Revised National Service Guide

A Resource for Developing
Sexual Assault Referral Centres

NHS

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Revised National Service Guide

A Resource for Developing Sexual Assault Referral Centres

Prepared by

Department of Health, Home Office, Association of Chief Police Officers

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Foreword

Rape and sexual assault are devastating crimes. They can have long-lasting effects on the lives of victims; their health and well-being, their enjoyment of community life and their contribution to work. No matter where they live, it is important that victims should receive the help and support they need quickly to overcome the physical and mental impact of this kind of crime. It is vital that victims get the support they need to recover and, for both victims and communities, that the perpetrators are caught and brought to justice.

Sexual Assault Referral Centres (SARCs) exemplify how organisations can work in partnership to provide services to victims whilst also providing high quality forensic care to improve evidence, and ultimately improve criminal justice outcomes. SARCs are a highly skilled, one-stop destination in the aftermath of a rape or sexual assault. They provide services that are tailored to the needs of victims and underpinned by principles of dignity, respect and belief.

This Government is committed to the extension and development of SARCs as part of making communities safer and improving people's health, care and well-being. We want a SARC to be available in every police force area by 2011. We can't do this alone - local partnerships are essential to the commissioning and development of SARC services. We strongly encourage those who provide these services and those who commission them - primary care trusts, the police, local authorities and children's trusts to work together with third sector organisations and local people to develop and grow the services in their areas. The minimum elements for operating a SARC as set out in this document are just the basic and essential components of SARC provision. Managers of existing SARCs and those in development will wish to ensure that, at the very least, their provisions reflect this foundation.

Ann Keen
Parliamentary Under Secretary
of State for Health
Department of Health

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Parliamentary Under Secretary
of State
Home Office

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Summary

A SARC is a one-stop location where victims of rape, sexual abuse and serious sexual assault, regardless of gender or age, can receive medical care and counselling, and have the opportunity to assist a police investigation, including undergoing a forensic examination, if they so choose.

Primary care trusts, local police forces and local authorities commission SARCs for services that are provided by a range of organisations from the NHS, independent and third sectors. SARCs are a beacon of the specialist clinical assessment, treatment and integrated care and support that is needed by victims in the aftermath of sexual assault As such, they co-ordinate and simplify the pathway for victims to access wider healthcare, social care and criminal justice processes to improve individual health and well-being, as well as criminal justice outcomes.

The challenge for SARC providers, whether they are new or established, and for commissioners, is to be able to work in partnership to drive quality through integrated services, delivered by highly skilled staff from public, independent and third sector organisations to meet existing and rising demand. The SARC is more sustainable when funded jointly by the local police force(s), NHS and local authorities in a strategic partnership that is also reflected in how the SARC is run.

The minimum elements set out in this guide are an essential foundation for every SARC and should guide providers and commissioners alike.

This guide is for use by a range of key players, including SARC managers, providers of SARC services in the public, independent and third sectors and of related services such as NHS urgent care, sexual health or mental health and those who commission them; and those who are concerned with criminal justice outcomes.

A Resource for Developing Sexual Assault Referral Centres combines the *National Service Guidelines for Developing Sexual Assault Referral Centres,* and *Sexual Assault Referral Centres: Getting Started Guide,* both of which were published in 2005.

1 Introduction

Purpose of document

1.1 This resource guide combines the *National Service Guidelines for developing Sexual Assault Referral Centres (SARCs)*[1] and *Getting Started*[2]. It updates the two documents with the minimum elements of provision that are essential to operate as a SARC. The material is drawn from evaluations, [3, 4] good practice in existing SARCs and expert opinion.[5]

Who should use this guide

1.2 The guide will be reviewed in March 2011 and is provided for:

- SARC managers;
- providers of SARC services in the public, independent and third sector, including independent forensic providers;
- providers of related NHS services such as urgent care, mental health or sexual health; independent forensic providers;
- commissioners in the public, independent and third sectors who may be considering developing a SARC or improving a SARC;
- commissioners of related health services for urgent care, mental health or sexual health;
- Chief Police Officers responsible for sexual offences investigations;
- Crime and Disorder Reduction Partnerships (CDRPs);
- regional agencies such as Government Offices (GOs) and strategic health authorities (SHAs) who will find it useful in their improvement and performance work with commissioners;
- the National Support Team for Response to Sexual Violence[6] to support its work with health service and police commissioners.

1.3 This document is also of interest to a range of key players, including:

- local safeguarding children boards;
- staff who work with victims of sexual violence whether in policing, healthcare or social care;
- others in the criminal justice system, such as local criminal justice boards and the Crown Prosecution Service.

1.4 At present, the services provided by SARCs tend to be commissioned by local police forces. The intention in the longer term is to move towards a partnership arrangement for both commissioning and provision whereby partner agencies work together to assess and address local needs. This is intended to involve services provided by SARCs which are jointly commissioned by PCTs, the Police and local

"The intention in the longer term is to move towards a partnership arrangement for both commissioning and provision."

authorities for victims of sexual violence and assault, including rape and child sexual abuse. A range of providers from the NHS, independent and third sector may be involved in providing a SARC service and necessary follow-on services to ensure holistic provision for victims. This resource guide sets out the impact of sexual violence and abuse on victims, describes the benefits of SARCs and the minimum elements necessary for their operation.

1.5 Providers are expected to adopt the minimum elements necessary for delivering local SARC services. These elements are an essential foundation for providing services to victims.

1.6 Commissioners are expected to:

- collaborate with key stakeholders, partners and other agencies from the public, independent and third sectors who are involved in the delivery of SARCs;
- provide clear expectations and expected outcomes at the tender stage;
- have clear guidance in the service specification document, including the minimum elements and requirements for complying with legal duties and statutory guidance.

What are SARCs?

1.7 SARCs aim to promote recovery and health following a rape or sexual assault on victims, whether or not victims wish to report to the police. A SARC typically provides specialist clinical care and follow-up to victims usually in one place, regardless of gender, age, ethnicity or disability.[7] In addition, victims can choose to undergo a forensic medical examination if they want. 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 well-being, as well as criminal justice outcomes for adult and child victims of sexual assault as appropriate. Robust partnership working is therefore vital for the successful planning, commissioning and running of SARCs.

1.8 SARC services are likely to be delivered by a range of public, independent and third sector[8] providers, ideally all in one location. Such SARCs are more likely to be located in urban areas with higher population densities and better public transport, and many are based in separate police-owned customised facilities whilst the remainder are located in NHS premises.[6] A regional SARC can offer advice, highly experienced

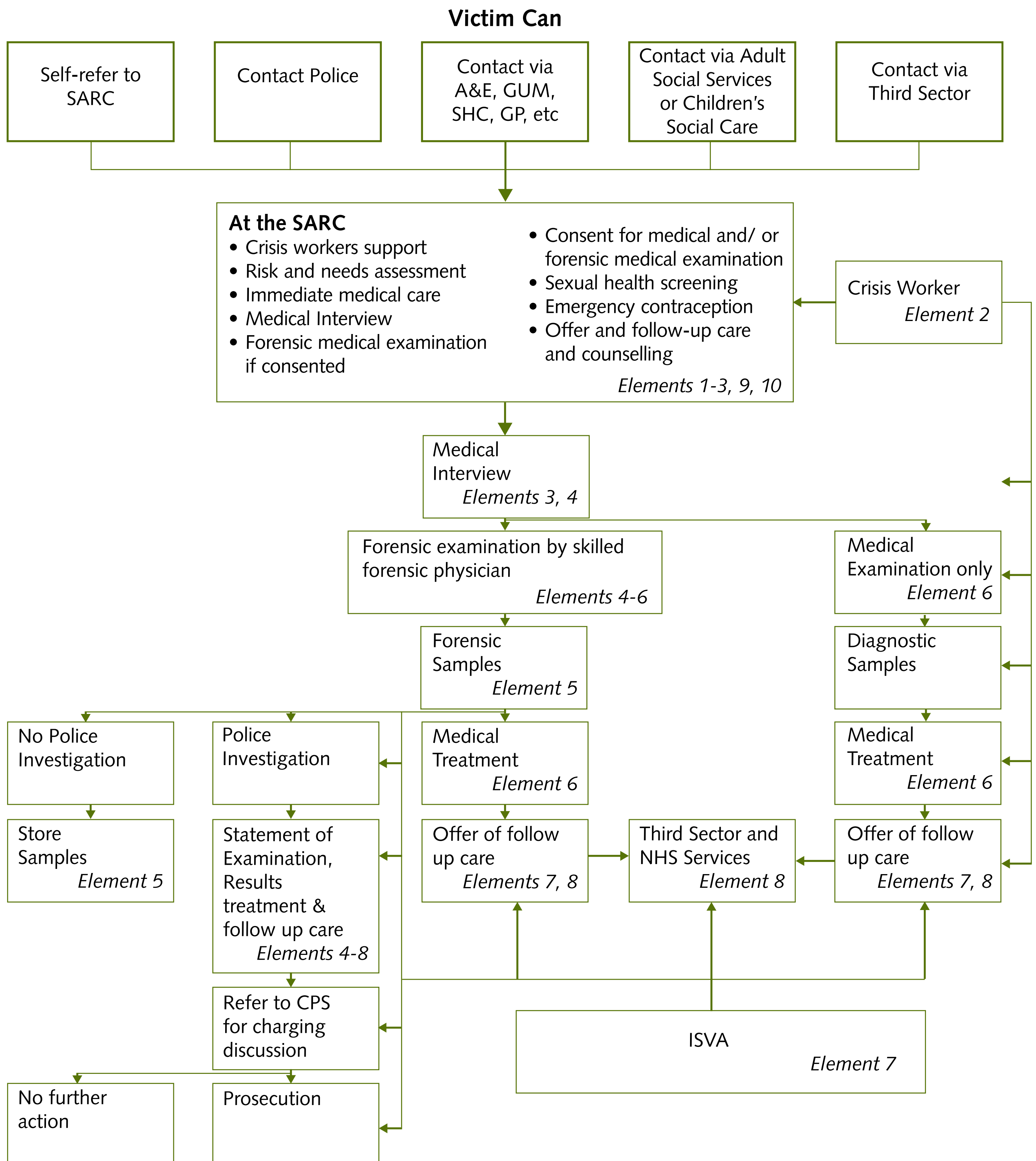
expert victim and forensic medical services through a managed clinical network with other local SARCs[9] that are spread across a wider geographical area, especially in rural and semi-rural areas where sexual assault may be low in volume. To increase access, a SARC may also be networked to other services such as sexual health clinics, genito-urinary medicine centres, paediatrics, social care and victim support services. Some SARCs or their network partners will have particular expertise in a service component or strong links with particular client groups, for example, with children and young people.[10] For all types of SARCs, services need to work towards attaining the minimum elements set out in this guide, managed in a co-ordinated way, so that victims can progress easily from initial referral to care and follow-up in order to meet their needs and optimise health and social outcomes, and where possible, criminal justice (see figure 1).

Children and young people

1.9 Children who may have been sexually abused quite often experience more than one type of abuse so sexual abuse cannot be dealt with in isolation. As set out in *Working Together,*[11] they require a multi-disciplinary and multi-agency coordinated approach to identify abuse, assess risk and devise and implement management, protection and aftercare plans effectively. Key partners in the initial assessment stages are children's social care, education, specialist child protection police teams and paediatric services. Any services developed for children who are abused should be developed as part of the wider integrated children's services encompassed within children's trust arrangements and in keeping with the requirements of the guidance and NHS clinical governance requirements. Managed networks in children services and paediatric forensic services for sexually abused children and

The Havens are the three SARCs providing services to all of London. They are integrated with sexual health services in their host teaching hospitals (King's College, St Mary's and the Royal London). Doctors working in the Havens are employed directly by the NHS and are required to have sexual health skills, such as those acquired in general practice or gynaecology, and where possible female. All doctors are funded to attend a number of compulsory courses and receive regular updates. Each Haven has senior doctors who are available to provide support and supervision; the doctors work as a team. A rota of paediatricians is available for joint examinations of children under the age of 13 and older children with special needs.

Figure 1: Sexual Assault Referral Centres – Pathways and Minimum Elements



young people are being scoped and could provide further opportunity for partnership working with SARCs to improve availability of services and raise standards of care for children and young people who are sexually abused.[9, 12, 13, 14]

Policy

1.10 Addressing sexual violence is a key element of the Government's wider strategy on *Saving Lives, Reducing Harm*.[15] The Government is committed to expanding access to the network of SARCs, with a SARC in every police force in England and Wales by 2011.[16] The *Cross-Government Action Plan on Sexual Violence and Abuse* brings together all the work in hand to address all aspects of sexual violence and sets out the roles and responsibilities of key agencies, including the NHS. The Plan affirms the role of SARCs in providing more accessible healthcare and forensic choices for victims.[17] Further cross-government work is progressing on what more can be done to maximise prevention, increase access to support and health services for victims, and improve the criminal justice response.[18, 19]

1.11 SARC services contribute to achieving a range of local and national priorities and policies to improve health and well-being, tackle violence and abuse, reduce inequalities and tackle discrimination.[20, 21, 22, 23, 24, 25, 26] Chiefly, SARCs contribute to implementing a number of cross-cutting *Public Service Agreements*[27] (PSAs) including the following:

- PSA12 Improve the health and wellbeing of children and young people;
- PSA 13 Improve children and young people's safety;
- PSA 15 Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief;
- PSA 18 Promote better health and wellbeing for all;
- PSA 19 Ensure better care for all;
- PSA 23 Make communities safer;
- PSA 24 Deliver a more effective, transparent and responsive Criminal Justice System for victims and the public;
- PSA 25 Reduce the harm caused by alcohol and drugs.

1.12 The *NHS Operating Framework*[28] identified five national priorities for the NHS to deliver during the current planning period (2008/09 – 2010/11). These priorities are underpinned by the vital sign indicators, which support the development of local priorities alongside those nationally

identified. The development of SARCs is one way to contribute to performance improvements in areas such as prevalence of chlamydia and guaranteed access to a genito-urinary medicine (GUM) clinic within 48 hours of contacting a service where it is the first contact (or as follow up within 7 to 14 days of the incident). In addition, *High Quality Care for All* [29] affirmed six goals for the NHS in the coming years. SARCs contribute to delivering three of these:

- improving mental health;
- improving sexual health;
- *reducing alcohol harm. [30]

1.13 PCTs have had limited experience of commissioning to meet the special needs of victims of sexual violence and rape and, where there are no SARCs in their areas, victims have to negotiate a disjointed and complex care pathway across many services such as general practice, accident and emergency, mental health services and sexual health. A number of existing mechanisms for partnership working can be used to develop SARCs to help in tackling violence and abuse and to link the victim pathway more effectively to longer-term follow-up such as counselling and support, which is generally provided by the third sector. These include:

- *World Class Commissioning*, which encourages PCTs to take a strategic partnership approach to improve service outcomes for local people; [31]
- existing partnership arrangements such as Local Area Agreements (LAA), which are agreed by all members of the Local Strategic Partnership (LSP); [32, 33]
- Joint Strategic Needs Assessments (JSNA) which will form the basis of discussions to agree priorities within the LAA, which may include the development of SARCs, where the health needs of victims of violence and sexual assault, along with the need to improve criminal justice outcomes in relation to sexual offences, are identified as a priority.[34]

1.14 To support local agencies in their strategies to cut crime, an indicator on sexual violence (NI 26) is being piloted in 2009 to assess readiness for inclusion in the national set from 2010-11.[35]

* Many perpetrators of sexual violence and abuse drink alcohol prior to the incident and/or have drinking problems, and/or use alcohol for victims as a method. Victims too may become vulnerable from excessive drinking

2 Key facts

Levels of sexual violence and abuse

2.1 Sexual assault is non-consensual sexual contact, often but not necessarily, characterised by use of physical threat or emotional abuse. Sexual offences are governed by the Sexual Offences Act 2003. Rape includes vaginal, oral or anal penetrative sex. Sexual assault is non-consensual sexual touching where the perpetrator has no reasonable belief that the victim is consenting. Sexual activity with a child under 16 is an offence, including non-contact activities such as involving children in watching sexual activities or in looking at sexual online images or taking part in their production, or encouraging children to behave in sexually inappropriate ways. In this document, sexual assault, sexual violence and sexual abuse are used interchangeably and not necessarily in their technical or legal definitions.

2.2 While accounting for less than 1% of all recorded crime,[36] and though hugely under-reported, the scale of sexual violence and abuse is significant. The police recorded 40,787 most serious* sexual offences in 2008/9, which accounted for 79% of all sexual offences.[36] Sexual violence and sexual abuse disproportionately affect women and girls.[36]

- Within the 2008/9 total, the percentage of rapes and sexual assaults on men fell and sexual assaults on women fell but rapes rose by 5%.
- 23% of women and 3% of men experience sexual assault as an adult.[17]
- At least 5% percent of women and 0.4% of men experience rape. Rape is also associated with the most severe cases of domestic violence, and is a risk factor for domestic homicide.
- Most perpetrators of rape are known to the victim and many are partners or family members.
- Amongst children, 21% of girls and 11% of boys experience some form of sexual abuse.

2.3 Sexual violence and abuse can cause severe and long-lasting harm to individuals across a range of health, social and economic factors. It can worsen the impact of inequalities affecting women, the vulnerable and the disadvantaged most and is often linked to domestic violence. Long-term effects can include depression, anxiety, post traumatic stress disorder, psychosis, drug and substance misuse, self-harm and suicide, of which a higher prevalence is documented amongst young victims of sexual assault.[10]

* See Endnote 36. 'Most serious' sexual crime (include rapes, sexual assaults, and sexual activity with children) as distinct from 'other sexual' offences which include (soliciting, exploitation of prostitution, and other unlawful sexual activity between consenting adults).

"40% of adults who are raped tell no-one about it and 31% of children who are abused reach adulthood without having disclosed their abuse."

2.4 The wider effects of sexual violence and abuse may be seen in the impact upon victims' families and community fear of crime: women are more worried about rape than any other crime. There is a burden to society from lost output and the long-term health issues faced by victims and the costs associated with these fall mainly on the NHS.[36, 37] Sexual offences make up 23% of the estimated total cost of crime against individuals and households, the physical and emotional impact being the most costly.[37]

2.5 Unfortunately, victims do not always get the support that they need, sometimes due to poor progress through uncoordinated services. 40% of adults who are raped tell no-one about it and 31% of children who are abused reach adulthood without having disclosed their abuse. Even where victims have tried to access support, it has not always been available.

2.6 Studies suggest that only 15% of rape allegations against people aged 16 years and over are reported to the police and of the total reported, fewer than 6% result in an offender being convicted. However, where an allegation of rape is prosecuted, then 59% of those result in a conviction. This is quite significant for victims who are going through the court process.

2.7 A number of factors can reduce reporting and subsequent progression to criminal justice processes. Some victims want to get on with their lives. Others may be affected by inter-personal relationships, fear of reprisal, fear of cultural and social isolation, economic dependency, immigration status, not knowing where to go for support, belief that services or criminal justice processes are ineffective and fear of the court process.

The Benefits of SARCs

2.8 The benefits of SARCs for the health and well-being of the victim and delivery of justice can be considerable. There are also significant benefits for the NHS, especially when considered in the context of sustainable quality, innovation, productivity and prevention.[38] Research reports commissioned by the Home Office and published in 2004 and 2005 remain the most definitive evaluations of the contribution of SARCs.[3,4] These evaluation results underpin this guidance and are confirmed by expert opinion and good practice from existing SARCs.[5] More generally, the availability of a SARC can raise awareness of sexual violence and abuse and how such abuse can be dealt with which helps boost public confidence in the health and criminal justice systems. The key benefits that SARCs offer to the

victim, the health service and the criminal justice process are summarised below.

Victim care

- A high standard of victim care to reduce the physical and psychological impact of sexual assault;
- the opportunity for victims, if they wish, to access SARCs as self-referrals;
- choice of whether or not to involve the police;
- choice of gender of physician (most victims prefer to see a female doctor);[39]
- high levels of victim satisfaction;
- opportunity for victims to agree to evidence being stored in case they decide to report to the police at a later date, as well as to provide evidence anonymously.

Through a process of improving employment issues such as availability and call out fees, induction, training, mentorship, supervision, peer review and opportunities in career development, St. Mary's SARC are now in the fortunate position of having a waiting list of female doctors to join the team.

Specialist health services

Provision of mental and sexual health services in the SARC leads to:

- increased likelihood that the client will access the treatment they need, thereby reducing the immediate and future burden on the health service from poor co-ordination;
- availability of specialist staff, trained in caring for victims of sexual violence;
- strong links with the third sector, enabling a seamless provision of care for victims and the sharing of information and good practice;
- development of a centre of excellence and expertise, providing advice, training, and support to local health practitioners, police and CPS involved in this work.

Police and Crown Prosecution Service

- An improved standard of forensic evidence;
- informal discussions with appropriately trained police officers before a victim decides whether to report a crime;
- improved detection from anonymised forensic samples collected from victims enabling links to be identified. In this way, SARCs can help police and the CDRP to

build a picture of a potential series of sexual offences. The intelligence gained can help prevent sexual violence by better understanding of its distribution and pattern in an area and enhanced detection through collection of high quality forensic evidence;

- storage of material where victims do not agree to anonymous sampling – some victims subsequently change their minds;
- reduced attrition in the months between reporting and court;[5]
- an increased potential to bring more offenders to justice on the basis of better evidence, fewer withdrawals because of better victim care, increased reporting and access to intelligence from self-referrals;[7]
- improvements in forensic science have enabled cases to be prosecuted years after the event, particularly where DNA samples have been obtained. The assistance of SARCs in providing evidence for, and supporting victims through these "cold cases" has produced good results with a very high proportion of convictions.

St. Mary's SARC continues to work very closely with the police and independent sexual violence advisers (ISVAs) on "cold case" reviews, especially on planning how to approach a victim, years after a rape, to support them throughout the criminal justice process.

The Third Sector

2.9 Third sector organisations are an important provider of specialist services to adult and child victims of sexual assault and abuse. They are major providers of specialist advocacy, counselling and support services and see recent victims as well as survivors, sometimes targeting specific client groups. Their services are pivotal to supporting well-being, recovery and independence. Provision is across a wide choice of environments from one-to-one to groups. Clients can be supported with advocacy for agencies such as housing, the NHS and mental health, and the criminal justice system. Many specialist rape and sexual violence services host independent sexual violence advisory services.

2.10 Consultation feedback from *Together We Can End Violence*[19] suggests there is a perception that the devolution of funding to local commissioners has been associated

with reductions in the sector's funding and delivery capacity. Additional grant funding from Government has continued into 2009/10, but the Government is clear that local commissioners, such as local councils and PCTs remain responsible for ensuring the vital services provided for victims of sexual violence by third sector organisations are supported through responsive local commissioning.[38] Organisations in the sector play an integral role in:

- supporting victims 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 to recover from their experiences;
- sign-posting victims to additional services;
- supporting victims who approach services long after the abuse has taken place.

Funding and Commissioning

2.11 The devolution of health and policing budgets means that SARCs are funded and commissioned at a local level, currently mainly from police funds. The commissioning of SARCs should be undertaken jointly by the key public sector agencies including partners in the NHS and third sector, and the process is best informed by a clear assessment of local needs and services. Local sources of funding for SARCs include:

- Police forces;
- PCTs;
- Local authorities;
- Local CDRPs/Community Safety Partnerships;
- Local Criminal Justice Boards;
- Children's Trusts;
- donations from businesses and private benefactors, especially for capital funding.

Costs

2.12 The set-up and running cost of a SARC will vary according to a variety of factors such as:

- whether it is located in existing accommodation or new build;
- the staffing arrangements;
- the level of demand for the SARC service.

2.13 As SARCs often cover large geographical areas with some covering part of the area of a police force (please follow link for details: www.dh.gov.uk/en/Publichealth/Healthimprovement/NationalSupportTeams/), it may be appropriate to spread the health funding contribution across a number of PCTs. In London, for example, each of the 31 London PCTs have 'top-sliced' funding that goes towards the running of the three SARCs that make up the London Havens.[6] Many existing SARCs exemplify effective joint or matched funding arrangements to meet local needs.[6]

Each of the three SARCs that comprise the London Havens SARC are supported by a consortium of 31 PCTs and the Metropolitan Police. Set-up costs were in the region of £0.3m and running costs are up to £1 million/1000 cases/per annum.

2.14 The set-up and running costs of SARCs as set out above may be offset against the likely savings to the wider health economy and the long-term costs to the economy as a whole, to assess the net benefit. For instance, the effective services provided by a SARC may reduce the number of people later referred for specialist services, such as secondary mental health and sexual health services, as well as reducing multiple assessments and waiting times for patients who use alternative services that are not integrated. Each adult rape is estimated to cost over £76,000 in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health services and costs incurred in the criminal justice system.[17, 37] The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion.

2.15 Addressing the needs of victims early through the provision of SARCs can reduce these costs and deliver benefits to victims in terms of better health, well-being and quality of life as well as long-term productivity savings in services if the immediate aftermath of sexual assault is managed effectively (see paragraph 2.8). Given the poor reporting of rape, commissioners should assume that the development of a SARC would lead to increased demand for care from unmet need but yield long-term savings, especially in the context of quality and productivity.[38]

"...the provision of SARCs can reduce these costs and deliver benefits to victims in terms of better health, well-being and quality of life..."

Commissioners may be able to improve productivity by simplifying the patient journey. For example, existing resources spent on sexual assault in sexual health and other health services could easily be provided in the SARC instead.

Quality Assurance

2.16 It is essential to develop a high quality SARC service if the needs of victims are to be met effectively across the complex network of provision. In particular, developing the clinical and forensic aspects of SARC provision enables confidence in victim care and the integrity of evidence collected to be accepted in court and admissible at trial.

2.17 Implementation of *High Quality Care for All*[29] is a further opportunity for commissioners to develop effective partnerships with a focus on managing the quality and productivity challenge to deliver a better experience of care and outcomes for victims.[38] In addition, it encourages clinical teams to use clinical indicators to measure the quality of care they deliver, highlight areas for improvement and track the changes they implement. As part of the Department's commitment to improving the commissioning of services for victims of violent sexual crime, including children, further work is underway to develop resources for benchmarking SARC services alongside clinical outcome indicators and victim-reported outcomes.[16]

3 Key elements of a SARC

3.1 SARCs should provide equitable access to an individually tailored service based on comprehensive need assessments, choice of action at every stage of care, immediate clinical and non-clinical care and support, forensic examination and referral to appropriate services. Some SARCs continue to provide ongoing support to victims who attend follow-up services or enter criminal justice processes. To avoid a postcode lottery for victims of sexual violence and abuse, SARCs are expected to work towards attaining the minimum elements of a SARC set out below to ensure consistency in the service provision for victims across the country. Links to more detailed resources are provided on the National Support Team's web pages.[6]

1. **Twenty-four hour access,** including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.
2. Appropriately trained **crisis workers** to provide immediate support to the victim and significant others where relevant, throughout the examination process.
3. **Choice of gender of physician** wherever possible.
4. Access to **forensic physicians** and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.
5. **Dedicated, forensically approved premises** and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a robust chain of evidence.
6. The medical consultation includes a **risk assessment** of harm/self harm, together with an assessment of vulnerability and sexual health; **Immediate access** to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.
7. Access to support, advocacy and follow-up provided through an **independent sexual violence adviser (ISVA)** service, including support throughout the criminal justice process, should the victim choose that route.
8. Well **co-ordinated interagency arrangements** are in place, involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.
9. **The SARC has a core team** to provide 24/7 cover for services which meets NHS standards of clinical governance and the European Working Time Directive.
10. A **minimum dataset** and **appropriate data collection procedures** in each SARC.

Minimum Element 1: Twenty-four hour access to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit. [9, 40, 41, 42, 43]

- Twenty-four hour access to SARC services, either in person or by phone.
- Arrangements are in place to accept self-referrals (see figure 1).
- A forensic physician is normally available within one hour; victims are seen or triaged according to clinical need and forensic need.
- A personal appointment systems, with victims assessed for immediate need being seen as early as possible and no later than within 4 hours, where there are cases booked before them.
- First aid is provided for minor injuries.
- Security and safety protocols to protect victims and staff, including risk assessment of victims and co-ordination with other relevant safeguarding agencies.[6]

Minimum Element 2: Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant. [9, 44, 45]

The crisis worker is an advocate and independent supporter who is available when a victim first discloses. Several of the Skills for Justice national occupational standards in the suite *Preventing and Tackling Domestic and/or Sexual Abuse/ Violence* are relevant to developing training programmes for crisis workers and independent sexual violence advisers (see also minimum element 7).[44]

- Crisis workers are trained, undergo supervision and have access to continuing development;
- Crisis worker training includes the nature of the role; communicating and working effectively with victims and third parties; assessing victims' needs initially (safety and risks); advocacy and supporting the victim, and their partner where relevant;[44] basic forensic awareness and assisting with taking samples during medical examination;
- Additional training for any roles involving protecting forensic integrity in self-referrals and non-police referrals e.g. joint risk assessments;
- Works in co-ordination with victim support from other multi-agency

"...more than 90% of sexual assault victims are women. 77% of victims (male and female) would prefer a female examiner..."

arrangements, such as independent domestic violence advisers (IDVAs) where the victim is also subject to domestic violence.[45]

Minimum Element 3: Choice of gender of physician, wherever possible[39]

- Victims can choose the gender of forensic physician for their clinical examination (45% of victims would not agree to clinical examination by male examiners).
- Adequate access to female forensic physicians to meet expected patient choice: more than 90% of sexual assault victims are women. 77% of victims (male and female) would prefer a female examiner.

Minimum Element 4: Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children[9, 46, 47, 48]

Sexual assault care can be demanding and challenging. All staff involved, including forensic physicians need to be supported and trained to do their job well. This can also affect retention and recruitment, where there is a particularly challenging task for SARCs in the long-standing shortage of suitably qualified and skilled forensic physicians.

There are currently no national standards for training forensic physicians or nurses in sexual offences work. These issues are expected to be addressed in the implementation of the Bradley review.[46] Meanwhile:

- The Department of Health is exploring the options to recognise formally the skills and expertise of forensic physicians.
- The long term aim is for forensic physicians to undertake the membership examination of the Faculty of Forensic Legal Medicine (FFLM) and the Diploma in the Forensic and Clinical Aspects of Sexual Assault (both starting in autumn 2009), or equivalent professional accreditation, and are supported to do so by their employers. Paediatricians who undertake assessments of children with an allegation of sexual assault must have higher level competencies (above level 3) in paediatric and forensic medicine. These may be obtained through the Diploma.
- Forensic physicians, whether working with children or adults or both, have practical experience of working as a Sexual Offences Examiner, with ongoing supervision such as peer review, annual appraisal and revalidation underpinned by continuing professional development.[47]
- For examination of children and young people, forensic physicians follow the FFLM[47] and Royal College of Paediatrics and Child Health (RCPCH)[48] guidelines and other local protocols.[49]
- Professional training courses undertaken must be approved or accredited nationally with documented evidence of completion of the competency level achieved.
- The following staff competences are required and should be included in training:
  - A good understanding of the medico-legal background to evidence collection in sexual assault; forensic requirements and the potential physical and psychosocial needs of those who have been sexually assaulted.

- – Understanding and dealing with the needs of children and vulnerable adults.
- – Ability to undertake detailed forensic medical examination, including the use of a speculum, proctoscope and colposcope; document injuries; collect and label samples.
- – Assessing any acute problems, such as injuries, and after-care requirements.
- – Prescribing emergency contraception and drugs to prevent sexually transmitted infections, including HIV.
- – Providing excellent, clear, accurate and comprehensive documentation, including recording examinations and writing detailed statements.
- – Giving evidence both as a witness of fact in court and, where appropriate, setting out their qualification for providing expert opinion.

- Supervision, peer review and continuing professional development for all staff who work directly with victims.
- The Clinical Director of the SARC is responsible for clinical governance including training and education.
- Training is given to all staff involved in the evidence collection process including practical use of kits and packaging materials.
- All staff involved in the evidence collection process are aware that they could be requested to provide a DNA sample to eliminate their DNA profile where contamination is suspected by a forensic science provider.
- All staff are abreast of developments in forensic practice, law and technology e.g. DNA profiling and attend at least an annual update.
- ‘Forensic surgeries’ are available three to six-monthly for staff to discuss queries and practical issues with key experts.

"...assessment includes physical, sexual and mental health, clinical and social care / support needs and risks to the victim's safety and security..."

Minimum Element 5: Dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high quality forensic integrity and a robust chain of evidence

- Protocols, procedures and audit are in place for decontaminating examination facilities.
- Professional guidance is available from the Faculty of Forensic and Legal Medicine (FFLM) on sample collection and labelling, and the recommended equipment for obtaining forensic samples from complainants and suspects. [50]
- Regular multidisciplinary meetings for staff to discuss queries and practical issues with key experts and receive updates on developments in forensic practice from the lead forensic physician.

Minimum Element 6: The medical consultation includes risk assessment of harm/self-harm, together with an assessment of vulnerability and sexual health; there is immediate access to emergency contraception, post-exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed [9, 21, 40, 43, 45, 51, 52, 53, 54]

- Practitioners are skilled in discussing with victims the implications for confidentiality to inform choice and consent for screening. Screening within a forensic examination may not have the same confidentiality guarantee as other medical examinations.
- History-taking processes in sexual assault follow current guidelines and professional standards [41, 48]
- A comprehensive assessment includes physical, sexual and mental health, clinical and social care/support needs and risks to the victim's safety and security, especially where there is domestic violence or child abuse. [45, 48]
- Screening includes testing for pregnancy and sexually transmitted infections, and discussion of any medico-legal implications
- Access to a full range of contraception and sexual health services that meet current guidelines [43, 52, 53, 54]

- Agreed protocols for screening, communication of results and follow-up treatment across all medical and criminal justice service providers. Protocols conform to current guidelines/ recommendations across all the disciplines involved (e.g. genito-urinary medicine, paediatrics, forensic medicine and nursing, police etc) and take account of confidentiality and consent. [6]
- Information sharing protocols for safeguarding victims who are children or vulnerable adults are in accordance with national guidance on interagency working and local protocols. [6, 11, 21, 45]
- Referral between services, including third sector and non-statutory providers reflect victims' needs and choices.

Minimum Element 7: Access to support, advocacy and follow-up through an independent sexual violence adviser (ISVA) service, including support throughout the criminal justice process, should the victim choose that route. [55]

- Clear, easily accessible, victim-centred policies that emphasise victims' right to choice at every stage of care.
- Victims have access to clear and appropriate information at all points of the process.
- ISVA provision is integrated with follow-on services for psychosocial support and counselling to provide advocacy and case tracking, and with other multi-agency support, such as independent domestic violence advisers (IDVA) where the victim is also subject to domestic violence. [45]
- ISVAs are trained [44] and have access to continuing development.

Minimum Element 8: Well co-ordinated interagency arrangements are in place, involving local third sector service organisations supporting victims and survivors, Local Safeguarding Children Boards (LSCBs) where children are seen, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards[11, 35, 56, 57]

- Commissioning arrangements for SARCs:
  - are joint, based on partnerships and funding between the police, PCTs and local authorities and others as appropriate, for example, children's trusts;
  - are underpinned by a clear understanding of local needs and the services available in the locality, including those provided by third sector organisations;
  - recognise the resource requirements to sustain third sector services for victims and survivors of sexual assault;
  - promote high quality and innovative service design, and delivery of fully integrated care pathways across all areas of the needs of victims.
- Governance arrangements in the SARC:
  - involve all key agencies and local partners, including third sector organisations, to develop and deliver integrated services through shared care pathways with immediate access to medical/clinical intervention, forensic response, support, counselling and follow-up;[58]
  - reflect that SARC services are delivered by a range of providers, including independent and third sector organisations and that the full range of partners are involved in the co-ordination of delivery;
  - provide for multi-agency SARC operational meetings to be held regularly to review whether delivery is meeting the needs of victims and service requirements.
- Partners are involved in agreeing access criteria and arrangements, referral protocols and care pathways and include LSCBs where children are seen;
- Audit, quality management and evaluation processes are in place across all provider services and care pathways and involve partners, including LSCBs, and users.
- High quality partnership arrangements exist between the relevant police force(s) and the SARC, each force appointing two officers, one of senior officer rank to liaise with the SARC team on strategy, service development and delivery and an officer to act as the designated lead on rape issues.

"...policies clearly outline the responsibilities of all staff across all agencies regarding data collection, sharing and confidentiality..."

Minimum Element 9: The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive [6, 9, 59, 60]

- A clinical team of forensic physicians, paediatricians and nurses;
- Counsellors, crisis workers and ISVAs;
- A clinical director (who may be shared with other health services), with a clearly defined role and accountability, including clinical governance and clinical quality;
- A SARC manager who is accountable for:
  - strategic management of the SARC;
  - operations, including structures and processes for risk management, quality assurance, maintenance of agreed policies and procedures, audit and evaluation;
  - developing and implementing local policies and operational procedures including:
    - decontamination processes;
    - adequate staffing levels and skills mix;
    - safeguarding children and young people in accordance with protocols agreed by local safeguarding children boards (LSCBs); [11, 57]
    - safeguarding vulnerable adults; [21]
    - multi-professional meetings;
    - co-ordination of training;
    - information procedures including an agreed local minimum dataset (see minimum element 10).

Minimum Element 10: Minimum dataset and appropriate data collection procedures in each SARC

- Information procedures comply with relevant legal and NHS policies on confidentiality and data protection [11, 21, 61, 62, 63, 64]
- Information policies clearly outline the responsibilities of all staff across all agencies regarding data collection, sharing and confidentiality.
- Agreed standards and protocols for data collection and frequency within the service, between agencies, including LSCBs where children are seen, and across pathways.
- The service policy on confidentiality [6] is discussed with victims and displayed prominently to build trust and encourage uptake of services.
- Service data includes demographic data and incident details on all service users, where possible (including age, gender, sexual orientation, disability, ethnicity, religion or belief) and other good practice requirements. [65]
- Service data integrates into wider multi-agency data capture systems. Data can be anonymized. Systems allow secure storage, transfer and relevant information sharing.
- A minimum dataset for logging forensic examinations. [6]
- A promotion plan on how and when information can be used to support service development (e.g. positive information about SARCs may encourage other victims to seek help).

4 Conclusion

4.1 As more SARCs become established, it is essential that, regardless of the model of provision, victims receive the highest standards of service and that the so-called 'postcode lottery' is eliminated. The quality of SARC provision and its origin in multiple funding streams and sectors makes partnership working essential for the successful commissioning and delivery of services. This guide clarifies the essential components of a SARC as a minimum foundation for the healthcare, forensic and psychosocial response needed by victims of sexual violence and assault. The elements form a baseline upon which commissioners and providers of SARC services will wish to build a consistent and high quality service.

4.2 Developments in line with this approach require SARC services to be established not as stand alone projects rather, they should be brought into the mainstream and linked to other services through strong partnerships across police, NHS, local authorities, third and independent sector organisations. Sexual violence and assault are harrowing experiences which impact significantly on the health and wellbeing of the individual. Integrated provision of the elements set out in this Guide will help provide a simplified pathway of high quality services where care can be tailored to the needs of each victim.

Glossary

CDRP Crime and Disorder Reduction Partnerships.
CDRPs are charged with reducing crime and disorder in their areas. The local authority, police, primary care trusts and fire authority are statutory members of the CDRP and must be involved.

DH Department of Health

FFLM Faculty of Forensic and Legal Medicine
The FFLM is a charity set up to develop and maintain high standards of competence and professional integrity in forensic and legal medicine.

GOs Government Offices of the Regions.
Nine regional offices across the country located in major cities across England. They offer experience and expertise to 12 Whitehall Departments in the development of policy and in the way that policies are best implemented, and are the primary means by which a wide range of government policies and programmes are delivered in the English regions.

GUM Genito-Urinary Medicine

HO Home Office

IDVA Independent Domestic Violence Advisers
IDVAs address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. They are the victim's primary point of contact and normally work with their client from the point of crisis to assess the level of risk, discuss the range of suitable options, develop safety plans and implement them. Plans will include actions from the Multi-Agency Risk Assessment Conference (MARAC), which meets regularly to share information to help increase the safety, health and well-being of high-risk victims of domestic abuse and their families, as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs are most effective as part of an IDVA service and within a multi-agency framework.

ISVAs Independent Sexual Violence Advisers ISVAs
ISVAs work with victims of sexual violence and abuse to provide support, whether or not the victim chooses to access the criminal justice service. ISVAs help victims to access the services they need after and to come to terms with their experiences. ISVAs can be located within a SARC or third sector organisation. The work of the ISVA will link to the work of the other essential services such as the IDVA, victim and

witness organisations, counsellors and health services. The ISVA works with such organisations to ensure the safety of the victim is taken into account throughout the process. Where they have been involved in SARCs, the emerging view is that their proactive follow-up of cases through practical support, case tracking and advocacy, reduces victims' dropout rates in the criminal justice process.

JSNA Joint Strategic Needs Assessments
The means by which the Primary Care Trust and local authorities work together to understand the future health, care and well-being needs of their community. The JSNA aims to support action to improve local people's well-being by ensuring that services meet their needs. It is designed to inform and drive future investment priorities.

LAA Local Area Agreements
Set out the priorities for a local area agreed between central government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level.

LSP Local Strategic Partnership
A non-statutory partnership that brings together organisations from public, private, community and voluntary sector in a local authority area so that different initiatives and services support each other and work together. It is also responsible for developing and driving the implementation of LAAs.

NST National Support Team for Response to Sexual Violence
A Department of Health sponsored team, it assists local partnerships in planning and developing SARCs to meet the Government's commitment for a SARC in each police force area by 2011. The NST also works with existing SARCs to ensure that partnership arrangements deliver appropriate and high quality care for victims of sexual violence and brings experts together from the health service, forensics services, the Crown Prosecution Service and the police to advise on local needs.

PCTs Primary Care Trusts
PCTs are part of the National Health Service in England. They assess the health needs of their population and ensure that services are in place to meet these needs, including hospitals, dentists, opticians, mental health services, NHS walk-in centres, NHS Direct, patient transport, population screening, and pharmacies. They are also responsible for getting health and social care systems working together for the benefit of patients. PCTs control

80% of the NHS budget. There are currently 152 PCTs in England.

PEP Post Exposure Prophylaxis
Prophylactic treatment started immediately after exposure to a pathogen in order to prevent infection and the development of disease.

PSAs Public Service Agreements set out the Government's highest priority outcomes for the Comprehensive Spending Review 2007 period, 2008/09 to 2010/11.

RCPCH Royal College of Paediatrics and Child Health is one of the Medical Royal Colleges. It has a major role in postgraduate medical education and professional standards: setting syllabuses for postgraduate training in paediatrics, overseeing the training, running examinations, organising courses and conferences, issuing guidance and conducting research.

SARCs Sexual Assault Referral Centres

SHAs Strategic Health Authorities.
The 10 SHAs in England manage the NHS locally and are a key link between the Department of Health and the NHS.

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