Public health functions to be exercised by NHS England

Service Specification No. 30
Sexual Assault Referral Centres
This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by Public Health Commissioning Central Team, Operations and Information.

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Publications Gateway Reference 08482
## CONTENTS

1. **THE PURPOSE OF SERVICE SPECIFICATION NO.30** 7

2. **LEGAL FRAMEWORKS AND DEFINITIONS** 10

2. **THE NATIONAL CONTEXT AND EVIDENCE BASE** 10
   - The Benefits of SARCs 12
   - The Evidence Base 12

4. **SCOPE OF SARC SERVICES** 16
   - The Role of SARCs 16
   - Model of SARC Service Provision and Key Elements 17
   - Geographical Location of SARC Services 19
   - Essential Areas of SARC Provision 20

5. **COMMISSIONING** 23
   - Aims and Objectives 23
   - NHS England Commissioning Model 24
   - Collaborative Commissioning and Partnership Working across the SAAS Care Pathway 24
   - Information Sharing 29

6. **APPLICABLE SERVICE STANDARDS FOR SARC SERVICES** 30
   - Introduction 30
   - National Standards and Requirements 30
   - Quality Assurance Standards 31

7. **PERFORMANCE MANAGEMENT AND ACTIVITY REPORTING** 33

8. **EQUALITY AND DIVERSITY** 34

8. **SERVICE USER ENGAGEMENT** 35

APPENDIX 1: ADULT CARE PATHWAYS 36

APPENDIX 2: CHILDREN AND YOUNG PEOPLES’ CARE PATHWAY 45
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPG</td>
<td>All Party Parliamentary Group</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>BASHH</td>
<td>British Association for Sexual Health and HIV</td>
</tr>
<tr>
<td>BHIVA</td>
<td>British HIV Association</td>
</tr>
<tr>
<td>CAHVIO</td>
<td>Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Groups</td>
</tr>
<tr>
<td>CEOP</td>
<td>Child Exploitation and Online Protection Centre</td>
</tr>
<tr>
<td>CJS</td>
<td>Criminal Justice System</td>
</tr>
<tr>
<td>CP-IS</td>
<td>Child Protection – Information Sharing</td>
</tr>
<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
</tr>
<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>CSEW</td>
<td>Crime Survey for England and Wales</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People</td>
</tr>
<tr>
<td>DCLG</td>
<td>Department for Communities and Local Government</td>
</tr>
<tr>
<td>DfE</td>
<td>Department for Education</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FFLM</td>
<td>Faculty of Forensic &amp; Legal Medicine</td>
</tr>
<tr>
<td>FSRH</td>
<td>Faculty of Sexual and Reproductive Healthcare (at the Royal College of Obstetricians and Gynaecologists)</td>
</tr>
<tr>
<td>GUM</td>
<td>Genitourinary Medicine</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>ISVA</td>
<td>Independent Sexual Assault Advisor</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>LSCB</td>
<td>Local Safeguarding Children Board</td>
</tr>
<tr>
<td>MARAC</td>
<td>Multi-Agency Risk Assessment Conference</td>
</tr>
<tr>
<td>MoJ</td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td>NCA</td>
<td>National Crime Agency</td>
</tr>
<tr>
<td>NPCC</td>
<td>National Police Chiefs Council (previously ACPO)</td>
</tr>
<tr>
<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
</tr>
<tr>
<td>PCC</td>
<td>Police and Crime Commissioner</td>
</tr>
<tr>
<td>PEPSE</td>
<td>Post-Exposure Prophylaxis after Sexual Exposure</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>RCPCH</td>
<td>Royal College of Paediatrics and Child Health</td>
</tr>
<tr>
<td>SARC</td>
<td>Sexual Assault Referral Centre</td>
</tr>
<tr>
<td>SARCIP</td>
<td>Sexual Assault Referral Centre Indicators of Performance</td>
</tr>
<tr>
<td>SAAS</td>
<td>Sexual Abuse and Assault Services</td>
</tr>
<tr>
<td>YPA</td>
<td>Young People’s Advocates</td>
</tr>
</tbody>
</table>
Service Specification No. 30

This is a service specification to accompany the ‘NHS public health functions agreement 2018-19 (the ‘2018-19 agreement’) published in March 2018.

This service specification is to be applied by NHS England in accordance with the 2018-19 agreement. This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

Where a specification refers to any other published document or standard, it refers to the document or standard as it existed at the date when the 2018-19 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2018-19 agreement in accordance with the procedures described in Chapter 3 of the 2018-19 agreement.

Service specifications should be downloaded in order to ensure that commissioners and providers refer to the latest document that is in effect.

The 2018-19 agreement is available at www.gov.uk (search for ‘commissioning public health’).

All current service specifications are available at www.england.nhs.uk (search for ‘commissioning public health’).
1. THE PURPOSE OF SERVICE SPECIFICATION NO. 30

1.1 The NHS Public Health Functions Agreement (Section 7A or s.7A) made under the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines the specific responsibilities of National Health Service England (NHS England) for commissioning certain public health services as part of the wider system design to drive improvements in population health. The services under s.7A are directly commissioned by NHS England on behalf of the Secretary of State for Health, which has the capability to develop a single approach to commissioning that improves the distribution of, and access to those services across the country. The overall aim is to:

- Improve health outcomes and reduce health inequalities.
- Contribute to a more sustainable public health, health and care system.

1.2 Underpinning the agreement are thirty service specifications for s7A public health services falling under the following categories:

- Immunisation programmes
- Screening programmes
- Cancer screening programmes
- Children’s public health services (from pregnancy to age 5)
- Child health information systems
- Public health care for people in prison and other places of detention
- Sexual assault referral centres

1.3 The purpose of Service Specification No. 30 is to outline the public health functions to be exercised by NHS England in regards to the commissioning of Sexual Assault Referral Centres (SARC). This Service Specification covers the period from 2018-19.

1.4 NHS England, with a range of partners in the health system (e.g. CCGs), Local Authorities and the Criminal Justice System (e.g. Police, PCCs) is jointly responsible for the commissioning of a cost-effective, integrated response to sexual violence and rape in order to meet the needs of local populations. With the Police and PCCs, NHS England co-commissions SARC services. NHS England is specifically responsible for commissioning the public health services elements of SARC services. SARC services also comprise of sexual assault forensic medical examinations and independent sexual violence advisory support.

1.5 A SARC provides services to victims of rape or sexual assault regardless of age and gender, and whether the victim reports the offence to the police or not, and can provide onward referrals to other health and social care services according to need. SARC services can deliver services to both recent and non-recent victims, and can offer victims the opportunity to assist in a police

---

1 Where the assault is said to have occurred more than 7 days previously
investigation of the sexual offence against them, including a forensic medical examination with consent.

1.6 In any local area the SARC provision is part of a network within the wider sexual assault and abuse services (SAAS) care pathway, for example, psychological therapies, commissioned by CCGs and other specialist support and therapy available from the Third Sector as follow-on services for those who have attended a SARC or for those who do not wish to utilise SARC services. SARC commissioners themselves do have a requirement to commission an element of therapeutic support within the pathway for survivors, as part of the service specification. The commissioning of the full SAAS care pathway is only possible in partnership with the other commissioners in the wider health, social care and criminal justice commissioners sectors. NHS England is committed to working with all NHS, local authority and criminal justice commissioners, as appropriate, to secure the best possible outcome for service users within available resources.

1.7 Whilst NHS England is specifically responsible for commissioning the public health services elements of SARC services, this document will focus on the entirety of the role and scope of SARC services and the current model of service delivery for children, young people and adults, as it is important to highlight the areas of co-commissioning. Hence, this document is relevant to commissioners in the NHS (e.g. CCGs), Local Authorities and in the Criminal Justice System (e.g. Police, PCCs), who are responsible for commissioning various aspects of SARC provision and/or commissioning elements within the wider SAAS pathway. It is important to recognise that the pathway for each individual will commence from the point at which they are referred or present themselves. For adults and young adults this may be via a self-referral or a police referral, while for children and young people it may be through a safeguarding referral to social services or the police.

1.8 In recognition of both the number and the wide range of commissioners involved and the differing levels of knowledge and understanding of SARC services and the SAAS pathway, this specification will consider the interfaces and interdependences between SARC services and the commissioners and providers within the wider SAAS care pathway. However, SARC and SAAS provision is a whole system concern and cannot be neatly grouped and categorised as a primary health, public health, mental health, social care or police issue, which can make identifying commissioning responsibilities complex. Table 1 below attempts to summarise the current responsibilities along the SARC/SAAS pathway. It outlines which functions may be the commissioning responsibility of more than one organisation so needs to be jointly commissioned. It also demonstrates the complexities of the pathway.

1.9 It is important to note this document is not a service specification for service providers. Neither will this document prescribe time-frames, for example, for the acute period of psychological therapies. Such issues should be outlined in local partnership agreements around service delivery.
Throughout this document the terms sexual assault, sexual offence, sexual violence and sexual abuse are used interchangeably and not necessarily always according to their technical or legal definitions.

Table 1 – Summary of the current responsibilities along the SARC/SAAS pathway

<table>
<thead>
<tr>
<th>NHS England</th>
<th>Police</th>
<th>PCCs</th>
<th>LAs</th>
<th>CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibilities within SARCs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual assault public health services e.g. sexual health services. Therapeutic pathways</td>
<td>Sexual assault forensic medical examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forensic cleaning/swabbing of SARC premises</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Workers</td>
<td></td>
<td>ISVAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SARC facility/operational management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibilities within wider SAAS pathway</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Liaison and Diversion services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prison Healthcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance Misuse Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult mental health, IAPT &amp; Mental Health Services for CYP provision including therapeutic support for recent and non-recent cases, as required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care services</td>
<td>GP services in the few remaining non-delegated CCG areas.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>S7A Public Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV Treatment Services (specialised commissioning)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public Health Services e.g. GUM/sexual health services for over 13s.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accident &amp; Emergency services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GP Services in delegated areas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Healthcare Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Care/Support services</td>
<td>Victim support services* (support for victims of crime)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Victim support services* e.g. specialist sexual violence Third Sector counselling, advocacy and support</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. LEGAL FRAMEWORKS AND DEFINITIONS

2.1 Sexual offences are governed by the **Sexual Offences Act 2003 (England and Wales)** and include sexual activity with a child under 18 years of age. The definitions of sexual offences outlined in the Act are summarised below:

- **Rape** - A person commits rape if they intentionally penetrate the vagina, anus or mouth of another person with their penis without consent.

- **Sexual assault** - A person commits sexual assault if they intentionally touch another person, the touching is sexual and the person does not consent.

- **Serious sexual assault** - Assault by penetration - a person commits assault by penetration if they intentionally penetrate the vagina or anus of another person with a part of the body or anything else, without their consent.

- **Sexual activity with a child under 16** - Sexual activity with a child under 16, causing or inciting a child to engage in sexual activity, engaging in sexual activity in the presence of a child, and causing a child to watch a sexual act, are offences irrespective of whether the child consents or not.

2.2 **The Care Act 2014** sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect, and outlines local authorities’ safeguarding duties.

2.3 The care and safeguarding of children is governed by **The Children’s Act 1989 and 2004**: 

*Currently the Ministry of Justice directly funds through grants an element of local rape and sexual abuse support services, which are primarily provided by the Third Sector.*
• **The Children Act 1989** – Under s17 every Local Authority has a duty to safeguard and promote the welfare of children within their area. The Local Authority must provide services to ensure that children are able to achieve and maintain a reasonable standard of health and development to ensure that individual children’s health is not impaired, or further impaired.

• **The Children Act 2004** - This Act extends this duty to safeguard and promote children’s welfare to the Local Authority’s partners and places a duty on them, including SARC services to work with Local Authorities to promote the wellbeing of children (s.10) and places a duty on a range of agencies and people to ensure that all their staff have regard to the need to safeguard the welfare of children and young people in their care (s.11). It provides the legislative underpinning for integrated working and safeguarding activity. The document *Working Together to Safeguard Children* sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Act.

**2.4 Child sexual exploitation** is a form of child sexual abuse and is covered by the Sexual Offences Act 2003. The transporting element of children across different areas domestically or abroad i.e. Human Trafficking is covered by a number of Acts including The Children Act 1989 and 2004; Asylum and Immigration (Treatment of Claimants, etc.) Act 2004; Modern Slavery Act 2015; Nationality, Immigration and Asylum Act 2002; and the Human Rights Act 1998. The definition in the recently published national policy document, *Tackling Child Sexual Exploitation – Definition and Guide for Practitioners* is as follows:

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

**2.5** People can also experience sexual violence through intimate partner violence and abuse, chiefly domestic violence. There is currently no single legal definition of domestic violence but the Government definition of domestic violence and abuse is as follows:

---

2 *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government*

3 *Tackling Child Sexual Exploitation – Definition and Guide for Practitioners’, Department for Education. 2017*
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological; physical; sexual; financial; and emotional.”

2.6 Female Genital Mutilation is a collective term for a range of procedures which involve partial or total removal of the external female genitalia for non-medical reasons. It is sometimes referred to as female circumcision, or female genital cutting. Section 74 of the Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 to introduce the legal duty for regulated health and social care professionals and teachers to make a report to the police if: they are informed by a girl under the age of 18 that she has undergone an act of FGM. Further guidance for healthcare professionals is available at www.england.nhs.uk

Whilst FGM is not categorised as sexual assault, the ability of SARC services to accurately capture evidence means that there are real benefits for victims in including this in scope of the SARC service. However, it is not anticipated that every SARC should need to provide this service and it is recommended provision is locally negotiated.

3. THE EVIDENCE BASE

The Benefits of SARC Services

3.1 The provision of a SARC service can have significant benefits for the individual and for public services i.e. the NHS, Local Authorities and the Criminal Justice System. Each adult rape is estimated to cost over £96,000 in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health service and costs incurred in the criminal justice system. The overall financial cost to society is high with estimates suggesting that child sexual abuse alone results in £182m of health spending annually. Victims can benefit from expert treatment and support not available in other services, including ISVAs who can provide seamless support to survivors whether or not they are pursuing criminal justice proceedings.

3.2 SARC services can provide both the police and the service user with the best possible opportunity to recover evidence for use within an investigation. Without such an approach, support to these vulnerable clients within the criminal justice system would be significantly reduced.

---

3.3 More generally, the presence of a SARC can raise public awareness of sexual violence and abuse and how such abuse can be dealt with, which in turn helps boost public confidence in both the health and criminal justice systems.

3.4 It is vital to have an understanding of the evidence base, including the profile of victims and the current trends around sexual violence if commissioners are to effectively target and deliver services. A summary of the key areas is outlined below.

**Victims of violent crime and sexual violence**

3.5 Estimates on the prevalence of sexual abuse are wide-ranging. In 2013, a joint report, by the Ministry of Justice, the Home Office and the Office of National Statistics, was published on sexual violence showing that approximately 85,000 women and 12,000 men are raped in England and Wales alone every year; nearly half a million adults are sexually assaulted in England and Wales each year; 1 in 5 women aged 16 - 59 has experienced some form of sexual violence since the age of 16 and only around 15% of those who experience sexual violence choose to report to the Police.

3.6 Around 0.5% of females reported being a victim of the most serious offences of rape or sexual assault by penetration in the previous 12 months, equivalent to around 85,000 victims on average per year. Among males, less than 0.1% (around 12,000) reported being a victim of the same types of offences in the previous 12 months.

3.7 The number of police recorded sexual offences in the year to March 2014 showed a 20% increase compared with the previous year, rising to a total of 64,205 incidents across England and Wales. This latest figure is the highest ever recorded on a financial year basis. Within this, the number of rape offences increased by 26% to 20,745 incidents, and the number of other sexual offences increased by 17% to 43,460 incidents.

3.8 The ONS stated that increases were considered to be due to greater victim confidence and a willingness of victims to come forward to report such crimes together with improved recording by the police rather than more sexual assaults taking place. Therefore, it is important that these increases are viewed in the context of the effects of police operations such as Operation Yewtree and other high profile cases involving sexual abuse that improved the willingness of people to report abuse. Improved compliance with recording standards for sexual offences in some police forces may also have been a factor in the rise.

3.9 Nonetheless, only about 11% of sexual abuse is estimated to be reported to the Police. Analysis of the 2014 adult psychiatric morbidity survey reported

---

7 An Overview of Sexual Offending in England and Wales (10 January 2013) Ministry of Justice, Home Office & the Office for National Statistics (Statistics bulletin)
8 Chapter 1: Violent Crime and Sexual Offences Overview (12 February 2015) Office for National Statistics
that 5% of people had experienced sexual violence in childhood, 3% in adulthood and a further 4% in both childhood and adulthood. The findings of this population health survey are generalizable to the population of England and indicates that the prevalence of sexual abuse may be higher than thought.

**Child Sexual Abuse**

3.10 In regards to the prevalence of child sexual abuse, the NSPCC\(^\text{11}\) reported that there were a total of 23,663 sexual offences against children recorded by the police in the UK in 2012/13 and 6,296 rapes of children recorded by police in England and Wales. Further, it is estimated that only 1 in 8 child victims are identified by professionals\(^\text{12}\) indicating a significant level of unmet need.

3.11 The data from individual SARC services suggested that between 22% and 50% of service users seen are young people under 18 years old.\(^\text{13}\)

3.12 The vast majority of child sexual abuse is familial and is perpetrated by people related to, or known to the victim, and often goes unreported and undetected. In 2012/13, nearly half of the young people who contacted the NSPCC’s ChildLine service about child sexual abuse said the perpetrator was a family member.\(^\text{14}\) Children who have been sexually abused by a family member have an increased vulnerability to child sexual exploitation, as well as other forms of abuse including physical and sexual violence.\(^\text{15}\)

3.13 The overall health consequences for sexually abused children and young people can be devastating:\(^\text{16}\)

- Abused children are more prone to sexually transmitted infections;
- Abused young people are at increased risk of homelessness, which may result in risk-taking behaviours and increased vulnerability;
- The risk of suicide doubles for abused young people when they reach their late twenties;
- Sexually abused adolescents are at risk of ongoing health problems such as chronic pelvic pain and gynaecological problems;

---


11 How Safe Are Our Children (2014) Sonja Jutte, Holly Bentley, Pam Miller, Natasha Jetha; NSPCC


13 Securing Excellence in commissioning sexual assault services for people who experience sexual violence (13 June 2013) NHS England


• Sexual abuse in children and young people is associated with mental ill health including self-harm and depression, which may continue into adulthood.

**Child Sexual Exploitation**

3.14 It is important for SARC services to understand the characteristics of child sexual exploitation (CSE) in order to provide a suitable response to this form of child sexual abuse. In 2011, the Child Exploitation and Online Protection Centre (CEOP)\(^{17}\) found:

- **Majority of CSE victims were girls** - However in 31% of cases, gender was unknown. It is likely that male victims are under-represented due to difficulties in identifying sexual exploitation in boys and young men.
- **14 and 15 year olds are most likely to be noticed by authorities** - Some victims of sexual exploitation were as young as 9 or 10 years old, but young people most commonly came to the attention of statutory and non-statutory authorities aged 14 or 15.
- **Majority of victims were White** - 61% of the victims were White, 3% were Asian and 1% were Black. Ethnicity was unknown in 33% of cases. Children from minority ethnic backgrounds are likely to be under-represented in statistics because of barriers to reporting and accessing services.
- **Children who go missing are risk of sexual exploitation** - Information about whether children went missing was incomplete but 842 children were reported as missing on at least one occasion. However, it was not known whether these children were sexually exploited before, during or after they went missing.

3.15 There are links between child sexual exploitation and youth offending. A University College London study\(^{18}\) of 552 victims of child sexual exploitation in Derby found that nearly 4 out of 10 young people had a history of criminal behaviour.

3.16 Although there is research evidence into the factors that are associated with child sexual exploitation, very few studies look into the numbers of children who have been exploited. The available research and data shows that over 2,400 children were victims of sexual exploitation in gangs and groups from August 2010 to October 2011\(^{19}\) and the most common reasons for children to

---

\(^{19}\) Berelowitz, S. et al (2012) “I thought I was the only one. The only one in the world.” The Office of the Children’s Commissioner’s inquiry into child sexual exploitation in gangs and groups: interim report London: Office of the Children’s Commissioner.
be trafficked in the UK are sexual exploitation and criminal exploitation. In 2014, 152 children were trafficked for sexual exploitation.  

**Prosecutions of sexual offences against children**  

3.17 SARC services that work with children are an important part of the criminal justice service for sexually abused children. In 2014/15, sexual offences against children reached their highest volumes ever:  

- **Rape prosecutions** rose by 16.6% (645) to 4,536.  
- 9,789 defendants were prosecuted for **sexual offences, excluding rape**; a rise from 8,554 in 2013/14.  
- **Child abuse prosecutions** completed in 2014/15 reached 10,045, a rise of 2,047 (25.6%) since 2013/14.  
- There was 22% rise in the volume of **successful outcomes in the overall child abuse cases** from 6,096 in 2013/14 to 7,469 in 2014/15.  

### 4. SCOPE OF SARC SERVICE  

**The Role of SARC Services**  

4.1 SARC services provide around the clock support to victims of sexual assault and rape, including health care and onward referral to other health and social care services. They deliver services both to recent and non-recent victims and can offer victims the opportunity to assist in a police investigation of their crime. The services provided under s.7A are:  

- Crisis care  
- Forensic medical examinations with consent  
- Health care that includes emergency contraception, Post-Exposure Prophylaxis after Sexual Exposure (PEPSE), testing for sexually transmitted infections  
- Access to Independent Sexual Assault Advisor (ISVA) support  
- Referral for a minimum of 6-10 psychological therapy sessions including pre-trial and post-trial therapy and to Third Sector specialist sexual violence support, including advocacy.  

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

---  

20 Serious Organised Crime Agency (SOCA) and UK Human Trafficking Centre (UKHTC) (2013). *A Strategic Assessment on the Nature and Scale of Human Trafficking in 2012*
4.3 The majority of SARC services are not designed to offer long term support and so need to work closely with services within the SAAS pathway such as Improving Access to Psychological Therapies (IAPT) and those provided by the Third Sector in order to improve outcomes for all victims of sexual violence and support longer-term survivor recovery.

**Model of Service Provision and Key Elements**

4.4 SARC services should provide equitable access to an individually tailored care packages based on comprehensive need assessments, with a choice of action at every stage of care, clinical and non-clinical care and support, forensic examination and referral to appropriate services. The model of service of a SARC may vary according to the demographics and level of sexual violence in an area, and the resources available within the partner agencies, however, all SARC services are expected to provide the following key elements within their service model to ensure consistency of provision for service users nationally:

- Assess and deliver the healthcare and support needs of the service user and, where appropriate, offer and provide a forensic medical examination;
- Where service users are unsure as to whether they wish to take up a criminal justice action, provide the opportunity for service users to agree to evidence being stored in case they decide to report to the police at a later date;
- Provide secure storage of medical records and forensic samples (Faculty of Forensic & Legal Medicine (FFLM) guidance).
- Manage the prescribing, storage and supply of medicines in line with legislation and good practice.
- Provide immediate attention, in a timely fashion, to the service user. Early engagement and treatment initiation enhances the chances of both good criminal justice and health outcomes. This needs to be balanced with other factors such as the service user’s wishes and time since assault.
- Any medical consultation should include immediate health assessment e.g. assessment of injuries, and a risk assessment for self-harm, vulnerability and sexual health. Therefore, there should be immediate access to emergency contraception, PEPSE or referral to other acute, mental health or other health services, as required
- Where possible, allow service users a choice of gender of physician – most service users prefer to be seen by a female clinician;
- Address safeguarding, care and support issues for all service users;

---

21 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
23 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
- Ensure service users are referred to psychological therapy services and informed of independent advocacy services
- Where there are no overriding safeguarding concerns about a third party, give service users who are competent adults the choice of whether or not to involve the police.

**Service Model for Children and Young People**

4.5 Services to meet the needs of children and young people who are raped or sexually abused must be provided in ways that take account of the differences between adults and children and young people. Children and young people who may have been sexually abused often experience more than one type of abuse and they may be from families where there are many complex needs. Sexual violence and abuse including child sexual exploitation can also cause severe and long-lasting harm to individuals across a range of health, social and economic domains. Victims may present acutely, but victims of intra-familial abuse may present many years afterwards. Sexual abuse can worsen the impact of inequalities that are often linked to domestic violence and mostly affect women and vulnerable and disadvantaged people. Long-term effects can include depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide. A higher prevalence is documented amongst children and young people who have experienced sexual assault.

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

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

- There is clear information for children and young people about who to speak to, and how to access SARC services, and where to find local centres in the community, so that they do not need a family member or someone else to take them. This must be done in partnership with the Local Authority to ensure that systems are in line with local safeguarding procedures.
- SARC services should be designed to make children and young people feel at ease. There should be good security, and they should be decorated in child and young person friendly ways, which makes the users feel safe, comfortable and welcome.
- SARC services need to have ready access to skilled paediatric services that are available when required. This includes appropriate access to
clinicians trained in both forensic examination and safeguarding, and on-going psychological and other relevant support.

- Specific consideration of capacity and consent must be taken into consideration for children and young people. Confidentiality and autonomy can require careful negotiation between the child or young person, family and safeguarding requirements.

4.8 The recommended service model for meeting the needs of the child or young person who has been sexually assaulted, raped or abused is to deliver provision through a managed clinical network. This will have the acute forensic examination and care delivered at a SARC "hub" with referral pathways in place to local paediatric services for support and follow-up care where these are needed.24

4.9 The acute forensic examination should identify any forensic issues, safeguarding and provide access to emergency contraception, PEPSE, first aid or other acute mental health or sexual health services where indicated. Either during the initial presentation or at follow-up appointment, the medical consultation may identify unmet health needs or further safeguarding issues, such as a risk assessment of harm/self-harm and/or an assessment of vulnerability, safeguarding and sexual health needs. An onward referral to appropriate services may be required to address these issues.

4.10 This means that the service model is more than the medical examination and includes mental health assessment and referral as appropriate, access to crisis workers trained to work with children, Child Advocates (or advocates/independent sexual violence advisors trained to work with children), and on-going support that may include counselling and/or practical support for the child and their carers. The importance of liaison with other health providers, social care, education and relevant local Specialist Third Sector providers for play therapy, long-term therapy, counselling and support for parents/carers, practical support and resilience-building cannot be overestimated. Availability of this range of support, delivered in a seamless manner, is vital.

Geographical Location of SARC Services

4.11 There are currently 47 SARC services across England and many of these services are located in urban areas with high population densities and good access to public transport. Some are based in separate police-owned customised facilities whilst others are located in NHS premises, such as in hospitals, primary health care centres or premises in residential areas.

4.12 In some rural and semi-rural areas or for children and young people it may be inappropriate to establish a SARC service at a local level due to the very low volume of work. In these situations, regional SARC can offer advice, highly

---

24 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
experienced expert victim and forensic medical services through a managed clinical network with other local SARCs that are spread across a wider geographical area. In order to increase access to SAAS provision, a SARC may also be networked to other services such as sexual health clinics, genito-urinary medicine centres, paediatrics, social care, Specialist Third Sector services and victim support services.

4.13 In the majority of cases service users will either reside in the area, or the offence will have occurred in the area where the SARC is commissioned. However, there should be no geographical restrictions to a SARC service. There may be an entry requirement based on age but this should only occur where there is appropriate provision elsewhere in the area for those young people or children who are under that age for entry.

**Essential Areas of SARC Provision**

**Ensuring Access**

4.14 Ease of access is important to encouraging use of SARC services by people who have been sexually assaulted. SARC services should integrate seamlessly within the local SAAS care pathway, especially the psychotherapeutic care, and enable access to other essential services in the wider health and social care system and specialist sexual violence support in the Third Sector. This is vital as many victims do not seek help or report incidents to the police. Services should monitor and review self-referrals to encourage the same.

4.15 SARC services and what they provide are not generally well known. Therefore, raising awareness and promoting SARC provision and ease of access to services is a priority and all local areas should ensure that there is:

- An opportunity for victims to access SARC services as self-referrals
- Choice of whether or not to involve the police
- Choice of gender of physician, where practicable
- High levels of victim satisfaction
- An opportunity for the service user to agree to evidence being stored in case they decide to report to the police at a later date or to provide evidence anonymously

**Addressing Physical and Mental Health Needs**

4.16 The health needs of victims include the physical health consequences of sexual violence and rape, a risk of pregnancy in 5% of cases, acquisition of sexually transmitted infections and HIV and, for all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services. The psychological consequences are linked to profound long-term health issues with one third of rape survivors going onto develop post-traumatic stress disorder, relationship problems and
longer term psychological needs, mental illness and an increased risk of suicide for abused children when they reach their mid-twenties.\(^\text{25}\)

4.17 SARC services support the service user to deal with the immediate crisis around their physical and mental health needs and should focus on providing:

- A high standard of victim care to reduce the physical and psychological impact of sexual assault. This will also increase the likelihood that the service user will further access the treatment they need, so reducing the immediate and future burden on the health service from poor co-ordination.
- Availability of specialist staff, trained in caring for victims of sexual violence
- Strong links with the health and social care services in both the statutory and Specialist Third Sector, enabling a seamless provision of care for service users and the sharing of information and good practice.
- The development of a local centre of excellence and expertise, providing advice, training, and support to local health practitioners, police and CPS.
- A pathway including in the commissioning responsibilities for short to medium term therapeutic care.

4.18 As well as meeting the immediate health needs of service users, SARC services must develop effective partnerships and have seamless access to a range of health care services, including sexual and reproductive health screening, treatment and care, HIV testing, follow-up care for service users prescribed PEPSE and access to choice of contraceptive methods including emergency contraception. Service users who have positive results for sexually transmitted infections need to be offered the appropriate treatment, including assistance with partner notification in line with Society of Sexual Health Advisor's guidelines, and, referral to the Genitourinary Medicine (GUM) clinic. SARC providers will need to ensure that survivors are appropriately referred and monitored to ensure attendance at follow up services.

4.19 There are also health interdependencies with mental health services and it is essential that service users have a choice of care provision in on-going support and counselling. When service users' mental health needs exceed the remit of SARC provision i.e. needs are greater than Improving Access to Psychological Therapies (IAPT) level 3 support for adults, the SARC will need to refer the individual to local community mental health services or acute

\(^{25}\text{Securing Excellence in commissioning sexual assault services for people who experience sexual violence (13 June 2013) NHS England}\)
services. Referrals should be with consent or, in the case of adults without capacity, in their best interests.\textsuperscript{26}

There needs to be a mental health assessment for all CYP attending the SARC and for them to be referred on to the relevant pathway of care –‘high quality care and support to meet their needs’

Where such services do not exist discussions will need to be held between the relevant commissioners and partners.

**Supporting the Criminal Justice System**

4.20 SARC services can help to raise the awareness of sexual violence and abuse, and how such abuse can be dealt with by providing good ISVA services, which supports victims through the criminal justice journey to achieve better criminal justice outcomes. This in turn helps boost public confidence in the health and criminal justice systems. Therefore, it is vital that SARC services work closely with agencies in the Criminal Justice System in order to:\textsuperscript{27}

- Ensure access to ISVA services either within the SARC or externally within another service or premise.
- Improve standards of forensic evidence.
- Improve detection from anonymised forensic samples collected from victims enabling links to be identified. In this way, SARC services can help the police and Community Safety Partnerships to build a picture of sexual offences at a local level. The intelligence gained can help prevent sexual violence by better understanding its distribution and pattern in an area and enhanced detection through collection of high quality forensic evidence.
- Provide storage of material whilst a victim decides whether they wish to pursue a criminal justice outcome or not.
- Help to reduce attrition in the months between reporting an assault and any court hearing/appearance.
- Help to increase the potential to bring more offenders to justice on the basis of better evidence, fewer withdrawals because of better victim care, increased reporting and access to intelligence from self-referrals.
- Improvements in forensic science have enabled cases to be prosecuted years after the event, particularly where DNA samples have been obtained. The assistance of SARC services in providing evidence for, and supporting victims through these ‘cold cases’ has produced good results with a very high proportion of convictions.

\textsuperscript{26} Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

\textsuperscript{27} Revised National Service Guide A Resource for Developing Sexual Assault Referral Centres (21 October 2009) Home Office and Department of Health
5. COMMISSIONING

Aims and Objectives

5.1 NHS England is committed to working with all NHS (e.g. CCGs), Local Authority and Criminal Justice (e.g. Police, PCCs) commissioners to secure the best possible outcome for service users within available resources. The SARC commissioning framework summarizes the key deliverables that all stakeholders and partners including NHS England should deliver across the SAAS care pathway. While acknowledging the limitations that local commissioning arrangements may create in some areas, NHS England aims to ensure that providers of SARC services achieve the following:

- A high quality service whilst ensuring integrated care pathways to other health and social care services, safeguarding and criminal justice services.
- Ease of access to mental health and psychological therapies.
- Access to medicines to manage acute physical health needs.
- Access to long-term support from Specialist Third Sector SAAS providing advocacy, sexual violence counselling, pre-trial and longer term therapy and support.
- Ensuring the supply of competent forensic examiners in SARC services, including paediatric forensic medical examiners.
- Ensuring appropriate clinical governance systems and process are in place in SARC services.
- Ensuring that the service users’ experience and satisfaction with access, healthcare, ancillary forensic medical examination and follow-up aftercare, are monitored, examined and used to improve the service provision within SARC services.
- Ensuring that appropriate safeguarding processes and systems are in place, including links with Local Safeguarding Boards, to meet the needs of sexually-assaulted children, young people and vulnerable adults.
- Supporting and facilitating decisions to prosecute in cases of rape and sexual assault through improved forensic medical provision for children, young people and adults, and ISVA support.
- Ensuring equity of access in SARCs across England in line with the requirements of the Public Sector Equality Duty of the Equality Act (2010).

NHS England Commissioning Model

5.2 NHS England’s regional teams (London, Midlands and East, North and South) cover healthcare commissioning and delivery across their areas. The funding that NHS England receives for SARC services from the Department of Health is directed to the regional teams, who enter into local agreements with relevant partners e.g. police, LAs, CCGs and PCCs to establish, where

28 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
appropriate, pooled budgets and collaborative commissioning arrangements. NHS England also works with the youth service to maximise the efficient use of resources and to improve outcomes for co-commissioning substance misuse, mental health, children’s services and sexual health services.

5.3 **SARC Partnership Boards** should be in place at a local level and are responsible for co-commissioning SARC services. The Board should define and agree a shared strategy and vision for the local SARC for children, young people and adults that covers the entire service user journey from initial access to the SARC, to accessing appropriate follow-on support. The Board should oversee and review the communication, partnership arrangements, referral protocols and feedback/outcome mechanisms within their local SARC service. The aim is to develop a seamless service for service users and ensure that all relevant practice guidance and governance structures are in place, including making sure that risk assessments and safeguarding protocols are understood by SARC staff and followed correctly. Regional commissioning arrangements are assured locally with national oversight of how each region is carrying out its commissioning function.

**Collaborative Commissioning and Partnership Working across the SAAS Care Pathway**

5.4 SARC services should not be established as stand-alone services but should be considered as a mainstream provision that is linked to other services through the SAAS care pathways and strong partnerships across health and social care, the Specialist Third Sector and the Criminal Justice System. Examples of SARC care pathways for children, young people and adults can be found at Appendices 1 and 2. The examples provide models of some of the existing approaches and focus on the journey in and out of SARC services and show how to access the services and the various agencies engaged in delivering the service provision.

5.5 Effective partnership working can provide an integrated, simplified pathway of high quality services tailored to the needs of each individual. It is essential to get the best outcomes for victims and their families. Partners will include:

- Police Service
- Police and Crime Commissioner
- Local Authorities
- Clinical Commissioning Groups
- Local Safeguarding Boards
- Local Paediatric Services
- Child and Adolescent Mental Health services
- Adult Mental Health services

---

29 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
• Crown Prosecution Service
• Forensic Science Service Providers
• Specialist Third Sector Organisations
• Sexual Health Services
• Social Care Agencies
• Other stakeholders including MoJ and Home Office who provide grant support to SARCs and Third Sector therapeutic support.

5.6 The challenge for commissioners of SARC services is to act as system leaders in order to be able to work in partnership with Local Authorities, CCGs and Health and Justice Commissioners, to develop a high quality, integrated SAAS care pathway delivered by highly trained and skilled staff able to meet existing and future demands. In order to achieve this SARC services and their partners will need to ensure that:

• Effective care pathways and working in partnership results in better available support for victims and their families through statutory and Third Sectors working together to share information and agree practical action.
• While each locality will have varying needs and different approaches, consistency in core areas must be agreed by each of the partners to ensure a co-ordinated and integrated care pathway.
• Robust care pathways for victims and appropriate referrals are available at a time of crisis including psycho-social interventions that may be required at the time of presentation, and links to accessing therapeutic support.

5.7 There are a complex set of interdependencies within the SAAS care pathway. Commissioners will need to have a good understanding of the agencies and interdependencies within their local SAAS care pathway, as this may vary from area to area. In addition to providing services to significant numbers of victims who choose not to access SARC services, Specialist Third Sector Organisations can add value to the system by attracting external funding for longer-term therapy and support services for victims. Without a more inclusive approach to addressing sexual abuse and sexual exploitation, there is a risk that individuals will fall through the gap and services will fail to protect children, young people and vulnerable adults now and prevent further abuse occurring in the future. Therefore, outlined below are the key commissioning partners and the agencies and services in the SAAS care pathway, and their roles and responsibilities.

• Police and Crime Commissioners (PCCs)

5.8 PCCs have a responsibility for commissioning local victims services for victims of crime, including those provided by the Third Sector, in line with the legal entitlements in the Victims Code of Practice 2013 and EU Directive on the Rights, Support and Protection of Victims of Crime effective from
November 2015 2012/29/EU on Victims Services. These services help victims to cope with, and recover from the impacts of crime. Support services should be provided even if the victim has not reported to the Police. PCCs also have a responsibility to ensure a service which is able to provide an effective response to sexual offence investigations and therefore the requirement for SARCs.

- **Clinical Commissioning Groups (CCG)**

5.9 Victims of rape and serious sexual assault require therapeutic support to aid their recovery. Whilst NHS England commissioners fund initial support for victims attending SARC services, including an element of therapeutic support, some victims will require longer-term on-going support. This is a CCG commissioning responsibility and CCGs may commission Specialist Third Sector services to provide these services. NHS England and CCGs need to work closely together to ensure the integration of provision within the SAAS care pathways for victims of sexual violence and abuse, regardless of whether a victim has attended a SARC, and to avoid the duplication of service provision in a local area. CCGs, therefore, have a duty to engage with NHS England commissioners to commission the referral pathway for victims that need longer term therapeutic care.

5.10 In relation to children and young people, CCGs have a statutory duty (Crime and Disorder Act 1998) to co-operate in the provision of multi-agency Youth Offending Teams. CCGs, as members of Community Safety Partnerships are responsible for identifying and sharing information on violence as part of their contribution to a strategic assessment of crime and disorder, anti-social behaviour, and drug and alcohol misuse. CCGs are also responsible for commissioning children’s healthcare treatment services for mental health, including psychological and therapeutic services. National guidance on Local Transformation Plans states that what is included in local plans should be decided at a local level in collaboration with key partners, but plans should:

30 Along with the 26 other member states, the UK is bound by the obligations in the EU Victims Directive, which established minimum standards on the rights, support and protection of victims of crime, which came into force in 2015. The directive aims to ensure that a victim of crime anywhere within the EU receives a minimum standard of support and protection, including information about criminal proceedings; the circumstances in which victims can access legal aid, interpretation and expenses; and measures to assist victims who give evidence in court. The directive sets out support services that must be available to victims and, in some instances, to their families, in accordance with their needs and the harm caused by the crime.
31 The funding of refuge spaces remains the responsibility of local authorities as a victim’s refuge place is funded through housing support.
32 https://consult.justice.gov.uk/digitalcommunications/victims-witnesses
33 Health and Social Care Act 2012. Schedule 5, Paragraph 84: 1 April 2013, clinical commissioning groups (CCGs) became ‘responsible authorities’ on community safety partnerships (CSPs)
34 Health Working Group Report on Child Sexual Exploitation An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff Executive Summary (January 2014)
35 Local Transformational Plans for Children and Young People’s Mental Health and Wellbeing Guidance and support for local areas (03.08.2015) NHS England
“describe the working arrangements with collaborative commissioning oversight groups in place between NHS England specialised commissioning teams and CCGs and with NHS England Health and Justice teams who have direct commissioning responsibility for the Children and Young People’s Secure Estate. This includes transition to and from secure settings to the community for children placed on both youth justice and welfare ground; robust care pathways from Liaison and Diversion schemes and from Sexual Assault Referral Centres.”

- Local Authorities (LAs)

5.11 Local Authority responsibilities in the context of SAAS falls into the two main areas - public health and safeguarding.

- Public Health:

5.12 LAs are responsible for championing public health, promoting healthier lifestyles and working with the NHS and other partners to promote better health and ensure threats to public health are addressed. LAs have considerable freedom in terms of how they choose to invest their funds to improve their population’s public health, although the Government mandates a small number of steps and services, including appropriate access to sexual health services.

5.13 LAs commission open access sexual health clinics, GUM clinics and other services used by victims of rape and sexual abuse. It is vital that LAs work closely with NHS England to integrate provision within the SAAS care pathways so that victims receive improved care and on-going support. LAs and NHS England need to make use of opportunities for integration when they arise, for example, where SARCs, sexual health and/or GUM clinics are co-located. Good practice published by the Local Government Association shows that effective LAs are fully engaged in their local SARC programmes and consider them as necessary to evidence their wider requirements to develop efficient sexual health services.36

- Local Safeguarding Children Boards

5.14 A Local Safeguarding Children Board (LSCB) has been established in every local authority area under the requirements of the Children Act 2004. Under the statutory guidance37, all children who are victims of sexual abuse should be assessed and safeguarded. The needs of the children are paramount and it is the responsibility of every LSCB to ensure the effectiveness of child safeguarding procedures and system and to promote the welfare of children in the local area including child sexual exploitation (CSE).

- Local Safeguarding Adults Boards

36 Making it work A guide to whole system commissioning for sexual health, reproductive health and HIV (September 2014 (revised March 2015)) Public Health England
37 Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government
5.15 Safeguarding adults is a multiagency responsibility. The Care Act 2014 sets out a legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect, including the establishment of Safeguarding Adults Boards. These Boards include the local authority, CCGs and police who will develop, share and implement a joint safeguarding strategy. Good interagency working at Board level is promoted by a history of joint working, information sharing protocols, goodwill/positive relationships between individuals and mutual understanding/shared acknowledgement of the importance of adult protection. It is hindered by poor information sharing, limited understanding of roles, non-attendance or involvement of key agencies at meetings and conflicting organisational priority given to safeguarding.

- Third Sector Specialist Sexual Violence Services
  - Independent Sexual Violence Advisors (ISVAs)

5.16 ISVAs are part of the SARC service provision, however, not all ISVAs are co-located within SARC services. This is a choice and decision for local commissioners. The support provided by an ISVA will vary from case to case, depending on the needs of the victim and their particular circumstances. The main role of an ISVA includes making sure that victims of sexual abuse have the best advice on what counselling and other services are available to them, the process involved in reporting a crime to the police and journeying through the criminal justice process, should they choose to do so.

5.17 The Home Office previously provided funding to support sexual violence services to young people (under 18 year olds) through the establishment of Young Persons Advocates. Supporting younger victims is an important part of the ISVA role and a number of ISVAs specialise in supporting children and young people.

Rape and Sexual Abuse Support Services

5.18 The Ministry of Justice (MoJ) directly, and locally through Police and Crime Commissioners, funds local sexual violence support services. Rape Support Centres are provided by specialist third sector organisations. They provide crucial long-term specialised pre-trial therapy, support, sexual violence counselling, play therapy and independent advocacy for women, men and children, who have experienced any form of sexual abuse at any time in their lives, whether recently or in the past, including support for family members, parents and carers. These organisations will often provide services for people who do not wish to approach SARC services or desire a criminal justice outcome.

39 The governance of adult safeguarding: findings from research into Safeguarding Adults Boards (September 2011) Social Care Institute for Excellence (SCIE)
5.19 The MOJ Female Rape Support Fund funds 85 Rape Support Centres across England and Wales to provide direct services for women and girls until April 2018. The MOJ Male Rape Support Fund funds 12 Rape Support Centres across England and Wales to provide direct services for men and boys until April 2018, a MoJ funded national online and helpline support for men who prefer to access indirect support via these services. In London, the commissioning of Rape Support Centres has been devolved to MOPAC, alongside victims commissioning.

STPs and Health and Wellbeing Boards

5.20 STPs and Health and Wellbeing Boards (HWBs) are responsible for linking the NHS, public health and social care with a wide range of partners by providing the platform for ensuring commissioned services meet the needs of their local populations. For example, a HWB’s decision on whether to prioritise child sexual exploitation should be an informed one, based on local understanding of the issue.40

Information Sharing

5.21 Following the “chronic failures to protect children from sexual exploitation in Rotherham”41, the Government have focused on improving a number of key areas, including information sharing. The Secretaries of State from DH, Home Office, DCLG and MoJ, have come together to produce a letter42 on the importance of information sharing, which states:

‘.... a teenager at risk of child sexual exploitation is a child at risk of significant harm. Nothing should stand in the way of sharing information in relation to child sexual abuse, even where there are issues with consent.”

5.22 Therefore, it is vital that SARC services work with their partners to standardise and improve information sharing in order to meet the needs and best interests of service users. Information sharing agreements should be established between SARC services and their partners in order to ensure that service users receive appropriate and co-ordinated support in the service and ongoing care and support.

5.23 The statutory guidance in Working Together to Safeguard Children43 supports the effective sharing of information to improve identification, assessment and service provision.

---

40 Health Working Group Report on Child Sexual Exploitation An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff Executive Summary (January 2014)
43 Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government
6. APPLICABLE SERVICE STANDARDS FOR SARC SERVICES

Introduction

6.1 It is vital to develop a high quality SARC service to meet the needs of victims by adhering to national standards and quality assurance processes. This is essential to increase confidence in victim care and the integrity of evidence collected for courts. The national requirements and the quality assurance standards required specifically of SARCs are outlined below.

National Standards and Requirements

6.2 All SARC services must actively pursue compliance with national healthcare standards, including clinical governance and risk management, such as:

- **The NHS Outcomes Framework 2016/17**\(^{44}\) - has set five domains that the NHS should be aiming to improve. Domain 5 covers *treating and caring for people in a safe environment and protecting them from avoidable harm*.

- **The Public Health Outcomes Framework for England, 2016-2019**\(^{45}\) - overarching aims are to increase healthy life expectancy and reduce differences in life expectancy and healthy life expectancy between communities. The indicators presents an opportunity for health and criminal justice partners to work together more effectively. Partner agencies should work together to develop outcomes aligned to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWBSs).

- **Recommendations for the Collection of Forensic Specimens from Complainants and Suspects’ published by FFLM** - these are reviewed and updated every 6 months (January & July).

- **Forensic and legal medicine guidelines and standards** - including those produced by the FFLM, RCPCH, BASHH and FSRH guidelines and standards on sexual and reproductive health service provision.

- **National Service Framework for Children, Young People, and Maternity Services**\(^{46}\) - this document set out 11 standards to improve the health and lives of children and young people, including Standards 4 (growing up into adulthood), 5 (safeguarding and welfare) and 9 (mental health and psychological wellbeing).

- **Clinical governance frameworks** – including those that assist services in achieving Standards for Better Health.

---

\(^{44}\) The NHS Outcomes Framework 2015/16 (December 2014) Department of Health


\(^{46}\) National Service Framework for Children, Young People and Maternity Service Core Standards (4 October 2004) Department of Health and Department for Education and Skills
- **National Service Standards for Organisations Working with Victims/Survivors of Rape and Sexual Abuse** – standards established by The Survivors Trust and Rape Crisis England and Wales in delivering specialist support and therapy services to victims and survivors of sexual violence and abuse

### Quality Assurance Standards

6.3 All SARC services need to work toward compliance with the quality assurance standards set out below and be compliant with NHS Clinical Governance. SARC providers must deliver a service that meets the standards set out by the 2016 FFLM operational procedures and equipment for medical facilities in SARC services:

- For acute cases; twenty-four hours access to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure and age appropriate venue.
- Appropriately trained crisis workers to provide immediate support to the service user and significant others, where relevant.
- Choice of gender of physician, where practicable.
- Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offence examinations for adults and children.
- Dedicated forensically approved premises (preferably for sole use).
- Decontamination protocols in place to ensure high quality forensic integrity and a robust chain of evidence in keeping with FFLM guidelines.
- The medical consultation includes an immediate health assessment including assessment of injuries and a risk assessment for self-harm, vulnerability and sexual health, and immediate access to emergency contraception, PEPSE, mental health and other health services and follow-up support, as required.
- Access or referral to support, advocacy and follow-up through a counselling service, including support through the criminal justice process (should the service user choose that route). Following a mental health referral to the appropriate service, there should be an offer of counselling from specialists trained in pre-court age appropriate counselling, if necessary.
- Well-co-ordinated interagency arrangements will be in place, involving local Third Sector services supporting victims and survivors, LSCBs, Safeguarding Boards for Vulnerable Adults, and Health and Wellbeing Boards.

The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive.

**Quality Assurance for Young People and Children**

6.4 A SARC that provides services to young people and children should be delivered in locations that are safe fit for purpose and have the necessary facilities to meet the child and young persons’ needs. The FFLM and RCPCH recognise that there are likely to be variations in commissioning at a local level resulting in variations in service delivery and the ability to measure and compare outcomes across the country, and have outlined and updated their quality standards. The FFLM and RCPCH have highlighted good practices, specifically that:

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

7. **PERFORMANCE MANAGEMENT AND ACTIVITY REPORTING**

7.1 NHS England have developed a commissioning assurance process, including appropriate performance and quality monitoring mechanisms that cover the paediatric element of services and the therapeutic care of victims, and demonstrates the collaborative commissioning approach/agreements used for local SAAS commissioning.

7.2 SARC providers must provide activity reports in line with the SARCs management information template, *Sexual Assault Referral Centres Indicators of Performance (SARCIP)*, at least quarterly to inform national commissioning assurance and any regional, sub regional assurance. The most recent version of the SARCIPs user guide and data input template is available via contacting: ENGLAND.SARCIPS@nhs.net. In summary, SARC providers will be required to demonstrate to commissioners:

---

48 Service specification for the clinical evaluation of children and young people who may have been sexually abused (September 2015) Faculty of Forensic and Legal Medicine of the Royal College of Physicians and Royal College of Paediatrics and Child Health

49 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
• Equitable and consistent standard and delivery of SARC provision to service users.
• A high level of choice of service users’ access provided through police, health and social care, and self-referral processes.
• Improved sexual health outcomes, in accordance with BASHH, BHIVA and FRSH guidelines for service users, as well as reducing longer-term demands on the NHS through early intervention.
• Improved mental health outcomes through early support of service users’ needs, by having access to counselling and pre-trial therapy.
• Improved mental health outcomes for CYP by having access to appropriate services.
• Support to criminal justice outcomes through close working relationships with the police, achieving a high standard of forensic evidence (retrieval of trace evidence, injuries, including the absence of injuries), maintaining service user confidence in the criminal justice system and information sharing.
• Development of excellence and expertise to provide advice, training, and support to health professionals, relevant Third Sector organisations, police and CPS.
• Delivery of wider service user support through strong Third Sector relationships.

SARCIPs will be reviewed regularly to ensure they are fit for purpose, by both the SARC Strategic Clinical Forum and via the external SARC Partnership Group.

8. EQUALITY AND DIVERSITY

8.1 The Equality Act 2006 created a general duty on public authorities, when carrying out all their functions, to have due regard to the need to eliminate unlawful discrimination and harassment on the grounds of sex, and to promote equality of opportunity between women and men. The Equality Act 2010 replaced the 2006 Act and created a new ‘public sector equality duty’ covering all forms of discrimination, and which requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.

8.2 It is a statutory requirement under the Equality Act 2010 and the NHS and Social Care Act 2008 that public sector agencies make ‘reasonable adjustments’ to their practice that will make them as accessible and effective
for individuals under the nine protected characteristics.\textsuperscript{50} This includes making adjustments such as removing physical barriers to accessing health services, supporting access to specialist provision such as learning disabilities services, and also making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for all parts of society.

8.3 SARC services specifically have a responsibility to assure the effective implementation of this Act as women and girls are the major group of sexually assaulted people.\textsuperscript{51} There is also a significant cohort of boys who may be at risk of child sexual abuse.

8.4 Commissioners will need to work with providers to market the service to increase awareness. Therefore, the numbers of individuals reporting sexual assault may increase over time by ongoing awareness campaigns to promote accessibility of the service. In order to monitor the effectiveness of this process, SARC providers will keep information on ethnicity and diversity, which they will analyse quarterly to monitor access by hard to reach and vulnerable groups. This process is in line with performance management and activity reporting through SARCIP.

9. SERVICE USER ENGAGEMENT

9.1 In upholding the NHS Constitution, NHS England is committed to ensuring that service users are at the centre of every decision that NHS England makes. NHS England, through the geographical teams will ensure that this is demonstrated in the way care is provided and monitored through the formal contracting process with providers.

9.2 All providers are expected to demonstrate real and effective service user participation. It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation, and offer their service users the right information at the right time to support informed decision making about their treatment and care.

9.3 Providers of public health s.7A services should look to provide appropriate and accessible means for service users to be able to express their views about, and their experiences of services, making best use of the latest available technology and social media as well as conventional methods.

9.4 As well as capturing service users experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

\textsuperscript{50} The nine protected characteristics are Age; Disability; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Race; Religion and Belief; Sex; Sexual Orientation).

**APPENDIX 1: ADULT CARE PATHWAYS**

*These are from National Framework Specification and the Service improvement will develop pathways in 2013-14*

- SARC Adult Care Pathway (police case): Initial attendance at SARC
- SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)
- SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate) - range of support services
- SARC Follow-up Adult Care Pathway (police case): Counselling services
- SARC Adult Care Pathway (self-referral): Initial attendance at SARC
- SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)
- SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate) - range of support services
- SARC Follow-up Adult Care Pathway (self-referral): Counselling services
SARC Adult Care Pathway (police case): Initial attendance at SARC

Initial report to Police of sexual assault/rape

Initial police response including Early Evidence Kit

Referral to SARC

Appointment arranged for Forensic Medical Examination

Police Officer escorts complainant/patient to SARC

Crisis worker greets complainant/patient and outlines SARC procedures

Forensic physician obtains initial account from police officer

Forensic physician obtains consent for the forensic medical examination and takes a history from complainant/patient

Forensic medical examination

Risk assessment self-harm, child protection/vulnerable adult

Complainant/patient offered a shower and change of clothing

Crisis worker outlines follow on arrangements

Forensic samples/documentation handed to police

Victim and police officer leave SARC

Centre decontaminated

Case reviewed next working day

Immediate referral to Social Care Emergency Duty Team or crisis team/A+E

Where appropriate

Letter to GP (consent from patient)

Referral to A+E for assessment of injuries where appropriate

Does not wish SARC referral

Police alert complainant to seek medical advice in relation to sexual health/emergency contraception
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)

**Within 5 working days**

- SARC ISVA or SARC (as appropriate) makes telephone contact with victim
- Support needs assessment
  - SARC Counselling
  - SARC ISVA or SARC support (as appropriate)
  - Local ISVA or SARC support (where appropriate/available)
  - Local sexual health services
  - Victim Support
  - Other specialist counselling provider

Safeguarding referral where child protection/vulnerable adult issue (no immediate action required – see safeguarding pathway)
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate range of support services)

SARC ISVA

- Support needs assessment
  - Within 5 working days
- Face to face support
  - As required *
- No support required – Continued telephone support
  - At 2 weeks; 1 month; 3 months; 6 months
- Repeat support needs assessment

SARC Counselling
- Criminal Injuries Compensation Authority
  - Domestic Violence services
- Pre court visit
  - Third sector services
  - Pre trial conference
  - Safeguarding

Support at ABE interview
- Housing
  - Local ISVA services
  - Other healthcare services as required
SARC Follow-up Adult Care Pathway (police case): Counselling services

SARC Counselling services

Initial counselling assessment

Counselling re offered pre trial

Six– ten sessions

SARCP re trial therapy

SARC ISVA services

Safeguarding referral where child protection/vulnerable adult concerns

Third sector/local counselling services

Mental health services

Local ISVA support (Where appropriate/available)

GP

Available 1 month post assault
SARC Adult Care Pathway (self-referral): Initial attendance at SARC

Complainant/Patient makes direct contact with SARC
Reports sexual assault (does not wish to make report to police)

Crisis worker outlines SARC services

Complainant/patient requests a forensic medical examination

Crisis worker contacts forensic physician on call
Forensic examination appropriate

Appointment arranged for Forensic Medical Examination
Complainant/patient attends SARC at appointed time

Crisis worker greets complainant/patient and outlines SARC procedures

Forensic physician obtains initial account from complainant/patient
Forensic physician obtains consent for the forensic medical examination and takes a history from complainant/patient

Forensic medical examination

Risk assessment self-harm; child protection/vulnerable adult
Complainant/patient offered a shower and change of clothing

Crisis worker outlines follow on arrangements

Forensic samples/documentation stored at SARC
Complainant/patient leaves SARC

Centre decontaminated
Case reviewed next working day

Immediate referral to Social Care Emergency Duty Team or crisis team/A&E
Where appropriate

Letter to GP (consent from patient)

Referral to A&E for assessment of injuries where appropriate
SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)

SARC ISVA or SARC, as appropriate, makes telephone contact with complainant/patient

Support needs assessment

SARC Counselling

SARC ISVA or SARC support as appropriate

Local ISVA support (Where appropriate/available)

Local sexual health services

Victim Support

Other specialist counselling provider

Safeguarding referral where child protection/vulnerable adult issue (no immediate action required – see safeguarding pathway)

Within 5 working days

Samples stored x 7 years

Next working day
SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate) - range of support services

- **SARC ISVA**
  - Support needs assessment: **Within 5 working days**
  - Face to face support: **As required**
    - No support required – Continued telephone support: **At 2 weeks; 1 month; 3 months; 6 months**
    - Repeat support needs assessment

- Complainant/patient offered opportunity to provide anonymous intelligence
- Declines anonymous submission of samples

- Anonymous intelligence +/- submission of anonymous samples to police
  - Results to ISVA
  - ISVA discusses results with complainant/patient
    - Results on SARC file
  - Report to police

- Samples stored x 7 years

- **SARC Counselling**
  - Local ISVA services
  - Other healthcare services as required:
    - Housing
    - Domestic Violence services
    - Third sector services

- Samples stored x 7 years

**Note:** Depending on support needs assessment and information received.
SARC Follow-up Adult Care Pathway (self-referral): Counselling services

Available 1 month post assault

SARC Counselling services

Initial counselling assessment

Counselling re-offered pre trial

Six – ten sessions, or as appropriate

Conclusion of SARC counselling

SARC ISVA services

Safeguarding referral where child protection/vulnerable adult concerns

Third sector/local counselling services

Mental health services

Local ISVA support (Where appropriate/available)

GP
APPENDIX 2: CHILDREN AND YOUNG PEOPLES’ CARE PATHWAY

Note: self-referrals are also included as an entry point

Initial report to Police and/or Social Services of sexual assault/rape (or suspicion of such)

All paediatric referrals should go to a Strategy Discussion, Some out of hours cases will not have this before FME

Initial police response (including Early Evidence Kit where appropriate)

Consult with SARC to consider:
- Urgency of examination/assessment
- PEPSE/Emergency contraception
- Sexually transmitted infection
- Other health issues
  (with reference to FFLM guide on establishing urgency of examination)

Joint investigation
Strategy discussion: Health (Paediatric sexual offences medicine* qualified doctor PSOM), social care and police
PSOM* qualified doctor, social care and police

Referral to SARC
In non-acute cases referral form to be completed by either social worker or investigating officer and returned to SARC
(if this is a non-acute case, you can carry out relevant activities including those listed for next working day)

Forensic Medical Examination
(with reference to FFLM guide on establishing urgency of examination)

Child/young person attends SARC accompanied by carer, police, +/- social worker

Crisis worker greets child/young person and carer and outlines procedures, including safeguarding/confidentiality issues

PSOM* doctor obtains history from police officer/social worker and where appropriate from carer/child/young person and obtains consent for the forensic medical examination/assessment from parent where appropriate

Forensic medical examination/assessment
(including photodocumentation of anogenital examination)

Assessment of immediate medical needs including:
- Risk assessment HIV/HEP B PEP
- Pregnancy testing
- Emergency contraception
- STI screening

Risk assessment self harm

Referral to crisis team/A+E where appropriate

Referral to A+E for assessment of injuries where appropriate

Information given to child and family/carer outlining on-going services

Child offered a shower and change of clothing where appropriate

Forensic samples/documentation handed to police officer

Report to police officer and social worker

Immediate risk
Social care Emergency Duty Team

No immediate risk
Trust Safeguarding team within one working day

Letter to GP and where appropriate others, e.g. health visitor, school nurse and referral to Trust Safeguarding team

Case reviewed within one working day
SARC Children and Young People Care Pathway, continued

Case reviewed within one working day

Screened for child sexual exploitation
Appointment for sexually transmitted infection screening
SARC Paediatric follow up as required

SARC Child Advocate/Independent Sexual Violence Advisor (ISVA) support (age dependent)

Support needs assessment

Within 5 working days unless otherwise clinically indicated

SARC Child Advocate/ ISVA support (age dependent)

SARC Child therapy/ Counselling service (age dependent)

Local ISVA support
(where appropriate/available)

Community sexual health services

Child & Adolescent Mental Health Services (as appropriate)

Child Sexual Exploitation team (as appropriate)

Victim support

School nurse/Health Visitor

Relevant CCG Safeguarding team

Paediatrician to assess unmet health needs

Multi Agency Referral Form (MARF) to Trust Safeguarding team

MARF to local children and families team


** Age appropriate