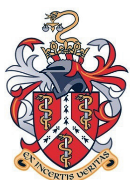
# Service specification for the clinical evaluation of children and young people who may have been sexually abused

September 2015



Faculty of Forensic and Legal Medicine
of the Royal College of Physicians

RCPCH
Royal College of Paediatrics and Child Health
*Leading the way in Children's Health*

# Service specification for the clinical evaluation of children and young people who may have been sexually abused

**Revised September 2015**

Produced by The Royal College of Paediatrics and Child Health (RCPCH) on behalf of the RCPCH and the Faculty of Forensic and Legal Medicine of the Royal College of Physicians.

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# Acknowledgments

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# 1. Introduction

1.1 This document outlines the standards for the provision of a paediatric forensic medical service for children and young people who may have been sexually abused. It has been prepared by a working group of the Royal College of Paediatrics and Child Health (RCPCH) Child Protection Standing Committee to inform the establishment of these services in the UK.

1.2 The specification is concerned with the provision of paediatric and forensic services specifically for child sexual abuse (CSA) of all types and within all time frames. It does not address the prevention or the identification of CSA.

1.3 This document uses the Department of Education (England) definition of CSA as outlined in *Working together to safeguard children*[1]:

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

1.4 This document is a revision of the original standards published by the RCPCH in 2009 and takes into account new national guidance[2]. It deals with the principles and standards required to deliver a high quality service to enable the provision of best practice in the field.

1.5 Commissioning arrangements vary across the four nations. This document deliberately does not seek to comment upon these arrangements, however variation in commissioning is likely to result in variation in service delivery and the ability to measure and compare outcomes across the UK. Clinicians, including paediatricians and Forensic Physicians (FPs), with the responsibility for the delivery or development of CSA assessment services must familiarise themselves with local arrangements, in order to enter into dialogue with commissioners, partners and stakeholders. The delivery models will inevitably vary according to local demand, resource and other factors. The important principle is that the locally commissioned services achieve the desired outcome for children and their families.

1.6 CSA should not be considered in isolation from all other forms of physical and emotional abuse and neglect. The service specified will therefore support children and their families by ensuring they are assessed with this in mind and in a timely, appropriate and empathetic way.

1.7 All services commissioned to provide a paediatric and forensic service must employ those who have high level skills in identification, assessment, and both multi-disciplinary and multi-agency management of all forms of child maltreatment. This may be done directly or through clear arrangements with related paediatric provider services. The recommendation to continue the development of clinical network arrangements for child protection will contribute to this process, especially for this highly specialised, low volume work. Quality standards around service delivery have been jointly agreed between the RCPCH and Faculty of Forensic and Legal Medicine (FFLM)[3].

1.8 It is important to ensure a universally equitable service for children and young people of all ages from 0 to 18 years of age, including those with disabilities, that is delivered in a timely fashion. In this document, the term 'child' or 'children' is used for anyone under the age of 18 years. It must always be remembered that the holistic health needs of the child are paramount in approaching any medical assessment for CSA.

## Background

1.9 Paediatric and forensic services for CSA continue to be unacceptably variable and occasionally even deficient across the UK. Children are seen in a variety of settings including non-dedicated inpatient or outpatient units in NHS Trusts, dedicated children's facilities within NHS Trusts, forensic suites or specific Sexual Assault Referral Centres (SARCs). The future development of local services depends upon many factors including: historical arrangements; local procedures and protocols; and local clinical networks and funding arrangements. The presence or absence of appropriately trained paediatricians and FPs and the arrangements requiring single or joint examinations (between paediatricians and FPs or other practitioners, such as genitourinary physicians) vary depending on the availability, skills and competences of individual examiners.

1.10 As in all forms of abuse, high quality photo-documentation and video-documentation, using appropriate equipment is an essential part of the documentation of physical signs of sexual abuse where consent is given. However, this is a difficult skill to acquire and can therefore be of variable quality and the availability of peer review and support is not always uniform.

1.11 Research published in 2006 highlighted the inadequate number of FPs in some areas to provide coverage for the examination of children, in addition to a lack of appropriate forensic facilities as cross-contamination must be avoided in acute cases of CSA[4]. In some of the non SARC services studied challenges included a lack of co-operative working with local health services, suitable equipment, and timely and available 'in house' paediatric medical follow up.

1.12 There has been significant progress made in improving services since the original service specification, however feedback from RCPCH members continues to suggest that service provision remains variable, and is not always integrated with other child protection services. In 2015, a review of sexual assault services for children and young people in London also identified variation in paediatric (and sexual health) assessment and review. The review found that there was a lack of appropriate psychological service provision, a lack of service flexibility and choice for follow-up care, and there was little support available for patients, caregivers and families[5].

1.13 Commissioners and service planners across the UK need to undertake further work to consider what constitutes a high quality service for all children in the UK and ensure that service provision best meets the needs of children and young people.

1.14 Since the 2009 RCPCH service specification was published, quality standards have been developed further and include: training and qualifications required to perform such assessments; on-going training and supervision required for those doctors practising in the field; requirements for high quality photo-documentation; requirements for the timing of a paediatric forensic assessment; and recommendations for peer review.

1.15 There have been a number of documents published which have educated practitioners and have set quality standards, underpinned by evidence. All working in this field should be familiar with the following:

- *Quality standards for doctors undertaking paediatric sexual offence medicine*[6].
- *Child protection companion (2nd edition)*[7].
- *The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice (2nd edition)*[8].
- *Guidelines on paediatric forensic examinations in relation to possible child sexual abuse*[3].
- *Sexual offences: pre pubertal complainants*[9] and *post pubertal complainants*[10].
- *Guidance for best practice for the management of intimate images that may become evidence in court*[11].
- *Peer review in safeguarding*[12].

## Philosophy

1.16 As for all child protection service provision, the philosophy of the service is underpinned by the principles set out in the United Nations Convention on the Rights of the Child (UNCRC)[13] and the European Convention on Human Rights (ECHR)[14]. This emphasises the child as an individual, as part of a family, and part of a community who has rights which should be recognised and upheld.

1.17 The following UNCRC rights most applicable to this document are:

- Article 4 (protection of rights): governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled.
- Article 12 (respect for the views of the child): when adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.
- Article 16 (right to privacy): children have the right to privacy.
- Article 19 (protection from all forms of violence) states that all children have a right to be protected from 'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.'
- Article 24 (health and health services): every child has the right to the best possible health and to medical care and information.
- Article 39 (rehabilitation): children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society
- Article 34 (sexual exploitation): governments should protect children from all forms of sexual exploitation and abuse.

1.18 Each nation needs to develop a service based on the following:

- General Medical Council (GMC) *0-18 years: guidance for all doctors*[15]
- GMC *Protecting children and young people: the responsibilities of all doctors*[16]
- Child protection guidance from across the UK nations, including:
    - England: *Working together to safeguard children*[1]
    - Scotland: *National guidance for child protection in Scotland*[17]
    - Wales: *Safeguarding children: working together under the Children Act 2004*[18]
    - Northern Ireland: *Co-operating to Safeguard Children 2003*[19]

# 2. Service description

## Definition of the service

2.1 The service will include holistic assessment and care for children referred whenever there is an allegation of sexual abuse, sexual abuse has been witnessed, or when there is a suspicion by the referring agency that sexual abuse has occurred, whether this be recent or historic.

### Client group

2.2 The service will ideally see children up to their eighteenth birthday, but definitely children up to their sixteenth birthday.[i]

2.3 Individual decisions regarding where a child is seen must take into account the needs of each child, and all services must have clear arrangements in place for children with learning disabilities, communication difficulties, or other special needs to ensure they are seen by an appropriate service regardless of their age.

### Organisational structure

2.4 The preferred overall model for sexual abuse referral services is a 'hub and spoke', with a central hub, a paediatric SARC or equivalent, seeing all acute forensic cases for a defined geographical and demographic population (see also section 4.0). This service is often best provided through a managed clinical network arrangement.

2.5 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. Both the hub and spoke will work in partnership with police and children's social care.

2.6 Historical cases may be seen in the 'hub' or the 'spoke' depending on forensic requirements and local resources. Where there is a need for intimate body samples the child should be seen in the paediatric SARC or equivalent, however place of follow up will depend on the service and where the child lives.

2.7 The combined service will:

- Provide a rapid response (see sections 2.18 to 2.25) when a child requires acute forensic medical assessment, including the provision of crisis workers and/or other similarly trained professionals.
- Provide a timely response to requests for historic CSA medical assessments.
- Provide follow up appointments for both acute and historic CSA.
- Refer to other assessment and therapeutic services as required (both immediate and long term).

[i] A young person aged over 16 years may choose to be seen in an adult sexual assault referral service and that wish should be respected. While recognising that the use of an adult venue might not be avoidable due to the absence of a suitable child and young person friendly environment, this is not good practice. In either situation, the examination must be undertaken by a doctor(s) with the relevant competencies to ensure that appropriate measures are taken to assess and safeguard the young person.

- Have staff who are competent in both forensic medical examinations and in assessing and providing for the holistic needs of children, including safeguarding from all forms of maltreatment and in the assessment and management of physical and emotional conditions that may or may not be related to the alleged CSA.

2.8 The service will have links with other sexual assault services such as Independent Sexual Violence Advisors (ISVA), children's ISVAs or equivalent third sector providers to support the child and family through the criminal justice process as well as signposting them to counselling and other rehabilitative safeguarding services.

2.9 It is important that wherever the child is assessed the appropriate quality standards for the service are securely in place.

## Quality standards

2.10 In order to be of high quality, paediatric forensic assessments must adhere to the agreed quality standards outlined in the documents listed in the introduction.

2.11 Assessments for children up to their eighteenth birthday (see sections 2.2 and 2.3) must be undertaken by a qualified medical practitioner with appropriate competences.

2.12 Each service needs to address all of the following:

- Issues around consent and confidentiality.
- The threshold for and the timing of a paediatric forensic assessment.
- The availability of an appropriate chaperone for the child during the examination. For children under sixteen years this role should be undertaken by a nurse with appropriate paediatric competences. However, young people aged 16 years and over may be offered a crisis worker (present either in the room, or on the patient side of a curtain screen). If a young person requests that a chaperone not be present, a record of the conversation must be documented in the notes[20].
- A suitable physical space, waiting area, age appropriate toys and distraction for the examination, including access to a play therapist where possible.
- The elements that such an assessment should contain, including a comprehensive history (covering developmental history); a full paediatric general and ano-genital examination; screening for sexually transmitted infections (STIs); and the provision of appropriate treatment such as emergency contraception, Hepatitis B immunisation, HIV post exposure prophylaxis and other STI treatment(s).
- Risk assessment for suicide, self-harm, child sexual exploitation and domestic abuse.
- An appropriate standard of documentation, using a specifically designed standard medical proforma.
- High quality photo-documentation using a colposcope or colposcopic-equivalent, adhering to guidelines for labelling and storage.
- That doctors undertaking such assessments have the training and qualifications required to achieve the specific skills and competences; maintain their competence by seeing a specific number of cases each year (see section 3.5); have protected time for preparation of statements and reports for child protection enquiries, criminal investigations, and the courts; have protected time for court attendance; and undergo case supervision and regular peer review (also see sections 3.4 and 3.5):

- Continuing professional development requirements for all health staff.
- Appropriate pathways for holistic follow-up of all identified needs including counselling, Child and Adolescent Mental Health Services (CAMHS), and other rehabilitative needs of the child and family.

2.13 Furthermore it is also good practice that:

- All acute cases have a crisis worker.
- All children whether their case is acute or historic, going through the criminal justice process should be offered access to a child advocate or ISVA to support themselves and their families. This may include victim support from the police.
- Children's social care should be involved at an early stage. Normal practice should be at a minimum, a strategy discussion between children's social care, the Police and the paediatrician and/or FP at the time that the concerns emerge or as soon as possible after the child has presented to a health service. Wherever possible, children's social care are partners in the process even when there are no obvious concerns about the care afforded to the child by the immediate family.

2.14 Standards to ensure the integrity of forensic samples in acute cases are provided in the *Forensic Science Regulator: Codes of Practice and Conduct*[21]. These need to be considered with all stakeholders in order to ensure that standards regarding the integrity of forensic samples in acute cases are met. However, there may be the need for a degree of compromise in situations where strict application of these standards are not felt to be in the best interests of the child and may jeopardise the child's overall wellbeing which must be the paramount consideration.

## Care pathway

2.15 The definition of what constitutes an acute case is complex and needs to be negotiated with commissioners and service planners, with input from the multi-agency team.

2.16 Forensic sampling of intimate body swabs is rarely productive more than seven days following an allegation of sexual assault. Consideration should be given to the FFLM guidance *Recommendations for the collection of forensic specimens from complainants and suspects*[22] which are updated every six months. However, clinical signs may still be present on examination up to 21 days after the assault, for example, healing genital injury, anal injury or other injury[8]. These injuries may be forensically significant, so in some circumstances strict adherence to a seven day timeframe may not be indicated. The timing of when an acute case is seen, whatever the definition, needs to follow the recommendations as set out in *Sexual offences: pre pubertal complainants*[9] and *post pubertal complainants*[10].

2.17 If the timeframe for a case to be treated as acute is agreed by commissioners and service planners to be less than 21 days, there still needs to be flexibility as to whether a case may in some circumstances, need a more rapid response. The decision on the timing of the medical assessment must involve medical personnel with the necessary experience and skills, ideally at the initial multi-agency referral discussion.

## Referral process and timings

2.18 A multi-agency protocol will be agreed by the Local Safeguarding Children Board (LSCB) or equivalent[ii] describing how children should be referred for a paediatric forensic assessment. The protocol must ensure that there is the involvement of health professionals in early multi-agency discussions for all children where CSA is being considered.

2.19 The referral protocol will include the process for ensuring access to advice where concerns of possible CSA have arisen during the course of an assessment in children with other health issues, including those seen with child protection concerns where professionals are unsure or unclear as to how to proceed in the best interests of the child.

2.20 All children with acute health care needs (e.g. bleeding or other physical injury) should be referred immediately to an appropriate acute paediatric facility and assessed by the paediatric team.

### Acute cases

2.21 The timing of an acute forensic assessment is outlined in *Sexual Offences: Pre Pubertal and Post Pubertal Complainants*[9,10].

2.22 It is envisaged that specialist medical advice should be sought within one hour of a complaint or allegation being made from a doctor with Paediatric Sexual Offences Medicine (PSOM) competences (see section 3.4); this initial advice may be provided via telephone.

2.23 It is essential that a multi-agency discussion takes place. This may be face-to-face or via telephone. This should include input from the paediatrician or FP likely to conduct the medical assessment. The discussion needs to include where and when the assessment should take place and by whom, taking into consideration a number of factors including the age of the young person, their vulnerability and other relevant factors including the preference of the child and/or family and establishing who is available to consent to the assessment.

2.24 Once a case is identified as acute they should have an examination in line with joint RCPCH and FFLM guidance[3].

### Non-acute cases

2.25 How quickly a non-acute or historical case needs to be seen may vary according to clinical need. However, it is envisaged that such cases would be seen for paediatric assessment within two weeks of a decision being made that such an assessment is required, usually following the Achieving Best Evidence[iii] interview. This makes the history taking and discussion afterwards easier and more fruitful for both the child and the clinician.

[ii] Regional Safeguarding Children's Boards (Wales); Safeguarding Board for Northern Ireland (Northern Ireland); Child Protection Committees (Scotland).
[iii] In Scotland this would be the Joint Investigative Interview

## Assessment

2.26 A comprehensive and documented assessment, using a specifically designed standard proforma which includes body maps, will be undertaken according to the quality standards previously described.

2.27 This will include:

- Consultation with the child as appropriate to their age and development.
- Obtaining and recording informed consent using a form approved by the Trust or health organisation for the examination, photo-documentation, and for the sharing of information according to local procedures and guidance. The consent form must be kept in a secure location and the process of obtaining consent must take into account confidentiality, competence, capacity and parental responsibility.
- Past medical and social history.
- A general whole body physical examination including assessment for physical abuse, neglect and growth.
- Examination of the genital and anal areas for clinical evidence of injuries, including photo-documentation.
- Obtaining forensic samples including intimate body swabs.
- Baseline screening for STIs, including swabs and blood tests if appropriate, should be undertaken in line with current guidance from the British Association of Sexual Health and HIV (www.bashh.org).
- Plan for immediate healthcare including emergency contraception, antibiotic and or HIV/Hepatitis B prophylaxis (for further information see the British Association for Sexual Health and HIV, (www.bashh.org).
- A comprehensive paediatric assessment including all health and wider safeguarding needs, including risk assessment for suicide, self-harm, other mental health difficulties, child sexual exploitation and domestic abuse.
- Detailed documentation of all the assessments, including body charts, and photo-documentation (with consent).

## Follow-up arrangements

2.28 Following the examination, children will be offered follow up as necessary, either at the ‘hub’, the SARC or equivalent, or, depending on local expertise and service arrangements, the follow-up could take place at a ‘spoke’ unit closer to the child’s home.

2.29 Where there is healing to be monitored or some doubt about the interpretation of the physical signs observed at the initial assessment, a follow up examination may need to be undertaken. This is best performed by one of the original medical examiners. However, in the unlikely event that this is not possible then the photo-documentation of the original examination should be available to the doctor performing the follow-up examination.

2.30 Follow up may include:

- Consideration of unmet health needs.
- Addressing new or continuing symptoms.
- Review of the healing process.
- STI screening/treatment, Hepatitis B immunisation, HIV counselling and testing.

- Exclusion of pregnancy, even when emergency contraception has been given.
- Psychological support.
- Addressing any queries the child or family may have.
- Giving children and families relevant information in an accessible format.

2.31 Children will have a range of needs post abuse, dependent upon many factors including the age of the child, the timing and type of assault, the relationship of the alleged assailant to the child, the characteristics of the child, the ongoing legal process and family support.

2.32 Children commenced on HIV post exposure prophylaxis will need to see an appropriate specialist locally soon after commencing treatment. There will be local protocols and pathways to follow to ensure this occurs.

2.33 Post abuse support is a key component of this service and access to immediate and longer term support (at an appropriate level) must be commissioned alongside the paediatric forensic service. This may include provision of an ISVA (including more specialised Children's ISVAs) or ongoing support from a social worker, as well as involvement from counselling services, play therapists and CAMHS as appropriate.

## Reports and documentation

2.34 Standard documentation will be used to provide the full range of reports including letters to the GP, medical and forensic reports, criminal witness statements and reports for the family court. The reports will follow an agreed protocol based upon the *Child Protection Companion*[7]. Further reports for family court proceedings may be required.

2.35 There will be a clear procedure adopted for the management of photo-documentation and intimate images resulting from the assessment in line with best practice recommended by the current and FFLM and RCPCH Guidance[3,11].

2.36 All health professionals writing reports should participate in peer review, according to agreed standards.

2.37 All records including any non-intimate photo-documentation (e.g. photos, DVDs) are the property of the host NHS Organisation or other provider. Access to these will be via the health organisation's access to medical records policy. A copy of any report about the child and non-intimate images should be kept with the child's health record according to local policy. Access to intimate images is **not** dealt with through the organisation's access to medical records policy; the storage and sharing of intimate images must comply with the current and FFLM and RCPCH Guidance[11].

# 3. Workforce

3.1 The range of professionals and the sessional requirements or programmed activities will depend upon the particular local arrangements and will need to reflect the population covered, geographical size, and demand. The exact nature of the particular hub and spoke model adopted will depend upon many local factors.

3.2 The core staff group ideally should include:

- Clinical Director or equivalent for the service
- Administrator or Specialist Centre Manager
- Doctors
- Nurses
- Crisis workers
- Play worker(s)
- Children and Young People Sexual Violence Advocates
- Clerical support staff

3.3 The Clinical Director or equivalent will provide professional leadership and the Administrator will facilitate and coordinate the provision of a high quality equitable service.

### Doctors

3.4 Medical staff will:

- Require competencies from paediatrics, forensic medicine, gynaecology and sexual health.
- Come from various specialities including paediatrics, forensic medicine, paediatric gynaecology, sexual health services and general practice.
- Be of sufficient seniority to carry case management responsibility.
- Be trained to have the specific skills outlined in guidelines on *Paediatric forensic Examinations in relation to child sexual abuse*[3].
- Have obtained the formal qualifications as outlined in the *Quality Standards for Doctors undertaking Paediatric Sexual Offences Medicine (PSOM)*. Experienced FPs and paediatricians who currently undertake this work may be regarded as meeting these requirements by virtue of 'grandparent' rights following discussion at appraisal[23].
- Have undertaken further professional development such as the Diploma in the Forensic and Clinical Aspects of Sexual Assault and considered membership of the FFLM.
- Fulfil all GMC standards for revalidation including annual appraisal, undertaking basic life support training and safeguarding children training to Level 3 as per intercollegiate safeguarding guidance[24]. They will also undertake one FFLM or RCPCH approved SARC best practice course at least every three years[23].
- Attend a minimum of four CSA peer review sessions a year.

3.5 In addition to this it is recommended that doctors undertake a minimum of 20 forensic examinations for alleged or suspected CSA per year in order to maintain their skills[23]. It is acknowledged however that some flexibility around this matter is desirable to accommodate operational issues in some areas.

3.6 Where possible a choice of gender of doctor should be offered. However, it is acknowledged that this may not always be possible. Where there is no choice, for example there is only a male doctor to examine a post pubertal girl, the girl needs to be supported to make an informed decision about her options[iv].

### Nurses

3.7 Nursing staff will require competences in paediatrics, forensic and sexual health medicine. They will come from various backgrounds including children's nursing, health visiting, public health school nursing, forensic nursing, sexual health, and emergency medicine.

3.8 Nursing staff:

- Will support the child throughout the assessment and examination.
- May undertake specific tasks alongside the examining doctor including the taking of STI swabs, dispensing of medication, immunisation and provision of information.
- May perform follow-up clinics to address sexual health and other issues where further medical input is not required.

3.9 Nursing staff may also act as a chaperone (see section 2.12).

### The play worker/specialist

3.10 With younger children, and often with older children and adolescents, a play worker's skill in making the child feel relaxed and comfortable is invaluable in facilitating the medical assessment.

### Crisis worker

3.11 Crisis workers support the child and family/carer throughout the assessment process, and depending on local service arrangements, may provide other support services such as telephone advice.

3.12 Crisis workers should be appropriately trained and supervised and in some circumstances appropriately trained nursing staff may undertake this role.

### Interpreters

3.13 If there is any suggestion of language or communication difficulty for the child or caregiver, it is essential to work with a facilitator trained in safeguarding, e.g. a registered interpreter or an individual trained in Sign Language.

3.14 Face-to-face professional interpreters should be used. Exceptionally, however, the immediate health needs of the child may need to be addressed via telephone interpreting services. It is not appropriate that other members of the family act as interpreters or for people not trained as interpreters to perform this role[7].

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[iv] The Victims and Witnesses (Scotland) Act 2014 states that the constable must give the person an opportunity to request that any such medical examination be carried out by a registered medical practitioner of a gender specified by the person.

## Wider staff team

3.15 The service will require access to:

- Specialist advice and assessment from a wide range of medical and surgical disciplines.
- Age-appropriate early counselling and therapeutic services, including links with CAMHS.
- Independent Sexual Violence Advisors (ISVA) or Children's ISVAs.
- Services for the staff group, including dedicated psychological support.

# 4. Service location

4.1 The central hub must be designed to meet the demands of forensic evidence collection, i.e. capable of being forensically cleaned and capable of storing forensic samples, as well as providing a child friendly environment. The facility should provide wheelchair and pram access and there should also be easy access to other health professionals who may be required as part of the assessment.

4.2 Depending on local design, the assessment centre will ideally be located within a hospital facility providing the full range of paediatric clinical and investigative services, as well as appropriate security and out of hour's access as required. It could also be provided in a sexual abuse referral service or SARC if there are purpose built facilities for children with easy access to acute medical facilities for children.

4.3 Regardless of the location, the service will have:

- Full laboratory facilities (i.e. microbiology, virology, radiology, neuroradiology, haematology, medical illustration) and chain of evidence mechanisms for STI screening.
- Colposcope or colposcopic-equivalent equipment for high quality photo-documentation and video-documentation of anogenital findings.
- Additional non-clinical provision including dedicated access to Information Communication Technology such as telemedicine and telephone; IT; private office space; and facilities for peer review, audit and training meetings.

4.4 The spokes of the service will have similar specification to the central hub but as they are not being used to obtain forensic samples they will not need to comply with guidance regarding their collection or storage. They will however need to have the full range of other services documented in sections 4.2 and 4.3.

4.5 Clinicians will more easily maintain competencies if they work in both the central hub and the spoke.

# 5. Clinical governance

5.1 Any health organisation, hosting either a SARC or local community paediatric service, must ensure the service has a robust clinical governance plan which is reviewed on an annual basis. The Clinical Director or equivalent will be responsible for the development of protocols, training programmes, clinical supervision and clinical governance with the support of the service administrator.

5.2 It is important that there are regular clinical governance meetings with staff looking at quality and standards, latest evidence-based research, audit, case review and review of critical incidents. Staff need adequate IT facilities including on line access to evidence-based resources.

5.3 An annual report should be written and submitted to the Board of any health organisations hosting the sexual assault referral service, commissioners and other stakeholders including LSCB or equivalent[v]. It may be that a number of such annual reports will be required if there are a number of host organisations, but wherever possible a single amalgamated report should be available to commissioners to facilitate their assessment of overall service provision. Details of information to be included in the annual report can be found at Appendix 1.

5.4 It is likely that the core staff, particularly the Clinical Director, nursing staff and the administrator will be employed directly by the SARC host organisation.

5.5 Doctors from different professional backgrounds may be primarily employed by another provider and be part of a wider managed clinical network[25], holding an honorary contract with the SARC host organisation.

5.6 It is essential that there is clarity about the governance arrangements for the staff with particular reference to line management, medico-legal indemnity and job planning between the SARC host organisation and the local employing bodies.

### Monitoring, review and continuous performance improvement

5.7 To fulfil this function services will need to establish a record keeping system, a case tracking system, and a system to record audit data (Appendix 2) to contribute to performance management, including the collection of epidemiological information to inform a needs assessment for service planning.

[v] Regional Safeguarding Children's Boards (Wales); Safeguarding Board for Northern Ireland (Northern Ireland); Child Protection Committees (Scotland).

# 6. Responsibilities of the SARC and local specialist services

6.1 It is likely that the SARC host organisation may need to access a network of doctors from other health organisations to deliver the required level of service at all times. This includes cover for study leave, holidays and exceptional sick leave.

6.2 The SARC host organisation will enter into formal agreements with the participating health organisations.

6.3 This will include arrangements for:

- Job planning.
- Appraisal
- Financial payment for out of hours rota cover in line with other acute on call systems.
- Medico-legal indemnity.
- Legal advice for health professionals.
- Clinical governance.
- Quality improvement.
- Continuing Professional Development including attendance at peer review and national conferences.
- Commitment to release doctors to attend case related professional meetings including court proceedings.

6.4 The SARC host organisation will identify a group of skilled doctors and other health staff though their local and regional arrangements, with the support of the named and designated safeguarding professional, or equivalent. They will ensure that the LSCB or equivalent are aware of and endorse the arrangements.

6.5 Similar arrangements will need to be in place for the local specialist services depending on local arrangements. It is envisaged that the SARC host organisation and local paediatric services would work together to address the above issues.

# 7. Stakeholders

7.1 The key stakeholders of the service are:

- Children.
- Families and carers.
- Social Services (children's social care).
- Police Forces and Police Commissioners.
- Voluntary Organisations (Rape, Counselling, Advice and Support).
- NHS Trusts or Health Boards.
- Local Health Commissioners.
- CAMHS.
- Children and Young Peoples Partnerships.
- LSCB (England and Wales), Child Protection Committees (Scotland), Safeguarding Board for Northern Ireland.
- Crown Prosecution Service (England and Wales), Crown Office and Procurator Fiscal Service (Scotland), Public Prosecution Service Northern Ireland.

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# Appendix 1

## Annual report

The report should include the following information[vi]:

1. Service specification, i.e. overview of the service and staffing details.
2. Number of initial assessments, acute and historic.
3. Number of follow up appointments.
4. Demographic information of children and young people seen by the service, including:
    a. Gender
    b. Age
    c. Catchment area of residence
    d. BME status
    e. Disability
5. Percentage of cases where initial advice offered within an hour of referral having been received by the specialist centre (see section 2.22).
6. Confirmation of compliance with RCPCH / FFLM Quality Standards and this document, including;
    a. auditing of procedures against the standards
    b. percentage of acute and historical cases seen within specified time periods (see section 2.21)
7. Key challenges and priorities, including difficulties or gaps in service provision and cover for the rota.
8. Details of activity to engage and involve key stakeholders and in particular children and their families who have been referred to the network.
9. Details of patient satisfaction surveys or other measures.
10. Contribution to multi-agency training.
11. Case examples.

[vi] In locations where there are a very small number of cases, consideration should be given to releasing data which could be identifiable.

# Appendix 2

## Key Performance Indicators

These KPIs should be used in conjunction with Appendix 4 *Commissioning Framework for Paediatric Sexual Assault Referral Centre (SARC) Services. NHS England. 2015.* These are a suggestion and should be developed in discussion with commissioners and multi-agency partners.

| KPI | Indicator | Detail |
|---|---|---|
| 1 | Clinical governance | Total number of peer review sessions, total number of cases peer reviewed and proportion of staff in attendance. |
| 2 | Care management | Number of children, young people and families are referred appropriately to counselling services (with consent) within documented timescale. |
| | | Number of children, young people and families referred to domestic abuse services where appropriate |
| | | Number of children and young people who are provided sexual health assessment and care at follow-up. |
| 3 | Information governance | Compliance with RCPCH /FFLM intimate images guidance. |
| 4 | Child protection or criminal justice procedures and outcomes | These indicators need to be discussed with commissioners as measures are problematic to collect due to the timeframe between assessment and court proceedings. The following may be considered:<br>• number of statutory child protection enquiries carried out<br>• number of child protection conferences<br>• number criminal witness statements presented to court<br>• clinician attendance at court proceedings (both family and criminal)<br>• number of criminal convictions<br>• number of perpetrators who are under 18 years |

<table>
<tr><td rowspan="5">5</td><td rowspan="5">Audit</td><td>Defined collection period</td></tr>
<tr><td>Referral information for each contact requesting advice (including source, time, day of the week, date.)</td></tr>
<tr><td>Demographic information:<br>• age (incl. total number under 13 years of age)<br>• gender<br>• BME status<br>• disability<br>• Health Board and SCB/CPC/SBNI where child is usually resident.</td></tr>
<tr><td>Detail of assessment<br>• Location of incident.<br>• Time, day of week, date of assessment (with definition of start and end points).<br>• In hours or out of hours (with agreed definitions).<br>• Who conducted the examination e.g. forensic physician, paediatrician or both.<br>• Whether general examination was carried out or not.<br>• Whether anogenital examination was carried out or not<br>• Place where examined and distance from home for child.<br>• Time between request and start of assessment.<br>• Who was present at assessment (professionals, the examining doctors, carers - specify which).</td></tr>
<tr><td>Record of vulnerability factors present:<br>• under care of CAMHS.<br>• currently open to children’s social care.<br>• learning difficulty<br>• disability<br>• previous self-harm<br>• previous substance misuse<br>• alcohol vulnerability associated with the incident<br>• on ‘Child in Need Plan’ or ‘Child Protection Plan’<br>• is a Looked After Child<br>• domestic abuse in the household<br>• CSE (risk or actual)<br>• FGM (risk or actual)</td></tr>
</table>

| | | |
|---|---|---|
| | | • Social media or internet contact with perpetrator |
| | | Sexual health<br>• Total number and proportion of clients or children who received STI screening within two weeks; attendance and outcome when indicated.<br>• Total number and proportion of clients or children who completed syphilis and virology screening at three months when indicated.<br>• Total number of children started and completed HIV prophylaxis when indicated. |
| | | Photo-documentation with type (e.g. DVD/Video). |

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