NHS England

Securing Excellence in commissioning sexual assault services for people who experience sexual violence

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Introduction

Purpose of the document

1. From April 2013, NHS England undertook its full duties to ensure that the NHS delivers better outcomes for patients within its available resources, and upholds and promotes the NHS Constitution. As a single national organisation, NHS England is responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality across the country. NHS England will work through its national, regional and area teams to discharge these responsibilities.

2. One of NHS England's responsibilities is to directly commission health services for people who experience sexual assault or rape. Sometimes the term "victim" is used for people who experience such violence but it is not a term that is universally liked. NHS England will commission Sexual Assault Services (SAS) in collaboration with Police Forces who commission the forensic medical aspects and related support, Local Authorities (LAs) on ongoing support and social care, and Police and Crime Commissioners and their Community Safety Partnerships (CSPs). This document sets out the operating model through which the NHS England will secure the best possible health outcomes for victims of sexual assault.

3. The operating model has been developed collaboratively with stakeholders across the NHS, Police and Youth and Criminal Justice System, including key contributions from colleagues in the Department of Health, regional and local NHS Offender Health teams and National Offender Management Service, the Home Office, commissioners of existing sexual assault referral services or Sexual Assault Referral Centres (SARCs) and public health colleagues. This document is one of a series describing the commissioning arrangements of NHS England, which includes primary care, specialised services, military health and those public health services commissioned by the NHSCB (i.e. screening, vaccinations, and child health for 0-5 year olds, sexual assault services and public health for people in prisons).

4. This document aims to support commissioners in delivering a consistent, high quality approach to the delivery of services that secure the best outcomes for victims of sexual assault and rape. NHS England will use the framework to drive local improvements in quality and outcomes and reduce health inequalities.

5. Sexual assault is non-consensual sexual contact, often but not necessarily, characterised by use of physical threat or emotional abuse. In this document, sexual assault and sexual violence are used interchangeably. The Sexual Offences Act 2003 created fifty-two sexual offences in England and Wales, all based on lack of consent,

except in relation to children.[1] Offences include sexual assault against children and young people under 16 years old, adults over 16 years old, people with mental disorders (mental illness or a learning disability), people trafficked for sex, giving substances without consent for sexual intent and sex between adult relatives. In law, there is a distinction between *rape, assault by penetration and sexual assault.*[2] *Rape* is vaginal, oral or anal penile penetrative sex without consent. *Penetration by assault* is to any part of the body (except the mouth) using any part of the body or anything else without consent. S*exual assault* is non-consensual sexual touching where the perpetrator has no reasonable belief that the victim is consenting. Any sexual activity with a child under 16 is an offence, including non-contact activities such as involving children in watching sexual activities or images or taking part in their production, or encouraging children to behave in sexually inappropriate ways. It is important to understand that SAS offer victims a total service whether or not they wish to report their experience to the Police and therefore the care they receive is by choice and they can also opt in/out of a police investigation. This key message needs to be understood widely by people in England to encourage uptake of services.

Overview

5. Section 22 of the Health and Social Care Act 2012[3] inserts a new power in section 7A of the NHS Act 2006, to enable the Secretary of State to delegate commissioning of public health services to the NHS England by mutual agreement. Sexual assault services (SAS) for victims of sexual offences are a public health function under this provision. In November 2012, the Department of Health and NHS England signed an agreement for NHS England to commission directly certain public health functions on behalf of the Secretary of State. The *Public Health Functions*[4] agreement covers thirty services, each with a specification, one of which is for SAS.[5]

6. Sexual assault services (SAS) *"integrate care pathways in a seamless way for victims, so they tell their story once and can choose care journeys to access crisis support , assessment, specialist clinical*

[1] Sexual Offences Act 2003. http://www.legislation.gov.uk/ukpga/2003/42/contents
[2] The Crown Prosecution Service. Sexual offences Act 2003. Legal Guidance. http://www.cps.gov.uk/legal/s_to_u/sexual_offences_act/#Sexual_Assault
[3] Health and Social Care Act 2012, http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[4] NHS Commissioning Board. Department of Health. Public health functions to be exercised by the NHS Commissioning Board. https://www.wp.dh.gov.uk/publications/files/2012/11/s7A-master-131114-final.pdf
[5] NHS Commissioning Board. Department of Health. Public health functions to be exercised by the NHS Commissioning Board. Service Specification No. 30. Sexual assault services. Police Forces in England jointly with the NHS Commissioning Board and Local Authorities. https://www.wp.dh.gov.uk/publications/files/2012/11/30-Sexual-Assault-Services-specification-121029.pdf

interventions, options for forensic medical examination, support, counselling and where needed mental health and other physical health services such as gynaecology. SAS enables co-ordination with wider health and care, third sector specialist sexual violence support and criminal justice processes, to improve health and well-being, as well as justice outcomes. Robust partnership working is therefore vital for the care and criminal justice outcomes that service users and victims want."[6]

7. NHS England will commission Sexual Assault Services which cater for the needs of victims of sexual assault. The reason for including SAS within the responsibilities of NHS England is the close alignment needed between the NHS and Police to deliver specialist services of relatively low volume equitably, which address both the patient's health needs and forensic enquiry to support any criminal investigation, and the wider recovery and safety needs of victims. The health aspects of SAS will be funded through the public health ring fenced allocated to NHS England

8. NHS England will be responsible for ensuring that services are commissioned in ways that support consistently high standards of care and quality across the country, and which promote the NHS Constitution and deliver the requirements of the Secretary of State's Mandate with the NHS England.

9. *Developing the NHS Commissioning Board (July 2011)*[7] sets out a number of features that will characterise the culture of the NHS England. The proposals for commissioning services for victims of sexual assault reflect these characteristics and key requirements:

- A clear **sense of purpose** focused on improving quality and outcomes
- A commitment to putting **patients, clinicians and carers** at the heart of decision-making
- An **energised and proactive** organisation, offering leadership and direction
- A **focused and professional** organisation, easy to do business with
- An **objective** culture, using evidence to inform the full range of its activities
- A **flexible** organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local

[6] [DH and partners: to be published] Sexual Assault Services in England. Looking to the future.
[7] Developing the NHS Commissioning Board', DH, 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128118

- An organisation committed to **working in partnership** to achieve its goals, in particular, by developing an effective and mutually supportive relationship with Clinical Commissioning Groups (CCGs)
- An **open and transparent** approach, sharing information freely wherever appropriate
- An organisation with clear **accountability arrangements** and a grip on those things for which it will be held to account.

Context of Health Sexual Assault Services

10. There is an agreed direction of travel to migrate a range of healthcare provision, which involve the justice sector to the NHS. These include healthcare in some secure accommodation as currently commissioned by other government bodies, such as the UK Borders Agency (Immigration Removal Centres), Youth Justice Board (Secure Children's Homes and Secure Training Centres) and Police Forces (Police Custody Suites, forensic medical aspects of sexual assault and support).

11. Although sexual assault services are a public health function, the commissioning model is through health and justice arrangements because of the alignment with the criminal justice system, but it will be supported by the public health arrangements in NHS England and Public Health England.

12. The table below summarises the new health commissioning responsibilities, transition pathways where relevant and estimates[8] of associated resources and funding streams. Meanwhile, the Early Adopter Project, which brings current commissioners of SARCs together into collaborative partnerships, includes work on mapping and costing SARC care pathways and who funds what.[9]

[8] [to be published by Department of Health and others] Evaluation of Data on Sexual Assault Referral Centres In England.

[9] SARCs Costing Model with Pathway Analytics. Contact Ivan Tretheway at the NHS Commissioning Board

Service	Current / Transitional Commissioner	Commissioning Responsibility from 2013/14	Approximate Resources 2012/2013
Sexual Assault Services	Individual Police Forces	Collaborative commissioning between NHSCB, police forces and LAs	Estimate for all Police Forces : £10.1m
	PCTs	Collaborative commissioning between NHSCB, police forces and LAs	Estimate from contributing PCTs: £7.9m
	Local Authorities (from 11 upper tier LAs only so underestimated)	Collaborative commissioning between NHSCB, Police Forces and LAs	Estimate from contributing LAs £1.1m
	Home Office	Funding local commissioners for independent sexual violence advisers (ISVAs)	£1.6m (Until 2014/15)
	Ministry of Justice	Directly funding and commissioning local rape support services and commissioning new ones in areas with gaps in the service	£3m until 2014/15 (Coalition commitment)

13. It is key to the success of this framework that there should be a seamless commissioning and provision of services, using as a minimum the same standards and quality of care that can be expected in the NHS as well as in forensic science services. The specification for sexual health services in the 2013/14 Public Health Functions Agreement sets out the required standards.[5] The Secretary of State's Mandate to the NHS England, which sets out the Government's expectations of the NHS, contains the following reference to violence[10]:

"contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners, and supports victims of crime;"

14. The Government accepted the recommendation in Baroness Stern's review (2010) into how rape complaints are handled by public authorities in England and Wales, that:

" funding and commissioning of forensic medical services should be transferred from the police to the NHS. We also endorse the view of the taskforce led by Sir George Alberti that forensic physicians should be employed by the NHS, have better access to

[10] The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf

high quality training, be an integrated part of the new NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of rape victims".[11]

15. Sexual assault affects large numbers of people, women and children in particular and, for women, the figures are close to the incidence of stroke in women in the UK.[12, 13] Most rapes are no longer stranger rapes and increasingly victims know or are acquainted with their perpetrators. Few adults tell the police about being raped (11%). Others tell friends and relatives (33%) and 45% tell no one. Whilst few seek the specialist support available from SAS, it is highly likely that many seek help from sexual health services and GUM clinics for contraception or prevention of infection respectively, without disclosing sexual assault.

16. The Crime Survey for England and Wales has shown no significant change in the prevalence of sexual assault since 2004, but police-recorded crime (less reliable because of under-reporting by victims and fluctuations due to local practices and campaigns) register declining rates apart from rises in 2005/6 and 2009/11. The 2011/12 Survey found 42,976 most serious sexual assaults were recorded by the police in England and Wales. Most serious sexual offences comprise rape, sexual assault or sexual activity with children.

17. The self-completion module of the 2010/11 British Crime Survey which focused on people between 16-59 years old, found 1 in 5 women (19%) and I in 5000 men (2%) to have experienced sexual violence and attempted sexual violence since the age of 16 years. In the last year, around 1 in 33 women (3%) and 1 in 50 men (2%) had experienced some form of sexual assault including attempted assault. The prevalence of serious sexual assault in the last year was six times higher for women (1 in 167) than for men (1 in 1000).

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[11] Home Office. Government Response to the Stern Review. An Independent Review into how Rape Complaints are Handled by Public Authorities in England and Wales. 2011 http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/government-stern-review?view=Binary

[12] Department of Health. The Report of the Taskforce on the Health Aspects of Violence against Women and Children. Responding to Violence against women and children – the role of the NHS. 2010 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113824.pdf

[13] Department of Health. Interim Government Response to the Report of the Taskforce on the http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113826.

16. Data from an NSPCC Survey in 1998 suggest that 16% of young people under 16 years old in the UK i.e. 1 in 6 (up to five are girls) or 2 million children experience sexual abuse.[14] A more recent NSPCC UK study in 2009 used definitions that differed from the Sexual Offences Act. For unwanted sexual activity in under 17 year olds, the study reported 5% for penetrative sex of any orifice or fondling; 6% for attempted penetration and 11% for non-contact sexual activity. All these amount to serious sexual offences under the Act for children under 16 years old. It is not known from the literature whether these findings are additive. Data from individual SARCs suggest that between 22% and 50% of clients seen are young people under 18 years old.

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

19. Sexual assault referral centres (SARCs) provide a 24/7, one-stop shop to support victims of sexual assault and rape and include forensic medical examinations with consent, medical care including emergency contraception, post exposure prophylaxis after sexual exposure, sexually transmitted infection (STI) tests and treatment and referral for psychological support including pre-court counselling. Children and vulnerable adults seen in SARCs are also referred to local safeguarding services and support for children and young people, and for vulnerable adults. Care and support of sexually abused children needs to be integrated with care pathways to local paediatric services and community mental health services.

20. The key challenges and priority service areas include:

- assuring that victims of sexual assault and rape, irrespective of age, sexual orientation, gender or other protected characteristics[15] have access to SARCs across England that meet NHS standards and which integrate a seamless care pathway to create sexual assault services (SAS) that enable access to other necessary services in health and care system,

[14] Cawson, P., Wattam, C., Brooker, S. and Kelly, G. Child maltreatment in the United Kingdom. NSPCC. 2000

[15] Equality and Human Rights Commission. http://www.equalityhumanrights.com/legal-and-policy/

and to specialist sexual violence support in the voluntary and community sector;

- skilled paediatric services across acute and community care pathways setting that are available when needed with appropriate access to clinicians trained in both forensic examination and safeguarding any on-going psychological and other support;
- integrated care pathways across health, care and criminal justice.

Commissioning Functions

21. The functions which underpin this responsibility are:

a. **Service specification** Commissioners will specify the nature, outcome and standards of the services they want and will secure that service from providers. Providers will respond to service specifications with service plans, for which they would be held to account by commissioners for delivering what has been specified in their contracts. Commissioners will ensure that services meet national standards and local ambitions through partnerships with police forces, police and crime commissioners and local authorities and that they meet the needs of the population. Key stakeholders should be involved in the process, including representatives of service users and a range of health professionals who contribute to patient care and their associations which contribute to setting professional standards;

b. **Securing services-** through collaborative commissioning with police forces, local authorities and other funders, using appropriate procurement approaches with outcome-orientated contracts that specify effective service requirements to secure high quality services and outcomes for people through integrated pathways that promote continuity of care and are delivered with sensitivity, dignity and respect;

c. **Monitoring –** using relevant data, including users' perspectives to assess and challenge the quality of services; and using this intelligence to specify continuously improving outcomes for the future.

The New commissioning Landscape

22. The following organisations have roles to play in the commissioning of health care for victims of sexual violence:

a. **Department of Health (DH)** – the DH will set out the Secretary of State's expectations and requirements of the NHS in the Mandate, agreed with the NHSCB, which will accompany the resources allocated by government to the NHS. The Secretary of State retains responsibility for public health functions and will enter into agreements for these responsibilities to be discharged by Local Authorities, NHSCB and Public Health England.

b. **NHS England-** will be responsible for the direct commissioning of certain public health services through a section 7a agreement made with the Secretary of State, including public health services for victims of sexual assault.

c. **Clinical Commissioning Groups (CCG)** – CCGs will be responsible for commissioning health services for most of the population. In relation to children and young people, CCGs are under a statutory duty (Crime and Disorder Act 1998) to co-operate in the provision of multi-agency Youth Offending Teams. CCGs will also be responsible for the commissioning of emergency care services for 'every person present in its area,' as well as mental health services, including primary mental health, psychological therapies and child and adolescent mental health services. The NHSCB and CCGs would therefore need to work on integrating those care pathways into SAS for victims of sexual violence.

d. **Local Authorities (LAs)** – LAs will be responsible for commissioning the majority of public health services for people in their area. Local authorities will commission open access sexual health clinics and GUM clinics, services which are also used by victims of rape (many of whom will not disclose their experiences). Close working will be needed with NHS England to integrate care pathways for such victims to receive improved care and support as they choose and to exploit synergies in co-location between SARCs and sexual health and GUM clinics.

e. **Public Health England (PHE)** – Will provide local authorities and the NHS CB with leadership, public health expertise and health improvement support to promote early diagnosis in community and primary health care, and with intelligence and information on health improvement and protection. The NHSCB will commission related NHS data. PHE will also be responsible for social marketing and behavioural change campaigns and for oversight of infectious diseases control.

Values and principles

23. Ensuring high standards of patient care for commissioned services is one of the core values within the NHS Constitution and therefore places a requirement on all providers to strive to deliver high quality and safe care to patients. In addition, commissioners of health care have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations from whom they commission services.

24. NHS England is at the heart of an integrated system of organisations and services that are bound together by the values and principles of the NHS Constitution. NHS England is committed to joint working relationships with a wide range of organisations at a national and local level to ensure that there are continuous improvements in health and wellbeing.

The Integrated Commissioning Model

25. NHS England is structured with 4 regions and 27 Area Teams (ATs). Nine ATs and a regional team for London (Appendix 1) have been designated to build the expert capacity necessary to undertake NHS England commissioning role in respect of health services for victims of sexual assault, as part of commissioning arrangements for persons detained in prison or in other secure accommodation in collaboration with local police forces, local authorities and other partners.

26. The funding NHS England receives for NHS care through the Mandate, and for public health services for SAS through the Section 7a agreement, will be unified and directed through NHS England structures to the ATs to be used in partnership with other funding streams from local police forces, local authorities and police and crime commissioners, especially in respect of CSPs.

27. The nine ATs and London region will enter into local agreements with other partners in particular Police Forces, LAs and CCGs to establish, where appropriate, pooled budgets and collaborative and joint and commissioning arrangements. Working also with the youth and criminal justice systems, this would maximise the efficient use of resources and concentrate collaborative expert commissioning (eg for substance misuse, mental health or children's services open sexual health services or GUM).

28. Appendix 1 details existing SARCs situated in each of the ATs, by police forces within NHSCB region.

Map of SARCs by NHSCB Region

29. Health system reform presents an opportunity for health and criminal justice partners to work together more effectively. This opportunity is supported by inclusion of related indicators in the Public Health Outcomes Framework and the requirements of the Mandate to NHS England. Partner agencies will be able to work together to develop outcomes aligned to local joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWBSs).

The Operating Model

30. The scope of health commissioning for victims of sexual assault transferred to NHS England is set out in the Public Health Functions agreement. [5]

31. The national responsibility for commissioning of sexual assault services collaboratively lies with the Operations Directorate of NHS England. The national support team will provide the framework to ensure consistency and will set the national strategic commissioning direction.

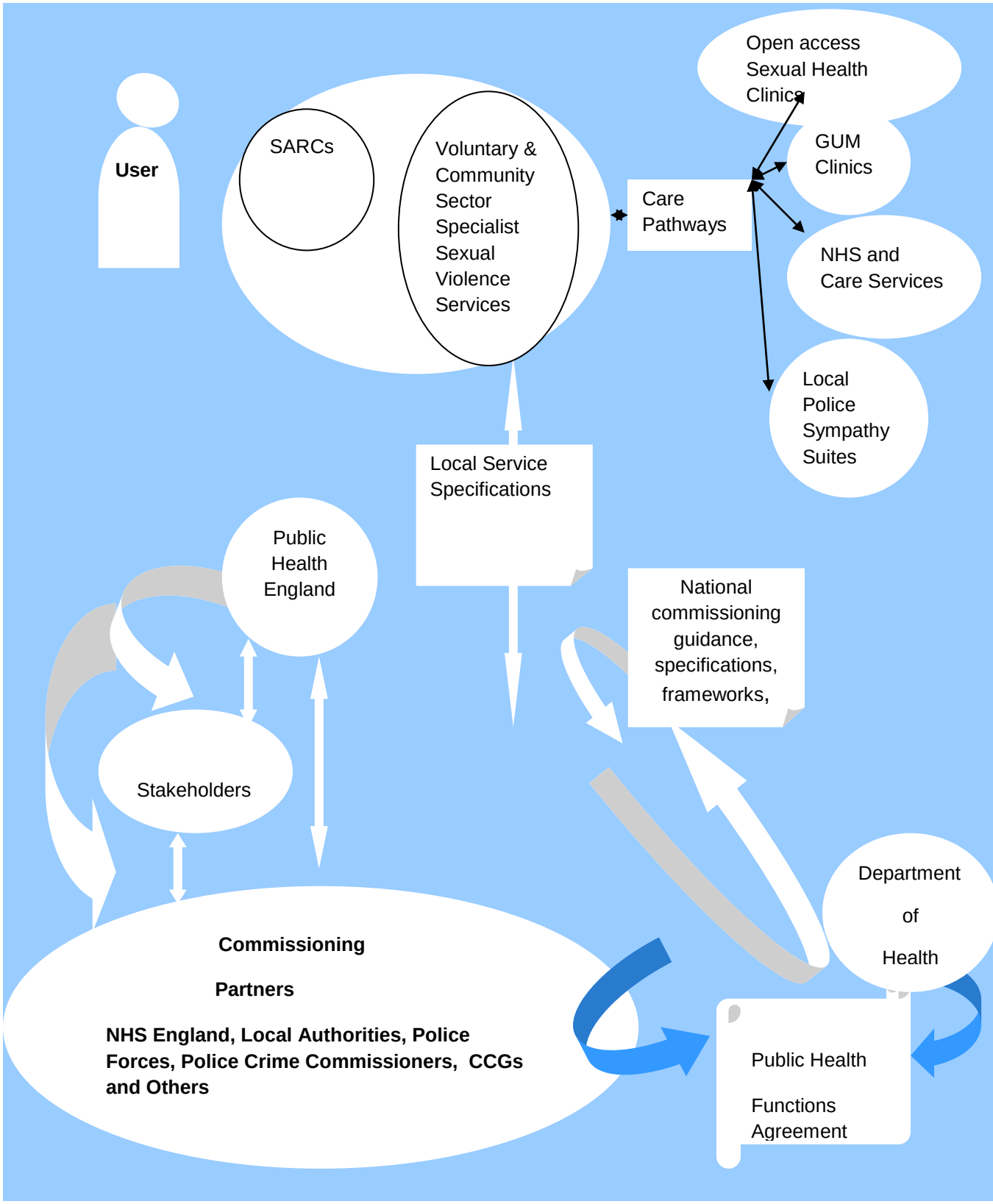
32. NHS England has inherited many contractual forms and service level agreements, which have been negotiated locally. These presents a challenge in the new system. A strategy for managing these locally negotiated contracts will be required until such a time that all contracts are brought in line with the approach in the standard NHS contract. It will be important to review the content of current contracts to ensure their fitness for purpose and consistency with the agreed national approach and standards. A national specification for commissioners of sexual assault referral centre services to use and customise to local circumstances is available.[16]

33. The NHS England will develop a single approach for agreeing what will be commissioned and to what standard, within available resources. This approach will help address inequities in access to high quality services which people who are sexually assaulted currently experience across England.

34. There will be governance mechanisms through which NHS England will discharge its responsibilities. These are currently being worked through with support from the regions and Area Teams to ensure that the system is integrated.

35. By definition, SAS requires seamless commissioning and service delivery across pathways. It is important for NHS England to engage locally with Police Forces, LAs and CCGs to manage the interface between services commissioned for victims of sexual violence so that integration between different providers is achieved in the care journeys take victims take.

[16] NHS Primary Care Commissioning:
http://www.pcc-cic.org.uk/article/sarc-specification


User
SARCs
Voluntary & Community Sector Specialist Sexual Violence Services
Care Pathways
Open access Sexual Health Clinics
GUM Clinics
NHS and Care Services
Local Police Sympathy Suites
Local Service Specifications
Public Health England
National commissioning guidance, specifications, frameworks,
Stakeholders
Commissioning Partners
NHS England, Local Authorities, Police Forces, Police Crime Commissioners, CCGs and Others
Department of Health
Public Health Functions Agreement

Content of the Framework

36. The new commissioning system aims to be driven locally with shared national values and behaviours and have information flowing between local and national teams that contributes to the key outcomes[17,18] and improvement areas in discharging the Board's functions[7] which include:

    a. Reducing health inequalities, promoting equality and diversity.
    b. Supporting quality improvements.
    c. Improving healthcare outcomes
    d. Ensuring services are integrated.

Relationship to Outcomes Frameworks

37. The Public Health Outcomes Framework[17] and NHS Outcomes Framework[18] has produced indicators that will form part of the overall assurance to NHS England.

Key Principles

38. NHS England will usually expect contractual relationships to be managed within a consistent national framework. However, commissioning should be flexible enough to allow service developments and improvements that meet the needs of users and their local communities. Commissioning decisions will increasingly be based on outcomes and value for money and have regard to changing policy and national commissioning guidance.

39. Commissioning should aim to reduce inequity in care provision and show improvements against the wider factors that affect health and wellbeing and health inequalities.

Commissioning Support Service Functions

40. Commissioning support arrangements are set out in *Developing Commissioning Support: Towards Service Excellence*.[19]

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[17] Healthy lives, healthy people. Improving Outcomes and supporting transparency Part 1: A Public Health Outcomes Framework for England, 2013- 2016, , http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf

[18] The NHS Outcomes Framework 2012/13 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf

41. The following functions have been purchased from commissioning support services :

- Specialist Procurement support:
  - market analysis,
  - identifying best value providers to respond to service needs
  - lead on the tendering process up to the point of contract award.
- Business intelligence support:
  - data collection and information analysis (Secondary care and contractual data)
  - data validation
  - database management
  - monitoring of achievement of key performance indicators and quantitative service standards
  - contract reporting and forecasting.

The Local/Central relationship

42. The relationship between the local NHS England, local clinicians, local authorities and sexual violence sector stakeholders is central to the operating model. This will require a new way of working and will need clinical support and expertise along with high quality management and systems.

43. The national NHS England support team will provide the framework to ensure consistency in commissioning. This will draw on nationwide insight and intelligence and reflect innovation, clinical expertise, the NHS Constitution and Mandate.

Common operating procedures and principles

44. In collaboration with commissioning leads and other key stakeholders a series of common operating policies and principles to support local area teams are being developed and include;

    a. Secondary care commissioning

[19] Developing Commissioning Support: Towards Service Excellence. February 2012. http://www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-2012-8-Guidance-Developing-commissioning-support-Towards-service-excellence.pdf

b. The management of the commissioning interface of public health specifications
c. Standard policies for the delivery of the public health service specifications which are relevant to this group of service users
d. Standard models for delivery.

Indicators

45. The set of Indicators that are relevant to the care and outcomes for victims of Sexual Assault includes:

a. Guidance for those working in health, the voluntary and community sector, youth and criminal justice, education and social care sectors on the early intervention and management of young people who display sexually harmful behaviour, and safeguarding.
b. Indicators that are not currently in any of the frameworks but are felt to be significant for this health community, that meet the overall aims of reducing inequalities.
c. Outcomes set out in the 2013/14 Public Health Functions Agreement for Sexual Assault Services.[5]

Tasks and Functions

46. The table below set outs how commissioning tasks and functions have been allocated within the NHS England structures

Specifying	The Optimum Services to meet national standards and local ambitions
National Team	• Develop needs-based commissioning policy • Commissioning outcomes framework • Healthcare budgets • Manage and engage with national bodies and Government departments and key national stakeholders • Develop national policy
Area Team	• Implement national policy and strategic vision • Ensure that the needs of people who expereince sexual violence are integrated into local joint strategic needs assessments to meet local needs • Engage and consult with key stakeholders, including CCGs, Health & Wellbeing Boards, NOMS, Local Authorities, Probation, Police Forces and their local

	Crown Prosecution Services, Police and Crime Commissioners, Local Safeguarding Children Boards etc • Agree commissioning plans • Undertake service reviews • Health & Wellbeing Assessments • Patient/User/Carer/Citizen Consultation & involvement
Regional Team	Will support and work with the national team & Areas to develop needs-based policy and strategy.
Securing	Services through the contracting route which delivers the best qualtiy and outcomes
National Team	• Provides guidance on model of commissioning • Agree national performance frameworks with partners • Ensure that services meet national targets on quality and cost.
Area Team	• With local police forces, local authorities and police and crime commissioners, commissioning appropriate qualiity and volume of services for the local setting to meet prioritised needs • Customising national service specifications to local needs • Supporting providers in the delivery of services • Agreeing contracts • Developing statements of readiness in the transfer of SASs funding streams
Regional Team	• Approving the annual regional needs-based procurement plan • Provide regional guidance to ATs on contractual consistency
Monitoring	Monitoring, Assessing and where necessary challenginq quality and outcomes, including arrangements for contract management
National Team	• Engage with MOJ, Home Office, DH and CQC, HMIC and HMCPSI • Manage national contingencies and risks • National performance monitoring
Area Team	• Risk management • Oversight of remedial action plans • Contract management (including contractual notices) • Advice providers on delivery, through service specification and contract variation • Carry out commissioning audits • Quality assure service delivery • Finanical monitoring of budgets • Performance monitoring and management

	• Demand planning and activity monitoring • Patient/User satisfaction analyses
Regional Team	• Ensure best practice is adopted across the commissioning board • Support the regional development of standard service specfications and tender templates

Next Steps

47. In the coming months NHS England will provide more details about the operating arrangements including:

a) Fully explore the interdependent relationships, including the collaborative commissioning critical for the operating model and actions to ensure they work effectively.
b) Continue to work with stakeholders to identify risks and manage the transition.
c) Test standard operating models and where necessary make adjustments.
d) Refine the scope and requirements for commissioning support services.
e) Develop a communications plan to the NHS, Police Forces Local Authorities and other key stakeholders

Acknowledgements

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Appendix 1

Lead Area Teams commissioning Sexual Assault Services

Region	Lead Area Teams for SAS	SARCs	Police Force
North			
	Durham, Darlington & Tees	Durham Middlesbrough Sunderland *No SARC (uses Preston)*	County Durham Cleveland Northumbria Cumbria
	Lancashire	Preston Manchester Liverpool *No SARC (uses Manchester)*	Lancashire Greater Manchester Merseyside Cheshire
	West Yorkshire	*No SARC* *No SARC (limited facilities)* Rotherham Hull	West Yorkshire North Yorkshire South Yorkshire Humberside
Midlands			
	Derbyshire & Nottinghamshire	Derby Nottingham Leicester Lincoln	Derbyshire Nottinghamshire Leicestershire Lincolnshire
	East Anglia	Bedford Peterborough Brentwood Northampton Norwich Ipswich *Limited service at Hemel Hempstead*	Bedfordshire Cambridgeshire Essex Northamptonshire Norfolk Suffolk Hertfordshire
	Shropshire & Staffordshire	*Pilot SARC at Stoke* *Shared SARC to open near Worcester* *Limited facilities at Walsall and Birmingham being converted to SARCs* *Nuneaton SARC opens 2013*	Staffordshire West Mercia (covers Herefordshire, Shropshire and Worcestershire) West Midlands Warwickshire

Region	Lead Area Teams for SAS	SARCs	Police Force
South			
	Bristol, North Somerset and South Gloucestershire	Bristol Gloucester Swindon Truro, Exeter, Plymouth	Avon & Somerset Gloucestershire Wiltshire Devon & Cornwall
	Kent & Medway	Dartford Cobham Crawley	Kent Surrey Sussex
	Thames Valley	Slough Bletchley Bournemouth Portsmouth	Thames Valley (Berkshire, Buckinghamshire, Oxfordshire) Dorset Hampshire
	London	Camberwell, Paddington) Whitechapel))	Metropolitan Police City of London British Transport Police