



Public Health  
England



# NHS public health functions agreement 2019-20

**Service Specification No. 30  
Sexual Assault Referral Centres**

NHS England and NHS Improvement



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**Service Specification No. 30**  
**Sexual Assault Referral Centres**

Version number: FINAL

First published – July 2019

Publication number – 000019

Prepared by: Public Health England with NHS England and NHS Improvement Public Health Commissioning

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement 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

## LIST OF ABBREVIATIONS

<b>APPG</b>	All Party Parliamentary Group
<b>A&amp;E</b>	Accident & Emergency
<b>BASHH</b>	British Association for Sexual Health and HIV
<b>BHIVA</b>	British HIV Association
<b>BME</b>	Black and Minority Ethnic
<b>CAHVIO</b>	Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence
<b>CCG</b>	Clinical Commissioning Groups
<b>CEOP</b>	Child Exploitation and Online Protection Centre
<b>CJS</b>	Criminal Justice System
<b>CPIS</b>	Child Protection Information Sharing
<b>CPS</b>	Crown Prosecution Service
<b>CSA</b>	Child Sexual Abuse
<b>CSE</b>	Child Sexual Exploitation
<b>CSEW</b>	Crime Survey for England and Wales
<b>DCLG</b>	Department for Communities and Local Government
<b>DfE</b>	Department for Education
<b>DHSC</b>	Department of Health and Social Care
<b>FFLM</b>	Faculty of Forensic & Legal Medicine
<b>FGM</b>	Female Genital Mutilation
<b>FSRH</b>	Faculty of Sexual and Reproductive Healthcare (at the Royal College of Obstetricians and Gynaecologists)
<b>GUM</b>	Genitourinary Medicine
<b>IAPT</b>	Improving Access to Psychological Therapies
<b>ISVA</b>	Independent Sexual Assault Advisor
<b>JSNA</b>	Joint Strategic Needs Assessment
<b>LA</b>	Local Authority
<b>LGBT</b>	Lesbian, Gay, Bisexual, and Transgender
<b>LSCB</b>	Local Safeguarding Children Board
<b>MARAC</b>	Multi-Agency Risk Assessment Conference
<b>MoJ</b>	Ministry of Justice
<b>NCA</b>	National Crime Agency
<b>NPCC</b>	National Police Chiefs Council (previously ACPO)

# Contents

<b>1 THE PURPOSE OF SERVICE SPECIFICATION NO. 30</b> .....	<b>8</b>
Background and Context to Sexual Assault and Abuse Services .....	8
<b>2 LEGAL FRAMEWORKS AND DEFINITIONS</b> .....	<b>12</b>
<b>3 THE EVIDENCE BASE</b> .....	<b>15</b>
The Benefits of SARCs .....	15
<b>4 SCOPE OF SARCS</b> .....	<b>20</b>
The Role of SARCs .....	20
Model of Service Provision and Key Elements .....	21
Geographical Location of SARCs .....	24
Essential Areas of SARC Provision .....	25
<b>5 COMMISSIONING</b> .....	<b>28</b>
Aims and Objectives .....	28
NHS England’s Commissioning Model .....	29
Collaborative Commissioning and Partnership Working across the SAAS Care Pathway .....	29
Information Sharing .....	35
<b>6 APPLICABLE SERVICE STANDARDS FOR SARCS</b> .....	<b>37</b>
Introduction .....	37
National Standards and Requirements .....	37
Quality Assurance Standards .....	38
Quality Standards for the Workforce .....	40
<b>7 PERFORMANCE MANAGEMENT AND ACTIVITY REPORTING</b> .....	<b>42</b>
<b>8 EQUALITY AND DIVERSITY</b> .....	<b>44</b>
<b>9 SERVICE USER ENGAGEMENT</b> .....	<b>45</b>
<b>Appendix 1: Children and Young Peoples’ Care Pathway</b> .....	<b>46</b>
<b>APPENDIX 2: ADULT CARE PATHWAYS</b> .....	<b>47</b>

<b>NSPCC</b>	National Society for the Prevention of Cruelty to Children
<b>NHS</b>	National Health Service
<b>ONS</b>	Office of National Statistics
<b>PCC</b>	Police and Crime Commissioner
<b>PEPSE</b>	Post-Exposure Prophylaxis after Sexual Exposure
<b>PHE</b>	Public Health England
<b>QA</b>	Quality Assurance
<b>RCPCH</b>	Royal College of Paediatrics and Child Health
<b>SARC</b>	Sexual Assault Referral Centre
<b>SARCIP</b>	Sexual Assault Referral Centre Indicators of Performance
<b>SAAS</b>	Sexual Abuse and Assault Services
<b>YPA</b>	Young People's Advocates

## Service Specification No. 30

This is a service specification to accompany the 'NHS public health functions agreement 2017-18 (the '2017-18 agreement') published in March 2017.

This service specification is to be applied by NHS England and NHS Improvement in accordance with the 2017-18 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 2017-18 agreement was made between the Secretary of State and NHS England and NHS Improvement Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2017-18 agreement in accordance with the procedures described in Chapter 3 of the 2017-18 agreement

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

The 2017-18 agreement is available at [www.gov.uk](http://www.gov.uk) (search for 'commissioning public health').

All current service specifications are available at [www.england.nhs.uk](http://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 regard to the commissioning of Sexual Assault Referral Centres (SARCs). This Service Specification covers the period from 2019-20.**

## Background and Context to Sexual Assault and Abuse Services

- 1.4 Sexual assault and abuse are serious crimes, which continue to have a significant impact on our society. Sexual Assault and Abuse Services (SAAS) are those services that a victim of sexual assault (abuse, sexual violence including rape) may need to support recovery and facilitate a criminal justice outcome.
- 1.5 The landscape for SAAS is wide and complex. It spans several different systems and government organisations, including health, social care and justice, and requires them to work together. The commissioners of services are varied, and there is a wide range of providers, including specialist and voluntary sector organisations. This creates a significant challenge, and all the different bodies can find it difficult to work together effectively to meet the lifelong needs of victims and survivors. This can result in fragmentation in service delivery and poor outcomes for victims and survivors of sexual assault and abuse over their lifetime.<sup>1</sup>

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<sup>1</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

- 1.6 In any local area the SARC is part of a network within the wider SAAS care pathway, for example, psychological therapies, commissioned by CCGs and other specialist support and therapy available from the voluntary 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 do have a requirement to commission an element of therapeutic support within the pathway for survivors, as part of the service specification.
- 1.7 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 sectors. Therefore, NHS England have developed strategic partnerships with Public Health England, the Department of Health and Social Care, the Home Office, Police and Crime Commissioners and the Ministry of Justice to improve services for the victims of sexual assault and abuse.
- 1.8 NHS England's Strategic Direction for Sexual Assault and Abuse Services<sup>2</sup> sets out what is needed by 2023 to improve service provision and consequently patient experience for those who have experienced sexual assault or abuse. Government departments and national and local organisations with responsibility for commissioning SAAS, need to ensure that existing and newly commissioned services are developed and delivered in line with this strategic direction and with the new quality standards for sexual assault and abuse services. Table 1 below provides a summary of the current commissioning responsibilities.

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<sup>2</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

Table 1 – Summary of commissioning responsibilities<sup>3</sup>

Commissioning Responsibility	Service
NHS England	<ul style="list-style-type: none"> <li>• SARCs responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police</li> <li>• Child and adolescent mental health services Tier 4 (CAMHS Tier 4)</li> <li>• Contraception provided as an additional service under the GP contract</li> <li>• HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE))</li> <li>• Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs</li> <li>• Sexual health elements of prison and Immigration Removal Centre health services</li> <li>• Cervical screening</li> <li>• Specialist foetal medicine services</li> </ul>
Clinical Commissioning Groups	<ul style="list-style-type: none"> <li>• Mental health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of victims and survivors of sexual assault and abuse, including the voluntary sector</li> <li>• Most abortion services</li> <li>• Sterilisation</li> <li>• Vasectomy</li> <li>• Non-sexual health elements of psychosexual health services</li> <li>• Gynaecology, including any use of contraception for non-contraceptive purposes</li> <li>• Secondary care services, including A&amp;E</li> <li>• NHS 111</li> <li>• Sexual health services for children and young people including paediatric</li> <li>• Specialist voluntary sector services (in some areas)</li> <li>• Ambulance/blue light services</li> </ul>
Police and Crime Commissioners	<ul style="list-style-type: none"> <li>• Specific commissioning responsibilities for victims, including victims of sexual assault and abuse</li> <li>• Specialist voluntary sector services</li> <li>• Police 101</li> <li>• In some forces, the police lead on the procurement of SARC services</li> </ul>
Local Authorities	<ul style="list-style-type: none"> <li>• Comprehensive sexual health services, including most contraceptive services and all prescribing costs (excludes additional services commissioned from primary care)</li> <li>• STI testing and treatment, chlamydia screening and HIV testing</li> <li>• Specialist sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention, sexual health promotion and services in schools, colleges and pharmacies</li> <li>• Specialist voluntary sector services</li> </ul>
Ministry of Justice	<ul style="list-style-type: none"> <li>• National Male Survivor helpline</li> <li>• Rape support services with dedicated emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over</li> </ul>
Home Office	<ul style="list-style-type: none"> <li>• National services for victims of child sexual abuse</li> </ul>

<sup>3</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

- 1.9 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 SARCs 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.
- 1.10 In recognition of both the number and the wide range of commissioners involved and the differing levels of knowledge and understanding of SARCs and the SAAS pathway, this specification will consider the interfaces and interdependences between SARCs and the commissioners and providers within the wider SAAS care pathway.
- 1.11 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.
- 1.12 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.

## 2 LEGAL FRAMEWORKS AND DEFINITIONS

2.1 The World Health Organization (WHO) defines sexual health as:

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”<sup>4</sup>

2.2 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.**

2.3 **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.

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

- **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 SARCs 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<sup>5</sup>

<sup>4</sup> [https://www.who.int/reproductivehealth/topics/sexual\\_health/sh\\_definitions/en/](https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/)

<sup>5</sup> Working together to safeguard children A guide to inter-agency working to safeguard and promote the

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.

- **The Children and Social Work Act 2017** – This Act is intended to improve support for looked after children and care leavers, promote the welfare and safeguarding of children, and make provisions about the regulation of social workers. The Act sets out corporate parenting principles for the council to be the best parent it can be to children in its care. The Act makes changes to the arrangements for local child safeguarding partnerships and the serious case review process, including provision for a central Child Safeguarding Practice Review Panel for cases of national importance. It also establishes a new regulatory regime for the social work profession.
- **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 several 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 national policy document, Tackling Child Sexual Exploitation - Definition and Guide for Practitioners<sup>6</sup> 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 no single legal definition of domestic violence, but the Government definition of domestic violence and abuse is as follows:

“.. 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<sup>7</sup>”.

2.6 **Female Genital Mutilation (FGM)** 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](http://www.england.nhs.uk)

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welfare of children (July 2018) HM Government [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/729914/Working\\_Together\\_to\\_Safeguard\\_Children-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

<sup>6</sup> Tackling Child Sexual Exploitation – Definition and Guide for Practitioners’, Department for Education. 2017

<sup>7</sup> Domestic violence and abuse: <https://www.gov.uk/domestic-violence-and-abuse#domestic-violence-and-abuse-newdefinition>

2.7 The ability of SARCs to accurately capture evidence means that there are real benefits for victims in including this in scope of the SARC. 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 SARCs

3.1 The evidence<sup>8</sup> indicates that:

- Women who have experienced sexual assault have three main care needs: physical health care; psychosocial care and assistance; and support from the Criminal Justice System.
- Negative experiences are related to long waits for the forensic examination and negative interactions with the examiner (e.g. disbelieving account of events).
- Responding to sexual assault requires addressing multiple dimensions of care in clinical, psycho-social and legal sectors.
- How service providers respond to service users can have profound consequences for receiving appropriate care and later adjustment and recovery.

3.2 The provision of a SARC 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<sup>9</sup>.

The overall financial cost to society is high with estimates suggesting that child sexual abuse alone results in £182m of health spending annually<sup>10</sup>. 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.

3.3 SARCs 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.

3.4 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.

3.5 It is vital to understand 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

3.6 The Crime Survey for England and Wales (CSEW) estimated that 20% of women and 4% of men have experienced some type of sexual assault since the age of 16, equivalent to an estimated 3.4 million female victims and 631,000 male victims<sup>11</sup>.

<sup>8</sup> Kanan, Y. (2018) Overview and comparison of international models of service provision for victims of sexual assault Final Report

<sup>9</sup> The economic and social costs of crime against individuals and households 2003/4. <http://www.crimereduction.homeoffice.gov.uk/rds/>

<sup>10</sup> Saied-Tessier, A., Estimating the costs of child sexual abuse in the UK. 2014.

<sup>11</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017>

- 3.7 An estimated 3.1% of women (510,000) and 0.8% of men (138,000) aged 16 to 59 experienced sexual assault in the previous 12 months (year ending March 2017)<sup>12</sup>.
- 3.8 It is estimated that up to 80% of incidents are unreported and as few as 28% of victims report their experience to the police<sup>13</sup>.
- 3.9 More than a third of rape victims and half of female victims of other sexual offences, including assaults, grooming and sexual exploitation, are under the age of 16. Girls aged 10 to 14 are most likely to be the victims of reported rape<sup>14</sup>.
- 3.10 Reports of sexual offences against men and boys have more than tripled in the past decade and there were 12,130 offences reported in England and Wales in 2016-17, compared with 3,819 in 2006-07<sup>15</sup>.
- 3.11 In the year ending September 2017, police recorded 138,045 sexual offences, the highest figure recorded since the introduction of the National Crime Recording Standard in 2002 and a 23% increase on the previous year<sup>16</sup>.  
The increase in sexual offences recorded by the police is thought to be driven by improvements in recording practices and a greater willingness of victims to come forward to report such crimes, including non-recent victims<sup>17</sup>.

### **Child Sexual Abuse**

- 3.12 The World Health Organisation (WHO) defines child sexual abuse (CSA) as ‘the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to’<sup>18</sup>.
- 3.13 In regard to the prevalence of child sexual abuse, the evidence indicates:
- 1 in 20 children in the UK have been sexually abused<sup>19</sup>
  - 1 in 4 women and 1 in 6 men have been sexually abused before the age of eighteen<sup>20</sup>. Women are four times as likely as men to be a survivor of such abuse during childhood (11% compared with 3%)<sup>21</sup>.
  - Over 2,900 children were identified as needing protection from sexual abuse in

<sup>12</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017>

<sup>13</sup> Howard League for Penal Reform: Coercive sex in prison: briefing paper by the commission on sex in prison, 2014.

<sup>14</sup> Focus on violent crime and sexual offences, England and Wales: year ending March 2016, Office for National Statistics.

<sup>15</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017>

<sup>16</sup> Crime in England and Wales: year ending September 2017, Office for National Statistics

<sup>17</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017>

<sup>18</sup> World Health Organisation (1999) report of the consultation on child abuse prevention 29-31 March 1999. WHO: Geneva.

<sup>19</sup> Radford, L. et al (2011) [Child abuse and neglect in the UK today](#).

<sup>20</sup> Smith, N., Dogaru, C. & Ellis, F. (2015). Hear me, Believe me. Respect me: a survey of adult survivors of childhood sexual abuse and their experiences of support services. University Campus Suffolk and Survivors in Transition

<sup>21</sup> Office for National Statistics (2016). Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016

2015/16<sup>22</sup>

- 1 in 3 children sexually abused by an adult did not tell anyone<sup>23</sup>
- Over 90% of sexually abused children were abused by someone they knew<sup>24</sup>
- 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<sup>25</sup>.
- Around a third of sexual abuse is committed by other children and young people<sup>26</sup>
  - Disabled children are more likely to be abused than non-disabled children<sup>27</sup>
  - Over 63,00 sexual offences against children were recorded by the police in the UK in 2016/17<sup>28</sup>
  - Nearly 30,000 registered offenders have been convicted of offences against children<sup>29</sup>

3.14 The overall health consequences for sexually abused children and young people can be devastating:<sup>30</sup>

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

3.15 Since Operation Yewtree began in 2012, there has been a significant rise in the reporting and recording of contact child sexual abuse to the police. In the year to March 2016, there was an increase of 24% in recording of contact child sexual abuse

<sup>22</sup> <https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/sexual-abuse-facts-statistics/>

<sup>23</sup> Radford, L. et al (2011) [Child abuse and neglect in the UK today.](#)

<sup>24</sup> Radford, L. et al (2011) [Child abuse and neglect in the UK today.](#)

<sup>25</sup> Berelowitz 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.

<sup>26</sup> Hackett, S. (2014) Children and young people with harmful sexual behaviours.

<sup>27</sup> Jones, L. et al (2012) [Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies.](#)

<sup>28</sup> <https://learning.nspcc.org.uk/research-resources/how-safe-are-our-children/>

<sup>29</sup> <https://publications.parliament.uk/pa/cm201213/cmhansrd/cm121213/text/121213w0002.htm#12121349000032>

<sup>30</sup> Lazenbatt A. The Impact of Abuse and Neglect on the Health and Mental Health of Children and Young People. NSPCC Research Briefing. 2010. [http://www.nspcc.org.uk/Inform/research/briefings/impact\\_of\\_abuse\\_on\\_health\\_wda73372.html](http://www.nspcc.org.uk/Inform/research/briefings/impact_of_abuse_on_health_wda73372.html)

offences by the police (to 41,000 offences) compared with the previous year (up from 33,000 offences) (this increase rises to 137% compared with the year to March 2012).<sup>31</sup>

- 3.16 During the same period, children's services saw a 3.5% increase in the number of children who became the subject of a child protection plan (CPP) as a result of sexual abuse (to 2,970 children, up from 2,870 the previous year)<sup>32</sup>.

### **Child Sexual Exploitation**

- 3.17 It is important for SARCs to understand the characteristics of child sexual exploitation (CSE) in order to provide a suitable response to this form of child sexual abuse. The Child Exploitation and Online Protection Centre (CEOP)<sup>33</sup> 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.

- 3.18 There are links between child sexual exploitation and youth offending. A University College London study<sup>34</sup> of 552 victims of child sexual exploitation in Derby found that nearly 4 out of 10 young people had a history of criminal behaviour.

- 3.19 The year ending March 2016 has seen significant increases in reporting to the police relating to both the sharing of indecent images of children and of contact child sexual abuse. For example, in 2010, approximately 400 referrals a month were received from industry alone, in respect of indecent images of children. This had risen to around 1800 referrals a month by March 2016<sup>35</sup>.

### **Prosecutions of sexual offences against children**

- 3.20 The increases in offences have been met with rises in the number of offenders being brought to justice. In the year to December 2015, 8,593 defendants were prosecuted

<sup>31</sup> ONS. (2016) Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016.

<sup>32</sup> DfE (2015) Characteristics of children in need: 2014 to 2015.

<sup>33</sup> CEOP (2013) Threat assessment of child sexual exploitation and abuse

<sup>34</sup> Cockbain, E. and Brayley, H. (2012) [Briefing document: CSE and youth offending \(PDF\)](#). London: UCL Jill Dando Institute of Security and Crime Science.

<sup>35</sup> HM Government (2017) Tackling Child Sexual Exploitation Progress Report

for child sexual abuse-related offences (including imagery offences), a rise of 14% on the year to December 2014 (up from 7,536), and 5,940 were convicted, an increase of 19% on the number of convictions in 2014 (up from 4,982)<sup>36</sup>.

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<sup>36</sup> Ministry of Justice. (2016). A further breakdown of the criminal justice system statistics quarterly: December 2015

## 4 SCOPE OF SARCS

### The Role of SARCS

- 4.1 SARCS provides accessible 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) for HIV, 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 voluntary 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.
- 4.3 The evidence<sup>37</sup> indicates several good practice features that should be built into service design and provision to improve the effectiveness and accessibility of services. These include:
- Providing comprehensive care and support for the clinical, psycho-social and legal needs of service users.
  - Providing co-ordinated, specialised services in sexual assault.
  - Providing staff training on technical aspects of service provision and crisis intervention.
  - Encouraging staff specialisation in sexual assault.
  - Providing services without time limits, i.e. independently of when the assault occurred, and accessible 7 days a week and 24 hours a day.
  - Reducing variability in service quality and accessibility.
  - Providing language support such as translation services.
  - Providing childcare and other social services (e.g. shelter, refuge).
  - Providing self-referral pathways to access services.
  - Providing information on the intended course of action and obtaining service user's consent.

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<sup>37</sup> Kanan, Y. (2018) Overview and comparison of international models of service provision for victims of sexual assault Final Report

- Ensuring that services are, and are perceived to be, independent and confidential.

4.4 The majority of SARCs 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 voluntary sector to improve outcomes for all victims of sexual violence and support longer-term survivor recovery.

### **Model of Service Provision and Key Elements**

4.5 NHS England's vision<sup>38</sup>, which is shared by its partners<sup>39</sup>, is to improve access to services for victims and survivors of sexual assault and abuse and support them to recover, heal and rebuild their lives, specifically for those who have experienced:

- recent sexual assault and abuse and who are in the immediate aftermath – the aim is to provide highly responsive, personal services delivered by trained and competent practitioners in settings that respect privacy and that are easy to access. These services should include specialist medical and forensic examinations, practical and emotional support and support through the judicial process.
- non-recent sexual assault and abuse – the aim is to provide therapeutic care that recognises the devastating and lifelong consequences on mental health and physical and emotional wellbeing.

4.6 Therefore, SARCs 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 SARC model may vary according to the demographics and level of sexual violence in an area, and determined by health needs assessments and the resources available within the partner agencies, however, all SARCs are expected to provide the following key elements within their service model to ensure consistency of provision for service users nationally<sup>40</sup>:

- 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<sup>41</sup>. Ensure procedures are updated and in line with the FFLM's 'Recommendations for the Collection of Forensic Specimens

<sup>38</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>39</sup> The SAAS Strategy is being delivered through the Partnership Board with Ministry of Justice, Home Office, Department of Health and Social Care and Public Health England.

<sup>40</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

<sup>41</sup> <http://fflm.ac.uk/wp-content/uploads/2016/12/SARC-Storage-of-Forensic-Samples-and-the-Human-Tissue-Act-FAQs-Dr-C-White-November-2016.pdf>

from Complainants and Suspects<sup>42</sup>

- 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<sup>43</sup>.
- 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 examiner – most service users prefer to be seen by a female;
- Address safeguarding, care and support issues for all service users;
- 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

4.7 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.

4.8 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.

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<sup>42</sup> <https://fflm.ac.uk/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-3/>

<sup>43</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

- 4.9 The 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. SARCs 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 SARCs, 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.
  - SARCs 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.
  - SARCs need to have ready access to skilled paediatric services that are available when required. This includes appropriate access to doctors trained in both forensic examination and safeguarding, and on-going psychological and other relevant support<sup>44</sup>.
  - 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.
- 4.10 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<sup>45</sup>.
- 4.11 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.
- 4.12 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 voluntary sector providers for play therapy, long-term

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<sup>44</sup> 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

<sup>45</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

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.

- 4.13 In addition, every organisation involved in the delivery of sexual assault and abuse services has a responsibility to help stop these crimes from happening. SAAS, across the whole pathway, need to work in partnership to assess proactively, the risk amongst vulnerable groups, as well as previous victims and survivors, and to take action to minimise their exposure to harm. In terms of strengthening the approach to prevention NHS England will.<sup>46</sup>
- undertake discussions with the national SARC Clinical Forum around the appropriateness of developing specific care pathways for children and young people who display harmful sexual behaviours.
  - work with the SARC Clinical Forum and Lived Experience Group to support an improvement in access to services by developing and sharing information which raises awareness of service availability.
  - work with the police to increase awareness of the services provided by SARCs, particularly through the LGBT communities, BME communities and vulnerable women's centres; and develop easy-read information on the role of a SARC for people with learning disabilities.

### **Geographical Location of SARCs**

- 4.14 There are currently almost 50 SARCs 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 in NHS premises, such as in hospitals, primary health care centres or premises in residential areas.
- 4.15 In some rural and semi-rural areas or for children and young people it may be inappropriate to establish a SARC at a local level due to the very low volume of work. In these situations, regional SARCs can offer advice, highly 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 voluntary sector services and victim support services.
- 4.16 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. 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.

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<sup>46</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

## Essential Areas of SARC Provision

### Ensuring Access

- 4.17 Ease of access is important to encourage the use of SARCs by people who have been sexually assaulted. SARCs should integrate seamlessly within the local SAAS care pathway, especially the psycho-therapeutic care, and enable access to other essential services in the wider health and social care system and specialist sexual violence support in the voluntary 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.
- 4.18 SARCs 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 SARCs as self-referrals
  - Choice of whether or not to involve the police
  - Choice of gender of examiner, 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

- 4.19 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 on to 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<sup>47</sup>.
- 4.20 SARCs 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 voluntary 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.

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<sup>47</sup> Securing Excellence in commissioning sexual assault services for people who experience sexual violence (13 June 2013) NHS England

- A pathway including in the commissioning responsibilities for short to medium term therapeutic care.

- 4.21 As well as meeting the immediate health needs of service users, SARCs 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 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 the 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.
- 4.22 There are also health interdependencies with mental health services and it is essential that service users have a choice of care provision in terms of 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 services. Referrals should be with consent or, in the case of adults without capacity, in their best interests<sup>48</sup>.
- 4.23 There needs to be a mental health assessment for all children and young people attending the SARC and for them to be referred on to the relevant pathway of care. Where such services do not exist, discussions will need to be held between the relevant commissioners and partners.

### **Promoting safeguarding and the safety, protection and welfare of victims and survivors**

- 4.24 Safeguarding is the most effective way to protect children, young people and vulnerable adults against any form of harm, abuse and neglect, and this must be a priority for all providers of services. The responsibility to safeguard those who we know to be particularly vulnerable and those who are placed in the care of others is supported by the Health and Social Care Act 2012, Working Together to Safeguard Children (2018),<sup>49</sup> the Children Act (2004) and supporting vulnerable adults, the Care Act (2014).
- 4.25 Particular consideration should be given to safeguarding those whose circumstances make it difficult to report their sexual assault or abuse and who may feel reluctant to make a disclosure. For instance, those whose immigration status is uncertain, who have minor criminal offences, those who are misusing substances, those with a specific language barrier and those whose families are carers or have been involved in any assault or abuse that has taken or is taking place<sup>50</sup>.

<sup>48</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

<sup>49</sup> Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (July 2018) HM Government [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/729914/Working\\_Together\\_to\\_Safeguard\\_Children-2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf)

<sup>50</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

4.26 Making a commitment to safeguard individuals means that statutory and specialist voluntary sector organisations must work together at both strategic and operational levels - joined-up, collaborative working is paramount. Therefore, NHS England will aim to<sup>51</sup>

- develop and use commissioning frameworks that explicitly describe what safeguarding means for victims and survivors of sexual assault and abuse, define responsibilities and clarify what is expected of providers of services.
- improve information sharing by supporting the Child Protection Information Sharing (CPIS) programme, which aims to ensure that 80% of unscheduled care settings are signed up to the CPIS protocol by 2019. This will allow service providers to understand if a child or young person is already known to services.

### Supporting the Criminal Justice System

4.27 SARCs can help to raise the awareness of sexual violence and abuse, and how such abuse can be dealt with through the provision of 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 SARCs work closely with agencies in the Criminal Justice System to:<sup>52</sup>

- 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, SARCs 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 based on 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 SARCs in providing evidence for, and supporting victims through these 'cold cases', has produced good results with a very high proportion of convictions.

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<sup>51</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>52</sup> 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 It is vital that all commissioners and providers of SAAS, which support victims and survivors of sexual assault and abuse, work together to create an integrated care pathway that recognises individual needs and reduces fragmentation and gaps between services. This is vital to improve the health outcomes for victims and survivors of sexual assault and abuse<sup>53</sup>.
- 5.2 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<sup>54</sup> summarises 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 SARC providers 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 voluntary sector SAAS providing advocacy, sexual violence counselling, pre-trial and longer-term therapy and support.
  - Ensuring the supply of competent forensic examiners in SARCs, including paediatric forensic medical examiners.
  - Ensuring appropriate clinical governance systems and process are in place in SARCs.
  - 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 SARCs.
  - 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.

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<sup>53</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>54</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

## **NHS England's Commissioning Model**

- 5.3 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's from the Department of Health and Social Care is directed to the regional teams, who enter into local agreements with relevant partners e.g. police, local authorities, CCGs and PCCs to establish, where 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.
- 5.4 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**

- 5.5 Victims and survivors of sexual assault and abuse experiences of moving between the health, social care and criminal justice systems is often described as fragmented and they find that services can be difficult to navigate.
- 5.6 Victims and survivors will need different levels of care and different types of support at different times in their lives and this will be dependent on their circumstances, the pace of their recovery and the level of expertise and support received at the point of disclosure. The commissioning and provision of services supporting those who have been sexually assaulted or abused cannot be channelled through a linear pathway of care. Prior to disclosure, several different service providers may have been involved in an individual's care and support, for example, as a direct result of drug or alcohol dependency, self-harm, sexual risk taking and some criminal behaviours. Victims and survivors may also already be known to specialist and community mental health teams or crisis support services, as well as substance misuse, community sexual health or educational support teams, social services or the criminal justice system.
- 5.7 Therefore, SARC's 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 voluntary sector and the Criminal Justice System.

5.8 A joined-up approach to the commissioning and provision of services is vital to provide people with the right support at the right time.<sup>55</sup> 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:<sup>56</sup>

- 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
- Crown Prosecution Service
- Forensic Science Service Providers
- Specialist Voluntary Sector Organisations
- Sexual Health Services
- Social Care Agencies
- Other stakeholders including MoJ and Home Office who provide grant support to SARCs, Public Health England who provide public health expert advice and support evidence-based practice, and voluntary sector therapeutic support.

5.9 The challenge for commissioners of SAAS 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.

5.10 Accordingly, NHS England will<sup>57</sup>:

- ask all organisations that commission or deliver services to sign up to a new governance framework that explicitly outlines the outcomes that they are expected to achieve and how they will report those outcomes. This will be done through the SAAS Partnership Board, which includes representation from cross government departments, CCGs, local authorities, Police and Crime Commissioners and voluntary sector organisations.
- ensure the commissioning of services is trauma informed. This will be done by ensuring that service specifications and tenders recognise and encourage the

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<sup>55</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>56</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

<sup>57</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

links between the trauma victims and survivors of sexual assault and abuse and mental health, as well as the benefits of the principles of integrated child house type models.

- improve information sharing between regional teams around procurement opportunities to ensure the best response from the market.

5.11 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 SARCs, specialist voluntary 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)**

5.12 PCCs have a responsibility for commissioning local victims services for victims of crime, including those provided by the voluntary 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.<sup>58 59</sup> These services help victims to cope with, and recover from the impacts of crime<sup>60</sup>. 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 can provide an effective response to sexual offence investigations and therefore the requirement for SARCs.

### **Clinical Commissioning Groups (CCG)**

5.13 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 voluntary 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

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<sup>58</sup> 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.

<sup>59</sup> The funding of refuge spaces remains the responsibility of local authorities as a victim's refuge place is funded through housing support.

<sup>60</sup> <https://consult.justice.gov.uk/digitalcommunications/victims-witnesses>

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.

- 5.14 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<sup>61</sup>. CCGs are also responsible for commissioning children's healthcare treatment services<sup>62</sup> for mental health, including psychological and therapeutic services<sup>63</sup>. 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:

“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)

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

### Public Health:

- 5.16 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.
- 5.17 Sexual health clinics and genito-urinary medicine clinics are used by older children and adults and are public health services commissioned by LAs, including 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

<sup>61</sup>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)

<sup>62</sup>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)

<sup>63</sup>Local Transformational Plans for Children and Young People's Mental Health and Wellbeing Guidance and support for local areas (03.08.2015) NHS England

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<sup>64</sup>.

5.18 Local authorities also commission health visiting and school nurse services, which are part of local safeguarding and the response to children and families. Substance misuse services, commissioned by local authorities have a role especially given the high association of sexual abuse with drug and alcohol 'self-medication'.

- Local Safeguarding Children Boards

5.19 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 guidance<sup>65</sup>, 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.

- Local Safeguarding Adults Boards

5.20 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<sup>66</sup>, 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<sup>67</sup>.

## Voluntary Sector Specialist Sexual Violence Services

### Independent Sexual Violence Advisors (ISVAs)

5.21 ISVAs are part of the SARC provision, however, not all ISVAs are co-located within SARCs. 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 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.

5.22 The Home Office previously provided funding to support sexual violence services

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<sup>64</sup> Making it work A guide to whole system commissioning for sexual health, reproductive health and HIV (September 2014 (revised March 2015)) Public Health England

<sup>65</sup> Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government

<sup>66</sup> <http://www.scie.org.uk/care-act-2014/safeguarding-adults/>

<sup>67</sup> The governance of adult safeguarding: findings from research into Safeguarding Adults Boards (September 2011) Social Care Institute for Excellence (SCIE)

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 some ISVAs specialise in supporting children and young people.

## Rape and Sexual Abuse Support Services

5.23 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 voluntary sector organisations. They provide crucial long-term specialised pre-trial therapy, support, sexual violence counselling, play therapy and independent advocacy for adults, young people and children, who have experienced any form of sexual abuse in their lives, whether recently or in the past, including support for family members, parents and carers. These organisations will provide services for people who do not wish to approach SARCs or desire a criminal justice outcome.

## Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs)

5.24 As part of the Five Year Forward View, in March 2016, NHS England divided the country into 44 footprints, bringing together NHS, local authority and other health and care organisations to collaboratively determine the future of their health and care system. These systems were first required to develop five-year, place-based plans for the health and social care within their footprint, then referred to as Sustainability and Transformation Plans. Subsequently, as NHS England have put greater emphasis on system-wide working and integration, their name and nature have changed. In March 2017, these 44 systems were renamed Sustainability and Transformation Partnerships (STPs) with the launch of Next Steps on the Five Year Forward View, which gave them a greater role in the planning of health and care. In some areas, partnerships have evolved to form an integrated care system. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

## Collaborative Commissioning for Children and Young People

5.25 There are some high risk and vulnerable children and young people with complex needs who need a very wide range of services, including mental health services. These services would be most effective if the organisations which commission them coordinated their planning activity, so that the children and young people in question received continuity of care throughout their care pathway and did not fall through the gaps that exist between organisations. However, the quality of this collaboration is compromised by the complexity of the commissioning arrangements. As a result, some children and young people are not receiving the services they require. Within the Health and Justice and Specialised Commissioning Workstream<sup>68</sup> is a workstream project tasked specifically with improving the collaboration amongst commissioners across the system.

5.26 This workstream project is focused on those children and young people who are in receipt of services from some or all of the following:

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<sup>68</sup> <https://www.england.nhs.uk/commissioning/health-just/children-and-young-people/>

- Youth Justice System, including in custody and detention
- SARCs
- Liaison and Diversion
- Welfare placements in the Children and Young People's Secure Estate

5.27 The workstream project is driving a collaborative commissioning approach nationally. This will involve NHS England Health and Justice commissioners working together within local partners to coordinate commissioning activities more effectively.

5.28 The workstream has three projects, each of which focuses on a different area of care:

- Workstream project 1: Specialist Child and Adolescent Mental Health Services for High Risk Young People with Complex Needs
- Workstream project 2: Development of a framework for integrated care for the Children and Young People's Secure Estate (SECURE STAIRS)
- Workstream project 3: Collaborative Commissioning Networks

5.29 The outputs of this work will include:

- Identification of where there are currently gaps in the commissioning and provision of services.
- Growth in capacity where required across the system, where new provision or networks are developed (and where assessment procedures are improved to identify individuals who are currently slipping through gaps).
- Joint Strategic Needs Assessments for Clinical Commissioning Groups to include this cohort of children and young people as part of their Child and Adolescent Mental Health Services Transformation planning.
- A better understanding of the needs of this cohort of children and young people across all commissioning partners, and especially Clinical Commissioning Groups.

5.30 These outputs should enable the following outcomes:

- Full clinical pathway consideration for all children and young people who have received services delivered via NHS England Health and Justice directly commissioned provision.
- Children and young people who have been in contact with NHS England Health and Justice directly commissioned services will be better linked to mainstream services in the community, in the future.
- Parity of benefits from Children and Adolescent Mental Health Services Transformation for this cohort of children and young people.

### **Information Sharing**

5.31 Victims and survivors, along with their information, should flow seamlessly between the different services within the SAAS pathway, including those provided by specialist voluntary sector organisations, without complication and over their lifetime.

Without this collaboration, there is a risk that limited access to support services and therapeutic provision, and high thresholds and long waiting lists will harm the recovery of victims and survivors<sup>69</sup>.

- 5.32 Following the “chronic failures to protect children from sexual exploitation in Rotherham”<sup>70</sup>, the Government focused on improving several key areas, including information sharing. The Secretaries of State from DH, Home Office, DCLG and MoJ, came together to produce a letter<sup>71</sup> on the importance of information sharing, which stated: 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.”
- 5.33 The statutory guidance in Working Together to Safeguard Children<sup>72</sup> also supports the effective sharing of information to improve identification, assessment and service provision.
- 5.34 NHS England have stated that they will work to improve information sharing by supporting the Child Protection Information Sharing (CPIS) programme which aims to ensure that 80% of unscheduled care settings are signed up to the CPIS protocol by 2019. This will allow service providers to understand if a child or young person is already known to services<sup>73</sup>.
- 5.35 Therefore, it is vital that SARCs work with their partners to standardise and improve information sharing to meet the needs and best interests of service users. Information sharing agreements should be established between SARCs and their partners to ensure that service users receive appropriate and co-ordinated support in the service and on-going care and support.

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<sup>69</sup>NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>70</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408843/info\\_sharing\\_letter5.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408843/info_sharing_letter5.pdf)

<sup>71</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/408843/info\\_sharing\\_letter5.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408843/info_sharing_letter5.pdf)

<sup>72</sup> Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (July 2018) HM Government

<sup>73</sup>NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

# 6 APPLICABLE SERVICE STANDARDS FOR SARCS

## Introduction

- 6.1 Victims and survivors of sexual assault and abuse describe significant variations in the quality of service they experience when trying to access support. The delivery of good quality, consistent care to victims and survivors is paramount to their ability to recover, heal and rebuild their lives.
- 6.2 Therefore, it is vital to develop a high quality SARC to meet the needs of victims and survivors 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.

## National Standards and Requirements

- 6.3 All SARC services must actively pursue compliance with national healthcare standards, including clinical governance and risk management, such as:
  - The NHS Outcomes Framework<sup>74</sup> - has set five domains that the NHS should be aiming to improve. Domain 4 covers 'Ensuring that people have a positive experience of care'; and 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<sup>75</sup> - overarching aims are to increase healthy life expectancy and reduce differences in life expectancy and healthy life expectancy between communities. The indicators present 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)<sup>76</sup>.
  - 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.

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<sup>74</sup><https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework#framework-domains>

<sup>75</sup> <https://www.gov.uk/government/publications/public-health-outcomes-framework-2016-to-2019>

<sup>76</sup> <https://fflm.ac.uk/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-3/>

- National Service Framework for Children, Young People, and Maternity Services<sup>77</sup> - 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.
- 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**

6.4 A set of standards would help to drive up quality and to measure success and understand what needs to be done to achieve the best possible results for victims and survivors. Moreover, collaboration and a reduction in fragmentation should underpin the delivery of all priorities and should form part of the quality standards for sexual assault and abuse. Therefore, NHS England will <sup>78</sup>:

- Work with organisations across the health, care and justice sectors, as well as victims and survivors, to develop a set of quality standards that:
- supports delivery of the best possible outcomes for individuals accessing services and care;
- sets a clear expectation that care is compassionate, sensitive and delivered in a non-judgemental manner and is centred around the needs of the victim or survivor;
- is underpinned by a strong governance and accountability framework that is clear about the role of each organisation within the system and what is expected of them;
- provides a framework against which to measure and evaluate the quality of care, identify gaps, support future goal setting and a cycle of continuous improvement;
- informs future policy and commissioning decisions;
- supports the criminal justice process;
- reflects interdependencies across the health, social care and criminal justice systems.
- Revise existing service specifications to include specific quality standards, reduce variation and highlight interdependencies with other services such as:
- adult and paediatric services;
  - therapeutic support;
  - educational, training and clinical requirements;
  - leadership and governance arrangements.

<sup>77</sup> National Service Framework for Children, Young People and Maternity Service Core Standards (4 October 2004) Department of Health and Department for Education and Skills

<sup>78</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

- Work with the Care Quality Commission (CQC) to ensure that their programme of SARC inspections is based on a strong, person-focused inspection regime that examines the wider pathways of care for sexual assault and abuse.
- Work with other commissioners to ensure that interdependencies throughout pathways of care are reflected in the associated service specifications, in particular around access to:
  - paediatrics, including GUM services for children under the age of 13;
  - specialist mental health services which children, young people and adults can access.

6.5 Within SARCs, providers 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 is in line with the quality standards set out by the FFLM including<sup>79</sup>:

- It is essential to recruit a highly trained workforce to ensure patient safety, high quality care and aftercare, integrity of forensic sampling, statement writing, court room skills etc. All doctors in training should have appropriate supervision.
- All doctors must keep detailed contemporaneous notes and ensure effective communication between colleagues and other professionals including safety netting of vulnerable patients. There must be clear procedures in place for sharing confidential information and individual doctors who are responsible for holding their notes should be registered with the Information Commissioner.
- All doctors should have access to advice (by telephone) when on duty from an experienced consultant (or equivalent) forensic physician with FFLM Membership.
- Call handling systems should enable the police and self-referrals to be provided with immediate telephone advice in the contextual situation and also allow the forensic physician to assess call priority.
- The overall workforce provided should be sufficient in numbers to provide a timely response (within 2 hours, or as agreed for a particular case) to reflect the clinical and forensic needs of patients and the contracting police authorities.
- The healthcare professionals: doctors, nurses, emergency care practitioners and paramedics, must be adequately trained within the scope of their professional competency and be able to work co-operatively in multi-disciplinary teams where each professional is fully aware of the skills of the other.
- Ideally, complainants of alleged sexual assaults should be offered and given the opportunity to choose the gender of the doctor they see e.g. they should have the opportunity to see a female doctor if they choose it.
- Anti-contamination practices meeting the requirements set out by the Forensic Science Regulator<sup>80</sup> and a robust chain of evidence in keeping with FFLM guidelines.

<sup>79</sup> FFLM (Feb 2016) Quality Standards in Forensic Medicine <https://fflm.ac.uk/wp-content/uploads/2014/04/Quality-Standards-in-Forensic-Medicine-February-2016.pdf>

<sup>80</sup> [www.gov.uk/government/publications/sexual-assault-referral-centres-and-custodial-facilities-dna-anti-contamination](http://www.gov.uk/government/publications/sexual-assault-referral-centres-and-custodial-facilities-dna-anti-contamination)

## Quality Assurance for Young People and Children

- 6.6 Consistent quality standards are important in paediatric services within the SAAS pathway to meet the complex needs of child victims. The paediatric model requires mechanisms that ensure timely and easy access and structured, seamless referral into clinical commissioning group (CCG) commissioned child and adolescent mental health services and other specialist support. For example, paediatric genito-urinary medicine (GUM) services for children under the age of 13 and services provided by the voluntary sector to ensure access to appropriate assessment, treatment and ongoing specialist care. Structured and seamless transition from paediatric services into adult services should be included as part of the standards.<sup>81</sup>
- 6.7 In regard to SARCs that provide services to young people and children, these services 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, so updated their quality standards<sup>82</sup> and highlighted good practices, specifically stating 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.

### Quality Standards for the Workforce

- 6.8 In order to help and support victims and survivors of sexual assault and abuse who may be experiencing complex trauma and re-traumatisation and achieve the best outcome, it is important that those with whom they come into contact at any given point in their journey to recovery are appropriately trained and are aware of the effects and manifestations of sexual assault and abuse. By improving awareness and training across the SAAS workforce, victims and survivors will be better able to access specialised services, safeguarding will be enhanced, the quality of care received improved and ultimately patient experience and outcomes heightened.

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<sup>81</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>82</sup> 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

## 6.9 Therefore, NHS England will<sup>83</sup>

- Include workforce requirements in the quality standards. This should cover training needs and guidance on optimal skill mix.
- Set out workforce requirements within the quality standards, identify training needs against quality standards and work with commissioners to ensure that they have plans for meeting any gaps.
- Require all providers to develop workforce plans, which include a process for developing skills and competencies to the national standards.
- Ask the SARC Clinical Forum to adopt 'workforce' as one of its key work streams.
- Work with therapeutic providers, including the specialist voluntary sector, to develop guidance on delivering trauma-informed services aligned to the Crown Prosecution Service provision of pre-trial therapy guidance.

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<sup>83</sup>NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

## 7 PERFORMANCE MANAGEMENT AND ACTIVITY REPORTING

- 7.1 NHS England 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 survivors, and demonstrates the collaborative commissioning approach/agreements used for local SAAS commissioning<sup>84</sup>.
- 7.2 NHS England primarily monitors progress through established governance mechanisms, specifically the Health and Justice Oversight Group and the Sexual Assault and Abuse Services Partnership Board. NHS England also uses its new national victims and survivors voices group to hold these groups to account for delivery. Progress will be ascertained by self-assessment against the quality standards with an accompanying verification process alongside findings from the CQC's inspection process.
- 7.3 SARCs must provide activity reports in line with the SARCs management information stipulated template, Sexual Assault Referral Centres Indicators of Performance (SARCIP) to inform national commissioning assurance and any regional, sub regional assurance. Under the public health functions agreement <sup>85</sup> NHS England agreed to the following key deliverables and performance indicators:

### Key deliverables

- Report quarterly to the Department of Health and Social Care from April 2018 on SARCIP data. The most recent version of the SARCIPs user guide and data input template is available via contacting: [ENGLAND.SARCIPS@nhs.net](mailto:ENGLAND.SARCIPS@nhs.net)
- Support SARCs to ensure robust data collection and submission to influence service priorities.
- In collaboration with Public Health England, develop and agree benchmark standards for SARCIPs, based on robust national and international evidence base and clinical input from the advisory forum for the 2019-20 agreement.
- Support commissioners of SARCs to act as system leaders to work in partnership with local authorities, CCGs and criminal justice commissioners, to develop a high quality, integrated SAAS care pathway.

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<sup>84</sup> Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

<sup>85</sup> Department of Health & Social Care and NHS England (2018) NHS public health functions agreement 2018/19 Public health functions to be exercised by NHS England [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/694130/nhs-public-functions-agreement-2018-2019.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694130/nhs-public-functions-agreement-2018-2019.pdf)

## Performance indicators

- Percentage of survivors for whom sexually transmitted infections, HIV, Hepatitis B and Hepatitis C was indicated and were:
  - a) tested in the SARC or;
  - b) referred elsewhere for testing
- Percentage of survivors in whom Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) was indicated, who received a PEPSE starter pack within 72 hours.
- Percentage of survivors in whom emergency contraception was indicated, who were prescribed or were given Emergency Contraception.

## 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, which replaced the 2006 Act, created a '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.<sup>86</sup> 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 In terms of SAAS, regardless of the part of the country in which victims and survivors are accessing services and regardless of their gender, ethnicity, sexual orientation, age and relationship with the criminal justice system, the standard and quality of care should be the same. Any standards should particularly support those people with disabilities as they will often face additional difficulties in attempting to access support. They may already be socially isolated because of their disability and may find it difficult to disclose as they may have no opportunity to seek help without their abuser being present. Victims and survivors with a specific language barrier and, in particular, those who rely on sign language, may also face additional difficulties in accessing support.<sup>87</sup>
- 8.4 SARC specifically have a responsibility to assure the effective implementation of the Equality Act as women and girls are the major group of sexually assaulted people.<sup>88</sup> There is also a significant cohort of men and boys who may be at risk of child sexual abuse.
- 8.5 Commissioners will need to work with providers to market SARCs 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.

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<sup>86</sup> The nine protected characteristics are Age; Disability; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Race; Religion and Belief; Sex; Sexual Orientation).

<sup>87</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

<sup>88</sup> The British Crime Survey 2010/11. <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/>

## 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.
- 9.2 Victims, survivors and advocacy organisations are the most important voices in service re-design and development in terms of their ability and power to help others to recognise and to understand the scale, complexity and impact of sexual violation. Involving survivors and advocacy organisations in the improvement and development of services, offers an opportunity for them to be heard without judgement or stigmatisation. It is vital that we use their expertise to influence service improvement through direct experience.
- 9.3 When involving victims and survivors in the development and improvement of services, it is important to consider a range of options to involve people. For example, engaging with men may need a different approach to that used to engage with women and likewise for children and younger people.
- 9.4 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.
- 9.5 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.
- 9.6 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.
- 9.7 Therefore, NHS England will:<sup>89</sup>
  - Develop, publish and circulate a set of principles to govern the involvement of survivors and survivors' advocates in the commissioning and delivery of SAAS. These principles will build upon NHS England's 'What Works' publication and will be developed jointly with the wide range of stakeholders. They will be circulated to all organisations that commission or provide services, which support victims and survivors of sexual assault and abuse.
  - Continue to monitor the diversity of the national victims and survivors voices group managed by NHS England and make all efforts to broaden the membership as appropriate. This is significant as this group will help to ensure that ongoing service developments are informed by lived experience and will help to hold services to account.

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<sup>89</sup> NHS England (2018) Strategic Direction for Sexual Assault and Abuse Services Lifelong care for victims and survivors: 2018 - 2023

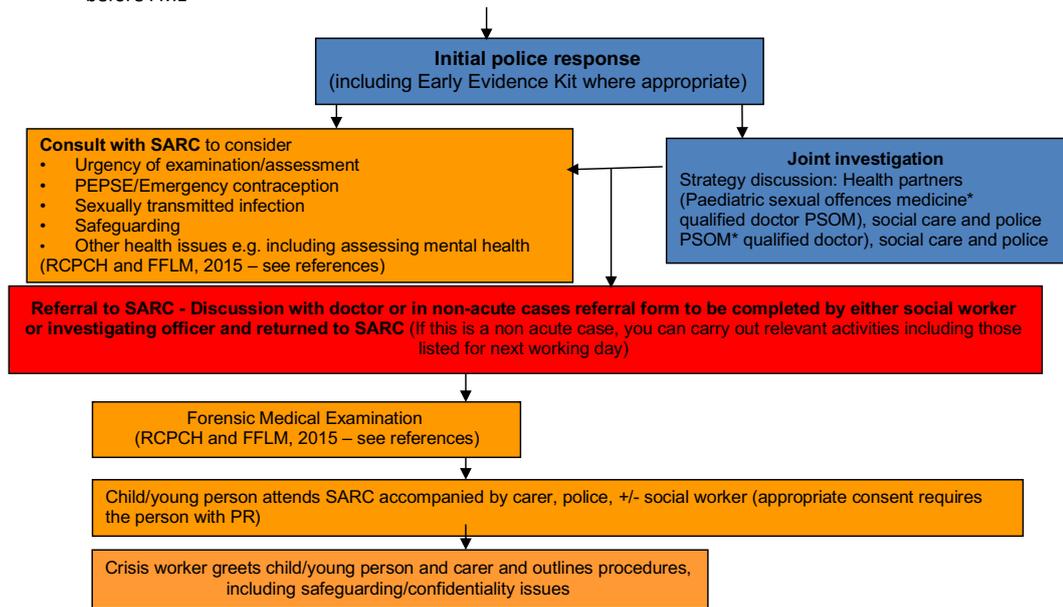
# Appendix 1: Children and Young Peoples' Care Pathway

## APPENDIX 1: CHILDREN AND YOUNG PEOPLES' CARE PATWAY

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) – good initial history must be taken by police prior to examination to avoid having to interview child twice.**

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

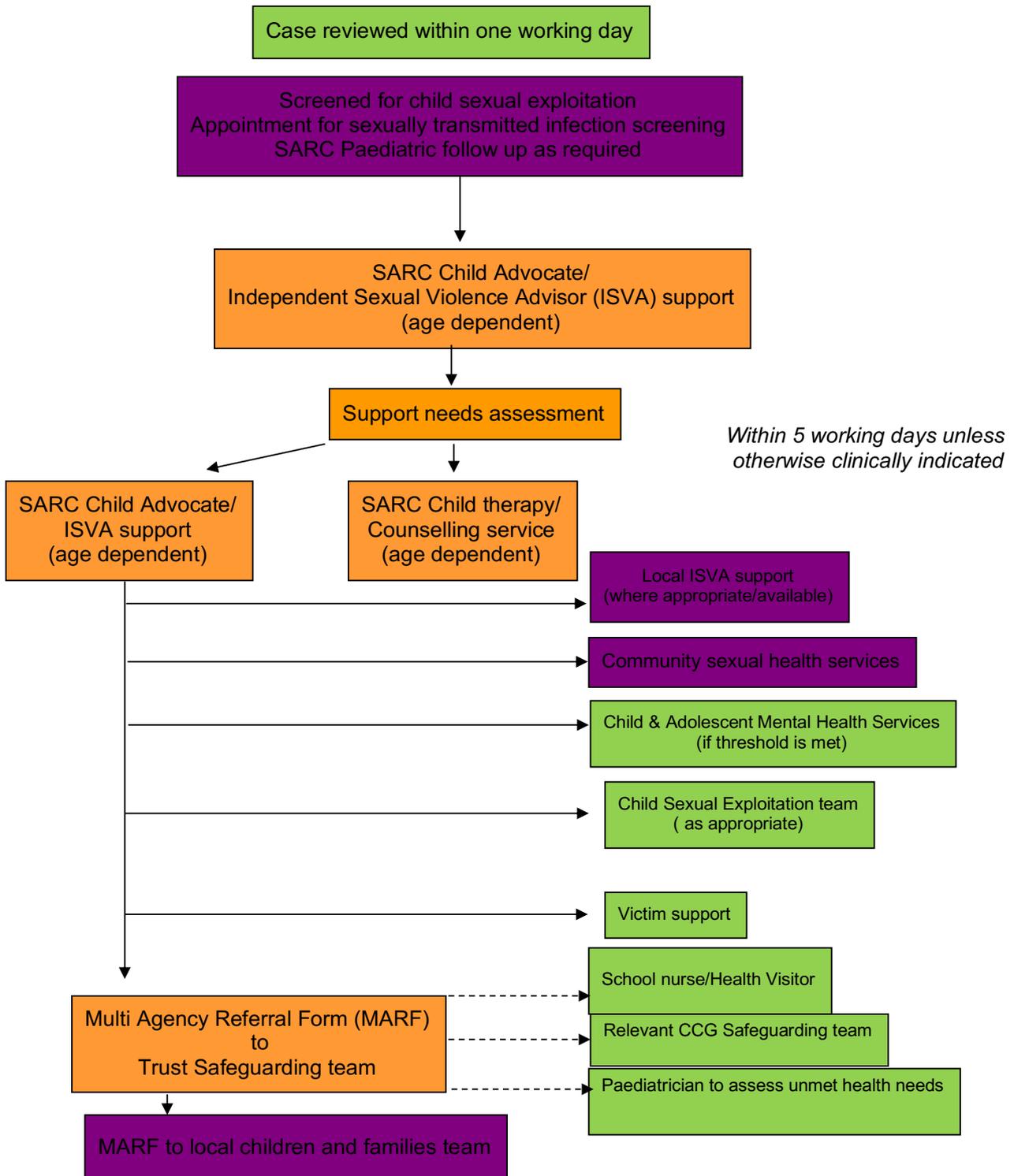


## APPENDIX 2: ADULT CARE PATHWAYS

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

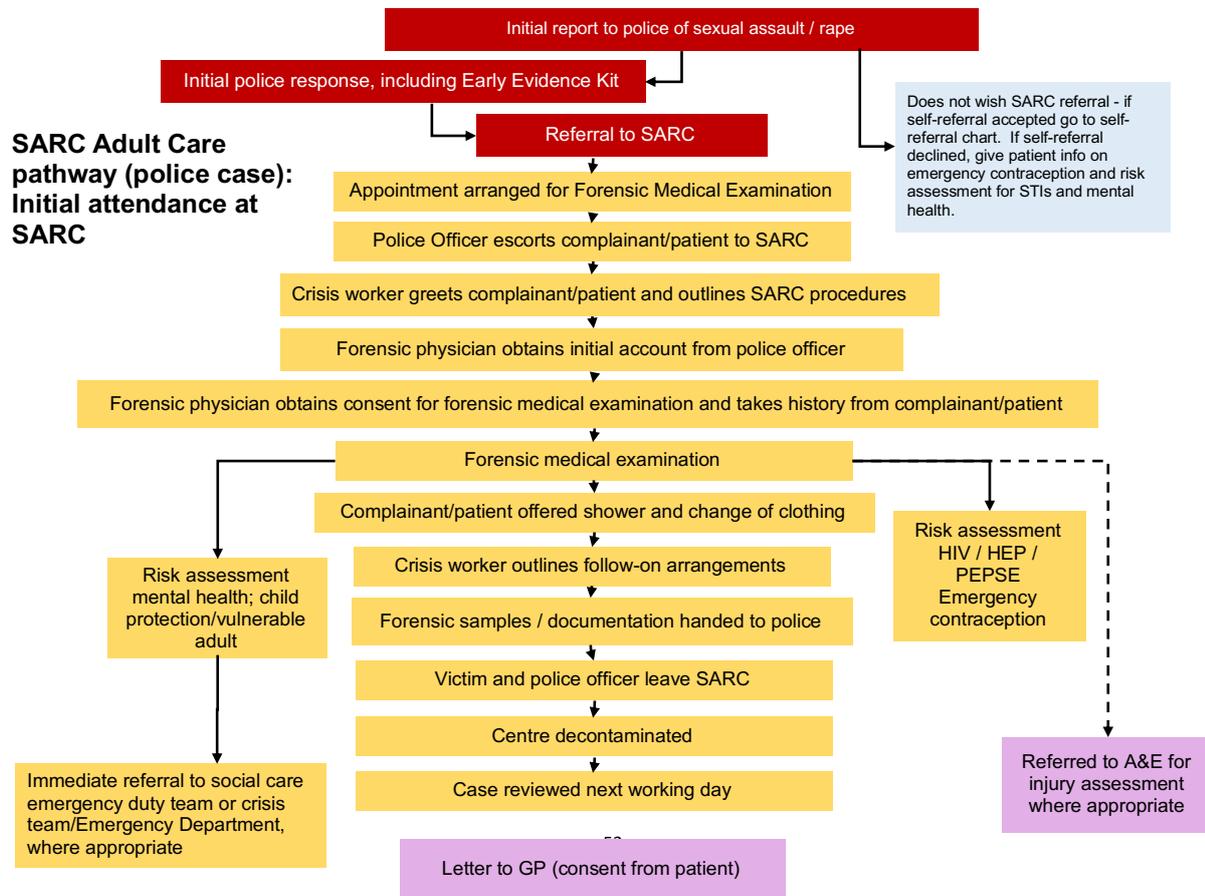
- SARC Adult Care Pathway (police case): Initial attendance at SARC
- SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)
- SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)- range of support services
- SARC Follow-up Adult Care Pathway (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 Children and Young People Care Pathway, continued

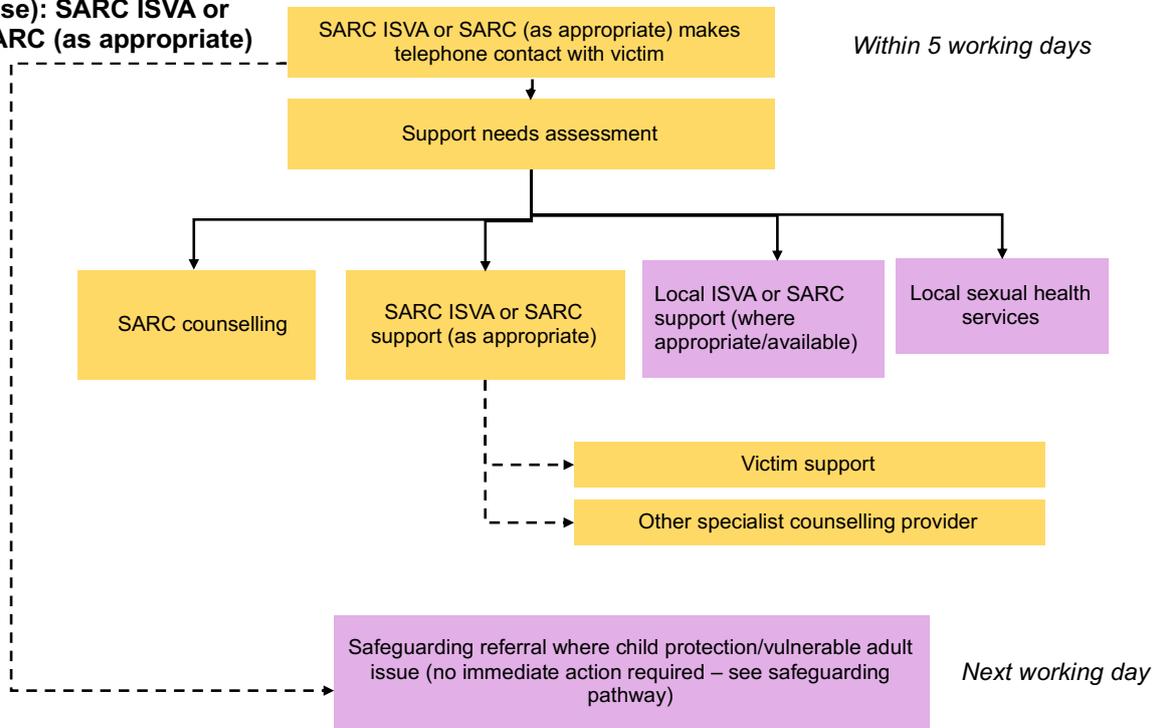


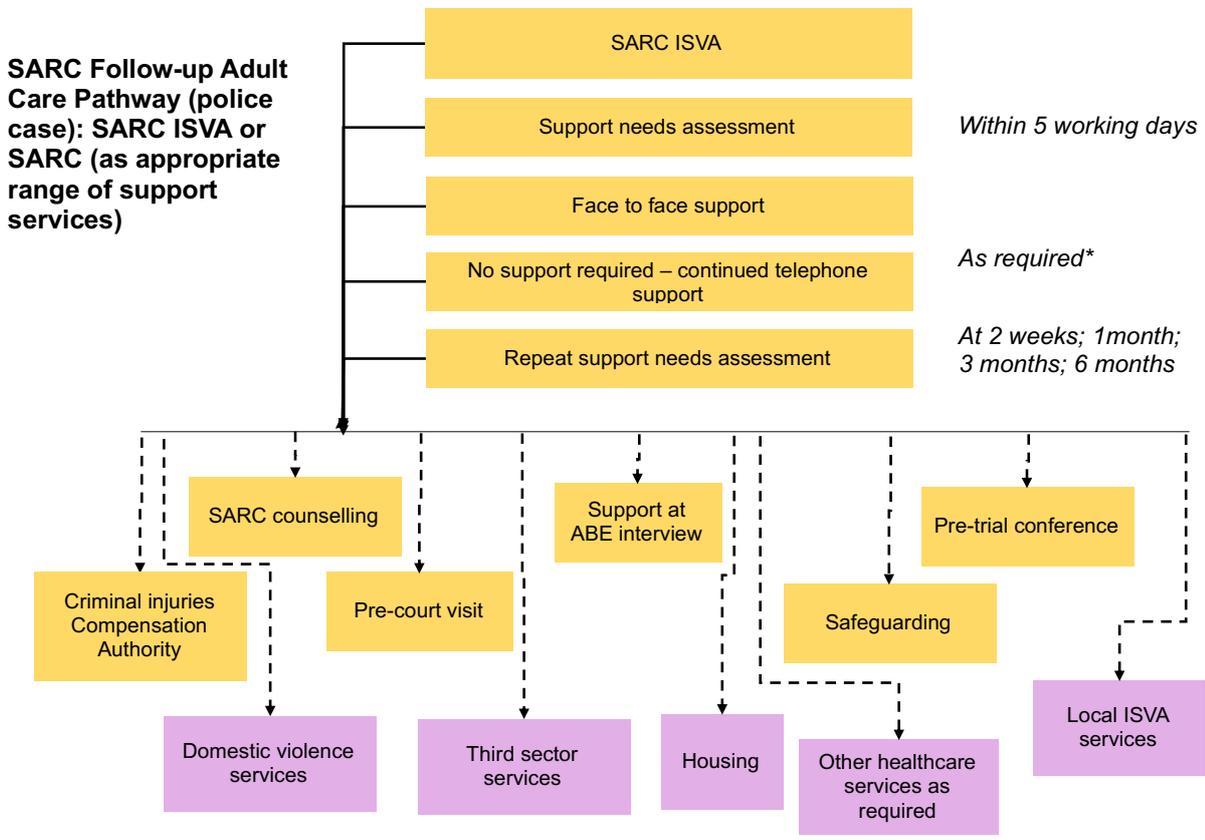
\* Paediatric Sexual Offence Medicine (Quality Standards for Doctors Undertaking Paediatric Sexual Offence Medicine (2014): <http://fflm.ac.uk/upload/documents/1393326841.pdf>)

\*\* Age appropriate

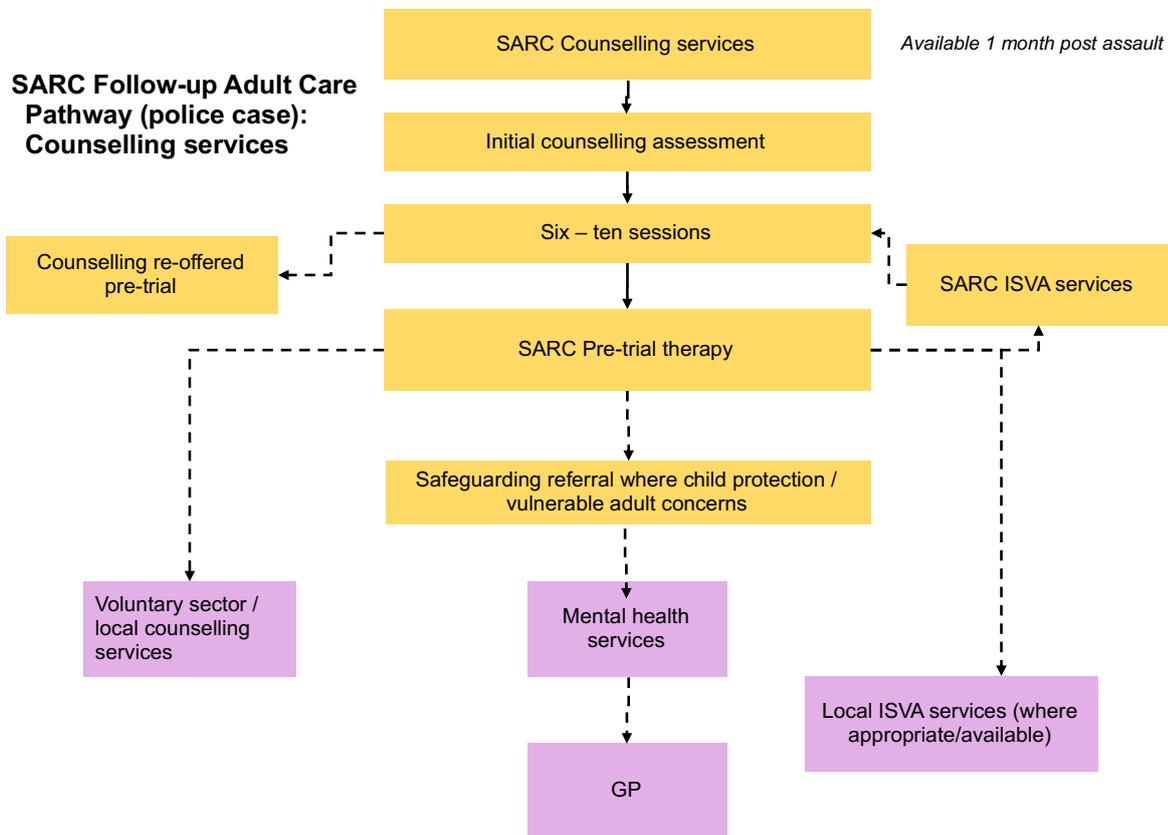


**SARC Follow-up Adult  
Care Pathway (police  
case): SARC ISVA or  
SARC (as appropriate)**

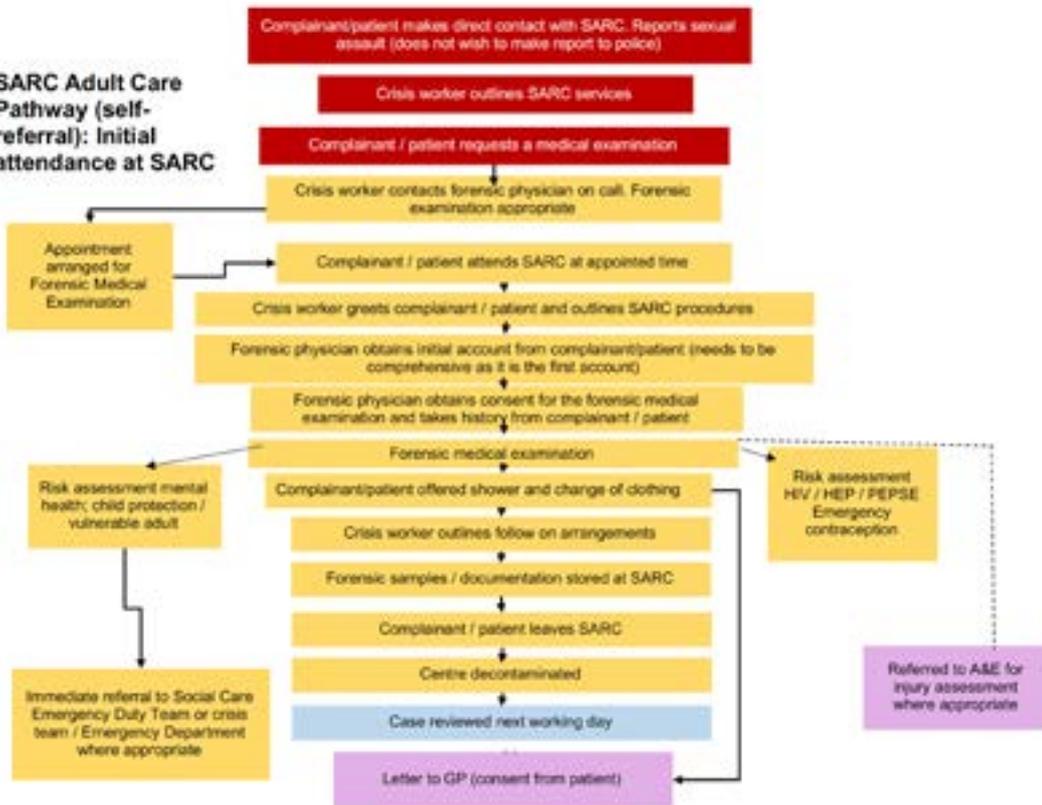




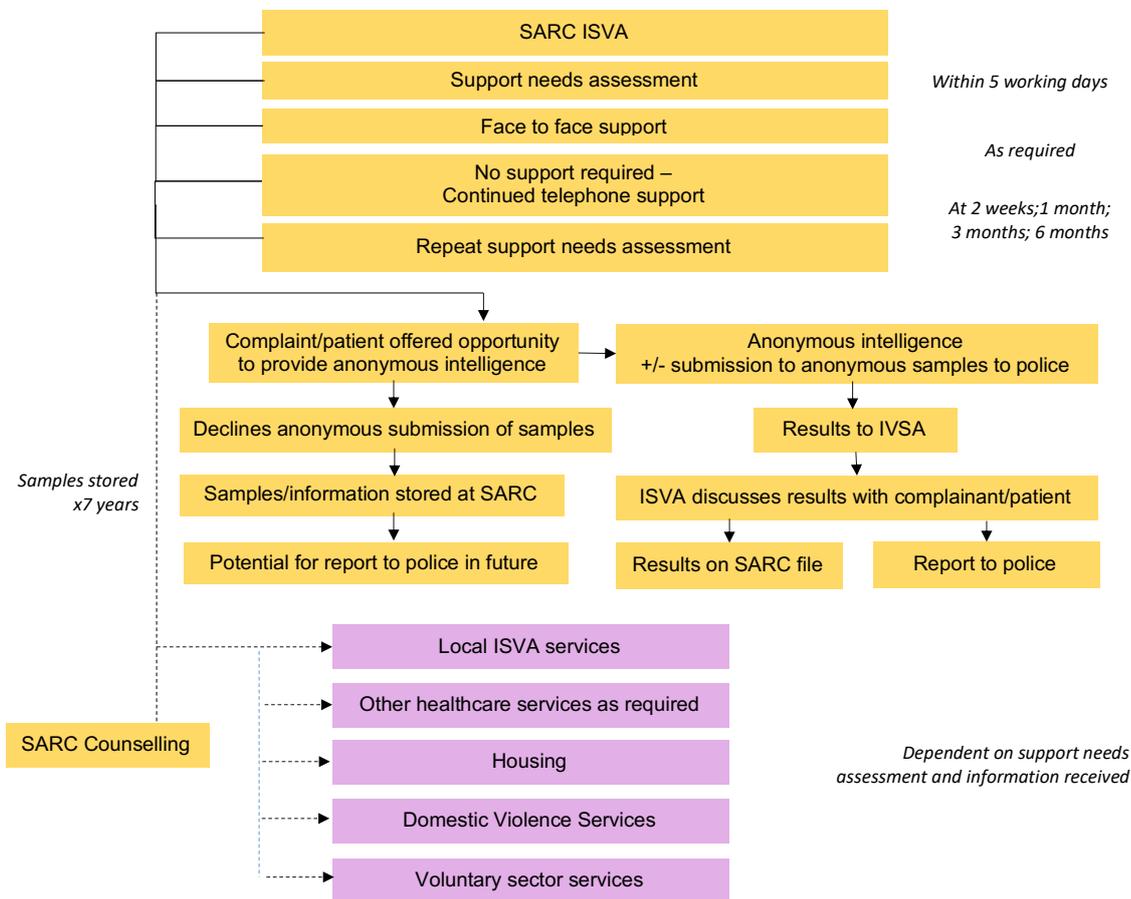
**SARC Follow-up Adult Care Pathway (police case):  
Counselling services**

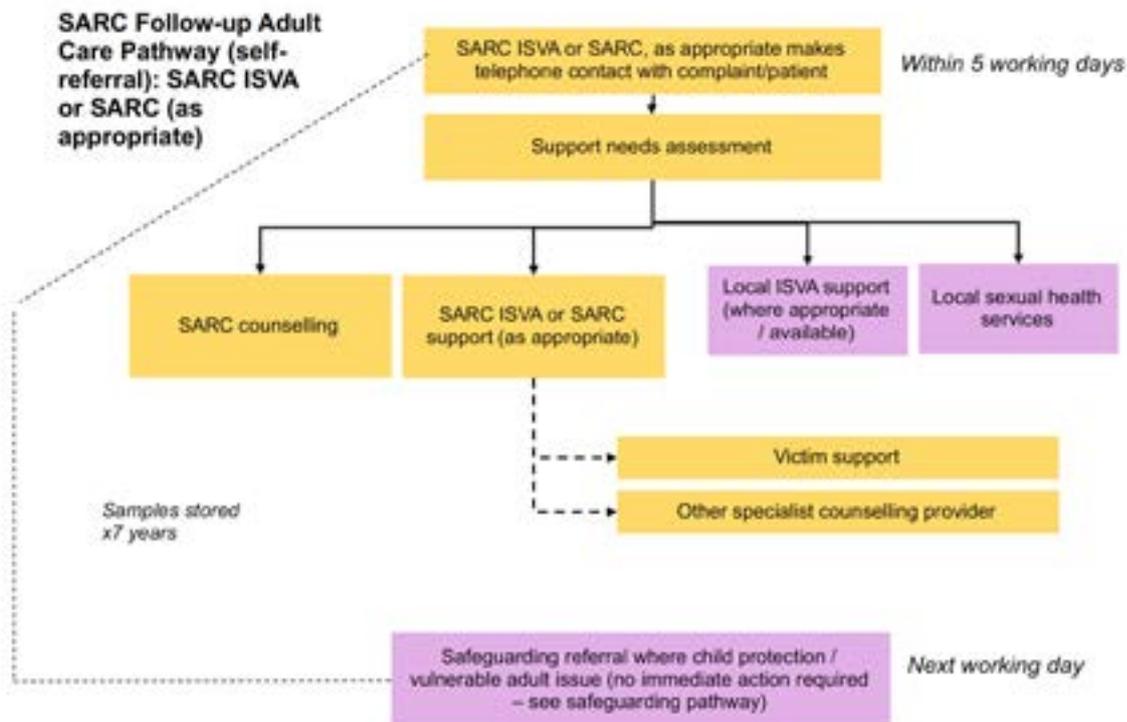


**SARC Adult Care Pathway (self-referral): Initial attendance at SARC**

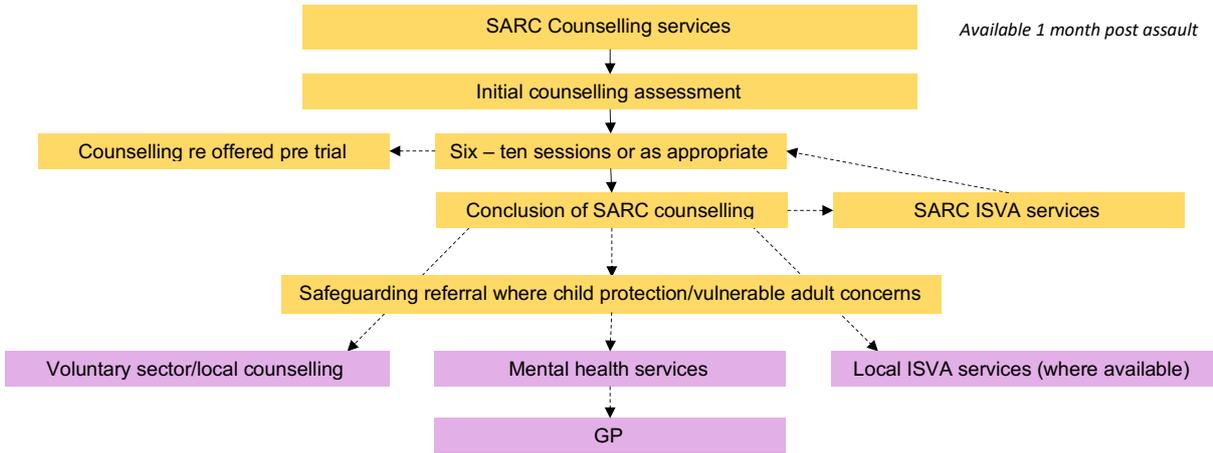


## SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate) – range of support services





## SARC Follow-up Adult Care Pathway (self-referral): Counselling services



## References

RCPCH and FFLM (September 2015) Service specification for the clinical evaluation of children and young people who may have been sexually abused [https://www.rcpch.ac.uk/sites/default/files/Service\\_Specification\\_for\\_the\\_clinical\\_evaluation\\_of\\_children\\_and\\_young\\_people\\_who\\_may\\_have\\_been\\_sexually\\_abused\\_September\\_2015.pdf](https://www.rcpch.ac.uk/sites/default/files/Service_Specification_for_the_clinical_evaluation_of_children_and_young_people_who_may_have_been_sexually_abused_September_2015.pdf)