

Public health functions to be exercised by NHS England

Service Specification No. 30 Sexual Assault Referral Centres

NHS England INFORMATION READER BOX

Directorate

Medical

Nursing

Finance

Commissioning Operations
Trans. & Corp. Ops.Patients and Information
Commissioning Strategy

Publications Gateway Reference:

04575

Document Purpose Guidance

Document Name Service specification No. 30 Sexual Assault Referral Centres

Author NHS England (prepared by PHE)

Publication Date 05 February 2016

Target Audience NHS England Regional Directors

Additional Circulation
List

Description This is a service specification to accompany the 'NHS public health functions agreement 2016-17 (the '2016-17 agreement') published in December 2015.

This service specification is to be applied by NHS England in accordance with the 2016-17 agreement.

Cross Reference NHS public health functions agreement 2016-17

Superseded Docs
(if applicable) 2015/16 Service Specification

Action Required n/a

Timing / Deadlines
(if applicable) n/a

Contact Details for further information Section 7a Programme Management Office
NHS England Public Health Commissioning Central Team
4E46 Quarry House
Leeds
LS2 7UE
0113 8247235

<https://www.england.nhs.uk/commissioning/pub-hlth-res/>

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

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

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

CONTENTS

1. THE PURPOSE OF SERVICE SPECIFICATION NO.30	5
2. LEGAL FRAMEWORKS AND DEFINITIONS	8
2. THE NATIONAL CONTEXT AND EVIDENCE BASE	10
• The Benefits of SARCs	10
• The Evidence Base	10
4. SCOPE OF SARC SERVICES	14
• The Role of SARCs	14
• Model of SARC Service Provision and Key Elements	14
• Geographical Location of SARC Services	17
• Essential Areas of SARC Provision	17
5. COMMISSIONING	21
• Aims and Objectives	21
• NHS England Commissioning Model	21
• Collaborative Commissioning and Partnership Working across the SAS Care Pathway	22
• Information Sharing	27
6. APPLICABLE SERVICE STANDARDS FOR SARC SERVICES	28
• Introduction	28
• National Standards and Requirements	28
• Quality Assurance Standards	29
7. PERFORMANCE MANAGEMENT AND ACTIVITY REPORTING	31
8. EQUALITY AND DIVERSITY	32
8. SERVICE USER ENGAGEMENT	33
APPENDIX 1: ADULT CARE PATHWAYS	34
APPENDIX 2: CHILDREN AND YOUNG PEOPLES' CARE PATHWAY	43

LIST OF ABBREVIATIONS

ACPO	Association of Chief Police Officers
APPG	All Party Parliamentary Group
A&E	Accident & Emergency
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
CAHVIO	Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence
CAMHS	Child and adolescent mental health services
CCG	Clinical Commissioning Groups
CEOP	Child Exploitation and Online Protection Centre
CJS	Criminal Justice System
CP-IS	Child Protection – Information Sharing
CPS	Crown Prosecution Service
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
CSEW	Crime Survey for England and Wales
DCLG	Department for Communities and Local Government
DfE	Department for Education
DH	Department of Health
FFLM	Faculty of Forensic & Legal Medicine
FSRH	Faculty of Sexual and Reproductive Healthcare (at the Royal College of Obstetricians and Gynaecologists)
GUM	Genitourinary Medicine
IAPT	Improving Access to Psychological Therapies
ISVA	Independent Sexual Assault Advisor
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
MoJ	Ministry of Justice
NCA	National Crime Agency
NPCC	National Police Chiefs Council (previously ACPO)
NSPCC	National Society for the Prevention of Cruelty to Children
NHS	National Health Service
ONS	Office of National Statistics
PCC	Police and Crime Commissioner
PEPSE	Post-Exposure Prophylaxis after Sexual Exposure
PHE	Public Health England
QA	Quality Assurance
RCPCH	Royal College of Paediatrics and Child Health
SARC	Sexual Assault Referral Centre
SARCIP	Sexual Assault Referral Centre Indicators of Performance
SAS	Sexual Assault Services
YPA	Young People's Advocates

This is a service specification to accompany the 'NHS public health functions agreement 2016-17 (the '2016-17 agreement') published in December 2015.

This service specification is to be applied by NHS England in accordance with the 2016-17 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 2016-17 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2016-17 agreement in accordance with the procedures described in Chapter 3 of the 2016-17 agreement

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

The 2016-17 agreement is available at www.gov.uk (search for 'commissioning public health').

All current service specifications are available at www.england.nhs.uk (search for 'commissioning public health').

1. THE PURPOSE OF SERVICE SPECIFICATION NO. 30

- 1.1 The NHS Public Health Functions Agreement (Section 7A or s.7A) made under the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines the specific responsibilities of National Health Service England (NHS England) for commissioning certain public health services as part of the wider system design to drive improvements in population health. The services under s.7A are directly commissioned by NHS England, 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 services**
- 1.3 **The purpose of Service Specification No. 30 is to outline the public health functions to be exercised by NHS England in regards to the commissioning of Sexual Assault Referral Centres (SARC). This Service Specification covers the period from 2016-17.**
- 1.4 NHS England, with a range of partners in the health system (e.g. CCGs), Local Authorities and the Criminal Justice System (e.g. Police, PCCs) is jointly responsible for the commissioning of a cost-effective, integrated response to sexual violence and rape in order to meet the needs of local populations. **With the Police and PCCs, NHS England co-commissions SARC services. NHS England is specifically responsible for commissioning the public health services elements of SARC services.** SARC services also comprise of sexual assault forensic medical examinations and independent sexual violence advisory support.
- 1.5 A SARC provides services to victims of rape or sexual assault regardless of age and gender, and whether the victim reports the offence to the police or not, and can provide onward referrals to other health and social care services according to need. SARC services can deliver services to both recent and non-recent victims, and can offer victims the opportunity to assist in a police investigation of the sexual offence against them, including a forensic medical examination with consent.
- 1.6 In any local area the SARC provision is part of a network within the wider sexual assault services (SAS) care pathway, for example, psychological therapies, commissioned by CCGs and specialist support available from the

Third Sector. The commissioning of the full SAS care pathway is only possible in partnership with the other commissioners in the wider health, social care and criminal justice commissioners sectors. NHS England is committed to working with all NHS, local authority and criminal justice commissioners, as appropriate, to secure the best possible outcome for service users within available resources.

- 1.7 Whilst NHS England is specifically responsible for commissioning the public health services elements of SARC services, this document will focus on the entirety of the role and scope of SARC services and the current model of service delivery for children, young people and adults, as it is important to highlight the areas of co-commissioning. Hence, this document is relevant to commissioners in the NHS (e.g. CCGs), Local Authorities and in the Criminal Justice System (e.g. Police, PCCs), who are responsible for commissioning various aspects of SARC provision and/or commissioning elements within the wider SAS 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 this may be via a self-referral or a police referral, while for children and young people it may be through a safeguarding referral to social services or the police.
- 1.8 In recognition of both the number and the wide range of commissioners involved and the differing levels of knowledge and understanding of SARC services and the SAS pathway, this specification will consider the interfaces and interdependences between SARC services and the commissioners and providers within the wider SAS care pathway. However, SARC and SAS provision is a whole system concern and cannot be neatly grouped and categorised as a primary health, public health, mental health, social care or police issue, which can make identifying commissioning responsibilities complex. Table 1 below attempts to summarise the current responsibilities along the SARC/SAS pathway. It outlines which functions may be the commissioning responsibility of more than one organisation so needs to be jointly commissioned. It also demonstrates the complexities of the pathway.
- 1.9 It is important to note this document is not a service specification for service providers. Neither will this document prescribe time-frames, for example, for the acute counselling period. Such issues should be outlined in local partnership agreements around service delivery.
- 1.10 Throughout this document the terms sexual assault, sexual offence, sexual violence and sexual abuse are used interchangeably and not necessarily always according to their technical or legal definitions.

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

	NHS England	Police	PCCs	LAs	CCGs
Responsibilities within SARCs					
	Sexual assault	Sexual assault forensic			

	public health services e.g. sexual health services	medical examination			
	Crisis Workers				
		ISVAs*			
	SARC facility/operational management				
Responsibilities within wider SAS pathway					
Mental Health					Adult mental health, IAPT & CAMHS provision including therapeutic support for recent and non-recent cases, as required.
Primary Care services				Public Health Services e.g. GUM/sexual health services	Accident & Emergency services
Social Care/Support services			Victim support services** (support for victims of crime)	Crisis/social workers for children & young people and vulnerable adults ISVAs	
Safeguarding	Safeguarding responsibilities for children and adults			Lead for children and adults safeguarding & child sexual exploitation	Safeguarding responsibilities for children and adults

* Currently the Home Office match-funds 87 ISVAs to work with victims of recent and non-recent serious sexual crimes.

** Currently the Ministry of Justice directly funds through grants an element of local rape support services, which are primarily provided by the Third Sector.

2. LEGAL FRAMEWORKS AND DEFINITIONS

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

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

- **Sexual assault** - A person commits sexual assault if they intentionally touch another person, the touching is sexual and the person does not consent.
 - **Serious sexual assault** - Assault by penetration - a person commits assault by penetration if they intentionally penetrate the vagina or anus of another person with a part of the body or anything else, without their consent.
 - **Sexual activity with a child under 16** - Sexual activity with a child under 16, causing or inciting a child to engage in sexual activity, engaging in sexual activity in the presence of a child, and causing a child to watch a sexual act, are offences irrespective of whether the child consents or not.
- 2.2 **The Care Act 2014** sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect, and outlines local authorities' safeguarding duties.
- 2.3 The care and safeguarding of children is governed by **The Children's Act 1989 and 2004**:
- **The Children Act 1989** – Under s17 every Local Authority has a duty to safeguard and promote the welfare of children within their area. The Local Authority must provide services to ensure that children are able to achieve and maintain a reasonable standard of health and development to ensure that individual children's health is not impaired, or further impaired.
 - **The Children Act 2004** - This Act extends this duty to safeguard and promote children's welfare to the Local Authority's partners and places a duty on them, including SARC services to work with Local Authorities to promote the wellbeing of children (s.10) and places a duty on a range of agencies and people to ensure that all their staff have regard to the need to safeguard the welfare of children and young people in their care (s.11). It provides the legislative underpinning for integrated working and safeguarding activity. The document *Working Together to Safeguard Children*¹ sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Act.
- 2.4 **Child sexual exploitation** is a form of child sexual abuse and is covered by the Sexual Offences Act 2003. The transporting element of children across different areas domestically or abroad i.e. Human Trafficking is covered by a number of Acts including The Children Act 1989 and 2004; Asylum and Immigration (Treatment of Claimants, etc.) Act 2004; Gangmasters Licensing

¹ Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government

Act 2004; Nationality, Immigration and Asylum Act 2002; and the Human Rights Act 1998. The definition in the national policy document, *Tackling Child Sexual Exploitation - Action Plan*² is as follows:

“Child sexual exploitation is a form of child abuse (“child” being defined as anyone under 18 years of age). It is complex and can manifest itself in different ways.but essentially it involves children and young people receiving something – for example, accommodation, drugs, gifts, or affection – as a result of them performing sexual activities, or having others perform sexual activities on them. It can occur without physical contact, when children are groomed to post sexual images of themselves on the internet.”

- 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”.*³

3. THE EVIDENCE BASE

The Benefits of SARC Services

- 3.1 The provision of a SARC service can have significant benefits for the individual and for public services i.e. the NHS, Local Authorities and the Criminal Justice System. Each adult rape is estimated to cost over £76,000 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.⁴ The overall cost to society of sexual offences in 2003/04 was estimated at £8.5 billion, although this did not include long-

² Tackling Child Sexual Exploitation – Action Plan. Department for Education. 2011

³ Domestic violence and abuse: <https://www.gov.uk/domestic-violence-and-abuse#domestic-violence-and-abuse-newdefinition>

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

term health impacts such as post-traumatic stress disorder or mental health costs.

- 3.2 SARC services can provide both the police and the service user with the best possible opportunity to recover evidence for use within an investigation. Without such an approach, support to these vulnerable clients within the criminal justice system would be significantly reduced.
- 3.3 More generally, the presence of a SARC can raise public awareness of sexual violence and abuse and how such abuse can be dealt with, which in turn helps boost public confidence in both the health and criminal justice systems.

The Evidence Base

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

Victims of violent crime and sexual violence

- 3.5 Estimates of the prevalence of sexual abuse are wide-ranging. The Crime Survey for England and Wales (CSEW) in 2009/10, 2010/11 and 2011/12, reported that 2.5% of females and 0.4% of males said that they had been a victim of a sexual offence (including attempts) in the previous 12 months. This represents around 473,000 adults being victims of sexual offences (around 404,000 females and 72,000 males) on average per year.⁵
- 3.6 Around 0.5% of females reported being a victim of the most serious offences of rape or sexual assault by penetration in the previous 12 months, equivalent to around 85,000 victims on average per year. Among males, less than 0.1% (around 12,000) reported being a victim of the same types of offences in the previous 12 months.⁶
- 3.7 The number of police recorded sexual offences in the year to March 2014 showed a 20% increase compared with the previous year, rising to a total of 64,205 incidents across England and Wales. This latest figure is the highest ever recorded on a financial year basis. Within this, the number of rape offences increased by 26% to 20,745 incidents, and the number of other sexual offences increased by 17% to 43,460 incidents.⁷
- 3.8 The ONS stated that increases were considered to be due to **greater victim confidence** and a willingness of victims to come forward to report such crimes together with **improved recording by the police** rather than more sexual assaults taking place. Therefore, it is important that these increases are viewed in the context of the effects of police operations such as Operation

⁵ An Overview of Sexual Offending in England and Wales (10 January 2013) Ministry of Justice, Home Office & the Office for National Statistics (Statistics bulletin)

⁶ An Overview of Sexual Offending in England and Wales (10 January 2013) Ministry of Justice, Home Office & the Office for National Statistics (Statistics bulletin)

⁷ Chapter 1: Violent Crime and Sexual Offences Overview (12 February 2015) Office for National Statistics

Yewtree and other high profile cases involving sexual abuse that improved the willingness of people to report abuse. Improved compliance with recording standards for sexual offences in some police forces may also have been a factor in the rise.

- 3.9 Nonetheless, only about 11% of sexual abuse is estimated to be reported to the Police.⁸ Analysis of the 2007 adult psychiatric morbidity survey reported that 5% of people had experienced sexual violence in childhood, 3% in adulthood and a further 4% in both childhood and adulthood.⁹ The findings of this population health survey are generalizable to the population of England and indicates that the prevalence of sexual abuse may be higher than thought.

Child Sexual Abuse

- 3.10 In regards to the prevalence of child sexual abuse, the NSPCC¹⁰ reported that there were a total of 23,663 sexual offences against children recorded by the police in the UK in 2012/13 and 6,296 rapes of children recorded by police in England and Wales.
- 3.11 The data from individual SARC services suggested that between 22% and 50% of service users seen are young people under 18 years old.¹¹
- 3.12 The vast majority of child sexual abuse is familial and is perpetrated by people related to, or known to the victim, and often goes unreported and undetected. In 2012/13, nearly half of the young people who contacted the NSPCC's ChildLine service about child sexual abuse said the perpetrator was a family member.¹² 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.¹³
- 3.13 The overall health consequences for sexually abused children and young people can be devastating:¹⁴
- 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;

⁸ Home Office. Crime in England and Wales 2010.

<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/>

⁹ NatCen Social Research. Responding Effectively to Violence and Abuse. Department of Health Commissioned Research. 2015

¹⁰ How Safe Are Our Children (2014) Sonja Jutte, Holly Bentley, Pam Miller, Natasha Jetha; NSPCC

¹¹ Securing Excellence in commissioning sexual assault services for people who experience sexual violence (13 June 2013) NHS England

¹² ChildLine (2014), Can I tell you Something?: What's affecting children in 2013?, London: ChildLine.

¹³ 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.

¹⁴ 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

- 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.

Child Sexual Exploitation

- 3.14 It is important for SARC services to understand the characteristics of child sexual exploitation (CSE) in order to provide a suitable response to this form of child sexual abuse. In 2011, the Child Exploitation and Online Protection Centre (CEOP)¹⁵ found:
- **Majority of CSE victims were girls** - However in 31% of cases, gender was unknown. It is likely that male victims are under-represented due to difficulties in identifying sexual exploitation in boys and young men.
 - **14 and 15 year olds are most likely to be noticed by authorities** - Some victims of sexual exploitation were as young as 9 or 10 years old, but young people most commonly came to the attention of statutory and non-statutory authorities aged 14 or 15.
 - **Majority of victims were White** - 61% of the victims were White, 3% were Asian and 1% were Black. Ethnicity was unknown in 33% of cases. Children from minority ethnic backgrounds are likely to be under-represented in statistics because of barriers to reporting and accessing services.
 - **Children who go missing are risk of sexual exploitation** - Information about whether children went missing was incomplete but 842 children were reported as missing on at least one occasion. However, it was not known whether these children were sexually exploited before, during or after they went missing.
- 3.15 There are links between child sexual exploitation and youth offending. A University College London study¹⁶ of 552 victims of child sexual exploitation in Derby found that nearly 4 out of 10 young people had a history of criminal behaviour.
- 3.16 Although there is research evidence into the factors that are associated with child sexual exploitation, very few studies look into the numbers of children who have been exploited. The available research and data shows that over 2,400 children were victims of sexual exploitation in gangs and groups from August 2010 to October 2011¹⁷ and the most common reasons for children to

¹⁵ CEOP (2013) Threat assessment of child sexual exploitation and abuse.

¹⁶ Cockbain, E. and Brayley, H. (2012) [Briefing document: CSE and youth offending \(PDF\)](#). London: UCL Jill Dando Institute of Security and Crime Science.

¹⁷ Berelowitz, S. et al (2012) "I thought I was the only one. The only one in the world." [The Office of the Children's Commissioner's inquiry in to child sexual exploitation in gangs and groups: interim report London](#): Office of the Children's Commissioner.

be trafficked in the UK are sexual exploitation and criminal exploitation. In 2014, 152 children were trafficked for sexual exploitation.¹⁸

Prosecutions of sexual offences against children

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

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

4. SCOPE OF SARC SERVICE

The Role of SARC Services

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

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

¹⁸ Serious Organised Crime Agency (SOCA) and UK Human Trafficking Centre (UKHTC) (2013). [A Strategic Assessment on the Nature and Scale of Human Trafficking in 2012](#)

- 4.2 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 majority of SARC services are not designed to offer long term support and so need to work closely with services within the SAS pathway such as Improving Access to Psychological Therapies (IAPT) and those provided by the Third Sector in order to improve outcomes for all victims of sexual violence and support longer-term survivor recovery.

Model of Service Provision and Key Elements

- 4.4 SARC services should provide equitable access to an individually tailored care packages based on comprehensive need assessments, with a choice of action at every stage of care, clinical and non-clinical care and support, forensic examination and referral to appropriate services. The model of service of a SARC may vary according to the demographics and level of sexual violence in an area, and the resources available within the partner agencies, however, all SARC services are expected to provide the following key elements within their service model to ensure consistency of provision for service users nationally:¹⁹
- 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) guidance²⁰).
 - 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.²¹
 - Any medical consultation should include immediate health assessment e.g. assessment of injuries, and a risk assessment for self-harm, vulnerability and sexual health. Therefore, there should be immediate access to emergency contraception, PEPSE or referral to other acute, mental health or other health services, as required
 - Where possible, allow service users a choice of gender of physician – most service users prefer to be seen by a female clinician;

¹⁹ Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

²⁰ <http://fflm.ac.uk/upload/documents/1348663369.pdf>

²¹ Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

- Address safeguarding, care and support issues for all service users;
- Ensure service users are informed about psychological therapies and independent advocacy services;
- Where there are no overriding safeguarding concerns about a third party, give service users who are competent adults the choice of whether or not to involve the police.

Service Model for Children and Young People

- 4.5 Services to meet the needs of children and young people who are raped or sexually abused must be provided in ways that take account of the differences between adults and children and young people. Children and young people who may have been sexually abused often experience more than one type of abuse and they may be from families where there are many complex needs. Sexual violence and abuse including child sexual exploitation can also cause severe and long-lasting harm to individuals across a range of health, social and economic domains. Victims may present acutely, but victims of intra-familial abuse may present many years afterwards. Sexual abuse can worsen the impact of inequalities that are often linked to domestic violence and mostly affects women and vulnerable and disadvantaged people. Long-term effects can include depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide. A higher prevalence is documented amongst children and young people who have experienced sexual assault.
- 4.6 Victims of sexual violence and assault should be considered as children and young people until their 18th birthday and services should be commissioned accordingly. However, some young people between the ages of 16-17 years may prefer to attend an adult service. In these cases children's safeguarding procedures will still apply.
- 4.7 Sexual abuse of children and young people cannot be dealt with in isolation and will need a multi-disciplinary and multi-agency coordinated approach to identify abuse, assess risk, and devise and implement child protection and aftercare plans effectively. SARC services particularly have a key role to play and need to ensure:
- There is clear information for children and young people about who to speak to, and how to access SARC services, and where to find local centres in the community, so that they do not need a family member or someone else to take them. This must be done in partnership with the Local Authority to ensure that systems are in line with local safeguarding procedures.
 - SARC services should be designed to make children and young people feel at ease. There should be good security, and they should be decorated in child and young person friendly ways, which makes the users feel safe, comfortable and welcome.
 - SARC services need to have ready access to skilled paediatric services that are available when required. This includes appropriate access to

- clinicians trained in both forensic examination and safeguarding, and on-going psychological and other relevant support.
- Specific consideration of capacity and consent must be taken into consideration for children and young people. Confidentiality and autonomy can require careful negotiation between the child or young person, family and safeguarding requirements.
- 4.8 The recommended service model for meeting the needs of the child or young person who has been sexually assaulted, raped or abused is to deliver provision through a managed clinical network. This will have the acute forensic examination and care delivered at a SARC "hub" with referral pathways in place to local paediatric services for support and follow-up care where these are needed.²²
- 4.9 The acute forensic examination should identify any forensic issues, safeguarding and provide access to emergency contraception, PEPSE, first aid or other acute mental health or sexual health services where indicated. Either during the initial presentation or at follow-up appointment, the medical consultation may identify unmet health needs or further safeguarding issues, such as a risk assessment of harm/self-harm and/or an assessment of vulnerability, safeguarding and sexual health needs. An onward referral to appropriate services may be required to address these issues.
- 4.10 This means that the service model is more than the medical examination and includes 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 Third Sector providers for practical support and resilience-building cannot be overestimated. Availability of this range of support, delivered in a seamless manner, is vital.

Geographical Location of SARC Services

- 4.11 There are currently 39 SARC services across England and many of these services are located in urban areas with high population densities and good access to public transport. Some are based in separate police-owned customised facilities whilst others are located in NHS premises, such as in hospitals, primary health care centres or premises in residential areas.
- 4.12 In some rural and semi-rural areas or for children and young people it may be inappropriate to establish a SARC service at a local level due to the very low volume of work. In these situations, regional 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 SAS provision, a SARC

²² Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

may also be networked to other services such as sexual health clinics, genito-urinary medicine centres, paediatrics, social care and victim support services.

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

Essential Areas of SARC Provision

Ensuring Access

- 4.14 Ease of access is important to encouraging use of SARC services by people who have been sexually assaulted. SARC services should integrate seamlessly within the local SAS 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 Third Sector. This is vital as many victims do not seek help or report incidents to the police.
- 4.15 SARC services and what they provide are not generally well known. Therefore, raising awareness and promoting SARC provision and ease of access to services is a priority and all local areas should ensure that there is:
- An opportunity for victims to access SARC services as self-referrals
 - Choice of whether or not to involve the police
 - Choice of gender of physician, where possible
 - High levels of victim satisfaction
 - An opportunity for the service user to agree to evidence being stored in case they decide to report to the police at a later date or to provide evidence anonymously

Addressing Physical and Mental Health Needs

- 4.16 The health needs of victims include the physical health consequences of sexual violence and rape, a risk of pregnancy in 5% of cases, acquisition of sexually transmitted infections and HIV and, for all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services. The psychological consequences are linked to profound long-term health issues with one third of rape survivors going 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.²³
- 4.17 SARC services support the service user to deal with the immediate crisis around their physical and mental health needs and should focus on providing:

²³ Securing Excellence in commissioning sexual assault services for people who experience sexual violence (13 June 2013) NHS England

- 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 Third Sector, enabling a seamless provision of care for service users and the sharing of information and good practice.
 - The development of a local centre of excellence and expertise, providing advice, training, and support to local health practitioners, police and CPS.
- 4.18 As well as meeting the immediate health needs of service users, SARC services must develop effective partnerships and have seamless access to a range of health care services, including sexual and reproductive health screening, treatment and care, HIV testing, follow-up care for service users prescribed PEPSE and access to choice of contraceptive methods including emergency contraception. Service users who have positive results for sexually transmitted infection need to be offered appropriate treatment, including assistance with partner notification in line with Society of Sexual Health Advisor's guidelines, and referred to the Genitourinary Medicine (GUM) clinic.
- 4.19 There are also health interdependencies with mental health services and it is essential that service users have a choice of care provision in on-going support and counselling. When service users' mental health needs exceed the remit of SARC provision i.e. needs are greater than Improving Access to Psychological Therapies (IAPT) level 3 support, 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.²⁴ Where such services do not exist discussions will need to be held between the relevant commissioners and partners.

Supporting the Criminal Justice System

- 4.20 SARC services can help to raise the awareness of sexual violence and abuse, and how such abuse can be dealt with by providing good ISVA services, which supports victims through the criminal justice journey to achieve better criminal justice outcomes. This in turn helps boost public confidence in the health and criminal justice systems. Therefore, it is vital that SARC services work closely with agencies in the Criminal Justice System in order to:²⁵
- Provide an ISVA service either within the SARC or externally within another service or premise.
 - Improve standards of forensic evidence.

²⁴ Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

²⁵ Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres (21 October 2009) Home Office and Department of Health

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

5. COMMISSIONING

Aims and Objectives

- 5.1 NHS England is committed to working with all NHS (e.g. CCGs), Local Authority and Criminal Justice (e.g. Police, PCCs) commissioners to secure the best possible outcome for service users within available resources. The SARC commissioning framework²⁶ summarises the key deliverables that all stakeholders and partners including NHS England should deliver across the SAS care pathway. While acknowledging the limitations that local commissioning arrangements may create in some areas, NHS England aims to ensure that providers of SARC services achieve the following:
- A high quality service to service users 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 long-term support from Third Sector SAS providing advocacy, counselling and support.
 - Ensuring the supply of competent forensic examiners in SARC services, including paediatric forensic medical examiners.
 - Ensuring appropriate clinical governance systems and process are in place in SARC services.
 - Ensuring that the service users' experience and satisfaction with access, healthcare, ancillary forensic medical examination and follow-up aftercare, are monitored, examined and used to improve the service provision within SARC services.

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

- Ensuring that appropriate safeguarding processes and systems are in place, including links with Local Safeguarding Boards, to meet the needs of sexually-assaulted children, young people and vulnerable adults.
- Supporting and facilitating decisions to prosecute in cases of rape and sexual assault through improved forensic medical provision for children, young people and adults, and ISVA support.
- Ensuring equity of access in SARCs across England in line with the requirements of the Public Sector Equality Duty of the Equality Act (2010).

NHS England Commissioning Model

- 5.2 NHS England's four regional teams (London, Midlands and East, North and South) cover healthcare commissioning and delivery across their areas. The funding that NHS England receives for SARC services through the Public Health Reference is directed to the regional teams, who enter into local agreements with relevant partners e.g. police, LAs, 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.
- 5.3 **SARC Partnership Boards** are 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.

Collaborative Commissioning and Partnership Working across the SAS Care Pathway

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

5.5 Effective partnership working can provide an integrated, simplified pathway of high quality services tailored to the needs of each individual. It is essential to get the best outcomes for victims and their families. Partners will include:²⁷

- 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
- Third Sector Organisations
- Sexual Health Services
- Social Care Agencies
- Other stakeholders including MoJ and Home Office who provide grant support to SARCs and Third Sector therapeutic support.

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

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

5.7 There are a complex set of interdependencies within the SAS care pathway. Commissioners will need to have a good understanding of the agencies and interdependencies within their local SAS care pathway, as this may vary from area to area. 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

²⁷ Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

below are the key commissioning partners and the agencies and services in the SAS care pathway, and their roles and responsibilities.

- **Police and Crime Commissioners (PCCs)**

- 5.8 PCCs have a responsibility for commissioning local victims services for victims of crime, including those provided by the Third Sector, in line with the legal entitlements in the Victims Code of Practice 2013 and EU Directive on the Rights, Support and Protection of Victims of Crime effective from November 2015 2012/29/EU on Victims Services.^{28 29} These services help victims to cope with, and recover from the impacts of crime.³⁰ Support services should be provided even if the victim has not reported to the Police.

- **Clinical Commissioning Groups (CCG)**

- 5.9 Victims of rape and serious sexual assault require therapeutic support to aid their recovery. Whilst NHS England commissioners fund initial support for victims attending SARC services, some victims will require longer-term on-going support. This is a CCG commissioning responsibility and CCGs may commission Third Sector services to provide these services. NHS England and CCGs need to work closely together to ensure the integration of provision within the SAS care pathways for victims of sexual violence and abuse, and to avoid the duplication of service provision in a local area. CCGs, therefore, have a duty to engage with NHS England commissioners to commission the referral pathway for victims that need longer term therapeutic care.
- 5.10 In relation to children and young people, CCGs have a statutory duty (Crime and Disorder Act 1998) to co-operate in the provision of multi-agency Youth Offending Teams. CCGs, as members of Community Safety Partnerships are responsible for identifying and sharing information on violence as part of their contribution to a strategic assessment of crime and disorder, anti-social behaviour, and drug and alcohol misuse.³¹ CCGs are also responsible for commissioning children's healthcare treatment services for mental health, including CAMHS and other psychological and therapeutic services.³² National guidance on Local Transformation Plans³³ states that what is included in local plans should be decided at a local level in collaboration with key partners, but plans should:

²⁸ 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.

²⁹ The funding of refuge spaces remains the responsibility of local authorities as a victim's refuge place is funded through housing support.

³⁰ <https://consult.justice.gov.uk/digitalcommunications/victims-witnesses>

³¹ 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)

³² 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)

³³ Local Transformational Plans for Children and Young People's Mental Health and Wellbeing Guidance and support for local areas (03.08.2015) NHS England

“describe the working arrangements with collaborative commissioning oversight groups in place between NHS England specialised commissioning teams and CCGs and with NHS England Health and Justice teams who have direct commissioning responsibility for the Children and Young People’s Secure Estate. This includes transition to and from secure settings to the community for children placed on both youth justice and welfare ground; robust care pathways from Liaison and Diversion schemes and from Sexual Assault Referral Centres.”

- **Local Authorities (LAs)**

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

- **Public Health:**

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

5.13 LAs commission open access sexual health clinics, GUM clinics and other services used by victims of rape and sexual abuse. It is vital that LAs work closely with NHS England to integrate provision within the SAS care pathways so that victims receive improved care and on-going support. LAs and NHS England need to make use of opportunities for integration when they arise, for example, where SARCs, sexual health and/or GUM clinics are co-located. Good practice published by the Local Government Association shows that effective LAs are fully engaged in their local SARC programmes and consider them as necessary to evidence their wider requirements to develop efficient sexual health services.³⁴

- **Local Safeguarding Children Boards**

5.14 A Local Safeguarding Children Board (LSCB) has been established in every local authority area under the requirements of the Children Act 2004. Under the statutory guidance³⁵, all children who are victims of sexual abuse should be assessed and safeguarded. The needs of the children are paramount and it is the responsibility of every LSCB to ensure the effectiveness of child safeguarding procedures and system and to promote the welfare of children in the local area including child sexual exploitation (CSE).

- **Local Safeguarding Adults Boards**

³⁴ Making it work A guide to whole system commissioning for sexual health, reproductive health and HIV (September 2014 (revised March 2015)) Public Health England

³⁵ Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government

- 5.15 Safeguarding adults is a multiagency responsibility. The Care Act 2014 sets out a legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect³⁶, 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.³⁷

- **Third Sector Specialist Sexual Violence Services**

- ***Independent Sexual Violence Advisors (ISVAs)***

- 5.16 ISVAs are part of the SARC service provision, however, not all ISVAs are co-located within SARC services. This is a choice and decision for local commissioners. The Home Office part-funded 87 ISVAs to work with victims of recent and non-recent serious sexual crimes to give them the help that they needed. The support provided by an ISVA will vary from case to case, depending on the needs of the victim and their particular circumstances. The main role of an ISVA includes making sure that victims of sexual abuse have the best advice on what counselling and other services are available to them, the process involved in reporting a crime to the police and journeying through the criminal justice process, should they choose to do so.
- 5.17 The Home Office provided funding to support sexual violence services to young people (under 18 year olds) through the establishment of Young Persons Advocates. Supporting younger victims is an important part of the ISVA role and a number of ISVAs specialise in supporting children and young people.

- ***Rape Support Services***

- 5.18 The Ministry of Justice (MoJ) directly funds and commissions local rape support services. Rape Support Centres are primarily provided by the Third sector e.g. Rape Crisis and the Survivors Trust, and provide crucial crisis and long-term specialised support, counselling and independent advocacy for women and girls, and in some cases men and boys, who have experienced any form of sexual abuse at any time in their lives, whether recently or in the past. These organisations will often provide services for people that do not wish to approach SARC services or desire a criminal justice outcome.
- 5.19 MoJ has worked with the Third Sector to develop 15 new rape support centres in areas that lack this provision and there are now 86 Rape Support

³⁶ <http://www.scie.org.uk/care-act-2014/safeguarding-adults/>

³⁷ The governance of adult safeguarding: findings from research into Safeguarding Adults Boards (September 2011) Social Care Institute for Excellence (SCIE)

Centres across England and Wales that are funded to provide direct services for women and teenage girls until April 2016. There are 12 Rape Support Centres across England and Wales that are funded to provide direct services for men and teenage boys until April 2016 and a MoJ funded online and helpline support for men who prefer to access indirect support via these services.

Health and Wellbeing Boards

- 5.20 Health and Wellbeing Boards (HWBs) are responsible for linking the NHS, public health and social care with a wide range of partners. HWBs provide the platform for ensuring commissioned services meet the needs of their local populations. For example, the HWB's decision on whether to prioritise child sexual exploitation should be an informed one, based on local understanding of the issue.³⁸

Information Sharing

- 5.21 Following the *“chronic failures to protect children from sexual exploitation in Rotherham”*³⁹, the Government have focused on improving a number of key areas, including information sharing. The Secretaries of State from DH, Home Office, DCLG and MoJ, have come together to produce a letter⁴⁰ on the importance of information sharing, which states:

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

- 5.22 Therefore, it is vital that SARC services work with their partners to standardise and improve information sharing in order to meet the needs and best interests of service users. Information sharing agreements should be established between SARC services and their partners in order to ensure that service users receive appropriate and co-ordinated support in the service and on-going care and support.
- 5.23 The statutory guidance in *Working Together to Safeguard Children*⁴¹ supports the effective sharing of information to improve identification, assessment and service provision.

³⁸ 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)

³⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408843/info_sharing_letter5.pdf

⁴⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408843/info_sharing_letter5.pdf

⁴¹ Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) HM Government

6. APPLICABLE SERVICE STANDARDS FOR SARC SERVICES

Introduction

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

National Standards and Requirements

- 6.2 All SARC services must actively pursue compliance with national healthcare standards, including clinical governance and risk management, such as:
- **The NHS Outcomes Framework 2015/16⁴²** - has set five domains that the NHS should be aiming to improve. Domain 5 covers *treating and caring for people in a safe environment and protecting them from avoidable harm*.
 - **The Public Health Outcomes Framework for England, 2013-2016⁴³** - overarching aims are to increase healthy life expectancy and reduce differences in life expectancy and healthy life expectancy between communities. The indicators presents an opportunity for health and criminal justice partners to work together more effectively. Partner agencies should work together to develop outcomes aligned to local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWBSs).
 - **Recommendations for the Collection of Forensic Specimens from Complainants and Suspects' published by FFLM** - these are reviewed and updated every 6 months (January & July).
 - **Forensic and legal medicine guidelines and standards** - including those produced by the FFLM, RCPC, BASHH and FSRH guidelines and standards on sexual and reproductive health service provision.
 - **National Service Framework for Children, Young People, and Maternity Services⁴⁴** - this document set out 11 standards to improve the health and lives of children and young people, including Standards 4

⁴² The NHS Outcomes Framework 2015/16 (December 2014) Department of Health

⁴³ Improving outcomes and supporting transparency part 1: A public health outcomes framework for England, 2013–2016. (2012) Department of Health

⁴⁴ National Service Framework for Children, Young People and Maternity Service Core Standards (4 October 2004) Department of Health and Department for Education and Skills

(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.

Quality Assurance Standards

6.3 All SARC services need to work toward compliance with the quality assurance standards set out below and be compliant with NHS Clinical Governance. SARC providers must deliver a service that meets the standards set out by the 2012 FFLM operational procedures and equipment for medical facilities in SARC services:⁴⁵

- Twenty-four hours access to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure and age appropriate venue.
- Appropriately trained crisis workers to provide immediate support to the service user and significant others, where relevant.
- Choice of gender of physician, where possible.
- Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offence examinations for adults and children.
- Dedicated forensically approved premises (preferably for sole use).
- Decontamination protocols in place to ensure high quality forensic integrity and a robust chain of evidence in keeping with FFLM guidelines.
- The medical consultation includes an immediate health assessment including assessment of injuries and a risk assessment for self-harm, vulnerability and sexual health, and immediate access to emergency contraception, PEPSE, mental health and other health services and follow-up support, as required.
- Access or referral to support, advocacy and follow-up through a counselling service, including support through the criminal justice process (should the service user choose that route). There should be an offer of counselling from specialists trained in pre-court age appropriate counselling, if necessary.
- Well-co-ordinated interagency arrangements will be in place, involving local Third Sector services supporting victims and survivors, LSCBs, Safeguarding Boards for Vulnerable Adults, and Health and Wellbeing Boards.
- The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive.

Quality Assurance for Young People and Children

⁴⁵ <http://fflm.ac.uk/upload/documents/1348663369.pdf>

6.4 A SARC that provides services to young people and children should be delivered in locations that are safe, fit for purpose and have the necessary facilities to meet the child and young persons' needs. The FFLM and RCPCH recognise that there are likely to be variations in commissioning at a local level resulting in variations in service delivery and the ability to measure and compare outcomes across the country, and have outlined and updated their quality standards.⁴⁶ The FFLM and RCPCH have highlighted good practices, specifically that:

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

⁴⁶ 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

7. PERFORMANCE MANAGEMENT AND ACTIVITY REPORTING

7.1 NHS England have developed a commissioning assurance process, including appropriate performance and quality monitoring mechanism that covers the paediatric element of services and the therapeutic care of victims, and demonstrates the collaborative commissioning approach/agreements used for local SAS commissioning.⁴⁷

7.2 SARC providers must provide activity reports in line with the SARCs management information template, *Sexual Assault Referral Centres Indicators of Performance (SARCIP)*, at least quarterly to inform national commissioning assurance and any regional, sub regional assurance. The full set of SARCIP can be found in NHS England's commissioning framework.⁴⁸ In summary, SARC providers will be required to demonstrate to commissioners:

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

⁴⁷ Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

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

8. EQUALITY AND DIVERSITY

- 8.1 The Equality Act 2006 created a general duty on public authorities, when carrying out all their functions, to have due regard to the need to eliminate unlawful discrimination and harassment on the grounds of sex, and to promote equality of opportunity between women and men. The Equality Act 2010 replaced the 2006 Act and created a new 'public sector equality duty' covering all forms of discrimination, and which requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
- 8.2 It is a statutory requirement under the Equality Act 2010 and the NHS and Social Care Act 2008 that public sector agencies make 'reasonable adjustments' to their practice that will make them as accessible and effective for individuals under the nine protected characteristics.⁴⁹ This includes making adjustments such as removing physical barriers to accessing health services, supporting access to specialist provision such as learning disabilities services, and also making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for all parts of society.
- 8.3 SARC services specifically have a responsibility to assure the effective implementation of this Act as women and girls are the major group of sexually assaulted people.⁵⁰ There is also a significant cohort of boys who may be at risk of child sexual abuse.
- 8.4 Commissioners will need to work with providers to market the service to increase awareness. Therefore, the numbers of individuals reporting sexual assault may increase over time by ongoing awareness campaigns to promote accessibility of the service. In order to monitor the effectiveness of this process, SARC providers will keep information on ethnicity and diversity, which they will analyse quarterly to monitor access by hard to reach and vulnerable groups. This process is in line with performance management and activity reporting through SARCIP.

⁴⁹ The nine protected characteristics are Age; Disability; Gender Reassignment; Marriage and Civil Partnership; Pregnancy and Maternity; Race; Religion and Belief; Sex; Sexual Orientation).

⁵⁰ The British Crime Survey 2010/11. <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/>

9. SERVICE USER ENGAGEMENT

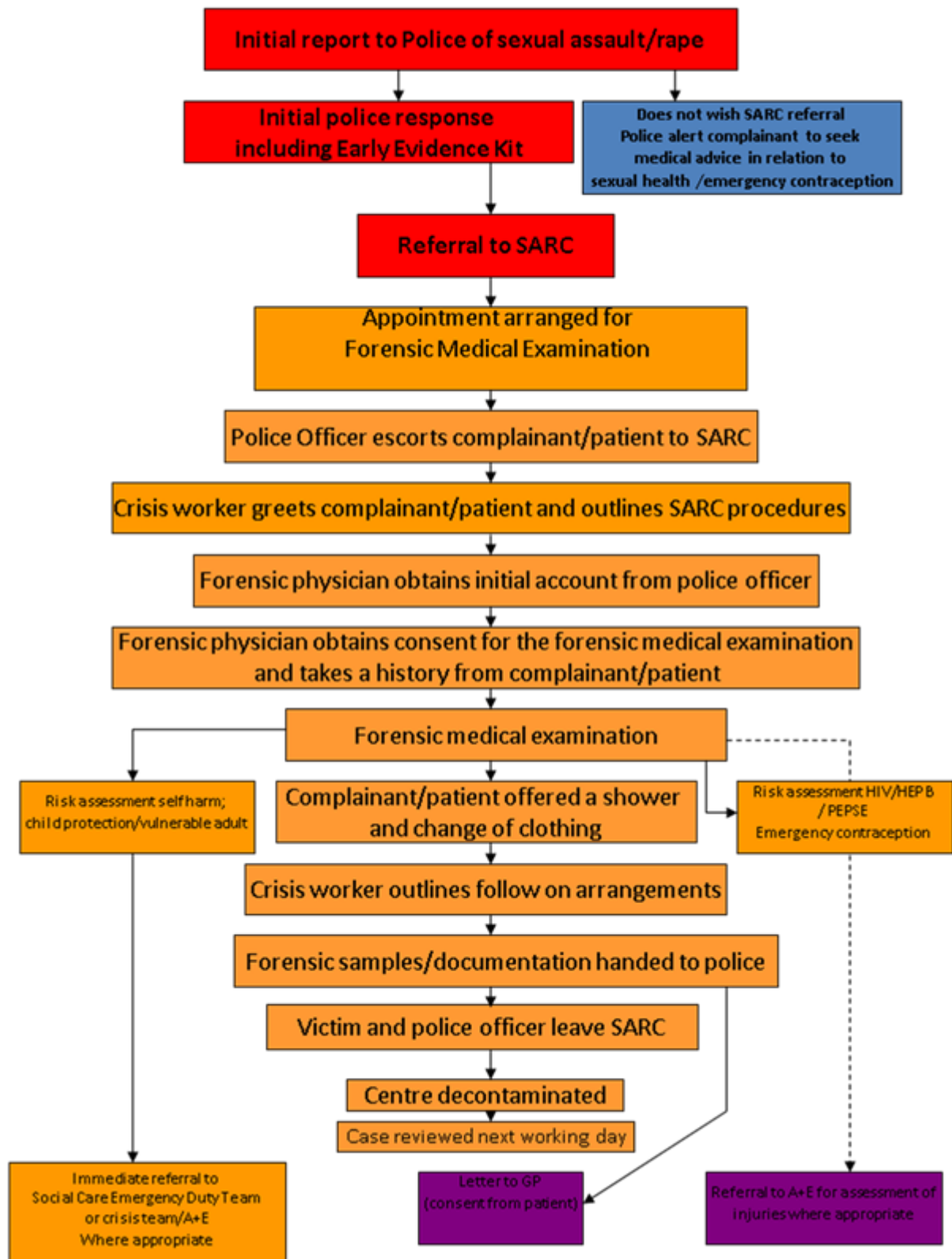
- 9.1 In upholding the NHS Constitution, NHS England is committed to ensuring that service users are at the centre of every decision that NHS England makes. NHS England, through the geographical teams will ensure that this is demonstrated in the way care is provided and monitored through the formal contracting process with providers.
- 9.2 All providers are expected to demonstrate real and effective service user participation. It is essential that all providers of public health s.7A services demonstrate the principles of transparency and participation, and offer their service users the right information at the right time to support informed decision making about their treatment and care.
- 9.3 Providers of public health s.7A services should look to provide appropriate and accessible means for service users to be able to express their views about, and their experiences of services, making best use of the latest available technology and social media as well as conventional methods.
- 9.4 As well as capturing service users experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

APPENDIX 1: ADULT CARE PATHWAYS

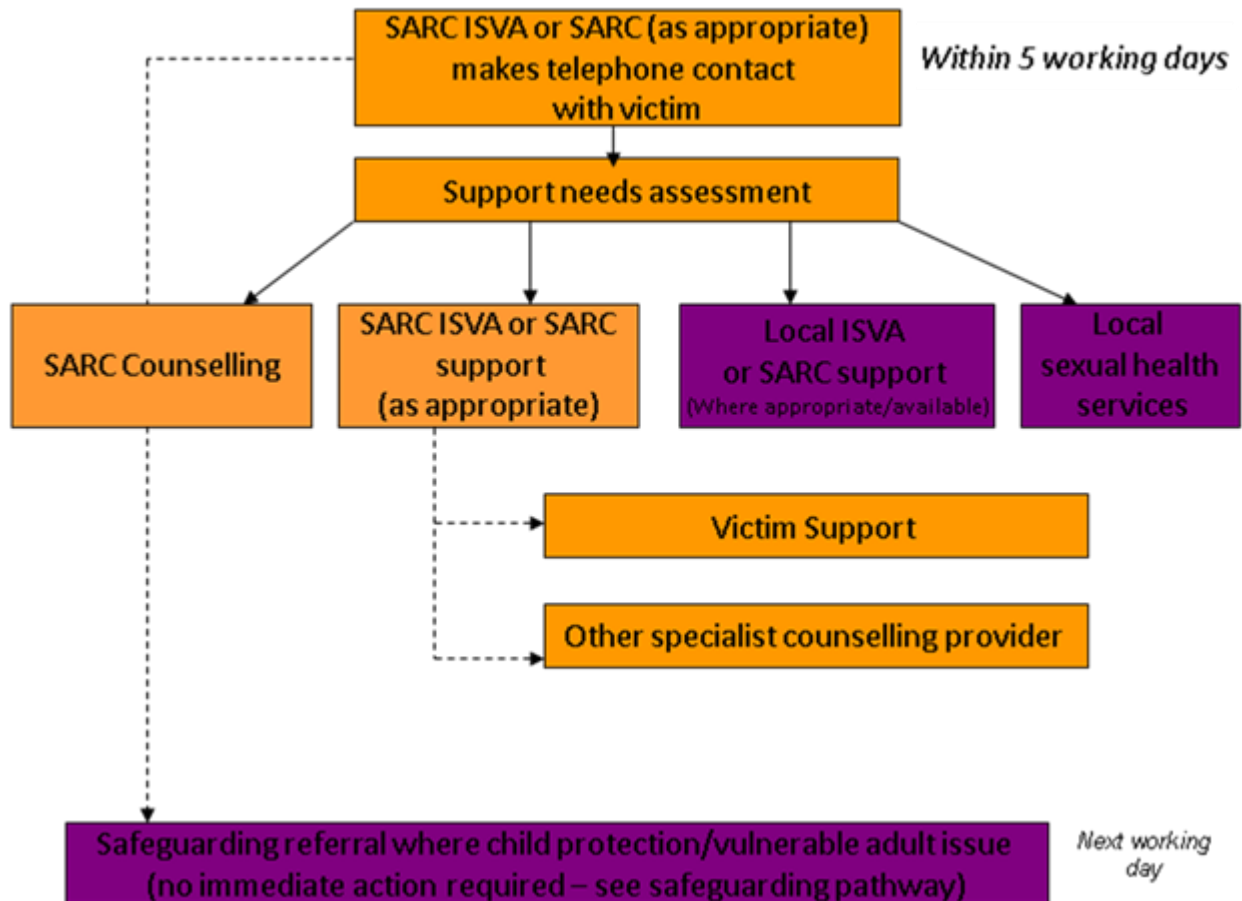
*These are from National Framework Specification and the Service improvement will develop pathways in 2013-14

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

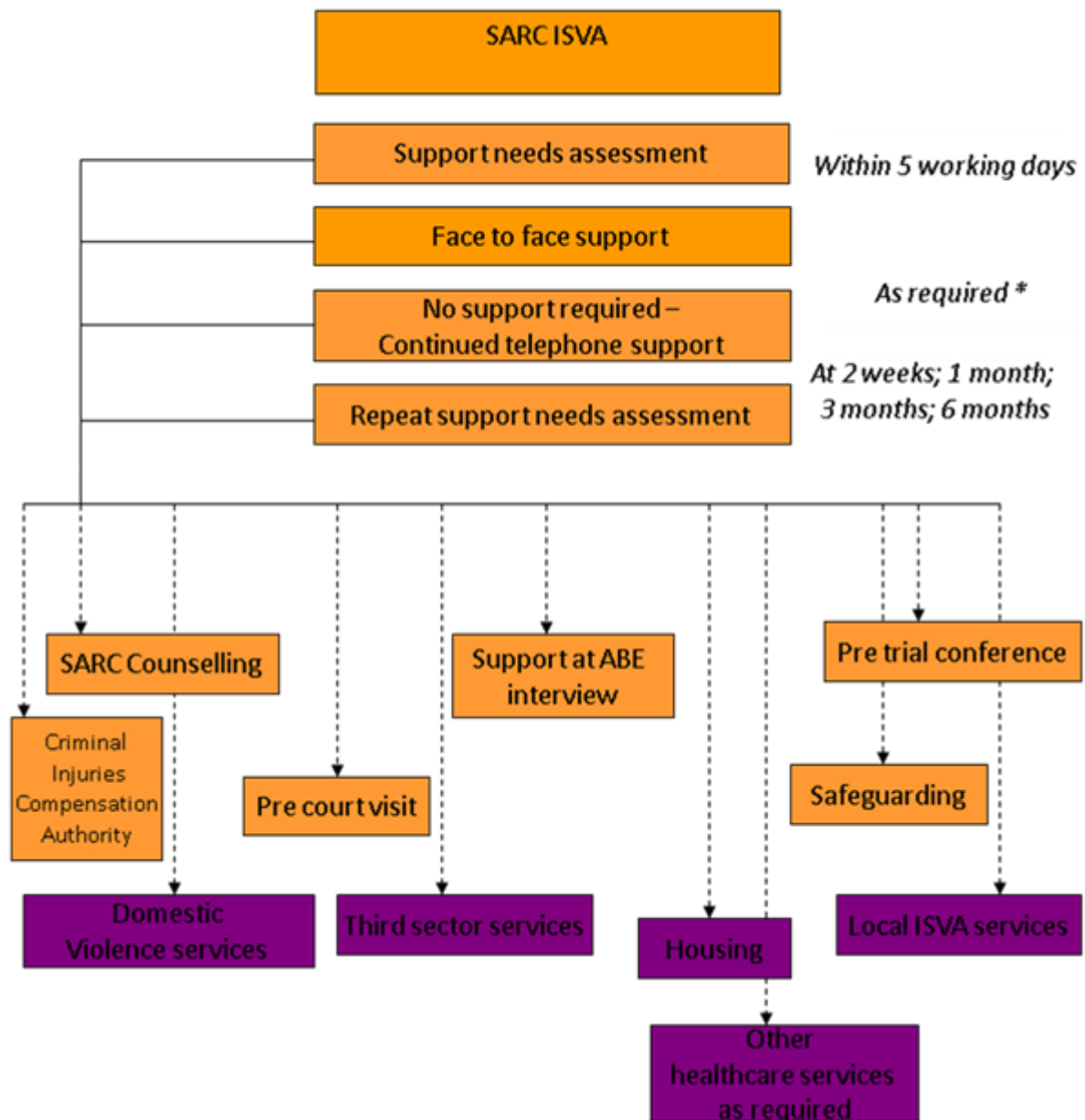
SARC Adult Care Pathway (police case): Initial attendance at SARC



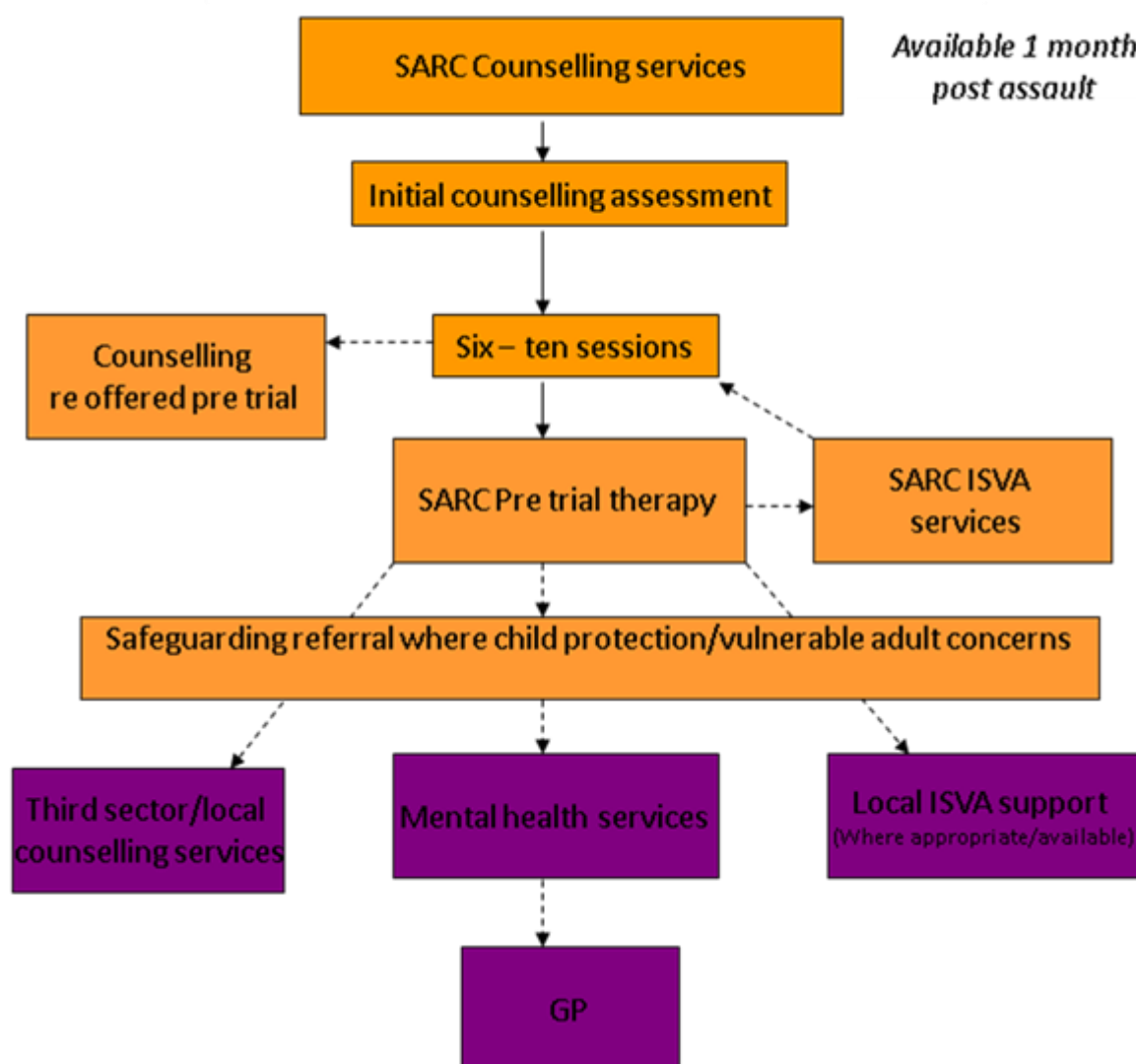
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)



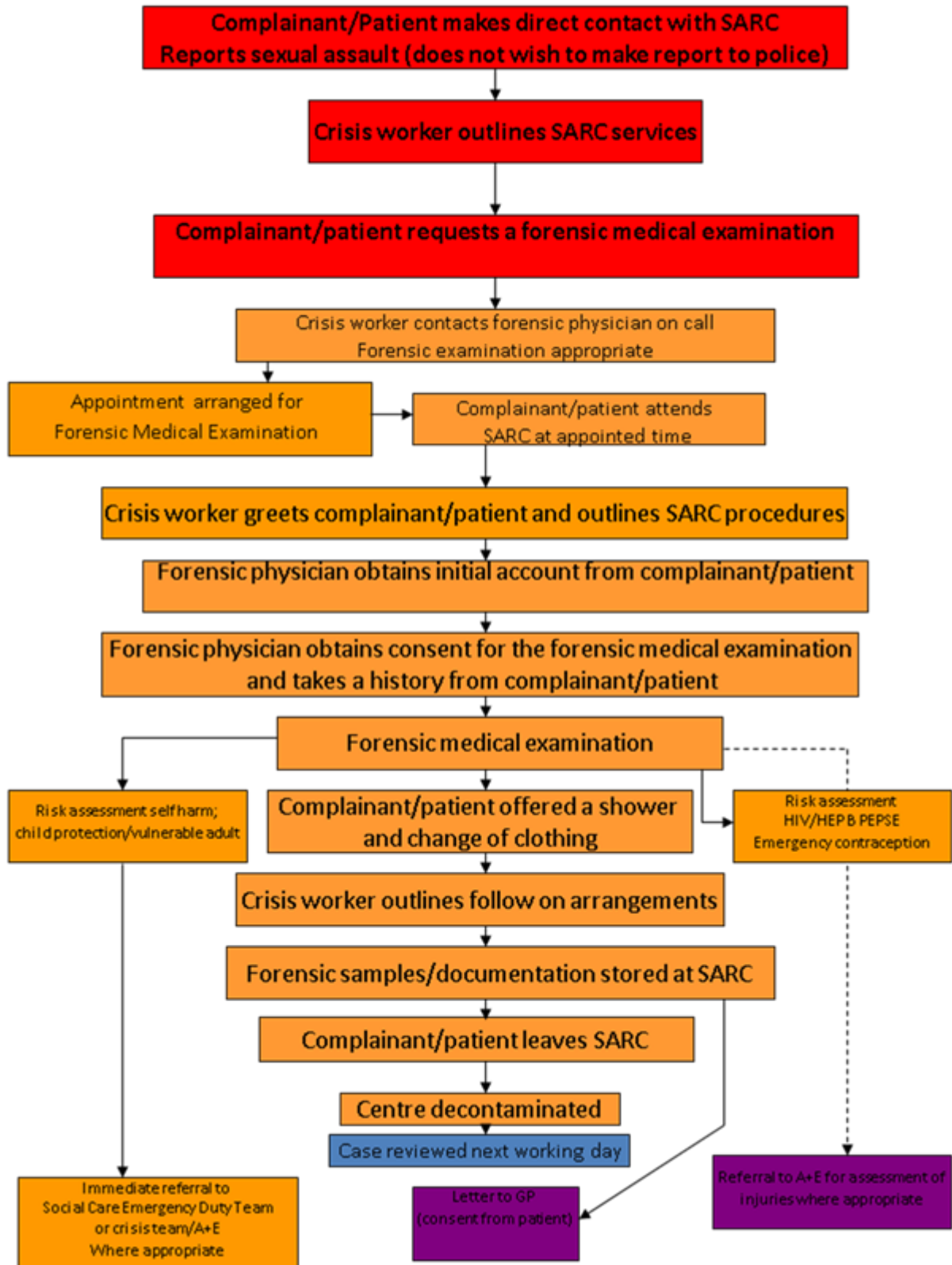
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate range of support services)



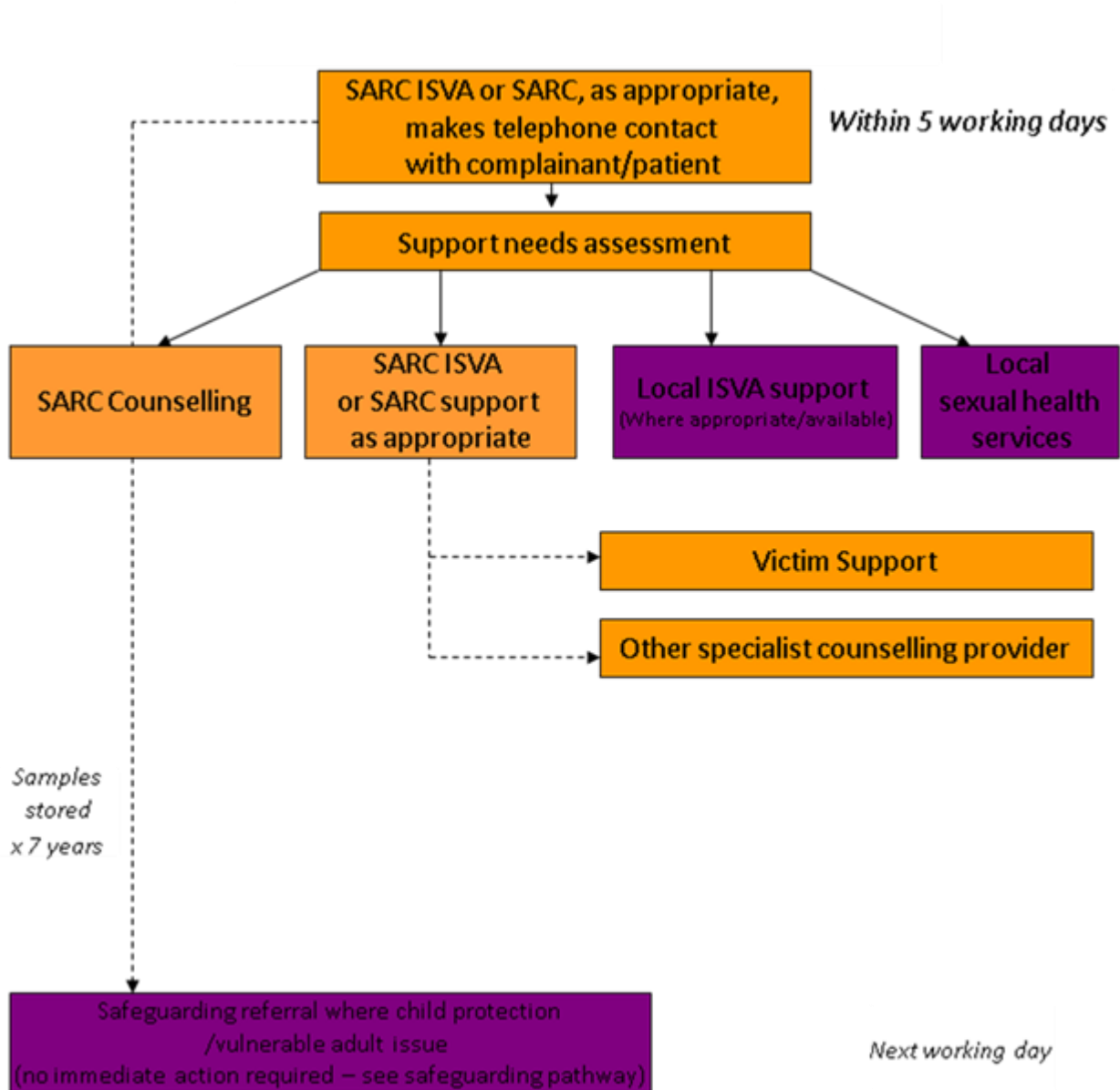
SARC Follow-up Adult Care Pathway (police case): Counselling services



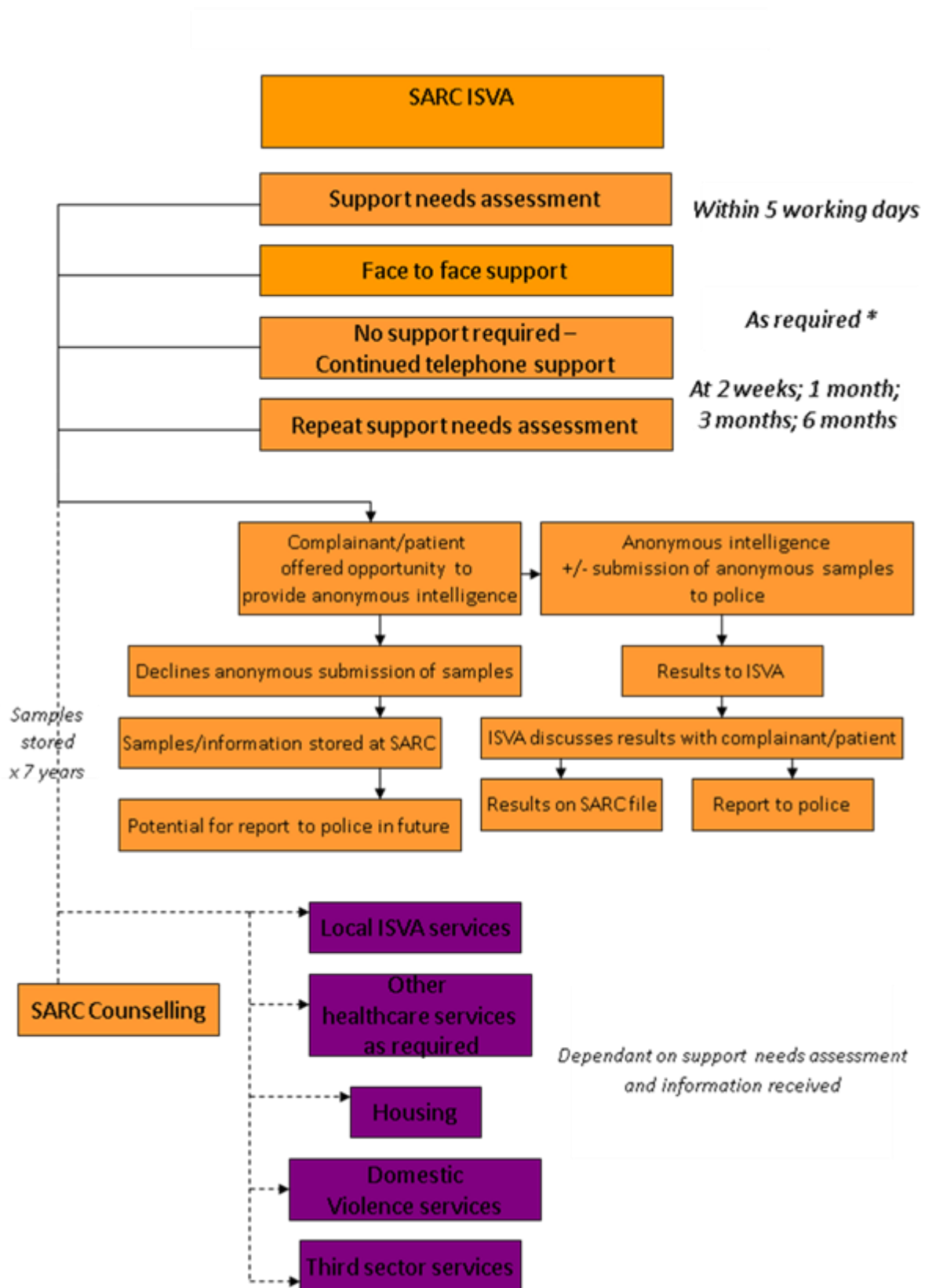
SARC Adult Care Pathway (self-referral): Initial attendance at SARC



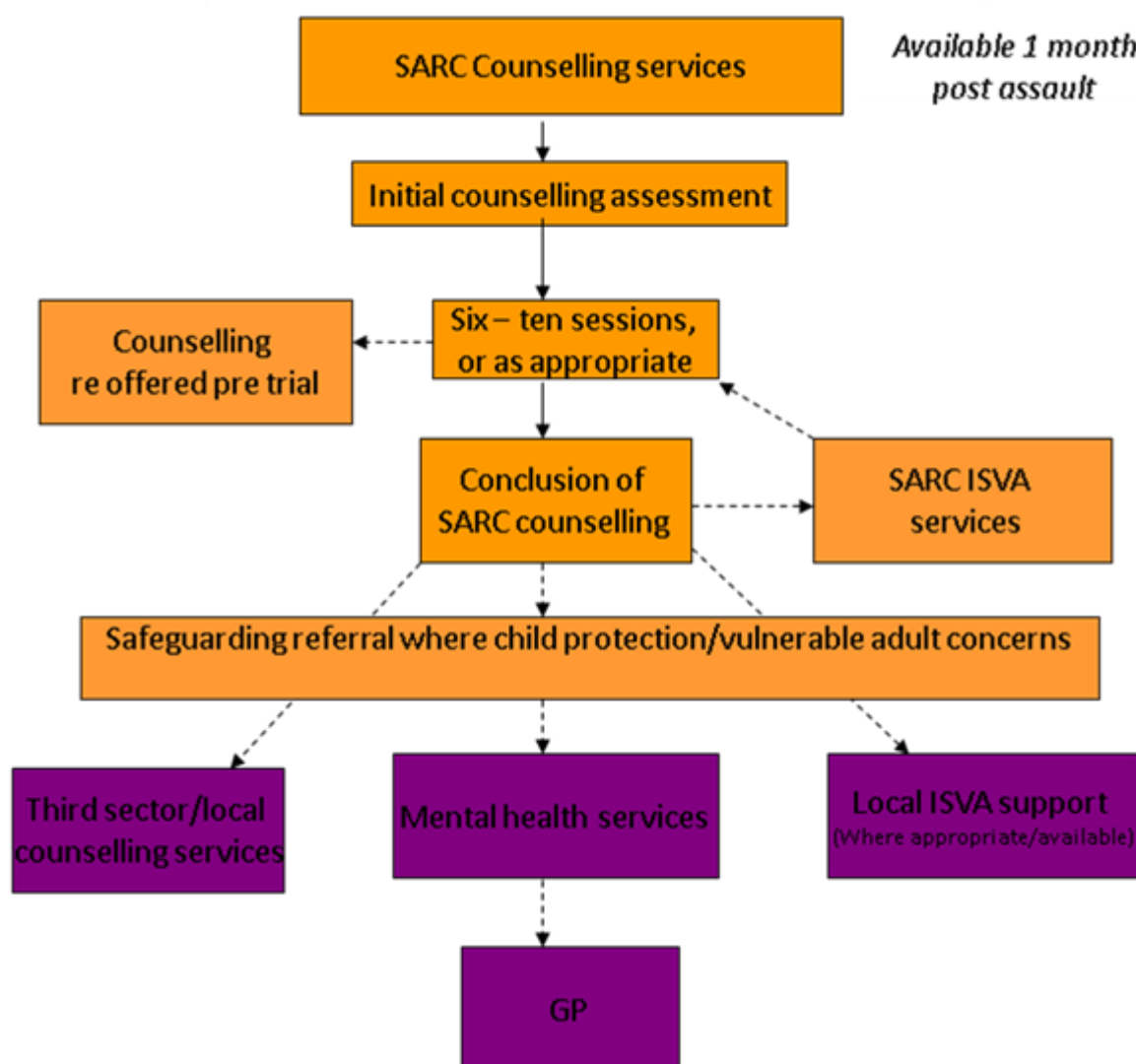
SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)



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



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

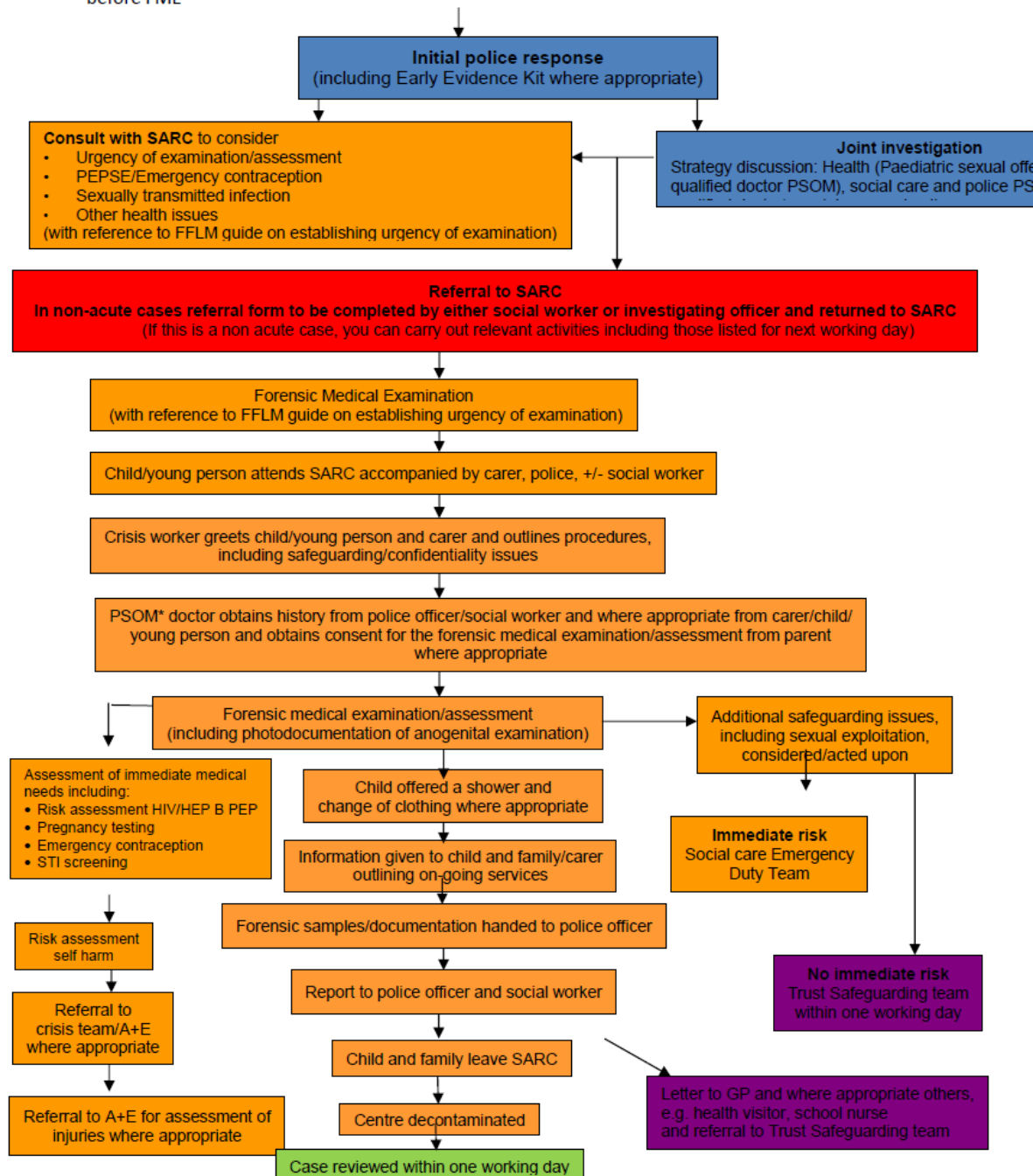


APPENDIX 2: CHILDREN AND YOUNG PEOPLES' CARE PATHWAY

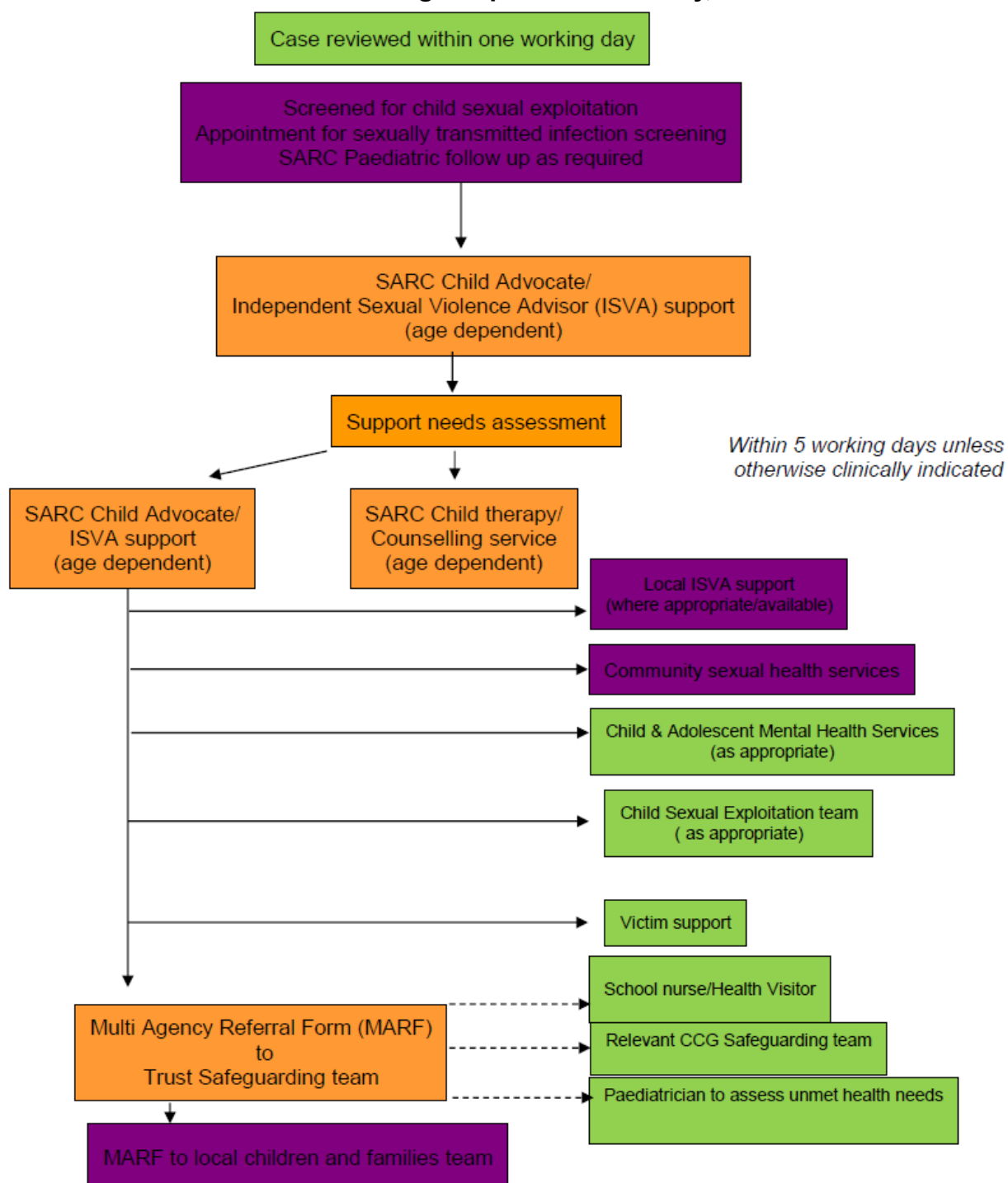
Note: self-referrals are also included as an entry point

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

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



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