



An Roinn Sláinte
Department of Health

Department of Health Policy Review: Sexual Assault Treatment Units (SATUs)

March 2019

Summary

PROCESS

Review Process

- The SATU Policy Review began in September 2018 and concluded in February 2019
- The Review examined the policy efficacy of SATUs asking “how well is current policy working in practice?”
- The Review Team comprised staff from the Department of Health, HSE, Department of Justice and Equality and SATUs
- The team completed its work in 10 collaborative working days and 10 fieldwork days – using the DoH Pathfinder Model.¹
- The Review presents 10 medium-term action areas, 4 short-term action areas and 2 long-term action areas

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FINDINGS

The Policy Review is satisfied with:

- The hard wired emphasis on patient* choice and consent
- The positive patient perspective and experience of SATU
- The extraordinary commitment and dedication of SATU staff in very challenging contexts
- Retaining the service in an acute (as opposed to community) setting
- Retaining the nurse-led model but within a blended team
- The levels of inter-agency cooperation
- The demonstrable focus on continuous service improvement

2

The Policy Review has identified a need to:

- Increase resourcing to ensure a sustainable service into the future
- Introduce more holistic, whole-person care for patients after first presentation to SATU
- Enhance the patient experience and service setting
- Improve national decision making to reduce local variation in services
- Strengthen accountability and quality assurance
- Increase staff supports to resolve systemic under-management

CONCLUSION

Key Takeaways

- Ireland led Europe in establishing specialist units to respond to sexual assault, 33 years later there is still huge pride in the service delivered to patients
- However, the combination of increased demand, financial constraints and localised decision making have resulted in a series of developments that have put SATU services seriously under pressure
- It is possible to find policy solutions and improvements now which can create a more sustainable and consistent SATU service and improve patient access, quality of care, and patient experience
- These changes will be critical to sustaining a high-quality service over time

* For the purposes of this Review, the term patient is used for consistency to reflect health sector terminology.

Actions

1 CONSISTENT

Every patient should have a common and consistent experience of the service irrespective of where they live or where the assault happens. **National planning, decision making, accountability and investment** is the only way to achieve this.

2 SUSTAINABLE

A patient's experience is influenced almost exclusively by the staff they meet. It is critical to take action to build a **flexible, competent, supported SATU workforce** for the long-term.

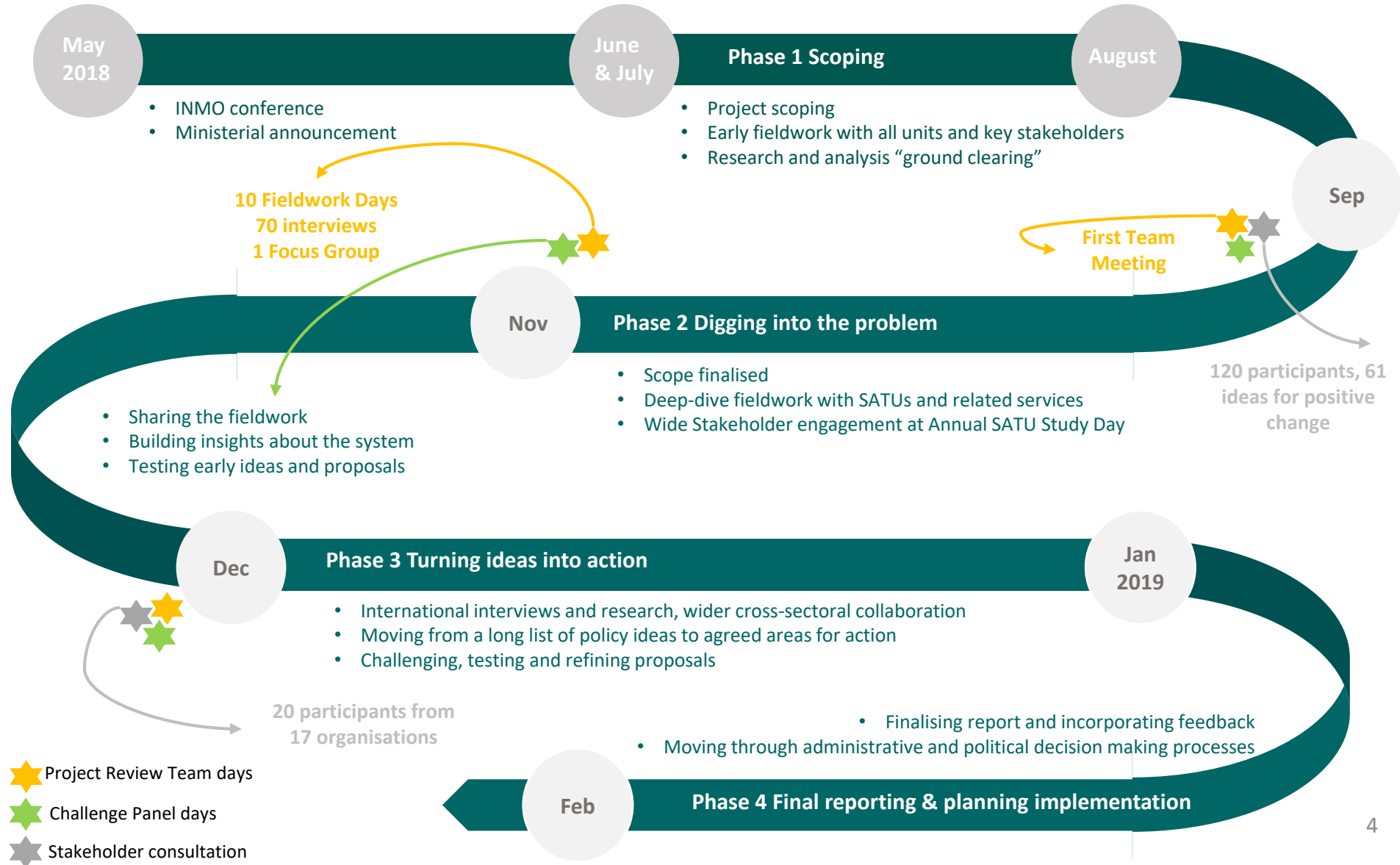
3 COORDINATED

Boundaries between professionals and services make it too easy for patients to get "lost in the cracks". **Increasing awareness of SATU and coordination within health services and across social services for patients** is a primary step to improving this.

Medium-Term Actions:

1. Increase and ring-fence baseline funding for SATUs nationally by 25%
2. Create a National SATU Service Network, supported by a National Management Team
3. Resource a minimum day-time, team-based staffing model for each SATU
4. Create a rapid responder 'on-call' rota so that forensic examiners can travel to support patients in their local unit
5. Roll out more frequent, flexible, modular, and inter-professional training to build a sustainable pipeline of qualified staff
6. Recognise the challenge of the working environment by introducing high quality emotional supports for all staff (core and on-call)
7. Improve oversight and quality assurance by introducing mandatory clinical supervision for all core and on-call staff
8. Expand the scope of service to include patient liaison and the coordination of medium-term after-care for patients
9. Communicate the role of and support available through SATUs more routinely and effectively
10. Convene a Sexual Assault Services Management Group of senior operational decision makers from different sectors to improve patient experiences and outcomes

Process



1

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

Appendices

In 2006 a National Review of SATU services led to a series of positive changes

The 2006 Review sought to develop a sexual assault treatment service which was local, accessible, discreet, compassionate and empathetic while underpinned by expertise and high standards of service delivery.²

It recommended:

1. "Standardisation of existing services"	Implemented in part
2. "Expansion of SATU services"	Implemented in full
3. "Pilot programme on forensic nursing"	Implemented in full
4. "Addressing gaps in the legal system"	Implemented in part
5. "Promote networking and sharing of information"	Implemented in full
6. "Further research requirements"	Implemented in part
7. "Training"	Implemented in part

Two major service developments followed the '06 Review:

- The opening of two new units (Galway and Mullingar) leading to 6 nationally
- The development of Forensic Nurse Examiners (FNEs) operating autonomously to carry out forensic examinations.

In 2018, a Policy Review was initiated in response to issues highlighted by SATU staff

SATU nurses highlighted a number of key issues in Spring 2018...

At a meeting with the Minister for Health, nursing staff highlighted a number of issues:

Variations in On-Call Pay

Scope for Advanced Nurse Practitioners

Appropriateness of Acute Setting

Development of a Paediatric Service

Staff Retention and Turnover

“...many developments (that) have taken place since the O’Shea Report on the service was published in 2006...high time for a further review of service provision...I will initiate stakeholder engagement on a new national policy for Sexual Assault Treatment Units”

Minister Harris, INMO Conference, 4 May 2018.

... In response, the Minister announced a Policy Review and scoping began in summer 2018

A series of meetings and SATU visits highlighted a number of additional critical areas:

Sustainability and Staffing

Issues raised around funding, service development, the staffing model, clarity of roles and responsibilities, appropriate scope of practice, training and retention.

Governance, Standards and Consistency

Issues raised around assessing victims needs, meeting fundamental forensic requirements, setting professional standards, oversight, accountability and access.

Patient-centred, Co-ordinated and Connected

Issues raised around follow up care, emotional support for patients, pathways and connections to wider health services, children's services, social services and justice.

New models for future service delivery

Issues raised around demand growth, service setting, centres of excellence, hub and spoke model and keeping pace with international developments.

A policy review is different to the normal policy or strategy development process

A POLICY REVIEW

A policy review is:

A Department-led but system-informed review of current health policy performance in a particular area.

A policy review is **not**:

- a system-led or expert-led working group process
- a new policy developed from first principles and informing the formulation of a vision, service objectives, model of service delivery etc.
- a clinical review of clinical standards
- a HSE-led operational service review

OBJECTIVES OF THE SATU POLICY REVIEW

1. To review the impact of current policy choices (both explicit and implicit) underpinning the operation of SATUs.
2. To use this information to identify policy opportunities to improve key service challenges in the short and medium term.
3. To identify strategic policy opportunities for long-term service development.

Value of a Policy Review

- Collaborative - entails deep engagement with all perspectives to build detailed system knowledge
- Practical – targeted focus leads to practical actions
- Fast – shorter timeframe
- Instructive - scope to pursue more detailed policy or strategy development in key areas, if warranted

It requires high levels of collaboration and accelerated problem solving....

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1. Different Methodology



Learning from the first DoH Pathfinder Project – Youth Mental Health, the Review aimed to:

- bring different system perspectives into the same room at the same time to work on a shared problem
- focus on policy in practice and think about how to design and deliver policy differently
- test and use ‘new’, interesting, relevant ideas, tools and techniques
- combine learning and experience
- work at pace: “perfect is the enemy of good”
- test policy ideas through iteration and connecting them with “deliverability” & “implementation”
- work differently: collaborative, innovative, iterative
- evaluate outputs based on impact and outcomes that change lives

2. Accelerated Timeframe

June – Aug 2018: What’s the issue?

- Scoping
- Research and Analysis
- “Ground Clearing” (review of current policy and evidence)

Sep 2018 – Dec 2018: Where’s the potential?

- Fieldwork
- Challenging/Testing
- Developing Areas for Action

Jan – Feb 2019: Refining

- Senior Stakeholder Engagement
- Report Preparation

March 2019

- Publication
- Implementation

10 + 10 + 3

Team
days

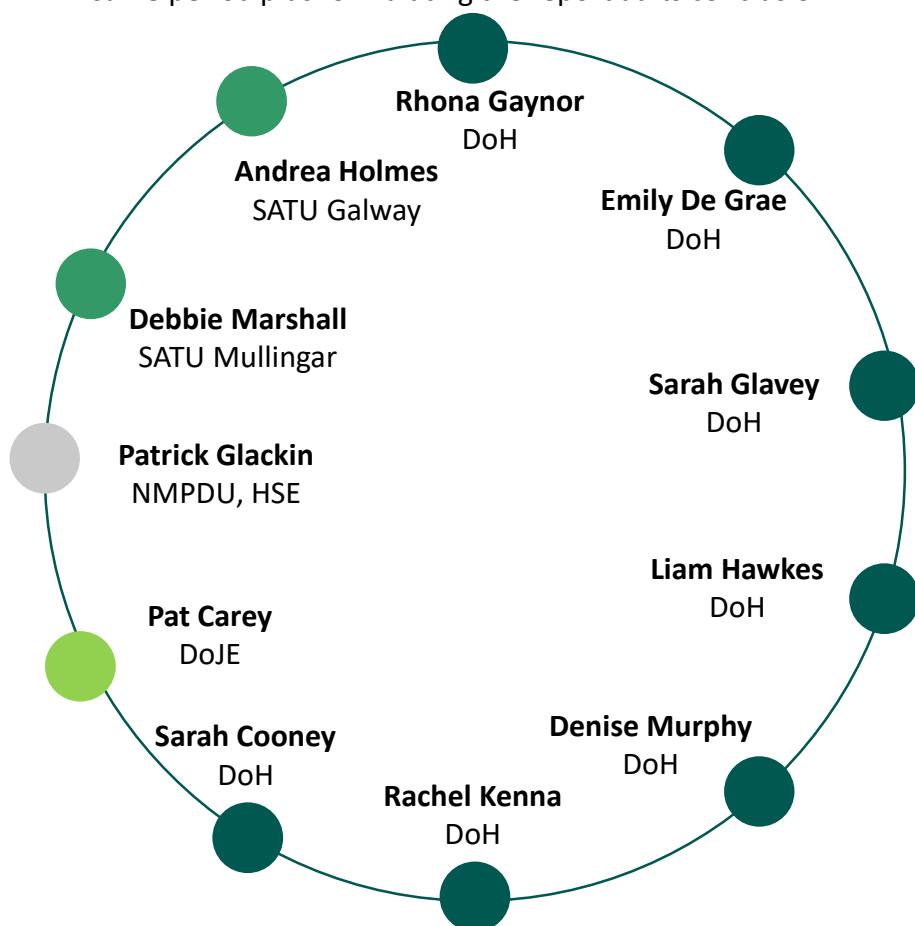
Fieldwork
days

Challenge
Panels

.... led by a team of internal and external perspectives working together....

Policy Review Team

- A small team of 11 committing 1 day a week for 16 weeks
- A core team of 3 committing 2.5 days a week over the same period plus formulating the report at its conclusion.



Policy Review Challenge Panel

A group of senior frontline staff and policy experts committing 3 x 2.5 hour sessions to act as critical friends to challenge and support the thinking of the Review Team in real time.

Dr. Maeve Eogan

National Medical Director

Connie McGilloway

SATU Donegal

Gerry O'Dwyer

HSE, CEO SSWHG

Aideen Walsh

SATU Crumlin

Sarah O'Connor

SATU Rotunda

Ross Wynne

DoJE, Cosc

Michele Clarke

DCYA

Noeline Blackwell

Dublin RCC

Sorcha Murray

DoH, National HR

Colm O'Reardon

DoH, Policy & Strategy

Ciara Pidgeon

DoH, Acute Hospital Policy

Dr. Colette Bonner

DoH, Deputy CMO

...and expansive, frontline fieldwork analysis involving a broad range of diverse voices

The SATU Review engaged with more than 200 Stakeholders in a 4 month period. A snapshot of key contributors:

SATU Dublin	Hospital Managers	An Garda Siochána	Rape Crisis Network Ireland	Irish Coast Guard	St Mary's SARC Manchester
SATU Mullingar	SATU Clinical Directors	NGOs/Victim Support	National Rape Crisis Centre Forum	Organ Donation and Transplant Ireland (ODTI)	SARC Netherlands
SATU Galway	SATU Patients	COSC	Dublin Rape Crisis Centre (DRCC)	Out of Hours Social Work Service	SARC Belgium
SATU Cork	HSE, various directorates	Director of Public Prosecutions (DPP)	Institute of Public Administration (IPA)	Tusla	The Rowan Centre, Northern Ireland
SATU Donegal	Hospital Group CEOs	Law Library of Ireland	Royal College of Surgeons in Ireland (RCSI)	College of Psychiatrists	SARC Finland
SATU Waterford		Forensic Science Ireland	Pavee Point	Psychological Society of Ireland	

To align with parallel processes, key areas were excluded from the scope of the Review

Out of Scope	Rationale for Excluding	Action to Align
Clinical Care Guidelines & Standards	National Guidelines are in place and supported by three-yearly multidisciplinary review process	<ul style="list-style-type: none"> • Fourth Ed. published in course of Review
Children's Sector Policy	DCYA Review of children's SATU service underway and pilot Barnahus site is in development	<ul style="list-style-type: none"> • DoH and HSE participating in DCYA project • DCYA and Tusla contributed to the Review • Ongoing engagement between DoH and DCYA
Industrial Relations Issues	Industrial Relations issues must be progressed through the appropriate IR machinery. Human Resources issues (staffing model, training, scope of practice, professional development) will be in scope	<ul style="list-style-type: none"> • National HR DoH contributed to the Review • Staff representative organisations were invited to contribute to the Review • Intention to align timeframes, where possible
Justice Sector Policy	Key related reviews ongoing within the justice sector (e.g. Review of the Investigation and Prosecution of Sexual Offences)	<ul style="list-style-type: none"> • Justice sector contributed to the Review • A Phase 2 could be considered to allow for deeper engagement with the justice sector on key findings

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Fieldwork and Analysis

Key Information and Data

Patient Perspectives

Staff Perspectives

Management Perspectives

System Perspectives

International Perspectives

Ireland does not have reliable or comprehensive data on the prevalence of sexual violence

Garda figures recorded approximately 3,000 sexual offences in 2017 although these offences are not well defined and the data has not been validated⁴

Almost 13,000 contacts were made to the Rape Crisis Centre 24hr Helpline in 2017⁶, an increase of 65% in two years since 2015⁷

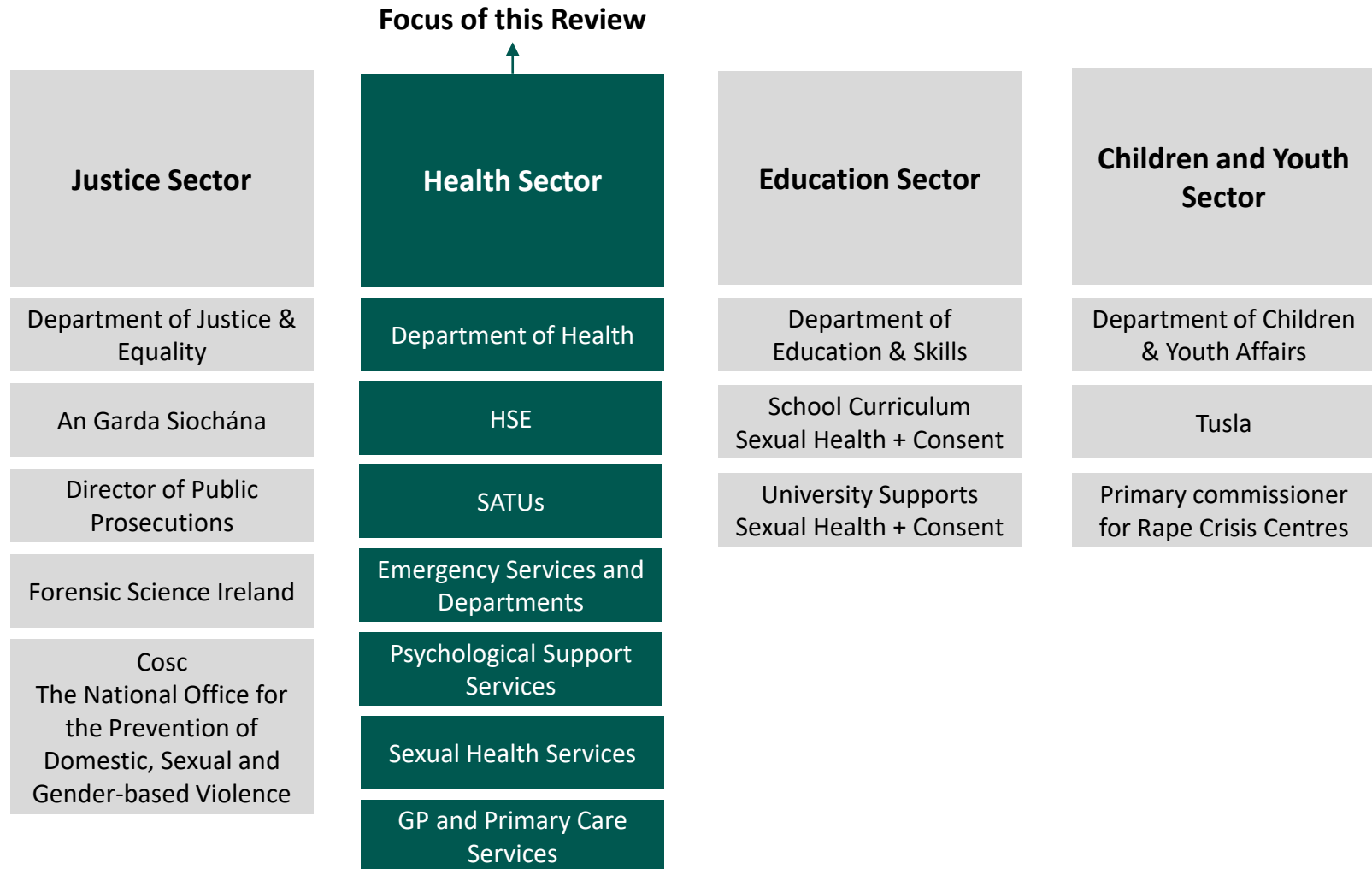
Sexual violence is systemically under-reported⁵

Over 1 in 4 have suffered sexual violence in their lifetime⁸

941

women, men and adolescents attended a SATU following a sexual assault in 2018⁹

Responsibility for responding to sexual violence is shared across Government



Voluntary organisations are commissioned to provide a range of services and supports across these sectors

SATUs are a key element of the support available in the Health Sector to victims of rape and sexual assault

Because of data gaps it is not possible to estimate how many seek or do not seek help after a sexual offence

Seek Help

Do Not Seek Help

Adults and adolescents that do seek help might choose to do so in a number of ways:

By seeking social or emotional support

For example:

- By contacting a local psychology/counselling service
- By contacting a local Rape Crisis Centre or National Helpline

By seeking medical support

For example:

- By contacting a GP or A&E who can refer to a **SATU**
- By self-referring to a **SATU**, an option available to all adults
- By seeking specialist support following STI screening etc.

By reporting to An Garda Síochána

For example:

- By contacting the Gardaí directly, who will then offer accompaniment to a **SATU**
- On the advice of public service professionals, friends or family

SATU Services are available to adults and adolescents through all of these pathways and the earlier contact is made with SATU the better

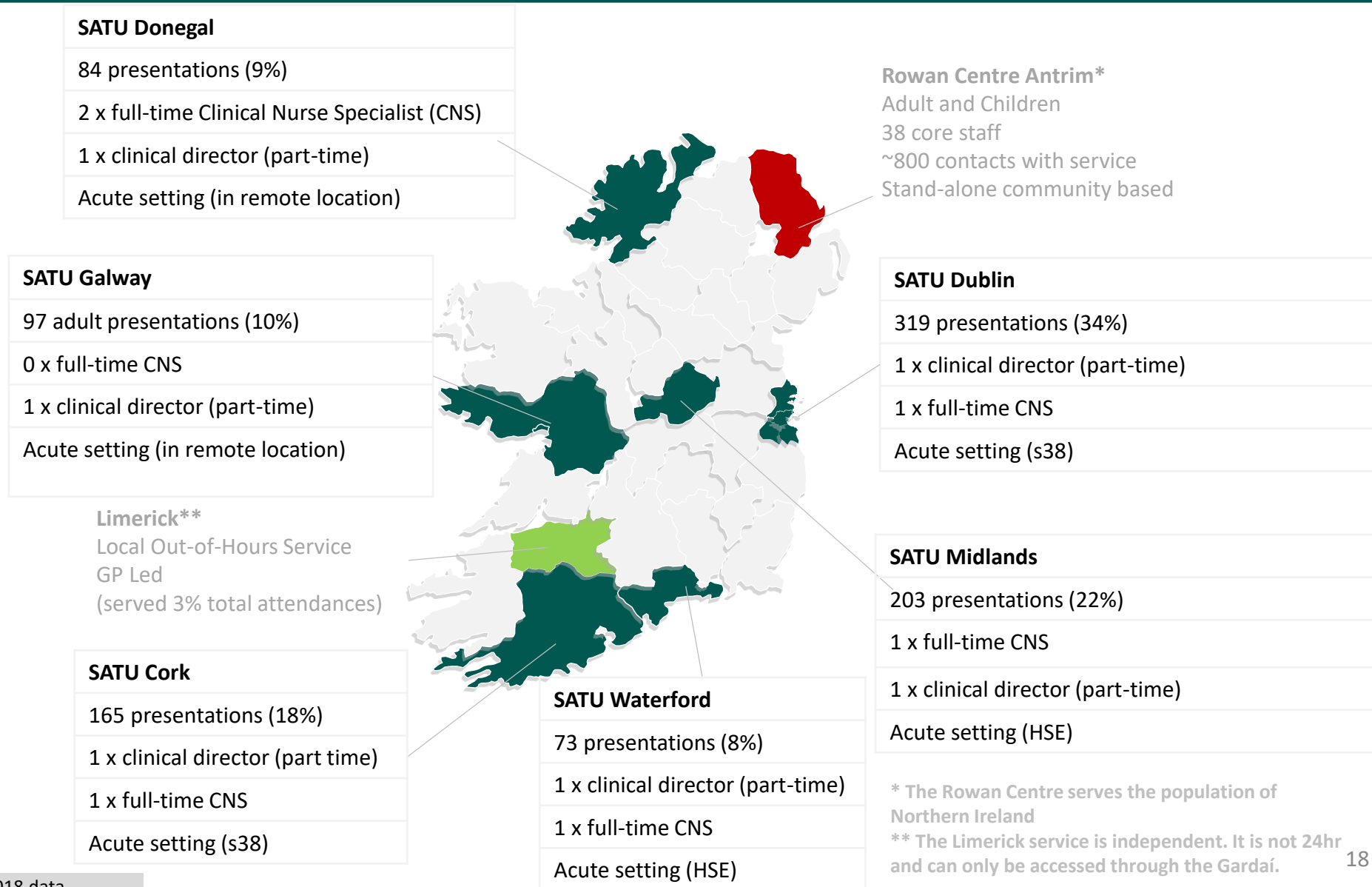
There are six SATUs nationally responding to 900+ cases annually⁹

Review Process

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SATUs provide an acute medical forensic health service

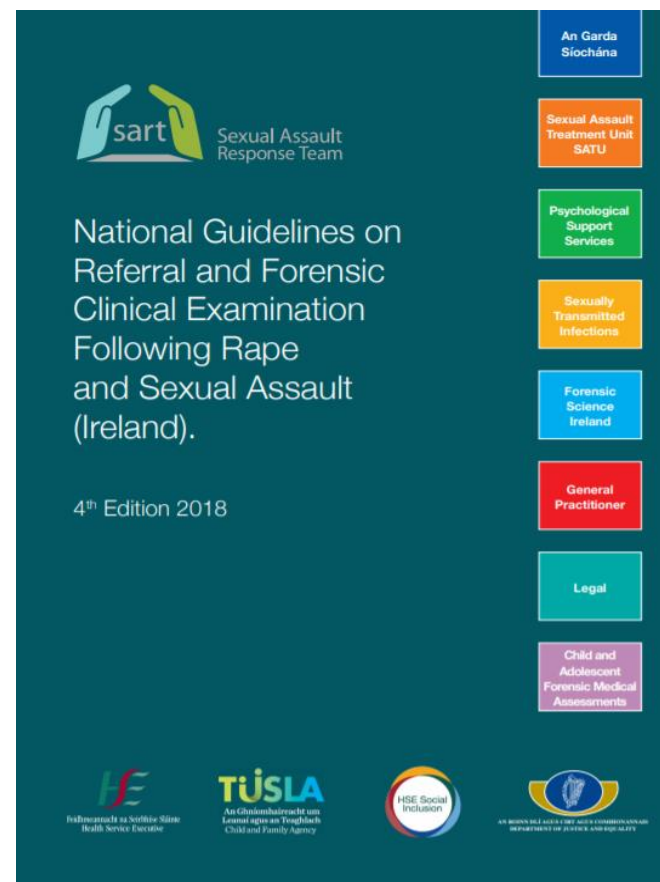
WHAT SATU DOES:

SATUs provide responsive and patient focused care for women, men and adolescents who have experienced sexual violence. The service has two main components:

- 1 Provision of medical and supportive care
- 2 Collection of forensic evidence

These are based on:

- ✓ A core agreed model of care
- ✓ Defined multi-agency guidelines¹⁰ and referrals
- ✓ A choice of care pathways for the patient
- ✓ Close partnership working with key services: Rape Crisis Network Ireland, Tusla, An Garda Síochána, Infectious Diseases Clinics etc.



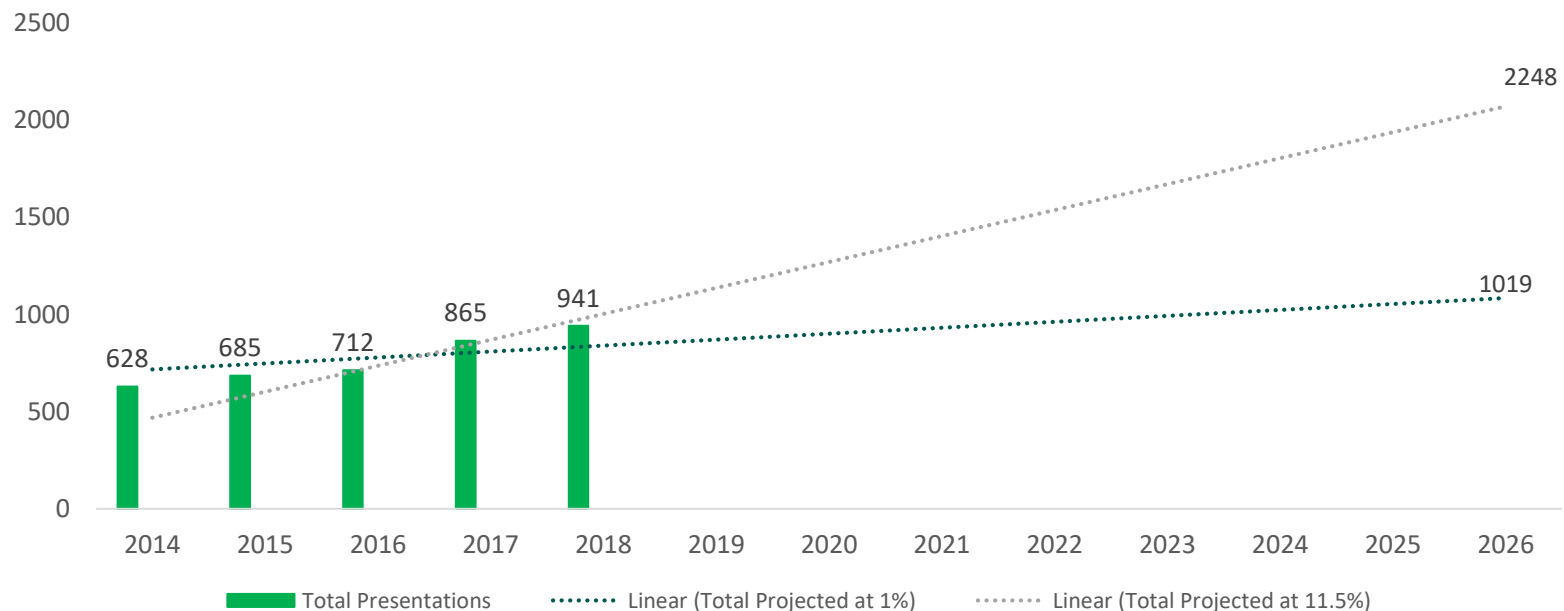
- The Health Sector response is therefore predominantly an acute response (focussed on the first 24 hours - 7 days following an assault).
- It responds to the immediate medical and forensic needs of adult and adolescent victims of sexual assault aged 14 and over.
- There are particular complexities in caring for adolescent patients who have varying degrees of maturity and capacity.

Demand for this service is unpredictable but increasing rapidly

- Rates of reported sexual violence¹¹ show an average annual increase of 13.5% since 2014¹²
- Rates of presentation to SATU show an average annual increase of 11% over the last 4 years¹³ and 44% since 2009, the first recorded national statistics
- A simplified and conservative projection¹⁴ linking presentations to anticipated population growth (range of 1% to 11.5% over the period) shows demand could increase nearly threefold in the next 8 years.
- This estimate excludes other factors that could influence demand (e.g. increases in awareness and self-referral, increases in rates of sexual violence etc.)

Possible Demand Growth for SATU Services

Estimated demand range 2018-2026, CSO data combined with service data*



Units are funded locally to meet this need with limited national strategy or planning

Units report collectively spending €2.1m on SATU Services in 2017....

Rounded pay and non-pay expenditure figures from each local unit for 2017:

Unit	2017 Reported Funding
1	250,000
2	400,000
3	430,000
4	730,000
5	200,000
6	130,000
TOTAL	2.1million

....However, this estimate does not capture all service developments funded in that year

SATU staff work jointly on a range of initiatives that are typically funded on a once-off basis from a range of acute or community funding lines.* For example:

Health €

Justice €

Annual Study Day

6,500 p/a

National Guidelines

23,000 every 3 years

National Database

85,000 set-up, 8,000 p/a

Secure Freezers

21,000 - once off

CNS Training

Salary + 13,000 – once-off

ANP Training

Salary + 12,000 - once-off

CNS CPD

14,000

- Clinical Directors and staff report having no visibility over the level of funding to their unit or scope to manage or direct the funding available to their unit
- Combined with the reported invisibility of SATU at governance and management forums (See Slide 36), this is problematic

This has the potential to directly impact the quality and experience of the service for patients

The absence of strategic, national decision making on the development or delivery of SATU services has a number of practical consequences.

For example:

Setting	Consistency	Availability
<ul style="list-style-type: none">• SATUs are intended to be distinct centres where patients can access the services they need discreetly• A number of linked rooms are ideal to provide the service with some limited specialist technology and equipment required (see Slide 49)• The ability to forensically clean the environment is a key requirement• The ability to treat patients in different settings for an acute examination versus follow up appointments is desirable.• Staff in all of the units agree that significant improvements are needed to the physical setting available to SATU patients	<ul style="list-style-type: none">• The National Guidelines provide comprehensive instructions for forensic examination• The service educates core and on-call staff regularly about changes and developments in procedures• Staff shortages mean a high-dependence on on-call service provision for SATUs• This is always likely to be appropriate given the 24/7 nature of the service• However, the absence of funded clinical directorship time means there is patchy provision of clinical supervision. This time is crucial to maintain and ensure a consistent standard in a service dependent on multiple contributions	<ul style="list-style-type: none">• The absence of national service planning for SATUs has led to staff shortages in every unit• Exit interviews (slide 34) highlight various underlying reasons for staff shortages which can be addressed with appropriate management of the service• The real-world consequence of this shortage is some SATUs may not be able to cover 24/7/365, meaning patients may have to travel to access the service• 5% of patients were required to travel additional hours to access a service in 2018• This has a direct impact on the level of trauma endured by patients and particularly impacts self-reporters

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Fieldwork and Analysis

Key Information and Data

Patient Perspectives

Staff Perspectives

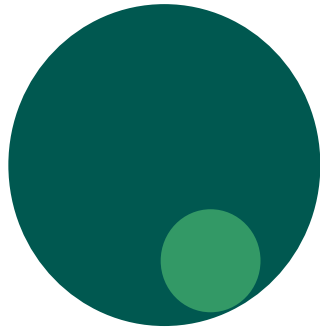
Management Perspectives

System Perspectives

International Perspectives

Like most traumas, no patient ever expects to use the SATU service and SATU patients are diverse

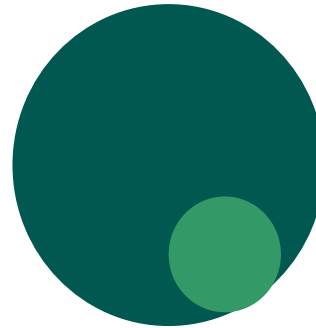
Who comes to SATU:



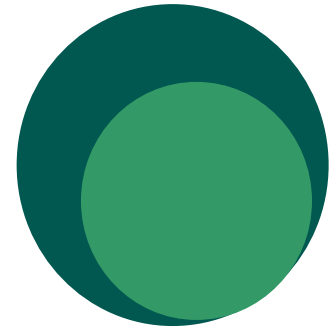
1 in 10
patients are men⁹



1 in 2 patients are under
25 years of age⁹
1 in 10 are between 14
and 18 years of age⁹



~13% have an
intellectual disability*



~55% have a self-reported
history of mental ill-health*

Where do they come from?

Over 1 in 4 patients suffer physical trauma as part of their assault¹

6 in 10 patients come with the Gardaí, almost half do not and 1 in 5 self-refer and come directly⁹

~16% patients come from state settings: prisons, residential care homes, nursing homes, direct provision, homelessness*

Almost half of all national presentations are Dublin-based⁹

When do assaults happen?³

During freshers week, leaving cert results night

At music festivals, conference events, gigs

At home, in a close relationship, within family

On holidays, at home or abroad

The pathway into SATU is not always visible to patients but is well understood between key services...

Review Process

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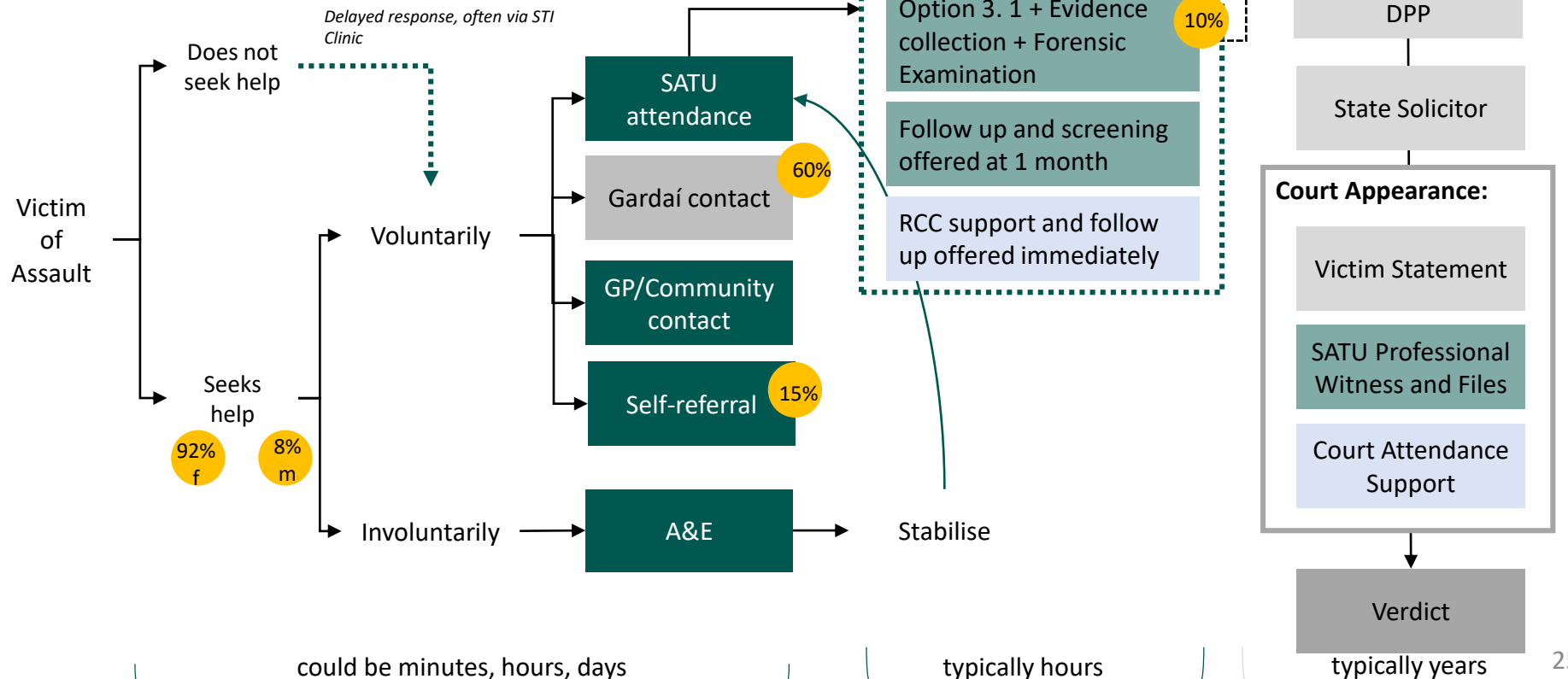
Typical Patient Pathways

Adult Victims of sexual violence

NGO Sector

Justice Sector

Health Sector



...however, the absence of managed transitions between services means patients can fall through gaps

Patient Lens

Envisaging the pathway in the patient's shoes highlights flashpoints(⚡) and raises a number of critical questions that underline the importance of a cohesive response:

How we do we encourage help-seeking behaviours?

How do we reduce the rate of violence and reoffending?

Victim of Assault

Can we be pro-active in supporting vulnerable or at-risk groups?

Does not seek help

Seeks help

Voluntarily

Involuntarily

SATU attendance

Gardaí attendance

GP/Community /RCC attendance

A&E

Stabilise

Can we create a more patient friendly setting?

Patient choices:

1. Medical review, treatment and support

1 + Garda Reporting + Forensic Examination

1 + Evidence collection + Forensic Examination

Medical follow up and screening at 1 month

RCC support and follow up offered immediately

Return to pre-trauma life post-trauma

Possible legal action

How do we create a seamless and supported transitions?

Can we strengthen follow up and focus on recovery?

How do we improve service connections before first contact with health system?

could be minutes, hours, days

typically hours

SATU patients are positive about staff and their immediate experience, but not their follow up

10 patients contributed to the Review by confidentially sharing perspectives on their experience...*

They told us:

"Can't fault it" - on experience at SATU

"I haven't heard anything; I don't know what's happening" - on follow up and reporting

"My only problem was travel....they say SATU is a 24 hour service and its not" - on access

"It was everything I hoped and expected" - on experience

"I feel like you're left on your own....people should check in on us" - on follow up and reporting

"Area was very clinical, very cold, not welcoming" - on setting

"The detective I rang in July, he phoned back in October" - on follow up and reporting

"I felt safe" - on experience

"It was what it was" - on experience

* Efforts were made to collect recent data to inform the review and ensure a representative sample

2

Fieldwork and Analysis

Key Information and Data

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Each unit aims to provide a 24/7/365 service to meet demand and respond to patients within 3 hours

Each unit responds to a case in the same way, following the National Guidelines

The following staff are essential:

A forensic examiner

Note: Only staff with specialist training in forensic examination can complete a forensic exam and may be expected to attend court as a professional witness, if a case progresses

A support nurse

Additionally cases may involve:

A psychological support /crisis worker being available to patient (typically a RCC volunteer)

The Gardaí will be available to patients, if desired/if reporting

Family or friends who may attend to support the patient

3 Hours*

Target Response Time

- Following the 2006 Review, the Units are geographically distributed to enable any patient nationally to access the service within a 3 hour window
- This reflects the time from when a call is made requesting service (from the Gardaí, the patient, or related health professionals) to the time a patient enters the door of a SATU

3 Hours

Target Response Time

In 2018 this standard was met in 90% of cases**

4 Hours

Average Case Length

- Each case differs depending on the unique needs and requirements of patients
- Broadly, in order to provide an explanation to patients of the process, support them to take the right decision for them, conclude a forensic examination, provide appropriate medical intervention and make a plan for further care requirements, staff report most cases taking approximately 3 -5 hours

* As measured by the key performance indicators (KPIs) and Monitoring and Evaluation in Irish SATUs

** As recorded in the SATU National Database

To enable this, the SATU staffing model is largely specialist nurse delivered

The nursing component:

1

The SATU service is largely nurse delivered - unlike other countries which are clinician delivered or team based (NI, UK, BEL, NL)

2

This development has been possible in an Irish context because we train the highest qualified forensic nurse examiners in Europe – Clinical Nurse Specialists (CNS) Forensic Examiners

3

The Irish service also incorporates advanced nursing with 1 current Advanced Nurse Practitioner (ANP) post and 1 approved

4

The pipeline to train staff is long, however 12 CNS Forensic Examiners are in training and 9 will be released to support the adult service by autumn 2019

5

In line with best practice, all nursing staff report through the Director of Nursing/Midwifery in their hospital who maintains overall responsibility for standards and competencies

Wider service elements:

Clinical Oversight

Is provided at consultant clinician level in each unit but time is not always protected for this.

Counselling for Patients

Is provided on a commissioned basis through DCYA by the local Rape Crisis Centre.

Clinical Support for Patients

Is provided by support nurses on each case and a range of related professionals who may be called to provide advice or referral (e.g. a psychiatric review).

Emotional Support for Staff

Specialist vicarious trauma support is not provided. Wellbeing support is provided through the Employee Assistance Programme (EAP).

Administrative Support

Is crucial given the legal status of all documentation. It is available in some but not all units impacting on clinician time and availability for service delivery.

However, there are staff shortages across units...

The current staffing profile varies from unit to unit.....

- The national caseload is currently being managed by a small number of full-time staff supported by an on-call rota
- SATU is largely a nurse delivered service but the staffing profile is different in each unit due to the availability of expertise – this is most noticeable in the development of advanced nurse practitioners (ANPs) which has been supported in two units but not in others
- There is no agreed staffing model for this service, and there is variation in managerial and clinical oversight
- That the current case load has been met from within existing resource demonstrates significant commitment and dedication from the current staff cohort but does not represent best practice

...and does not currently align with Safe Staffing Frameworks.¹⁵

- As a predominantly nurse led and nurse delivered service the Framework for safe Nurse Staffing and Skill Mix (DOH, 2018) is applicable to the SATU service
- The Framework has been piloted in other areas and is a proven methodology to calculate the number and skill mix of nurses and other staff for a 24/7 service
- Providing a critical mass of ANPs in 4 other challenging areas of healthcare (recently piloted) has shown increased access, less contacts to get appropriate care and efficient episodes of care and follow up for patients
- Initial pilot data shows that ~67% of patients seen by an ANP in the acute/emergency setting have their episode of care completed by the ANP and do not require referral to another health professional

	Correct as of January 2019					
Unit	1	2	3	4	5	6
Clinical Director (PT)	1	1	1	1	1	1
ANP forensic nurse examiner	0	0	1	0	0	0
CNS forensic nurse examiner	2	1 (PT)	1	1	2 (PT)	1
Staff Nurse	0	1	0	0	0	0
Admin	1	1	0	1	0	0

Comparator Services:

- An example of other 24/7 services where senior/specialist nursing is required is the emergency department staffing model
- In order to provide a CNM 2 shift leader 24/7 365 a WTE of 5.5 is required. This allows for annual leave cover facilitating the 24/7 requirement

...requiring a high dependence on on-call service provision and/or the transfer of patients

A small number of staff carry the weight of the 'out of hours' service delivery...

Adult services nationwide are currently supported by the following forensic examiners*:

Unit	FNE On-Call	FME On-Call	Support Nurse
1	1	3	Requirement for support nurse on-call to support each case
2	0	3	
3	2	1	
4	2	6	
5	2	0	
6	1	6	
Total	8	19	

Fieldwork suggests declining numbers participating in on-call.

- Despite this, it is not always possible to fully staff a unit due to the lack of availability of qualified forensic examiners
- Where it is not possible, it becomes necessary to transfer patients to the nearest available unit
- This happened on more than 50 occasions in 2018
- The recent addition of FMEs to the on-call rota in the busiest SATU has already had an impact on reducing this number, showing the importance of sustainable staffing supported by on-call availability

Informal estimate, correct as of November 2018.

Staff shortages are driven by an extraordinarily high attrition rate and a training time-lag

Of the 20 FNEs trained since 2008, only 6 remain in the service

A number of factors relate to this trend:

1 Pay and Conditions (Out of Scope of this Review)

- Fieldwork highlighted variance in on-call payments for forensic examination. Contributors cited two areas of concern (1) on-call rates between FNE and FME staff (2) local variations in rates paid to FNE staff
- There are also outstanding WRC recommendations in relation to pay and allowance since 2011

2 Professional Support and Development

- CNS training is 12 month duration and available every three to four years
- The HSE currently mandates that a post must be available before candidacy for the training programme can be considered this limits the development of a qualified pipeline
- Medical Examiner Training is more sporadic and last occurred five years ago
- Medical Examiner numbers have reduced and fieldwork highlighted a need for CPD and competency supports to encourage this cohort to volunteer for on-call work
- Very limited CPD is available to staff and in some cases not provided at all – either in terms of financial support or protected time
- No career progression currently for nursing staff – applications for development of advanced practice rejected in a number of units – this is a disincentive for staying in the service long-term
- No career progression for medical staff either – clinical directorships are largely voluntary and not remunerated - e.g. no professional forensic pathway as exists in the UK
- No protected time for peer support or learning (e.g. guidelines, study day)

3 Management and Support

- Fieldwork highlighted key elements of support missing from this service [that you would expect to see]
- For example, clinical supervision support to staff is voluntary, occurring inconsistently and infrequently
- There is no specialist vicarious trauma support [as you would expect] for a 'blue light' service responding to trauma and violence - other Irish comparators (e.g. Coast Guard) are ahead in this regard
- Hospital Managers and governance structures maintain light-touch engagement with the service
- Key performance indicators (KPIs) are recorded for this service but not reviewed

However, changes to scope of service and organisational support could be enough to stop or reduce attrition

21 Interviews

3 - DON/M
ADON/M

11 FNE

4 CDs

2 On-Call GPs

1 Admin

The Review Team interviewed 21 current and former staff members to understand why staff were leaving the service

- No one had led exit interviews to understand these perspectives, some staff left voluntarily, some retired.
- The Review Team had some assumptions as to why staff had left – pay and the traumatic nature of the work.
- But discovered that caring for the patients was the most satisfying part of the job: *"You could 100% care for somebody for the time they were with you...there was nobody waiting at the door for me to go and see another patient"* - FNE.
- While pay and allowances were mentioned as a contributing factor – there were other important issues too...

A lack of management structure

"It's just a very unsupported job really... you either sink or swim." - FNE

A lack of support structures

"I suppose I'm burnt out really. I'm demoted, I'm on less pay and working less hours – that's the impact it had on me." - FNE

No understanding of the service

"You just sort of got to the stage where you just sorted things out yourself...we were the poor relation of the hospital." - FNE
"They didn't get the importance of what we did." - FNE

Staff shortages

"I have been on call every weekend of the last four weekends, and I have been called in every weekend, I have a young family." - FNE

"I was in and out of occupational therapy. I'm not an anxious person but by the end of the job I was on anti anxiety meds." - FNE

Inflexible working arrangements

"Morale has been very poor at times. I don't think it would be an easy place to work Monday to Friday 9-5." - FME

Lack of CPD

"I hope I'm still current." - FME

Pay disparity

"We were all trained the same – we should be paid the same." - FNE

Underfunding

"Mother of invention is not how we should be functioning." - FNE

No career pathway

I left "to get a better job, get a promotion – it was the right time." - FNE

"The whole nature of forensics is moving faster than all of us put together." - FNE

2

Fieldwork and Analysis

Key Information and Data

Patient Perspectives

Staff Perspectives

Management Perspectives

System Perspectives

International Perspectives

SATU staff are focussed on quality measurement and improvement but this data is not being used management level

Review Process

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Proposed Actions

Staff continue to lead a number of quality improvements for the service independently

- Staff developed a set of KPIs which are routinely tracked
- Staff have also independently developed an online platform since 2017 which local units can update, to provide an overview of performance at a national level
- Each unit also produces an annual report and submits this to the National Medical Director who publishes the reports
- KPIs include clinical metrics at the local unit level, but do not include corporate or financial measures, and do not include national level metrics

SATU KPI Measures in 2018

KPIs are used to measure performance against 5 key target areas

SERVICE ATTENDANCE ACTIVITY

QUALITY OF RESPONSE

QUALITY OF CARE

QUALITY OF FORENSIC SERVICE

QUALITY OF SERVICE

The SATU service could be better supported by corporate quality improvement programmes...

For example

- HSE Quality Improvement Division – Framework for improving quality
- HSE Accountability Framework
- HIQA National Standards for Safer, Better, Healthcare



HSE framework for improving quality

And a number of related strategies and policy initiatives...

For example

- The National Sexual Health Strategy
- SláinteCare Implementation Strategy with its focus on integration of care across acute and community settings

Management are aware of the challenges but low volumes and lack of visibility mean SATU is rarely prioritised...

The governance structure for SATU is poor with significant gaps

- Responsibility within HSE corporate is dispersed with no clear accountable officer
- Reporting lines within Women and Children's Directorates is an okay but not ideal fit, particularly given male presentations
- Traction and visibility within Hospital Group governance is negligible
- Connection to local hospital governance and resolution processes is largely linked to urgent issues only, not service planning and development, quality improvement etc.
- All managers who participated in fieldwork could identify the challenges for SATU but referenced competing high-volume pressures (e.g. trolleys, waiting lists) as reasons it is systemically under-prioritised
- These factors have persisted over the medium-long term despite no shortage of senior decision makers who have responsibility for SATU within their remit. For example:

4 Hospital Group CEOs with a SATU within their remit

6 Hospital Managers with responsibility for SATU

6 Directors of Nursing with line management responsibility

6 Clinical Directors with named responsibility for SATU activity

1 National Medical Director with no budgetary control or authority

1 informal HSE Lead, not a part of formal responsibilities

1 HSE Commissioning Lead for specialist acute centres since late 2018

Management Perspectives during fieldwork:

"no one has the first idea of what we do" - CD

"high impact service, runs very well because nurses are excellent" - CD

"I should know more about what's going on, would prefer to know more about what's going on, unfortunately I end up reacting" - CD

"role is pragmatic rather than strategic, a lot of time spent fire fighting" - NMD

"[SATU is] a Cinderella service" - HSE

"needs a clinical programme like the maternity strategy"
- Hospital Management

"small fish in a big pond" - CD

"decisions are not transparent" - CD

"would prefer protected time rather than money" - CD

"it's one of these services that is very much under the radar" - CD

"Be careful not to raise expectations you cannot meet" –
Hospital Management

Governance and accountability gaps are key barriers to strategic service improvement

1

Structural Changes.....

- Fieldwork shows a strong consensus that SATUs should remain within the acute hospital structure to maintain connection to A&E as necessary and to enable appropriate mobility and flexibility for staff
- There may be benefits to re-alignment or greater alignment with urgent and unscheduled care directorates either through joint governance and decision making or joint training/skills development

2

...and clearer roles and responsibilities at all levels are essential and urgent

- While responsibilities are clear within hospital setting, this is not always matched by interest or attention
- Accountability is insufficiently clear
- National Medical Director post has responsibility but not authority to drive change nationally
- No appraisal or review process to assure service quality or outcomes

Sufficient

Insufficient

National clinical guidelines

National Service KPIs

National clinical leadership

National corporate and operational decision maker

National service planning

National quality review and assurance

National cross-sectoral coordination

National data, research or communications

National Governance

Women and Children's Directorates

Regional Governance

Women and Children's Directorates

Local clinical leadership

Local unit management

Local Governance

	Clinical Accountability	Corporate Accountability	Financial Accountability
HSE Corporate	Unclear	Unclear	Clear
Hospital Groups	Unclear	Clear	Clear
Hospital	Clear	Unclear	Unclear
Units	Clear	Unclear	Unclear
Staff	Clear	Unclear	Unclear

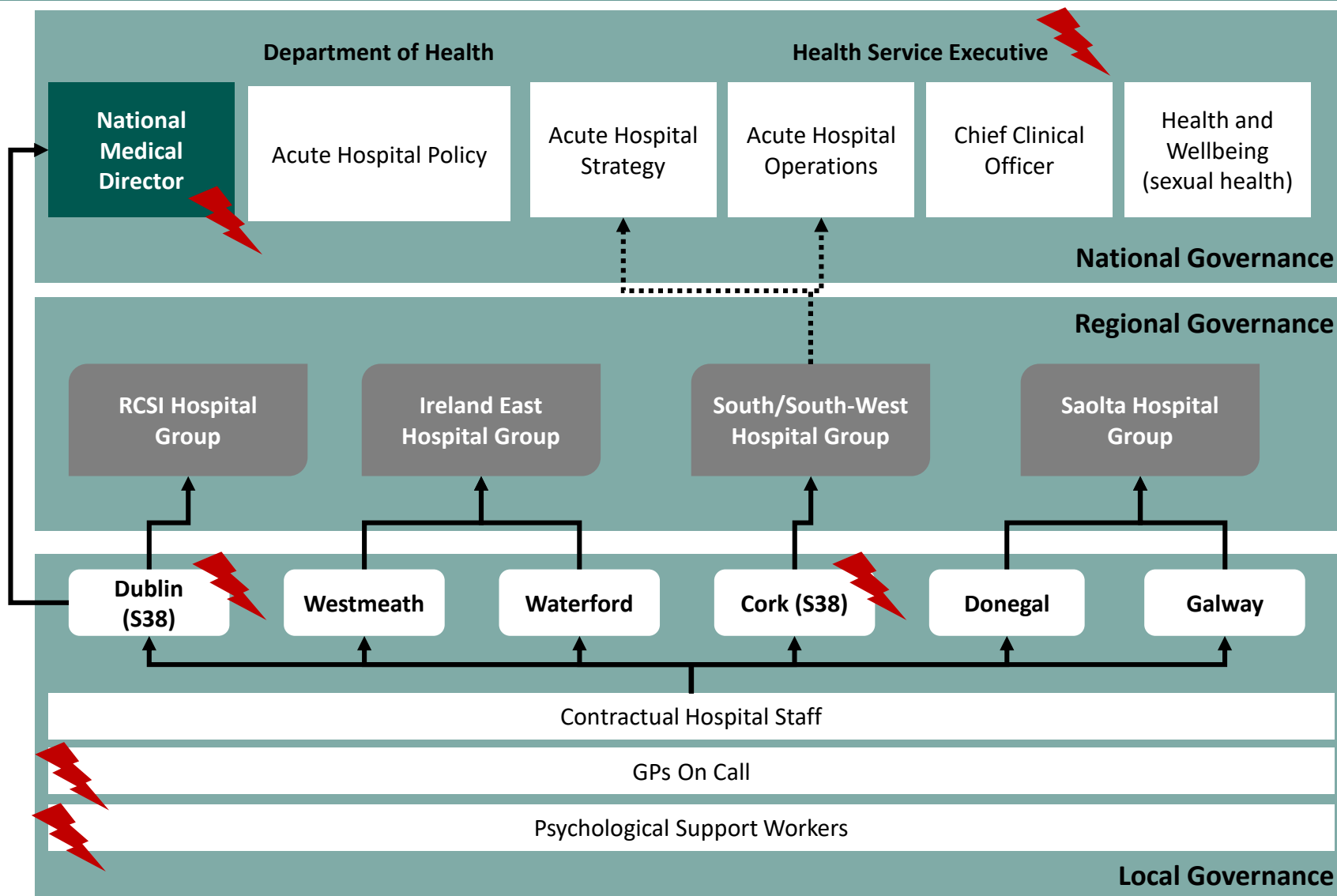
And reporting lines require clarity in a number of key areas

Review Process

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Indicated areas where roles and responsibilities need to be clarified

2

Fieldwork and Analysis

Key Information and Data

Patient Perspectives

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Inter-agency working is common but is mostly local and informal which can impact on consistency...

There is a strong appetite for more defined inter-agency working around SATUs for a range of reasons....

1. Improving consistency of standards for inter-agency working across the service will improve consistency for patients

- *“shared standards that everyone could sign up to.” - RCNI*
- *“the guidelines are setting as high a standard as possible...but the problem is on the ground.” – a local RCC*
- *“goodwill makes up for a lot of things.” – a local RCC*

2. Relying on personal relationships and goodwill to support inter-agency working is a risk:

- *“important it doesn’t depend on a few personalities to get along.” – RCNI*
- *“At the moment, it is managed goodwill.” – local RCC*
- *“sometimes it goes wrong and its down to personalities.” - local RCC*
- *“it all comes down to relationships and how you get on...so much comes down to who you meet and people getting on... shouldn’t only be down to that.” – local RCC*
- *“reliant on the people in it...not a good thing.” – FNE*
- *“inter-agency working shouldn’t come down to people having a good day.” – FNE*

3. Improving the connection to services that help patients in their medium and long-term recovery:

- *“a standalone area, not well connected.” – FNE*
- *“relies on personalities rather than set-up care pathways.” – FNE*

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...and there is limited governance of inter-agency contributions to SATU services

Social and emotional supports are currently provided by the RCCs

There are organisational and regional variations within Rape Crisis which can mean patients can have different experiences

- There are 16 Rape Crisis Centres in Ireland, of which 6 provide SATU support.
- Many of the services offered to SATU patients are volunteer led.
- Each centre has its own governance, service standards, service offer, quality standards etc. This means the counselling services patients access can vary significantly.
- For example, fieldwork showed some SATU patients, if they become RCC clients, had been asked to make a contribution to the cost of their counselling. Some centres scheduled this as a costed amount or a sliding scale of costs, others as a discretionary amount.

"All required to have common standards thanks to Tusla...but not enough questioning of what this looks like for the patient" – National RCC Forum

"[there is a] question for the RCC around the role of the psychological support worker and whether this should be re-examined." - Tusla

"I don't agree with someone non-professional accompanying the patient before giving their statement... not trained to give (formal) psychological support and don't think they are providing this support." – FNE

RCCs provides a clear contribution to SATUs, but receive no health funding and is instead managed through DCYA

- RCCs are commissioned and funded by DCYA through a Tusla-RCC Service Level Agreement.
- This means the DoH does not have formal oversight over what is commissioned or how well.
- The localised structure of SATUs also means Tusla does not have a clear contact point in the health sector with which to address issues as they emerge.
- This also impacts the ability to quality assure services.

"we don't have a formal commissioning role in relation to RCC – most things continued as custom." – Tusla

"not sure core deliverers in SATUs see Tusla as a key stakeholder – not in an actual structure...don't have a key contact in the HSE." – Tusla

"Uncertain role in relation to SATUs...challenge...not entirely satisfactory." – Tusla

Those working in or with the service see a range of opportunities to improve “join-up”

Inter-agency Training

“Having a more collaborative, inter-agency approach to training creates a better shared understanding of the nature of sexual crime, improving rates of formal reporting [e.g. Donegal RCC-SATU-Garda joint training].” – RCNI

“Why weren’t the current batch of nurses provided with opportunity to partake in child forensic training? Bizarre” – FNE

Sexual Health Services

“should be agreement/connection between us and sexual health” – FNE

Children’s Services

“integrating services for children and adults would be excellent” - Tusla

Mental Health Services

“mental health needs to be integrated into the package of care...neglected slightly” – FNE

“[Integration with Mental Health services (referral from MH to RCC)] not always in the spirit of collaboration but more like a hot potato” - Tusla

Higher Education/Student Health Clinics

“good to have that face-to-face contact with the local unit” - GP/Irish Student Health Association

Need for greater awareness of the SATU at Student Union level and greater buy-in from 2nd and 3rd level education authorities to improve access to the service – Youth Sexual Assault Focus Group, 2018

The challenges faced by SATU are similar to other responsive 'blue-light' services (1)

Case Study: Organ Donation and Transplant Ireland (ODTI)

A specialist, low-volume, high-impact, 24/7 - 365 service

- ~100 cases/year.
- Geographically dispersed.
- 2-person on-call system in place to ensure permanent national cover.
- Structures in place to ensure staff who have been 'called out' during their on-call are given adequate rest the following day.

Clear clinical accountability and leadership combined with efficient operations management

- Clinical Director + National Manager (ADON) – full-time manager brings enhanced structure and focus to the service.
- Supported by 6 Donor Coordinators (CNM3) who provide round-the-clock, national cover.
- Minimal line-management at coordinator level, but heavily standardised, prescriptive working processes.
- National Organ Donation Transplant Advisory Group (**NODTAG**) governance and advisory group meets 12 times per year.

Innovative use of staffing resource, with – “down time” – managed effectively

- Opportunity to partake in accredited, role-enhancing initiatives outside of clinical work such as:
 - Quality Assurance • Education
 - Audit • Admin
- Enables staff to develop a 'dual-role' and have a less emotionally demanding element to their work.
- Different nurse specialities able to rotate into the service for placements (e.g. ICU, A&E).

A staff-centred work environment with built-in supports and CPD

- 3 month induction period.
- Staff entitled and encouraged to avail of group and confidential, one-to-one counselling.
- Support and learning through weekly, mandatory group de-briefing where cases are discussed.
- Mandatory multi disciplinary team (MDT) de-briefing with Hospital Group involvement every second month.
- Staff “downtime” well-protected through National Manager.

ODTI – Voluntary Counselling

- The ODTI uses a professional counselling service which they bring in to central officer 3 times p/a to provide group counselling.
- The counselling service's number is prominently displayed and staff can confidentially contact the service for one-to-one counselling as often as they see fit.
- The counselling service then bills (anonymously) the ODTI for counselling hours provided.
- Counselling is not mandatory but easy to access means uptake is good.

The challenges faced by SATU are similar to other responsive ‘blue-light’ services (2)

Case Study: Irish Coast Guard

Governance to ensure standard practice, without burdening local operations

- Top-down governance to ensure procedural consistency in all 55 units - local flexibility for all other arrangements.
- High national standard maintained through regular skills audit (18-month cycle).

A service that requires a variety of agencies to assist when called into action

- Service-Level Agreements/Liaison Agreements/MoUs in place with a range of related agencies such as:
 - Irish Aviation Authority
 - Dublin Fire Brigade
 - Department of Defence (DoF)
 - Garda Síochána
- An agreed “Matrix of Resources” response framework indicates whether inter-agency cooperation is guaranteed or discretionary.

A service that ensures adequate supports are in place for staff and volunteers

- Critical Incident Stress Management Programme – “Psychological First Aid” – available in the aftermath of critical/traumatic incident.
- Contracted, confidential, phone-in counselling service also available to staff to deal with trauma, if necessary.

The challenges faced by SATU are similar to other responsive 'blue-light' services (3)

Case Study: National Neonatal Transport Programme (NNTP)

A 24/7, nationally networked service

- One of 3 services within the National Transport Medicine Service (NTMS), integrated within the National Ambulance Service.
- A service that relies on 24/7 ambulatory services to enable a fully-integrated neonatal clinical network.

A relatively small staffing model in each unit

- Delivered on a weekly rotation between 3 Dublin-based tertiary units.
- Staffing in each unit consists of:
 - Consultant Neonatologist x4
 - Nurse Coordinator x1
 - Clinical Engineering support
 - Neonatal Registrars x6
 - Neonatal Nurses x6
- Transport team mobilised within 45 minutes and referral destination given estimated time of arrival.

Quality and performance monitoring in clinical and organisational operations

- Clinical Lead (Specialist Consultant) reports to **NNTP Clinical Advisory Group** which monitors clinical quality and practice. Committee includes Consultant Paediatricians, Clinical Directors, and other active users of the service.
- Clinical Service Manager (ADON) of NNTP represented on **NTMS Operations Management Group**. Key function to address operational performance issues related to agreed quality standards and KPIs.

Good clinical oversight with clear sight of budget

- Clinical Lead of service responsible for financial reporting to NNTP Clinical Advisory group.
- Budget held by the National Ambulance Service.

Shared clinical governance with clear accountability

- Shared clinical governance across National Ambulance Service, NNTP partner hospitals, and other hospitals using the NNTP service.
- Clinical Lead (Specialist Consultant) of NNTP has full responsibility, authority, accountability and autonomy for planning and developing the service, while reporting to the Clinical Director of NTMS.
- Clinical Service Manager (ADON) of NNTP responsible for performance of nursing staff engaged in NNTP activities, and reports to DON of NTMS.

Since becoming a 24/7 service, NNTP has been deployed in **over twice** the number of cases while it was a 9-5 service.

2

Fieldwork and Analysis

Key Information and Data

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The physical environment of each SATU varies, and does not compare to the facilities available internationally

All SATUs sit under Hospital Governance but often in remote locations. Staff feel strongly that they are not operating in an appropriate or patient friendly setting:

- *"When on call at night I personally feel frightened having to go and open up the building. We use only some of the building so I am always conscious could someone be in another part of the house."* - **Assisting Nurse**
- *"The client shouldn't have to pass family /friends if moving from examination room to bathroom."* - **CNS**
- *"Lacking in second cold/acute case examining room. Design of current one is also very restrictive with lithotomy bed pushing examiner up against window. Attention needs to be given to ease of circulation and space in rooms."* - **Forensic physician**
- *"Staff (not related to the service) walk up and down talking and laughing and unaware that a patient is lying on a bed just through the wall having recently been raped."* - **Assisting Nurse**
- *"We do not have a private waiting area for SATU patients. There is a small waiting area with two chairs outside the unit."* - **CNS**
- *"It is extremely distressing for patients to have to come in to the same rooms (used for forensic) for their follow up appointments."* - **CNS**



File storage in a separate building to treatment rooms

Unfriendly patient access points

Cramped conditions

There is no national plan for how SATU infrastructure should develop, although local projects are progressing

Staff improvements

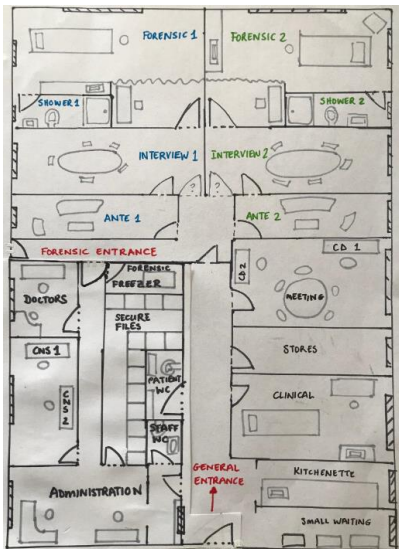
In a survey completed by staff from the 6 units on their environment, they requested the following improvements:

- Improved security
- Additional storage space
- Non-forensic clinical room
- Staff desks/office accommodation
- General redecoration
- Soundproofing
- Separate waiting area

Patient improvements

In a survey of 9 patients from 3 SATU locations:

- Most patients rated the facilities in the SATUs as comfortable
- One patient reported the setting as very clinical, very cold, and not welcoming
- Most patients felt the environment to be safe and discreet
- For patients unaccompanied by Gardaí, the signage could be better



Improvements are planned or underway in some locations, but this is also inconsistent

- Galway SATU will be refurbished and extended to accommodate the Barnahus pilot (from early 2019 for approx. 3 years. It will then be moved to Merlin Park Hospital purpose-built site (thereafter), likely a Barnahus
- Donegal SATU will be moved to a purpose-built, community-based location in 2019 which will also allow for future expansion and co-location of child services, if mandated
- Rotunda SATU will be redeveloped as part of the planned relocation to Connolly Hospital Campus Blanchardstown

International best practice example: The Rowan Centre

The Rowan Centre in Northern Ireland was designed by patients and staff and purpose-built to ensure a safe, discreet, comfortable patient and staff experience

Sketch of 'ideal' purpose built unit by a SATU Clinical Director

Having led Europe in developing SATU, how Ireland compares internationally now is mixed

International developments highlight interesting areas for new policy solutions:

Online modular training (USA, Australia)¹⁶⁻¹⁷

Case Management and follow up (Scotland, UK, NL, BEL)¹⁸⁻²¹

Team based service delivery (NL, UK, FI)^{20, 22-23}

Video Link to support capability in remote areas (NZ, USA)

Data Management and Evaluation (BEL, NO, FI, UK, IC)

Inter-professional training (NL, BEL)²⁰⁻²¹

Formal referral protocols (NI²⁴, NL)

Lessons from The Rowan Centre, Northern Ireland

- Scale of inter-agency cooperation profound – joint health and justice funding and management
- Clear, accountable budgeting – £900,000 annually
- Governance and decision making totally clear
- Patient needs and experience dictate all changes, strong patient involvement in service developments
- State of the art building, compassionate design
- Medical model – forensic medical examiners employed and paid for by the police
- Core team amplified by on-call provision

Lessons from St Mary's SARC Manchester, UK

- Clinical supervision and governance thorough and robust
- Daily case review to review clinical decisions and agree case management approach and follow up
- Minimum standards for all clinicians in the service (core and on-call)
- Shift away from autonomous forensic nurse examiners after a number of complex critical incidents
- Independent Sexual Violence Advisor (ISVA) patient advocate core to the service
- Counsellors, crisis workers, clinicians, patient advocates all employed by the SARC and subject to SARC standards and management (e.g. performance appraisal for clinicians)
- Core team 9am – 9pm amplified by on-call provision

Team-based, long-term care, and coordination are key trends in international SATU centres

Case Management and Follow up

The Netherlands:

For at least the first 4 weeks, the Case Manager is available to organise counselling or follow on care. After that, refers patients to mental health services for immediate access to care/support if needed.

St. Mary's, Manchester:

The independent sexual violence advisor (ISVA) contacts the person within 5 days to offer on-going support. Where appropriate, a referral is made to the SARC counselling team, and where follow on sexual health services are necessary, SARC signposts the person to the appropriate clinic.

Belgium

Patient is called 1 day after initial presentation, and once per week for first month. Case management every 3 weeks, 4 weeks, 5 weeks with phased withdrawal.

Inter-agency Training

The Netherlands

Inter-agency training occurs where, for example, a nurse will shadow a police officer in his/her job and vice versa. This happens across all the agencies involved and aims to build respect and understanding for each other's roles and responsibilities.

Team-Based Service Delivery

Belgium:

Multidisciplinary response team. Led by FNE, with diagnostic and supervisory support by doctors as required.

The Netherlands:

A team of doctors, nurses, police, and counsellor respond immediately and go to the Sexual Assault Centre when an initial call comes in.

Finland:

Offers all same services as Ireland but also has a psychologist and social worker working with centre, and a chaplain/priest as part of the team.

Modular Training and Development

USA: International Association of Forensic Nurses online Adult-Adolescent SANE Training course. This course contains 11 modules, and is self-paced but must be completed within 12 weeks of the candidate launching the introductory model.

Clinical preceptorship is designed to complement the 40-hour didactic course. Clinical experience is typically completed within six months of completion of the didactic training, with the guidance of a physician, advanced practice nurse or a forensically experienced registered nurse who determines competency.

Australia: Notre Dame University School of Nursing & Midwifery offers a Graduate Diploma of Forensic Nursing, a two-year program.

This course is aimed at registered nurses - much of the tuition is available online, in two of the semesters students are required to attend a three to five day intensive workshop at the University.

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SATU is not in crisis but it is seriously under pressure and immediate action is required

SATU shows ongoing evidence of commitment to quality and continuous improvement....

National Guidelines

National Database

National KPI Set

Nurse delivered care, Advanced Nursing

Option 3 - allowing patients to have forensic samples collected but defer reporting to Gardai

....and as a result the Review Team has prioritised identifying meaningful, practical changes

Actions must build on existing service and service improvements

Actions must connect to and support the enormous passion and commitment of staff

Long-term strategic change must not jeopardise practical improvements now

Actions must build in learning from comparator services and analogues who have tackled similar issues

Actions must be achievable in the medium-term given the urgency of some of the issues identified

Changes must also work within the hardstop design constraints for this service. In particular:

- Immediate and urgent need of patients
- Forensic requirements
- Unpredictable demand
- High specialist forensic examination
- Low volume service (<1,000 in 2019)
- Out of hours presentations
- Highly vulnerable patients, with complex social needs

Fieldwork showed strong consensus around what is needed for a fully supported patient experience

1 PREVENTION

We know that education, information and early intervention for at risk groups are all important components of reducing or preventing sexual violence

2 RESPONSE

We know that after an assault has occurred, time is critical to securing the safety of patients, supporting their physical needs and allowing for the collection of evidence

3 RECOVERY

We also know that experiencing sexual violence is a trauma that can have significant physical and emotional consequences for patients who need support to rebuild a normal life

4 REDRESS

We also know that victims of violence are entitled to redress through the justice system but that this system can be cold and re-traumatising without appropriate support

SATU can be a hub for a holistic health response to meet the ‘whole person’ needs of patients

Review Process

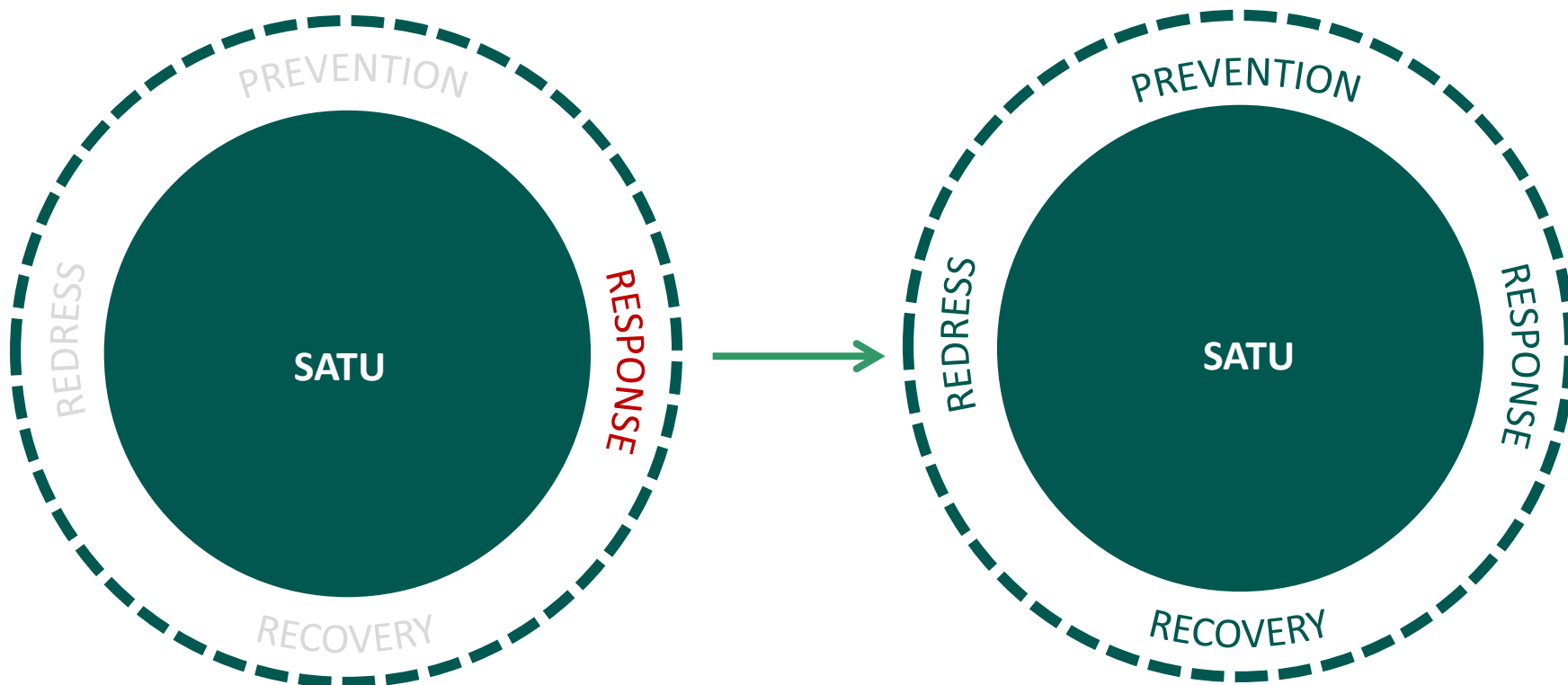
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Make Every Contact Count:

The health service is increasingly trying to ensure that patients are confronted by “no wrong door”. This principle is highly relevant to sexual assault victims as those who seek help are almost certainly going to be guided to the SATU door. Therefore, it presents an opportunity to ensure we respond to all needs in the best way possible.

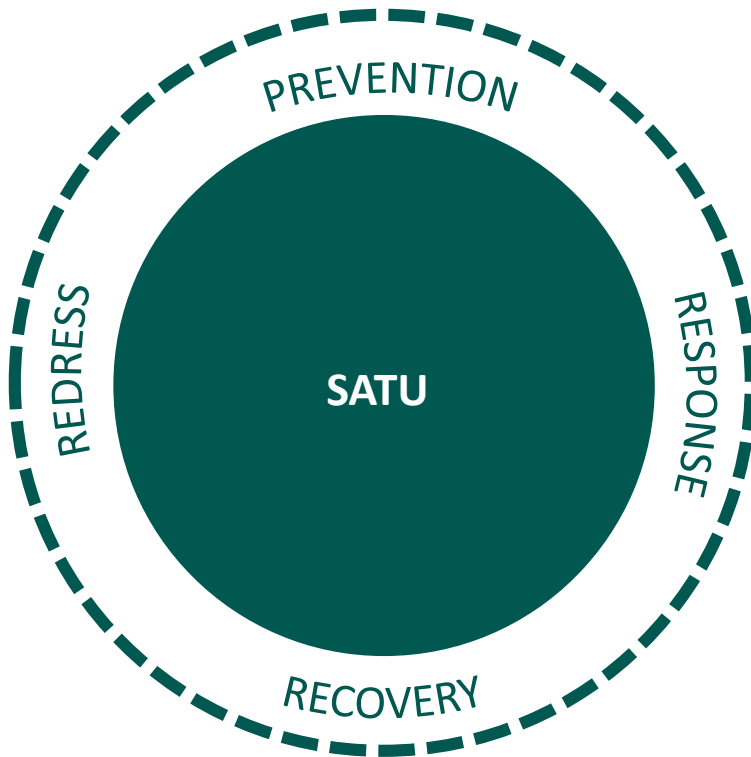


Health Policy Focus Now
Acute medical response focus

Health Policy Vision
Holistic whole-person focus

This expands the scope of service which will require investment but will also increase the impact of every euro invested

Shifting to a 'whole-person' lens reinforces lots of what is positive about SATUs now and also creates space for impactful change based on:



A service that cares for the 'whole-person' and takes responsibility for the long-term needs of patients who are the victims of a sexual assault

A service that judges itself, and is judged, by patient quality and patient experience, and where this information and data galvanises leadership and action

A service that is appropriately resourced but which is also innovative in how it uses capacity and anticipated "down-time" to respond to patient needs and develop the service

An expert service that provides consistent, high-quality, urgent, medical, physical, emotional, social care and support for every patient that attends there

Review Process

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Policy Opportunities

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Proposed Actions

Appendices

Systems change takes time, but there are three areas we can prioritise to make a positive difference in the next two years

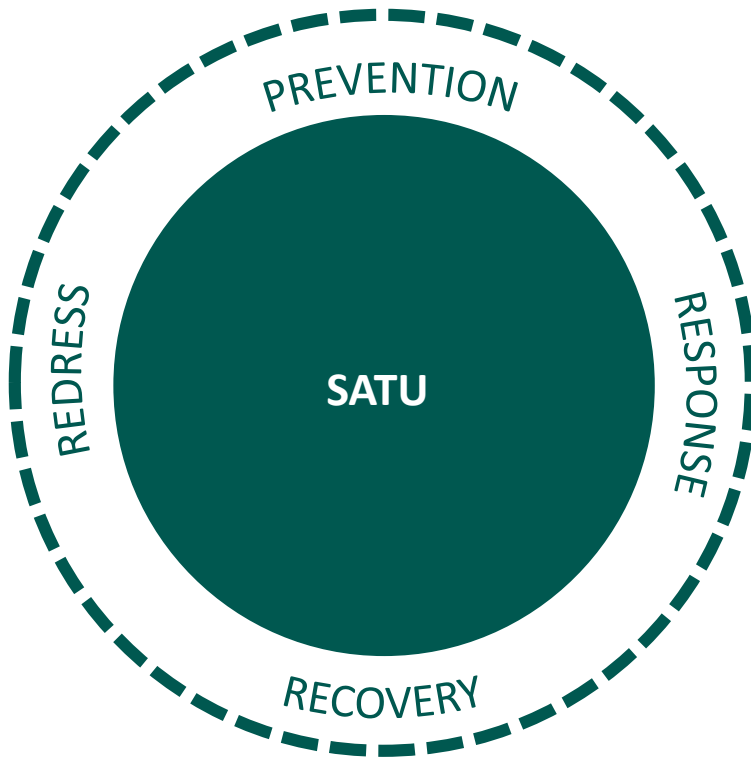
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Three priority areas of action have been identified through the Review to enable this re-orientation



1 CONSISTENT

Every patient should have a common and consistent experience of the service irrespective of where they live or where the assault happens. **National planning, decision making, accountability and investment** is the only way to achieve this.

2 SUSTAINABLE

A patient's experience is influenced almost exclusively by the staff they meet. It is critical to take action to build a **flexible, competent, supported SATU workforce**.

3 COORDINATED

Boundaries between professionals and services make it too easy for patients to get "lost in the cracks". **Improving awareness of SATU and coordination within health services and across social services for patients** is a primary step to improving this.

Ten actions can drive this transformation starting today

1 CONSISTENT

Every patient should have a common and consistent experience of the service irrespective of where they live or where the assault happens. **National planning, decision making, accountability and investment** is the only way to achieve this.

1. Increase and ring-fence baseline funding for SATUs nationally by 25%
2. Create a National SATU Service Network, supported by a National Management Team

2 SUSTAINABLE

A patient's experience is influenced almost exclusively by the staff they meet. It is critical to take action to build a **flexible, competent, supported SATU workforce** for the long-term.

3. Resource a minimum day-time, team-based staffing model for each SATU
4. Create a rapid responder 'on-call' rota so that forensic examiners can travel to support patients in their local unit
5. Roll out more frequent, flexible, modular, and inter-professional training to build a sustainable pipeline of qualified staff
6. Recognise the challenge of the working environment by introducing high quality emotional supports for all staff (core and on-call)
7. Improve oversight and quality assurance by introducing mandatory clinical supervision for all core and on-call staff

3 COORDINATED

Boundaries between professionals and services make it too easy for patients to get "lost in the cracks". **Increasing awareness of SATU and coordination within health services and across social services for patients** is a primary step to improving this.

8. Expand the scope of service to include patient liaison and the coordination of medium-term after-care for patients
9. Communicate the role of and support available through SATUs more routinely and effectively
10. Convene a Sexual Assault Services Management Group of senior operational decision makers from different sectors to improve patient experiences and outcomes

Area for Action 1: Increase and ring-fence baseline funding for SATU nationally by 25%

What is the Proposal?

- Establish a single, national, annual SATU service budget.
- This service budget will be made up of:
 - All Existing Level of Service (ELS) funding
 - Pay and non-pay in each unit
 - Additional funding for network costs (including funding for new national roles) and corporate costs.
- The budget will include all pay and non-pay costs for the service.
- There will be a single accountable budget holder in the HSE.
- The budget will be allocated by the HSE to individual SATUs based on demand/activity on an annual basis.
- The budget will include the appropriate level of investment to ensure:
 - Capacity to meet demand
 - ELS (to patient safety standards)
 - Service developments
 - CPD for staff.

What is it not?

- An unconstrained budget – it will be tied to activity levels and ideally outcomes in the longer term.
- An increased allocation to Acute Hospital Division Budget.

What is it like?

- Annual funding for the service will be negotiated and secured through the established Estimates and National Service Planning processes, like all other services, but on a national instead of local level.
- Activity based funding – given that established budget is linked to demand.
- Other ring-fenced funding is not typical however there are some examples:
 - NPSO central team for antimicrobial resistance (AMR)
 - Political priorities (e.g. mental health).

What is the aim?

- To strengthen financial management of the service at a national level.
- To ensure budget is allocated according to demand/activity to meet the needs of patients in the service as well as national objectives.
- To ensure units have a standard means of covering operating costs.

AFA 1 Contd.

Why is it important?

- There has been significant under-investment in this critical service (see slide 21).
- There is no national budget at the moment for the SATU service. Those in national management roles do not have sight of the total service budget and therefore cannot manage it or be held accountable for it.
- The current system of resource allocation is inefficient – each unit must make an individual business case for small costs and larger costs within the hospital with no strategic vision or oversight: ***“If something is needed for the unit, I’ll make a business case for it.”*** - Clinical Director
- Under-investment and staff shortages are not being addressed locally so must be addressed and prioritised at a national level at the same time as removing key barriers and blockages (e.g. training pipeline).
- Core service activities – CPD, training etc – have not been adequately funded especially at local level: ***“There is no budget for our annual national Study Day or the production of the National Guidelines.”*** - Clinical Director
- There is no official mechanism for securing and protecting the SATU budget at hospital level or nationally: ***“We’re a small fish in a big pond.”*** - SATU Clinical Director
- Those in managerial roles at all levels of the service are in favour of a coordinated budget (NMD, CDs, Hospital General Managers, HSE managers).

What impact could it have?

- Improved delivery of services through urgently needed investment.
- Improved transparency and accountability across the service.
- Recognised authority of the network and service managers (NCL and NSOM) and better coordination and governance of the service.
- Increased value for money across the service.
- Better align resources with activity.

AFA 1 Contd.

To initiate implementation, the Joint Review Implementation Team* will:

1. Cost the actions of this Review

- Identify a 25% increase and seek Ministerial approval. **(Complete)**
- Make business case to Finance division DoH for funding to establish the Network and appoint management team, with supporting resources. **(Complete)**
- Get letter of approval from DoH and establish a regular schedule of payments from the DoH to HSE for 2019 (e.g. quarterly).

Q1 2019

2. Establish national line of accountability for budget

- Define clearly the 2019 protected amount for SATU.
- Appoint an accountable officer in the HSE at National Director Level who is supported by the National Staffing and Operations Manager (NSOM of the National Management Team).
- The NSOM will actively manage the allocated budget for 2019 – both the new network budget and the ELS budget for all six SATUs.

Q2 2019

3. Identify 2020 Budget

- Work with HSE and Department of Public Expenditure and Reform (DPER) in Spring/Summer 2019 to identify new baseline for 2020.
- The accountable officer will determine allocation to units based on demand/activity.

Q3/Q4 2019

* A team consisting of officials from DoH, HSE and frontline staff tasked with commencing implementation of the areas for action outlined in this Review and who will provide a progress report to the Minister within the first six months of operation.

Area for Action 2 : Create a National SATU Service Network, supported by a National Management Team

What is the Proposal?

- To create a formal national network for the SATU service.
- This network will connect all six units, and will have a dedicated management team with core functions (see Slide 64).
- The new management team will consist of:
 1. A National Clinical Lead (NCL) (Consultant FME 0.5 WTE)
 2. A National Staffing and Operations Manager (NSOM) (DON/M or ADON/M 1 WTE)
 3. A Quality Assurance, Clinical Audit and Improvement Manager (1 WTE)
 4. A Data and Research Manager (including parliamentary tasks) (1 WTE)
 5. A Patient Liaison Manager (PLM) (1 WTE).
- All roles will be clearly defined and will have adequate protected time to carry out national functions. Roles will initially be contracted for a 3 year period.
- Local SATUs will retain responsibility:
 - for local service delivery in accordance with the national standards
 - for individual cases which will be quality assured through local clinical supervision and case review .

What is it not?

- A single, centralised service.
- The network will not replace existing reporting lines between SATUs and their hospitals and hospital groups, but it will have an additional reporting line directly into HSE.
- The management team roles are new roles, they must be filled through official recruitment processes, not just reallocations.
- Roles in this service will not operate in isolation but will be aligned with HSE functions and initiatives (e.g. QID, HSE Communications).

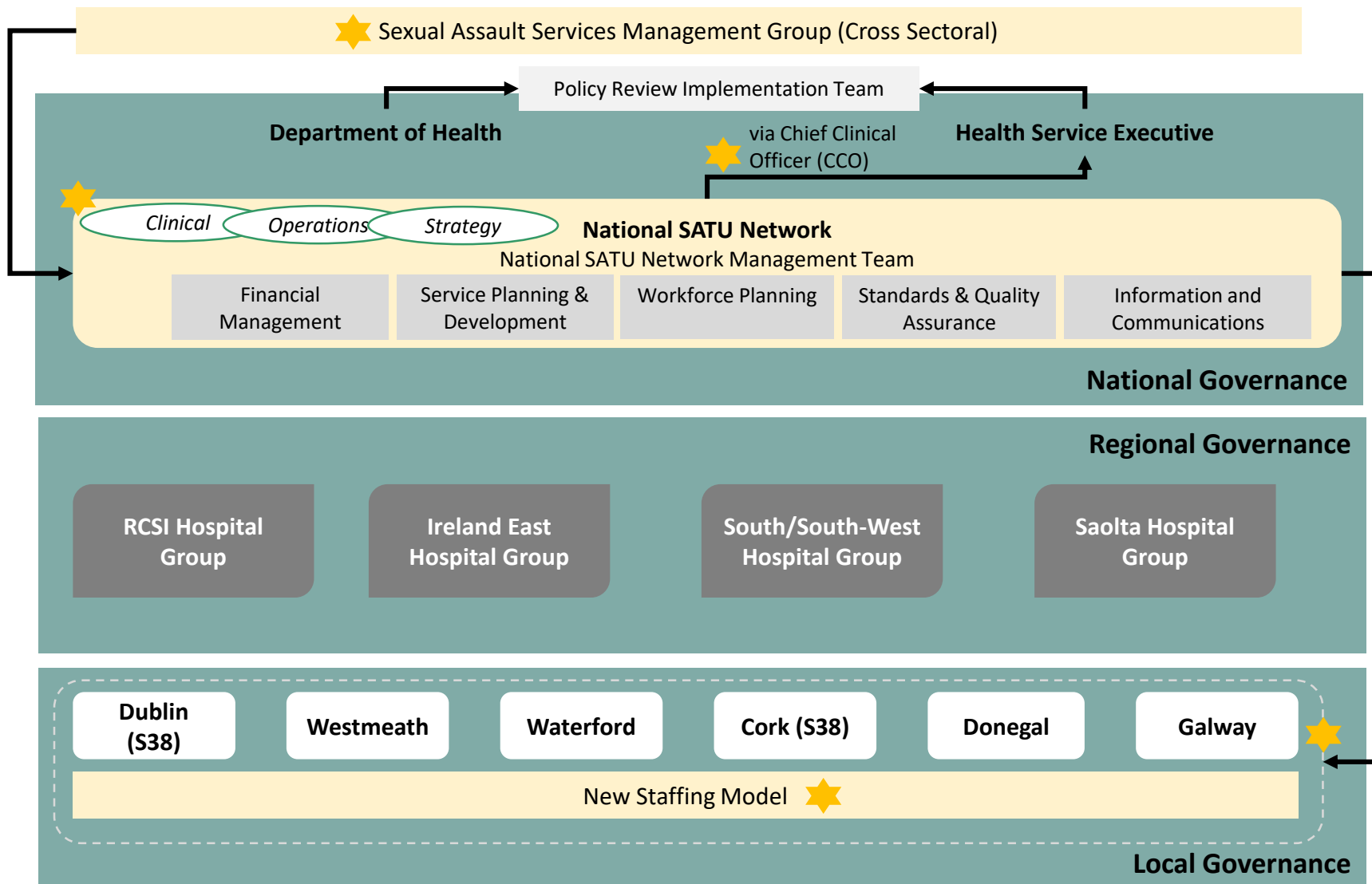
What is it like?

- The Trauma Strategy has a similar National Clinical Lead for Trauma Services and a National Office for Trauma Services.
- Organ Donation and Transplant Ireland has a central office with an ADON in a role similar to the NSOM role outlined.
- The 0.5 WTE structure for the National Clinical Lead is like multiple other services that contract a consultant part-time (e.g. Outpatient Antibiotic Treatment (OPAT) service).

What is the aim?

- To connect all six units and provide national level clinical and organisational leadership for the network in order to:
 - ensure quality and consistency of care for patients
 - ensure clearer decision-making and accountability for service quality and patient outcomes
 - provide a mechanism to resolve issues that are common to multiple SATUs
 - provide the service with a clear, formal source of authority which will strengthen national planning and decision-making.
- The establishment of the national management team will ensure a dedicated team is in place to support the functions of the new network. All national roles including the NCL role will have ample, protected time for national service planning and development.

AFA 2 Contd. New Governance Structure



AFA 2 Contd.

Why is it important?

- SATUs are currently independent units. There is varied and mostly informal contact between units. However, there is a demonstrated appetite for learning and sharing knowledge at the unit and national level, for example, the annual Study Day and the national peer-review sessions.
- Although clinical and forensic standards are clearly defined and implemented, unit operations are inconsistent, varying on key measures including: ratio of staff to patients, expenditure, collection and use of data relating to KPIs.
- SATUs are often in a removed (sometimes remote) setting from the rest of the healthcare campus (typically an acute hospital). On paper, while there is clear accountability within the hospital and hospital group structure, in reality SATUs are a small service which can be invisible or easily deprioritised in a large hospital system: ***“It’s one of these services that is very much under the radar.”*** - SATU Clinical Director
- Reporting lines and responsibilities at a national level are unclear with insufficient authority (e.g. CEO South/South West Hospital Group whose role is voluntary). There is also no senior accountable officer for the service within the HSE: ***“Because the service is small, it’s difficult to get attention of the hospitals and hospital groups, we need a direct reporting line to the HSE.”*** - HG CEO
- There are a number of pressures on the National Medical Director role and a lack of supports (e.g. clinical time pressures, responding to parliamentary questions and FOI requests and media relations). Managerial staff throughout the service (within the HSE and SATUs) also lack dedicated time to perform national functions for the service.
- Despite encouraging developments within the service (e.g. the creation and use of KPIs), data is not collected and used by management in a systematic way to make service improvements: ***“The KPIs were introduced and developed collaboratively but they are not being used properly yet.”*** - FNE
- Individual staff drive small research initiatives but the potential to carry out research nationally across the service is not exploited.

What impact could it have?

- The creation of a national governance structure (national network), with clearly defined roles and reporting lines, will close some of the current gaps in accountability, clarify decision-making and improve national service planning and development.
- Additional staffing and provision of dedicated time for all national level staff will ease some of the pressure of providing a national low volume, high impact 24/7/365 service.
- Dedicated roles will improve quality and consistency of the service, grow the use of data and research - in line with General Data Protection Rules (GDPR) and ensure holistic care is provided to victims of sexual assault.
- The network will provide a coherent voice for the service within the health system and for the public.

AFA 2 Contd. What needs to happen next?

To initiate implementation, the Joint Review Implementation Team will:

1. Agree structure and resource National Management Team

- Prioritising the appointment of the NSOM and the expansion of NCL's role are critical to the establishment of the network.
- Establish direct reporting line between the NCL and the HSE.



Q3 2019

2. Train and review performance of national management team

- Provide training for key national roles.
- Map training to aligned functions in HSE and DoH (e.g. communications, statistics and analytics).
- Regularly review and manage team performance.



Q4 2019

Area for Action 3: Resource a minimum day-time, team-based staffing model for each SATU

What is the Proposal?

- To ensure a model of differently skilled specialist staff to support an advanced nursing resource in each unit.
- To provide core clinical specialist FNE in each unit analogous to the number of presentations to meet the clinical and follow up needs of patients (including liaison – which would be additional to the work currently undertaken by nursing staff).
- In the future resourced model, to avoid burnout, staff will constructively spend “down time” on non-trauma but related work (e.g. STI clinics, colposcopy, outreach).
- All future rostering will seek to be in line with national employment standards.
- To provide standard senior clinical expertise and oversight by a CD - this position should be remunerated as 0.25 WTE in order to protect SATU related time.
- To provide administrative support in each SATU.
- This model retains FNEs and FMEs on-call to cover out of hours but savings may be possible here.

What is it not?

- It is not a local solution in selected units but a proportionate national solution for the entire service.
- It is not a replacement for the out-of-hours on-call rota, it is a necessary back-up to ensure continuity of the 24/7 national service.

What is it like?

- Like the NNTP and the ODTI.
- Like the ANP working as part of a multi-disciplinary team in Integrated Care Programme for Older People's COPD and Diabetes pioneer sites.

What is the aim?

- To stabilise the workforce by reducing churn and burnout.
- To create a sustainable workforce that includes a career pathway and progression for medical and nursing staff.
- To provide additional time to allow the nursing resource to focus on clinical and inter-agency liaison for patients.

AFA 3 Contd. Sample of minimum Core Team

NEW SATU Staffing Model

Clinical Director

Overall clinical responsibility for all activity within SATU, core day-time team

Blended team available to lead forensic examinations:

Advanced Nurse Practitioner

Senior responsibility for service development, unit management and staff support, core day-time team

Clinical Nurse Specialist

Forensic Nurse Examiner, core day-time team

Hospital Doctor/ GP

Forensic Medical Examiner (on-call only)

Clinical Nurse Specialist

Forensic Nurse Examiner, core day-time team

Hospital Doctor/ GP

Forensic Medical Examiner (on-call only)

FE Staff Nurse

Enhanced practice skills in forensic examination

Support Nurse

Available to support on a case by case basis

Administrative Support

G5 administrative manager

EXAMPLE: 7 CORE STAFF IN ROTUNDA SATU

Based on the Framework for Safe Nurse Staffing and Skill Mix (2018) and linked to demand (34% of presentations in 201):

Clinical Director

(0.25 WTE)

ANP Forensic Nurse Examiner

(1.0 WTE)

CNS Forensic Nurse Examiner

(1.0 WTE)

CNS Forensic Nurse Examiner

(1.0 WTE)

CNS Forensic Nurse Examiner

(1.0 WTE)

CNS Forensic Nurse Examiner

(1.0 WTE)

Admin G5

(1.0 WTE)

Support Nurse

2.0 WTE
provided to Rotunda to give sufficient capacity to be temporarily reassigned to SATU as required

Forensic Medical Examiner

On Call Rota

Forensic Nurse Examiner

On Call Rota

AFA 3 Contd.

Why is it important?

- Demand for the SATU Service is increasing by 10.4% annually (as reflected by the rise in SATU presentations since 2014).
- All SATUs currently report understaffing in terms of the full-time/day-time staff in both clinical and administrative grades.
- Of the 20 FNEs trained since 2008, only 6 remain. Clinical Directors are largely non-remunerated for their role, therefore it is challenging for CDs to ensure protected time for SATU. Several CDs have expressed dissatisfaction that their role is not recognised. In addition, there is little administrative support meaning nursing staff must make up this shortfall.
- Feedback from staff interviews indicates that staff have been providing a good service to patients based on goodwill and that the lack of team-based working and career progression is impacting on staff welfare and attrition rates: ***"I'm getting fed up of my goodwill."*** - Admin staff
- Fieldwork has also indicated that staff would prefer to split their time between managing cases and doing non-trauma work that allows them to maintain their general skills and competence (as well as specialist skills) and avoid becoming "submerged" by vicarious trauma: ***"I find when you're in a specialism you can lose your generalism...we are CNSs, not just forensic nurses."*** - FNE
- Given the low volume but high impact nature of the service, staffing up the existing units in this way is a more cost-effective response to service need than increasing the numbers of SATUs nationally.

What impact could it have?

- Protecting patient safety by ensuring safe and expert staffing levels, skills mix and clinical oversight.
- Stabilise the workforce by creating a clearly delineated, tiered system of nursing and supporting a dynamic, flexible working environment.

AFA 3 Contd. What needs to happen next?

To initiate implementation, the Joint Review Implementation Team will:

1. Confirm staffing needs based on proportion of presentations for each unit.

Assign an appropriately staffed blended day-time team for each SATU in proportion to its presentations.

(Complete)

2. Prepare job specifications

The job specifications should clearly define the distinct roles of the blended teams. They should facilitate flexible working while describing skill development, skill maintenance and competence criteria.

3. Secure budget for 0.25 clinical direction

To guarantee protected clinical leadership, a budget should be ring-fenced to remunerate all SATU Clinical Directors.

4. Develop a critical mass of ANPs

Create 1 ANP post within each SATU and invite applications to commence advanced practitioner training.

5. Create a critical mass of support nursing staff associated with each SATU

Using the Framework for Safe Nurse Staffing and Skill Mix, put additional nursing staff into associated organisations who would be released to the SATU when required and then return to their core duties.



Q1 2019

Q2 2019

Q2 2019

Q3 2019

Q3 2019

Area for Action 4: Create a ‘Rapid Responder’ on-call rota so that forensic examiners can travel to support patients in their local unit

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

What is the Proposal?

- To create a volunteer “rapid responder” on-call rota that allows forensic examiners (FEs) to travel to see patients in their local unit rather than patients having to travel to access SATU services.
- FEs would travel to patient’s nearest unit and meet the patient and the local support nurse, guards, RCC volunteer (all of whom will be familiar with the unit).
- This will be a transitional measure to provide additional back-up until staffing and on-call numbers are increased/stabilised.
- To enable staff to provide the service in this way by:
 - Funding travel and subsistence (T&S) - covered by the National Management Team (Staff providing the rapid responder service would be paid the agreed on-call rates by their local SATU);
 - Indemnifying all staff to work across the 6 units; and
 - Seeking “blue-light” cooperation where necessary.

What is it not?

- It is not a replacement for a core day-time team.
- It is not a replacement for locally available on-call FEs.

What is it like?

- NNTP.
- Service provided by Organ Donation and Transplant Ireland’s (ODTI) National Organ Procurement Service.

What is the aim?

- To speed up access to forensic examination and care – irrespective of where the patient is or how well their local SATU is staffed and ensure a truly 24/7 service.
- Minimise travel, distress and trauma of patients.
- Ensure patient-centred, timely, compassionate, high quality forensic examination by a qualified specialist.

AFA 4 Contd.

Why is it important?

- All SATUs currently report understaffing in terms of the full-time staff and on-call FEs.
- In 2018, approx. 50 patients had to travel to a SATU outside of their local area. Patients that cannot access service in their local SATU must travel to the nearest available FE. This can take several hours to facilitate and has been reported to delay a patient in being able to shower, eat or drink.
- Timing is critical in the collection of forensic evidence.
- Feedback from patient interviews indicates that travel added to their trauma: ***“They say SATU is a 24 hour service and it’s not. It was nerve wracking, it was very emotional waiting so long. I would rather get it over and done with quickly. It’s not really appropriate to wait hours and hours. I went to the station at 4am and didn’t get seen until 3pm in Mullingar. They said there were two cases in Mullingar before my case. I travelled down in an unmarked garda car.”*** - SATU Patient Interview
- Several FEs have indicated their preference to travel to patients rather than have patients travelling but that they face barriers in terms of working across sites and financial support (T&S) to provide the service in this way.

What impact could it have?

- Anticipated improvements in patient experience and long term outcomes (a patient’s recovery should start from the first/acute response).

AFA 4 Contd. What needs to happen next?

To initiate implementation, the Joint Review Implementation Team will:

1. Identify “Rapid Responder” FEs

- Seek volunteers (FNEs and FMEs) currently working or who have previously worked in the service (full-time and on-call) who would be willing to travel in identified radius.

2. Secure Accountable Officer

- The Accountable Officer would be required to oversee, support and monitor the implementation of this AFA until the NMT is in place.
- Support by ring-fencing T&S budget and ensuring indemnification for staff and ensuring standards of practice are maintained.

3. Introduce scheme on a pilot basis

- Introduce a pilot scheme using the already strong connections between Dublin and Mullingar or Cork and Waterford.
- Each SATU would hold the Rapid Responder Rota with contact information for travelling FEs.

4. Harness the SATU Network to achieve needed coordination

- The networking of the SATU service would support the freer movement of FEs within regions to provide rapid access to forensic examination.

5. Evaluate

- Fuller implementation would be preceded by an evaluation of the pilot.
- However, the rapid responder on-call rota should only be a temporary or back-up measure until staffing numbers are stabilised.

Q2 2019

Q2 2019

Q2 2019

Q3 2019

Q1 2020

Area for Action 5: Roll out more frequent, flexible, modular and inter-professional training to build a sustainable pipeline of qualified staff

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

What is the Proposal?

To redesign the training offer that includes 5 core elements:

1. To redesign the core CNS training programme in terms of flexibility (modular), frequency and the threshold required for candidacy on the course.
2. To run a pilot FME short programme in 2019 to fill the current gap on the on-call rota. Review and redesign FME training beyond this immediate need and examine opportunities to train FMEs and FNEs together. Also explore options to incorporate paediatric forensic examination training modules.
3. To develop a specific training programme (specialist FE modules) to allow nursing staff to develop enhanced practice skills in forensic examination and to provide on-call protocolised forensics and court report writing cover to SATU (following recent Rotunda precedent and subject to meeting strict competency criteria as signed off and monitored by the NMT).
4. Develop inter-agency training modules in specific areas (e.g. court reporting and appearance, capacity to consent, caring for distressed patients, long-term needs of vulnerable patients, assisting from “report to court”).
5. To introduce a scheme of funded and protected mandatory CPD for all SATU staff.

What is it not?

- It is not an attempt to dilute the competencies of the grades within the blended core team.
- It is not an attempt to replace the CNS grade.

What is it like?

- The training pattern for an ICU nurse from general nurse to specialist.
- The inter-agency/inter-professional training of the Centrum Seksueel Geweld Utrecht, Netherlands.
- The Sexual Assault Nurse Examiner (SANE) modular training in the US and the UK.
- The Specialists Interviewer Training undertaken by Gardaí, social workers, HSE staff for conducting interviews with children reporting sexual abuse, violence or threatened violence.

What is the aim?

- To create an adequate pipeline of expert staff (core and on-call) to provide a sustainable service to patients.
- To ensure a more cohesive delivery of holistic care to patients by all professionals working across the service.
- To maintain and enhance the competencies of both clinical and administrative staff working in SATUs and to keep pace with medical and legal developments.

AFA 5 Contd.

Why is it important?

- The infrequency, inflexibility of and threshold for participation in training is impacting staff numbers due to a lack of new entrants to replace staff leaving the service.
- Not everyone who has an interest in forensics may wish to work in SATU full-time so a more flexible approach to training may encourage more clinical staff to provide expertise on an on-call basis.
- Introducing an accredited forensic examination programme would increase the number of nurses who could work the on-call rota (subject to strict criteria such as participation in clinical supervision, handling at least one case per month etc.) and would mean that if these FNEs with enhanced practice skills wanted to progress to CNS and work as part of the core blended team, they would not have to repeat those modules.
- The acceptability of FNEs (who are not CNSs) working in SATU and providing professional witness testimony in court is supported by legal advice and precedent.
- Forensic examination is highly protocolised and carried out by both nurses and doctors, therefore, there is merit in considering inter-professional FE training: ***"I thinks the doctors and nurses courses should be merged and modularised to be flexible to people's needs."*** - FME
- Given the amount of cooperation between SATU staff and staff from allied agencies(e.g. Gardaí, DRCC) multi-disciplinary training would increase respect and understanding across the various agencies involved in caring for SATU patients and would reduce the need for multiple training programmes. Fieldwork highlighted the positive impact of staff from different agencies fully understanding each others' roles and learning how best to work jointly for the benefit of patients.
- Staff have expressed frustration at the lack of financial support and protected time for ongoing training. Fieldwork has also indicated that unless CPD is mandatory, not all staff will participate: ***"Unless its mandatory, it'll never happen. They should be made go."*** - FNE
- There are risks in terms of quality and patient safety if staff competency is not maintained or developed via CPD.

What impact could it have?

- The anticipated outcome would be a dynamic and expert patient-focussed service with a pipeline of qualified forensic examiners who are sufficiently supported in their role.

AFA 5 Contd. What needs to happen next?

To initiate implementation, the Review Implementation Team will:

1. Fund and run the FME pilot course

- Commit to providing €5,000, in line with the proposal submitted by two CDs, to NUI Galway to pilot and evaluate an FME short course in Q2 2019 (to be offered to doctors nationwide).

2. Direct the Office of the Nursing and Midwifery Services Director (ONMSD) to review current training

- Examine feasibility of redesigning the current training package in terms of frequency, flexibility and eligibility.
- ONMSD to commission a 3rd Level provider to design and deliver programme(s).

3. Direct the ONMSD to develop the FE enhanced practice programme

- Work with course director and explore options for course for nurses who wish to become FNEs and work towards providing accredited modules. For enhanced practice skills.
- This should be signed off by NCL.

4. Work with the Sexual Assault Services Management Group to drive inter-agency training

- This group to enhance inter-agency training for all organisations involved in SATU at a strategic level.

5. Identify a programme of CPD courses and commit funding and support for existing and future staff

- Ensure financial support and protected time for CPD for all staff to advance their skills and maintain competencies.
- CPD participation will be monitored and noted as part of performance management.



Q2 2019



Q3 2019



Q4 2019



Q4 2019



Q4 2019

Area for Action 6: Recognise the challenge of the working environment by introducing high quality emotional supports for all staff (core and on-call)

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

What is the Proposal?

- Provide and proactively encourage regular professional trauma counselling to all SATU staff.
- This will include a mix of group counselling and individually organised sessions.
- Group counselling will happen 3-4 times per year and individual sessions will be provided on request.
- Staff wishing to avail of individual counselling will be able to do so on an anonymous basis.

What is it not?

- It is not a general/generic Employee Assistance Programme (EAP), although staff would retain access to this.
- It is not mandatory but strongly encouraged and fully supported.

What is it like?

- Professional counselling services provided to other trauma services (e.g. RCC, Gardaí, Tusla and ODTI).
- Mindfulness training offered to social workers working in child protection.
- Coast Guard model – strongly encourages volunteers to seek help.

What is the aim?

- To ensure staff feel supported and valued in their difficult roles.
- To ensure the best standard of care is provided to patients accessing SATU services.

Why is it important?

- SATU staff have a difficult job and there are concerns that the absence of vicarious trauma support may be a contributing factor to staff burnout, the high attrition rates in the service and the difficulty in recruiting more on-call staff.
- An important component of a highly functioning SATU team is that each staff member (core, on-call, clinical and administrative) is supported in moving on from difficult cases so that they can provide high quality care to future patients: ***“If you need counselling you need to start it today – not next week.” – FNE; “Other people’s grief becomes yours if you’ve nowhere to offload it...how can you help next the family if you’re still stuck on last family, how can you make it better for them? Do it for them if not for you”. - ODTI***
- Staff interviews have clearly indicated the importance of providing specialised counselling to maintain a healthy and sustainable workforce. However, fieldwork has indicated SATU cases are becoming increasingly violent and complex and that the current EAP offer is insufficient and is not specialised to assist staff confronted with violent trauma.
- Fieldwork showed that all other agencies providing SATU related services offer counselling supports to their staff as do comparator trauma services and international SARCs (e.g. ODTI and the Coast Guard, the Rowan Centre in NI (mandatory group counselling) and Centrum Seksueel Geweld, Netherlands). ***“You have to think of the impact of the work on the person...if you’re minded in the work, you’ll be fit to do the work.” - DRCC***

What impact could it have?

- Anticipated reduction in “burnout” and a more sustainable workforce.
- Improved support to patients from staff who are fully supported in their roles.
- Protecting patient safety and quality.
- Better working culture in acknowledging and dealing with emotion in the workplace.

AFA 6 Contd. What needs to happen next?

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

To initiate implementation, the Joint Review Implementation Team will:

1. Prepare a business case for specialised professional trauma counselling

- Highlight the business need and seek costings for providing the service.



Q2 2019

2. Prepare a Request for Tender (RFT) for services and procure counselling services

- Write a specification of counselling requirements and initiate a tendering process to procure counselling services for both group and individual sessions.



Q2 2019

3. Alert all staff to the new service and encourage participation

- Inform all staff across the SATU service about the counselling offer and make it as easy as possible for them to avail of it (e.g. using technology to dial into group sessions, prominently displaying counselling contact details).



Q3 2019

4. Evaluate participation rates/feedback

- NMT to evaluate the participation rates and feedback from both group and individual counselling to ensure the best possible support is offered to staff.



Q2 2020

Area for Action 7: Improve oversight and quality assurance by introducing mandatory clinical supervision for all core and on-call staff

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

What is the Proposal?

- To establish a mandatory system of clearly defined clinical supervision (incorporating liaison/referral) for all clinical staff working in SATUs.
- Clinical supervision will be managed and provided by the CD linked to each SATU.
- Through weekly team meetings comprising SATU core and on-call staff (dialling in if more convenient) and the CD/ANP, have a clinical review of each case that presented to SATU.
- Where a challenging and/or complex case occurs, clinical supervision must be provided at the earliest opportunity.
- The NMT will be responsible for monitoring compliance with clinical supervision.
- Every two months, run a national-level review of clinical supervision as a forum for reviewing and discussing cases to support staff learning and competency development.

What is it not?

- Not an administrative or logistics-level meeting for business planning etc.
- Not for HR issues.
- Not related to counselling for SATU staff.

What is it like?

- Similar to current local clinical supervision/peer review but on a formalised and regular basis.
- Similar clinical supervision initiatives in the Rowan Centre (NI) and St. Mary's SARC (UK).

What is the aim?

- To ensure that SATU can standardise and account for the quality of care for every SATU patient.
- To ensure staff maintain and develop their competency on an on-going basis and feel supported to carry out their brief.
- To ensure any issues relating to the clinical handling and/or referral of a case are dealt with in a timely and efficient manner by the relevant CD.

Why is it important?

- Without regular and robust clinical supervision, there can be no assurance that the best standard of care is being provided to patients accessing the SATU service.
- Given the current lack of formal clinical supervision, fieldwork suggests that some SATU staff have reported not feeling fully supported in their challenging role: ***“Medical Director of the unit not always available....I’d say on a priority level one to ten – we were very low down.”*** - FNE; ***“You feel supported through clinical supervision and get a chance to talk through cases...you might not feel so stressed, questioning yourself.”*** - FME
- Fieldwork has indicated that a lack of time-protected, mandated clinical supervision has caused SATUs to be reactive in their approach to this issue: ***“No matter how experienced you are, there’s always something that can throw you.”*** - DRCC
- The needs of patients presenting to SATUs are becoming increasingly clinically complex (with more intimate partner assaults and increasing levels of violence being recorded). Without a means for evaluating how these cases are dealt with in the acute phase and medium-term, there are risks to quality of care for patients.
- Fieldwork also indicates that SATUs lag behind international comparators in terms of clinical supervision and case review (e.g. St. Mary’s SARC (UK), the Rowan Centre (NI)).

What impact could it have?

- Assurance that all SATU patients are accessing high-quality treatment with clear national standards.
- Continual enhancement of staff competency in their handling of cases.

AFA 7 Contd. What needs to happen next?

To initiate implementation, the Joint Review Implementation Team will:

1. Put mandated clinical supervision/case review process in place

- NCL to set clinical guidelines for SATU.
- NSOM to support learning and ensure protected time for clinical supervision/case review is established in each unit.



Q2 2019

2. Agree a protocol

- In partnership with local CDs/ANPs and the NCL agree a protocol for standardising practice in this area.
- NSOM to ensure there is unit-level understanding of clinical supervision protocol in each SATU.



Q3 2019

3. Establish compliance measures

- NSOM to monitor this practice and contact local SATUs to ensure clinical supervision including case review is being provided.



Q3 2019

4. Ensure that all CDs have some formal training in forensic examination

- NSOM to explore ways in which non-forensically trained CDs can be given time to take part in FME course in the next year.



Q1 2020

Area for Action 8: Expand the scope of service to include patient liaison and coordination of medium-term after care for patients

What is the Proposal?

- To introduce a Patient Liaison Manager (PLM) role within SATU represented at the level of the National Network.
- This liaison officer acts as the identifiable contact person for patients with long-term, complex needs, connecting with the patient within the first 5 days after their presentation and is responsible for:
 1. Coordinating patient aftercare.
 2. 'Checking in', appointment reminders, querying around additional supports required.
 3. Advocating for the patient's long-term needs with other agencies.
- This additional service will be available to patients that want this extra support from 'report to court', but will not exclude self-referral or Option 3 (i.e. deferral of reporting to Gardaí) cases.
- Patients have support from SATU beyond their initial presentation, with the service acting as a 'hub' for further onward referral to whatever supports they need.
- Once staff resources are at the recommended level, protected time should be made available for case management.

What is it not?

- Not replacing the role of voluntary organisations in patient after-care (e.g. RCC counsellors or volunteers or Victim Support Service).
- Not a replacement for the liaison role undertaken by CNSs.
- Not a substitute for formal inter-agency working agreements.
- Not solely focused on the criminal justice element of a patient's recovery.
- Not a court accompaniment service.

What is it like?

- Independent Sexual Violence Advisor (ISVA) role in UK and NI.
- Nursing case-managers in Belgian and Dutch SARCs.
- 0.5 WTE social worker role in Helsinki Sexual Assault Centre.
- Homelessness Liaison Nurse – Mater Hospital.
- Cancer Care CNS, who also has significant non-medical responsibilities.

What is the aim?

- Formalise and improve focus of SATU on coordinating follow up services for especially vulnerable victims of sexual assault to ensure a holistic, long-term recovery.
- Ensure patients with complex needs have a designated contact and advocate within a large, inter-connected system that is responding to sexual assault from response to redress.

AFA 8 Contd.

Why is it important?

- Following a sexual assault, patients may require a range of different supports depending on their unique needs to aid their recovery.
- SATUs seek to provide excellent acute care, but have a limited formal role in coordinating a patient's follow up care/referral. Fieldwork indicates that some SATU patients have reported feeling ***"left on their own"*** after their initial treatment in SATU, expressing that more regular follow up would have helped their recovery, a concern shared by staff: ***"Really am doing a liaison role, as well as clinical – always a follow on call...pick up on someone not doing so well...access to social workers would be helpful. We're not trained in social work. - FNE***
- Internationally, treatment for victims of sexual assault has greater emphasis on case-management/patient advocacy roles in recognition of the need to coordinate long-term patient recovery (e.g. UK, Netherlands, Belgium, Finland).
- The complexity of a high number of cases and the availability of expertise in other sectors means that patients will continue to need referral to a range of different services to support their long-term recovery.

What impact could it have?

- Improved long-term outcome for patients with the highest level of vulnerability and complexity.
- The empowerment of more victims of sexual assault to bring their case to the attention of Gardaí and DPP.

AFA 8 Contd. What needs to happen next?

To initiate implementation, the Policy Review Implementation Team will:

1. Commence recruitment process to the NMT on 3-year, fixed-contract basis

- Define competencies required, scope, and responsibilities associated with the role at network level.
- Ensure that a mechanism for reviewing the effectiveness of the role after three years is built-in definition of the role.
- Launch recruitment campaign.



Q2 2019

2. Plan an evaluation of the effectiveness and need for this specific role

- Monitor the referral practices of SATU staff to other agencies as well as to and from the PLM.
- Assess patient uptake of the follow up liaison services by both SATU staff and the PLM.
- Evaluate the effectiveness of the PLM service in terms of interagency collaboration and patient outcomes.



Commence Q3 2019

3. Assign the NCL and NSOM to determine the medium-term requirements in terms of patient liaison and follow up

- Based on the findings of the pilot evaluation make a decision on the optimal way of fulfilling the needs of the most vulnerable and complex SATU patients.



2022

Area for Action 9: Communicate the role of and support available through SATUs more routinely and effectively

What is the Proposal?

- To make it easier for patients, professionals and public to access information about the SATU service.
- To develop a comprehensive communications strategy similar to that established for My Options - the unplanned pregnancy support service, which could include:
 - Dedicated SATU website hosted by the HSE;
 - Investment in the website's Search Engine Optimisation (SEO) so that it tops google keyword searches;
 - Utilising an existing 24/7 number that is manned by professionals who can refer patients to appropriate SATU/allied service;
 - Investment in social media campaigns (Twitter, Facebook, Instagram) across all agencies (SATU, Gardaí, RCC);
 - Offline campaigns (e.g. poster, sticker). Embed templates into website that can be downloaded, printed and distributed locally.
- To assign communications responsibility to the NSOM and ensure it is reflected in role profile.
- To proactively seek opportunities to engage with key groups (e.g. universities' Freshers' weeks).
- To actively seek opportunities to engage with key groups (e.g. student bodies, schools).

What is it not?

- Not the responsibilities of individual staff in SATU units to manage (though they may wish to contribute content).
- Not a new dedicated freephone/callsave number (this is a low numbers service so it would be more efficient to align with an existing service).

What is it like?

- The communications approach by [My Options](#) or Local Injury Units (local and national focus).
- Standalone sources for accessing treatment following sexual assault in [Belgium](#), [The Netherlands](#), [UK](#) and [Northern Ireland](#).
- Including a link to SATU through the DRCC help-line, Cosc website, [Tusla website](#).

What is the aim?

- To close the gap between the number of reported sexual offences and the number of cases reporting into the SATU service.
- Ensure information about SATU services can be easily accessed by patients, their friends and families and the public.
- Increase awareness among professionals about SATU services - acute and follow up.
- To raise awareness of the issues associated with sexual assault at a 'whole-of-society' level.

AFA 9 Contd.

Why is it important?

- Accessing information about SATU services is not straight forward as there are numerous sources and levels of information available. This is particularly concerning in the case of people who have experienced trauma.
- Key elements of the service remain misunderstood or unknown (e.g. Option 3, deferred reporting to the Gardaí, the importance of being examined as early as possible to preserve forensic evidence and to receive appropriate medical treatment).
- The CSO reported over 3,000 sexual offences (not clearly defined) in 2017, and stated that the real prevalence is likely to be much higher than reported. Given that 865 patients presented to SATU services in 2017, lack of awareness or visibility of the service could potentially be an issue.
- SATU patients have publicly highlighted the difficulty in accessing information about SATU services.
- SATU staff have voiced frustration that every time rape or sexual assault are discussed on the national stage there is routinely voluntary sector representation but after that SATU services/contact details are not publicised.
- Internationally, there is an increasing trend towards having standalone means of accessing sexual assault treatment services online and by phone (e.g. Northern Ireland, UK, Netherlands).
- Having a range of information access points, tailored to different target audiences, can ensure comprehensive awareness of and access to the service.

What impact could it have?

- Better quality SATU information that is easily accessible to those who need it especially in crisis situations.
- Increased referral rates from professionals (e.g. ED staff, GPs etc.) and self-referrers.
- Increased public awareness of the services and the issues associated with sexual assault.

AFA 9 Contd. What needs to happen next?

To initiate implementation, the Joint Review Implementation Team will:

1. Prioritise Communications

- Ensure that NSOM role profile incorporates communications responsibility.
- NSOM to engage with HSE and DoH and other agency comms resources re. communication strategy for SATU to maximise national awareness.
- Consider rebranding SATU service to best reflect this professional and compassionate service.



Q2 2019

2. Allocate a budget to implement the comms strategy

- Budget should be made available to invest in:
 - focus groups with various target audiences to design messaging/channels of communication;
 - creating and maintaining the website and phonline;
 - ensuring SEO;
 - online and offline campaigns.



Q2 2019

3. Identify and agree with appropriate helpline to link with SATU service

- Examine potential options for SATU to be linked to other helplines (e.g. RCC, 999 emergency service, My Options).



Q2 2019

4. Develop information sources

- NSOM to identify responsible agents for content and web-development and maintenance as defined by the strategy.
- Aiming to minimise time required from frontline staff.



Q3 2019

5. Increase information sources integration

- NSOM to engage with RCC, Gardaí, HSE, Tusla etc. to develop means of seamlessly integrating SATU information into other agencies' various communication channels.



Q3/Q4 2019

Area for Action 10: Convene a Sexual Assault Services Management Group of senior operational decision makers from different sectors to improve patient experience and outcomes

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

What is the Proposal?

- To establish a new group to bring together senior operational decision makers/executives (individuals with responsibility for service delivery) from agencies that have a role in preventing and responding to sexual assault.
- This group will oversee the planning and delivery of a 'whole-person' response to sexual assault nationally and should be supported by cross-departmental collaboration.
- The group members will be at a sufficiently senior level to take decisions on behalf of their organisation at meetings.
- The National Staffing and Operations Manager from the SATU Network will sit on the group and provide the secretariat function.
- There is an opportunity to scope whether this group should focus on SATU services only or also include representatives from children's services.

What is it like?

- National Child Safeguarding Strategic Liaison Management Committee.
- DoJE High Level Group on Traveller Issues.
- Existing SATU Regional Inter-Agency Group(s) but at national rather than regional level and with more senior membership .

What is it not?

- Not a committee but a decision making group with service improvement remit.
- Not a replacement for the SATU National Guidelines Group.
- Not a full-time group - meetings will take place 2-4 times per year.

What is the aim?

- To create a forum for strategic, cross-sectoral service planning for how sexual assault is dealt with as a national concern, and how the State responds to and cares for victims of sexual assault.
- To formalise and strengthen inter-agency working as part of this cross-sectoral response.

Why is it important?

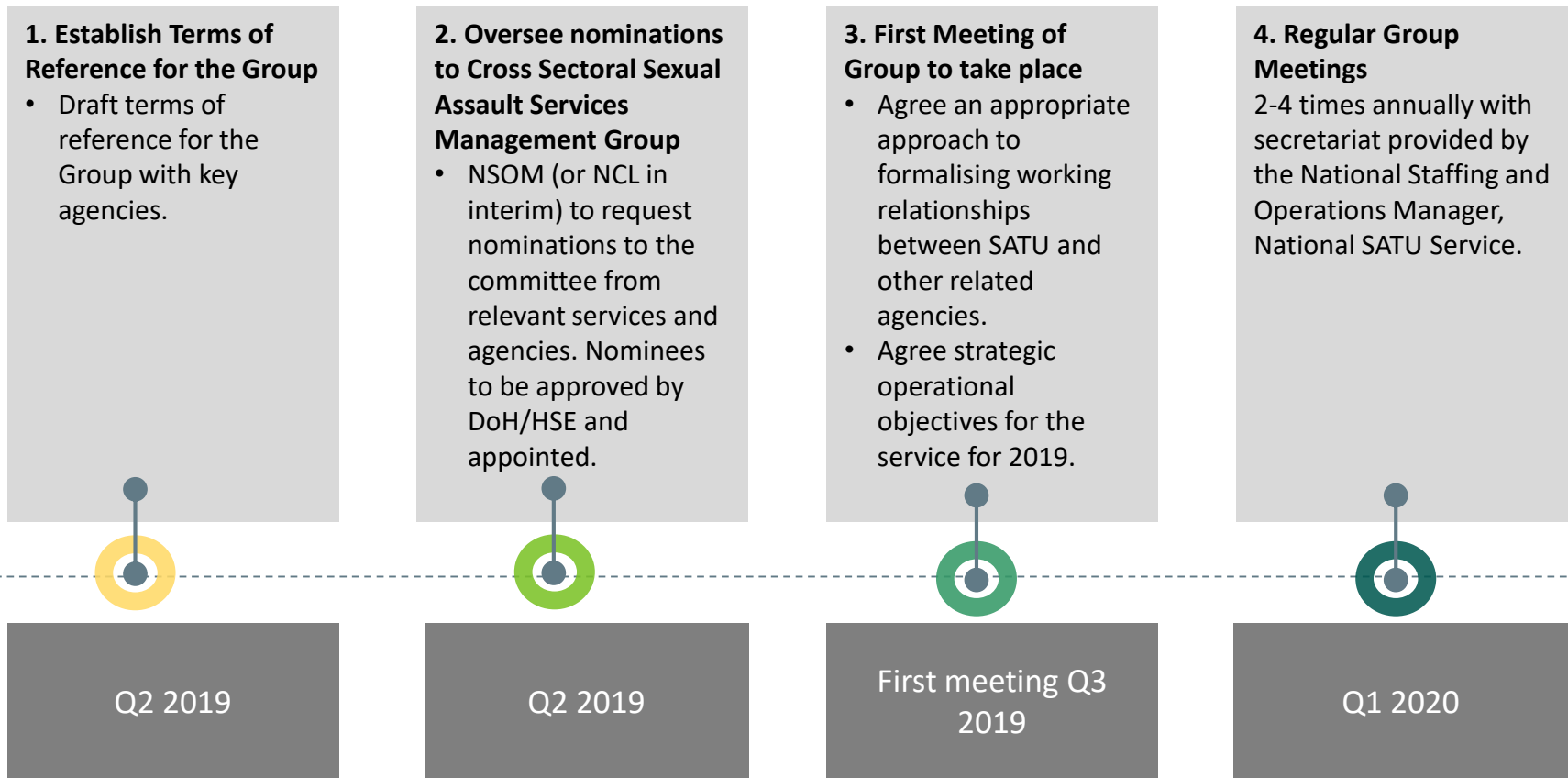
- The current SATU National Guidelines and Guidelines Group show excellent inter-agency *collaboration*, and are a very strong foundation from which to build service planning and operational *coordination*, but this must now be strengthened and formalised.
- While SATUs seeks to provides excellent acute medical care for victims of sexual assault, lack of formal inter-agency links puts SATU at risk of operating in isolation, impacting on patients.
- Increased cross-sectoral engagement between agencies responding to sexual assault is vital to ensuring patients are responded to in a way that recognises their longer-term, 'whole-person' needs.
- Fieldwork has indicated that inter-agency working in SATU has developed on an ad-hoc basis, often hinging on personal relationships and goodwill. There are sustainability risks associated with this approach: ***"Inter-agency working shouldn't rely on people having a good day."*** – Challenge Panel 1.
- Fieldwork has also indicated that where formal inter-agency arrangements are in place (e.g. SOPs), units have seen an increase in the number of patients reporting the assault to the Gardaí (e.g. Donegal RCC-SATU SOPs).
- The SATU service is often not visible or well-understood at a senior decision making level across agencies responding to sexual assault. The SATU service needs to be connected to the operations of related agencies at a senior level to ensure a strong, system-wide response to caring for victims of sexual assault.
- The increasing complexity of cases indicates that patients have a range of different needs (counselling, welfare, social work, mental health etc.) and could benefit from a range of different services to support their long-term recovery. Having seamless working arrangements with each of these agencies is vital to ensuring patients have the appropriate long-term support.

What impact could it have?

- A national 'whole-person', cross-sectoral service response to sexual assault.
- SATU is better positioned to care for patients as part of this holistic response.

AFA 10 Contd. What needs to happen next?

To initiate implementation, the Joint Review Implementation Team will:



4 additional Areas for Action can be implemented in the short term to respond to immediate 2019 challenges

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

ACTION

1. Patient Quality

- Prioritise recruitment of the National Staffing and Operational Manager and secure transitional clinical leadership
- Urgently identify and fill remunerated clinical directorship posts to improve governance

2. Patient Experience

- Immediately provide a small investment to enable improvements to the physical environment for patients (e.g. doorbell, paint etc.)
- Commit to provide a CPD bursary to all existing full-time SATU staff in order to allow space to prioritise personal recovery and wellbeing in 2019 given their extraordinary level of commitment to date

3. Patient Recovery

- Immediately develop and introduce case review and management processes
- Urgently review pathways to mental health services in addition to the RCC provision
- Immediately recruit Patient Liaison Manager

4. Patient Access

- Invest €5,000 in a national peer-led medical training programme to increase number of FMEs available to support on-call in year.
- Pilot the “Rapid Responder” programme in Dublin, Galway and Mullingar
- Canvass health sector staff to identify colleagues with FNE or FME qualifications from other jurisdictions who may have the competency to support on-call provision in 2019

ANALYSIS

At-Risk Groups

Findings on page 23 highlight the importance of immediately initiating cross-Government work on identifying vulnerable patient groups and examining options to best protect and support this cohort

Offending and Re-Offending

This report contains no analysis on perpetration. There would be immense value in understanding offending and re-offending and how this analysis can contribute to support for at risk groups

2 Areas for Action present opportunities to develop SATUs strategically over the long-term

1. Long-Term Service Configuration

There are several cross-government processes in train which may impact on SATU service delivery: the Children's SATU Services Barnahus Pilot and the Policing Review (Commission on the Future of Policing in Ireland).

Following this, the Review Team recommends initiation of a short, deliberative process to consider the following options with a view to ensuring sustainability, consistency and integration of SATU services over the long-term:

1. Developing a mobile SATU Service
2. Developing a resourced night service
3. Integrating adult and child services
4. Developing a smaller number of centre(s) of excellence which are purpose built, co-located and co-funded with An Garda Síochána and other relevant services (learning from the Rowan Centre in Northern Ireland).

2. Long-Term Service Setting

Planning should begin immediately to ensure a high-quality, purpose-built environment for patients in each location, informed by decisions taken under Action 1 above. This should be aligned with and embedded in all relevant capital decisions (e.g. Rotunda re-location, GUH re-location etc.)

Implementation

The Department of Health will support and oversee implementation in the following ways:

1. Communicating the findings to the public to provide assurances that positive changes are underway for this service into the future
2. Resourcing implementation
3. Supporting the Joint Implementation Review Team
4. Reviewing progress regularly at MB/HSE Leadership Monthly Performance Review Meetings commencing March 2019
5. Ministerial Review after the first six months (September 2019)

The HSE will support and oversee implementation in the following ways:

1. Assigning responsibility to the Chief Clinical Officer HSE for the implementation of the SATU Policy Review
2. Assigning a project lead to support implementation of priority actions, in particular actions relating to the establishment of the National SATU Network
3. Lead further engagement on long-term issues identified

Hospital Management and SATU staff will be invited to:

1. Actively participate on the Joint Implementation Review Team
2. Contribute ideas and suggestions for how to ensure successful implementation

Review Process

Fieldwork and Analysis

Policy Opportunities

Proposed Actions

Appendices

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Abbreviations List

- **ADON** – Assistant Director of Nursing
- **ADON/M** – Assistant Director of Nursing Manager
- **AFA** – Area for Action
- **AMAU** – Acute Medical Assessment Unit
- **ANP** – Advanced Nurse Practitioner
- **CEO** – Chief Executive Officer
- **CCO** – Chief Clinical Officer
- **CD** – Clinical Director
- **CMO** – Chief Medical Officer
- **CNM** – Clinical Nurse Manager
- **CNS** – Clinical Nurse Specialist
- **CPD** – Continuing Professional Development
- **CSO** – Central Statistics Office
- **DCYA** - Department of Children and Youth Affairs
- **DPER** – Department of Public Expenditure and Reform
- **DoES** – Department of Education & Skills
- **DoH** – Department of Health
- **DoJE** – Department of Justice and Equality
- **DON** – Director of Nursing
- **DON/M** – Director of Nursing Manager
- **DPP** – Director of Public Prosecutions
- **DRCC** – Dublin Rape Crisis Centre
- **EAP** – Employee Assistance Programme
- **ED** – Emergency Department
- **ELS** – Existing Level of Service

- **FE** – Forensic Examiner
- **FME** – Forensic Medical Examiner
- **FNE** – Forensic Nurse Examiner
- **FOI** – Freedom of Information request
- **FSI** – Forensic Science Ireland
- **GP** – General Practitioner
- **GUH** – Galway University Hospitals
- **HEA** – Higher Education Authority
- **HG** – Hospital Group
- **HIQA** – Health Information and Quality Authority
- **HSE** – Health Service Executive
- **ICU** – Intensive Care Unit
- **INMO** – Irish Nurses and Midwives Organisation
- **IPA** – Institute of Public Administration
- **ISVA** – Independent Sexual Violence Advisor
- **KPI** – Key Performance Indicator
- **MB** – Management Board
- **MoU** – Memorandum of Understanding
- **NCL** – National Clinical Lead
- **NGO** – Non-Governmental Organization
- **NMD** – National Medical Director
- **NMT** – National Management Team
- **NMPDU** – The Nursing & Midwifery Planning & Development Unit
- **NNTP** – National Neonatal Transfer Programme
- **NODTAG** – National Organ Donation Transplant Advisory Group

- **NPSO** – National Patient Safety Office
- **NSOM** – National Staffing and Operations Manager
- **NTMS** – National Transport Medicine Service
- **ODTI** – Organ Donation and Transplant Ireland
- **ONMSD** – Office of the Nursing and Midwifery Services Director
- **OPAT** – Outpatient Parenteral Antimicrobial Therapy
- **OPD** – Outpatients' Department
- **PLM** – Patient Liaison Manager
- **PT** – Part-time
- **QID** – Quality Improvement Division
- **RCC** – Rape Crisis Centre
- **RCSI** – Royal College of Surgeons in Ireland
- **RFT** – Request For Tender
- **S38** – Section 38 Organisation
- **SANE** – Sexual Assault Nurse Examiner
- **SARC** – Sexual Assault Referral Centre
- **SATU** – Sexual Assault Treatment Unit
- **SEO** – Search Engine Optimisation
- **SOP** – Standard Operating Procedure
- **SSWHG** – South/South-West Hospital Group
- **STI** – Sexually Transmitted Infection
- **T&S** – Travel & Subsistence
- **WRC** – Workplace Relations Commission
- **WTE** – Whole Time Equivalent

Definitions

- **Acute** – a medical event involving a person in need of urgent specialist care.
- **Barnahus/‘One House’ model** – a model for child victims of sexual assault where medical, justice, and social services can be accessed in a single location.
- **“Blue-light” services** – services that respond to emergencies.
- **Case management** - a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a patient’s health and human service needs.²⁵
- **Clinical Nurse/Midwife Specialist** - a nurse or midwife in clinical practice who has undertaken formal recognised post-registration education relevant to his/her area of specialist practice.¹⁰
- **Clinical supervision** - facilitated, in-depth reflection of clinical practice.²⁶
- **Cosc** – The National Office for the Prevention of Domestic, Sexual and Gender-based Violence
- **Domestic violence** - The use of physical or emotional force or the threat of physical force, including sexual violence in close adult relationships. The terms “domestic violence and “intimate partner violence” are both used to describe violence between two adults in an intimate relationship.¹⁰
- **Holistic** – addressing the needs of the whole person (e.g. emotional, mental and social) by not focusing solely on their medical symptoms.
- **Forensic Clinical Examination** – the act of having forensic evidence collected from a patient following alleged rape or sexual assault by a qualified healthcare professional as defined in the SATU guidelines.
- **Forensic Clinical Examiner** - an appropriately trained healthcare professional who undertakes the forensic clinical examination and collects forensic evidence from the patient, following alleged rape or sexual assault. This healthcare professional may be a medical doctor, a registered nurse or a registered midwife.¹⁰
- **Liaison** – communication between patients and SATU staff relating to a patient’s care and recovery.
- **Option 3** - collection and preservation of evidentially valuable forensic samples, in circumstances where the patient has yet to decide to report to An Garda Síochána.¹⁰
- **Psychological support/crisis worker** – a Rape Crisis Centre volunteer trained and available to provide advocacy, crisis intervention and support to a sexual violence victim/survivor in a SATU.¹⁰
- **Safe Staffing Framework** - a framework for determining the safe nurse staffing and skill mix (whereby nurse staffing refers to the nursing team including both the nurse and healthcare assistant roles) in a range of major specialities.¹⁶
- **Self-refer** – where a patient attends a SATU without reporting to An Garda Síochána.
- **Sexual assault** – a sexual act performed without consent as defined by the Criminal Law (Sexual Offences) Act 2017.²⁷
- **Sexual Assault Treatment Unit (SATU)** – a specialist unit where victims of sexual assault can avail of medical care and have forensic samples taken by a qualified forensic clinical examiner.
- **Sexual offence** – offences as described in the Sex Offenders Act (2001)²⁸ including rape and sexual assault.
- **Sexual violence** - Sexual violence is any sexual act that is forced against someone's will. Sexual violence occurs if you are forced to participate in a sexual act without your consent. It may include rape or other types of sexual assault. The force involved may take the form of threats, coercion or physical violence.¹¹
- **Tusla** – The Child and Family Agency
- **Vulnerable person** – a person who is or may be in need of community care services by reason of mental illness or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself from significant harm or exploitation.¹⁰

If you have been affected by the issues raised in this report...

If you have been affected by any of the issues highlighted in the Review:

Support is available from the Rape Crisis Centres National 24-hour helpline every day of the year on 1800778888. This phone line offers a free, confidential listening and support service for women and men who have been raped, sexually assaulted, sexually harassed or sexually abused at any time in their lives.

Further information on free of charge services provided through the Sexual Assault Treatment Units (SATUs) in Dublin, Mullingar, Galway, Waterford, Cork and Donegal is available through www.hse.ie/satu

