



Home Office

Commissioning Framework

For all commissioners of support services for victims and survivors of child sexual abuse in England

July 2019





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Introduction



Introduction

Child sexual abuse (CSA), of which child sexual exploitation (CSE) is a form, is a serious crime which can have a devastating and long-lasting impact on victims and survivors. It is vital that both children and adult victims and survivors have access to effective and timely services to help them cope with the immediate impact of abuse and, as far as possible, recover from its effects.

Who is the framework for?

This framework is targeted at all commissioning bodies in England with responsibility for support services for victims and survivors of CSA, including child and adult victims and survivors of non-recent abuse. Local authorities, NHS England, Clinical Commissioning Groups (CCGs) and Police and Crime Commissioners (PCCs) all play a fundamental role in commissioning appropriate services, with each accountable for different elements of a system response. For example, local authorities have responsibility for specialist sexual health services, NHS England for Sexual Assault Referral Centres (SARCs) and Tier 4 Child and Adolescent Mental Health Services (CAMHS); CCGs have responsibility for mental health services, including services for depression and Post Traumatic Stress Disorder (PTSD) and PCCs are grant funded by the Ministry of Justice (MoJ) to commission and deliver support services for victims of crime. Annex A contains a detailed list of commissioning responsibilities.

Health is a devolved matter in Wales and there are separate commissioning arrangements being developed for SARC services. NHS Wales is also working with its partners to further develop a sustainable model of sexual assault services across Wales.

Why has it been produced?

The commissioning landscape for such support services is complicated; it can be fragmented and has led to gaps in provision. A contributing factor is that responsibility for the commissioning of CSA support services cuts across a number of commissioning bodies. The framework aims to outline the responsibilities of individual agencies as well as promote the need to work in partnership. Addressing the needs of individuals who have been sexually abused cannot be met by one agency alone, something that is outlined in NHS England's Strategic Direction for Sexual Assault and Abuse Services 2017–2022.¹

This framework has been developed to assist commissioners with responsibility for CSA support services to navigate their way through the commissioning landscape. It should be read alongside the Strategic Direction for Sexual Assault and Abuse Services, which seeks to improve the availability and delivery of care which supports victims and survivors of recent and non-recent sexual assault and abuse over a lifetime.

Evidence suggests that while services for victims and survivors of CSE are more commonly commissioned, this is less frequently the case for broader CSA, or for harmful sexual behaviour. Commissioners should be supporting children and adults affected by all of the above forms of harm, and this document will support them in doing so.

While this framework contains some strong recommendations it is important to note that it is not statutory guidance. Commissioners should use this framework as a tool to understand the commissioning landscape, and how they can implement some of the examples of good practice within their own jurisdiction.

¹ <https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>

How should it be used?

The framework should be used by commissioners to provide overarching guidance and support for navigating the commissioning environment for CSA support services. It should be read prior to making commissioning decisions and when formulating commissioning plans or CSA strategies. It should not supersede existing frameworks and guidance but should provide supplementary advice to ensure that support services for adult and child victims and survivors of CSA are targeted at those most in need, as well as providing the best possible outcomes for the best value. Please see Annex B for a list of supplementary documents and publications.

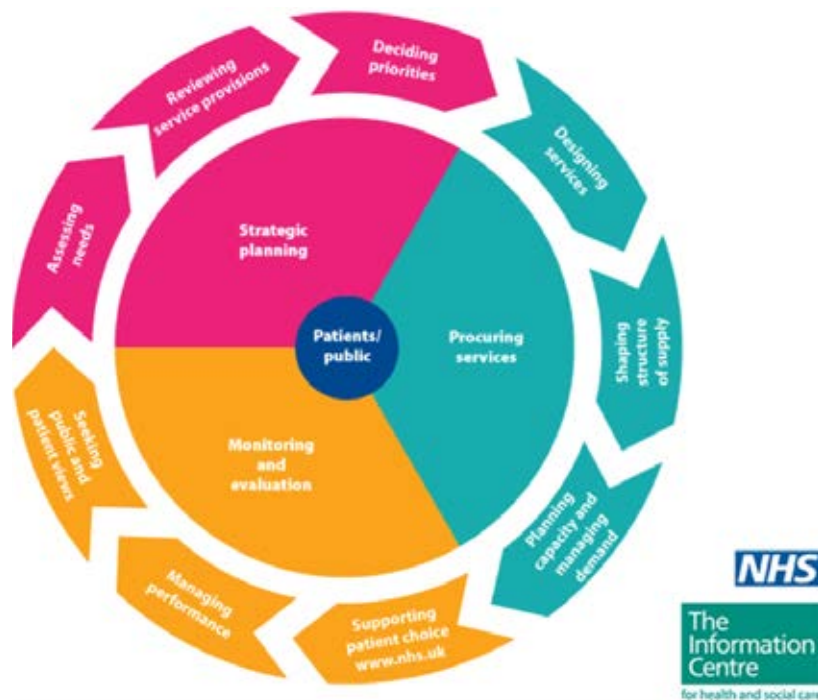
This framework highlights the key issues commissioners need to consider when commissioning support services and should help to achieve smarter, more effective and innovative commissioning.

How does this framework fit in with other guidance?

This framework should be read alongside the Strategic Direction for Sexual Assault and Abuse Services,² the strategy to end Violence against Women and Girls (VAWG Strategy),³ the Victims Strategy,⁴ The Violence Against Women and Girls National Statement of Expectations⁵ and Violence Against Women and Girls Services Local Commissioning Toolkit.⁶

There is an expectation that commissioners will take all of these documents into account.

Commissioning cycle:



It is best practice for commissioners to follow the commissioning cycle, which underpins this Framework.

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2 <https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>

3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF

4 <https://www.gov.uk/government/publications/victims-strategy>

5 <https://www.gov.uk/government/publications/violence-against-women-and-girls-national-statement-of-expectations>

6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576238/VAWG_Commissioning_Toolkit.pdf

Key terminology

Child Sexual Abuse (CSA)

The government's definition of child sexual abuse as set out in Working Together to Safeguard Children (HM Government, 2018)⁷ is:

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Child Sexual Exploitation (CSE)

Following a formal consultation by the government in 2016, the statutory definition of child sexual exploitation was updated and the following definition is now included in Working Together to Safeguard Children:

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

Harmful Sexual Behaviour (HSB)

Services responding to harmful sexual behaviour should be considered as part of a wider CSA commissioning strategy. HSB is defined by the NSPCC as:

Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult.⁸

Support services

For the purpose of this framework, the term support services is defined as follows:

Services that can demonstrate the necessary skills and experience in sexual violence and abuse in order to provide services to victims and survivors of child sexual abuse. These services support victims and survivors to cope with the impact of the abuse and recover from its effects as far as possible. Services may provide emotional, physical and social support in a variety of forms to offer this help.

Joint commissioning

This framework encourages a collaborative approach to commissioning, with the term joint commissioning defined as:

A strategic approach to planning and delivering services in a holistic, joined-up way. It is about different commissioning bodies with responsibilities in the same or linked business area, working together to deliver the best outcomes.

⁷ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

⁸ <https://www.nspcc.org.uk/globalassets/documents/publications/harmful-sexual-behaviour-framework.pdf>

Understanding CSA



Understanding CSA

Overview of CSA

The aim of this section of the framework is to provide a basic understanding of CSA and to demonstrate why it is important to provide services for victims and survivors of this abuse. It should be noted that reference to CSA throughout this framework encompasses CSE.

National scale and commissioning issues

In recent years, the number of victims and survivors of CSA coming forward has risen sharply, which has resulted in an increase in the demand for statutory and non-statutory organisations providing support. This follows several high-profile incidents of CSA and the continuing Independent Inquiry into Child Sexual Abuse (IICSA). The prevalence of CSA is clearly demonstrated in national level statistics:

7% of adults aged 16 to 59 have experienced some form of CSA⁹

5% of children aged 11 to 17 (1 in 20) have experienced contact abuse¹⁰

It must be recognised that while the reporting of CSA has increased, particularly among adults, there are many more victims and survivors who do not come to the attention of statutory authorities. Disclosure from children and young people remains low.¹¹ This could be linked to a greater willingness or readiness to both recognise and report sexual abuse in later years. This indicates a need for those working with children to understand and act on the alerting features for child abuse and neglect, and to promote support for young people who are showing signs of trauma but are yet to disclose.¹²

The way children and young people use technology and social media is also changing our understanding of the nature and scale of child sexual abuse.

For further information please see the Scale and Nature of Child Sexual Abuse and Exploitation Report produced by the Centre of expertise on child sexual abuse.¹³

Impact of CSA

The impact of CSA will vary significantly between different victims and survivors and is not always obvious, either during childhood or in adulthood.

However, it is widely recognised that the effects of CSA can have a life-long impact on mental and physical health, as well as a negative impact on other elements of wellbeing such as social functioning, relationships, educational attainment and employment. Common effects on mental health specifically can include anxiety, depression, post-traumatic stress disorder, suicidal thoughts and eating disorders. As well as the impact on victims and survivors, it is also important to consider the impact on parents and carers and the wider family. A proactive welfare response across a number of different agencies, which ensures consistency of support and the potential for long-term engagement, is therefore required.¹⁴

Further information can be found in the IICSA publication: The impacts of child sexual abuse: A rapid evidence assessment.¹⁵

Victims and survivors need to have access to appropriate support services, and commissioners play a fundamental role in listening to their voices and commissioning services that meet their varying

9 <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuseduringchildhood/findingsfromtheyearendingmarch2016crimesurveyforenglandandwales>

10 www.nspcc.org.uk/globalassets/documents/research-reports/child-abuse-neglect-uk-today-research-report.pdf

11 <https://www.csacentre.org.uk/csa-centre-prod/assets/File/CSA%20Scale%20and%20Nature%20full%20report%202018.pdf>

12 <https://www.nice.org.uk/guidance/ng76/chapter/Recommendations>

13 www.csacentre.org.uk/research-publications/scale-and-nature-of-child-sexual-abuse-and-exploitation/

14 www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/UniBed_MakingNoise-20_4_17-1.pdf

15 <https://www.iicsa.org.uk/document/iicsa-impacts-child-sexual-abuse-rapid-evidence-assessment-full-report-english>

needs. It is important that, where possible, victims and survivors are listened to in terms of what support they wish to receive as one individual survivor's needs may vary over that person's lifetime.

Responsibilities

Please see Annex A for a full list of key responsibilities of PCCs, NHS England, CCGs, MoJ and local authorities in relation to CSA support service commissioning.

Support services

There are a range of different support services available to help victims and survivors cope with and recover from the harm experienced as a result of abuse. Services include advocacy, information provision, sexual violence and abuse counselling, peer support, practical assistance and emotional and therapeutic support. The SAAS Strategic Direction developed by NHS England highlights the importance of specialist care which targets the specific health needs of victims and survivors.¹⁶ Criminal justice support for victims is also available through Independent Sexual Violence Advisers (ISVAs) who work with people who have experienced rape or sexual assault, irrespective of whether they have reported it to the police. ISVAs provide impartial information to victims and survivors about all of their options, such as reporting to the police and accessing Sexual Assault Referral Centre (SARC) services, as well as specialist support such as pre-trial therapy and sexual violence counselling.

Sexual Assault Referral Centres (SARCs)

SARCs are a specialist statutory service commissioned by NHS England, sometimes in collaboration with the police. They are a partnership model of service provision which aims to co-ordinate medical, legal and advocacy arrangements for victims and survivors under one roof. Across England there are now a number of paediatric SARCs along with adult SARC services. These 24/7 support centres often employ ISVAs and Child Advocates whose role is to provide emotional and practical support through the criminal justice system, including attending court and advising on post-trial matters such as compensation claims. The service allows victims to access the support and advice they need in a timely manner while ensuring the continuity of forensic evidence to secure prosecutions.

As well as statutory services such as Children and Adolescent Mental Health Services (CAMHS) and front-facing health professionals such as school nurses, the voluntary sector plays a vital role in providing therapeutic services for CSA victims and survivors. In particular voluntary sector organisations are often able to reach vulnerable groups of young people and adults who may avoid statutory services; have strengths in community outreach; and are able to provide bespoke, longer-term support to victims.¹⁷

¹⁶ <https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>

¹⁷ <https://www.csacentre.org.uk/research-publications/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/>

RoSA

RoSA is a member of The Survivors Trust and a local service dedicated to delivering specialist support to communities throughout Warwickshire for men, women, children and young people from the age of five who are victims and survivors of rape, sexual abuse, CSE, trafficking and female genital mutilation. Support is also offered to families and carers of victims and to anyone at risk and vulnerable to the trauma of sexual abuse. RoSA was established 27 years ago and since then has worked tirelessly to provide a person-centred holistic approach to support.

Activities include: person-centred counselling; support groups for men and women; drop-ins, mentoring and befriending groups; pre-trial therapy; ISVAs (for adults and children and young people); a support and information helpline, online counselling and support; self-esteem and confidence building workshops; and training for front-line professionals and volunteers.

Commissioners must recognise that there is not a single model which will meet the needs of all victims and survivors across England. This framework does not provide a prescriptive list of the services that should be commissioned, however chapter 6 explores some areas of interesting commissioning practice across the sexual assault and abuse sector.

Commissioning principles



Commissioning principles

These commissioning principles have been formulated from the overarching Victims' Services Commissioning Framework produced by MoJ.¹⁸ They provide a basis for good commissioning decisions for CSA support services.

Principle 1 - Commission services according to need

Assess need through analysis of robust evidence. Use demographic and other data to target communities and groups that find it hard to access support, or have suffered the greatest impact.

Commissioning decisions must be based on a good understanding both of the current and future needs of individual victims and survivors, and whether those needs are being met by existing services. If understanding of people's needs is poor then the design and delivery of services is unlikely to meet their needs and achieve the outcomes required.

Principle 2 - Understand the local commissioning environment

Develop an understanding of all commissioning bodies' roles and aligned strategies. Ensure best use of resources to build capacity and achieve the highest quality of services. Understand the commissioner's role in local provision and boundaries of responsibility. Consider also the pathway for typical individuals and how each service can refer to another as seamlessly as possible.

A good understanding of the local commissioning landscape is needed to ensure services are co-ordinated, existing resources are utilised, best practice is shared and victims of CSA are provided as seamless a service as possible. Consideration should also be given to the transition between child and adult services.

Principle 3 - Put the victim at the centre of service delivery

Keep victims and survivors safe and support them to cope with the immediate impacts of abuse, facilitate long-term recovery and improve emotional wellbeing. Ensure complex needs are taken into account. Ensure the support pathway runs smoothly and consider how recovery can be measured.

Every victim and survivor has different experiences, reactions and needs. Commissioners should ensure that services are flexible and responsive to the experience of victims and survivors.

¹⁸ <https://www.gov.uk/government/publications/victims-services-commissioning-framework>

Principle 4 – Services should be locally led and should involve multi-agency working

Improve partnership working. Involve, engage and empower communities to seek, design and deliver services. Look to commission services which work across agencies. Talk to sector experts not just as bidders but as providers of knowledge.

The value afforded to multi-agency work for child safeguarding in England is evident in statutory guidance Working Together to Safeguard Children.¹⁹ Specifically for victims of CSA, multi-agency working can help reduce the likelihood of re-traumatisation. While needs will vary, this fundamental principle extends to both adult and child victims and survivors of CSA.

Principle 5 – Assess the value of services by measuring outcomes rather than activity

Measure success according to the result of the support provided. Outcomes should include helping victims and survivors cope with the impact of abuse and establishing improved emotional and physical wellbeing.

Outcome-based commissioning is about defining and establishing the outcomes which need to be achieved for victims to establish improved emotional and physical wellbeing. It is important to be ambitious and seek best practice, both from the domestic and international arena, to achieve the desired result. This approach is important for tracking the progress of service users, improving the quality of the service and providing evidence of the service's impact.

¹⁹ <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

Commissioning practice: collaborative working



Commissioning practice: collaborative working

“Specialist child sexual abuse services seem to suffer because they fall between health, justice and social care.”

Service Provider

The commissioning landscape for CSA support services can be complicated and fragmented. This has led to gaps in service provision causing difficulties for both adult and child victims and survivors in accessing the services they need at the right time.²⁰ It is important for a collaborative approach to be taken to:

- provide consistency of provision
- encourage more joined-up services
- provide a cost-effective approach for both commissioners and service providers

The Strategic Direction for Sexual Assault and Abuse Services²¹ recognises this, with a key ambition to encourage integrated commissioning and service provision.

In any given area, at a minimum, the following organisations have some responsibility for commissioning CSA victims’ services:

NHS England: responsible for Sexual Assault Referral Centres (SARCs) and Tier 4 Child and Adolescent Mental Health Services (CAMHS).

Clinical Commissioning Groups (CCGs): commission most of the hospital and community NHS services in the local areas for which they are responsible including mental health services for adults and children.

Police and Crime Commissioners (PCCs): responsible for the local commissioning of the majority of services to support victims of crime and also work in partnership with service providers and other commissioners of services to ensure an integrated approach to supporting victims. For example, many PCCs co-commission services for survivors of sexual violence, such as SARCs, with health commissioners/NHS England.

Local authorities: have a key leadership role around CSA because of their statutory responsibility for social care and safeguarding children. This ranges from understanding the profile and prevalence of sexual abuse in their local area, to working with partners to ensure that responses are co-ordinated.²²

In some areas other organisations, such as independent funding bodies, will also fund victims’ services.

20 <https://www.csacentre.org.uk/research-publications/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/>

21 <https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>

22 <https://www.csacentre.org.uk/research-publications/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/>

Responsibilities, governance and partnership

Commissioners should look for opportunities to jointly commission CSA services. For joint commissioning to work, there needs to be clear responsibilities and robust governance. When exploring commissioning options, effective leadership must be established to ensure services are responsive to the needs of victims and survivors of CSA. The following are key components to achieve this:

- **Form a joint commissioning committee**
Identify the right people, bring commissioning bodies together and meet on a regular basis to agree priorities, service needs, discuss budgets etc. Annex C lists key stakeholders and suggested membership – although note that commercial decisions should not be made by a group including potential beneficiaries. Links must be made with Health and Wellbeing Boards in particular. Consider if the development of CSA services needs to be as part of a wider sexual abuse or violence agenda.
- **Identify a lead organisation**
As responsibility for victims and survivors of CSA falls across a number of organisations, this can vary but there has to be a lead agency driving the joint commissioning forwards. The lead organisation should be identified and agreed by the joint commissioning committee. In most cases however, the lead organisation is likely to be the chair of the joint commissioning committee.
- **Agree terms of reference for the committee**
These should clearly set out the objectives of the committee.
- **Create joint commissioning agreements**
These will be required to formally implement joint working between commissioning bodies. This should include interoperability protocols for joint working with clear lines of reporting and must set out clear policies for information sharing, risk management and risk sharing.

Mapping local structures

Mapping the key agencies and local structures relevant to CSA commissioning in the area will allow commissioners to identify the right contacts. At a minimum, commissioners should have a collective understanding of every partner with a stake in local service provision or a formal role to play. This will also help to develop appropriate governance structures for joint working. This mapping should include key information on what role organisations perform, what operational policies they have in place and what role they play in assessing risks and, where relevant, delivering services to victims.

Joint strategy

Commissioning bodies should work towards producing a joint strategy, setting clear responsibilities and goals. The process of producing joint commissioning strategies is a key platform for exploring sexual abuse and exploitation issues locally, and has been emphasised as an effective way for commissioners to help consolidate joint working between health, local authority, and wider partners.²³ This is something that is made clear in the Strategic Direction for Sexual Assault and Abuse Services.

The strategy should cover CSA, including CSE, HSB and sexual violence. While there are often CSE strategies in local areas, there are currently fewer CSA and HSB strategies. These issues have significant cross-over and should be aligned under one strategy.

Additionally, other relevant strategic plans such as violence against women and girls (VAWG) and Health and Wellbeing Board plans should be considered. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) reports on police response, local force action plans and learning from other CSA reports including joint targeted area inspections should be linked into local commissioning strategies.²⁴ This should not be an onerous task, but is about bringing together existing work to help identify gaps.

23 <https://www.csacentre.org.uk/research-publications/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/>

24 <https://www.gov.uk/government/publications/joint-inspections-of-the-response-to-child-sexual-abuse-in-the-family-environment>

Pooling budgets

Commissioners should aim to pool local budgets and funding sources. Having a number of different funding streams contributes to the complex commissioning landscape and makes it harder for service providers to know where to bid to. Pooling budgets will promote integrated services, prevent duplication of effort and increase efficiency. It allows organisations to align services against agreed outcomes and facilitates and promotes joint commissioning.

There are some legal mechanisms in place to allow for pooled budgets such as Sec 75 NHS Act 2006²⁵, which allows budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be reallocated between partners. Commissioners should also encourage, where possible, working collaboratively across trusts to achieve scales of economy.

While there is currently no statutory provision to underpin the pooling of budgets between NHS England, CCGs, local authorities and PCCs, which can cause barriers, this is something commissioning bodies can still consider.

Advisory group

It is important for commissioners to consider relationships with key stakeholders beyond commissioning colleagues to build local networks and capacity. An advisory group to inform joint commissioning decisions is a way to involve other professionals, service providers, victims and survivors in decision making, drawing on frontline expertise and experience.

An advisory group should create proactive and constructive links and ensure that the victim is at the centre of service delivery. Membership could include:

- local domestic and sexual violence co-ordinators
- multi agency safeguarding hubs
- non-statutory service providers
- victims and survivors

The importance of the involvement of victims and survivors in making commissioning decisions is highlighted as one of the fundamental commissioning principles and an advisory group can be an effective method to implement this.

²⁵ www.legislation.gov.uk/ukpga/2006/41/section/75

Commissioning practice: assessing need



Commissioning practice: assessing need

Services must be commissioned according to need, ensuring the victims and survivors are at the centre of delivery. Commissioners must understand the need in their area for CSA services, which should be used to directly inform future service specification and delivery. In particular, commissioners should be aware that police-recorded CSA will only represent a fraction of overall CSA taking place locally. This will ensure that CSA services are targeted, with the needs of victims and survivors fully understood. The following provides guidance for the method of undertaking a comprehensive and effective needs assessment for CSA services.

1. Compile existing sources of information

The following are examples of the types of data sources commissioners should use when assessing need:

- national prevalence statistics
- caseload and waiting lists of existing support services
- existing, relevant joint strategic needs assessment (JSNA)
- CAMHS transformation plans
- joint commissioning strategy for mental health services or children's services
- data on police recorded crime and the Crime Survey for England and Wales published by the ONS
- publications and research on the prevalence of CSA such as from the CSA Centre²⁶
- Ofsted reports for local providers
- Serious Case Reviews
- service provider activity data
- clinical commissioning groups' performance data
- Police National Intelligence Model problem profiles
- Care Quality Commission reviews
- health and wellbeing boards' data
- Health Watch data

2. Map existing services against need

Mapping which services are currently available to victims across an area from public, private and third sector providers can be helpful to understand the local environment and assist joint working. Although good services should be re-commissioned, it is important that a mapping exercise does not prevent a full consideration of need and which services are required to meet this.

Mapping of services should go beyond specialist CSA provision. For example, other local services and agencies may be working with children, adults and young people vulnerable to CSA but not on CSA related issues. This could include services for young and older people with learning disabilities, services for young people and older people in contact with the criminal justice system and normal service interactions, such as school nurses, GPs, health visitors, cope and recovery services.

Key tips for mapping CSA services:

- Map current services providing support for child and adult victims and survivors including both statutory and voluntary sector provision
- Undertake a gap analysis of services, considering location and service types and identify elements of the pathway that are missing
- Estimate the existing capacity in service providers
- Estimate the current demand for services from activity data and local audits
- As far as possible, consider future demand looking at national trends and the impact of preventative services, such as awareness raising

²⁶ www.csacentre.org.uk/research-publications/scale-and-nature-of-child-sexual-abuse-and-exploitation/

3. Involve victims and survivors and service providers in the process

The views and experiences of those accessing services and frontline organisations are essential to having an informed and comprehensive understanding of local need. It is also important to understand whether there are any barriers to accessing support. An advisory group can be an effective way to engage victims and survivors in the commissioning process, but victims and survivors themselves might have a particular view or preference. One such example is the Amplified Hub run by Young Minds, NHS England and North East London Commissioning Support Unit. It seeks to develop the participation of children, young people and their families in every level of the mental health system. In February 2018, the Amplified Hub published their insights survey where young people, parents and carers expressed their opinions on their participation in mental health services.²⁷

4. Analysis and interpretation

Time must be taken to understand and analyse the information gathered, which will allow the identification of gaps, establish priorities and indicate which services are required.

The following provides a checklist for commissioners to identify if they are conducting an effective CSA needs assessment:

- Have you engaged directly with victims and survivors, local service providers and others to gain an understanding of the needs of victims and the types of services, which might best meet those needs? Engaging with adult and child victims and survivors and providers will help to understand the wide range of CSA, such as intra-familial and extra-familial, online sexual grooming and image offences and how this may alter the support services required by victims and survivors. NHS England, for example, have a legal requirement to engage with victims and survivors as part of commissioning.

- Have you considered associated vulnerabilities outside CSA and that victims and survivors may have suffered victimisation beyond CSA? Relationships with other relevant commissioning bodies or joint commissioning relationships will help to make better links between relevant services, such as modern slavery, gang and youth violence, children in care, adult social care etc. and consider how these may cross over, or work together.
- Have you considered HSB as part of the needs assessment? HSB is a complex issue, closely linked to CSA, in which both the needs of the victims and perpetrators must be considered.²⁸
- Do you understand local demography sufficiently? What particular groups exist in the area? Which social demographics and ethnicities are represented. Is there a prison population? Are there children and young people's secure settings? Are there significant numbers of care leavers? How are these populations changing and what does that mean for service need?
- Do you understand the likely issues of groups identified in the local demography and of other general groups such as men, younger children and older people who may be victims of non-recent CSA? Male victims and survivors, for example, are known to make up a higher proportion of victims of non-recent abuse in institutions or by persons of public prominence.²⁹

27 <https://youngminds.org.uk/media/2152/amplified-insights-survey-2018.pdf>

28 www.nspcc.org.uk/globalassets/documents/publications/harmful-sexual-behaviour-framework.pdf

29 <http://www.npcc.police.uk/NPCCBusinessAreas/OtherWorkAreas/OpHydrant/Statistics.aspx>

- As far as possible, have you identified the likely prevalence of CSA in your area including online abuse and exploitation? Use demographic data as well as other sources, such as local crime data and national research. Recognise that members of groups who do not commonly disclose (including those that were sexually abused in a familial setting), may not do so because they do not find disclosure easy, rather than because there is no problem. Crime data alone cannot reveal the full extent of the issue in a local area because of the underreporting of CSA.³⁰
- Have you considered groups or communities that find it hard to access support? For example, people with learning difficulties, a group which, evidence suggests, are more likely to be victims of CSA.³¹
- Are you aware of the eight categories of need: mental and physical health; shelter and accommodation; family, friends and children; education, skills and employment; substance misuse; finance and benefits; outlook and attitudes; and social interaction?³² Services should be targeted in line with these, recognising that they are likely to cover more than one category.
- Is there any prevention work ongoing, or planned, in your area? Prevention activity can lead to an increase in disclosure; spikes in demand can, to a degree, be anticipated and should be robustly planned for in terms of increased referrals to existing services.

Transition pathways

It is important for commissioners to note that the transition from youth to adult services can be an extremely vulnerable time, as the entitlement to, and availability of, a range of statutory support services, changes significantly in a short space of time.

Commissioners should consider what is best for the individual when considering the transition.

30 www.beds.ac.uk/media/86813/makingnoise-20042017.pdf

31 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)60692-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60692-8/fulltext)

32 [Victims' Services Commissioning Framework \(Ministry of Justice, 2013\)](#)

Commissioning practice: identifying and measuring outcomes



Commissioning practice: identifying and measuring outcomes

Outcome measures are vital to allow commissioners to understand the impact of services for victims and survivors and to align funding to services which achieve the greatest impact. While outcome focused commissioning can be challenging, commissioners should encourage services to focus on outcomes as:

- It ensures that services focus on the benefit for victims and survivors rather than only on process and outputs
- It encourages services to develop monitoring and evaluation processes and embed outcomes measurement within their work.

The effects of CSA on victims and survivors can vary significantly. Likewise, services responding to CSA and the outcomes they seek to achieve are diverse. Commissioners are therefore encouraged to use a range of appropriate outcome measures. These measures should be tailored to the victims' and survivors' needs. For example, a significant proportion of services work with children and young people who may still be suffering abuse, and for these, no longer being abused is a key outcome. Whereas if a child or adult is safe, having a stable living situation or a positive relationship with an adult may be essential to their welfare.³³

It is important for commissioners to avoid imposing either outcomes or measurement tools on services. Where possible victims and survivors should be consulted in the process of developing outcome measures and service design.

Commissioners should aim to include service improvements and continuous learning as part of any monitoring and evaluation process. There should also be feedback loops in place to ensure managers and practitioners have access to information that enables them to make improvements.

The following provides key points for commissioners to remember when considering outcome measures:

- A collaborative approach must be taken to establish outcome measures, with communication between commissioners, service providers and victims and survivors
- Outcome measures should be reviewed on an ongoing basis to ensure they reflect adequately an ever-changing CSA environment
- Consider a range of measures and indicators, including victim-reported outcomes, staff-reported outcomes, and qualitative outcomes
- Ensure the measures are tailored to the level of funding, type of service and size of the organisation, ensuring measures are not onerous
- Ensure outcome measures encourage sustainability of support provision to reflect the long-term process of recovery for victims and survivors

33 www.csacentre.org.uk/research-publications/effectiveness/measuring-your-effectiveness/

In relation to effective services for children and young people, key principles identified by the CSA Centre's Knowledge Review included the ability to provide:³⁴

- A consistent relationship with a support worker
- A trusting relationship with staff
- Flexible support (flexible timeframes and a range of support available)
- Support for non-abusing parents or carers

Other factors in measuring outcomes for victims and survivors of child sexual abuse that commissioners may wish to consider include:

- The negative impact that the repeated use of measurement tools could have on victims and survivors who have experienced trauma
- Practitioners should consider building a relationship with victims and survivors before presenting them with measurement tools
- While the service user's own view is essential it is also important to collect information from practitioners and, where possible, parents and carers
- Change required can take a long time to happen. In some cases, changes may only manifest themselves years or even decades later.

See Appendix D for suggestions of outcome measures that might be suitable for services responding to CSA.

For more information on outcomes and monitoring and evaluation of services, see the CSA Centre's resources on commissioning and providing effective services.³⁵

34 Effectiveness of services for children and young people affected by child sexual abuse: A knowledge review, Di McNeish, Liz Kelly and Sara Scott, Centre of expertise on child sexual abuse. Forthcoming 2019

35 www.csacentre.org.uk/research-publications/effectiveness/

Examples of commissioning practice



Examples of commissioning practice

The following section provides a snapshot of interesting commissioning practice and is broken down into two sections. The first part looks at what support services could be considered and the second part looks at commissioning practice going on in the sector and how such services are commissioned through collaborative working, assessing need and looking at outcome measures.

1. Support services

Therapeutic intervention

Holistic therapeutic intervention should be considered when commissioning support services for victims and survivors of child sexual abuse. The National Institute of Clinical Excellence (NICE) recommends therapeutic interventions for children, young people and families after sexual abuse.³⁶ This includes services such as trauma-focused cognitive behavioural therapy, counselling, socio-educative and creative therapy. It is important to ensure therapeutic interventions are available which target both adult and child victims and survivors.

While this is a developing area, therapeutic interventions are being increasingly used in the sector with some positive results.

Letting the Future In

Letting the Future In is a structured therapeutic intervention developed by the NSPCC and implemented by 20 NSPCC service centres across England, Wales and Northern Ireland since 2011. It is available to children aged 4 to 17 who have made a disclosure and experienced sexual abuse, and involves individual sessions for the child as well as additional support sessions for the child's primary carer. A recent impact evaluation³⁷ examining the outcomes of this therapy found that older children and young people receiving treatment saw a statistically significant decrease in clinical symptoms (i.e. distress, trauma-related symptoms) at six-month follow-up. The evaluation also showed that the cost of the intervention for the NSPCC was £2,300 per case compared to an average case for Child and Adolescent Mental Health Teams (CAMHS) of almost £5,000.

Elements of good practice highlighted by children and carers were the positive therapeutic relationship and the supportive atmosphere fostered by practitioners. While further development of this and other therapeutic interventions are needed, particularly among younger children, this independent evaluation provided promising evidence of the effectiveness of therapeutic support in decreasing mental health problems associated with experiences of sexual abuse. The evaluation also demonstrated that therapeutic support can be provided by those from a social work background.

³⁶ www.nice.org.uk/guidance/ng76/chapter/Recommendations#therapeutic-interventions-for-children-young-people-and-families-after-child-abuse-and-neglect

³⁷ <https://learning.nspcc.org.uk/research-resources/2016/evaluation-of-the-letting-the-future-in-service/>

IMARA CIO

IMARA is a Nottingham-based specialist service that provides a systemic, early intervention service for children and young people following a disclosure or discovery of CSA. IMARA offers therapeutic care and provides legal and advocacy support for both survivors and safe family members e.g. siblings and parents.

IMARA aims to empower and promote the recovery of children, young people and their families affected by child sexual abuse, by offering early intervention in the form of:

- Access to pre-trial therapy
- Specialist risk and needs assessment, and referral to appropriate support and services
- Information, advice and consistent contact throughout the judicial process
- Support with education, health, housing and financial concern

Where appropriate IMARA works with children and young people within their family unit, empowering them to access and use the resources they have within themselves and their family in order to overcome the trauma and thrive going forward. This includes working not only with children and young people, but also their safe family members, including parents, carers, siblings and grandparents for whom a disclosure or discovery that sexual abuse has been occurring within their family and home can have profound and severe impacts.

Prevention services

While this framework is targeted at support services for victims and survivors, prevention should be considered as part of a whole system approach and included in the local strategy. Prevention services are those which look to prevent CSA from happening. Prevention could include: awareness campaigns; educating parents about abuse; identifying vulnerable families to reduce risks; training of teachers and school nurses in identifying signs of abusive behaviour and CSA; and addressing other vulnerabilities such as domestic abuse, substance misuse and mental health.

Licensing splinter group

Developed in partnership between the Slough LCSB and Thames Valley Police, a CSE awareness raising campaign was delivered to licensed premises, including taxi firms and private hire taxi drivers. A licensing splinter group was established with links to the CSE sub-group and with representation from Slough Borough Council, a CSE specialist team worker, and the police. Teams co-ordinated premise visits, developed informational brochures and posters, and educated taxi-drivers and workers in licensed establishments such as hotels and pubs on the warning signs of CSE. This model of awareness-raising on a community-wide level was highlighted as demonstrating good practice in promoting vigilance across sectors and encouraging referrals from individuals working in environments identified as being at high risk for sexual exploitation.

In May 2014 the Engage team at Slough Council received an award from the National Working Group: Tackling Sexual Exploitation Network for their work to address CSE. The council's licensing team was also recognised in early 2014 with a Berkshire Environmental Health Officers Award for Achievement for their work on raising awareness of CSE.

Linked to prevention are services that tackle HSB, which should not be overlooked by commissioners. HSB is sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult.

At least one third of all sexual offences against children and young people in the UK are committed by other children and young people. The NSPCC harmful sexual behaviour framework provides further detail.³⁸

Support to victims in the criminal justice system

Commissioners should be aware that the MoJ introduced a code of practice for victims of crime in 2006 which was updated in 2013 and expanded in 2015.³⁹ The code of practice is a statutory document. It sets out how victims of crime should be treated by the criminal justice system. The code states that extra support should be given to three priority categories of victims – victims of the most serious crime, persistently targeted victims, and vulnerable or intimidated victims.

Victims and survivors should not be denied the early therapeutic support they need to recover from the harm experienced and to cope with what happened to them. CPS guidance⁴⁰ makes it clear that both child and adults victims and survivors can receive pre-trial therapy. Commissioners should therefore ensure appropriate provision for pre-trial as well as post-trial support.

Commissioners should pay special attention to the needs of young witnesses, including where specialist communicators such as registered interpreters can play a role to support the criminal justice process and the therapeutic process.

Multi-agency services

The statutory guidance Working Together to Safeguard Children⁴¹ makes it clear that a multi-agency approach is fundamental to the safeguarding of children. Following this principle, some commissioners are moving towards a multi-agency approach to victim support, bringing together key services such as medical, legal and advocacy services in one place. For some victims and survivors, this type of service can help prevent re-traumatisation and improve outcomes in terms of care, evidence gathering and criminal justice outcomes.

NHS England has produced a toolkit for commissioners on a CSA hub model which provides guidance for setting up a hub based on experiences in London.⁴² The CSA hub model is a one stop shop for medical, advocacy and early emotional support for children and their families that have experienced CSA as well as offering advice and liaison to police and children's social care services. Children and young people attending the hub can access a holistic health assessment, examination, sexual health screening and treatment, with referral to long-term support as needed. The CSA hub model was developed to make the best use of existing services, creating a network of expertise and investing in additional emotional support following learning from international best practice. It is a first step towards a 'Child House' model.

38 www.nspcc.org.uk/globalassets/documents/publications/harmful-sexual-behaviour-framework.pdf

39 www.gov.uk/government/uploads/system/uploads/attachment_data/file/476900/code-of-practice-for-victims-of-crime.PDF

40 <https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-child-witnesses-prior-criminal-trial>

41 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

42 <https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2017/04/Child-Sexual-Abuse-Hub-Toolkit-March-2017.pdf>

The Lighthouse

The Lighthouse is a two-year pilot project run by University College London Hospitals (UCLH), the Tavistock and Portman NHS Foundation Trust, and NSPCC which adopts a model known as Child House. The Lighthouse is a multi-agency site which offers, in one location, medical, investigative and emotional support to children and young people who have experienced CSA. The hope is that this multi-agency approach will offer longer-term support to victims of CSA in the criminal justice system as well as helping gather better evidence and increasing the speed of its delivery to court.

The Child House model in England is based on the 'Barnahus' model developed in Iceland which is now spreading across Europe. The original model is essentially a one-stop-shop for victims of CSA, providing medical examinations, therapeutic support and ABE interviewing all under one roof in a child-friendly setting. It has produced excellent results for both children and the criminal justice system across Scandinavia, with a higher number of convictions and improved outcomes for child victims.

In England, Police and Crime Commissioners and NHS England commission Sexual Assault Referral Centres (SARCs) to provide acute healthcare, forensic medical examination, follow-up to address medical or psychological needs and access to Independent Sexual Violence Advocates (ISVAs). Provision for children and young people varies across regions with some SARCs providing a paediatric SARC service and others supporting children in generic SARC services. The service model recommended by NHS England for meeting the needs of the child or young person who has been sexually abused is to deliver through a managed clinical network with acute forensic examination and care delivered at a SARC "hub" and referral pathways in place to local paediatric services for support and follow-up care where these are needed.

While the hub model, Child House, and children and young people's SARCs provide a high standard for multi-agency work, commissioners should promote every avenue for joint commissioning, whether a physical building is available or not. All areas should have both adult and child and young person provision, including longer-term therapeutic care. It is the responsibility of CCGs to work in partnership with SARCs and other commissioners to develop robust pathways of care in a locality, including effective partnerships with the voluntary sector. Self-referrals into voluntary sector services must also be considered in any commissioning process.

The Hub and Spoke model

As part of the Alexi Project a Hub and Spoke model, designed to rapidly increase the capacity and coverage of specialist, voluntary sector CSE services in England, was implemented. The model involved a voluntary sector organisation (the hub) placing experienced CSE workers (spokes) either in its own or into new neighbouring local authority areas to extend its coverage and reach. These spoke workers undertook a variety of activities, including individual casework with children and young people, consultancy, and training and awareness-raising with children and young people and practitioners. 16 CSE services were funded for three years each, placing 53 spoke workers into 35 new local authorities.

The Hub and Spoke programme was evaluated by a team at the University of Bedfordshire: The International Centre: Researching child sexual exploitation, violence and trafficking. There are a series of key recommendations for commissioners in the key messages report⁴³ including: the conditions for effective partnerships between voluntary and statutory agencies; that involving voluntary sector services in co-location arrangements can be an effective method of partnership working and diffusing good practice in CSE; and that the Hub and Spoke model improves standards in local safeguarding – it extends the reach of training and resources, and shows how good casework can be undertaken.

Services responding to the wider context

CSA has a serious impact not just on the individual child or adult but on all the relationships in the family. For services to be effective it is likely that intervention with other family members, such as the non-abusing parent or carer and siblings, will be needed. Intervention may include: emotional support for parents in coping with what has happened; relationship building work between the victim and their parent or carer; and wider family communication work. In addition, when sexual abuse takes place in a family, other issues, such as parental mental ill-health or substance misuse, can be triggered or exacerbated, requiring additional services to meet these resulting needs. As such, thinking about the wider family context is essential.⁴⁴

This links with ongoing work on contextual safeguarding which may be helpful to understand for a wider commissioning environment approach. Hackney Council and the University of Bedfordshire have implemented a contextual safeguarding framework to strengthen the safeguarding response to vulnerable children and young people. The project provides an opportunity to create an enhanced safeguarding system that is equipped to identify, assess and engage with peer groups and with public and social spaces in which young people are exposed to significant harm.

43 <https://www.alexiproject.org.uk/assets/documents/Key-messages-Alexi-Project-Evaluation.pdf>

44 <http://www.csacentre.org.uk/research-publications/supporting-parents/evidence-review-by-sara-scott-and-di-mcneish-dmss-research/>

2. Commissioning practice

Collaborative working

Essex PCC

In 2015, the PCC for Essex undertook a victims' needs assessment which highlighted an inconsistency in the availability of specialist support for all victims of sexual abuse in Essex. The PCC made a commitment to rectify this inconsistency and was also keen to remove some of the reported instability of specialist support agencies for these victims by providing long-term funding via a commissioned contract that removed the unpredictability of existing grant arrangements. This was achieved by commissioning an all-age, holistic system of support for any victim of sexual abuse, regardless of where in Essex they live, when the abuse occurred, and any demographic factors such as age or gender. The tender was split into two lots: one for an ISVA service and one for a community-based wrap-around service of therapy, counselling and other advocacy services, made available to victims regardless or not of whether they have reported to the police.

In commissioning this service the PCC sought to ensure support was available to all victims and that it was appropriate, victim-led, timely and accessible. The PCC's office worked with the successful bidder to develop a performance toolkit which demonstrates the positive impact delivered by the service to ensure it was understood how well the contract has delivered against the PCC's objectives of supporting victims to cope and, as far as possible, recover from their experience.

Frankie Workers – Hampshire

PCCs and CCGs have worked together to fund a new dedicated counselling service for victims of CSA, CSE and female genital mutilation. Frankie Workers aim to prevent trauma developing into poor mental health.

The Frankie Workers service is available to children aged 0 to 18 years. The Hampshire Frankie Workers are provided by YPI Counselling, a Basingstoke-based charity specialising in counselling for young people, and work closely with Hampshire County Council's children's services.

Kingfisher Team – Oxfordshire

The Kingfisher Team is a joint team set up by social care and police in Oxfordshire with the support of local health services, the city council, and Barnardo's, which was developed as a centre of knowledge and skill that offers a first response to concerns about CSE. This service provides the local area with a first point of contact for all professionals working with children if and when concerns are raised, and enables sites to pool together information and expertise. Low caseload numbers and strong relationships with other agencies are just some of the ways this team has demonstrated good practice.

Project Phoenix – Greater Manchester

Project Phoenix is Greater Manchester's single, collaborative effort, which aims to improve consistency and cross-border working between local authorities in Greater Manchester. Under Project Phoenix, there are now specialist CSE teams in place in each of the 10 districts of Greater Manchester. One of its primary achievements has been to develop and produce a risk assessment tool used to measure a young person's risk of CSA/CSE; young people across all areas of Greater Manchester will receive the same assessment, meaning that local authorities and key partners have a shared definition and understanding of risk. This structured professional judgment tool also allows for a consistent approach to data collection, so that a fuller picture of the scale and scope of CSA/CSE issues is developed.

Catch 22 – Merseyside

Since 2017 the PCC for Merseyside has commissioned a joint CSE and child criminal exploitation service - the Pan Merseyside Child Exploitation Service - which is being delivered by the provider Catch 22. The PCC has also worked with local authority partners to co-commission joint missing from home and child exploitation support services with two of the five Merseyside local authorities. This has allowed for joint contract management, a more joined-up approach to service delivery, care for victims, and ties in the service to tactical and strategic management through multi-agency child exploitation meetings. Combining the child exploitation and missing from home services allows for seamless referral from one element of the service to another.

Furthermore, the PCC has worked with other agencies to co-commission an aftercare service for sexual assault victims. The PCC currently delivers an aftercare/long-term support provision for sexual assault survivors across the region. Since 2018, the PCC has jointly commissioned with NHS England and three of the five Merseyside local authority areas offer a joint aftercare and ISVA service for Merseyside victims, jointly delivered by RASA and RASASC organisations. This has proven to have the same benefits in terms of efficiency and improved support for victims as the child exploitation commission.

Review and evaluation



Review and evaluation

Local

Commissioners must continually review the impact of individual services commissioned using appropriate outcome measures and outputs. In addition, there also has to be an overarching review of whether the system as a whole is appropriately responding to the needs of victims and survivors in line with the needs assessment for the area. To do this commissioners must:

- continually listen to the concerns and issues of victims and survivors and service providers through advisory groups
- be alert to developments and emerging trends in the area of CSA through the service providers, other commissioning bodies and agencies, the media and government
- continue dialogue and joint working with commissioners in the area to keep mapping of services up to date

National

This framework is intended to encourage a more joined up approach to commissioning child sexual abuse and exploitation services, ensure delivery is tailored to the needs of victims and survivors in different areas and to share best practice.

The Home Office and key partners involved in the development of the framework are keen to ensure it has been utilised by commissioners and has had a positive effect on the commissioning environment. The publication is intended to be a living document which can continue to be used for the future, developing in line with the sector.

The Home Office will commit to:

- implementing a review of the framework after one year of publication, producing the next iteration in 2020
- seek feedback and understand what has worked, what has not worked and how the approach could be improved
- continue to support the sharing of best practice, working with others to develop thinking about the role of central government in facilitating the sharing of best practice across the sector
- continue to work together with partners across government to ensure alignment with other relevant work streams.

Please send any feedback on this Commissioning Framework to CSACommissioningFramework@homeoffice.gov.uk

Annexes

Annex A: Responsibilities

Commissioning responsibility	Service
NHS England	<p>Sexual Assault Referral Centres (SARCs) responsible for forensic medical examinations, medical care/support and follow up services in collaboration with PCCs/police</p> <p>Child and adolescent mental health services Tier 4 (CAMHS Tier 4)</p> <p>HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE))</p> <p>Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs</p> <p>Long-term specialist mental health services</p> <p>General Practice</p>
Clinical Commissioning Groups	<p>Mental health and Improving access to Psychological Therapies (IAPT); services for depression and Post Traumatic Stress Disorder (PTSD) that understand the specific needs of victims and survivors of sexual assault and abuse, including the third sector</p> <p>Non-sexual health elements of psychosexual health services</p> <p>Secondary care services, including A&E</p> <p>NHS 111</p> <p>Sexual health services for children and young people including paediatric care/support</p> <p>CAMHS Tier 3</p> <p>Voluntary sector services (in some areas)</p>
Police and Crime Commissioners	<p>Grant funded to commission or deliver support services for victims of crime including victims of CSA</p> <p>Victim referral hubs – assessing need and onward referral to victims' services (entitlement set out in Victims Code of Practice and the EU Victims' Directive 2012/29/ EU, adopted by the UK in 2012)</p> <p>Police 101</p> <p>In some forces, the police lead on the procurement of SARC services (see above for NHS)</p>
Local authorities	<p>Comprehensive sexual health services (excludes additional services commissioned from primary care)</p> <p>STI testing and treatment, Chlamydia screening and HIV testing</p> <p>Sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools such as school nurses, health visitors</p> <p>Voluntary sector services</p>
Ministry of Justice (MoJ)	<p>Contribute to some rape and sexual violence support services from the voluntary sector</p>

Annex B: Supplementary publications and guidelines

- The cross-government Victims Strategy (2018): [Victims Strategy](#)
- Ministry of Justice, Victims' Services Commissioning Framework (2013): [Victims' Services Commissioning Framework \(Ministry of Justice, 2013\)](#)
- NHS England, Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (2015): [Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres \(SARC\) Services \(NHS England, 2015\)](#)
- NHS England, Service Specification No. 30 Sexual Assault Services: [Service Specification No. 30 Sexual Assault Services \(NHS England, 2012\)](#)
- NHS England, Sexual Assault and Abuse Strategy <https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>
- HM Government, Working Together to Safeguard Children (2018): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf
- National Institute for Health and Care Excellence (NICE), Child abuse and neglect: www.nice.org.uk/guidance/ng76/chapter/Recommendations#therapeutic-interventions-for-children-young-people-and-families-after-child-abuse-and-neglect
- NSPCC, Harmful sexual behaviour framework: www.nspcc.org.uk/globalassets/documents/publications/harmful-sexual-behaviour-framework.pdf
- Ministry of Justice, Code of Practice for Victims of Crime (2015): www.gov.uk/government/uploads/system/uploads/attachment_data/file/476900/code-of-practice-for-victims-of-crime.PDF
- Centre of expertise on child sexual abuse. Local commissioning of services addressing child sexual abuse and exploitation in England (2018): www.csacentre.org.uk/research-publications/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/local-commissioning-of-services-addressing-child-sexual-abuse-and-exploitation-in-england/
- NSPCC, Child abuse and neglect in the UK today: www.nspcc.org.uk/globalassets/documents/research-reports/child-abuse-neglect-uk-today-research-report.pdf
- Children's Commissioner, Making Noise: Children's voices for positive change after sexual abuse (2017): www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/UniBed_MakingNoise-20_4_17-1.pdf Annex C: Stakeholders
- HMG, Ending Violence against Women and Girls: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF
- Centre of Expertise on child sexual abuse. Measuring the scale and changing nature of child sexual abuse and child sexual exploitation Scoping report (2017): www.csacentre.org.uk/csa-centre-prod/assets/File/CSA%20Scale%20and%20Nature%20full%20report%202018.pdf
- Centre of expertise on child sexual abuse. Measuring your effectiveness, using monitoring and evaluation to support effective intervention and recovery services for children at risk of or affected by sexual abuse: www.csacentre.org.uk/research-publications/effectiveness/measuring-your-effectiveness/
- Joint inspections of the response to child sexual abuse in the family environment (2018): www.gov.uk/government/publications/joint-inspections-of-the-response-to-child-sexual-abuse-in-the-family-environment
- Amplified Insights Survey Report (2018): <https://youngminds.org.uk/media/2152/amplified-insights-survey-2018.pdf>

Annex C: Stakeholders

Local authority	Chief executive of local authority
Local authority	Director / assistant director of children's services (responsible for all services for children and young people)
Local authority – social care	Head of safeguarding
Local authority – social care	Principal social worker / social care team leaders
Local authority – social care	MASH manager
Local authority – public health	Director of public health
Local authority – public health	Sexual health commissioner
Health – NHS England	Health and justice specialist commissioner (commissioner of SARC service)
Health – CCG	Chief officer of CCG
Health – CCG	Directors of commissioning and finance
Health – CCG	Directors of safeguarding
Health – CCG	Senior children's commissioner (in some cases joint with local authority)
Health – CCG	CAMHS commissioner
Health – CCG	Children's clinical lead
Health – CCG	Designated doctor for safeguarding
Health – CCG	Designated nurse for safeguarding
Health – CCG collaborative	Senior responsible officer for children for the sustainability and transformation plan footprint (STP)
Health – providers	Clinical director for local CAMHS service
Health – providers	Clinical/medical director at local health provider
Health – providers	Manager of children's services at local health provider
Health – providers	Named doctor at local health provider

Health – providers	Paediatricians carrying out medical examinations
Health – providers	Manager of SARC service
Police	Commander / assistant chief constable
Police	Chief superintendent for safeguarding
Police	Dedicated superintendent for specialist sexual offences teams
Police	Detective chief inspector for safeguarding teams (this could include specialist teams for rape, child abuse, CSE)
Police	Specialist sexual offences officers
Independent sector providers	CEO / service manager of rape crisis service
Independent sector providers	CEO / service manager of organisations employing independent sexual violence advocates (ISVA)
Independent sector providers	Service manager of local children's charities e.g. NSPCC, Barnardo's, Children's Society
Independent sector providers	CEO of local/national survivors' organisations/networks
Other stakeholders	Chair of the local safeguarding children board
Other stakeholders	Chair of the local health and wellbeing board
Other stakeholders	Local champions

Annex D: Examples of outcome measures for CSA services

The following is not an exhaustive list but some examples that can be considered by commissioners in the development or review of outcome measures.

Services for adults should focus upon meeting the following outcomes:

1. Help victims and survivors cope with the impact of abuse
2. Help victims and survivors improve their emotional and physical wellbeing as a form of recovery from the harm experienced

The following are examples that can be considered by commissioners in the development or review of outcome measures:

- Returning to employment or education
- Access to positive alternative activities, particularly for children and young people
- Increased social interaction and improved relationships
- Improved coping mechanisms
- Reduction in behaviours that indicate risk of further sexual abuse or exploitation particularly for children and young people (e.g. going missing, substance use, missing education, instances of offending)
- Improvement in subjective wellbeing measurement
- Level of victim satisfaction with support received

Commissioners may also wish to consider the outcomes identified through the CSA Centre's Evaluation Fund project.⁴⁵ The outcomes statements were that the child or young person:

- Has a positive, trusting relationship with an adult
- Has a suitable, stable living situation
- Is no longer being abused
- Is engaged with education
- Has reduced trauma symptoms
- No longer blames themselves
- Feels safe (in their body, family, neighbourhood)
- Has increased self-esteem/self-worth
- Is able to speak about their abuse
- Can imagine a positive future
- Is not going missing

The focus on outcomes measurement should not prevent services from collecting general feedback from victims and survivors, and where appropriate from their safe parents or carers, about the services they receive.

⁴⁵ www.csacentre.org.uk/research-publications/effectiveness/measuring-your-effectiveness/

