Yorkshire and The Humber SARCs

Annual Activity Report
1st April 2016 - 31st March 2017
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1 Introduction

This report contains activity data based on the clients who have been referred to four SARC s in Yorkshire and The Humber from 1st April 2016 to 31st March 2017. The SARC s are as follows:

a) The CASA Suite, Hull – Humberside
b) Hackenthorpe Lodge, Sheffield – South Yorkshire
c) The Hazlehurst Centre, Dewsbury – West Yorkshire
d) Bridge House, Bishopthorpe, York – North Yorkshire

This report is for the first year of the contract. It is a regional contract so on occasion, with Police / Client agreement, cases are diverted from the referring Force to be seen at another SARC in the region.

Our service is a Nurse Led Model (Forensic Nurse Examiners – FNE), supported by Doctors / Senior Clinicians and experienced Sexual Offence Examiners.

1.1 Services Available

All genders aged 16 years and over may access the SARC services through either reporting to the Police or by self-referring (non-Police) without Police involvement. They can also self refer completely anonymously.

All services are available 24 hours a day, seven days a week, including Bank Holidays.

Services offered include:
Access to another SARC in the region

Immediate Care
• Forensic Evidence Collection (Sexual Offence Examiners – Forensic Nurse Examiners and Doctors)
• Medical Care (Emergency Contraception)
• Healthcare Advice to clients who have concerns, queries or don’t know what to do
• Specially trained Police Officers provided by the four different Police Forces
• Crisis Support Workers
• Safeguarding and Referrals to appropriate support agencies

Aftercare
• ISVA Service (Independent Sexual Violence Advisors) Support and Advocacy
• Counselling provision
• Follow up heath checks
1.2 Police Referrals
If a client is referred to the service through reporting to the Police they will be accompanied to the SARC by a specially trained Officer. Once at the SARC the client will be introduced to the Crisis Support Worker who will act as a chaperone to support the client and be present during the forensic medical examination. A Sexual Offence Examiner will be present at the SARC to explain the Forensic Medical Examination to the client, this will normally be a Nurse Practitioner, and they will sensitively explain the process, conduct the examination and provide advice on any immediate and follow up medical care. The whole process is done at the client’s pace and the team will ensure the client has full control at all times to make decisions and feel comfortable throughout the examination process.

1.3 Non-Police Referrals / Self Referrals
If a client chooses to self-refer without police involvement, they will have the same access to a forensic examination and support from a Crisis Support Worker as a police referral. This service is invaluable for third party intelligence reasons and can help clients whilst they decide whether to proceed with criminal investigations. The Non-Police service (also known as self-referrals) is available on a 24/7 basis. This can be accessed via our phone helpline, or email contact through our websites for initial triage, confidential advice and support. If an examination is required, this is managed on a case by cases basis but normally directed to daytime hours, unless exceptional circumstances.

1.4 Definition of a SARC client
An individual is defined as a SARC client if they have engaged with at least 2 of the 3 SARC services; Police, SARC attendance for a Forensic Medical Examination and Independent Sexual Violence Advisor (ISVA) / ongoing referrals / Telephone Advice services. The SARC staff can discuss the options available to those who enquire for non-recent cases and may signpost on to suitable aftercare services.
2 SARC Activity Summary

<table>
<thead>
<tr>
<th>Month</th>
<th>Police Examinations</th>
<th>Non-Police Examinations</th>
<th>Total Examinations</th>
<th>Additional Referrals</th>
<th>Total Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>66</td>
<td>3</td>
<td>69</td>
<td>31</td>
<td>101</td>
</tr>
<tr>
<td>May-16</td>
<td>77</td>
<td>1</td>
<td>79</td>
<td>30</td>
<td>109</td>
</tr>
<tr>
<td>Jun-16</td>
<td>80</td>
<td>3</td>
<td>83</td>
<td>15</td>
<td>98</td>
</tr>
<tr>
<td>Jul-16</td>
<td>82</td>
<td>5</td>
<td>87</td>
<td>32</td>
<td>119</td>
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<tr>
<td>Aug-16</td>
<td>76</td>
<td>3</td>
<td>79</td>
<td>37</td>
<td>116</td>
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<tr>
<td>Sep-16</td>
<td>73</td>
<td>9</td>
<td>82</td>
<td>41</td>
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<tr>
<td>Oct-16</td>
<td>95</td>
<td>0</td>
<td>95</td>
<td>45</td>
<td>140</td>
</tr>
<tr>
<td>Nov-16</td>
<td>70</td>
<td>3</td>
<td>73</td>
<td>36</td>
<td>109</td>
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<tr>
<td>Dec-16</td>
<td>73</td>
<td>3</td>
<td>76</td>
<td>52</td>
<td>128</td>
</tr>
<tr>
<td>Jan-17</td>
<td>71</td>
<td>8</td>
<td>79</td>
<td>37</td>
<td>116</td>
</tr>
<tr>
<td>Feb-17</td>
<td>52</td>
<td>2</td>
<td>54</td>
<td>23</td>
<td>77</td>
</tr>
<tr>
<td>Mar-17</td>
<td>85</td>
<td>7</td>
<td>92</td>
<td>53</td>
<td>145</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>900</strong></td>
<td><strong>47</strong></td>
<td><strong>948</strong></td>
<td><strong>433</strong></td>
<td><strong>1381</strong></td>
</tr>
</tbody>
</table>

In terms of the number of clients being seen in the SARC in year one, the breakdown across the Force areas is as follows:
- South 23%
- North 18%
- West 44%
- Humberside 15%

3 Paediatric Services

Mountain Healthcare Limited are commissioned to provide a 7 day per week service to children and adolescents aged 0-15 years, this is delivered from the Hazlehurst Centre, West Yorkshire SARC.

During our first year we supported the Paediatric service in North Yorkshire at The Acorn Suite, York District Hospital by providing an FNE to assist the Paediatrician with forensic capture for acute cases for children and adolescents aged 0-15 years. Our Medical Director has worked with their service Nurse who is now fully competent to support these cases, with ourselves providing support when she is away on annual leave.
4 Executive Summary

In the period April 1st 2016 to March 31st 2017, 1,381 clients were referred to SARCs in Yorkshire and Humberside. The average number of examinations across the region for the year was 79 per month. February was the quietest month (54 examinations), and this was true across all our SARC services nationally. The two busiest months were October 2016 and March 2017. Since March we have seen numbers increase, in the first quarter of year two the number of examinations in April and June were over 100 for the first time since the contract started.

The number of Self-Referrals has increased across the year as follows:
- Q1 - 50
- Q2 – 57
- Q3 – 67
- Q4 – 65

The above figures show an increase of 15 (30%) throughout the year, and an increase of 3.75 (7.5%) self-referrals each quarter averaged out.

Figure 4.1 – Split of Examinations, Self-Referrals and Totals:
5 Supporting Data

5.1 Access by Gender

Our services are accessed predominantly by female clients (92%)

Male referrals into the SARC made up 95 of the caseload (7% of the total) across the region.

The remaining 1% is made up of those whose gender we were unaware of and 11 transgender clients.

*Figure 5.1.1 – Case Load split by SARC*
5.2 Client Demographics

*Figure 5.2.1: SARC Client Gender*

*Figure 5.2.2: Client Age*

The graph below shows the ages of all clients referred over the year on a quarterly basis. The graph shows an obvious trend that the most prominent number of clients referred throughout the year are aged between 18 and 45 years of age.
Figure 5.2.3: Client Ethnicity

Of the total 1381 referrals made during 2016/17, the overwhelming majority were recorded as White British. Ethnicity has historically been difficult to record. Ethnicity is recorded by the staff within the SARC or is provided on referrals (where available). It should be noted that clients are not given a list from which to identify their ethnicity.
5.3 Assault Details

As well as capturing key information on client referrals into the SARC, our database also allows us to capture and report in a lot more detail on meeting and assault location. We are able to analyse trends and share information. This is not something we include in the monthly / quarterly reports. Please see below the most common locations of any incidents.

*Figure 5.3.1: Meeting Location*

The graph above shows the 3 most prominent locations for clients to meet their assailants is at the victims home, at an entertainment venue or outdoors. This is not including the 101 clients that were already living with their assailant.
5.4 Assailant Details

*Figure 5.4.1: Client/Assailant Relationship*

![Assailant Relationship Chart]

N.B – For definitions of assailant / client relationship see glossary table 6.1

67% of clients presenting to the SARC who disclosed, knew, or were familiar with the assailant. Of this group 18% were categorized as ‘Stranger 1’ cases.
5.5 Identified Client Needs

5.5.1 Client Individual Needs

**Domestic Violence**
Domestic Violence was recorded in 66 SARC referrals throughout the year.

**Vulnerability Factors**
Other vulnerability factors we record include:
- Physical disability - 20
- Substance misuse – 57
- History or signs of self harm – 67
- Learning disability / difficulties – 67
- Sex worker - 13

A client may have more than one vulnerability factor, therefore the total does not equate to number of clients referred.

**Mental Health**
There were 243 clients that had identified as having mental health issues
6 Glossary

6.1 Assailant - Client Relationship

<table>
<thead>
<tr>
<th>Relationship to Client</th>
<th>Definitions – from Sussex Police (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stranger 1</td>
<td>Where the offender has no prior contact with the victim or where there are brief comments/questions between victim and suspect (e.g. Do you have the time?).</td>
</tr>
<tr>
<td>Stranger 2</td>
<td>Victim and suspect are briefly known to one another, for example they had met at a party, club or bar, or had a client/prostitute relationship. Includes minicabs, Internet approaches and positions of trust (i.e. bogus authority figures).</td>
</tr>
<tr>
<td>Not Known</td>
<td>Client has no recollection or knowledge of offender identity.</td>
</tr>
<tr>
<td>Family Member/Relative</td>
<td>Non-intimate family members and partners, honorary family members / family friends.</td>
</tr>
<tr>
<td>Partner</td>
<td>The suspect and victim are having a consensual sexual relationship prior to the attack. (i.e. husband/wife boyfriend/girlfriend, same sex relationships). This does not count if they were only intimate on the same evening as the attack.</td>
</tr>
<tr>
<td>Ex partner</td>
<td>The suspect and victim have previously, but are no longer, engaged in a consensual sexual relationship prior to the attack. This does not count if they were only intimate on the same evening.</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>Defined as a friend.</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>The relationship between the victim and the suspect has not been given or recorded.</td>
</tr>
</tbody>
</table>

6.2 Rape - Sexual Offences Act 2003

Any act of non-consensual intercourse by a man with a person, the victim can be either male of female. The 2003 Act extended the definition of rape from the Sexual Offences Act 1956 to include penetration by vagina, anus or mouth of another person (CPS, 2009).
6.3 Domestic Violence - Home Office Definition

The Home Office Definition of Domestic Violence is:

'Any incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults (aged 18 or over) who are or have been intimate partners or family members, regardless of gender and sexuality.'

In this definition:

**Intimate Partners** - where there is, or has been, a relationship with a degree of continuity or stability. The relationship must also have, or have had (or reasonably supposed to have had) a sexual aspect. The partners or ex-partners need not to have ever lived together.

**Family members** - includes mother, father, son, daughter, brother, sister, grandparents, in-laws and stepfamily.

**Psychological Abuse** - Could include humiliation, ridiculing, bullying, intimidation or deprivation of ordinary social contact.

**Physical Abuse** - any offence of violence.

**Sexual Abuse** - rape, and/or other sexual offence.

**Emotional Abuse** - harm which is deliberately or recklessly inflicted on a person's emotional well-being. May amount to an offence under the Protection from Harassment Act 1997.

**Financial Abuse** - where one party uses money as a means of exercising control over another.

7 References


8 Client Feedback

- Very warm, friendly environment
- Truly professional girls. Thank you support is amazing
- Very welcoming and polite
- I felt pushed by the police to come
- Very Friendly, made to feel at ease, given lots of support
- I was relieved when it was over
• The staff were brilliant, I felt I was not on my own
• When I left I felt like a big cloud has been lifted
• It felt like a hotel, I was catered for all my needs, thank you
• Crisis workers and nurses all were extremely professional
• Thank you for believing in me
• Score marks 10/10
• Nobody rushed me and I was able to be the boss
• It was too slow, it seemed I was waiting forever, the room was too cold
• It was informative well organised, we both felt at ease. Lots of support, coffee and toast.
• The staff listened to what I was saying, supported me through the process. I wasn't rushed. I was allowed to say no
• I just felt safe and wanted to be listened to. Examination not nice, but the staff made me feel happy
• As soon as you walk in you can feel the warmth. A lovely place, such lovely staff
• I was so looked after I hugged the staff - thanked them for all their help. Carry on with the good work. Fantastic staff
• They explained what would happen and were very supportive
• The staff looked after me, they spoke slowly as my English is not very good, I felt safe
• It was very friendly, I came scared and left feeling OK
• I felt very safe at the centre
• All the staff were fantastic. Well managed and very helpful
• Professional and discrete at all times
• It was good, they told me how it works and helped me through it
• The staff are very understanding and made me feel very comfortable and made me know that none of this was my fault and that I am the victim
• I want to thank you for the support and kindness shown and given

9 Aftercare Information

The SARC referrals provide us with an opportunity to ensure the correct health interventions have taken place, particularly in relation to sexual health. All clients who attend the SARC are also reviewed for their own sexual health needs and we are able to provide emergency contraception, pregnancy testing and also start them on HIV medication course if required.

9.1 Post Coital Contraception and HIV PEPSE
Post Coital Contraception was provided on 313 occasions last year. The number of clients risk assessed and consenting to PEPSE for the year was 126. Further clients may have chosen to be referred to local GUM services.
9.2 Aftercare Referrals - GUM, ISVA’s and Safeguarding

The SARC service has developed close working links with all sexual health services across the region, making 691 GUM Clinical Referrals from the clients that attended.

We work closely with our colleagues from the ISVA services and made 859 ISVA referrals in the year.

In addition to these referrals, we also have a mandatory process to make safeguarding children referrals for all children (under 18 years). We also made 280 safeguarding referrals in the year.

In addition we have also referred to other services not limited to GP, IDVA, SARC’s outside of the region. Our process for recording and following up referrals is being enhanced for 2017-2018.

10 Clinical Incidents (PAIERs)

Internally we call Clinical Incidents ‘PAIERs’, which stands for Positive Adverse and Irregular Event Reports. This is because we want to encourage reporting of all incident types, near misses and positive events, with a low threshold requirement to report and without worry of misinterpretation.

During the year of this report 78 PAIER’s were submitted since we introduced this method of reporting. These are processed through our Integrated Governance Board with Organisational Learning developed by investigating and reviewing the outcomes. This process was implemented part-way through this year.

11 General

Whilst our Regional 3 year contract commenced on the 1st April 2016, we stepped in two months early in Humberside taking over the service from the 1st February 2016 at short notice. During 2016 we delivered a number of training courses and programs as there were limited TUPE trained staff so we had to recruit and train both FNE’s and CW’s.

Yorkshire & Humberside has had a busy 1st year, all the teams are now settled and working effectively. The SARCs are all different in many ways, but maintain the high standards and fundamental Mountain Healthcare ethics. We are very proud of the team’s achievements, and the direction set for 2017. The implementation phase has now concluded, and the Managers are setting the pace and direction for the 2017/2018 year being more focused on tightening up procedures and consolidating.
With the support of the Commissioners three of the SARCs in the region have been funded for a brand new colposcope. We are soon to introduce a new regional mobile colposcope, the first one of its kind in the country.

12 Future Developments – Continuous Improvement Plan

Project 1: Environmental Improvement
Bridge House SARC, North Yorkshire closed for refurbishment during the last month of year 1, the longer-term plan is to find a new building.

The Hazlehurst Centre SARC, West Yorkshire is too small and not fit for purpose, especially with the daily paediatric clinics being delivered from the SARC. The West Yorkshire service is the busiest in the region (44% of the adult contract case load is within West Yorkshire), excluding the children and young people attending the CSAA Service.

Project 2: Establish Service User Forum
How do we know the change will result in improvement?
National Guidance and Statutory Legislation have identified service user engagement is vital for improving services.

NHS England and commissioning team have identified service user engagement as vital for delivery of their services.

Staff feedback has identified that no service users to date have been involved in service design.

Stakeholders have struggled to engage service users in a meaningful way therefore this is a gap in provision.

Mountain Healthcare commitment to a quality strategy has identified that patient experience is vital in establishing a service that is fit for purpose.

Improvement Update:
1) We have struggled to put together a specific forum of service users as our engagement with them is generally right after any abuse or trauma. However we are now collecting feedback through our 6 week follow ups.

2) We now give services users a variety of mediums to give us feedback. They can give us feedback whilst at the SARC using our anonymous comment box. They can submit feedback via prepaid post that we include in their aftercare pack or they can go on to our website and submit it online.
3) **Open Days in other areas have been held and include invites to specialist groups and have included schools and colleges and third sector organisations. These have proved extremely effective and we have had a really positive turn out of different people. We will implement this within the YaTH service in year 2.**

4) **Quality operations group - We have used this group to develop relationships with partners and to improve pathways:**
   a. **Robust pathways with ISVA providers –** They attend this group and always give positive feedback about the SARC’s services.
   b. **Services with Sexual Health –** We are working to engage with all local services and encourage implementation in such things as weekly sexual violence clinics. We also advocate carrying out their own audit of STI’s and SV cases.
   c. **Continuing to improve our relationship with the police.**
   d. **Engage with CPS requesting feed back about the quality of our statements.**
   e. **Mental Health is still an area for improvement engagement.**

5) **Engagement with Survivors Networks and work together to gather their feedback to improve our services.**

6) **Understand any other commissioned services we could link to in the region.**

Project 3: Improving Self Referrals – as evidence of improving access

How do we know the change will result in improvement?

The annual incidence of sexual violence reported to the police is 55,000 per year and it is reported that 11% of victims inform the police, yet the health consequences are devastating and leads to lifelong psychosocial consequences. Currently services are accessed by a relatively narrow social economic group demonstrating that current services fail to identify, support and prevent sequelae.

Improving self-referrals therefore should enable access to a service for those who do not want police involvement and in view of long term consequences, enable individuals support at a time when needed.

Self-referrals enable access to the criminal justice system but provide mechanisms such as third party reporting, anonymous testing as well as enabling police engagement but in a supported manner thereby improving intelligence of their local crime and improve criminal justice outcomes.

**Improvement Update:**
1) Our staff have all identified an area of interest and are championing links with that area. It is anticipated in the following years, consideration will be to use their feedback to identify an approach to different groups:
   - Young people
   - Men and Non Binary Genders
   - Nightclub and Bars
   - BME Community

2) Communication Strategy – our support for a Pan YaTH Communication Strategy is believed to underpin any successful increase in self-reporting however the SARC needs to be perceived as a holistic service rather than part of the legal response to sexual violence. This will and has included updating our website and social media sites so that they are more accessible. We have appointed a Communications and Information Governance Lead who is joining a YaTH Comms meeting in Aug 2017.

3) Improving Language and Marketing Materials – We are planning to work with local organisations to make sure that all of the language and artwork used in our marketing materials are accessible and inclusive of all genders. We believe that this will increase the amount of self referrals.

4) Pathways from professional groups – we would like to roll out robust pathways across professional groups.

High Quality Service Provision
Our staff have completed a competency framework for their role, have a person development plan and we are now completing their appraisals.

Data Collection
We have worked closely with commissioners to ensure that their performance data is fit for purpose, measures gaps as well as activity and allows health needs, outcomes and other measures to be monitored.

We are currently updating our client database to fit with the requirements of NHS England’s SARC IP’s template.

Our 6 week follow up has enabled follow up for sexual health, ISVA and mental health to be recorded. This development is still new and being refined.

Improvements to service is introduction of OASIS (Online and Secure Information System) changes to further enhance the recording of and acknowledgement of referrals made. This will greatly improve efficiency and accuracy of referrals and enable reporting of outcomes.

Continuing Professional Development
• Our framework in 2016 has included Child Sexual Exploitation, Female Genital Mutilation and Prevent which was added in response to national priorities.
• Our appraisal programme is utilising a software programme which enables recording of 360 feedback, complaints, clinical incidents, quality audit and continuing professional development which fulfils medical revalidation and in preparation for nursing revalidation requirements.
• Textbooks added to the SARC library have included:
  o Forensic Gynaecology
  o RCPCH Physical signs of child sexual abuse – 2015
• Our formulary has included changes to HIV PEP and has organised education to support the new regime.
• Peer Review has been established: fortnightly.
• Our team have attended a number of study days.
• We are supporting two places for Staffordshire University:- Forensic Practitioner Award.
• Our training platform is due to go live mid 2017.

Role of the Crisis Worker
As an organisation we have now started a project looking into the role of the crisis worker as we believe that there is no standardisation across the board and that the role changes depending upon which SARC they are in and the training they have had. We have been asking Crisis Workers and Nurse Examiners across all of the SARC’s we are involved with a series of questions based around what parts of the role they consider to be the most important. After all of the research has been completed we have put together a standard training programme and job description across all areas we are involved with.

Audit
• Our notes audit programme: all clinical staff have had an audit score >95%
• Our statement audit programme: all clinical staff have had an audit score >90%
• Our PGD audit: all staff have completed a compliant PGD audit
• Our infection control audit – is compliant
• Our Section 11 audit is compliant
• Our CQC compliance audit (in-house) has action plans included