



Department  
of Health

**NHS**  
*England*

# Public health functions to be exercised by NHS England

Service specification No.30

Sexual assault services

November 2013

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# Public health functions to be exercised by NHS England

Service specification No.30

Sexual assault services

Prepared by –

**Violence and Social Exclusion Team, Department of Health**

# Contents

Service specification No.30 .....	6
1. Purpose of service.....	7
National/local context and evidence base.....	7
The Need for Specialist Sexual Assault Services.....	10
Service Models .....	10
Service Data.....	11
2. Scope of service .....	12
Aims and objectives of service.....	12
Service description and use .....	13
Care Pathway.....	14
Population covered .....	16
Any acceptance and exclusion criteria.....	16
Interdependencies with other services .....	16
3. Applicable service standards.....	18
Applicable national standards eg NICE, Royal College .....	18
Applicable local standards .....	19
Applicable international standards .....	19
4. Key service outcomes.....	20
5. Location of provider premises .....	21
6. Commissioning.....	22
Commissioning Models.....	22
Issues for Commissioners.....	23
Commissioning Specifications for Contracting.....	24
Appendix 1: Example Adult Pathways.....	25
SARC Adult Care Pathway (police case): Initial attendance at SARC .....	26
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate) ...	27
.....	27
SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate) - range of support services.....	28
.....	28
SARC Follow-up Adult Care Pathway (police case): Counselling services.....	29
.....	29

SARC Adult Care Pathway (self-referral): Initial attendance at.....	30
SARC .....	30
SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)...	31
.....	31
SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA .....	32
or SARC (as appropriate)- range of support services .....	32
.....	32
SARC Follow-up Adult Care Pathway (self-referral): Counselling services .....	33
.....	33
Appendix 2: Example Child and Young People Pathways.....	34
SARC Child Care Pathway (joint investigation): Initial attendance at SARC.....	35
SARC Follow-up Child Care Pathway (joint police/social investigation): SARC Child Advocate or SARC (as appropriate).....	36
.....	36
SARC Children and Young People Acute* Care Pathway (police case): Initial attendance at SARC .....	37
SARC Follow-up Children and Young People Acute* Care Pathway: SARC ISVA/Child Advocate/SARC (as appropriate).....	38
∴	
References .....	39

# Service specification No.30

This is a service specification within Part C of the agreement 'Public health functions to be exercised by NHS England' dated November 2013 (the '2014-15 agreement').

The 2014-15 agreement is made between the Secretary of State for Health and NHS England under section 7A of the National Health Service Act 2006 ('the 2006 Act') as amended by the Health and Social Care Act 2012.

This service specification is to be applied by NHS England in accordance with the 2014-15 agreement. An update to this service specification may take effect as a variation made under section 7A of the 2006 Act. Guidance agreed under paragraph A38 of the 2014-15 agreement may inform the application of the provisions of this service specification.

This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

The 2014-15 agreement including all service specifications within Part C is available at [www.gov.uk](http://www.gov.uk) (search for 'commissioning public health').

# 1. Purpose of service

## National/local context and evidence base

- 1.1. Acts of sexual assault are crimes that are governed by the Sexual Offences Act 2003 (England and Wales). A distinction is made between sexual assault and serious sexual assault. A “rape” or serious sexual assault occurs when someone ‘intentionally penetrates the vagina, anus or mouth of another person with his penis’,<sup>1</sup> that the other person does not consent to the penetration, and the perpetrator ‘does not reasonably believe that the other person consents’. There is also a separate offence of assault by penetration when someone ‘intentionally penetrates the vagina or anus of another person with a part of his body or anything else’. Sexual assault is non-consensual sexual touching where the perpetrator has no reasonable belief that the victim is consenting. Sexual activity with a child under 16 is an offence, including non-contact activities such as involving children in watching sexual activities or in looking at sexual online images or taking part in their production, or encouraging children to behave in sexually inappropriate ways.
- 1.2. Sexual violence is predominantly a crime against women, children and vulnerable adults which may be contextualized in gender, equality and inequalities policies. The obligation to provide accessible and integrated services to victims of sexual violence is affirmed in Articles 24 and 25 of the Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence (CAHVIO). The UK Government became a signatory of the Convention in June 2012<sup>2</sup> and is already obliged to observe other international obligations to take actions to mitigate violence against women and children, including the United Nations Conventions on the Rights of the Child (UNCRC)<sup>3</sup> and on the Elimination of all Forms of Discrimination against Women (CEDAW).<sup>4</sup> These are also reflected in the Government’s strategy, Call to end Violence against Women and Girls.<sup>5</sup>
- 1.3. In this service specification, sexual assault, sexual offence, sexual violence and sexual abuse are used interchangeably and not necessarily in their technical or legal definitions. Sexual assault referral centres (SARCs), many still based on police referrals, describe the current service model in England and actual local facilities; but the term sexual assault services is used to describe existing services generically and in reflection of the direction of travel towards more open access, self-referral services (see paragraphs 1.10 and 6.7).
- 1.4. The annual incidence of sexual violence reported to the Police at just under 55,000 lies between that for strokes (60,000) and coronary heart disease (46,000) in women in the UK.<sup>6</sup> However, sexual violence is under-reported as a crime. Only 11% of victims of serious sexual assault told police about the incident<sup>7</sup> and few reveal the experience of prior sexual assault when using healthcare facilities. In 22.9% of cases where a young



person aged 11-17 was physically hurt by a parent or guardian, nobody else knew about it. The same applied in 34% of cases of sexual assault by an adult and 82.7% of cases of sexual assault by a peer.<sup>8</sup> The same research report by the National Society for the Prevention of Cruelty to Children in 2011 found declining rates of sexual abuse in children under 16 years old (5% in 2009). However, the health consequences for sexually abused children and young people can be quite devastating:<sup>9</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.

1.5. The relatively high prevalence of sexual violence in young women is worse for those with pre-existing vulnerabilities and for some, may be associated with several other life risks. Emerging and unpublished analysis from the Youth Justice Liaison and Diversion pathfinder scheme data set suggests that young women in gangs have some of the highest health and social vulnerabilities including sexual assault (x11) compared to the broader group (x2). The analysis is currently being tested for statistical significance but at the moment, 18.9% of girls in gangs experienced sexual assault compared to 6.1% reported by their non-gang counterparts. 24% of girls in gangs were taking part in sexually harmful and exploitative activity compared to 5% of their peers who were not in gangs. Although not correlated with sexual violence, 21% of the cohort were currently looked after children, a quarter had been looked after and a quarter were on current child protection plans.

1.6. Thus, sexual violence may have life-long psychosocial consequences, which may affect personal economic ability. More broadly, sexual violence can worsen the impact of inequalities in women, the vulnerable and the disadvantaged, and is often linked to domestic violence. The long-term effects of sexual violence are associated with depression, anxiety, post-traumatic stress disorder, psychosis, drug and substance misuse, self-harm and suicide and have a higher prevalence reported amongst young people. Research increasingly links the post-traumatic stress following sexual violence with mental illness and there is an association between child sexual abuse that is validated at the time, and a subsequent increase in rates of childhood and adult mental ill health.<sup>10</sup> There is also evidence suggesting that 40-60% of people receiving mental health services self-report a prior history of childhood sexual or physical abuse or both.<sup>9</sup> Mental health assessment is key to discovery of previous sexual assault and along with

the response, is therefore critical in aiding the pathway to recovery. A recent analysis of the Adult Psychiatric Morbidity Service reported as follows:<sup>11</sup>

*“One of the groups, representing 1 in 25 of the population (around 1.5 million adults) had experienced extensive forms of both physical and sexual violence, with an abuse history extending back to childhood. Nearly everyone in this group had, at some point in their life, been pinned down, kicked or hit by a partner. Half had been threatened with death. Most had been sexually abused as a child and some severely beaten by a parent or carer. Many had also been raped as an adult. Over half the members of this group had a common mental disorder such as clinical depression or anxiety. However, only 10% were in receipt of counselling or a talking therapy.”*

1.7. Over the past few years, the Association of Chief Police Officers and HM Inspectorate of Constabulary have promoted services to victims and better recording of police-recorded crime and there are improvements in the latter though variable. Although it is not possible to provide separate figures for England and Wales, latest figures from the 2010-11 British Crime Survey(BCS) and Police Recorded Crime statistics show for England and Wales show:<sup>7</sup>:

- *A 1% increase in the number of Police-recorded sexual offences to 54,982 recorded by the Police; a smaller rise than the previous year but following a longer-term decline in sexual offences recorded since 2005-06.*
- *Police figures show a 4% increase to 45,326 in serious sexual “offences” (rape, sexual assault and child sexual abuse) and a 12% decrease in other sexual offences (such as unlawful sexual activity and exploitation of prostitution and soliciting). This latter figure is particularly sensitive to changes in local police activity rather than changes in reporting by victims. However, BCS estimate no change in the overall prevalence of sexual assault between 2009-10 and 2010-11.*
- *Most reported rapes (serious sexual assault and child sexual abuse) are in women and children. Female reported rapes increased by 5% to 14,624 (of which 76% were in young people under 16 years old).*
- *Male rapes increased by 12% to 1,310 (35% in young people under 16 years old) and sexual assaults on a male increased by 7% to 2,412.*
- 1 in 40 (2.5%) women aged 16-59 and 1 in 200 (0.5%) men had experienced a sexual assault (including attempts) in the last year.
- The 2008/9 British Crime Survey self-completed questionnaire indicates that around 10,000 women are sexually assaulted and 2,000 women are raped each week.
- It is estimated that about half of women (40% - 50%) who have experienced domestic violence are raped within their physically abusive relationship.<sup>12</sup>

NB: For the figures above BCS survey analysis is in straight font and police recorded analysis is in italics

- Unpublished data from Her Majesty's Inspectorate of the Constabulary in June 2012, documents declining rates in the detection of all male and female rapes from 29% in 2008/9, to 24% in 2010/11. There are multiple factors that contribute to this in the criminal justice pathway, including but not exclusively, the quality of forensic medical examination.

See section 2.2 for data on the use of services

## The Need for Specialist Sexual Assault Services

- 1.8. The dual benefits of dedicated services for the health and well-being of victims of sexual violence and delivery of justice are considerable. Such a service will provide clients with the opportunity for high quality health care, independent sexual violence advice and the opportunity for forensic medical examination and sampling. This, where the clients consent, provides both the Police and the client with the best possible opportunity to recover evidence for use within an investigation. Without such an approach, support to clients, including consideration of initiating criminal proceedings would be relatively reduced and disjointed.
- 1.9. There are also significant knock-on benefits to the NHS for an integrated early response to sexual assault across the comprehensive health system, including the voluntary and community sector and criminal justice system. In 2003-4, each adult rape was estimated to cost over £76,000 in its initial emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health services and costs incurred in the criminal justice system.<sup>13</sup> The overall cost to society of sexual offences in 2003-04 was estimated at £8.5billion but this did not include long-term health impacts such as post-traumatic stress disorder or mental health costs.

## Service Models

- 1.10. At present, sexual assault referral centres (SARCs) are the typical model of service provision for victims of sexual violence in England and expectations of the "minimum elements" for a SARC service were set out in a document published jointly by the Department of Health, Home Office and Association of Chief Police Officers.<sup>14</sup> This guide, still extant for commissioners of sexual assault services, is being updated to reflect the revisions recommended in the University of Birmingham feasibility study on transferring SARC commissioning from police forces to the health services.<sup>15</sup> The SARC takes an integrative approach but other models of sexual assault services in other countries have been documented which show a wider scope for self-referrals and/or integration with the wider health system, the voluntary and community sector and criminal justice.<sup>16</sup> Only 11%

## Public health functions to be exercised by NHS England

of adults who experience rape report to the police. Thus, many more use counselling and support services in the voluntary sector than SARCs. About 84% of referrals to SARCs in England are through local police, which may be a hindrance for victims who do not wish to follow a criminal justice pathway, even though on access, SARCs give choice to victims to receive healthcare only or involve the police.<sup>15</sup> SARCs also provide an onward referral to the voluntary and community sector specialist sexual violence services as well as take clients referred from there. Integrated working with the sector, in a way that is underpinned by collaboration between the various commissioners is vital for appropriate funding flows to the voluntary and community sector for choice of complementary services.<sup>17</sup>

## Service Data

1.11. There is no minimum data set for services but many providers collect their own data, some of which are shared regionally for benchmarking. However, the picture is variable on returning routinely collected data to commissioners for performance management. A central data set that used to be returned to the Home Office on an informal basis by every service provider ceased to be returned in 2009. Sexual assault indicators relating to the Public Health Outcomes Framework are due to be issued shortly. The data collection and definitional problems in SARC services have limited it to levels of sexual violence and rape as currently reported to the Police. This would enable commissioning partners to engage in local conversations about what is happening locally nonetheless, commissioners would want to develop and agree common data definitions for both performance and outcomes management.

## 2. Scope of service

### Aims and objectives of service

2.1. NHS England is expected to commission jointly with police forces and local authorities in England (see paragraphs 6.1 to 6.3 for commissioning and funding responsibilities) a cost-effective, integrated public health service response to sexual violence and rape that will meet needs identified through joint strategic needs assessment expressed through health and well-being board strategies, taking into account users' views and the national standards set out at section 3. In so doing, the Board will take all reasonable steps to assure improvement in:

- the quality of services to victims whilst ensuring integrated care pathways to other health and healthcare services, safeguarding, social care and criminal justice services;
- access to long-term support from third sector specialist sexual assault services (provide advocacy, counselling and support), NHS psychological therapies and appropriate mental health services;
- victim's experience and satisfaction with access, healthcare, ancillary forensic medical examination and follow-up after-care;
- the supply of competent forensic examiners in sexual assault services, including paediatric forensic medical examiners;
- clinical governance and peer review in sexual assault services;
- safeguarding sexually-assaulted children, young people and vulnerable adults;<sup>18, 19, 20, 21</sup>
- facilitating decisions to prosecute in cases of rape and sexual assault through improved forensic medical provision for both children and adults;
- equity of access in sexual assault services across England and in keeping with the requirements of the Public Sector Equality Duty of the Equality Act (2010). This includes the majority of victims who are women and girls, as well as for people across all the protected characteristics of the Duty.<sup>2, 3, 4, 22,</sup>

2.2. Violent crime, including sexual violence is included in the indicators on improving the wider determinant of health, in the Public Health Outcomes Framework.<sup>23</sup> However, due to data quality issues for police-recorded crime, and the British Crime Survey data not being aggregatable in sufficient numbers to every local authority area, options for a

sexual violence indicator have been developed by Department of Health and Home Office and are expected to be published soon.

### Service description and use

2.3. Sexual assault referral centres (SARCs) are an open access one-stop service to help victims of rape or sexual assault, irrespective of age, on the journey to recovery by providing an immediate health and care response with access to criminal justice services, safeguarding services and integrated follow-up.<sup>14</sup> For children and young people, it is critical that the sexual abuse is managed as part of their total health and developmental needs and is integrated with local healthcare, children services and safeguarding arrangements. Many local areas have developed their own care pathways. The examples at Appendices 1 and 2 for adults and children are one of many existing approaches.<sup>24, 25</sup> This example focuses on the journey in and out of SARCs and shows how clients access the service and the various agencies engaged in delivering it. SARCs should provide:

- 24/7 or out of hours provision;
- timely acute healthcare assessment, including paediatric assessment, mental health risk assessment, treatment (public health services including emergency contraception, pregnancy and STI testing and post exposure prophylaxis) and crisis support;
- choice of gender of forensic examiner – most victims prefer to be seen by a female examiner;<sup>26</sup>
- timely and comprehensive forensic recovery, if the client chooses and for young people under 16 years old, timely paediatric forensic recovery;
- follow-up services which address the client's medical, safeguarding, psychosocial and on-going needs, including onward referral to other health and mental health services, NHS psychological therapy services<sup>27</sup> and specialist sexual violence psycho-social counselling and support (often undertaken by voluntary and community service providers);
- direct access or referral to an independent sexual assault advisor (ISVA). An ISVA is a trained support worker who provides advice and support to enable clients to access the services that they need. A report funded by the Home Office shows that clients supported by ISVAs are more likely to go through the full course of criminal justice proceedings;<sup>28</sup>
- access to the criminal justice system if the client chooses.

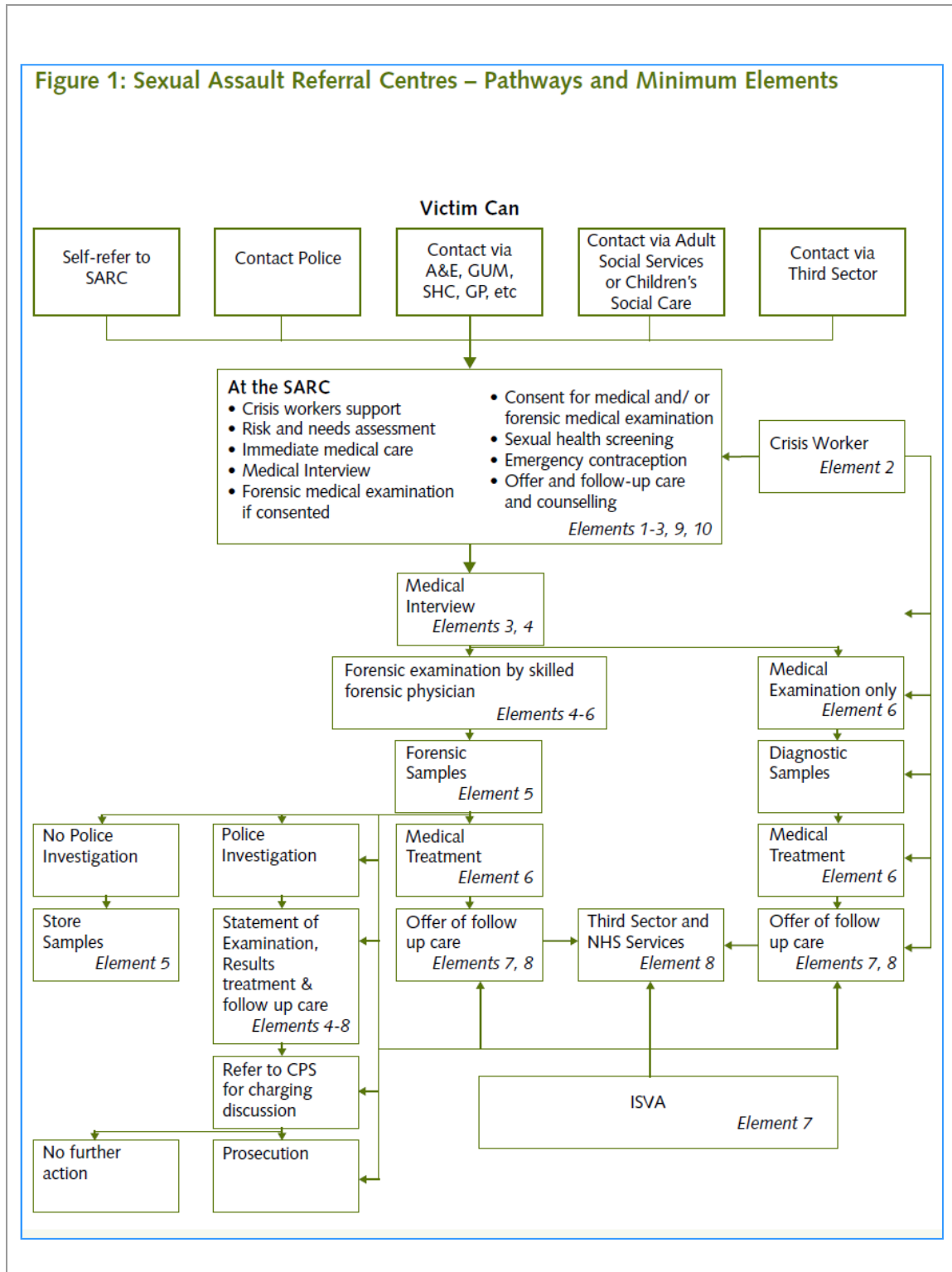
2.4. There are now 37 SARCs (see section 5) but the services they provide in relation to the above criteria are variable as set out in the *Revised National Service Guide* as the minimum elements<sup>14</sup>. Findings from the University of Birmingham Feasibility Report commissioned by the Department of Health and Home Office, and which are generalizable, are being used to update the Revised Guide. In summary, the Study shows that in 2009/10:<sup>15</sup>

- The 28 SARCs across the country covered 68% of population and 56% of the geographical area;
- sympathy suites located in police custody facilities covered the remaining 32% of the population and 44% of the area, suggesting that care would be disjointed and focused largely on the forensic medical examination, with multiple referrals to services such as independent sexual violence advice, contraception, screening for sexually transmitted diseases and HIV prophylaxis, and safeguarding. The Government's policy intention is to move away from this model of provision. Sympathy suites are not adequate for the holistic care that sexually assaulted people need.<sup>5,15,29,30</sup> However, the numbers of these facilities are diminishing as more SARCs open;
- population density per sq mile for SARCs was 1253 compared to 735 for sympathy suites, which covered areas that are more rural. This may indicate the need for different service models to concentrate the specialist skills needed for forensic and paediatric care;<sup>31,32,33</sup>
- on average, there were 27 referrals to SARCs and sympathy suites/100,000 population (min at 1.5, max at 66.3). The interquartile range yields a more accurate indicator between the Lower Quartile of 18.9 referrals per 100,000 population and the Upper Quartile of 36);<sup>15</sup>
- on average 33% of referrals were in young people below 18 years (this age group account for 21% of the country's population). In different areas, this proportion ranged between 17% and 50% with many being historic cases (outside the forensic examination window i.e. over 7 days since the assault):

## Care Pathway

2.5. A high-level sexual assault care pathway diagram is set out below. The elements therein refer to the expectations for delivery of a SARC service as set out in the joint Department of Health, Home Office and Association of Chief Police Officers guide.<sup>14</sup> Adult victims of sexual violence, but also children in particular, can access services through SARCs or through more routine health care, social care, the specialist third sector or police referral. Many local areas have developed care pathways in and out of SARCs in relation to these

multiple points of access. Examples of these more detailed care pathways are at Appendices 1 and 2. Some of these include timelines for services as a guide for local determination. References to “pre-trial” therapy in these diagrams, means therapy received by victims before their court cases are held, to help prepare them for what might be a very difficult ordeal.





## Population covered

- 2.6. Any one in England, who has been a victim of sexual assault (recent or historic), irrespective of age, gender, sexual orientation, disability or any other protected characteristics.

## Any acceptance and exclusion criteria

- 2.7. None at present.

## Interdependencies with other services

- 2.8. In April 2013, custody healthcare services came within the scope of the direct commissioning by NHS England and this includes health services commissioned for SARCs, which are a public health service. Responsibility for forensic medical examination in both custody healthcare and sexual assault remain with individual police forces but work continues to transfer the commissioning of both custody healthcare and SARCs to NHS England.
- 2.9. In terms of resource use in the immediate response to sexual violence, there are other interdependencies, chiefly with sexual health, HIV, genito-urinary (GUM) services, which are being commissioned by local authorities as well as abortion services. GUM and Sexual health professionals believe that they see many victims of sexual assault in their services, especially in relation to very vulnerable groups such as looked after young people, sexually-exploited young people and asylum seekers. There are also wider interdependencies with the criminal justice system, the comprehensive health care system and in particular with NHS mental health and improving access to psychological therapy<sup>27</sup> commissioned by clinical commissioning groups as well as wider police healthcare in relation to vulnerable people. The specialist sexual violence voluntary sector, has also articulated a clear case for choice of provision in support and counselling following sexual assault and the need for funded care pathways.<sup>17</sup> Partnerships are therefore essential, both for strategic commissioning by the NHS CB and others, and in the development of contract service specifications and delivery models in these interdependent areas.

**Public health functions to be exercised by NHS England**

## 3. Applicable service standards

### Applicable national standards e.g. NICE, Royal College

3.1. A range of national service standards, professional standards and legislative requirements as follows:

- British Association for Sexual Health and HIV – Guidelines.
  
- Department of Health, Home Office, Association of Chief Police Constables. Revised National Service Guide- A Resource for Developing Sexual Assault Referral Centres 2012 (updated version being published in 2012).
  
- Department of Health, Home Office. No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.
- Equality Act, 2010.
- Faculty of Forensic and Legal Medicine. Recommendations for the Collection of Forensic Specimens from Complainants and Suspects.
- Faculty of Forensic and Legal Medicine. Operational procedures and equipment for medical rooms in police stations and victim examination suites.2007.
- Faculty of Forensic and Legal Medicine, Royal College of Paediatrics and Child Health, Association of Chief Police Officers. Guidance for best practice for the management of intimate images that may become evidence in court. 2010.
- Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS. 2011.
- Faculty of Sexual and Reproductive Healthcare – Clinical Guidance.
- HM Government. Working Together to Safeguard Children 2013: A Guide to Interagency-Working to Safeguard and Promote the Welfare of Children.
- Intercollegiate Safeguarding Children and Young People: Roles and competences for health care staff. 2010.
- Guidelines by the National Institute for Health and Clinical Excellence:
  - Post-traumatic stress disorder
  - The treatment and management of depression in adults
  - Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care
  - Pregnancy and complex social factors

## Public health functions to be exercised by NHS England

- Postnatal care
- Drug Misuse: Psychosocial interventions
- When to suspect child maltreatment
- Depression in children and young people
- Royal College of Paediatrics and Child Health, Faculty of Forensic and Legal Medicine. Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse. 2007
- Royal College of Paediatrics and Child Health, Royal College of Physicians, Faculty of Forensic and Legal Medicine. The Physical Signs of Child Sexual Abuse, An Evidence-based Review and Guidance for Best Practice. 2008

## Applicable local standards

3.2. Variations to local standards are permissible where these are above national or international standards.

## Applicable international standards

3.3. International requirements to which the UK government is a signatory include the following:

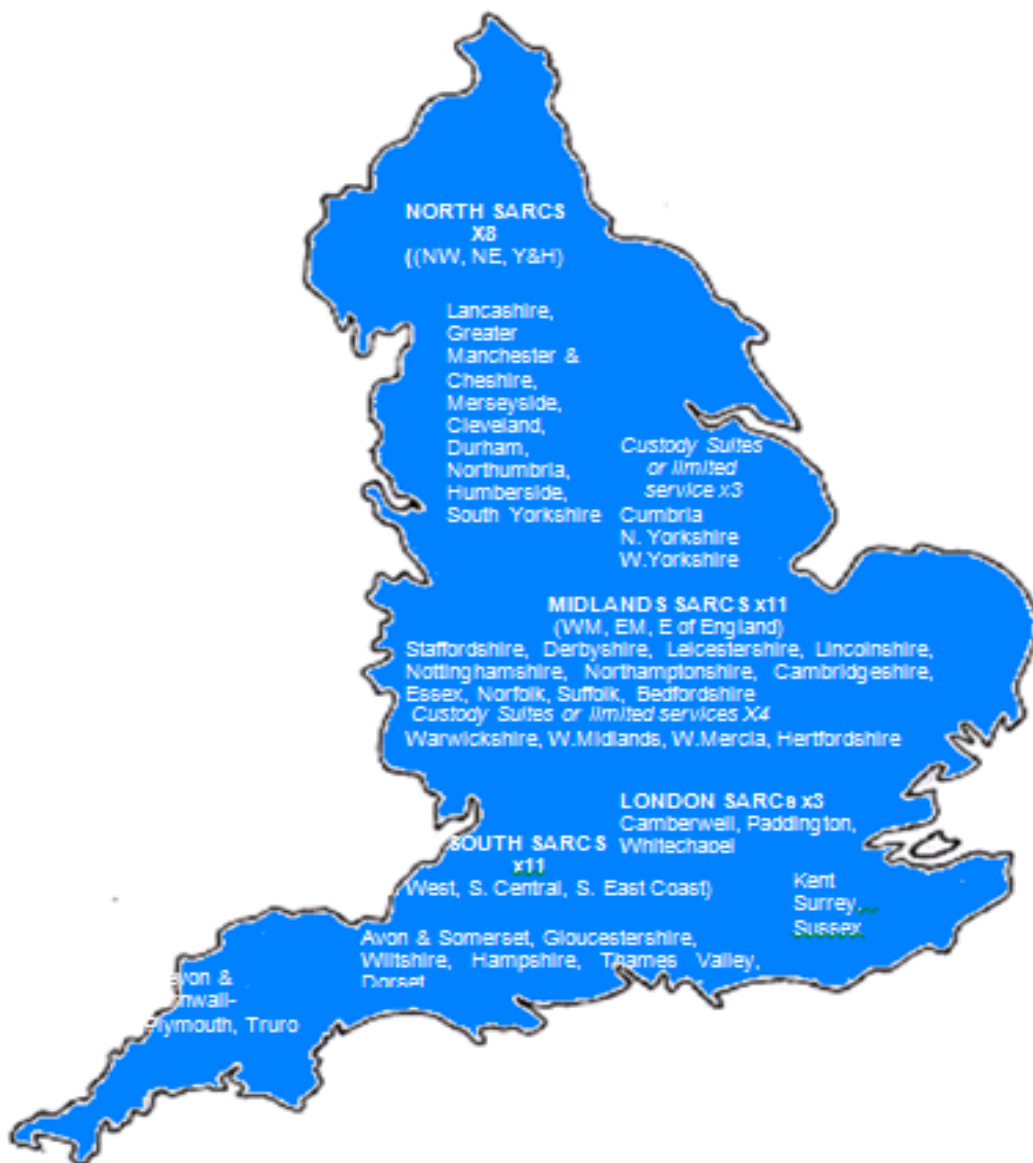
- Council of Europe Convention on Preventing and Combatting Violence against Women and Domestic:
  - Articles 23, 24.
- United Nations Convention on the Elimination of all Forms of Discrimination against Women:
  - The Convention;
  - Option Protocol to the United Nations Convention on the Elimination of all Forms of Discrimination Against Women;
  - General Recommendations of the Committee on the Elimination of Discrimination against Women.
- United Nations Convention on the Rights of the Child:
  - Articles 19 – protection from being hurt, violence, abuse and neglect;
  - Articles 34 – protection from sexual abuse;
  - Article 39 – help for hurt, neglect, abuse, exploitation, torture, Inhuman or degrading treatment or punishment.

## 4. Key service outcomes

- Cost-effective and innovative services that are accessible and client-centred in meeting victims' needs for a health response and onward referral in the immediate aftermath of sexual assault or historic cases (outside the forensic window of 7 days from the assault).
- Consent-based, fit for purpose forensic recovery, preservation, reporting of evidence and feedback to victims.
- Increased client satisfaction with sexual assault services.
- Improved and equitable distribution of integrated, high quality and readily accessible, 24/7, one-stop open access sexual assault services to victims of rape, sexual violence and sexual abuse across England regardless of age, gender or sexual orientation.
- Sexual assault services commissioned jointly (see paragraph 6.3), well promoted locally and delivered through partnerships.
- Use of indicators for sexual violence, developed as part of the violence indicator set (1.12) in the Public Health Outcomes Framework.<sup>34</sup>
- Key deliverables for NHS England for the commissioning of SARCs for 2014-15 can be found in Table 3 of the NHS public health functions agreement 2014-15.
- This sets out the deliverable that the core offer should include roll-out of the provision of HIV starter prophylaxis in all SARCs in 2014-15.
- Improved commissioning of the paediatric aspects of sexual assault services provision jointly with police partners

## 5. Location of provider premises

Locations of the 33 SARCs in England during 2012 are shown on the map below. An additional 4 SARCs have since opened. Forensic sexual assault provision in police custody examination suites (sympathy suites) are also indicated by Force.



## 6. Commissioning

### Commissioning Models

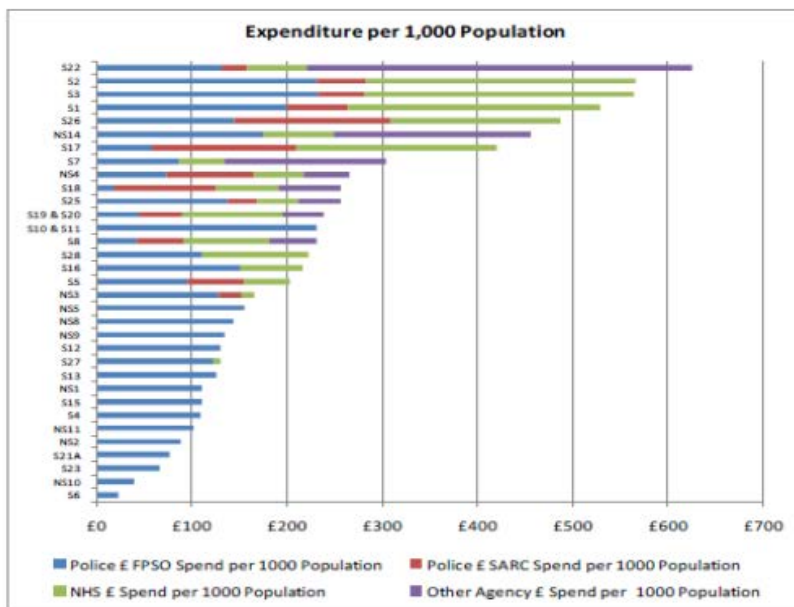
- 6.1. The 39 police forces in England are currently the commissioners for forensic services including forensic medical examination and independent sexual violence counsellors, in SARC's and police custody suites. The NHS has a responsibility for commissioning the public health and care aspects of services to victims and has focused this through SARC's only. Local authorities contribute, though not uniformly or consistently, to crisis workers in SARC's and to specialist sexual violence after care support such as is available in the third sector, for both users and non-users of SARC's. In the past, some of the previous PCT's also contributed to these.
- 6.2. Funding streams for commissioning SARC's are multiple and are typically brought together through collaborative commissioning with the police forces, NHS England's Public Health ring-fenced budget and local authorities, but historically, levels of full collaboration have been variable and also impact on commissioning models. NHS England published 'Securing excellence for the commissioning of sexual assault services' its operating model for how it would secure the best possible outcomes for victims of sexual violence. Working with partnerships is central to the model.<sup>35</sup>
- 6.3. The population-standardised figures further below for agency spend on SARC's are a proxy for funding streams. However, where costs were not separated out for SARC's in joint forensic medical contracts with custody healthcare (in 17 cases), an apportionment of 10% was used to determine the costs of forensic physicians for sexual offences (FPSO) examination, which maybe an underestimate. Nonetheless, taken along with the findings on existing poor commissioning of SARC's, it shows a wide inequity of resource provision across the country, and understates the NHS contribution (as some NHS Trusts provide support in kind such as premises and running costs).<sup>15</sup> NHS England has now reviewed the spending for 2014-15 with the aim to ensure a more equitable distribution of spend.
- 6.4. Public health services for people who experience sexual violence remain a responsibility of the Secretary of State, whilst currently custody healthcare and the forensic medical aspects of both services are a police responsibility. In the last six months of the financial year 2012/13, 34 of the 39 police force areas in England were participating in the voluntary Police Transfer Programme (PTP) for collaboratively commissioning custody healthcare and SARC's with their multi-agency partners. Notwithstanding these technical differences, the policy on the PTP continues to provide a voluntary and structured partnership approach to collaboration between the responsible commissioners for both

**Public health functions to be exercised by NHS England**

custody healthcare and sexual assault services across criminal justice, health and care locally. The experience should also help to facilitate the potential national transfer of commissioning responsibility for custody healthcare and police-commissioned forensic medical provision for sexual assault in the longer term.

6.5. Commissioning of custody healthcare services as part of justice health services by NHS England is therefore providing an invaluable opportunity to align economies of scale and quality in the operating model for sexual assault services within which SARCs play a key part.<sup>35</sup> SARCs are low volume and relatively low cost services. It is therefore possible to achieve scale economies in NHS England’s commissioning model based on national standards, national specifications that enable local variation worked through the ten Area Teams of NHS England with dedicated Justice Health commissioners, in contrast to having 39 individual police force commissioners. Nonetheless, a more regional or sub regional approach to commissioning SARCs is not uncommon and is the model adopted in some high population density areas such as London and Greater Manchester (now also in collaboration with Cheshire). It is also documented as offering the best prospects for child sexual assault paediatric forensic services.<sup>16,31</sup>

Per Capita Spend by Agencies (£ per 1000 population)



**Issues for Commissioners**

6.6. Because custody healthcare and SARCs involve forensic medical recovery, albeit from very different clinical expert bases, there is nonetheless, an advantage in bringing together their commissioning capacities. This is already happening in the PTP. However,



there are also distinct differences as follows, which the NHS England would need to address in their partnerships in taking forward their preferred operating model.<sup>35</sup> The first two points of differences below, also directly affect the quality of forensic recovery offered in SARCs:

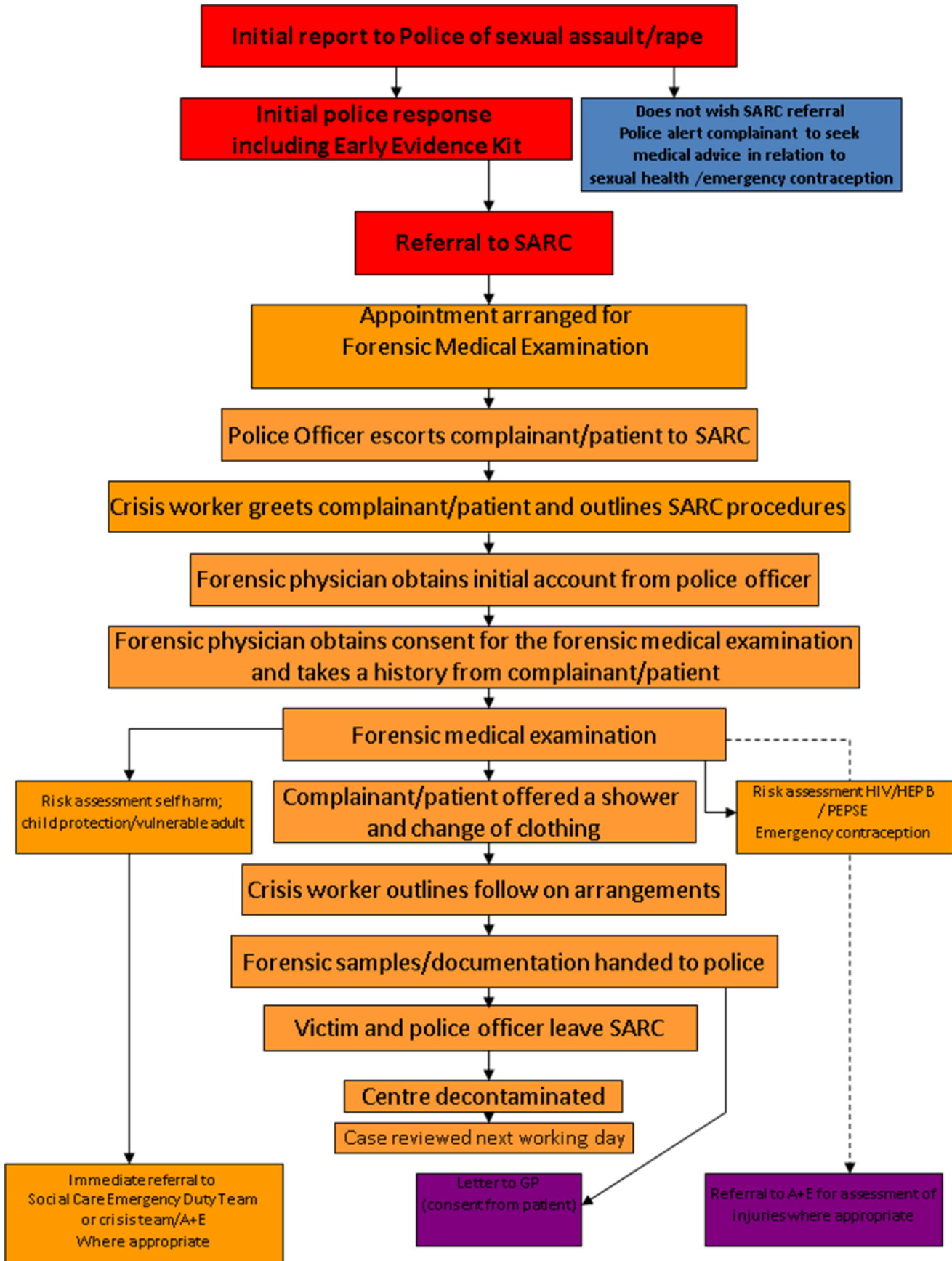
- The need for continuing expert capability in commissioning sexual assault referral services as part of healthcare and criminal justice services;
- victims, including male victims, prefer to be seen by female doctors (see paragraph 2.3 above);
- stakeholders, sensitive about subsuming sexual assault services under a commissioning system named “offender health” which is also securing services for sexually assaulted people as who are victims of crime, have welcomed NHS England’s badging of both under “justice health.”

## Commissioning Specifications for Contracting

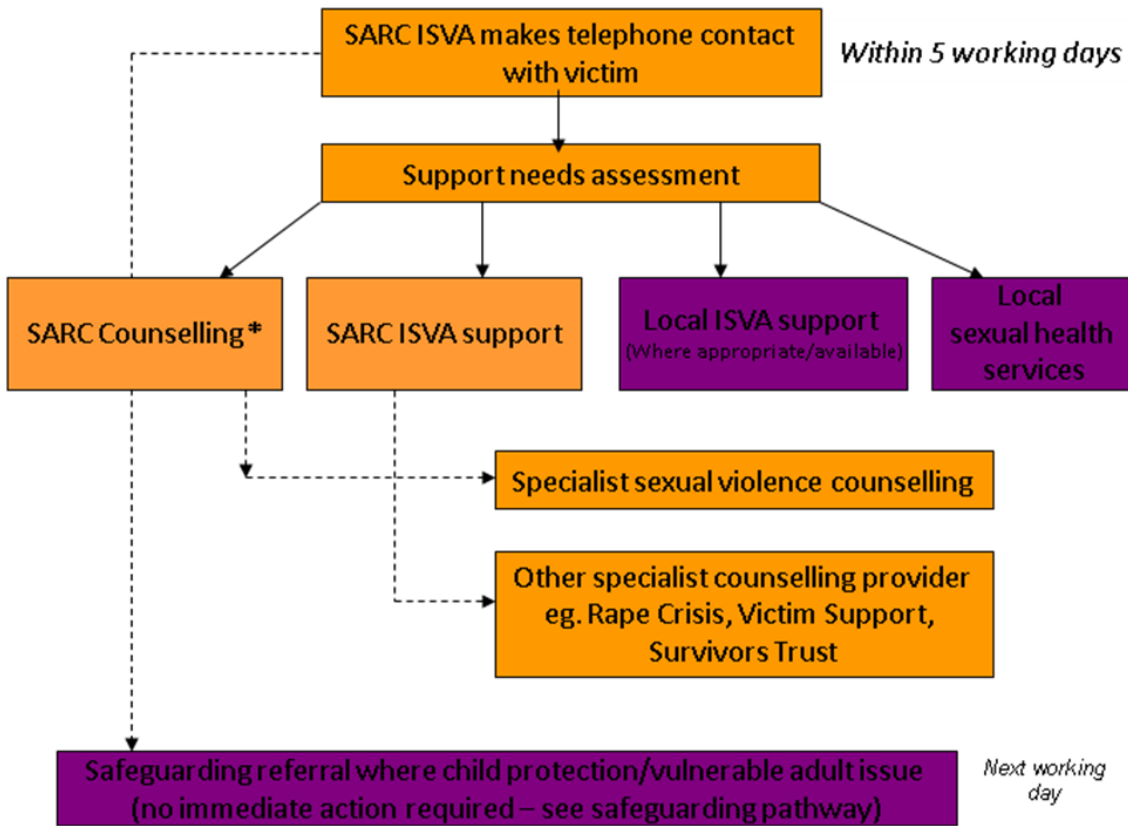
6.7. The SARC commissioning service specification developed by NHS London and modelled on the NHS contract, has been available as a model in NHS England for customised use by partnerships in its Area Teams:

# Appendix 1: Example Adult Pathways

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

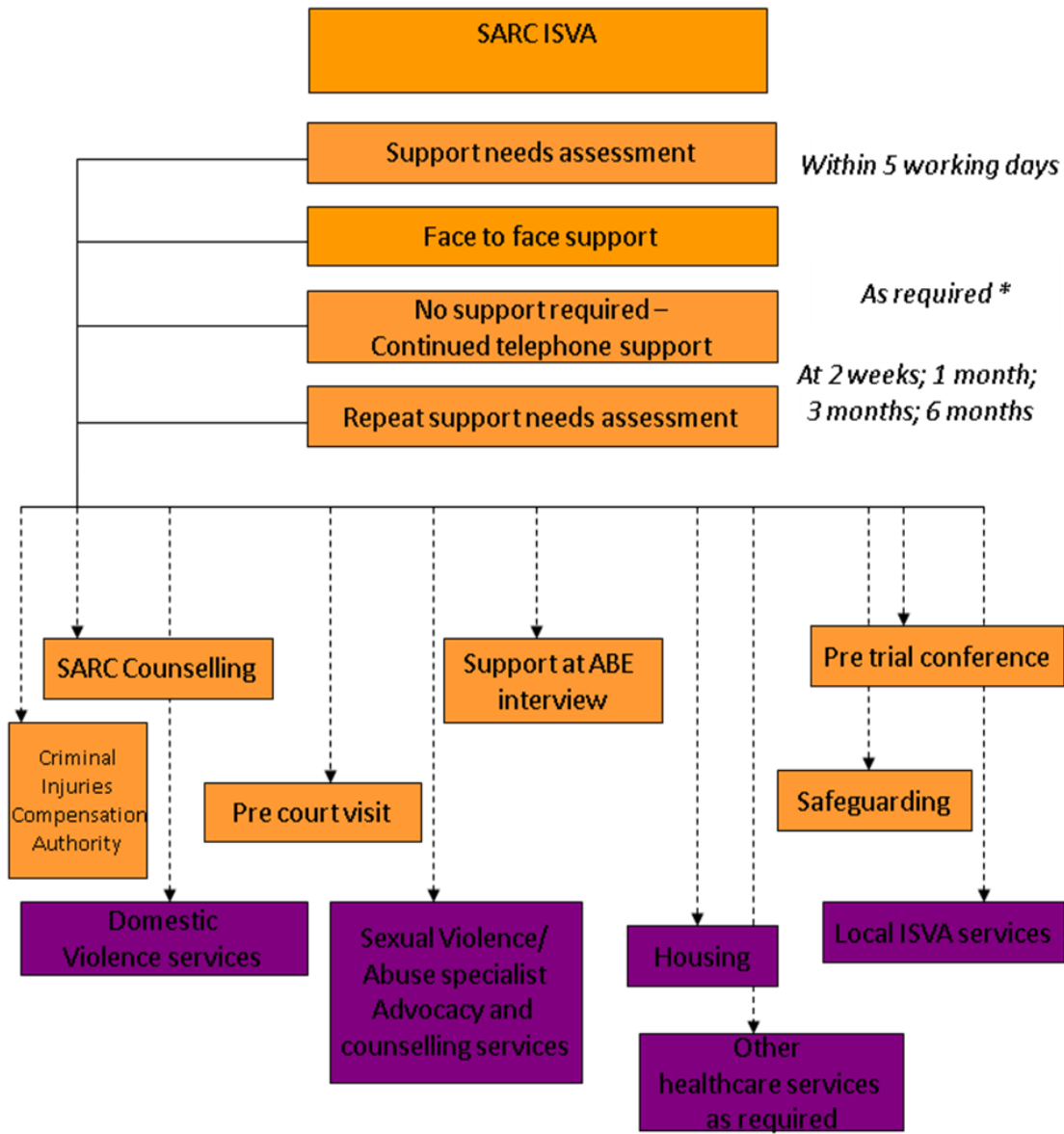


## SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)

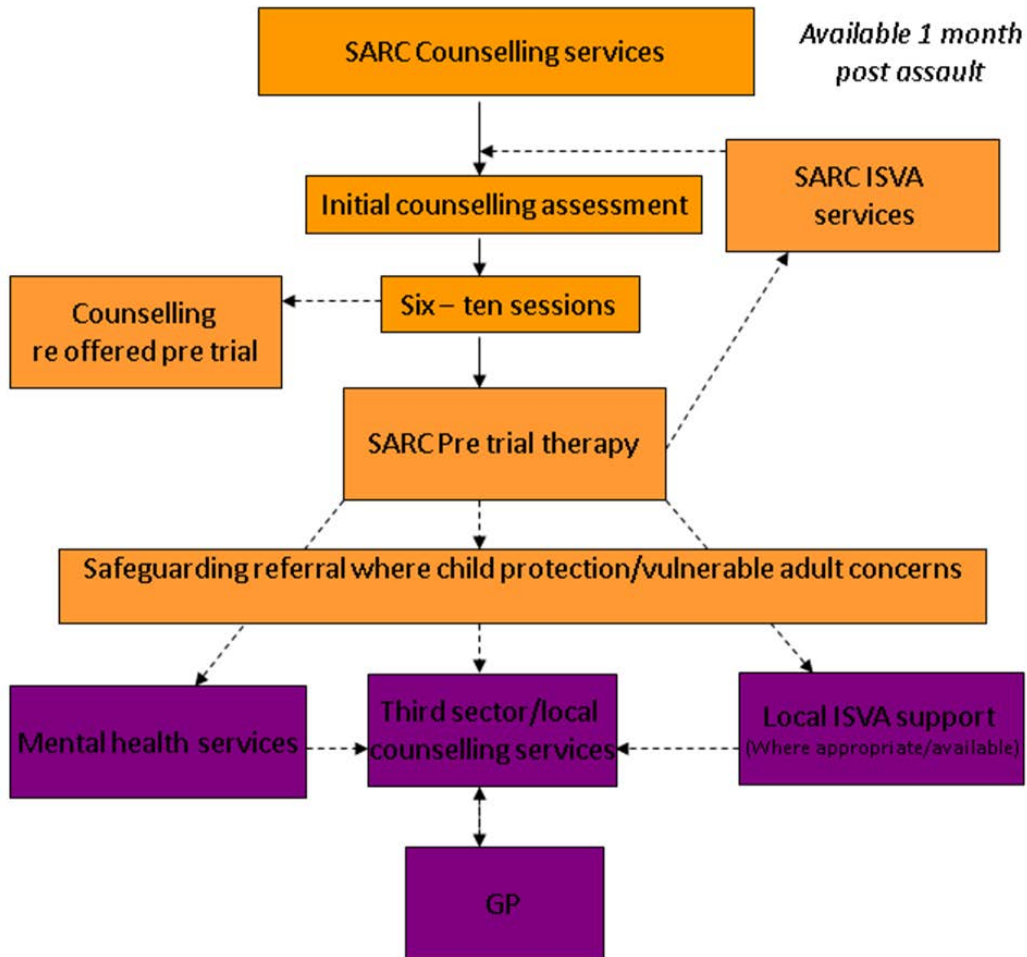


\* SARC Counselling also refers to specialist sexual violence counselling in the community e.g. Rape Crisis

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

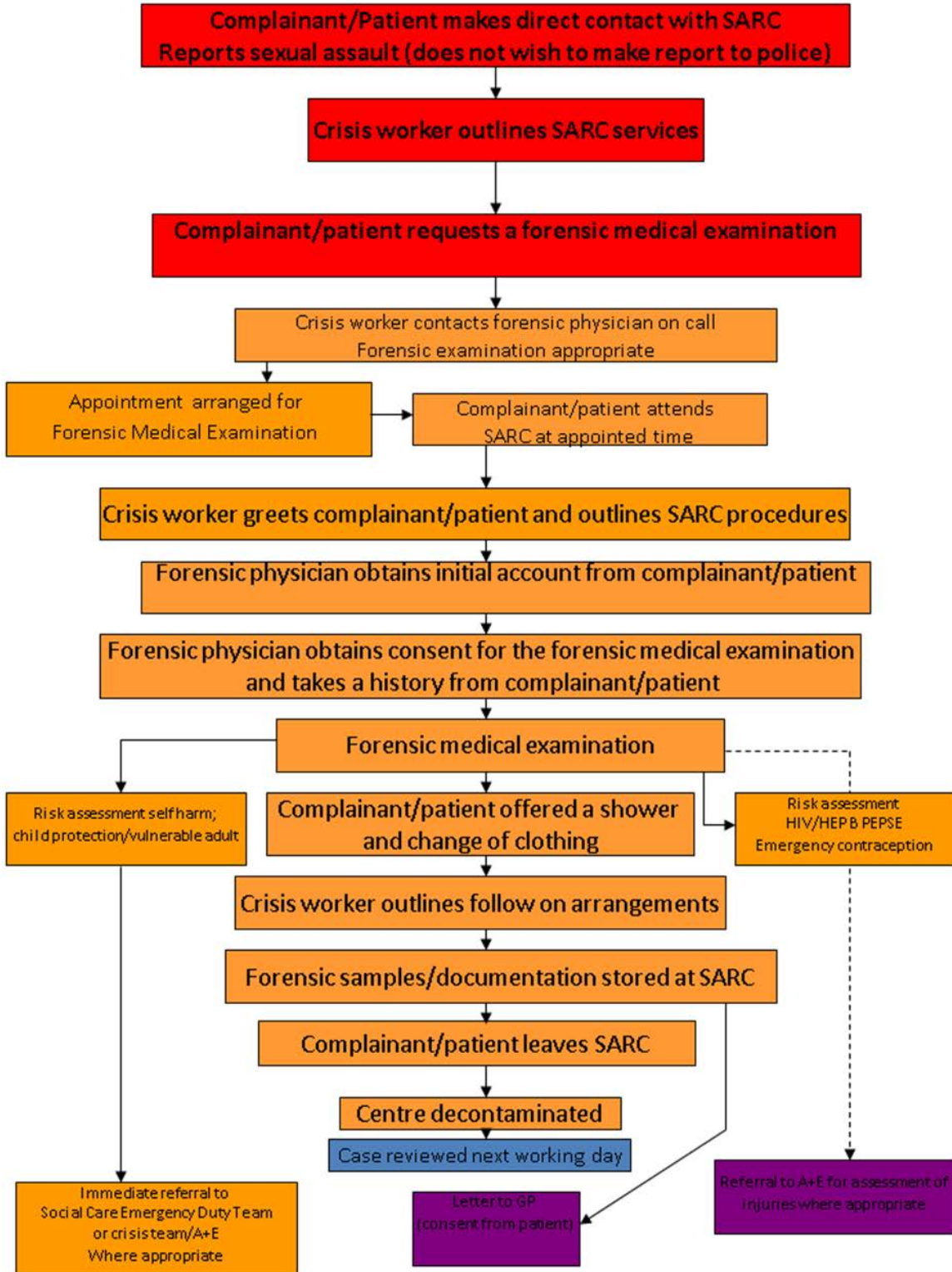


## SARC Follow-up Adult Care Pathway (police case): Counselling services

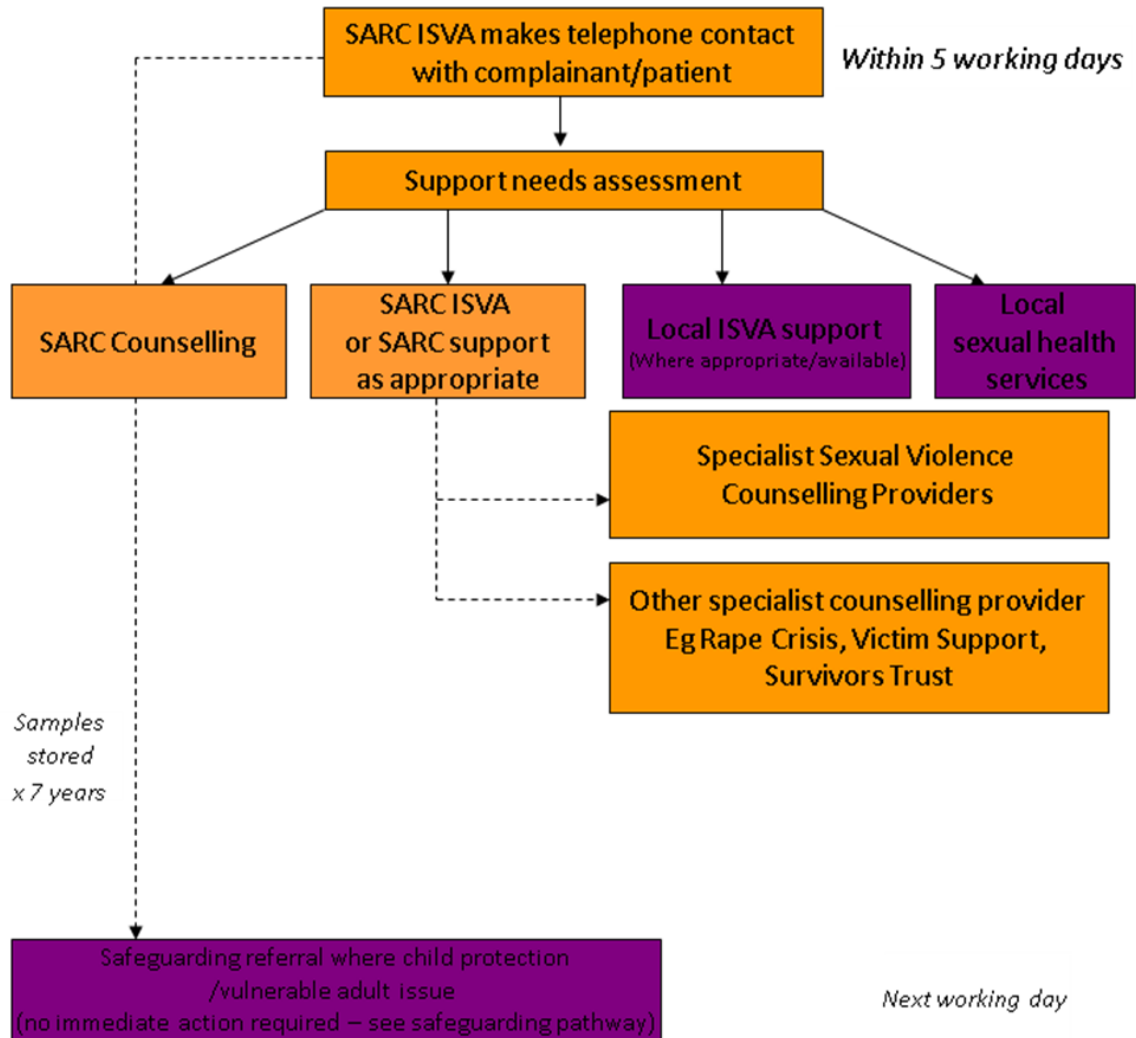


(\*note:Third sector = Third sector specialist sexual violence services)

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

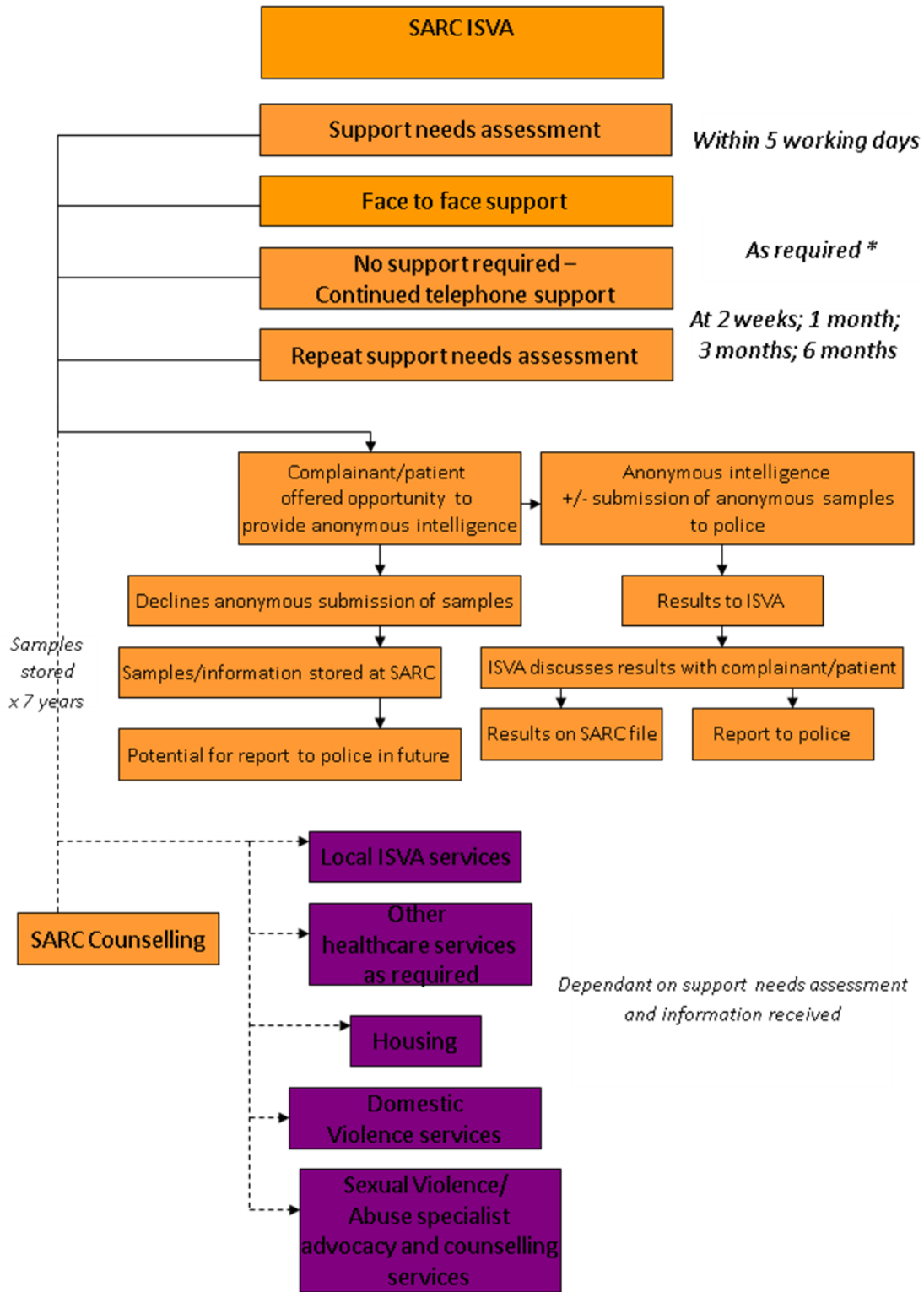


## SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)

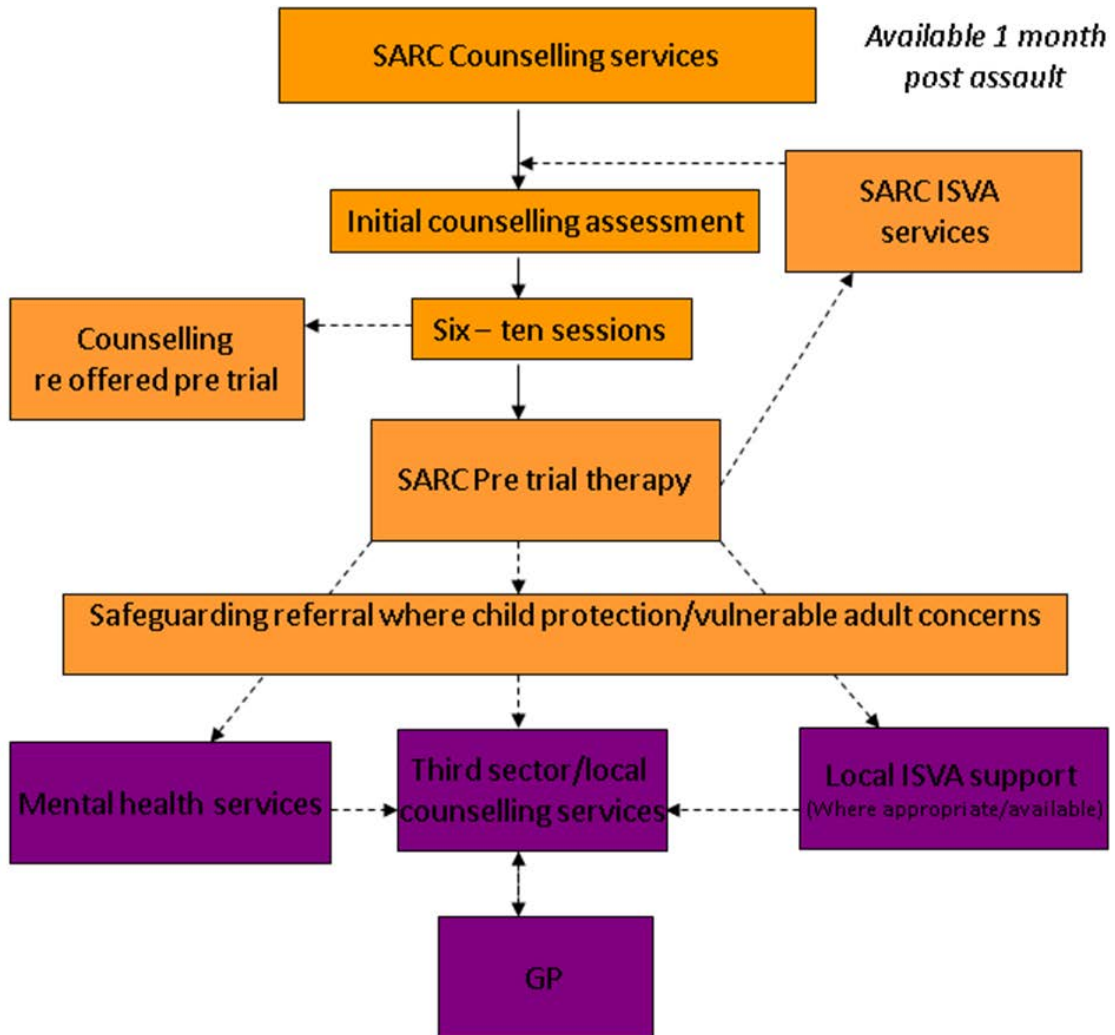




# SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)- range of support services



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



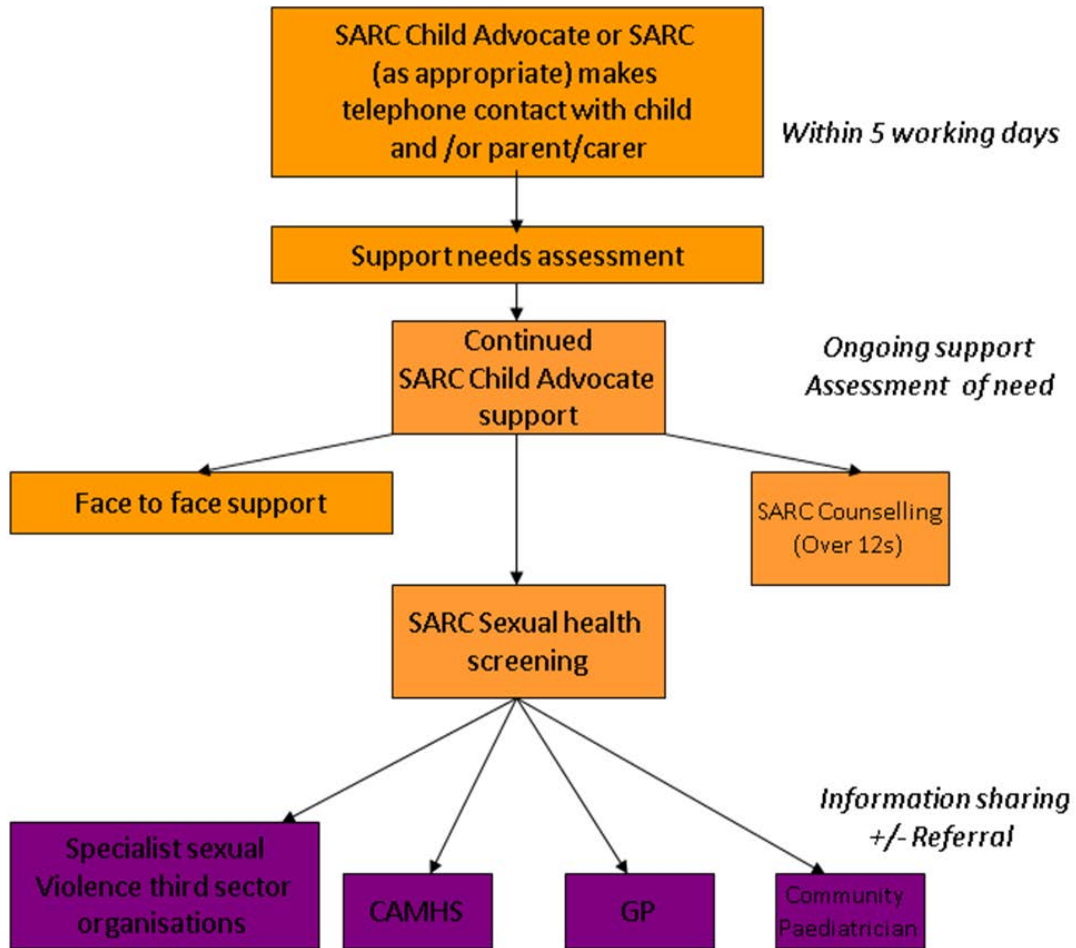
(\*note:Third sector = Third sector specialist sexual violence services)

## Appendix 2: Example Child and Young People Pathways

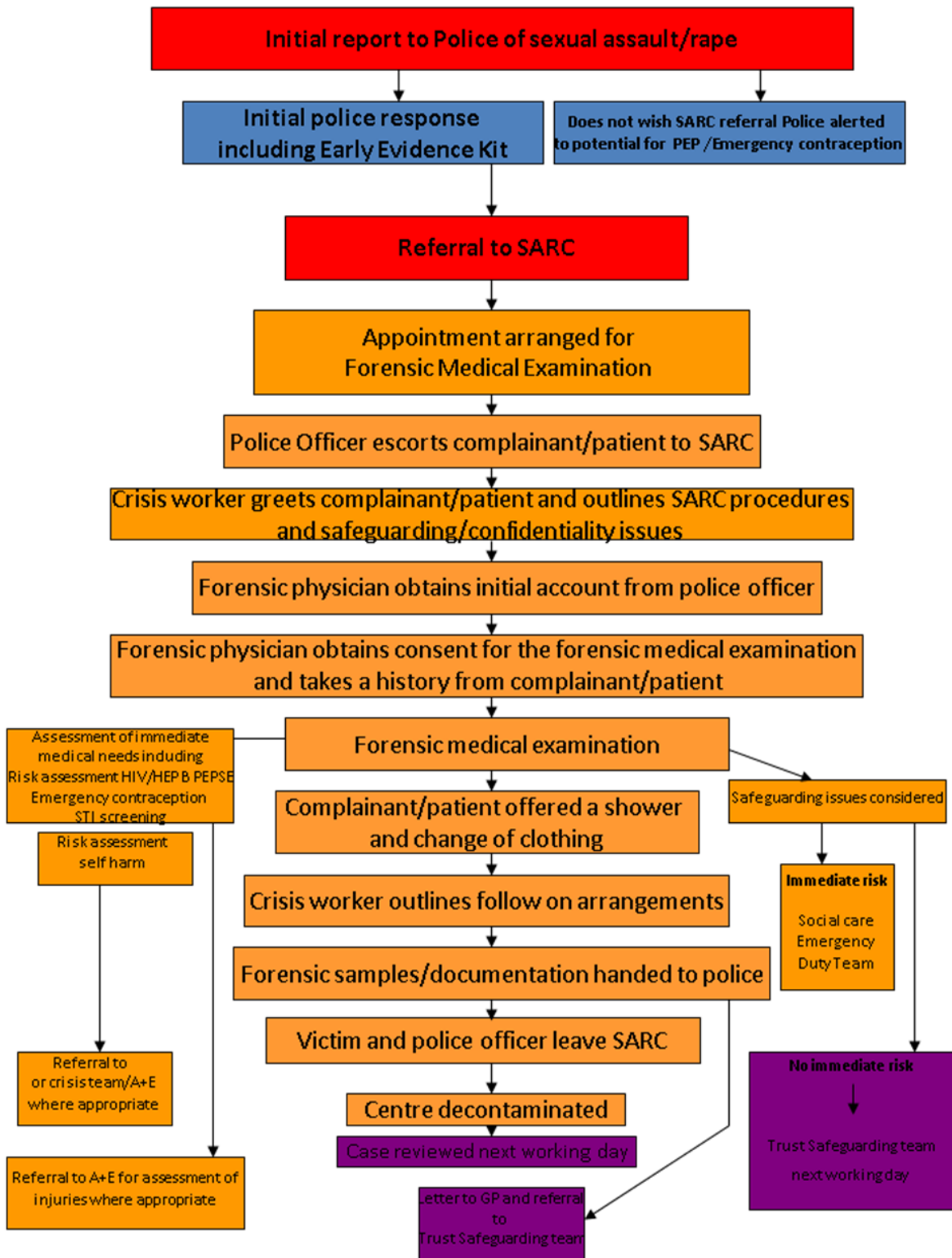
## SARC Child Care Pathway (joint investigation): Initial attendance at SARC



SARC Follow-up Child Care Pathway (joint police/social investigation):  
SARC Child Advocate or SARC (as appropriate)

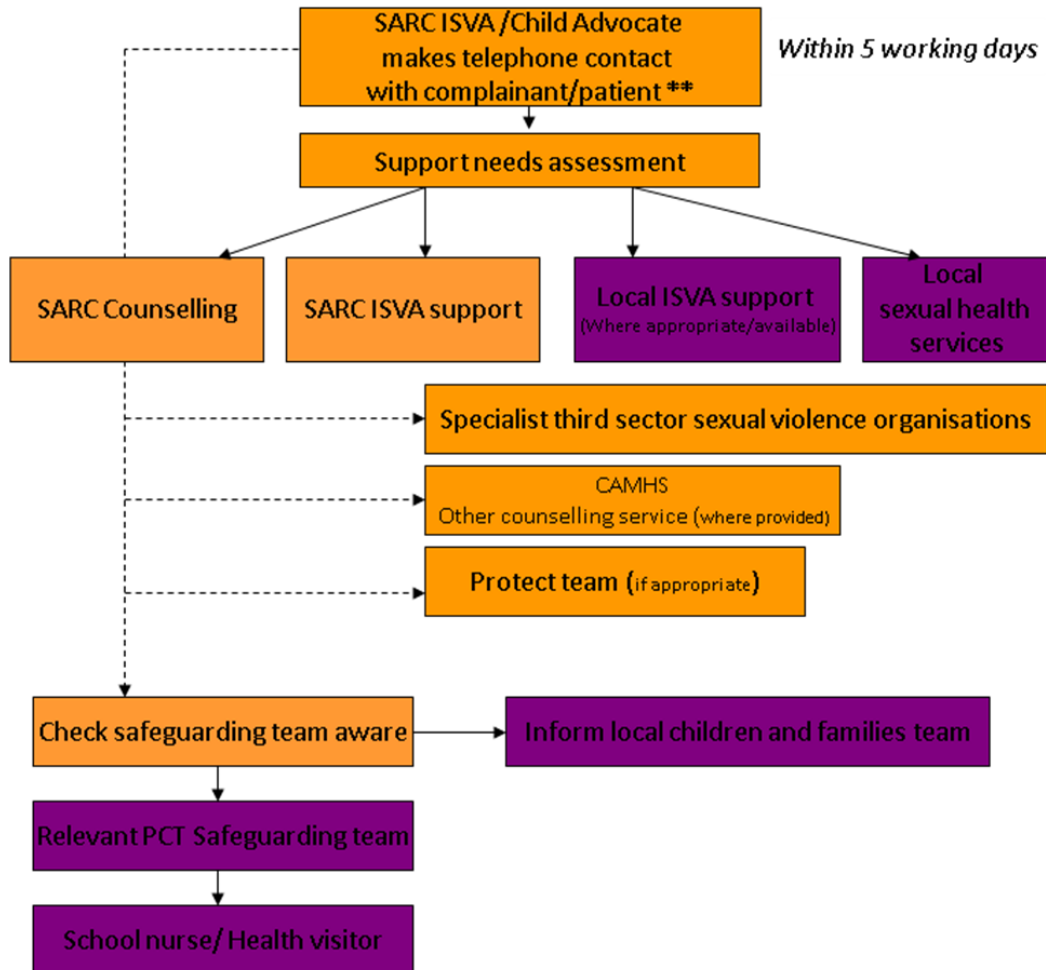


## SARC Children and Young People Acute\* Care Pathway (police case): Initial attendance at SARC



\* Acute- refers to one off sexual assault – forensically acute

## SARC Follow-up Children and Young People Acute\* Care Pathway: SARC ISVA/Child Advocate/SARC (as appropriate)



**\*\* Age appropriate**

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