a higher risk of sexually transmitted infections. However, it is important to note that men are also vulnerable to sexually transmitted infections.

1.3 Prevalence

Current prevalence of rape, sexual assault and/or abuse is challenging to measure for adults, children and young people. This is predominately due to the hidden nature of these crimes and the barriers that individual sufferers may have in coming forward. Other factors include the lack of understanding and/or distrust of the criminal justice system.

The Office of National Statistics Crime Survey for England and Wales (CSEW), for the year ending March 2022, showed that 2.7% of adults aged 16 to 59 years had experienced sexual assault (including attempted offences) in the last year. There was no significant change compared with the year ending March 2020 (2.2%), the last time the data was published prior to the COVID-19 pandemic. The CSEW estimated that 2.3% of adults aged 16 years and over had experienced sexual assault (including attempted offences) in the last year.

However, sexual offences, recorded by the police, were at the highest level recorded within a 12-month period (194,683 offences) in the year ending March 2022, a 32% increase from the same period in 2021. Within these annual figures, the number of recorded sexual offences were lower during periods of COVID-19 lockdown but there have been substantial increases since April 2021.

Of all sexual offences recorded by the police in the year ending March 2022, 36% (70,330) were rape offences. This was a 26% increase from 55,678 in the year ending March 2021. Other sexual offences increased by 35% to 124,353 compared with 92,212 the previous year.

High levels of non-reporting combined with changes in reporting trends can have a significant impact on sexual offences recorded by the police. Prior to the coronavirus

[13] Andrews G et al. Child sexual abuse. In: Ezzati M, et al, eds. Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors. Geneva, World Health Organization, 2004

[14] Dube SR et al. Long-term consequences of childhood sexual abuse by gender of victim. American Journal of Preventive Medicine, 2005, 28(5):430–38

[15] Patel V, Andrew G. Gender, sexual abuse and risk behaviours in adolescents: a cross-sectional survey in schools in Goa. National Medical Journal of India, 2001, 14(5):263–67

[16] Andrews G et al. Child sexual abuse. In: Ezzati M, et al, eds. Comparative quantification of health risks: global and regional burden of disease attributable to selected major risk factors. Geneva, World Health Organization, 2004.

pandemic, the number of police recorded sexual offences was well below the number of victims estimated by the crime survey, with fewer than one in six victims of rape or assault by penetration reporting the crime to the police.

The latest figures may reflect a number of factors, including the impact of high-profile incidents, media coverage, and campaigns on people's willingness to report incidents to the police, as well as a potential increase in the number of victims.

The CSEW also provides an indicator of child sexual abuse by measuring the prevalence of adults who experienced sexual abuse before the age of 16 years. This includes sexual abuse perpetrated by adults or children.

- The Crime Survey for England and Wales (CSEW) estimated that 7.5% of adults aged 18 to 74 years experienced sexual abuse before the age of 16 years (3.1 million people); this includes both adult and child perpetrators.
- The abuse was most likely to have been perpetrated by a friend or acquaintance (37%); around a third (30%) were sexually abused by a stranger.
- The majority of victims did not tell anyone about their sexual abuse at the time, with "embarrassment" cited as being the most common reason.
- In the year ending March 2019, the police in England and Wales recorded 73,260 sexual offences where the victim was a child.
- On 31 March 2019, 2,230 children in England were the subject of a child protection plan (CPP) for experience or risk of sexual abuse.
- Sexual abuse has become the most common type of abuse counselled by Childline in recent years; it was also the most commonly reported type of abuse by adults calling the National Association for People Abused in Childhood's (NAPAC's) helpline in the year ending March 2019

2. The role of Sexual Assault Referral Centres

2.1 SARC Aims

SARCs provide accessible support to victims/survivors of rape, sexual assault and/or abuse, including health care and onward referral to other health, social care services and specialist voluntary sector sexual violence and abuse services. They deliver services both to recent and non-recent victims/survivors and can support individuals with the opportunity to make a police report if they choose to do so. For children and vulnerable adults who lack capacity, the SARC is available where concerns about possible sexual abuse have arisen in the absence of a disclosure.

The term ‘SARC’ does not just refer to a building, but embraces a concept of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways. This allows co-ordination with wider healthcare, social care and criminal justice processes to improve health and wellbeing, as well as criminal justice outcomes for adult and child survivors of sexual assault.

The SARC ethos must be person-focused. Service users must feel that a SARC is a place where they will be supported, where their needs will be put first, and where they will be treated with dignity and respect. An effective SARC will not simply provide services but will help an individual understand the options available to them and facilitate their choices with care.

Services must also follow trauma informed practices and ensure that the focus is not “What’s wrong with the service user” but rather “What happened to the service user”.

A shift to a trauma informed focus requires everyone in the service to see a person in distress as reacting to the context of their experiences and understanding that everyone in a service (staff and service users) has unique and important wisdom about their own needs. It also requires acknowledgement that people who offer the help may also have been subject to traumatic contexts.[17]

The approach is grounded in the understanding that trauma exposure can impact an individual’s neurological, biological, psychological and social development – thus shaping a person’s world view and relationship development[18].

Being trauma informed means assuming that people are more likely than not to have a history of traumatic experiences, and that these experiences may impact on their ability to feel safe within or develop trusting relationships with services and their staff.

Trauma informed practice is not designed to treat trauma related difficulties. It seeks to address the barriers that those affected by trauma can experience when accessing care and services by using the six principles of trauma informed practice:

- safety
- trust
- choice
- collaboration
- empowerment
- cultural consideration

[17] Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: a vital paradigm shift. New directions for mental health services, 2001(89), 3-22.
[18] https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice#working-definition-of-trauma-informed-practice

The majority of SARCs are not designed to offer long term support since those that access SARCs usually attend the service for a limited time period which normally constitutes a few hours. Attending a SARC repeatedly may cause re-traumatisation since service users may re-experience thoughts and feelings relating to information previously shared as well as physical intimate examinations that may have occurred. Re-traumatisation is generally triggered by reminders of previous trauma which may or may not be potentially traumatic themselves.

The SARC also needs to recognise that some individuals will need to attend on more than one occasion, particularly those that have suffered repeated sexual violence. In these instances, the SARC will need to ensure that the ethos continues to be person centered and supportive.

Services provided for those who have experienced a recent sexual assault and abuse must aim to provide highly responsive, personalised services delivered by trained and competent practitioners in settings that respect privacy and that are easy to access. These services should include specialist medical and forensic examinations, practical and emotional support and support through the judicial process. Early engagement and treatment initiation also enhances the chances of both good criminal justice and health outcomes. This needs to be balanced with other factors such as the service user's wishes and time since assault.

Since SARCs are time limited they will need to work closely with services within the SAAS pathway such as NHS Talking Therapies and those provided by the specialist sexual violence and sexual abuse voluntary sector to improve outcomes for all victims of sexual abuse and violence and support longer-term recovery.

2.2 Collaborative commissioning and partnership working

SARCs operate within a wider landscape of Sexual Assault and Abuse Services (SAAS) which spans several systems and government organisations including health, social care and criminal justice partners.

The number of different commissioners, wide range of providers, specialist and voluntary sector organisations who deliver these services can result in fragmentation in delivery of sexual assault and abuse services locally. This fragmentation can result in poor outcomes for individuals and creates a significant challenge to our ambition of meeting the lifelong needs of individuals that have experienced sexual assault and abuse. Therefore, it is imperative that SARC providers and commissioners work in collaboration with other agencies to ensure that the needs of individuals that have been subject to rape, sexual assault and/or abuse are met.

Service users will need different levels of care and different types of support at different times in their lives and this will be dependent on their circumstances, the pace of their recovery and the level of expertise and support received at the point of disclosure. The commissioning and provision of support services cannot be channelled through a linear pathway of care since a one-size-fits-all approach will not recognise the uniqueness of those approaching services.

Prior to disclosure, several different service providers may have been involved in an individual's care and support, for example, as a direct result of drug or alcohol dependency,

self-harm, sexual risk taking and some criminal behaviours. The reverse can also be true since rape, sexual assault and/or abuse can happen to anyone and not all individuals subjected to harm will have previous connections with other services. Therefore, SARCs should not be established as stand-alone services but must be considered as mainstream provision that is linked to other services through care pathways and strong partnerships across health and social care, the specialist sexual violence and sexual abuse voluntary sector and the criminal justice system.

With the enactment of the Health and Care Act (2022), 42 Integrated Care Systems (ICSs) were established across England on a statutory basis on 1 July 2022. ICSs are underpinned by an NHS Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). An ICS will set out to achieve four aims:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

ICBs are required to prepare a joint forward plan (JFP) before the start of each financial year. The JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs, including addressing the particular needs of victims of abuse (including domestic abuse, sexual violence and sexual abuse, whether of children or adults).[19] This provides an opportunity to drive collaboration and develop partnerships within the wider SAAS pathway.

2.3 Service User Engagement

In upholding the NHS Constitution, NHS England is committed to ensuring that service users are at the centre of every decision that NHS England makes. Service users and advocacy organisations are the most important voices in service re-design and development in terms of their ability and power to help others recognise and understand the scale, complexity and impact of sexual violation. Involving service users and advocacy organisations in the improvement and development of services offers an opportunity for them to be heard without judgement or stigmatisation. It is vital that we use their expertise to influence service improvement through direct experience.

2.3.1 When involving service users in the development and improvement of services, it is important to consider a range of involvement options. For example, engaging with men may need a different approach to that used to engage with women and likewise for children and younger people.

2.3.2 All providers must demonstrate real and effective service user participation.

2.3.3 It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation and offer their service users the right

[19] newbook.book (legislation.gov.uk)

information at the right time to support informed decision-making about their treatment and care.

2.3.4 Providers of SARC services must look to provide appropriate and accessible means for service users to be able to express their views about, and their experiences of services, making best use of the latest available technology and social media as well as conventional methods such as anonymous suggestion boxes as well as taking direct verbal or written feedback from service users.

2.3.5 Information collected from service users must be used to improve services as well as complementing existing provision. Providers should instil a "you said, we did" approach and ensure that appropriate feedback mechanisms are in place to allow service users who choose to be kept informed of how their feedback was managed.

2.3.6 As well as capturing service users' feedback from a range of collection methods, providers must demonstrate robust systems for analysing and responding to that feedback.

2.3.7 Each commissioning region must also set up local Lived Experience Groups to enhance and support local delivery of services as well as provide a local voice across partnerships in the region expressing the needs of service users and improving outcomes for those that use SARC services. Family and carer views must also be valued where lived experience voices are promoted. Those on Lived Experience Groups should also have continuous support offered, where needed, to manage and minimise any trauma that they may be experiencing.

2.3.8 We have a responsibility for public involvement and consultation under section 13Q of the National Health Service Act 2006. NHS England has a duty to consult individuals to whom services are being or may be provided, in the planning and development of commissioning arrangements for those services. The Health and Care Act 22 extends this to include "carers and representatives" of people receiving a service or who may do so.[20]

2.3.9 To continually improve service provision every service user will be given a questionnaire to complete. Returned questionnaires will be reviewed regularly to inform actions plans.

2.3.10 The service provider must ensure the provision is trauma informed and based on the following principles.

- Ensure all service users are empowered to make informed choices.
- Ensure that all service users are aware of the range of options available to support them (e.g. ISVA / mental health / substance misuse / GUM and sexual health etc).
- Ensure all service users feel in control and are aware of and have access to services that are sensitive to their individual needs.
- Provide a non-judgmental service based on respect and dignity.

[20] https://www.legislation.gov.uk/ukpga/2012/7/contents

- Enable a safe environment for service users.
- Be caring and empathic to service users.
- All contacts including assessments and examinations will be carried out with privacy in an unhurried, empathetic and sensitive manner with excellent documentation.
- Ensure the best possible care of the service user by reducing the risk of further harm, identifying and assisting with any associated physical or psychological issues to promote recovery.

2.3.11 Lived experience feedback tools must be designed to incorporate feedback on the above principles.

3. Core Services

The following two sections are divided into core services that a SARC must deliver and population-based considerations, where each of the seven regional NHS England teams will consider what is most pertinent for delivery dependent on regional populations. Core services are there to ensure that service users obtain parity when accessing SARCs from one geographical location to the next.

Regional commissioning teams must ensure that providers deliver a SARC service which ensures that each individual service user receives the most appropriate care to meet their needs. This will take place in a timely manner, support the service user through their recovery, assist the investigative process if they wish to pursue a criminal justice outcome and ultimately reduce the amount of long-term care needed and future demand on the NHS.

3.1 Inclusion and exclusion criteria for services

SARC services must be accessible to any person in England that needs support as a consequence of experiencing sexual assault and/or abuse anywhere and at any time (recent or non-recent). This includes children and vulnerable adults (who do not have capacity) where a statutory agency has concerns that sexual abuse may have occurred. This support is irrespective of age, gender, sexual orientation, disability or any other protected characteristic.

3.2 Operational times

A SARC single point of contact (SPOC) will operate in each region and will provide advice and guidance to Police colleagues, health and social care staff, potential service users who are self-referring, inclusive of providing advice to those that are supporting potential service users. The SPOC must be available 24 hours a day, 7 days a week, including public holidays. The SPOC will arrange for acute medical and forensic examinations in a timely manner that considers the wishes and needs of the service user; the need to achieve the forensic window; and the availability of a forensic pod.

SPOCs will also have the ability to book appointments for further interventional support mechanisms for non-recent cases as well as the ability to provide guidance and sign posting initiatives where an individual does not fit the inclusion criteria for the SARC.

For recent cases, 24 hour access to crisis support, first aid, safeguarding, specialist clinical and forensic care is required. These services will be delivered in dedicated SARC premises where interventional support is age appropriate when considering both children and adults.

Providing timely attention and seeing individuals as soon as possible enhances the chances of good criminal justice and health outcomes. This needs to be balanced with other factors such as service user wishes and time since assault.

3.3 Comprehensive assessments

SARCs must provide equitable access to individually tailored care packages. This care is based on comprehensive assessments which include identifying risks with a choice of action at every stage of care, clinical and non-clinical care and support, forensic examination and onward referral to appropriate services.

Assessments will be holistic in approach and ensure that the principles of making every contact count are embedded into services. Providers must develop and maintain an organisational plan to ensure that staff use every contact as an opportunity to maintain or improve the health and wellbeing of service users.

Assessments will be conducted by an appropriately trained workforce and include support for both recent and non-recent cases. The assessment should include:

- The service user's emotional and mental health needs which may include onward referral to a mental health team, GP, psychology service or referral for counselling.
- Social care issues in the aftermath of rape and sexual assault e.g. housing, immigration, safeguarding adults and children.
- Risk assessments to identify and support those with vulnerabilities and self-harm, sexual health, suicidal ideation and domestic abuse.
- Additional support mechanisms required as a consequence of neurodiversity, learning difficulties, learning disabilities and physical disabilities.

3.4 Forensic medical examinations

Where forensic medical examinations need to be conducted, the Forensic Healthcare Practitioner must ensure they have received an account of the rape / sexual assault either from Sexual Offences Investigative Techniques (SOIT) police officers or SARC Crisis Workers to inform their forensic medical examination. The Forensic Healthcare Practitioner is required to obtain a medical account from the service user (or parent/care giver or professional supporting the child) that will assist in maximising both medical and forensic evidence.

For children who have not disclosed and vulnerable adults who may not have capacity the Forensic Healthcare Practitioner must take a skilled and detailed history of the grounds for concern, which may include a detailed family/household chronology of behaviour or physical symptoms. Information should be obtained from the child, parent and accompanying professionals such as social worker.

The forensic medical examination is a comprehensive assessment which includes addressing complex issues of capacity and consent, clinical history and full physical examination. Service users are offered an examination which proactively looks for unmet health/developmental needs and which also documents physical signs of neglect, physical abuse and sexual abuse. This will include:

- Clinical history (to include sexual health, surgical, gynaecological, obstetric, dermatological and mental health).
- Drug and alcohol history.
- Gynaecological and contraceptive history.
- Assessment of presenting symptoms and injuries (e.g. vaginal bleeding).
- Post assault sexual health (risk of pregnancy and infection).
- Other health interventions/considerations (medication, allergies).
- Safeguarding risk assessment.
- Collection of forensic samples to support the forensic strategy.

SARC providers and their Forensic Healthcare Practitioners must also ensure:

3.4.1 Forensic examinations are timely and reference the FFLM Guide to establishing the urgency of sexual abuse examination.

3.4.2 High quality photo-documentation using a colposcope or colposcopic-equivalent, adhering to guidelines for maintenance, labelling and storage.

3.4.3 The provider must deliver a SARC service which meets the standards set out by the Operational-procedures-and-equipment-for-forensic-medical-examination-rooms-in-SARCs-FSSC-Apr-2023.pdf (fflm.ac.uk)

3.4.4 That correct forensic samples are obtained, packaged and labelled correctly and provided for analysis following consultation with the investigating officer, including intimate samples. The collection will be based on the judgement of the Police in conjunction with the Forensic Healthcare Practitioner. With self referrals the Forensic Healthcare Practitioner will determine the forensic strategy.

3.4.5 Forensic Health Practitioners must have an understanding of what forensic samples may be appropriate to the investigation and how these samples should be obtained and packaged according to relevant Forensic Science Provider and FFLM guidance.

3.4.6 Secure storage of medical records is provided ensuring they are in line with NHS England policy.

3.4.7 Secure storage of forensic samples is provided ensuring procedures are in line with the FFLM's 'Recommendations for the Collection of Forensic Specimens from Complainants and Suspects.

3.4.8 Appropriate medical and forensic interventional support is provided to all service users presenting with sexual assault and/or sexual abuse where the presenting need also indicates non-fatal strangulation in accordance with https://fflm.ac.uk/resources/publications/non-fatal-strangulation-in-physical-and-sexual-assault/

3.4.9 Support the criminal and family justice process through the collection of samples, interpretation of findings, and information sharing. This includes clear safeguarding reports, court statements and being a professional witness when required.

3.4.10 Understand court proceedings and communicate effectively when required to give verbal testimony/professional opinion at court, and recognise the differences between Child Protection, which has a threshold of 'on the balance of probabilities' and the CJS which is related to a specific offence and is 'beyond all reasonable doubt'.

3.4.11 Ensure accurate written communication by way of a range of reports for child protection processes, including Child Protection reports on all children seen up to 18 years, police statements, medical reports for social services and court, and written reports for multi-agency strategy meeting and child protection conferences, to ensure medical, forensic and safeguarding needs are met, and information is shared appropriately.

3.4.12 Apply the evidence-base to form professional opinion and explain that evidence base (and limitations) clearly to others such as Police, social workers or courts in verbal or written forms.

3.4.13 There is a process for the production of statements and reports in a format that takes due regard to the disclosure obligations, the requirements set out in the Criminal Procedure Rules and Criminal Practice Directions for experts. Legal obligations are set out in FSR-I-400 21 and disclosure requirements in the Guidance for Experts on Disclosure, Unused Material and Case Management. Forensic Healthcare Practitioners shall be appropriately trained and supported to produce a report that is acceptable for use within the CJS. In the case of examinations for children under 18, providers/clinicians must ensure they provide a written report including the interpretation of the findings to Children's Social Care in every case, within 10 working days in accordance with https://childprotection.rcpch.ac.uk/resources/service-delivery-standards/

3.4.14 Where there are no overriding safeguarding concerns about a third party, give service users who have capacity the choice of whether or not to involve the Police.

3.4.15 Where a service user is unsure to take up criminal justice action, provide the opportunity 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.

3.5 Health and wellbeing interventions

Attending a SARC can be a significant step in recovering from a traumatic event for the individual service user and they have a key role in addressing health inequalities in partnership with the wider health systems.

3.5.1 Sexual Health

Interventions must include the provision, where appropriate, of:

- Sexually Transmitted Infection (STI) screening, testing, treatment and care. This may include self-sampling for STIs where clinically appropriate and available.
- HIV testing.
- Follow-up care for service users prescribed HIV post exposure prophylaxis after sexual exposure (PEPSE).
- Emergency contraception as required.
- Hepatitis B immunoglobulin and/or vaccination.
- Pregnancy Testing.

Every service user must be offered administration of emergency medical/sexual health treatments where appropriate, or referral on to appropriate services as currently recommended by British Association for Sexual Health and HIV (BASHH) and Faculty of Sexual and Reproductive Healthcare (FSRH). 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.

Regional commissioners along with providers must also develop strong links with commissioners and providers of sexual, reproductive health and HIV services to establish robust pathways.

1. Any service user receiving positive STI results will be offered treatment or supported to access treatment, including assistance with partner notification, and referred to the local Genito Urinary Medicine clinic where appropriate.

2. STI testing and treatment for children under the age of 13 is unlikely to form part of the contracted activity with Genito Urinary Medicine or Integrated Sexual Health Services. The service provider must ensure they are able to access STI testing and treatment for U13s by a service level agreement, sub-contract or other arrangement where existing services are not in place.

3.5.2 Physical injury

Adults and children may be subject to more than one form of assault/abuse examination should screen for signs of injury/neglect. The service provider will have care pathways in place to treat ongoing physical injuries identified through referral to other acute and health services, as required where injuries cannot be sufficiently managed within the SARC environment or require ongoing care. This must include referrals to Emergency Departments and other specialists who may need to consider additional investigations, e.g. endoscopy and imaging and to keep the service user under observation for some hours.

Where possible repeated examination should be avoided, for example if both physical and sexual abuse are suspected in a child, a single examination should be planned (which may require the presence of two examiners with complementary skills).

3.5.3 Mental Health

SARC services will work with local NHS Talking Therapies, Community Mental Health Teams, and the ICS to develop pathways of care and preferred screening tools for use in the SARC. These tools and pathways will be used to improve diagnosis of and support for mental health.

SARCs need to ensure access or referral to support, advocacy and follow-up through therapeutic services, including support through the criminal justice process (should the service user choose that route).

Well-co-ordinated interagency arrangements will be in place, involving local third sector service organisations supporting victims and survivors. These arrangements must be reviewed regularly to support the SARC in delivering to agreed care pathways and standards.

Where there is a live criminal investigation that is pre-trial, the Crown Prosecution Service has published new guidance on Pre-Trial Therapy[21] [22]. Therapy should not be delayed for any reason connected with a criminal investigation.

Pathways must also be in place with NHS England commissioned services for enhanced mental health support for adult victims and survivors of sexual assault and abuse with complex trauma related mental health needs. Full roll-out of these schemes is anticipated to be by financial year 2024/25.

The Voluntary Sector

Voluntary sector organisations, including Victim Support, Rape Crisis, The Survivors Trust, the NSPCC to name a few, are important providers of specialist services to adults and children who have experienced sexual assault and/or sexual abuse. They are major providers of specialist advocacy, sexual trauma counselling, pre-trial therapy and support services and see recent victims as well as survivors, sometimes targeting specific service

[21] https://www.cps.gov.uk/legal-guidance/pre-trial-therapy

[22] Bluestar Pre-Trial Therapy Protocol/Service Level Policy and Easy-read Guides are available here

user groups. Their services are pivotal to supporting service user well-being, recovery and independence.

Provision is across a wide choice of environments from one-to-one work to groups. Service users can be supported with advocacy for agencies such as housing, the NHS and Mental Health and the Criminal Justice System.

Organisations in the sector can play an integral role in:

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

It is expected that the SARC will develop and maintain referral pathways and working relationships with relevant voluntary sector services in the regional area.

3.5.4 Additional considerations for children

Victims/survivors of sexual violence should be considered as children and young people until their 18th birthday and services should be commissioned accordingly. However, some young people between the ages of 16-17 years may prefer to attend an adult service. In these cases, children's safeguarding procedures will still apply.

The sexual abuse of children and young people cannot be dealt with in isolation and will need a multi-disciplinary and multi-agency coordinated approach to identify abuse, assess risk, and devise and implement child protection and aftercare plans effectively. SARCs particularly have a key role to play and partnership working needs to ensure:

- Where a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by Section 47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child. For allegations of sexual abuse, the lead agency for strategy discussions, the local authority, will be able to request the attendance and representation of a SARC Forensic Healthcare Practitioner with appropriate paediatric competencies. Local arrangements will need to be established and

monitored to ensure the safety of children is not compromised inclusive of providing an emergency response where needed.

- Non-recent 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 achieving best evidence and strategy meetings. Such children may be seen in different settings depending on local arrangements away from the SARC such as a hospital paediatric setting.
- 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 supported by SARC clinical specialists where needed.
- There must be clear information for children and young people about who to speak to, and how to access SARCs, and where to find local centres in the community, so that they do not need a family member or someone else to take them. This must be done in partnership with the local authority to ensure that systems are in line with local safeguarding procedures.
- Child SARC services must be co-designed to make children and young people feel at ease. There should be good security, and they should be decorated in child and young person friendly ways, which makes the children feel safe, comfortable and welcome.
- Specific consideration of capacity, competence and consent must be taken into consideration for children and young people. Confidentiality and autonomy can require careful negotiation between the child or young person, family and safeguarding requirements.
- The recommended service model for meeting the needs of the child or young person who has been sexually assaulted, raped or abused (or where it is suspected) is to deliver provision through a managed clinical network. This will have the holistic health care and acute forensic examination delivered at a SARC "hub" with referral pathways in place to local paediatric services for support and follow-up care where these are needed.
- NHS England has developed the "Paediatric Forensic Healthcare Practitioner Capabilities Framework for Child Sexual Abuse Assessment". The framework supports commissioners of services to specify minimum standards for clinical employment and sets out clear expectations for Forensic Healthcare Practitioners.
- In providing ongoing support, the importance of liaising with other health providers, social care, education and relevant local specialist sexual violence and sexual

abuse voluntary sector providers for play therapy, long-term therapy, counselling and support for parents/carers, practical support and resilience building cannot be overestimated. Availability of this range of support, delivered in a seamless manner, is vital.

3.5.5 Independent Sexual Violence Advisors (ISVAs)

ISVA services are commissioned by colleagues within the Office of Police Crime Commissioners (OPCC) across England as a key aftercare component of SARC systems for both adults and children and young people. ISVA work to:

- Address safety issues for individuals and work to decrease the risk of harm faced by those referred to the service.
- Serve as the service users' primary point of contact*, except where there is high risk domestic abuse where the Independent Domestic Violence Adviser (IDVA) service would normally undertake this role.*
- Regularly assess the level of risk and needs, discuss the range of suitable options and develop support plans.
- Create safety and support plans which address immediate needs and safety (including practical steps service users can take to protect themselves), as well as longer term solutions.
- Consider a range of different mechanisms to improve health and wellbeing through housing, health, criminal and civil justice remedies.
- Work within a multi-agency framework to keep the service user's perspective and safety at the centre of proceedings.

3.6 Whole system relationships and pathways

As mentioned earlier, it's an essential requirement for SARC providers to work collaboratively across all cohort types.

Provision of robust referral pathways leads to:

- An increased likelihood that the service user will access the treatment they need, thereby reducing the immediate and future demand on the wider health service. This should also prevent poor co-ordination and lead to appropriate onward referral based on service users' needs.
- The availability of specialist staff specifically trained to deliver quality care for service users.
- Strong links with the specialist sexual violence and sexual abuse voluntary sector agencies for sexual trauma counselling and support services will enable a

seamless provision of care for service users including the sharing of information and good practice.

- The development of excellence and expertise, providing advice, training and support to local health professionals as well as colleagues in the voluntary sector, education, social care and criminal justice organisations.
- Greater awareness of the interventions that are available, understanding of sexual abuse and/or sexual assault and the risk signs, better collaboration to ensure survivors are identified sooner and that prevention is on the agenda across agencies.

SARCs will be expected to form relationships with other organisations and will have their own set of unique partners where relationships should be fostered by the provider to ensure referrals are accepted to and/or from. The list below are the pathways that will need to operate at a minimum.

Pathways		
Police	Substance Misuse Services	Community Pharmacists General Practitioners
Local Authorities, inclusive of Social Care Services and MASH teams	Paediatric Health Services (including LAC health teams and safeguarding named and designated professionals)	Mental health services inclusive of counselling services provided through NHS Talking Therapies, ICS's and the voluntary sector.
Child and adolescent Mental Health services	Emergency departments as well as other hospital based services.	
The Crown Prosecution Service	Sexual Health Services	Education establishments inclusive of Universities.
	Homelessness services	Military facilities
Domestic violence, sexual violence and sexual Abuse support services provided by the specialist voluntary sector	ISVA and IDVA services for adults, children and young people	Other NHS England Health and Justice services inclusive of Reconnect, Liaison and Diversion and Prison Healthcare.

The service will also participate in relevant sexual health networks as well as relevant national/local SARC and Police meetings. Partnership Boards should also operate across ICS and/or Police footprint areas. Provider(s) will be required to be part of boards to define and agree a shared strategy and vision for the local SARC for children, young people and

adults that covers the entire service user journey from initial access to the SARC, to accessing appropriate follow-on support. The boards may also oversee and review the communication, partnership arrangements, referral protocols and feedback/outcome mechanisms within their local SARC service.

The aim is to develop a seamless service for service users and ensure that all relevant practice, guidance and governance structures are in place, including making sure that risk assessments and safeguarding protocols are understood by SARC staff and followed correctly.

3.7 Safeguarding Duties

Children, young people and adults will be safeguarded to the best of the service's ability. This will be done in partnership with Local Authorities, Police and Integrated Care Boards and other responsible agencies. Safeguarding is everyone's responsibility.

3.7.1 Safeguarding must be firmly embedded within the core duties and statutory responsibilities of all organisations across the health system and includes SARCs.

3.7.2 All SARCs are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse.

3.7.3 SARCs must demonstrate that safeguarding is embedded at every level in their organisation with effective governance processes evident. SARCs must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working. All SARC partners also have statutory duties in relation to child and adult safeguarding.

3.7.4 Services must be provided in line with "Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework 2022".

3.7.5 Safeguarding Adults at Risk. Any person 18 years and over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themself, or unable to protect themself against significant harm or serious exploitation should be regarded as an adult at risk. When that person is at risk of abuse it is the duty of any professional to instigate adult safeguarding procedures. Local Vulnerable Adults Safeguarding Procedures must be adhered to. A referral must be made to the relevant local authority safeguarding team by SARC staff.

3.7.6 Safeguarding Children and Young People. The safety and welfare of young people up to the age of 18 years accessing the service should be considered within the context of national child protection guidance and legislation and local policy and practice requirements for Safeguarding Children and Young People. In addition, part of the assessment process for any service user should include consideration of the safety and welfare of any children living with them. Advice can be obtained from

local designated and named professionals or from Children's Social Care, who also operate an 'out-of-hours' service.

3.7.7 The Provider must comply with the principles contained in "Prevent" and the Prevent guidance toolkit[23]. Policies and procedures must reflect this requirement.

3.7.8 Female Genital Mutilation Act 2003[24] stipulates the mandatory reporting of FGM for all cases identified. The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the Police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her;
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

3.7.9 Where SARC staff identify potential victims of modern slavery a referral must be made to first responder organisations which includes the Police and Local Authorities. Further information can be found in statutory guidance[25][26].

3.7 Incident Reporting

The service provider must notify the NHS commissioner of any safety incidents (unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more service users) as defined in the documents "Patient Safety Incident Response Framework" and supporting guidance together with updates and further guidance as might be issued. Service user safety incidents such as 'never events' should also be reported in accordance with "Never Events policy and framework" or any document that supersedes it. Service user safety incidents must be reported in line with the pathway agreed with regional commissioners.

The service provider must also comply with the arrangements for notification of deaths and other incidents to the Care Quality Commission (CQC) in accordance with CQC regulations and guidance where applicable, and to any other regulatory or supervisory body, any office or agency of the Crown or any other appropriate regulatory or official body in connection with serious incidents, or in relation to the prevention of serious incidents in accordance with good practice and the law.

[23] Prevent duty guidance - GOV.UK (www.gov.uk)
[24] Female Genital Mutilation Act 2003 (legislation.gov.uk)
[25] modern slavery statutory guidance, non statutory guidance v2.11 (publishing.service.gov.uk)
[26] National referral mechanism guidance: adult (England and Wales) - GOV.UK (www.gov.uk)

3.8 Duty of Candour

If a reportable service user safety incident occurs or is suspected to have occurred, the provider must:

- Formally report the incident to the NHS commissioner responsible for commissioning the service using the standard NHS Serious Incident reporting template.
- Provide the service user and any other relevant person all necessary support and information in relation to the incident.
- Report the incident in accordance with local policies.
- Verbally notify the relevant person that the incident has occurred as soon as is practicable but within 10 days including:
- Apologise.
- Gather all the facts
- Offer the option of an additional written notification.
- Record in writing for audit purposes in accordance with guidance.
- As soon as practicable, but within 10 operational days, instigate and conduct a full investigation into the incident in accordance with NPSA incident investigation tools and guidance.
- As soon as practicable, give a step by step explanation of the events and circumstances which resulted in the incident to the relevant person.
- Complete an investigation within the relevant timescales identified for the serious incidents.
- Offer details of the complaint's procedure should the service users wish to.

3.9 Quality assurance

SARCs deliver both clinical and forensic services which will need to be quality assured. All SARCs are expected to be registered and abide by Care Quality Commission Standards as well as be accredited by the UK Accreditation Service (UKAS). Accreditation timelines will be determined by the Forensic Regulator.

3.9.1 Forensic Science Regulator (FSR)

The Forensic Science Regulator expects relevant legal entities that provide forensic services to comply with applicable standards and requirements and to seek and obtain accreditation from the United Kingdom Accreditation Service (UKAS).

A number of different areas will be assessed within SARCs for accreditation purposes inclusive but not limited to:

- ISO 15189:2022 (Purchasable documents)
- FSR's Codes of Practice and Conduct
- ILAC G19:06/2022 Modules in Forensic Science Process
- FSR-C-116 Sexual assault examination: requirements for the assessment, collection and recording of forensic science related evidence
- FSR-G-212 Issue 1 Guidance for the Assessment, Collection and Recording of Forensic Related Evidence in Sexual Assault Examinations
- FSR-G-207 Issue 2 The Control and Avoidance of Contamination in Forensic Medical Examinations

In very broad terms, the accreditation will seek assurance for quality management systems, staff competency and forensic processes and integrity which includes premises. Premises will have to be forensically suitable to achieve the accreditation. The following benefits are likely to be achieved through the accreditation of SARCs.

- Accreditation provides third party confirmation that the SARC is delivering safe, reliable and forensically compliant services.
- Competent staff to fulfil roles.
- Reliable methods which accurately reflect the evidence, and do not adversely alter or contaminate the exhibits.
- Optimal sampling.
- Use of appropriate equipment.
- Documented and traceable records.
- Appropriate exhibit handling, labelling, continuity.
- Control of contamination risks.
- Clear, concise and accurate reports enter the Criminal Justice System.

Service providers will also need to ensure that they continue to hold accreditation and that they have appropriate quality management systems to ensure continued compliance with accreditation.

Regional NHS England commissioners should work collaboratively with Police and Crime Commissioners who are the leads for forensic services within SARCs, to ensure accreditation in accordance with the Forensic Science Regulator and the appropriate Codes of Practice and Guidance.

3.9.2 Care Quality Commission (CQC)

All SARCs are required to be CQC registered and allow for inspections to take place. Inspections are conducted under Section 60 of the Health and Social Care Act 2008 as part of CQC regulatory functions and whether legal requirements and associated regulations are being fulfilled. To get to the heart of service users' experiences of care and treatment CQC colleagues will follow 5 key questions relating to service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

To further focus inspections, CQC inspection teams will use a set of key lines of enquiry (KLOEs) that directly relate to the five key questions. Further information on the KLOEs can be found on the CQC website.

3.9.3 NHS England quality assurance and SARCIPs

SARCs will be required to support commissioners' work plan objectives of evaluating the quality of the whole service including timeliness of forensic medical examinations. Regular evaluation will enable development of a best practice models which, in turn, will enhance productivity.

NHS England has developed a commissioning assurance process, including appropriate performance and quality monitoring mechanisms that covers both the paediatric/adult element of services and the therapeutic care provided to service users.

Nationally, NHS England primarily monitors progress through established governance mechanisms, specifically the Health and Justice Delivery Oversight Group and the Sexual Assault and Abuse Services Partnership Board.

NHS England also uses its national lived experience group to hold these governance groups to account for delivery.

Progress of the commissioning assurance process will be ascertained against forensic accreditation verification, findings from the CQC's inspection process and effectiveness of ongoing aftercare through referrals to support mechanism related to mental ill health and safeguarding support.

SARCs must also provide record level data in line with the SARCs management information stipulated template, Sexual Assault Referral Centres Indicators of Performance (SARCIP) to inform national commissioning assurance and any regional and sub regional assurance. Under the public health function's agreement NHS England has agreed to the following key deliverables and performance indicators:

Key deliverables

- Report monthly to NHS England from April 2022 on SARCIP data. The most recent version of the SARCIPs user guide and data input template is available via contacting: necsu.nhsebi@nhs.net
- Support SARCs to ensure robust data collection and submission to influence service priorities.
- Support commissioners of SARCs to act as system leaders to work in partnership with local authorities, ICS's and criminal justice commissioners, to develop a high quality, integrated SAAS care pathway.

Performance indicators

Public Health performance indicators will include but not be limited to:

- The percentage of survivors for whom sexually transmitted infections, HIV, Hepatitis B and Hepatitis C was indicated and were:

    a) tested in a SARC or
    b) referred elsewhere for testing.

- Percentage of survivors in whom Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) was indicated and who received a PEP pack within 72 hours.

- Percentage of survivors in whom emergency contraception was indicated and who were prescribed or were given emergency contraception.

Quality Dashboard

To complement the existing performance and assurance indicators collected through the use of SARCIPs and to inform our national ambition to ensure assurance a further quality dashboard will also be developed which will capture:

- The number of safeguarding referrals.
- The number of complaints and compliments.
- CQC Reports.
- Forensic Science regulation compliance.
- The number of people who have been referred for mental health support.

3.10 Infection Control

SARC providers must at all times comply with the law, guidance and any applicable operational standards, national quality requirements and local quality requirements in relation to the services environment and equipment. This includes, but is not limited to:

- Department of Health Code of Practice on the prevention and control of infections and related guidance
- NICE Guidance: Infection: Prevention and control of healthcare-associated infections in primary and community care
- National Standards of Healthcare Cleanliness 2021
- NHS patient safety strategy

The provider must ensure that SARC environments are fit for purpose for providing services and are clean, safe, suitable, sufficient, adequate, functional, accessible (making reasonable adjustments where required in order to ensure accessibility) and effective.

The provider must ensure that it has appropriate arrangements for infection control which include:

- Implementing infection control programmes.
- The management of outbreaks.
- Report any concerns or trends detected through infection control / communicable diseases activities.
- Developing infection control / communicable disease control policies, procedures and guidance.
- Assessing the healthcare environment against national cleaning standards.
- Undertaking infection control audits, developing and implementing action plans.
- Ensuring all clinical staff undertake infection control training.
- Having an awareness of the role they have to play in any outbreaks (including pandemic flu) and delivering agreed actions relevant to their area of responsibility.
- Escalation and learning processes in place.

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

The provider must ensure that all staff using equipment have received appropriate and adequate training and have been assessed as competent in the use of equipment.

3.11 Medicine Management

SARC providers are required to have a process using legal requirement and good practice when using non-medical prescribers in SARCs and for the development and authorisation of Patient Group Directions (PGD). For PGDs this requires a doctor with accountability to the provider who is required to support the development of PGDs along with a pharmacist and the clinicians using the PGD[27][28]

The provider must have a process enabling the identification, development, review and operational implementation of Standard Operating Procedures for Medicines. These should cover all the required aspects of the medicines handling process (i.e. prescribing, ordering, stock management, storage, supply, administration and disposal of pharmaceutical waste and all medicines) including record keeping and documentation.

Arrangements for the prescription, supply and administration of medicines within the law including:

- Medicines supply (including prescription provision) complying with quality and legal standards (i.e. Medicines Act and Misuses of Drugs Regulations) and in the main supplied as an individually labelled product for the individual.
- Abide by overall Medicine guidance.
- A clear communication process about current medication, changes to medication to wherever ongoing care is delivered.
- All medicines, equipment and consumables relating to medicines management are maintained in good working order with the required certification and documented service records.
- Delivering the medicines pathway and access in line with FFLM guidelines.[29]
- Adherence to BASHH guidelines and other relevant HIV Post-Exposure Prophylaxis (PEP) guidance inclusive of
  - UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021 (bashhguidelines.org)
  - https://www.nice.org.uk/guidance/ng221
  - Supply of emtricitabine/tenofovir disoproxil and raltegravir tablets for HIV Post Exposure Prophylaxis (HIV PEP): PGD template – SPS – Specialist Pharmacy Service – The first stop for professional medicines advice

[27] Patient group directions: who can use them - GOV.UK (www.gov.uk)
[28] Patient Group Directions – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
[29] FFLM Safe and secure handling of medicines in SARCs

The provider must deliver medicines management systems that, as a minimum, ensure:

- Standard Operating Procedures (SOPs) and staff training and development plans enable appropriate levels of access to medicines in the Location.
- Access medicines stock or named-service user supplies using national end to end medicines supply chains in line with NHS policy e.g. purchasing PEPSE medicines via the nationally agreed NHS contract and supply routes.
- Medicines are stored, prescribed and supplied in line with up to date clinical and safety guidelines.
- Auditable systems are in place to ensure compliance.
- The completion and submission of an annual self-audit of their procedures and update the list of Controlled Drugs Witnesses.

4. Population-based considerations

SARCs are based across England and will need to ensure that population-based consideration is incorporated in the design and delivery of local services that are procured. This approach has been adopted to facilitate effective commissioning of local services which are responsive to the needs of the local communities that the SARCs serve. As a consequence, regional commissioners may rely upon requesting the core services in this document from SARC providers but will wish to further specify what is required as a consequence of population-based consideration.

A local health needs assessment will need to be undertaken to understand the needs of the population for activity planning inclusive of information relating to gender, ethnicity mix, languages spoken, disabilities, social deprivation, sexual orientation and inclusion health populations such as people who experience homelessness, sex workers, people who use drugs and prisoners. Service improvement is a continuous process so regions will need to undertake needs assessments on a regular basis to ensure services continue to meet the needs of the local population.

4.1 Models of delivery

SARC services are delivered through different organisational models, including:

- NHS organisations working from NHS premises.
- Combined Police and NHS providers working from private premises, NHS premises or Police premises.
- Independent providers working from private, Police or NHS premises.

The SARC delivery model may also vary according to the demographics and level of sexual violence in an area and determined by heath needs assessments and the resources available within partner agencies.

Each commissioning region will consider the delivery model and ensure provision is made for all age groups. In some areas, a single 'all-age' service may be delivered from one or several locations; in other areas, separate services for adults and for children/young people and/or separate services for recent and non-recent assaults may be preferred. If desired models incorporate hub and spoke models, particularly for paediatric services, then regions should consider managed clinical network arrangements where:

"A central hub, a paediatric SARC or equivalent, sees all acute forensic cases for a defined geographical and demographic populations and the service may also have 'spokes' which will consist of local community paediatric or other health services (where local expertise is available) which link to the central hub."[30]

The model of delivery must also consider the level of expertise available within the region, to ensure the preferred model is sustainable and supported by an appropriately skilled workforce. In determining the model of delivery, regions will also consider how the SARC will support criminal justice partners, social care services as well as wider communities.

Each region will also give due regard to travelling times to a SARC and the need to provide individuals with a service that is timely, particularly when forensic examinations are concerned.

4.2 Geographic Coverage and Boundaries

The majority of services are designed around Police Force Areas (PFA). However, there is an expectation that neither residence nor location of offence present a barrier to accessing the service.

The SARC must offer services to any service user who has been a victim/survivor of rape or serious sexual assault who either resides in, or the offence has been committed in the PFA in which the SARC is located.

There may be occasions where service users from outside the PFA will be examined and there is an expectation of reciprocal agreements of support being in place between providers/commissioners. Where activity regularly occurs in one direction only, a meeting will be held between commissioner(s) and SARC managers to understand the reasons and an action plan will be put in place to reduce the out of area activity. Cross charging (SARC to SARC) will only be used where all other resolutions have failed and can only be done with the written permission of the commissioner(s).

4.3 Workforce and Governance

Models of delivery will be supported by regional determinations regarding staffing structures. Each commissioning region will need to ensure that providers have the correct staffing structures to provide for the highest levels of service user satisfaction and strong service resilience. This includes, where possible, allowing service users a choice of gender of staff.

[30] Service-Specification_FINAL.pdf (fflm.ac.uk)

Staffing capacity must be sufficient to ensure that all service users are offered services in a timely manner. Staff available must be able to meet the differing needs of children and adults as well as safeguarding, health and forensic needs of service users. Providers must also have a clear and robust clinical governance structure in place to ensure NHS standards of clinical governance and processes exist for:

- The communication and ongoing adherence to relevant safety alert broadcasts and safety notices.
- Reporting to the NHS commissioner where the provider has deviated from any national or locally agreed clinical guidance.
- Ongoing improvement of quality of care.
- Appropriate retention of clinical records. This will ensure that satisfactory audit trails are in place for the purposes of clinical governance.
- Regular clinical supervision and assessment of Forensic Healthcare Practitioners to be documented.
- The reporting, analysis and actioning of incidents, serious incidents and complaints (including an escalation process).

It will be the responsibility of each commissioning region to ensure provider rotas and staffing structures are able to offer timely and responsive forensic interventions which maximise the capture of evidential evidence, where services are available 24/7. For non-recent cases an appointment system may be used supporting best practice guidance.

Forensic Healthcare Practitioners
Service providers must ensure that Forensic Healthcare Practitioners have appropriate professional registration, are a member of an appropriate professional body and operate within their professional body's standards, regulations and codes of conduct. Paediatric Forensic Health Practitioners will have acquired appropriate competencies during at least three years' speciality training in one or more of the following disciplines:

- Genito-urinary Medicine
- Obstetrics and Gynaecology
- Paediatrics (for those conducting holistic health care and forensic examinations on children)
- Sexual and Reproductive Health
- Accident and Emergency
- General Practice
- Clinical Forensic Medicine

Forensic Healthcare Practitioners will have due regard for guidelines issued by the Faculty of Forensic and Legal Medicine (FFLM) and the Royal College of Paediatrics and Child Health (RCPCH) guidelines including any subsequent amendments but not limited to:

- Recommendations for the collection of forensic specimens from complainants and suspects January 2023
- Quality Standards in Forensic Medicine
- Quality Standards for clinicians undertaking Paediatric Sexual Offence Medicine
- Forensic clinicians (physicians, nurses and paramedics) as witnesses in criminal proceedings
- Consent from patients who may have been seriously assaulted
- Guidance for best practice for the management of intimate images which may become evidence in court

The SARC Clinical Director will be responsible for overseeing both the initial training and development of the individual, including their shadow and supervision programme prior to final sign-off, provide input into their annual appraisal, peer reviews and management of their ongoing performance. This is applicable to all Forensic Healthcare Practitioners regardless of profession.

Crisis Workers

The service provider may provide a broad range of support to service users through SARC Crisis Workers. They will deliver confidential, emotional and practical support to service users throughout their time with the SARC, before transitioning to the community ISVA service, in close co-ordination with the Police and other healthcare professionals.

Crisis Workers will advocate for the service user and will ensure that physical and wellbeing needs are met throughout their journey. Crisis Workers should have an awareness of the role of ISVAs.

The service provider shall ensure SARC Crisis Workers are appropriately trained and shall provide immediate support to the service user where relevant at the SARC or in exceptional circumstances at another suitable location.

SARC Crisis Workers will:

- welcome the service user and explain the various options available to them both with Police referrals and self-referrals. They will document all information required on referral, using the appropriate SARC administrative systems.

- explain to those that have self-referred the process for re-claiming property that has been seized as a result of the self-referral.

- support those who approach the SARC citing non-recent assault or abuse and will be responsible for ensuring adequate care pathways are initiated.

- maintain regular contact with the service user until longer term care is established within the SAAS system.

- be appropriately supervised and receive Continuing Professional Development (CPD).
- As a minimum, training shall include:
    - Adult & Children Safeguarding Level 3.
    - Consent & capacity training.
    - Communication - working effectively with victims and third parties.
    - Annual mental health awareness training.
    - Assessment - assessing service user needs, including risk assessment.
    - Advocacy and support for the service user, especially for people who face additional barriers accessing services.
    - Basic forensic awareness.
    - Assistance with forensic collection and medical examination.
    - Additional training for protecting forensic integrity in self and non-police referrals.
    - Awareness of the role and function of ISVAs.
    - Understanding trauma informed care.
    - Work in co-ordination with victim support from other agencies where appropriate e.g. referral to IDVAs in medium and high-risk cases of domestic abuse in the first instance.

It is also expected that other key governance roles will need to be in place inclusive of but not limited to:

- Clinical Directors. "The role of the Clinical Director"
- Quality Managers – who will lead on compliance with health and forensic standards.
- Risk Managers – who will assess and address any organisational & operational risk.
- Contract Managers – who will be the point of contact with the Commissioners.
- Named Safeguarding Lead – who will ensure safeguarding is embedded and effective in all SARC working practices.
- SARC Managers - who oversee the operational running of services.
- Outreach workers – who engage underrepresented groups into the service.

4.4 FGM Interventions

Female Genital Mutilation (FGM) is a collective term for a range of procedures, which involve partial or total removal of the external female genitalia for non-medical reasons. It is sometimes referred to as female circumcision or female genital cutting.

It is illegal in the UK and can seriously harm the health of women and girls and cause long-term problems with sex, childbirth and mental health.

Section 74 of the Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 to introduce a mandatory legal duty for a regulated healthcare professional to report any concerns they have about a female under 18 years and record when FGM is disclosed or identified as part of NHS healthcare. The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred.

The NHS offers National FGM Support Clinics (NFGMSCs) which are community-based clinics that offer a range of support services for women with female genital mutilation (FGM).

The responsibility for commissioning FGM services sits with ICBs as part of their statutory safeguarding responsibilities towards women and girls. There are a number of health settings that can support in the assessment of FGM, and each ICB will need to understand local prevalence and the needs of its population prior to determining and commissioning the most appropriate setting to support a local FGM pathway.

These local arrangements will not negate against the statutory responsibilities to make a report and those duties will remain regardless of the local policy.

4.5 Accessibility

The service provider will ensure that all service users are treated with courtesy and respect, acknowledging individual service user needs and recognising the importance of dignity, humanity, religious and cultural differences of service users. These obligations are mutual and service users are equally expected to respect those differences in the SARC team.

Care will be provided according to service users' individual preferences and needs wherever possible. Where language or communication barriers exist the SARC will arrange for interpreters or communication aids for those who require this assistance.

The provider will need to ensure that the team has the professional competence to meet service users' needs, and that they are supported and educated to ensure the maintenance of a service user's dignity, privacy and respect for religious, cultural and sexual diversity. Services must also cater for those with disabilities inclusive of both learning and physical disabilities and make reasonable adaptations to services to cater to all.

The SARC must be an open access service for any service user who has been a victim/survivor of rape, sexual assault and/or sexual abuse. This does not mean that it is a

walk in service but rather accessible to any individual that requires it services. Victims/survivors can be referred by the Police, Children's Social Care, or can self refer.

Commissioner, providers and health and care professionals should ensure that socially excluded people can access and benefit from SARC services. The basis to this is an understanding of inclusion health and social exclusion, how they influence people's health and access to care, and what professionals can do to include and support people who are minoritised.

The provider must conduct an annual Equality Impact Assessment of the SARC service, shared with regional Commissioners, and ensure an action plan is produced to review the accessibility of the service.

The provider must ensure that the SARC is adequately promoted, inclusive of promotion activities to those that are underrepresented in attendance at the SARC, so that the service is as accessible as possible.

The provider will continuously develop ongoing awareness campaigns to promote accessibility of the service and work with partners to enhance onward referrals and will be required to:

- Include the details of SARC services on any health/social care/criminal justice directory that is applicable inclusive of 111 services.
- Raise awareness of the SARC and the services it offers, through the use of local and national campaigns and training events for statutory and voluntary organisations and partners.
- Deliver a SARC website which must represent and promote diversity, access, dignity and respect.
- Keep service information and resources up to date and reviewed.
- Consider using social media to raise awareness of services.
- Make resources to promote SARC services available in a variety of languages and formats, including developing easy-read information on the role of a SARC for people with learning disabilities.

The provider, on a yearly basis, will produce and share a communication plan with regional Commissioners which will set out what the provider will do to raise awareness of the SARCs locally. The plan will also refer to specific cohorts that it will target who are underrepresented in SARCs for example veterans, military personnel, people who identify as LGBTQ+, university students, providers of Childrens Services, ethnic minority groups, boys and men.

4.6 Regional contract and performance monitoring

Performance reports will be produced by the provider to include activity monitoring for regional commissioning leads and will be discussed and reviewed at regular performance/contract and board meetings as and when required.

These performance reports will provide a narrative to accompany the SARCIPs and other reports, focussing, for example, on referral trends, local pathway issues and service innovations. Schedules for the submission of reports and attendance at contract and performance meetings will be arranged by either/or NHS England regional teams and Police and Crime Commissioners.

Regional performance reports will be measured within a comprehensive performance management framework that will reflect all the relevant outcomes, outputs and quality indicators. This will be negotiated by regional Commissioners and the provider with the ethos that continuous improvement in service delivery and standards can always be achieved.

Monitoring of services can include but not limited to

- Activity data collection
- Service user feedback
- Serious Incidents
- File and service auditing
- Stakeholder feedback
- Operational policies
- Staff feedback
- Workforce in operation and gaps in service
- Budget monitoring
- Quality monitoring

The commissioner on occasion will also request ad hoc reports to be completed and/or may ask for performance reports on a more regular basis i.e. weekly or monthly. The provider will facilitate these requests.

4.7 Core20PLUS5

Core20PLUS5 is an NHS England[31] approach developed by the Health Inequalities Improvement Team to support NHS Integrated Care Systems (ICSs) to reduce health inequalities.

Core20PLUS5 offers ICSs a focused approach to enable prioritisation of energies and resources as they address health inequalities in the period 2021-2024.

- Core20 represents the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

[31] core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

- PLUS represents ICS-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. This should be based on ICS population health data.

  - Inclusion health groups include: ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

The final part sets out five clinical areas of focus.

- Maternity: ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups.
- Severe Mental Illness (SMI): ensuring annual health checks for 60% of those living with SMI.
- Chronic Respiratory Disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID-19, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
- Early Cancer Diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
- Hypertension Case-Finding: to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke.

Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims. It is anticipated that SARCs should support Core20PLUS5 particularly in relation to supporting Maternity services and those with Severe Mental Illness.