THAMES VALLEY SEXUAL ASSAULT HEALTH NEEDS ASSESSMENT 2016

Full Report

February 2016

Ottaway Strategic Management

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Thames Valley Sexual Assault Health Needs Assessment (Paediatric and Adult Services)

Report by Ottaway Strategic Management ltd

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"[the assault] was it me, did I make this happen, is this all in my mind?"

"She [counsellor] was excellent. I've done a lot of thinking and working and she's given me the tools to think in a different way about what happened to me."

"If victims don't get the right kind of help then it could cost the NHS a lot of money. They could have lots of long-term health problems, become alcoholics or drug addicts, not be able to work, be destructive."

"If I didn't get the counselling support or attending group sessions, I would have probably turned to drugs and alcohol"

"If I wasn't for the support I have through my ISVA and IDVA then I would have dropped the case, I would not have been able to go through with it"

"I can see why so many victims give up…you can't take this on alone"

1 Executive Summary

1.1 This sexual assault health needs assessment for Thames Valley was commissioned by NHS England to help inform the development and delivery of high quality, accessible services, appropriate to meeting the needs of children, young people and adults and their families and carers. The full report provides a review of information and data available regarding the health needs of victims and their families and carers, assesses demand and availability and supply of services. It identifies and reviews current service provision and additional approaches that are likely to contribute to improved commissioning outcomes.

1.2 For the purposes of the review, sexual assault health needs have been defined to include the physical and mental health needs identified at the time of the assault for both the victims and their families and carers, the needs identified during the full medical and forensic examinations and their post assault trauma and crisis need.

1.3 Ottaway Strategic Management have used a range of methodologies to complete the assessment, including: desk research to review and analyse national and local data; qualitative interviews with key stakeholders; an online quantitative survey of relevant stakeholders. The findings from each methodology can be reviewed separately in the full report.

National context

1.4 Nationally, the last decade has seen increased interest and momentum in tackling sexual assault and violence. The legislative context is set by the Sexual Offences Act 2003, Domestic Violence Crime and Victims Act 2004 and the Adoption and Children Act 2002. These have all updated previous legislation and created wider definitions of sexual assault. There has been growth in the number of, and profile given to a network, of local Sexual Assault Referral Centers (SARCs) which provide a specialist 'one-stop shop' range of medical and forensic services accessible for victims of rape or sexual assault. The government has an ambitious strategy "A Call to End Violence against Women and Girls" and progress against this vision is set out in an action plan published in March 2014[1]. Nationally and locally there is a strong drive to address Child Sexual Exploitation.

1.5 The recent report produced by the Children's Commissioner; 'Protecting Children from Harm'[2], states that 'it is estimated that only 1 in 8 victims of sexual abuse come to the attention of statutory authorities. The scale of child sexual abuse is therefore much larger than is currently being dealt with by statutory and non-statutory services. The physical and emotional impact of child sexual abuse persists into adulthood for many victims. It is difficult to measure the scale of child sexual abuse in the family environment specifically, owing to serious deficiencies in data collection. Nonetheless, the Commissioner estimates, on the basis of evidence submitted to the Inquiry, that child sexual abuse in the family environment comprises around two thirds of all child sexual abuse. Victims are more likely to be female than male, though males are likely to be under-represented in the data examined.

[1] https://www.gov.uk/government/publications/a-call-to-end-violence-against-women-and-girls-action-plan-2014
[2] Children's Commissioner: Protecting Children from Harm: A critical assessment of child sexual abuse in the family network in England and Priorities for action. November 2015

Current service provision

1.6 Thames Valley Sexual Assault Referral Centers are commissioned jointly by NHS England and Thames Valley Police. Component parts of the wider sexual assault services are funded by the Office of the Police and Crime Commissioner (OPCC) and upper tier local authorities across the counties. There are a wide range of support services for sexual assault across Thames Valley and these are delivered within the 13 Local Authority areas of Thames Valley. Indeed, this local authority landscape creates inevitable complexities in the design and delivery of services but is nonetheless the circumstances against which services must operate.

1.7 Sexual assault services have undergone significant changes in the past year. Some elements of the sexual assault services (Thames Valley Independent Sexual Violence Advisor (ISVA) service for adults aged 16 and over and the SAFE project for children aged 8-12) have been commissioned pan Thames Valley to bring a universal and standardised approach to the way in which these services are delivered. There are two SARCs in Thames Valley, one in the north (Bletchley SARC) and the other in the south (Slough SARC).

Data findings: profile of local sexual offences

Rape data (national data)

1.8 National data from the Rape Monitoring Group (RMG) indicates that during 2014-15 (April 2014 to March 2015) there were just under 700 police recorded adult rape offences and around 400 police recorded child rape offences in Thames Valley. Compared to the previous year, these figures indicate a significant increase in both adult and child rape offences recorded by the police (58% increase in adults and 45% increase in child rape cases).

1.9 In the same period, 311 rapes cases (adults and children) were referred to the Crown Prosecution Service (CPS) for a decision to charge a suspect, in 70% of these cases the CPS decided to prosecute on the basis there was enough evidence, across England and Wales of the cases referred to the CPS 59% were prosecuted. There were 178 prosecutions for cases flagged as rape by the CPS, a 33% increase compared to the previous year, resulting in 112 convictions this equates to 63% conviction rate.

1.10 The time taken from being charged to the outcome of a prosecution takes on average seven and a half months, adding to this the length of time the police investigation can take means that victims who pursue the criminal justice route are involved in this process for a significant length of time.

Thames Valley Police (local data)

1.11 Nationally there has been an upward trend in the number of sexual offences being reported to the police. In the latest 12-month reporting period (y/e Sept 2015) Thames Valley police reported just under 4,000 children, young people and adult victims of sexual assault (including attempts). Compared with the previous 12 months this is an increase of 42%. Nine out of ten (87%) victims were girls and women. Over half (58%) of all sexual offences were reported by young people aged under 25 (with 27% involving children aged under 16).

1.12 In comparison to the ethnic profile of the whole population of Thames Valley, there are more victims reporting rape offences from BME populations (22%) compared

with the BME population across Thames Valley (15%), whilst fewer victims reporting other sexual offences from BME populations (12%)

1.13 One third of all sexual offences recorded by the police were rape offences (including attempts). Two thirds of all female rape offences were against women aged 16 over. Half of all male rape cases were against boys aged under 13.

Sexual Assault Referral Centres (SARC)

1.14 In the latest 12-month reporting period (y/e Sept 2015) the SARCs in Thames Valley supported 342 victims. This is an increase of 23% from the previous year. Nine out of ten victims were female (94%). A further 40 children (aged under 18) were supported through the historic sexual abuse paediatric clinic.

1.15 Of the 342 victims, almost two thirds (64%, 219) were children and young people aged 25 and under; with 9% (30) involving those aged under 13, 11% (38) involving those aged 13-15, 11% (36) involving those aged 16-17 and 34% (115) involving those ages 18-24. The ethnic profile of the victims seen by the SARC is broadly similar with the same proportion of victims from BME populations as there are across Thames Valley but with some differences between specific ethnic groups.

1.16 Three quarters (76%) of all victims knew the perpetrator. Victims seen by the SARC were from all areas of Thames Valley, with the majority being from Berkshire (39%), followed by Buckinghamshire (32%) and Oxfordshire (29%). Just under half (43%) reported a mental health need, 39% reported self-harm, 17% reported a disability (physical and learning) and 31% reported drug and alcohol use.

1.17 The length of time it takes a victim to be examined varies and is dependent on the capacity of the on duty forensic physician. Nationally it is recommended a victim is examined within one hour from the time the request is made, however due to the geography of Thames Valley and the availability of one forensic physician at any one time, the agreed window within which a victim is examined has been increased to within two hours. around 20% of all victims are seen by the forensic physician within one hour, for the majority (58%) of victims it takes between 1 and 2 hours to be seen by the forensic physician, for 20% it has taken 3 hours and longer.

1.18 Almost all referrals (95%) to the SARC originated from the police, social care and health, the remaining were self-referrals (4%) and GP or A&E referrals (1%). Almost all (92%) onward referrals from the SARC were to advocacy and support services, GPs (83%), GUM or sexual health clinics (72%), social services (39%) and paediatric services (27%).

Sexual assault and rape support services

1.19 Data recording activity and support for victims of sexual assault, rape or child sexual abuse is varied and therefore it is not possible to build an accurate picture of the extent of support delivered through specialist services. Based on the data provided through specialist support services, collectively around 1,100 children, young people and adult victims of sexual assault or rape were supported in the 12-month period y/e Sept 2015. In addition, many victims and their families or carers were support through helpline and email services. Almost all services have seen an increase in the number of victims they have seen in the latest 12-month reporting

period compared to the previous 12-month period (y/e Sept 2014), despite cuts in funding during 2015-16.

1.20 The nature of the sexual assault was not provided for all services to draw comparisons with police recorded sexual offences or comparisons to the numbers seen by the SARC. However, 1,100 victims would account for just over one fifth of all police recorded sexual offences and are almost three times the amount seen by the SARC over the same period. This would suggest many victims go straight to these services bypassing the SARC.

1.21 Victims in contact with support services accessed a range of services including counselling, group therapy, ISVA support, play therapy and helpline, email and text support. In addition, many more victims and concerned others have been supported through helpline, email and text contact.

1.22 Around 14% of all victims were children aged under 18. On average 93% of all victims supported were female (ranging between 87% and 100% by service). The majority of referrals to specialist support services were through self-referrals (20%), police (17%) and SARC (6%).

Estimating the scale of need

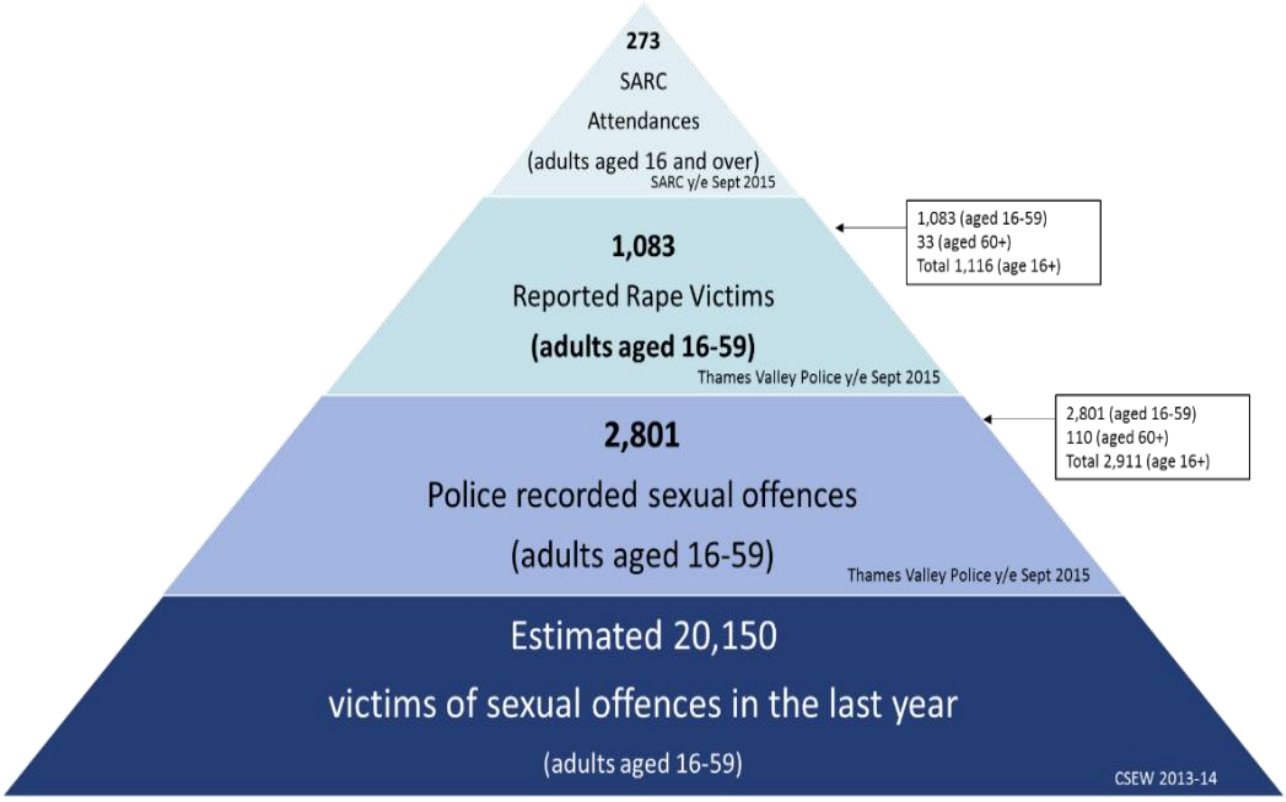
1.23 Estimates provide an idea of the likely scale of the number of victims of sexual offences over a given period. It is widely accepted that a significant gap exists between the estimated number victims, police recorded sexual offences and the number of victims in contact with SARCs.

Adults

1.24 Estimates from the Crime Survey for England and Wales (CSEW) indicate that in 2013-14, 2.2% of women and 0.7% of men (aged 16-59) stated they had been a victim of a sexual offence (including attempts) in the previous 12 months. Applying these percentages to the population of Thames Valley it can be estimated that around 20,150 might have been a victim of a sexual offence (around 4,900 men and 15,250 women) in the last year. In the 12-month period y/e Sept 2015 there were 2,801 police recorded sexual offences of this 1,083 were rape cases (adults aged 16-59). Over the same period there were 273 adult attendances at the SARC (aged 16-59).

1.25 This is summarised for adults in the pyramid below, illustrating the significantly gap between the CSEW estimates of the number of adults in Thames Valley that have been a victim of a sexual offence (including attempted) in the last year, the number of recorded sexual offences by the police and the number of victims referred to and seen by the SARC. Whilst direct comparisons cannot be drawn, the pyramid brings together these figures and the difference in numbers are stark.

Chart 4: Adult Sexual Offences, Estimates, Police Recorded sexual offences, rape offences, SARC attendances (Source: CSEW 2014-15, Thames Valley Police Data y/e Sept 2015, SARC Data y/e Sept 2015)

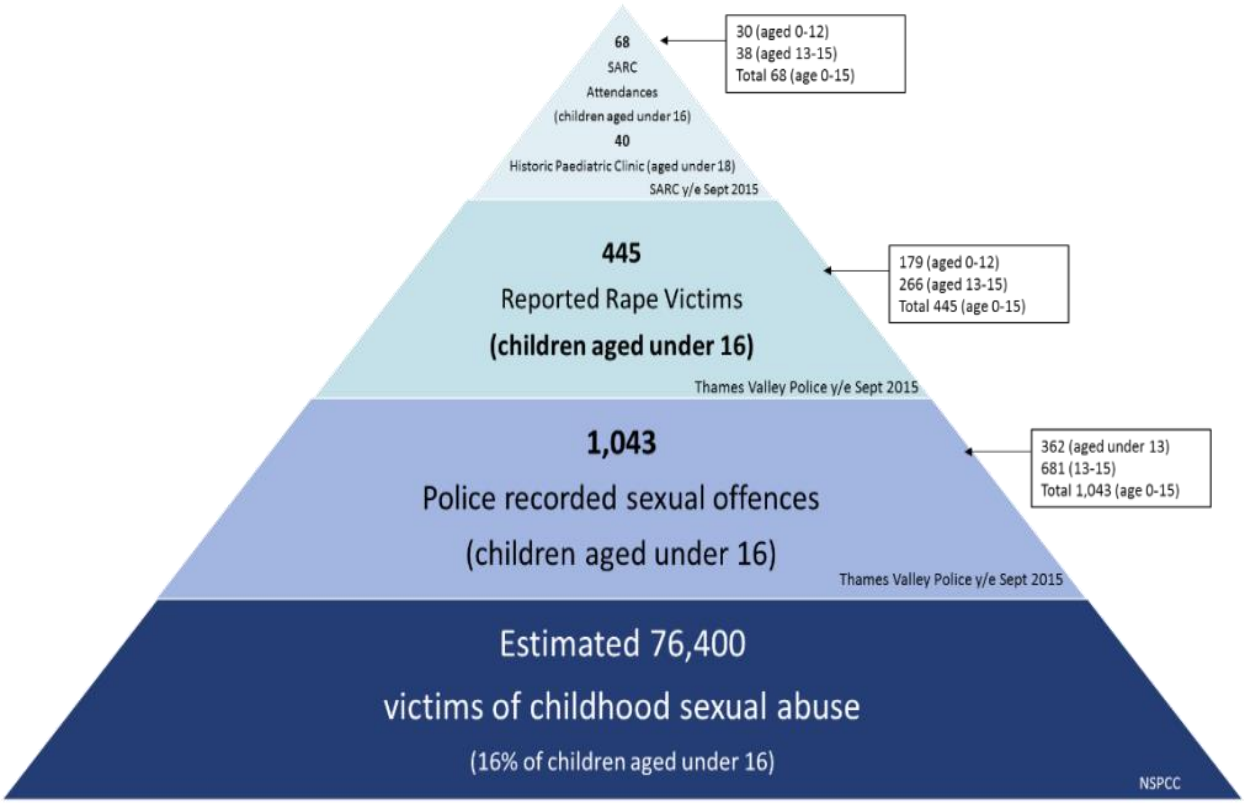


Children

1.26 National estimates (National Society for the Prevention of Child Cruelty, NSPCC) suggest that 16% of children aged under 16 in the UK experience sexual abuse during childhood. Applying this percentage to the Thames Valley population aged under 16 would indicate this is around 76,400 children. In the 12-month period y/e Sept 2015 there were 1,043 police recorded sexual offences, of this 445 were rape cases (children aged under 16). Over the same period there were 68 child attendances at the SARC (aged under 16).

1.27 This is summarised for children in the pyramid below. Similarly, illustrating the significant gap between the prevalence estimates of the number of children in Thames Valley that have been a victim of childhood sexual abuse, the number of recorded sexual offences by the police and the number of victims referred to and seen by the SARC.

Chart 5: Child Sexual Offences, Estimates, Police Recorded sexual offences, rape offences, SARC attendances (Source: CSEW 2014-15, Thames Valley Police Data y/e Sept 2015, SARC Data y/e Sept 2015)



1.28 The true prevalence is likely to fall somewhere between the estimate and the number of police recorded offences.

Views of stakeholders and victims

Services

1.29 In July 2015 the local Office of Police and Crime Commissioner (OPCC) for Thames Valley, commissioned the Thames Valley ISVA service to provide practical and emotional support to male and female victims aged 16 and over. In addition, the OPCC commissioned the SAFE project (based in Oxford) to provide services to children and young people (aged 8 to under 16). The OPCC are currently developing a counselling service in order to provide victims of sexual assault or rape a similar level of consistent and standardised service across Thames Valley.

1.30 Collectively, between the main specialist therapeutic services for victims of sexual assault and rape (Rape Crisis Centre's and Trust House Reading), a range of services are available. These services are located in Oxford, Aylesbury, Wycombe and Reading and provide services to victims in and around these locations. Services include specialist sexual assault counselling, group therapy, ISVA services and targeted therapies to support child victims including play therapy.

1.31 However, the services offered vary in each centre. As such not all services are available to all victims across Thames Valley. Moreover, specialist support services are predominately providing services to women only and are for victims aged 16

and over. The only service offering play therapy for children aged as young as four is located in Reading.

1.32 Oxfordshire NHS Foundation Trust in January 2016 launched their new service; Horizon: Supporting Young People and Families affected by Sexual Harm. This service aims to support professionals involved in the care of young people (aged under 18) and their families affected by sexual abuse.

Victim views

1.33 Coping with the short and long term effects of sexual violence can be devastating, overwhelming and confusing. Whether victims have reported their assault to police or not they often need someone who can help them through their various demands at this traumatic time and or how to go about getting them met. Victims can become distressed, they may want to 'hide away' from the world, express anger, sadness, experience loneliness and desperation, as well as many other emotions.

1.34 Overall victims felt their experiences of reporting the assault to the police and the SARC were positive and specialist sexual assault services had a positive impact on their mental health and wellbeing. It was clear that emotional and practical support is critical to help victims deal with the trauma of the assault and for those who prosecute the perpetrator. It was clear that emotional and practical support is critical to help victims deal with the trauma of the assault and for those who prosecute the perpetrator.

Referral pathways

1.35 The relationship between the police and SARC is well established and almost all referrals to the SARC are from the police (95%), many of which involve social care and health, few victims self-refer or are referred to the SARC by specialist support services (such as rape crisis center's). Despite referrals from police, social care and health only 68 children (aged under 16) attended the SARC and an additional 40 attended the historic paediatric clinic (aged 18 and under) in the same period when 445 police recorded child rape cases (y/e Sept 2015), this is the equivalent of around 75% children reporting rape not attending SARC.

1.36 The referral pathway between police, social services, the SARC and specialist support services will need to be further developed to ensure that every opportunity is afforded to enable children and young people to benefit from the sexual assault services in place. Therefore, continually improving the effectiveness of the referral pathway is critical. This is equally important as all the elements for an effective pathway are in place, not only does it meet the national guidelines it also has provided clear successes for those engaged into services.

1.37 Respondents to the stakeholder survey felt the location of the SARCs was an issue and in some cases made them inaccessible, this was a particular concern for those who choose not to report the assault to the police and those who lived in Oxfordshire.

Demand on services

1.38 It is clear that the increase in the number of victims reporting sexual offences to the police, accessing the SARC and support services is placing pressure on victim support services, with Specially Trained Officers (STOs) carrying caseloads of up to 40, and counselling and support groups operating long waiting lists. Cuts in funding

and uncertainty of funding beyond March 2016 among the voluntary sector's specialist sexual assault and rape services has further reduced capacity to deliver services to victims.

Support services for children

1.39 There was a collective concern among stakeholders that the needs of child victims of sexual abuse were not being met, in the same way that support exists for victims aged over 16. Stakeholders felt there was a lack of counselling provision and child therapy available across Thames Valley.

1.40 Many stakeholders expressed the need for a dedicated ISVA provision for children and young people under 16, particularly for those reporting child sexual offences where there is no police STO support (in cases where the assault was not interfamilial).

ISVA provision

1.41 As the new pan Thames Valley ISVA service continues to embed and become fully established there remains some confusion among stakeholders over the current arrangements between Thames Valley ISVA service, the role of the police STOs and the relation with the ISVA provision among support services. ISVA support provision across Thames Valley will need to develop a cohesive service and clear protocols and pathways between the collective ISVA support offered.

Awareness of services

1.42 Findings from the stakeholder survey suggest 61% were clear about the organisations and professionals that are providing sexual assault services, 68% knew how to access psychological support and counselling for victims of sexual assault and 73% knew where the SARCs were in Thames Valley.

Communications

1.43 Across Thames Valley there is a need to develop a communication strategy that promotes the services available for victims of sexual assault and rape. The communications strategy should promote the SARC and provide clarity of the work it undertakes to support victims at the early stages, particularly as this will vary if the victim is a child, young person or adult. Equally important is communicating the role of the other support services in the region and the services they provide.

1.44 It is important the communication strategy is developed to increase awareness and understanding of existing and new services provision. The OPCC are developing a directory of services to provide information concerning services to support victims of crime that are available across Thames Valley.

1.45 The strategy should provide clarification of the roles and responsibilities of different parts of the sexual assault care pathway to enable a better understanding among professionals of the processes and protocols surrounding the work of sexual assault services across Thames Valley.

Summary of recommendations

1.46 A range of strategic and operational recommendations are made to ensure relevant, effective services are commissioned to meet the needs of children, young people and adults and their families and carers.

Strategic

- Develop a Thames Valley Sexual Assault Strategy addressing prevention, immediate and post event response to acts of sexual violence.
- Plan for the likely growth in demand for services, reflecting the growing levels of victim reported sexual assault, rape or child sexual abuse (including historic cases), as well as the increasing number of victims seen by the SARC and support services.
- Develop a comprehensive communication strategy for victims to raise awareness of and promote services available to them and for professional to secure the pathways for referral between sexual assault services.
- Deploy innovative approaches to marketing and communications that include prevention and education.
- Communicate the roles and responsibilities of the Thames Valley ISVA service, rape crisis's and specialist support ISVA services and services offered through police STOs to promote the best possible care for victims.
- Review the capacity and capability of the current provision of forensic medical examinations to meet the needs of victims within agreed timescales.
- Review the funding arrangements for the support services particularly if referrals and service take-up increases.
- Work with partners to maintain and build the current community paediatric arrangements with the SARC
- Ensure that all victims, where the need is identified, have access to sexual assault services, in particular the therapeutic needs of children
- Develop safeguarding strategy meetings with mandatory health involvement to ensure the health needs of children and young people are routinely considered when child abuse cases are reviewed.
- Work with local children safeguarding boards and social care to build links and direct referrals to the SARC

Operational

Short Term

- Continue to develop clear pathways with partner agencies to enable ease of referrals into and onto relevant victim support services, setting guidelines for timely referral.
- Establish a commissioning framework to ensure a coherent set of victim support including counselling and therapeutic support services.
- Establish a clear marketing and communications campaign to ensure that partners, stakeholders and victims are aware of and able to access all sexual assault services (including SARC and rape crisis centres).
- Target awareness campaign with partners including, GP's, practice staff and pharmacists, sexual health practitioners, A&E departments and mental health teams, drugs and alcohol services, adult and young people's social care and commissioners across Thames Valley.

- Agree and set the baseline data collection arrangements with commissioned and partner services to monitor information and build a profile of victim need.
- Establish a data sharing agreement between service providers and partners, in order to make effective use of local intelligence.

Medium Term

- Develop training material for stakeholders in police, social care and health care services to support referrals of children, young people and adults to sexual assault services.
- Develop psychological interventions, in particular counselling and trauma therapy for victims meeting current and potential demand.

Long Term

- Establish ongoing health need reviews of victims as they move through the services by ensuring that referral partners are signed up to report outcomes.
- Carry out annual Health Needs Assessment 'refresh' and review sexual assault services in advance of future re-commissioning/procurement exercises.
- The needs of child and adult victims vary, and future HNA's should be undertaken separately for children and adults.

2 Introduction and context

2.1 This Health Needs Assessment is committed to provide evidence and information to support services to meet the needs of the regions' children, young people and adults who have been victims of sexual assault, and their families and carers. To this end the report reviews the health needs of victims, assesses demand and supply of services and identifies gaps and additional approaches that are likely to procure improved care provision and deliver cost effective high quality services. The Needs Assessment commenced in November 2015 and concluded in January 2016.

2.2 The specific outcomes and the governance arrangements sought in this needs assessment are set out below:

Aims of the commission

2.3 The key aims of this health needs assessment is to:

2.3.1 Examine, analyse and assess the special needs of victims of sexual violence and rape with Thames Valley.

2.3.2 Identify key stakeholders and established pathways with recommendations for increased partnership and stakeholder involvement.

2.3.3 Provide recommendations for service improvement including a model/pathway of care, onward referral and necessary follow-on services to ensure a holistic provision for victims based on Revised National Service Guide, A Resource for Developing Sexual Assault Referral Centres (2009).

2.3.4 Data will be compared to national, regional and local trends wherever possible.

2.3.5 The results of this HNA will inform on-going developments and future commissioning.

Outcomes

2.4 The outcomes of this health needs assessment are:

2.4.1 To identify a baseline data set for Thames Valley to include the following: incidence of sexual violence (rape, sexual abuse, and sexual assault), at risk groups, basic SARC data and evidence of outcomes from both health and criminal justice.

2.4.2 To identify current resources available for victims of rape and sexual assault making reference to national standards and good practice.

2.4.3 To identify current pathways for victims of rape and sexual assault.

2.4.4 To ensure that the views and experiences of victims and service users are included in the needs assessment and that there is an appropriate

mechanism for involvement in and shaping and development of SARC services.

2.4.5 To identify gaps and unmet needs in provision and pathways for victims of rape and sexual violence against core national standards and good practice in other SARC services. This should include the distances and time taken to travel to the SARC.

2.4.6 To identify priorities for Thames Valley SARC Commissioning Boards and partner commissioners to develop SARC services taking into account national standards and current policy.

2.4.7 To present the findings of the reports to the Thames Valley Stakeholder event on 11th January 2016 to be held at the Oxfordshire Shire hotel, Oxford.

2.5 In conducting this Sexual Assault Health Needs Assessment there has been strong engagement with local partners and stakeholders through meetings, one to one interviews and regular progress reports.

Methodology

2.6 The core components of this needs assessment have been the collation of available sexual assault data nationally and locally, a literature review of desk research and the completion of a range of primary research. To this end the needs assessment has taken an approach, starting with the mapping of the demand and availability of Paediatric sexual assault services and assessing gaps. This follows national guidelines for needs assessment particularly for multidisciplinary health and social care service provision.

2.7 The specific methodologies for addressing this supply and demand led needs assessment has included; desk research, data collation and analysis, practice reviews locally and nationally, primary research (interviews workshops and surveys), an assessment of findings and a review of recommendations. These are set out in more detail below.

Desk Research

2.8 In order to establish relevant context, this needs assessment has researched national and local policy and strategy, national guidance and evidence/literature on rape and sexual assault in relation to Children, young people and adults in the UK and Europe. This includes the following areas: policy, law, peer review, national standards, and other children and young people and adult Sexual Assault Referral models operating in the UK. Full details of which are set out in appendix 3 to this report.

Mapping Need

2.9 Mapping need has been achieved by analysing existing local and national reports and surveys and by analysing available sexual assault, crime and health data relating to children, young people and adults including:

- Sexual violence and recorded crime data (Public Health Outcomes Framework, Crime Survey for England and Wales and Home Office crime statistics)
- Convictions (Crown Prosecution Service)

- Sentencing (Ministry of Justice)
- Thames Valley Police, local recorded sexual offences data
- Home Office Studies
- Local Authority data, including safeguarding children and vulnerable adults
- Sexual Assault Referral Centre (SARC) activity data
- Third sector support services activity data
- Independent Sexual Violence Advisors (ISVA)
- Population Statistics

2.10 The key issue regarding 'need' will be to estimate the level of met and unmet need to establish the potential client pool. Police reports are recognised as being low in number compared to actual assaults and other agencies often only deal with a proportion of clients who have experienced sexual assault but who have not reported it to the police. All should be weighted to generate a multiplier to provide better 'understanding' of true demand.

2.11 Mapping supply has been undertaken by assessing range, scope and performance of local services and related activities, in particular to establish:

2.11.1 Where the services are located. Plotting services in relation to where they are located to one another particularly in the context of travel times and transport infrastructure.

2.11.2 What do the services provide and when? Mapping service provision and whether service provision reflects need and the flexibility of access to services (opening times, open access/referral only, drop-in and/or appointments).

2.11.3 Who delivers these services? Mapping the range of service providers, service user profiles to determine efficacy, effectiveness and value for money of these services.

2.11.4 What related services exist? Mapping services that offer ongoing support and health care for victims of sexual assault.

2.12 Assessing gaps – the above processes of mapping need, demand and supply will provide the evidence to set out the quality and impact of sexual assault services and how well services are configured to meet needs. Where gaps exist these are identified and recommendations listed to improve any mismatch in need, demand and supply.

Engagement and primary research

2.13 The primary research completed has sought to understand the experiences of stakeholders and victims of sexual assault. In particular, it reviews:

- current pathways and referral mechanisms
- existing support for victims and their families and carers
- how health, police and social services are perceived
- what practices they currently follow

- follow up services to support on-going health needs of victims and their families and carers
- what respondents generally feel is important
- what respondents feel is a priority

2.14 Indeed, aside from the engagement with the **Sexual Assault Health Needs Assessment Working Group**, established to support and oversee this work; other forms of primary engagement and research have been completed.

- Online stakeholder survey - that seeks to gather opinion, perceptions, knowledge and experience of working with victims both in response to their assault, in assessment of their immediate health care, assessment of their psychological wellbeing and associated psychological morbidity, in assessment of their case's forensic needs, in preparation of the legal cases and in respect to their ongoing healthcare.

- Interviews - with key professionals, stakeholders, care providers and relevant organisations who are well placed to support the strategic focus of this needs assessment and its likely operational impact.

2.15 Role of the Working Group

- Support the work by providing relevant contacts for engagement and identification of data sources
- Raise awareness with colleagues to ensure that the work has sufficient profile, including the stakeholder survey
- Engagement with key players across the region
- Commentary and sign off for the stakeholder survey
- Oversight of primary research
- Review and comment on health needs assessment findings

2.16 The commissioners of the Sexual Assault Health Needs Assessment agreed this methodology.

Definitions of sexual violence, sexual assault and Child Sexual Exploitation.

2.17 The WHO's definition of 'Sexual Violence' is:

> 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.[3]'

2.18 Unless specifically indicated, sexual assault, rape, sexual abuse and sexual violence are often used interchangeably in general literature. This needs assessment includes the dimensions of the WHO definition of sexual violence.

2.19 In the UK the definition of Adult rape is based on the concept of consent. Before 1994 the definition only considered non-consensual vaginal intercourse as rape, but since then it has been widened in scope to recognise male victims and non-consensual oral, anal and/or vaginal penetration (by a penis) as rape. According to the Sexual Offenses Act 2003:

> "rape occurs when someone intentionally penetrates the vagina, anus or mouth of another person with his penis; that other person does not consent to the penetration, and the perpetrator does not reasonably believe that the other person consents…whether the people involved know each other or not, have had a previous relationship with each other or not, or are married to each other"[4].

2.20 The definition of consent however does not apply to children aged under 16 where sexual intercourse is illegal. In the UK the age of consent to sexual intercourse is 16. For those aged 13-15 consent is considered is a grey area where as those aged under 13 consent is considered impossible. Where there is a power discrepancy true consent is considered impossible in adolescents and young people, even aged 16 and over.

2.21 The definitions below are useful to understand the range of activities that are summarised as 'sexual assault' and the definition used by the Crime Survey for England and Wales (formerly the British Crime Survey) has brought data collection in line with the Sexual Offences Act 2003. The format provided through the survey breaks down the definition of sexual assault and allows respondents to code this as appropriate. It separates five types of sexual assault based on 1994 Sexual Offences Act and the more up to date Sexual Offences Act 2003.

- *Serious sexual assault* – assault involving penetration of the body without consent.
- *Rape* (1994) – penetration of the vagina or anus by the penis without consent (legal definition in 1994)
- *Rape* (2003) – in addition to the 1994 definition penetration of the mouth by penis without consent (extension to the definition of rape in 2003)
- *Assault by penetration* (2003) – penetration of the vagina or anus by other body parts or objects (new offence)

[3] http://www.who.int/mediacentre/factsheets/fs239/en/
[4] Diesen & Diesen 2010, p.330

- *Less serious sexual assault* – incidents of flashing, sexual threats or touching that cause fear, alarm or distress.

2.22 *Child Sexual Exploitation*[5] – the sexual exploitation of children, young people and adults under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

2.23 Essentially sexual assault includes serious sexual assaults including non-consensual penetration of the body, rape (penetration with a penis; vagina, anus or mouth), assault penetration with an object including fingers; vagina, anus or mouth, and attempted penetration; vagina, anus or mouth, and non-consensual forced sex acts including masturbation or other humiliating sex acts.

2.24 Over the last decade, the Sexual Offences Act 2003 has been supported by other legislation including the Domestic Violence Crime and Victims Act 2004 and the Adoption and Children Act (2002). Moreover, in 2010 Baroness Stern's Report[6] of an independent review into the handling of rape and sexual violence complaints by public authorities recommended a new approach to give greater care and support to victims of sexual violence. In response the government published its strategic vision outlining its ambition to end sexual violence, particularly against women and girls (VAWG) through the 'Call to End Violence against Women and Girls'. Progress against the strategic vision was update in the action plan refresh, March 2014.

[5] This definition of child sexual exploitation was created by the UK National Working Group for Sexually Exploited Children, young people and adults (NWG) and is used in statutory guidance for England.
[6] http://webarchive.nationalarchives.gov.uk/20100418065537/http://equalities.gov.uk/PDF/Stern_Review_acc_FINAL.pdf

3 National and local policy context

3.1 Societally the typical approach to tackle the problems and needs associated with Children and Young People's sexual assaults, Child Sexual Exploitation and violence has been through three main forms of intervention:

- Legislative
- Preventative
- Response to and management of the children, young people, families and carers health, psychological and forensic needs

Across these three important areas of intervention, there is the commitment to provide specialist staff, trained and supported to fulfil the aims of each three areas of work.

Legislation

3.2 The Sexual Offences Act 2003[7] replaced older sexual offences laws with more specific and explicit wording. Part I of the Act makes many changes to the sexual crimes laws in England and Wales (and to some extent Northern Ireland), almost completely replacing the Sexual Offences Act 1956[8] and subsequent amendments.

3.3 The 2003 Act identifies and defines the sexual offences of rape, assault by penetration, sexual assault, causing a person to engage in sexual activity without consent. It further defines other sexual offences including rape or other offences against children under 13, and child sex offences and abuse of positions of trust, family CSA offences. It sets out offences against persons with a mental disorder impeding choice, care workers with a person with a mental disorder and indecent photographs of children, abuse of children through prostitution and pornography, trafficking, preparatory offences, sex with an adult relative. It also identified other offences for example but not exclusively, exposure, voyeurism, intercourse with an animal, sexual penetration of a corpse, sexual activity in a public lavatory etc)

Prevention

3.4 There are numerous forms of prevention activity and campaigns. Most start with a national, international or governmental commitment/pledge to prevent sexual assault and or violence. Examples include the Prevention of Sexual Violence Initiative[9], GE Declaration on Preventing Sexual Violence[10], and Global Summit to End Sexual Violence in Conflict[11].

3.5 Many prevention programmes operationally relate to relationship education, awareness programmes, and safety and risk avoidance techniques. Specific activity includes policy and policy reviews, designations of responsibilities and accountabilities, community engagement, communications, deterrents, incentives and harm reduction.

[7] http://www.legislation.gov.uk/ukpga/2003/42/part/1
[8] http://en.wikipedia.org/wiki/Sexual_Offences_Act_1956
[9] UK Government's Stabilisation Unit Foreign Office May 2012
[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/185008/G8_PSVI_Declaration_-_FINAL.pdf
[11] https://www.gov.uk/government/topical-events/sexual-violence-in-conflict/about

3.6 There are broadly speaking 3 types of prevention:

- Primary Prevention: Approaches that take place before sexual violence has occurred to prevent initial perpetration.
- Secondary Prevention: Immediate responses after sexual violence has occurred to address the early identification of victims and the short-term consequences of violence.
- Tertiary Prevention: Long-term responses after sexual violence has occurred to address the long-term consequences of violence and sex-offender treatment interventions.

3.7 The target of many prevention programmes is the education of society and in particular, boys and men to raise awareness and support sustained behavioural change. Programmes also target bystanders and their role in preventing rape and in preventing unwanted sexual advances.

Policy Drivers and National Guidance

3.8 National guidelines and policy drivers for Sexual Assault Referral Centres have been in place since they first developed, some 10 years ago. Since this time, there have been a number of updated policy documents and reviews that have had an important impact on the direction and development of SARCs and wider sexual assault services. It is vital to have an understanding of the key policy drivers and national guidance that have influenced the development of SARCs and wider sexual assault services. Equally, it is important to be aware of the national documents that outline the standards of health and social care provided to sexual assault victims.

3.9 This is in no way an exhaustive list but some of the key documents for adults, young people and children are listed below and summarised in section 11 Appendix 3 to this report.

- National Service Guidelines for Developing SARCs (2005)[12]
- A Resource for Developing SARCs (2009)[13]
- NHS Taskforce report by Sir George Alberti, "Responding to violence against women and children - the role of the NHS (2010)"[14]
- The Stern Review (2010)[15]
- Call to End Violence against Women and Girls (2010)[16]
- Transfer of Commissioning Responsibility from the Police to the NHS (2011)[17]
- Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence (CAHVIO) (2012)

[12] National Service Guidelines for Developing Sexual Assault Referral Centres (SARCs) (October 2005) Home Office, Care Services Improvement Partnership, National Institute for Mental Health in England, Department of Health
[13] A Resource for Developing Sexual Assault Referral Centres (SARCs) (27 October 2009) Department of Health, Home Office and the Association of Chief Police Officers
[14] Department of Health (2010) Responding to violence against women and children- the role of the NHS. The Report of the Violence Against Women and Children Taskforce, London: DH
[15] The Stern Review; A Report by Baroness Vivien Stern CBE of an independent review into how rape complaints are handled by public authorities in England and Wales (2010) Home Office and Government Equalities Office
[16] Call to End Violence against Women and Girls (November 2010) HM Government
[17] Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS: Evidence Base to Support the Impact Assessment (March 2011) Tessa Crilly, Gill Combes & Deborah Davidson: University of Birmingham; Olivia Joyner & Shaun Doidge: Tavistock Institute

- Victims' Services Commissioning Framework (2013)[18]
- Child sexual exploitation and the response to localised grooming (2013)[19]
- Health Working Report on Child Sexual Exploitation (2014)[20]
- Child Protection All Party Parliamentary Group (APPG) (2014)[21]
- Sexual Violence against Children and Vulnerable People National Group (2015)
- Cross Government Child Sexual Abuse (CSA) Directors' Group (2015)
- The Goddard Inquiry (2015)
- Commissioning Framework for Adult and Paediatric SARC Services (2015)[22]
- Risk Factors associated with Sexual Assault and Exploitation of children and young people [23]
- Crime and Forensic guidance[24]
- Revised Protocol between the Police Service and Crown Prosecution Service in the Investigation and Prosecution of Allegations of Rape 2015[25]
- Commissioning Guidance[26]
- Service Specification for the Clinical Evaluation of Children and Young People who may have been Sexually Abused 2015[27]

Safeguarding

3.10 The Children Act 2004 places a duty on every Local Authority to establish a Local Safeguarding Children Board (LSCB). The Government's Statutory Guidance, Working Together to Safeguard Children (2015) defines safeguarding and promoting the welfare of children as: Protecting children from maltreatment; Preventing impairment of children's health or development; Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; Taking action to enable all children have the best life chances.

Serious Case Review (SCR) into the Child Sexual Exploitation in Oxfordshire 2015

3.11 This Serious Case Review (SCR) was about the sexual exploitation of children and in Oxfordshire,[28] using the experiences of six girls who were the victims in the Operation Bullfinch trial. Operation Bullfinch was a joint investigation launched by

[18] Victims' Services Commissioning Framework (May 2013) Ministry of Justice
[19] Child sexual exploitation and the response to localised grooming: The Government response to the second report from the Home Affairs Committee Session 2013-2014 HC 68 (September 2013) Presented to Parliament by the Secretary of State for the Home Department by Command of Her Majesty
[20] Health Working Group Report on Child Sexual Exploitation: An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff Executive Summary (January 2014)
[21] Child Protection All Party Parliamentary Group Seminar Series on Child Sexual Abuse: Recommendations for the prevention of child sexual abuse and better support for victims (April 2014) NSPCC
[22] Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
[23] NHS England: Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services. August 2015
[24] http://www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/consent/
[25] Protocol between Police Service and CPS in the Investigation and Prosecution of Allegations of Rape (Jan 2015)
26 Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England
[27] Service Specification for the Clinical Evaluation of Children and Young People who may have been Sexually Abused 2015, RCPCH http://www.rcpch.ac.uk/news/rcpch-has-published-revised-%E2%80%98service-specification-clinical-evaluation-children-and-young-who-m
[28] http://www.oscb.org.uk/wp-content/uploads/SCR-into-CSE-in-Oxfordshire-FINAL-FOR-WEBSITE.pdf

Thames Valley Police and Oxford County Council Social Services in May 2011, into suspected serious sexual offences against a number of children and young people in Oxford. The SCR found that the "overall failings were those of a lack of knowledge and understanding around the concept of CSE that few understood and where few knew how it could be tackled, but also of organisational weaknesses which prevented the true picture from being seen."

3.12 Errors highlighted by the SCR included; "some organisations and some staff should have acted with more sensitivity, rigour, imagination or indeed common sense. Some processes and procedures should have been implemented much better, and the collective agency work around safeguarding before 2011 should have been much stronger. Over a number of years there were many signs of CSE of the type revealed in the Bullfinch trial, and whilst they were not recognised as 'CSE', the extreme nature of those signs required concerns to be escalated to top managers, but this did not happen. Even if what had been happening were unconnected individual cases, the effectiveness of professional work was not good enough. The abuse, as a result, continued for longer than could have been the case."

3.13 The local recommendations arising from the SCR below were set out for Oxfordshire Safeguarding Children's Board (OSCB) consideration, either for direct action or to oversee in its assurance role:

- Ask each member agency to review its escalation procedures, and provide assurance to the Board that they are understood and complied with
- Review the interrelationships with other multi-agency partnerships, such as District Community Safety Partnerships and the County Safer Community Partnership, to ensure there is mutual clarity about each other's roles and appropriate cross-representation
- Ask each agency to provide evidence of its supervision policies and how the agencies ensure they are effective
- Be assured that the lessons from this Review and IMRs are embedded in OSCB and single agency training
- Ensure that the messages from victims and their families given to this review are embedded in training
- Seek evidence that minutes of multi-agency meetings are clear about ownership, have consistent titles, and can be seen by their content and appearance to be of high value
- Seek assurance from TV Police about progress on recording crime relating to sexual offences
- Seek assurance from Oxfordshire County Council that there is appropriate access to the necessary range of LAC placements
- Ensure that reports on missing children statistics for the Board are fully interrogated to identify any emerging patterns
- Seek assurance from Oxfordshire County Council that there are good arrangements for the transfer of information between schools about child vulnerability, and that decisions around exclusion from school and its management (risk assessments and plans) take into account that the behaviour is or may be related to exploitation

- Seek assurance from NHS bodies, including general practice, that staff include the consideration that consent has been eroded through exploitation when assessing a child's ability to consent to treatment and that referrals to statutory agencies will be made appropriately
- Seek assurance from all member agencies that staff are aware of the guidance around consent to sexual activity, and relationships
- Continue to undertake rigorous multi-agency case audits where CSE is suspected

Children's Commissioner: Protecting Children from Harm; A critical Assessment of child sexual abuse in the family network in England and priorities for action.[29]

3.14 In July 2014, the Children's Commissioner launched an Inquiry into child sexual abuse in the family environment. Based on data examined by the Commissioner, it is likely that only 1 in 8 victims of sexual abuse come to the attention of the police and children's services. Up to two thirds of all sexual abuse happens in and around the family. Our evidence shows that children are sexually abused from a very young age, but most victims do not come to the attention of the police or children's services until they reach adolescence. Accessing help from the police and children's services is largely dependent on a child telling someone that they have been abused, but evidence examined by the Commissioner clearly demonstrates that most victims of sexual abuse in the family do not report it until they have the knowledge to recognise abuse and the words to describe it.

3.15 The Commissioner established a series of recommendations:

- A National Strategy for the prevention of child sexual abuse, in all its forms
- That the Government explores how to strengthen the statutory responsibilities of organisations and professionals working with children, to ensure that all professionals work together more effectively to identify abuse
- That the Government recognises the importance of and coordinates all sources of support for children and families where there is a particular risk of sexual abuse, to ensure that victims are more effectively identified and targeted
- That all schools equip all children, through compulsory lessons for life, to understand healthy and safe relationships and to talk to an appropriate adult if they are worried about abuse.
- That all schools take the necessary steps to implement a whole-school approach to child protection, where all school staff can identify the signs and symptoms of abuse, and are equipped with the knowledge and support to respond effectively to disclosures of abuse.
- That all teachers in all schools are trained and supported to understand the signs and symptoms of child sexual abuse.
- That all Achieving Best Evidence interviews are undertaken in the presence of an intermediary or a suitably qualified child psychologist, and that appropriate provision for this is made by the Ministry of Justice and police forces.

[29] http://www.childrenscommissioner.gov.uk/sites/default/files/publications/Protecting_children_from_harm_-_executive_summary_0.pdf

- That, from the moment of initial disclosure, children receive a holistic package of support, tailored to their needs, including therapeutic support to help them recover from their experiences
- That Government reviews the process of inter-agency investigation of child sexual abuse, including the role of the police and children's social workers, to ensure that the process minimises the potential for re-traumatisation, whilst maximising the possibility of substantiating abuse and taking effective protective action and taking the views of the child into account.
- That the Home Office amend and update the Annual Data Requirement to ensure that all police forces record this aspect of child sexual abuse-related crimes
- That children and young people with harmful sexual behaviour receive proportionate and timely intervention to reduce the risk of this behaviour continuing into adulthood

4 Estimating demand for services for victims of sexual assault and their families and carers

4.1 The quality and detail of victim based sexual assault data is limited. However, the available data is based on an accumulation of police, health, demographic and local authority information. Statistics can be brought together and reviewed to establish a level of need based on historic figures. The central limitation is that data is based on reported sexual assaults and sexual offences.

4.2 Clearly the level of reporting is extremely low and evidence suggests that only one in ten cases are ever reported. The most recent report about child sexual abuse produced by the Children's Commissioner suggest only one in eight child victims of sexual abuse come to the attention of statutory agencies. However whatever scale is used this suggests a vast number of cases of sexual assault which never see the light of day.

4.3 Different partners and stakeholders use different definitions of sexual assault, often recording sexual offences, sexual violence and sexual abuse. This wide array of definitions prohibits a comprehensive capability to fully analyse data effectively. However even within these limitations it is still possible to make some basic comparisons and certainly there are ways in which local partners can work more effectively together to improve data recording to enable a better picture of need going forward.

4.4 Officially reported crime data for sexual offences[30] is available for police forces at national and local levels. In terms of services for local victims a picture can be formed by analysing client data and service performance information. National trends and estimates, based on the Crime Survey for England and Wales (CSEW), can be applied and whilst these are estimates based on national norms they can be attributed to local populations to calculate the number of potential victims in a local area.

Prevalence - Sexual Offences (Adults)

4.5 The CSEW measures the extent of crime in England and Wales by asking people whether they have experienced any crime in the last year. In 2013-14, 2.2% of women and 0.7% of men stated they had been a victim of a sexual offence (including attempts) in the previous 12 months. Based on these findings of the CSEW and applying these percentages to the population of Thames Valley it can be estimated that around 20,150 have been a victim of a sexual offence (around 4,900 men and 15,250 women) in the last year.[31] It should be noted that these estimates are very crude, and do not take account of differences in demographics between populations.

[30] Definition set within the Sexual Offences Act 2003: http://en.wikipedia.org/wiki/Sexual_Offences_Act_2003

[31] Using Mid-year population estimates 2014, ONS

Table 1: Victims of sexual assaults (adults aged 16-59) in the last year (Source: Crime Survey for England and Wales 2013-14, ONS, released February 2015)

Victims of sexual assault (adults aged 16-59) - in the last year	Men	Thames Valley Population	Women	Thames Valley Population	All	Thames Valley Population
	(%)	(n)	(%)	(n)	(%)	(n)
Any sexual assault (including attempts)	**0.7**	**4,895**	**2.2**	**15,247**	**1.5**	**20,142**
Serious sexual assault including attempts	0.05	330	0.7	4,822	0.4	5,152
Serious sexual assault excluding attempts	0.03	181	0.4	2,858	0.2	3,039
- Rape including attempts	0.04	257	0.5	3,429	0.3	3,686
- Rape excluding attempts	0.03	181	0.3	2,061	0.2	2,242
- Assault by penetration including attempts	0.03	219	0.5	3,316	0.3	3,536
- Assault by penetration excluding attempts	0.02	147	0.3	1,970	0.2	2,117
Less serious sexual assault	0.7	4,633	1.8	12,398	1.2	17,031

4.6 The CSEW also measures whether a percson has been the victim of a sexual offence since the age of 16. In the same period (2013-14) 19.9% of women and 3.6% of men stated they had been a victim of a sexual offence at some point since the age of 16. Again, based on these findings of the CSEW and applying these percentages to the population of Thames Valley it can be estimated that around 160,600 people have been a victim of a sexual offence (around 24,600 men and 136,000 women) since the age of 16.[32]

Table 2: Victims of sexual assaults (adults aged 16-59) since the age of 16 (Source: Crime Survey for England and Wales 2013-14, ONS, released February 2015)

Victims of sexual assault (adults aged 16-59) - since the age of 16	Men	Thames Valley Population	Women	Thames Valley Population	All	Thames Valley Population
	(%)	(n)	(%)	(n)	(%)	(n)
Any sexual assault (including attempts)	**3.6**	**24,611**	**19.9**	**135,992**	**11.8**	**160,603**
Serious sexual assault including attempts	0.5	3,409	6.1	41,704	3.3	45,113
Serious sexual assault excluding attempts	0.4	2,774	5.2	35,693	2.8	38,466
- Rape including attempts	0.3	2,392	5.5	37,712	2.9	40,104
- Rape excluding attempts	0.2	1,701	4.7	32,338	2.5	34,039
- Assault by penetration including attempts	0.4	2,409	3.8	26,037	2.1	28,445
- Assault by penetration excluding attempts	0.3	1,754	3.0	20,232	1.6	21,986
Less serious sexual assault	3.4	23,254	18.8	128,872	11.2	152,126

Prevalence (Child Sexual Abuse/Sexual Assault)

4.7 The UK government publication Working Together to Safeguard Children (2013) child sexual abuse in defining sexual abuse states; "sexual abuse 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

[32] Using Mid-year population estimates 2014, ONS

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 or 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 (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women also can commit acts of sexual abuse, as can other children."[33]

4.8 The National estimates suggest that 16% of children aged under 16 in the UK experience sexual abuse during childhood. Across Thames Valley there are an estimated 477,450 children aged under 16, applying this estimate to the Thames Valley population aged under 16 would indicate this is around 76,400 children.

4.9 The recently published Inquiry into Child Sexual Abuse by the Children's Commissioner suggests the scale of child sexual abuse can be measured by its prevalence rate – the proportion of adults in the population who were sexually abused as a child, and by its incidence – the number of new cases of child sexual abuse occurring over a specified time period.[34] The report highlights a recent study of child maltreatment that found 11.3% of young adults aged 18-24 had experienced contact sexual abuse during childhood.[35] According to census data, there are approximately 11.5 million children and young people living in England. Based on the rate of 11.3% of young adults aged 18-24 reporting that they were a victim of contact sexual abuse at some point during childhood, it can be extrapolated that approximately 1.3 million children currently living in England will have been a victim of contact sexual abuse by the time they turn 18. In Thames Valley this is the equivalent of 61,500.

Police Recorded Sexual Offences – Adults (National Data)

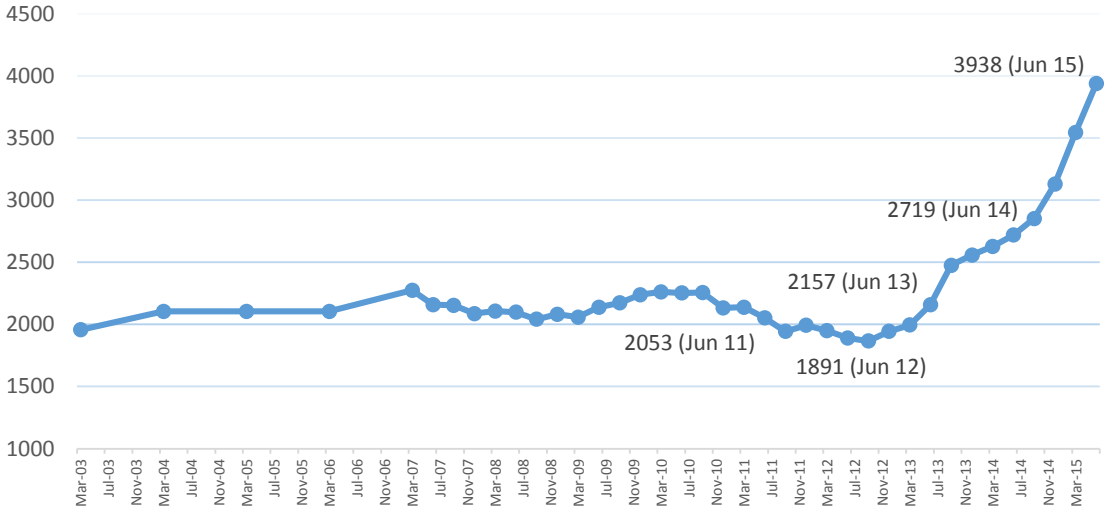
4.10 In the latest 12-month period, year ending (y/e) June 2015 there were 3,938 sexual offences recorded by the Thames Valley police force area (PFA),[36] representing 3.2% of all offences, whilst across the south east sexual offences account for 2.9% of all offences and across England and Wales account for 2.6%. In Thames Valley the latest recorded sexual offences figures are the highest since the introduction of the National Crime Recording Standards in 2002-03.

4.11 Across England and Wales sexual offences recorded by the police continue to rise with the latest figures (y/e June 2015) showing an increase of 41%.[37] In Thames Valley there has been a 44.8% increase against the previous year (up from 2,719 y/e June 2014), greater in comparison to the rise across England and Wales. In part the increase is the result of improvements in data recording over time, it is also thought to reflect a greater willingness of victims to come forward to report such crimes in the wake of high profile prosecutions or that victims have an increased understanding that a crime has been committed.

[33]Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children http://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf
[34] Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities, Children's Commissioner, 2015
[35] Radford, L et al. (2011) Child abuse and neglect in the UK today, NSPCC
[36] Quarterly Crime Statistics, 2003 to Year Ending June 2015, ONS October 2015
[37] Crime in England and Wales (Statistical Bulletin), Year Ending June 2015, December 2014, ONS October 2015

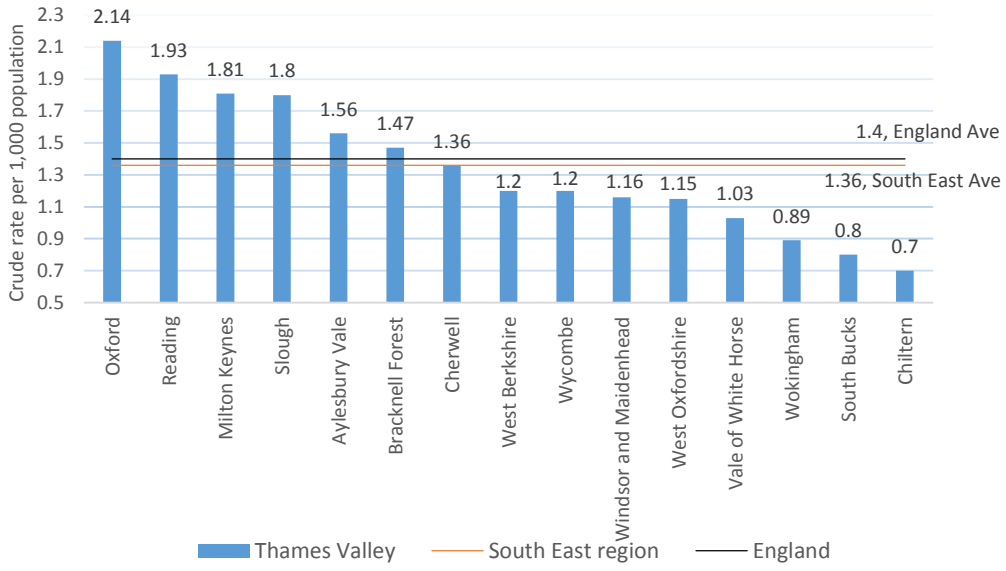
4.12 The chart below shows the changing pattern of recorded sexual offences across Thames Valley from 2002-03 baseline to y/e June 2015. The data is presented as rolling 12 month totals, with data points shown at the end of each financial year between 2002-03 and 2006-07 and at the end of each quarter from June 2007.[38]

Chart 6: Reported Sexual Offences, Thames Force Police Area 2003 – y/e June 2015 (Quarterly Crime Statistics, y/e June 15, ONS released October 2015)



4.13 The crude rate of sexual offences is a Public Health Outcomes Indicator. In 2014-15 the crude rate of sexual offences in across Thames Valley local authority areas ranged between 0.7 per 1,000 in Chiltern representing the lowest to 2.14 in Oxford representing the highest. Across England the rate was 1.4 per 1,000 and across the South East 1.36 per 1,000.

Chart 7: Crude Rate of Sexual Offences per 1,000 Population 2014-15 Thames Valley LA areas, South East, England (Source: Publich Health Outcomes Framework 2015)



[38] Police recorded crime by offence group and PFA (y/e June 15), Table P1, ONS October 2015

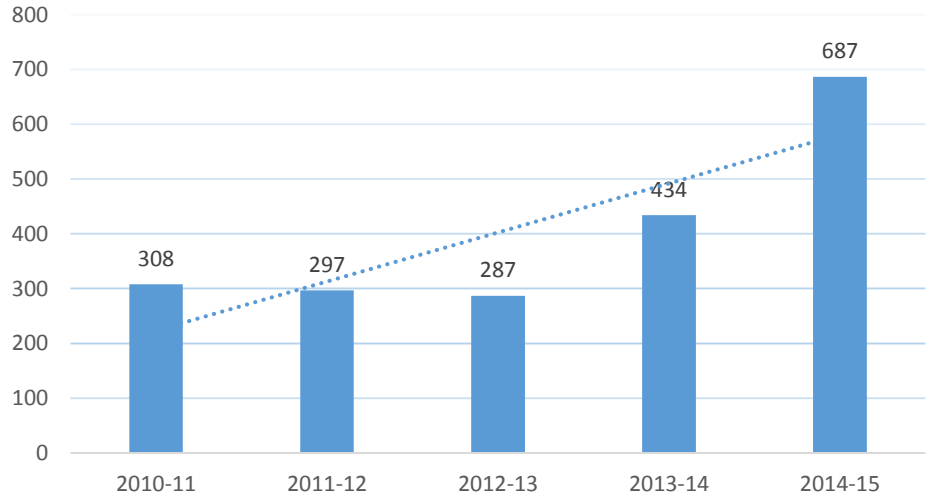
Police Recorded Rape (National Data)

4.14 Her Majesty's Inspectorate of Constabulary (HMIC)[39] have recently published reports for each police force showing data on how many rapes were recorded by the police in each PFA between 2010-11 and 2014-15. The report provides information on rape for adults aged over 16 and children aged under 16, in accordance with the definitions as set out in the Sexual Offences Act 2003. In addition, the report produces information about referrals and charges, prosecutions and convictions.[40] The figures for adults and children are for offences against both women and men. In 2014/15 across England and Wales, 95% of recorded rape offences against adults were against women, and 80% of recorded rape offences against children under 16 were against girls.[41]

Police Recorded Rape – Adults

4.15 In 2014-15 there were 687 rape offences recorded by the Thames Valley PFA for adults aged 16 and over, representing a 58.3% increase on the previous year (up from 434 in 2013-14). The police recorded rate for adult rape per 100,000 (adults aged over 16) in 2014-15 has risen to 41 from 28 in 2013-14. Overall the trend data indicates an increase in the number and rate of recorded adult rapes in Thames Valley. This can be seen in the two charts below.

Chart 8: Police Recorded Adult Rape (number, aged 16 and over) 2014-15 Thames Valley PFA (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley Area data for 2014-15)

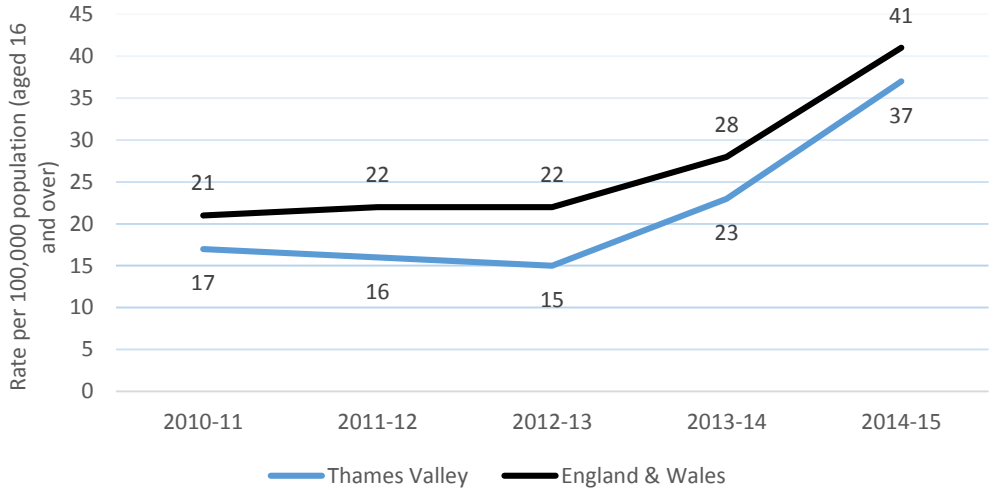


[39] Her Majesty's Inspectorate of Constabulary (HMIC). Rape Monitoring Group: Digests, data and methodology. 2014-15 http://www.justiceinspectorates.gov.uk/hmic/publications/rape-monitoring-group-digests-data-and-methodology-2014/

[40] Recent reports of rape that occurred in the past when the victim was under 16 years of age are recorded as a child rape regardless of the age of the victim at the time the report was made.

[41] Her Majesty's Inspectorate of Constabulary (HMIC). Rape Monitoring Group: Digests, data and methodology. 2014-15 http://www.justiceinspectorates.gov.uk/hmic/publications/rape-monitoring-group-digests-data-and-methodology-2014/

Chart 9: Police Recorded Adult Rape (rate per 100,000 population, aged 16 and over) 2014-15 Thames Valley PFA (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley Area data for 2014-15)



Police Recorded Rape – Children

4.16 Similar to adults, in the two charts below the trend data shows an overall increase in the number and rate of recorded child rapes in Thames Valley, with a 44.7% increase in the number of police recorded child rapes in 2014-15, compared with the previous 12 months. It should be noted police recorded child rape includes historic and recent cases.

Chart 10: Police Recorded Child Rape (number, aged 16 and under) 2014-15 Thames Valley PFA (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley Area data for 2014-15)

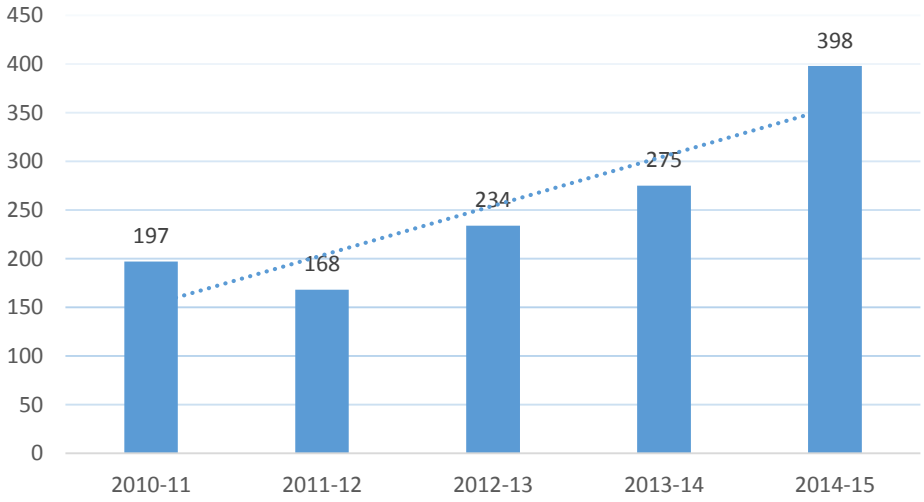
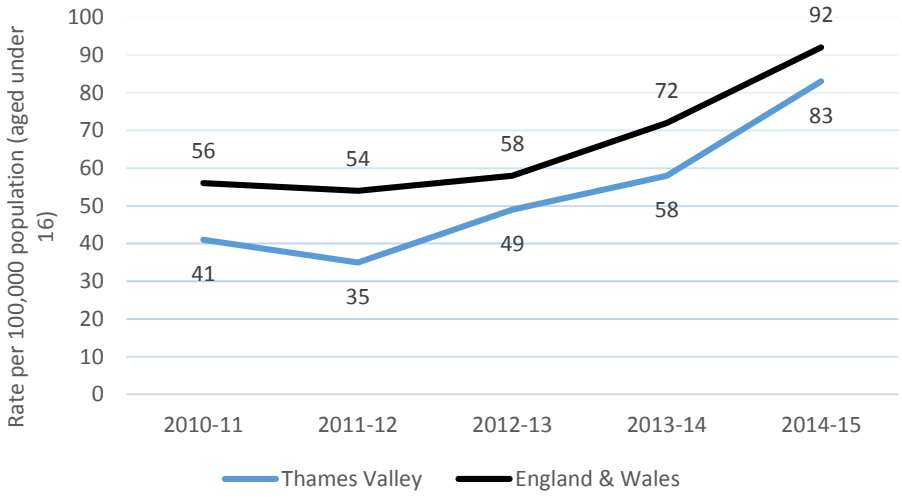


Chart 11: Police Recorded Child Rape, (rate per 100,000 population, aged 16 and under) 2014-15 Thames Valley PFA (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley Area data for 2014-15)



Charge/summons

4.17 Charge/summons, refers to the number of offences, where, based on the police investigation, the Crown Prosecution Service (CPS) decide there is sufficient evidence for a realistic prospect of conviction. The suspect will receive a charge/summons and the case will proceed to court. Cautions in rape cases are rare. This data is provided for adults (aged 16 and over) and children (aged under 16).

4.18 The charge/summons ratio is the number of charge/summons in one financial year, divided by the number of recorded rapes in the same financial year. However, offences recorded in a given year may not result in a suspect being charged/summonsed until the following year.

Charge/Summons - Adults

4.19 In 2014-15 there were 100 charge/summons for adult rape, with a charge/summons ratio of 15%, higher in comparison to the England and Wales average (12%). The table below shows the number of police recorded adult rapes, the number of charge/summons and the charge/summons ratio for Thames Valley and the England and Wales average. Whilst the number of charge/summons has risen the ratio of charge summons has fallen to below the 2010-11 rate.

Table 3: Charge/Summons for Adult Rape (age 16 and over) 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)

Charge/Summons for Adult Rape	Recorded Adult Rapes (police force data)	Charges/Summons (Crown Prosecution Service)	Charge/Summons ratio (Thames Valley)	Charge/Summons ratio (England and Wales)
2010-11	308	55	18%	18%
2011-12	297	72	24%	17%
2012-13	287	47	16%	18%
2013-14	434	77	18%	17%
2014-15	687	100	15%	12%

Charge/Summons - Children

4.20 In 2014-15 there were 119 charge/summons for child rape, with a charge/summons ratio of 30%, higher in comparison to the England and Wales average (23%). The table below shows the number of police recorded child rapes, the number of charge/summons and the charge/summons ratio for Thames Valley and the England and Wales average.

Table 4: Charge/Summons for Child Rape (aged 16 and under) 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)

Charge/Summons for Child Rape	Recorded Child Rapes (police force data)	Charges/Summons (Crown Prosecution Service)	Charge/Summons ratio (Thames Valley)	Charge/Summons ratio (England and Wales)
2010-11	197	71	36%	33%
2011-12	168	52	31%	33%
2012-13	234	65	28%	30%
2013-14	275	87	32%	29%
2014-15	398	119	30%	23%

Referrals and Charges

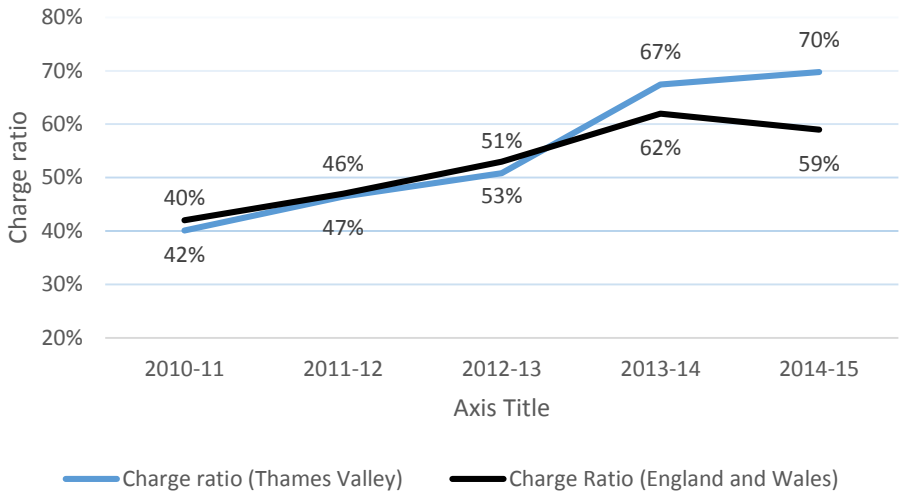
4.21 In 2014-15 there were a total of 311 rape cases referred to the CPS for a decision on whether or not to charge a suspect with rape this is an increase of 10.7% on the previous year (up from 297 in 2013-14). Overall the number of rape cases referred to the CPS have risen since 2010-11. In 2014-15 there were 217 defendants that the CPS decided to prosecute on the bases there was enough evidence.

Table 5: Referrals and Charges (number) 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)

CPS Referrals and Charges for Rape	Referrals	Charges
2010-11	329	132
2011-12	297	138
2012-13	183	93
2013-14	273	184
2014-15	311	217

4.22 The chart below shows the charge ratio, in Thames Valley the charge ratio in 2014-15 was 70%, greater than across England and Wales (59%). Thames Valley have since 2013-14 maintained a higher charge rate in comparison to England and Wales.

Chart 12: Charge Ratio 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)



Prosecutions and Convictions – Adults and Children

4.23 Prosecutions and convictions are recorded for cases flagged as rape by the CPS that finish in the financial year.[42] The CPS does not split the data into child and adult offences. In Thames Valley during 2014-15 there were 178 prosecutions for cases with a CPS rape flag, a 32.8% increase on the previous year (up from 155 in 2010-11). During the same period (2014-15) 112 defendants were convicted of rape, representing a 36.5% increase on the previous year. The table below shows the number of prosecutions and convictions for rape. This means 62.9% of prosecutions resulted in a conviction. The data reported here from the CPS will differ to that of PFAs for several reasons and therefore comparisons to PFAs cannot be made.[43]

Table 6: Persecution and Convictions (number) 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)

CPS Prosecutions and Convictions for Rape	Prosecutions	Convictions
2010-11	153	77
2011-12	155	93
2012-13	114	67
2013-14	134	82
2014-15	178	112

Prosecution Outcomes – Adults and Children

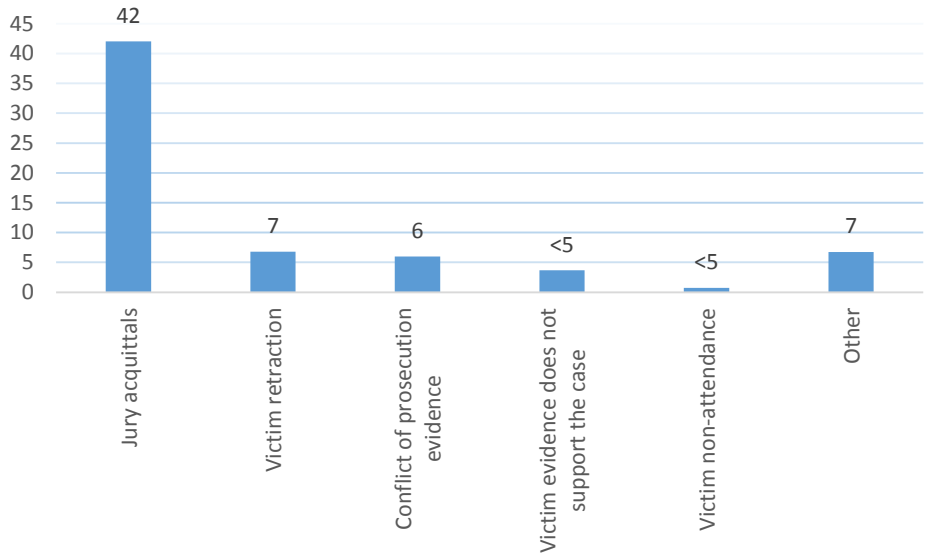
4.24 Just over half (56.3%) of prosecution outcomes across England and Wales for cases flagged as rape result in a conviction. The remaining outcomes do not result in a conviction for several reasons, largely due to jury acquittals (27.8%), victim

[42] A rape flag may be applied at the beginning of a case (where it remains even if the charges(s) of rape are later amended or dropped) or applied in the prosecution process where rape charges are subsequently applied.
[43] CPS areas do not strictly align with PFAs and there will be some level of cross border prosecutions as well in 2014-15 revised methods of reporting which additional figures from British Transport Police (BTP).

retraction (4.5%), conflict of prosecution evidence (4.0%), victim evidence does not support the case (2.4%), victim non-attendance (0.5%) and other (0.5%).

4.25 Applying these outcomes across England and Wales to the prosecutions for rape in Thames Valley, the chart below shows the equivalent number of outcomes for those cases where a prosecution did not result in a conviction.

Chart 13: Reasons for non-convictions as result of Prosecution 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)



Sentencing – Adults and Children

4.26 Across England and Wales, the average time from a defendant being charged to the eventual outcome of the prosecution at the Crown Court was around seven and a half months for rape cases completed in 2014-15. The average custodial sentence length for defendant's sentenced to custody in the calendar year 2014 was around 10 years.

Summary

4.27 In summary, just under 700 police recorded adult rape offences and around 400 police recorded child rape offences in 2014-15. Compared to the previous year, these figures indicate a significant increase in both adult and child rape offences recorded by the police (58% increase in adults and 45% increase in child rape cases).

4.28 During 2014-15, 311 rapes cases (adults and children) were referred to the CPS for a decision to charge a suspect, in 70% of these cases the CPS decided to prosecute on the bases there was enough evidence, across England and Wales this was 59%.

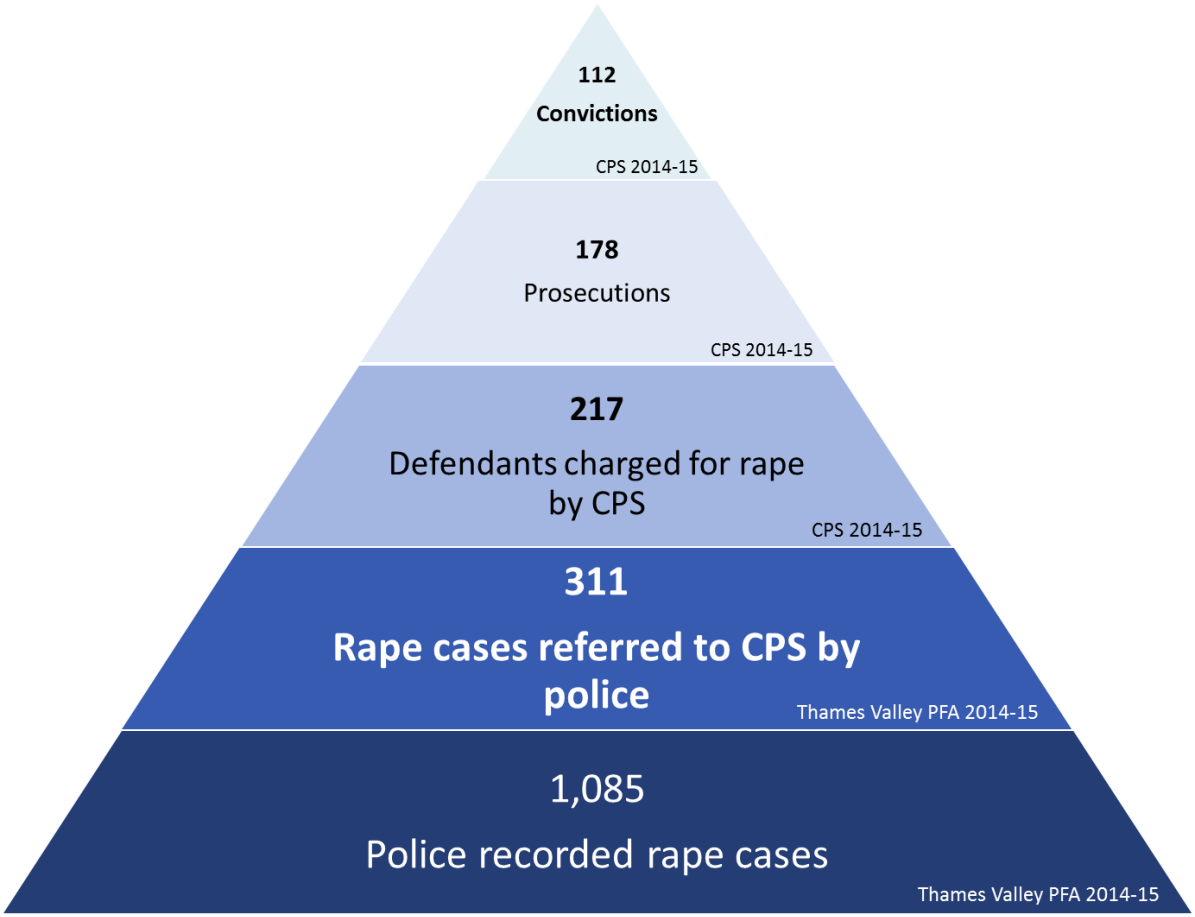
4.29 There were 178 prosecutions for case flagged as rape by the CPS, a 33% increase compared to the previous year, resulting in 112 convictions this equates to 63% conviction rate.

4.30 The average time taken from being charged to the outcomes of the prosecution takes on average seven and a half months, adding to this the length of time the

police investigation can take means victims who pursue the criminal justice route are involved in this process for a significant length of time.

4.31 The chart below draws together the key data sets from police recorded rape cases (combined adult and child rape cases), cases that are referred to the CPS for prosecution and the outcomes. Whilst the data does not allow for direct comparison, it does indicate the low level of reported rape cases resulting in a conviction; one in ten.

Chart 14: Recorded Rape Cases (adult and children), Referrals to CPS, Convictions 2014-15 (Source: HMIC, Rape Monitoring Group: Digests, Thames Valley PFA data for 2014-15)



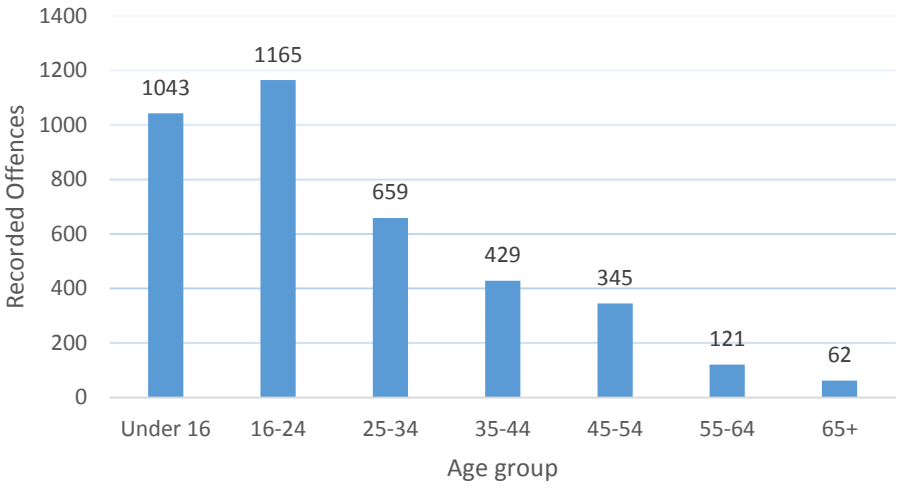
Thames Valley Police Recorded Sexual Offences (Local Data)

4.32 This section provides an analysis of the local data provided by Thames Valley police statistics team. The data is for two 12-month reporting periods (y/e Sept 2014 and y/e Sept 2015). The numbers will therefore differ from those provided through national datasets and are not directly comparable. However, what this section provides is a detailed demographic breakdown of all sexual offences recorded by the police. The data is presented by age at the time of reporting the offence and therefore will include recent and historic rape offences.

4.33 In the 12-month reporting period (y/e Sept 2015), Thames Valley police recorded 3,954 cases of sexual assault, an increase of 41.9% on the previous 12 months (2,787 in y/e September 2014). In the latest 12-month period, most assaults were reported by females (87.2%)[44]. Where age was known[45], over half (57.7%) of all police recorded sexual offences were reported by people aged under 25.

4.34 Around three in ten (1,043, 27.3%) cases of police recorded sexual offences involved children aged under 16 (this includes 362 children (9.5%) aged under 13 and 681 (17.8%). The remaining cases of sexual offences were reported by those aged 16 and over (2,871, 72.7%).

Chart 15: Recorded Sexual Offences, Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)



4.35 The table below shows the ethnic profile of police recorded sexual offences (where ethnicity was known[46]) in comparison to the ethnic profile for the total population of Thames Valley.[47] Broadly the ethnic profile of police recorded sexual assault cases is similar to that of the whole population across Thames Valley (15.1% and 15.4% respectively).

[44] Gender was known in 3,942 police recorded sexual offences
[45] Age was known in 3,824 police recorded sexual offences
[46] Ethnicity was known in 2,618 police recorded sexual offences
[47] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

Table 7: Ethnic Profile Recorded Sexual Offences (all), Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)

Ethnicity (all sexual offences)	Thames Valley (population)	Thames Valley Police recorded sexual offences
White	84.6%	84.8%
Mixed/multiple ethnic group	2.5%	3.6%
Asian/Asian British	9.2%	6.7%
Black/African/Caribbean	3.0%	3.8%
Other ethnic group	0.7%	0.9%
Total BME population	**15.4%**	**15.1%**

4.36 In the 12-month period (y/e Sept 2015), 97.9% of all recorded sexual offences were of people living within the Thames Valley area. The majority were from Berkshire (37.2%) followed by Buckinghamshire (32.7%) and the remaining Oxfordshire (30.1%). The table below shows the number and percentage of recorded sexual offences by the areas within Thames Valley.

Table 8: Thames Valley Area of Recorded Sexual Offences, Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)

Thames Valley area	Recorded sexual offences	
	(n)	(%)
Milton Keynes	540	13.9%
Oxford	451	11.7%
Cherwell and West Oxfordshire	424	11.0%
Reading	399	10.3%
Aylesbury	356	9.2%
Slough	298	7.7%
South and Vale of White Horse	292	7.5%
Wycombe	220	5.7%
Bracknell Forest	218	5.6%
West Berkshire	203	5.2%
Wokingham	161	4.2%
Windsor and Maidenhead	160	4.1%
Chiltern and South Bucks	149	3.8%

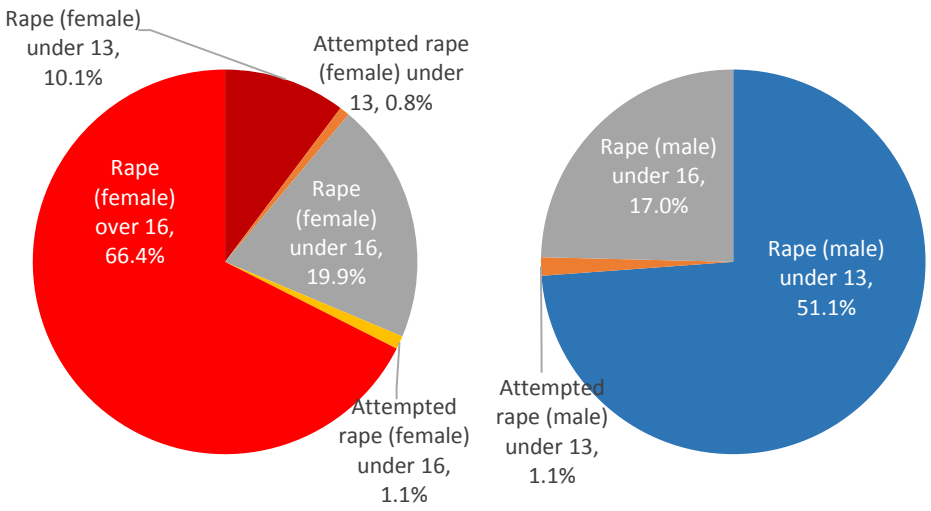
Thames Valley Police Recorded Rape Offences

4.37 In the 12-month reporting period y/e Sept 2015, there were a total of 1,286 police recorded rape and attempted rape offences across Thames Valley (1,241 rape cases, and 45 attempted rape cases). This is an increase of 56.4% on the previous 12 months (up from 882 in y/e Sept 2014, 868 rape cases and 14 attempted rape cases).

4.38 Over the same period, nine out of ten victims (92.7%) were female. The chart below shows recorded rapes by gender and age groups, age is shown at the time of reporting the offence and therefore will include recent and historic rape offences.

4.39 The majority of female rapes cases, including attempted rape, were recorded for those aged 16 and over (812, 68.1%), followed by those aged under 16 (250, 21.0%) and the remaining by those aged under 13 (130, 10.9%). However, the majority of male rape cases, including attempted were recorded for those aged under 13 (49, 52.1%), followed by those aged 16 and over (29, 30.9%) and those aged under 16 (16, 17.0%).

Chart 16: Police ecorded Rape Cases y/e September 2015, Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)



4.40 The table below shows the ethnic profile of police recorded rape offences (where ethnicity was known[48]) in comparison to the ethnic profile for the total population of Thames Valley.[49] This shows a greater proportion of rape offences being reported by BME populations in comparison to the whole BME population across Thames Valley.

Table 9: Ethnic Profile Recorded Rape Offences, Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)

Ethnicity (rape offences)	Thames Valley (population)	Thames Valley Police recorded sexual offences
White	84.6%	78.2%
Mixed/multiple ethnic group	2.5%	3.9%
Asian/Asian British	9.2%	11.0%
Black/African/Caribbean	3.0%	6.0%
Other ethnic group	0.7%	0.9%
Total BME population	**15.4%**	**21.9%**

[48] Ethnicity was known in 897 police recorded rape offences
[49] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

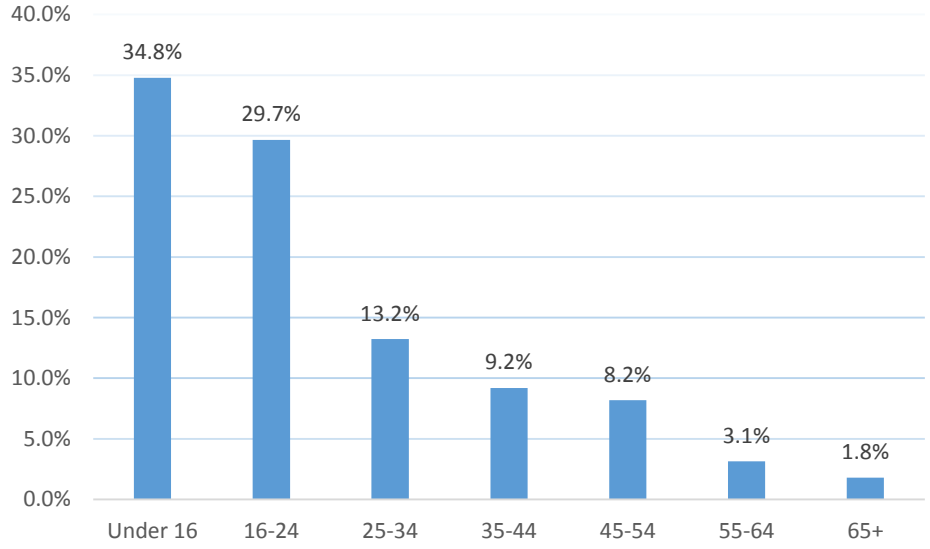
Thames Valley Police Other Sexual Assault Offences

4.41 In the 12-month period y/e Sept 2015, there were a total of 2,668 police recorded other sexual assaults (not including rape or attempted rape offences) across Thames Valley. This is an increase of 143.7% on the previous 12 months (up from 1,095 y/e Sept 2014).

4.42 Where age was known[50], around three quarters (64.4%) of all police recorded other sexual assaults were reported by people aged under 25.

4.43 Around one third (888, 34.8%) of police recorded other sexual assaults involved children aged under 16 (this includes 320 children aged under 13 and 568 children aged 13-15). The remaining cases of sexual offences were reported by those aged 16 and over (1,665, 65.2%).

Chart 17: Other Sexual Assault Offences, Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)



4.44 The table below shows the ethnic profile of police recorded other sexual assault offences (where ethnicity was known[51]) in comparison to the ethnic profile for the total population of Thames Valley.[52] This shows fewer people reporting other sexual assaults are from BME populations in comparison to the whole BME population across Thames Valley.

[50] Age was known in 2,553 police recorded other sexual assault cases
[51] Ethnicity was known in 2,618 police recorded sexual offences
[52] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

Table 10: Ethnic Profile Recorded Other Sexual Assault Offences, Thames Valley Police y/e Sept 2015 (Source: Thames Valley Police, Local Data – y/e Sept 2014 & y/e Sept 2015, released November 2015)

Ethnicity (other sexual assault offences)	Thames Valley (population)	Thames Valley Police recorded sexual offences
White	84.6%	88.4%
Mixed/multiple ethnic group	2.5%	3.9%
Asian/Asian British	9.2%	4.5%
Black/African/Caribbean	3.0%	2.7%
Other ethnic group	0.7%	0.9%
Total BME population	**15.4%**	**11.6%**

4.45 In summary, nationally there has been an upward trend in the number of sexual offences being reported to the police. In the latest 12-month reporting period (y/e Sept 2015) Thames Valley police reported just under 4,000 children, young people and adult victims of sexual assault (including attempts). Compared with the previous 12 months this is an increase of 42%. Nine out of ten (87%) victims were girls and women. Over half (58%) of all sexual offences were reported by young people aged under 25 (with 27% involving children aged under 16).

4.46 There are more victims reporting 'rape' from BME populations (22%) compared with the BME population across Thames Valley (15%), whilst fewer victims reporting other sexual offences from BME populations (12%) compared with the BME population across Thames Valley.

4.47 One third of all sexual offences recorded by the police were rape offences (including attempts). Two thirds of rape offences were against child and young women aged 16 over. Half of all male rape cases were against those aged under 13. Local data from Thames Valley police shows in the latest 12 month reported period (y/e Sept 2015), just under 4,000 children, young people and adults had reported being a victim of a sexual assault (including attempted sexual assault).

Safeguarding Data

4.48 In March 2015, there were a total of 1,634 children subject to a child protection plan (CPP) across Thames Valley. Of this, sexual abuse was reported in 71 children, representing 4.3% of the total. The breakdown by authority areas in Thames Valley can be seen in the table below

Table 11: Thames Valley data for children subject to CPP, reporting Sexual Abuse March 2015 (Source: SF41/2015 Characteristics of Children in Need 2014-15, DfE Table D4, Released October 2015)

Child Protection Plans (reporting sexual abuse)	Children Subject to CPP	Reporting sexual abuse
Bracknell Forest	122	-
Buckinghamshire	332	19
Milton Keynes	57	0
Oxfordshire	569	21
Reading	204	31
Slough	112	-
West Berkshire	126	
Windsor and Maidenhead	64	-
Wokingham	48	-
Total	**1634**	**71**

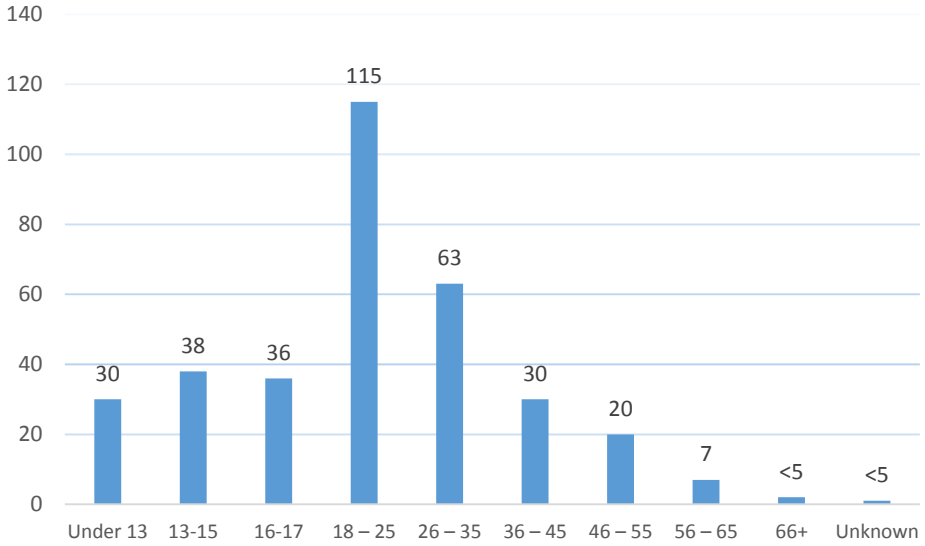
Thames Valley SARC

4.49 In Thames Valley there are two SARCs one located in Bletchley and the other in Slough, this sections reports on the activity of the two SARCs. The analysis of the SARC data in the following section focuses on the latest 12-month reporting period (y/e Sept 2015) during this time there were 342 children, young people and adults referred to and seen by the SARC. In addition, a further 40 children (aged under 18) were seen in the historic paediatric sexual abuse clinic.

4.50 The following analysis is based on the data provided for the 342 victims seen by the SARC. Over half were seen in the Slough SARC (59.1%, 187) and the remaining were seen in the Bletchley SARC (40.9%, 114). Almost all were females (93.9%). Compared with the previous 12 months there was a 22.8% increase in the number of people seen (up from 301, y/e Sept 2015).

4.51 Two thirds (64.0%) of all victims seen by the SARC were aged 25 and under. Of this, 9.4% were aged under 13, 11.1% aged 13-15, 10.5% aged 16-17 and 33.6% aged 18-25. The chart below shows the age profile of people seen by the SARCs.

Chart 18: Age Profile, Thames Valley SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



4.52 The table below shows the ethnic profile of the victims seen by SARC (where ethnicity was known[53]) in comparison to the ethnic profile for the total population of Thames Valley.[54] Broadly, the ethnic profile of SARC victims is similar to that of the whole population across Thames Valley, with a similar number of victims seen by the SARC from BME populations as there across Thames Valley (15.6% and 15.4% respectively). However, with some differences within specific BME groups, with mixed/mixed multiple populations representing 2.5% of SARC victims compared to representing 5.0% of the total population of Thames Valley and Asian/Asian British representing 9.2% of SARC victims compared to representing 5.9% of the total of Thames Valley population.

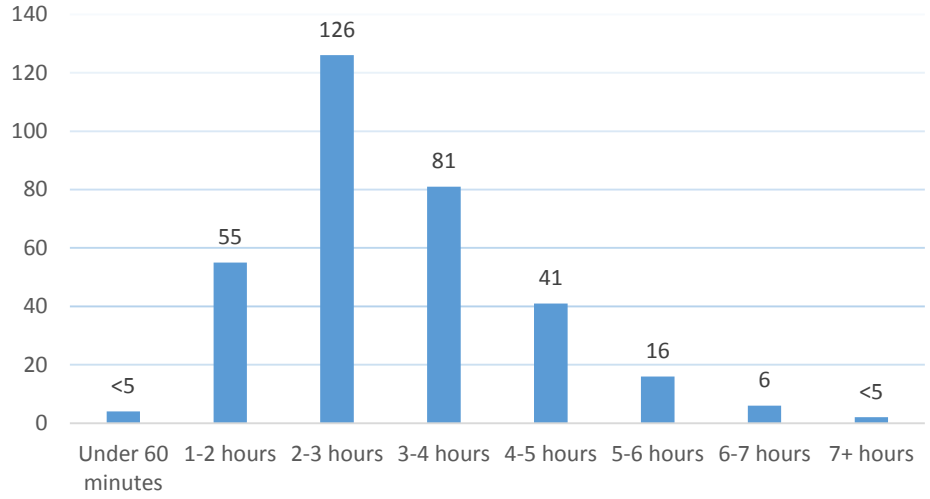
Table 12: Ethnic Profile, Thames Valley SARC y/e Sept 2015, Thames Valley population 2011 (total) (Source: Thames Valley SARC Data October 2013 – September 2015, Census 2011)

Ethnicity	Thames Valley (population)	SARC (victims)
White	84.6%	84.4%
Mixed/multiple ethnic group	2.5%	5.0%
Asian/Asian British	9.2%	5.9%
Black/African/Caribbean	3.0%	3.9%
Other ethnic group	0.7%	0.9%
Total BME population	**15.4%**	**15.6%**

4.53 The length of time victims spent in the SARC varied from under one hour to over 7 hours, with eight out of ten (88.6%) spending anywhere between 1-5 hours.

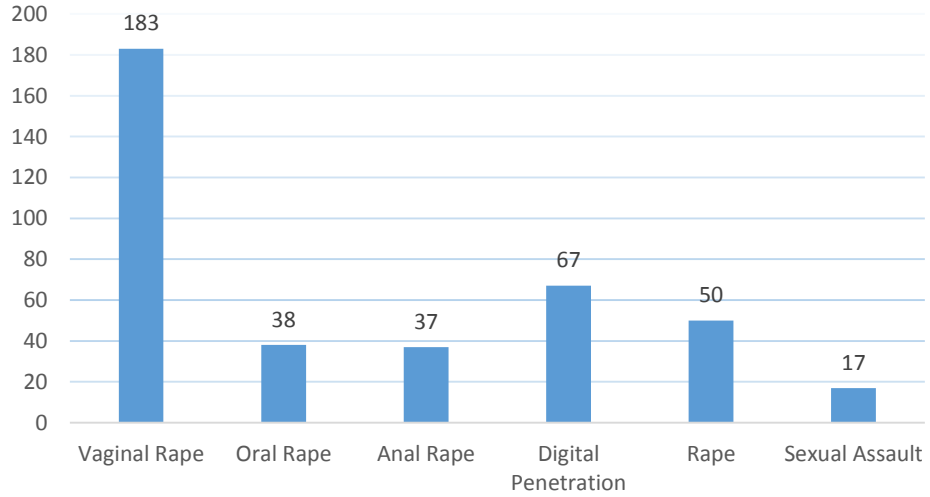
[53] Ethnicity was known in 340 SARC victims.
[54] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

Chart 19: Length of time spent at the SARC, Thames Valley SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



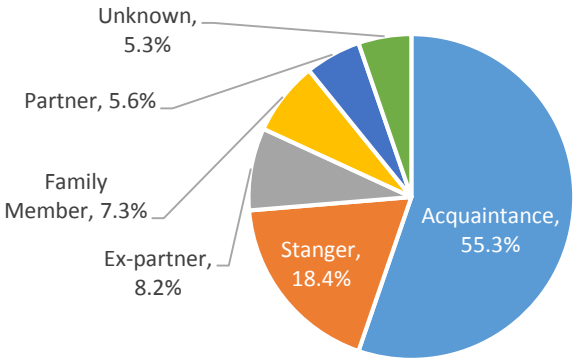
4.54 The majority of victims seen by the SARC were vaginal rape victims. The chart below shows the number of reported assault types, this is the count of assault type and not individuals and therefore includes multiple assaults reported by one individual. Of all assaults the majority were rape (95.7%) and sexual assault (4.3%).

Chart 20: Assault Type, Thames Valley SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



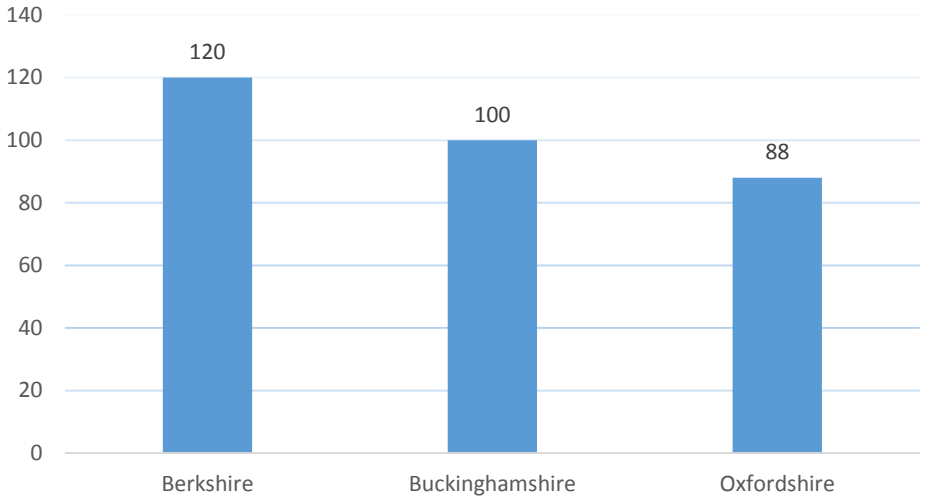
4.55 Over three quarters (76.3%) of victims were assaulted by someone they knew (55.3%, acquaintances, 8.2% ex-partner, 7.3% family member, 5.6% partner). The remaining were strangers (18.4%) and unknown (5.3%). This can be seen in the chart below.

Chart 21: Victim – Assailant Relationship, Thames Valley SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



4.56 The vast majority (90.1%) of victims seen by the SARC were from Thames Valley, the remaining 9.5% were from out of area or unknown. The chart below shows, for those victims, resident in Thames Valley[55], by county; 39.0% were from Berkshire, 32.5% from Buckinghamshire and 28.6% were from Oxfordshire.

Chart 22: Victims by Area of Residence, Thames Valley SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



4.57 The table below sets out the identified health needs of the victims seen by the SARC in relation to physical health, mental health, disabilities, drug and alcohol use.[56] This was reported for 320 SARC victims, of whom, four out of ten (43.8%) reported a mental health need, an almost similar proportion (39.4%) reported self-harm. Around 2% had a physical disability and 15.3% reported learning difficulties. Drug use was reported in 17.8% and alcohol use reported in 13.1%.

[55] NB these were the location of resident references used in the SARC Data set

[56] Identified mental health, disability, drug and alcohol use this was reported for 320 victims seen by the SARC.

Table 13: Reported Mental Health, Disability, Drug and Alcohol Use, Thames Valley SARC y/e Sept 2015, (Source: Thames Valley SARC Data October 2013 – September 2015)

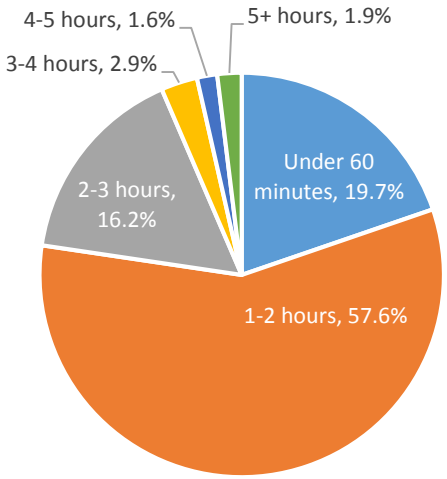
	Identified needs		No identified need	
	(n)	(%)*	(n)	(%)*
Mental Health	140	43.8%	180	56.3%
Self-Harm	126	39.4%	194	60.6%
Physical Disability	6	1.9%	314	98.1%
Learning Difficulties	49	15.3%	271	84.7%
Recreational Drug use	57	17.8%	263	82.2%
Alcohol Use	42	13.1%	278	86.9%

**as a % of total SARC victims*

4.58 Nine out of ten (90.9%) victims seen by the SARC underwent a forensic medical examination at the SARC. The length of time it takes a victim to be examined varies and is dependent on the capacity of the on duty forensic physician. Nationally it is recommended a victim is examined within one hour from the time the request is made, however due to the geography of Thames Valley and the availability of one forensic physician at any one time, the agree window within which a victim is examined has been increased to within two hours.

4.59 The chart below shows long it takes from the time a victim is referred for a forensic medical examination to the time the victim is seen by the forensic physician (y/e Sept 2015). Where the time was recorded,[57] eight out of ten victims were seen by the forensic physician within two hours of being referred (with over half (57.6%) seen within one to two hours and one in five (19.7%) seen within one hour). For the remaining 70 (22.7%) it took 3 hours or more to be seen by the forensic physician.

Chart 23: Time taken for Victim to be examined from point of referral to the SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



4.60 For the 70 where it took longer than 2 hours to be seen by the forensic physician, the majority (74.2%) of cases the reason was due to the examination being arranged at a time that was convenient for the victim. In other cases, it was due to the competing demands on the forensic physician, this happened in 14.2% of cases

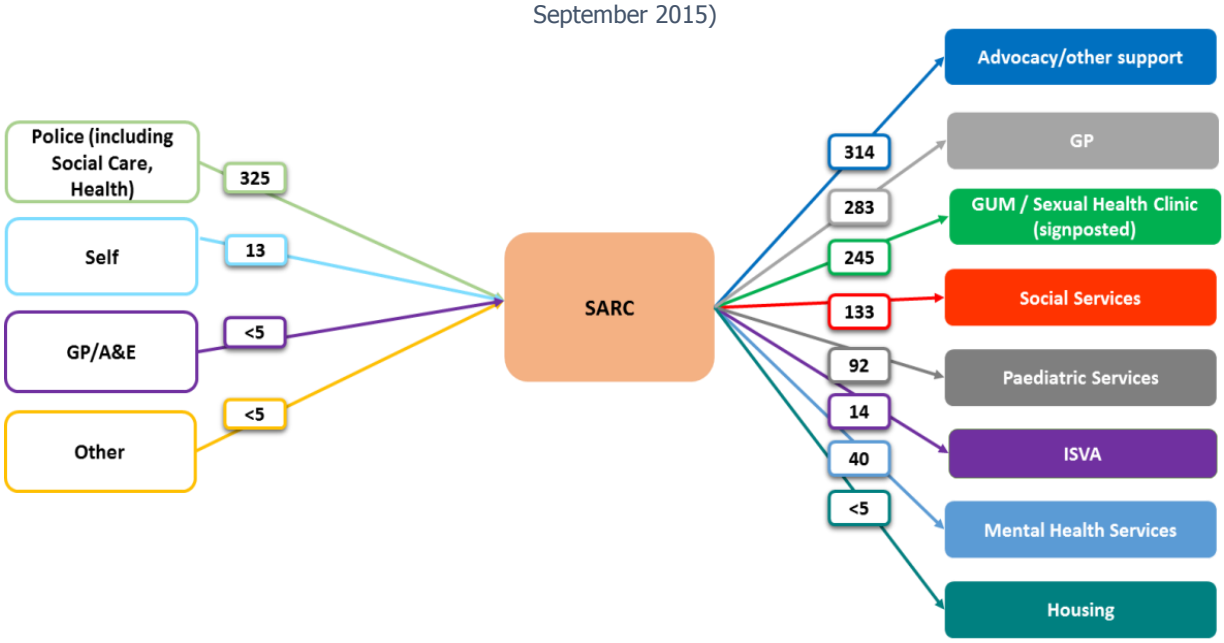
[57] Time taken to be seen by the SARC was recorded in 309 victims

and other reasons in the remaining 11.4%. On some occasions there are multiple victims presenting at the same time and possibly at both SARCs, taking account of the distance between the SARCs and travel, is a considerable factor in causing delays.

4.61 Emergency contraception was offered to 110 victims, of this number 92.7% took the offer of emergency contraception, the remaining (7.3%) refused. The majority of victims were referred to GUM clinic (83.8%), 9.2% of were prescribed at the SARC, 0.6% prescribed elsewhere and the remaining 6.4% declined.

4.62 The chart below shows the referrals routes into and out of the SARCs. Almost all referrals (95.0%) originated from the police (including social care and health) followed by self-referrals (3.8%), 0.9% from GP or A&E and 0.3% other. Almost all (91.8%) onward referrals from the SARC were to advocacy and support services, GPs (82.7%), GUM or sexual health clinics (71.6%), social services (38.9%) and paediatric services (26.9%).

Chart 24: Referral Source into and out of SARC y/e Sept 2015 (Source: Thames Valley SARC Data October 2013 – September 2015)



4.63 In summary, the SARCs in Thames Valley supported 342 victims (reporting period y/e Sept 2015) This is an increase of 23% from the previous year. Nine out of ten victims were female (94%). Almost two thirds (64%) were children and young people aged 25 and under (with 21% involving children aged under 16). The ethnic profile of the victims seen by the SARC has proportionately the same number of victims from BME populations as there are across Thames Valley but with some differences between specific ethnic groups.

4.64 Three quarters (76%) of all victims knew the perpetrator. Victims seen by the SARC were from all areas of Thames Valley, with the most being from Berkshire (39%) (29%). Just under half (43%) reported a mental health need, 39% reported self-harm, 17% reported a disability (physical and learning) and 31% reported drug and alcohol use.

4.65 Almost all referrals (95%) to the SARC originated from the police and social care, the remaining were self-referrals (4%) and GP or A&E referrals (1%). Almost all

(92%) onward referrals from the SARC were to advocacy and support services, GPs (83%), GUM or sexual health clinics (72%), social services (39%) and paediatric services (27%).

Estimating the scale of need

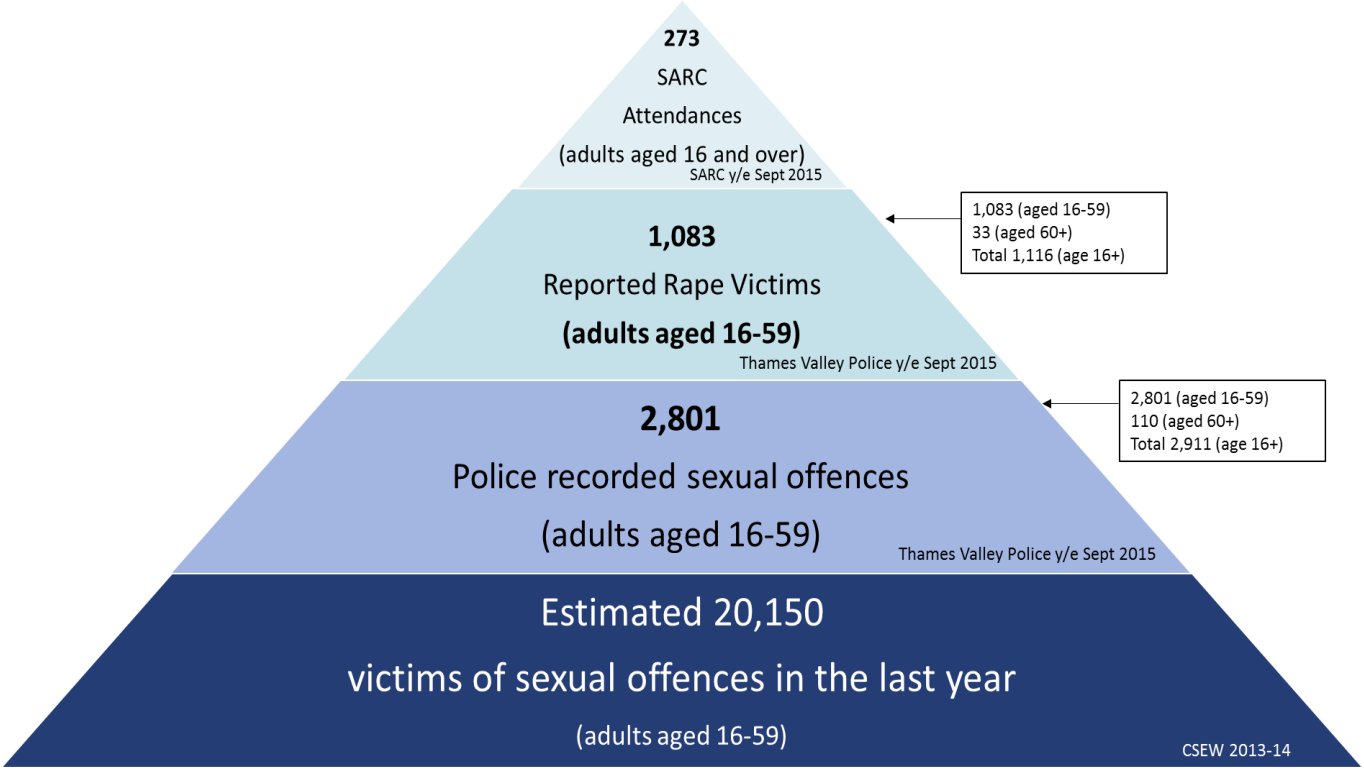
4.66 Estimates provide an idea of the likely scale of the number of victims of sexual offences over a given period. It is widely accepted that a significant gap exists between the estimated number victims, police recorded sexual offences and the number of victims in contact with SARCs.

Adults

4.67 Estimates from the Crime Survey for England and Wales (CSEW) indicate that in 2013-14, 2.2% of women and 0.7% of men (aged 16-59) stated they had been a victim of a sexual offence (including attempts) in the previous 12 months. Applying these percentages to the population of Thames Valley it can be estimated that around 20,150 might have been a victim of a sexual offence (around 4,900 men and 15,250 women) in the last year. In the 12-month period y/e Sept 2015 there were 2,801 police recorded sexual offences of this 1,083 were rape cases (adults aged 16-59). Over the same period there were 273 adult attendances at the SARC (aged 16-59).

4.68 This is summarised for adults in the pyramid below, illustrating the significantly gap between the CSEW estimates of the number of adults in Thames Valley that have been a victim of a sexual offence (including attempted) in the last year, the number of recorded sexual offences by the police and the number of victims referred to and seen by the SARC. Whilst direct comparisons cannot be drawn, the pyramid brings together these figures and the difference in numbers are stark.

Chart 25: Adult Sexual Offences, Estimates, Police Recorded sexual offences, rape offences, SARC attendances (Source: CSEW 2014-15, Thames Valley Police Data y/e Sept 2015, SARC Data y/e Sept 2015)

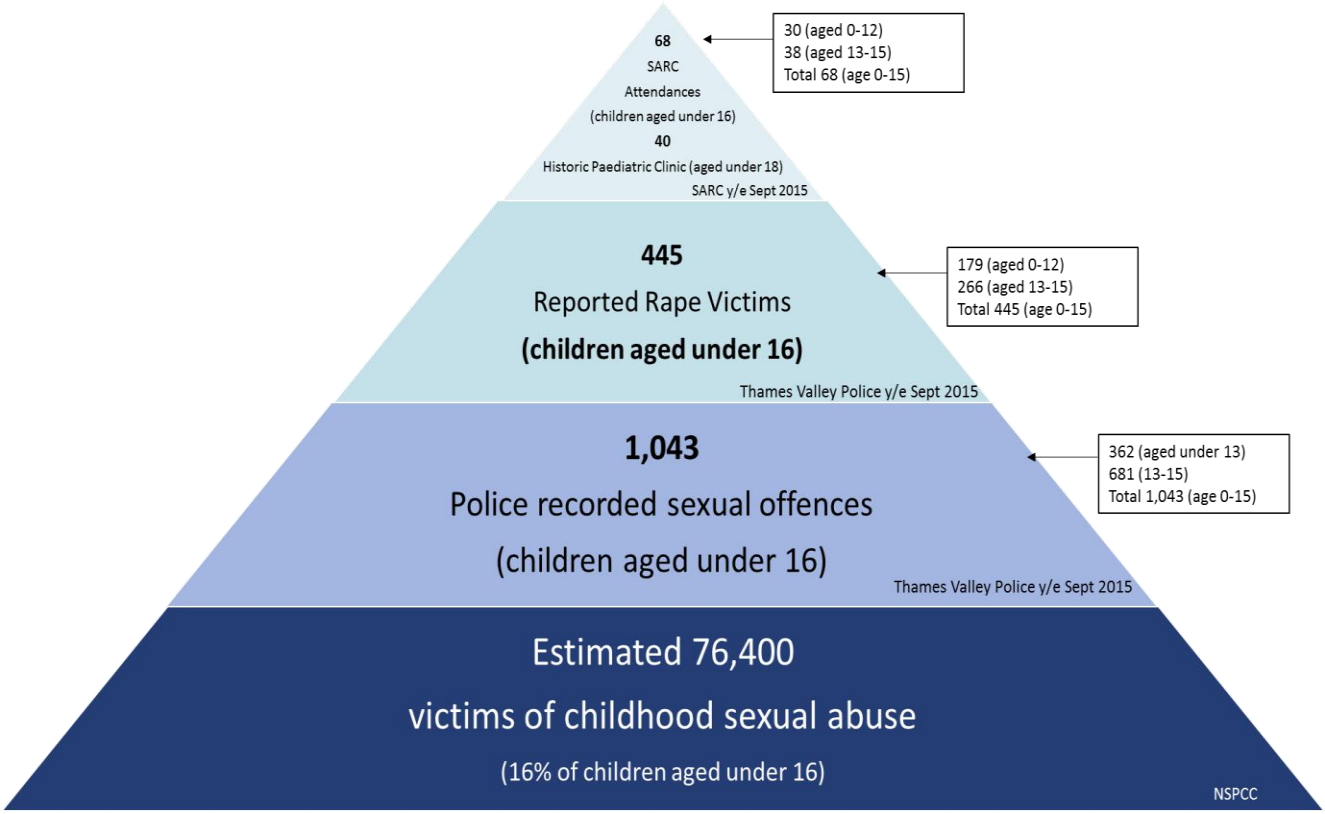


Children

4.69 National estimates (National Society for the Prevention of Child Cruelty, NSPCC) suggest that 16% of children aged under 16 in the UK experience sexual abuse during childhood. Applying this percentage to the Thames Valley population aged under 16 would indicate this is around 76,400 children. In the 12-month period y/e Sept 2015 there were 1,043 police recorded sexual offences, of this 445 were rape cases (children aged under 16). Over the same period there were 68 child attendances at the SARC (aged under 16).

4.70 This is summarised for children in the pyramid below. Similarly, illustrating the significant gap between the prevalence estimates of the number of children in Thames Valley that have been a victim of childhood sexual abuse, the number of recorded sexual offences by the police and the number of victims referred to and seen by the SARC.

Chart 26: Child Sexual Offences, Estimates, Police Recorded sexual offences, rape offences, SARC attendances (Source: CSEW 2014-15, Thames Valley Police Data y/e Sept 2015, SARC Data y/e Sept 2015)



4.71 The true prevalence is likely to fall somewhere between the estimate and the number of police recorded offences.

Thames Valley Independent Sexual Violence Advisor (ISVA) Service

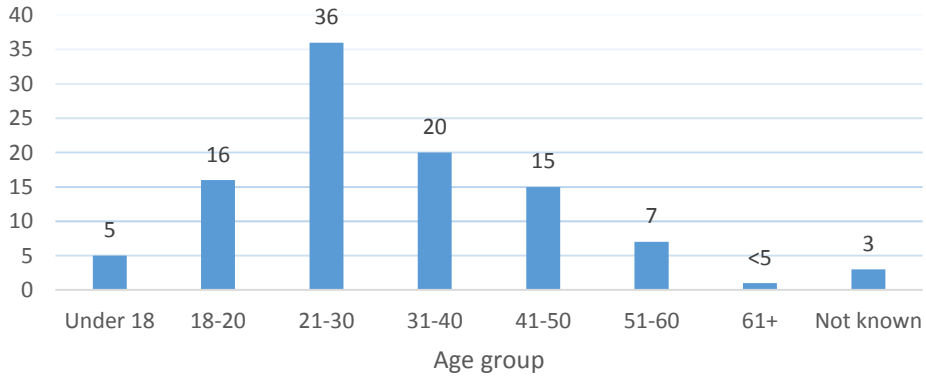
4.72 The ISVA service was launched in July 2015. This service is Thames Valley wide supporting the needs victims of sexual assault who are aged 16 and over. This service should work in alignment with the ISVA resources attached to the rape crisis and other support services as well as the police STOs.

4.73 The data for the ISVA service is presented for the four months of activity from July 2015 to October 2015. During this period there have been 155 referrals, of this 115

people engaged with the service (12 engaged in short term support and 103 in long term support).

4.74 Of the 103 victims Thames Valley ISVA service engaged with, the majority (87.3%) were female and the remaining 12.6% were male. Just over half (55.3%) were aged 30 and under. The largest number of people seen were those in the 21-30 age group representing over one third (35.0%) of all victims.

Chart 27: Age Profile, Thames Valley ISVA Service (Source: Thames Valley ISVA Service Data July 2015 – October 2015)



4.75 The table below shows the ethnic profile of those victims seen by the Thames Valley ISVA service (where ethnicity was known[58]) in comparison to the ethnic profile for the total population of Thames Valley.[59] The ethnic profile of victims seen by the Thames Valley ISVA service shows an underrepresentation of people from BME populations and an overrepresentation of people from white populations.

Table 14: Ethnic Profile, Thames Valley ISVA Service (Source: Thames Valley ISVA Service Data November July 2015 - October 2015)

Ethnicity	Thames Valley (population)	SARC (victims)
White	84.6%	88.4%
Mixed/multiple ethnic group	2.5%	1.1%
Asian/Asian British	9.2%	5.3%
Black/African/Caribbean	3.0%	5.3%
Other ethnic group	0.7%	0.0%
Total BME population	**15.4%**	**11.6%**

4.76 The vast majority (88.3%) of victims seen by the Thames Valley ISVA Service were from Thames Valley, the remaining 11.7% were from out of area or unknown. [60] The table below shows the majority (41.7%) were from Berkshire, followed by one in five (25.2%) from Buckinghamshire and one in five (21.4%) from Oxfordshire.

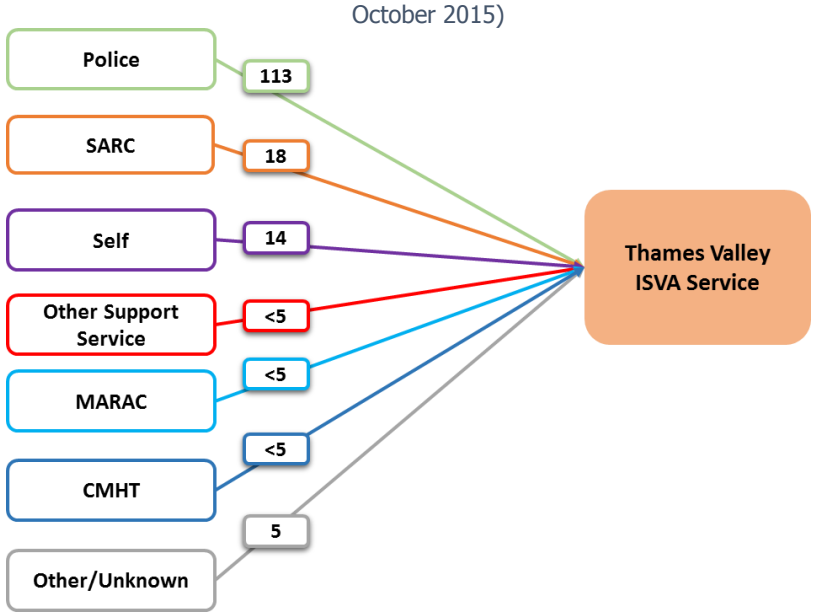
[58] Ethnicity was known in 95 Thames Valley ISVA Service victims
[59] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew
[60] NB these were the location of resident references used in the Thames Valley ISVA Data set

Chart 28: Victims by Area of Residence, Thames Valley ISVA Service (Source: Thames Valley ISVA Service Data July 2015 – ctober 2015)

Thames Valley area	Victims Supported	
	(n)	(%)
Reading	15	14.6%
Milton Keynes	13	12.6%
Vale of White Horse	8	7.8%
Oxford	7	6.8%
West Berkshire	7	6.8%
Wokingham	7	6.8%
Bracknell Forest	6	5.8%
Aylesbury Vale	5	4.9%
Slough	<5	-
Windsor and Maidenhead	<5	-
Wycombe	<5	-
Not known	<5	-
South Oxfordshire	<5	-
South Bucks	<5	-
Cherwell	<5	-
Chiltern	<5	-
West Oxfordshire	<5	-
Other or Unknown	11	11.7%
Total	**103**	

4.77 The chart below shows the inward referrals routes into the Thames Valley ISVA Service. This is the count of the total number of referrals to the services (155) rather than the count of the number of people engaged with the services (115). Almost three quarters (72.9%) of referrals were from the police, followed by 11.6% from SARC, 9.0% were self-referrals. The chart below shows the referrals routes into the Thames Valley ISVA service.

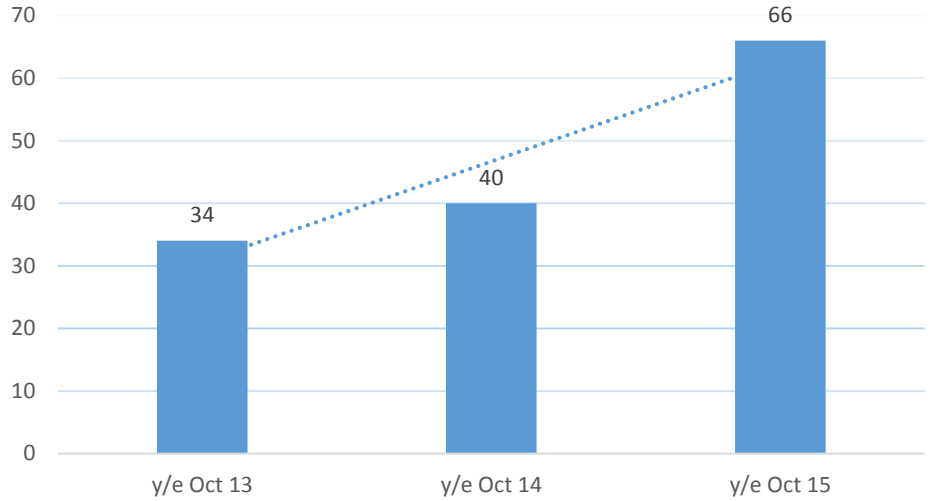
Chart 29: Referral Map, Thames Valley ISVA Service (Source: Thames Valley ISVA Service Data July 2015 – October 2015)



SAFE Project

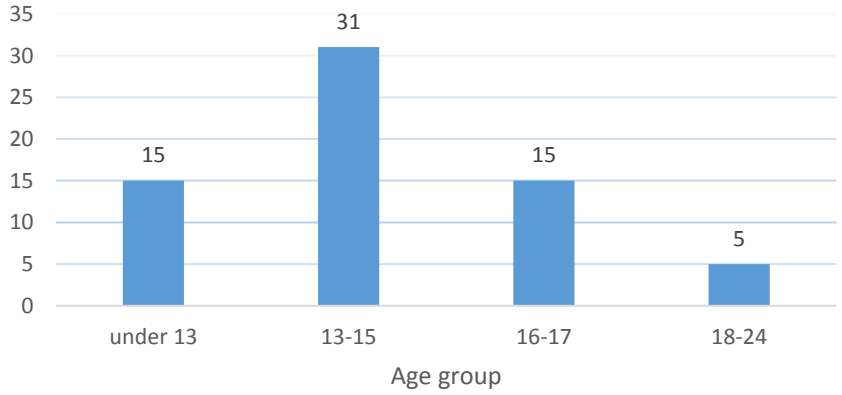
4.78 In the 12-month period y/e Oct 2015, there were a total of 66 young victims of child sexual abuse/sexual assault aged under 25 seen by the SAFE project. This is an increase of 65.0% on the previous 12 months (up from 40 y/e Oct 2014). The chart below shows the number of sexual abuse/sexual assault victims seen by the SAFE project in the past 3 years, this indicates an upward trend that is set to grow as SAFE expand their services from Oxfordshire to cover all areas of Thames Valley.

Chart 30: Number of children and young people seen by Thames Valley SAFE Project, y/e Oct 13, y/e Oct 14, y/e Oct 15 (Source: SAFE Project Data Thames Valley SAFE Project Data November 2012 – October 2015)



4.79 In the most recent 12-month period (y/e Oct 2015), around nine out of ten (89.4%) were females. Just under half (47.0%) were children aged 13-15, and further one in five (22.7%) were children aged under 13. The chart below shows the age distribution of young people seen by the SAFE project.

Chart 31: Age Profile, Thames Valley SAFE Project y/e Oct 15 (Source: Thames Valley SAFE Project Data November 2012 – October 2015)



4.80 The table below shows the ethnic profile of the victims seen by the SAFE project (where ethnicity was known[61]) in comparison to the ethnic profile for the total population of Thames Valley.[62] The ethnic profile of victims seen by the SAFE

[61] Ethnicity was known in 60 SAFE Project victims.
[62] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

project shows an underrepresentation of young people from BME populations and an overrepresentation of young people from White populations.

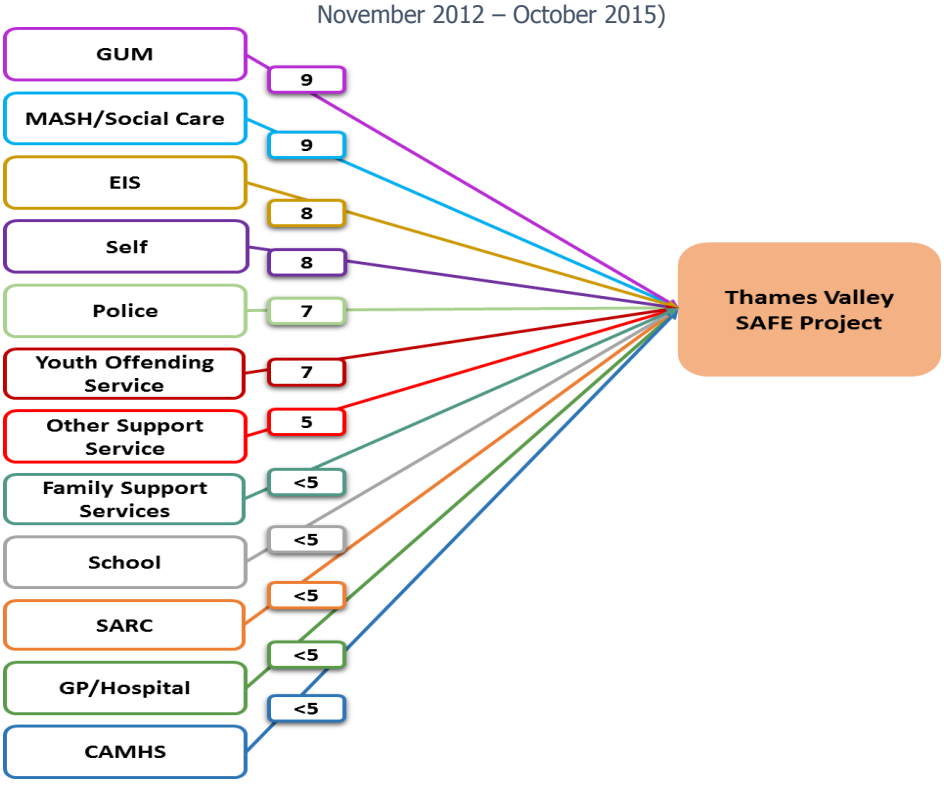
Table 15: Ethnic Profile, Thames Valley SAFE Project y/e Oct 2015 (Source: SAFE Project Data Thames Valley SARC Data November 2012 – October 2015)

Ethnicity	Thames Valley (population)	SARC (victims)
White	84.6%	93.3%
Mixed/multiple ethnic group	2.5%	0.0%
Asian/Asian British	9.2%	5.0%
Black/African/Caribbean	3.0%	1.6%
Other ethnic group	0.7%	0.0%
Total BME population	**15.4%**	**6.7%**

4.81 Where vulnerabilities were known, 15.9% of young people seen by the SAFE project were not in education, employment or training (NEET), [63] 12.9% reported a disability[64] and 6.8% reported being a carer.[65]

4.82 The chart below shows the referrals routes into the Thames Valley SAFE project. The highest level of referrals were from GUM clinics (13.6%) and MASH or social care teams (13.6%), followed by EIS (12.1%), family or self-referrals (12.1%), police (10.6%), youth offending services (10.6%) and other support services (7.6%). The remaining 19.7% were referrals from family support teams, SARC, schools, primary care and CAMHS.

Chart 32: Referrals, Thames Valley SAFE Project y/e Oct 2015 (Source: Thames Valley SAFE Project Data November 2012 – October 2015)

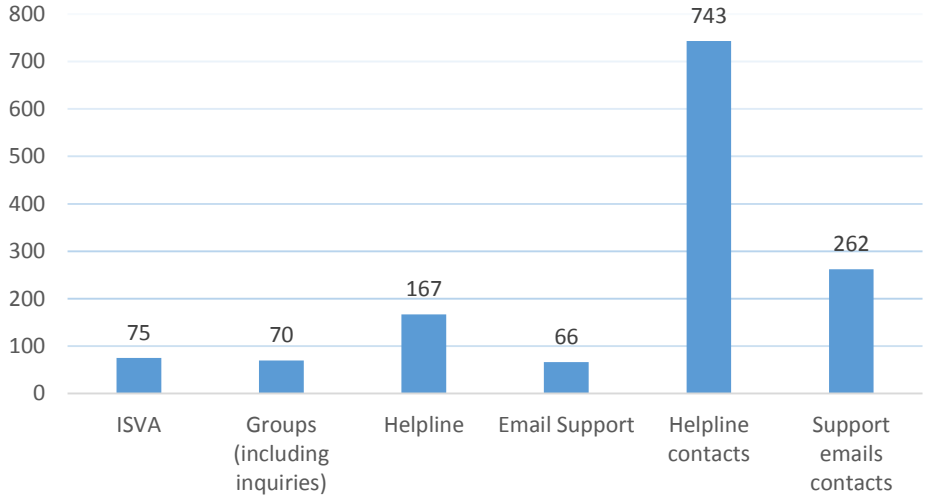


[63] NEET status was known in 63 victims
[64] Disability status was known in 31 victims
[65] Carer status was known in 63 victims

Oxfordshire Sexual Assault and Rape Crisis Centre (OSARCC)

4.83 During the 12-month period y/e Sept 2015 OSARCC supported 378 survivors, an increase of 57.5% on the previous 12 months (up from 240, y/e Sept 2014). The chart below shows the type of support offered during the reporting period y/e Sept 2015, 75 victims were supported by the ISVA service, 70 through group therapy, 167 through helpline and 66 through email support.

Chart 33: Type of Support Offered, OSARCC y/e Sept 2015 (Source: OSARCC Data October 2013 – September 2015)

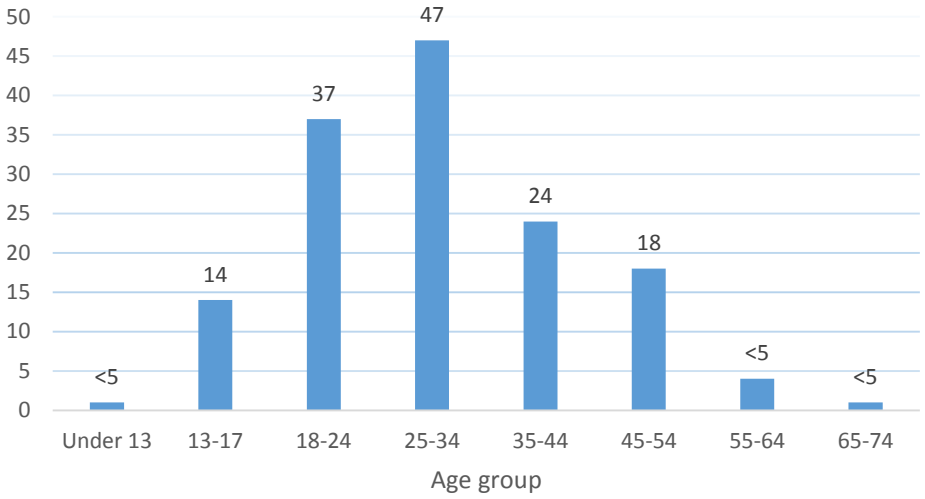


4.84 However, the actual volume of contacts through the helpline and email was much greater (740 helpline and 335 email contacts). OSARCC have recently launched their face to face counselling service which will add to the volume of victims seen in the future reporting periods.

4.85 Almost all (96.5%) were females, 3.2% male and 0.3% transgender. The age and ethnicity was reported for those who were offered support through advocacy and group support services (378 victims). The chart below shows the number of victims supported by OSARCC, (age was known in 38.6% of all victims and therefore may not be reflective of the age profile of all victims[66]). Just over two thirds of all people seen by OSARCC were aged under 25. The largest age group seen were those aged 25-34 representing 32.2%, followed by those aged 18-24 representing 25.3%.

[66] Age was known in 146 OSARCC victims

Chart 34: Age Profile, OSARCC y/e Sept 2015 (Source: OSARCC Data October 2013 – September 2015)



4.86 The table below shows the ethnic profile of the victims seen by OSARCC (ethnicity was known in 23.7% of all victims and therefore may not be reflective of the age profile of all victims [67]). Where known, the table below compares the ethnic profile of OSARCC victims to the ethnic profile for the total population of Thames Valley.[68] This shows underrepresentation of young people from BME populations seen by OSARCC.

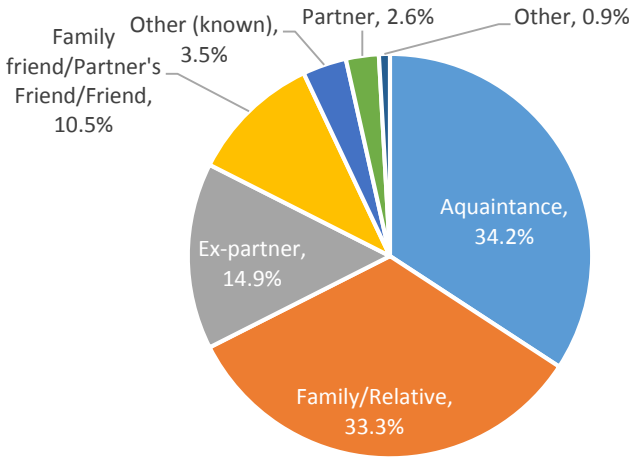
Table 16: Ethnic Profile, OSARCC y/e Sept 2015 (Source: OSARCC Data October 2013 – September 2015)

Ethnicity	Thames Valley (population)	OSARCC (victims)
White	84.6%	92.4%
Mixed/multiple ethnic group	2.5%	1.1%
Asian/Asian British	9.2%	5.4%
Black/African/Caribbean	3.0%	0.0%
Other ethnic group	0.7%	1.1%
Total BME population	**15.4%**	**7.6%**

4.87 The chart below shows the victim, assailant relationship (the victim, assailant relationship was known in 30.2% of all victims and therefore may not be reflective of the victim, assailant relationship of all victims [69]). Almost all victims were assaulted by someone they knew (34.2%, acquaintances, 33.3% family member or relative, 14.9% ex-partner, 10.5% family friend, partner's friend or friend, 2.6% partner, 3.5% other known).

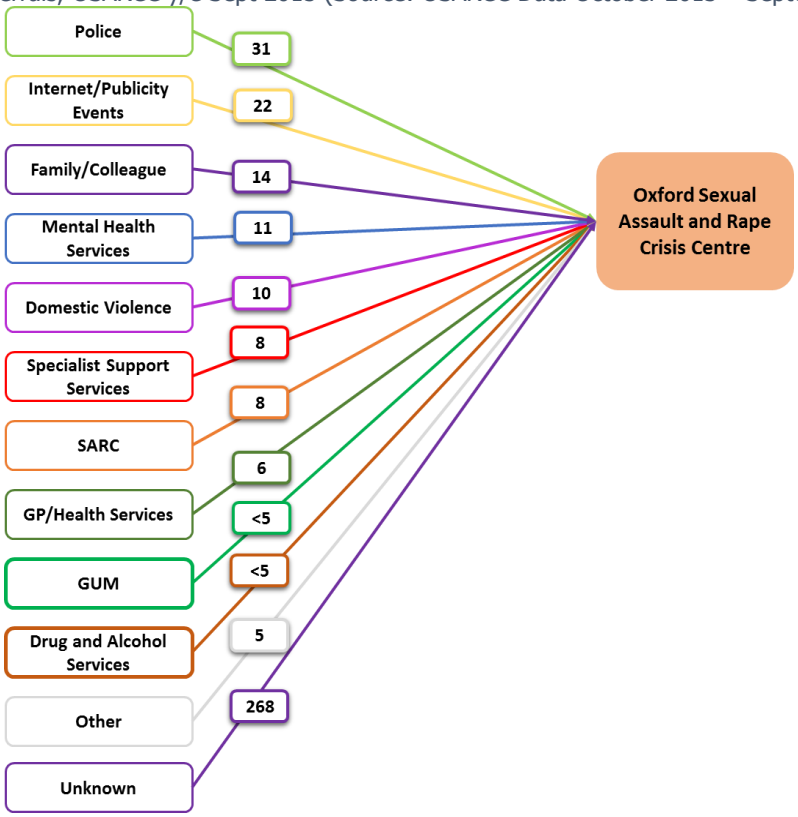
[67] Ethnicity was known in 92 OSARCC victims
[68] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew
[69] Victim, assailant relationship was known in 114 OSARCC victims

Chart 35: Victim, Assailant Relationship, OSARCC y/e Sept 2015 (Source: OSARCC Data October 2013 – September 2015)



4.88 The chart below shows the referrals routes into the OSARCC service. The majority of referrals (where referral sources were known[70]) were from police (26.5%), through internet or publicity events (18.8%), through a friend or colleague (12.0%), mental health services (9.4%), domestic violence services (8.5%). The remaining 24.8% were from other support services (6.8%), SARC (6.8%), GP or health services (5.1%), GUM clinic (0.9%), drug and alcohol services (0.9%) and other (4.3%).

Chart 36: Referrals, OSARCC y/e Sept 2015 (Source: OSARCC Data October 2013 – September 2015)



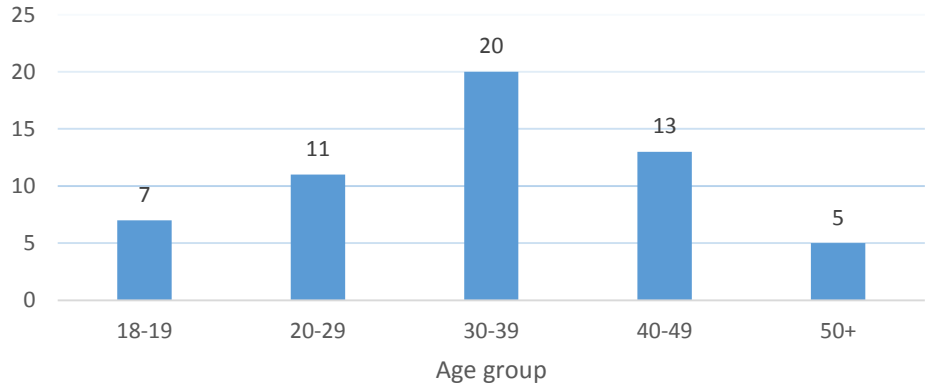
[70] Referral sources were known in 117 OSARCC victims

Trust House Reading (THT)

4.89 In the 12-month period y/e Sept 2015, 68 victims were referred to THR and a total of 61 victims were supported, a significant reduction on the numbers seen in the previous 12-months (169 in y/e Sept 14). Of the 61 victims supported in the most recent 12-month period (y/e Sept 2015), of this 25 victims were supported through counselling services, 13 through ISVA service, 17 received both counselling and ISVA support and the remaining 6 were recorded as not appropriate. In addition, THR supported around 40 children aged 4-11 through play therapy. THR support victims through telephone helpline, however the volume of calls generated through the helpline were not recorded.

4.90 Where gender was known, the majority of victims referred were female (87.3%, 55) and remaining were male (12.7%, 8). The chart below shows the number of victims supported by THR, (where age was known[71]). Two thirds of all victims were aged 30 and over, with one third, 35.7% aged 30-38, almost one quarter, 23.2% aged 40-49 and 8.9% aged 50 and over.

Chart 37: Age Profile, THR y/e Sept 2015 (Source: THR Data October 2013 – September 2015)



4.91 The table below shows the ethnic profile of the victims seen by THR, (where ethnicity was known[72]), the table below compares the ethnic profile of THR victims to the ethnic profile for the total population of Thames Valley.[73] The ethnic profile of victims seen by the THR shows more victims were from BME populations were seen in comparison to the total BME population across Thames, this is a reflection of the greater ethnic diversity among residents in Berkshire.

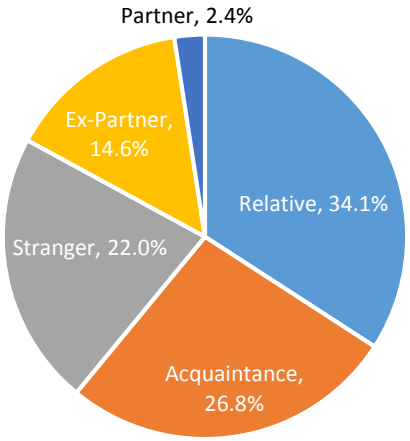
Table 17: Ethnic Profile, THR y/e Sept 2015 (Source: THR Data October 2013 – September 2015)

Ethnicity	Thames Valley (population)	THR (victims)
White	84.6%	78.6%
Mixed/multiple ethnic group	2.5%	0.0%
Asian/Asian British	9.2%	7.1%
Black/African/Caribbean	3.0%	12.5%
Other ethnic group	0.7%	1.8%
Total BME population	**15.4%**	**21.4%**

[71] Age was known in 56 THR victims
[72] Ethnicity was known in 56 THR victims
[73] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

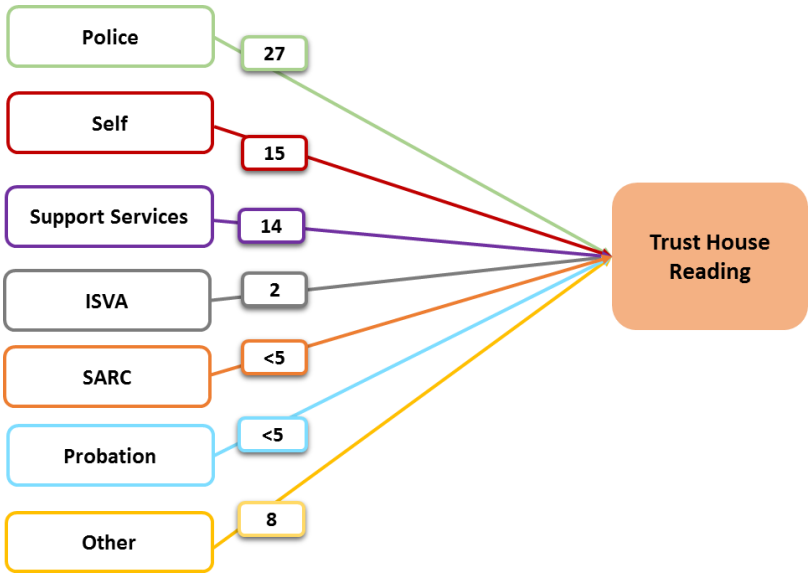
4.92 The chart below shows the victim and assailant relationship, over three quarters (78.2%) of victims were assaulted by someone they knew (34.1% relative, 26.8%, acquaintances, 14.6% ex-partner and 2.4% partner) and the remaining 22.0% were strangers.

Chart 38: Victim, Assailant Relationship, THR y/e Sept 2015 (Source: OSARCC Data October 2013 – September 2015)



4.93 The chart below shows two thirds of all referrals were from the police and self-referral (39.7% police and 22.1% self-referral), a further 20.6% were referred from other support services across Thames Valley, 2.9% from ISVA service, 1.5% from SARC, 1.5% from probation and the remaining 11.8% were other referrals sources.

Chart 39: Referrals, THR y/e Sept 2015 (Source: THR Data October 2013 – September 2015)

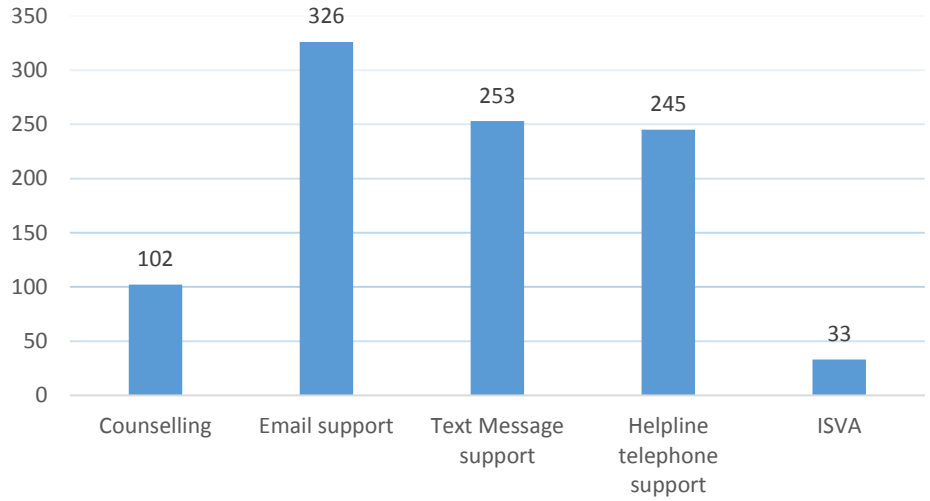


Aylesbury Vale Rape Crisis (AVRC) Service

4.94 The AVRC service has, since April 2015, started collating data about victims supported by their service. The data for AVRC service is based on the 6-month period (April 2015 – September 2015).

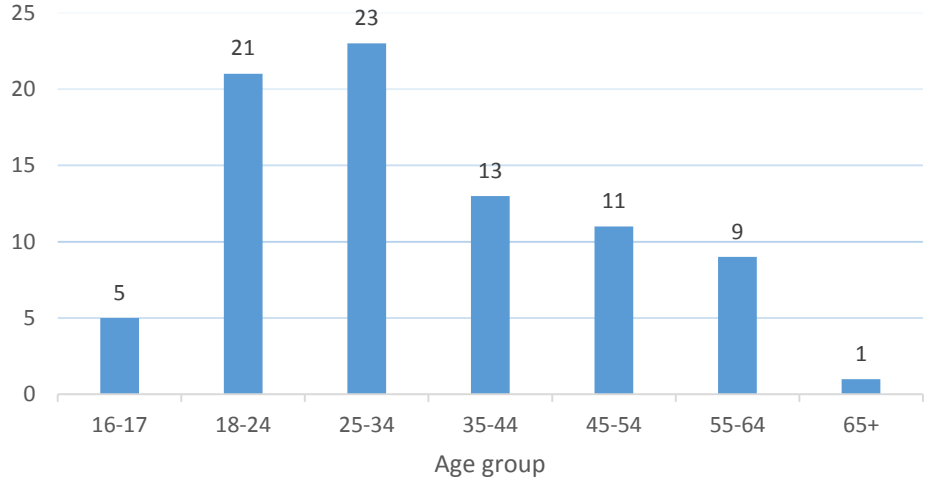
4.95 During this time the AVRC service supported 102 victims through counselling and 33 victims through ISVA services. In additional to this AVRC provided support to victims through non face to face methods, including 326 victims through email support, 253 through text messaging support and 245 through helpline calls. All victims supported through AVRC were female.

Chart 40: Type of Support Offered, AVRC 6 months – April – Sept 2015 (Source: AVRC Data April - September 2015)



4.96 The chart below shows the age profile of victims (where age was known[74]) who received counselling support through the AVRC services. Just under one third were aged 16-24 (31.3%).

Chart 41: Age Profile, Counselling Service, AVRC 6 months – April – Sept 2015 (Source: AVRC Data April - September 2015)



4.97 The table below shows the ethnic profile of the victims seen by AVRC (where ethnicity was known [75]) and compares the ethnic profile of AVRC victims to the ethnic profile for the total population of Thames Valley.[76] The ethnic profile of

[74] Age was known in 83 AVRC victims
[75] Ethnicity was known in 86 AVRC victims
[76] Ethnicity Data, Census 2011, Official Labour Market Statistics (NOMIS) DC2101EW, November 2015 https://www.nomisweb.co.uk/census/2011/dc2101ew

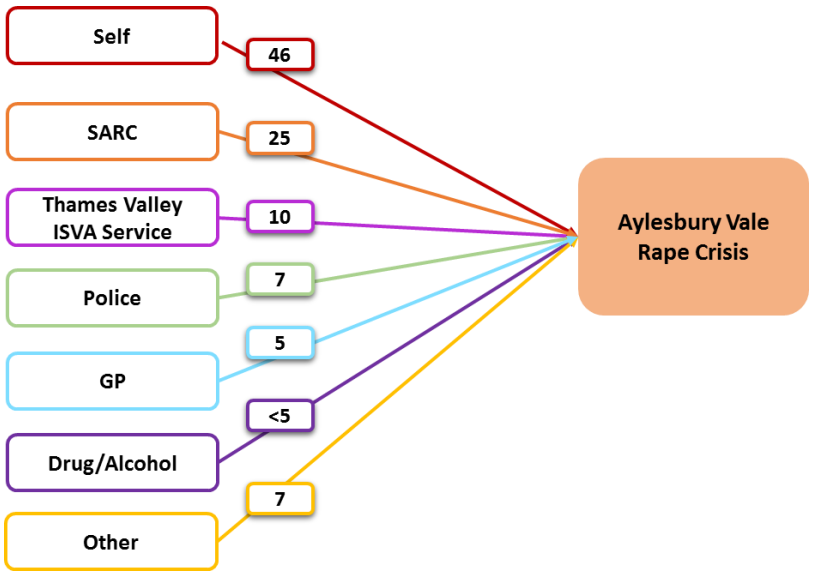
victims seen by the fewer were from BME populations compared to the BME population across Thames Valley (11.6% and 15.4% respectively).

Chart 42: Ethnic Profile, AVRC 6 months – April – Sept 2015 (Source: AVRC Data April - September 2015)

Ethnicity	Thames Valley (population)	OSARCC (victims)
White	84.6%	88.4%
Mixed/multiple ethnic group	2.5%	2.3%
Asian/Asian British	9.2%	5.8%
Black/African/Caribbean	3.0%	3.5%
Other ethnic group	0.7%	0.0%
Total BME population	**15.4%**	**11.6%**

4.98 The chart below shows the majority, over two thirds, were self-referrals or referrals from the SARC (45.1%, 24.5% SARC) followed by 9.8% from the Thames Valley ISVA service. The remaining were referred by the police (6.9%), GPs (4.9%), drug and alcohol services (2.0%) and other sources (6.9%).

Chart 43: Referrals, AVRC 6 months – April – Sept 2015 (Source: AVRC Data April - September 2015)

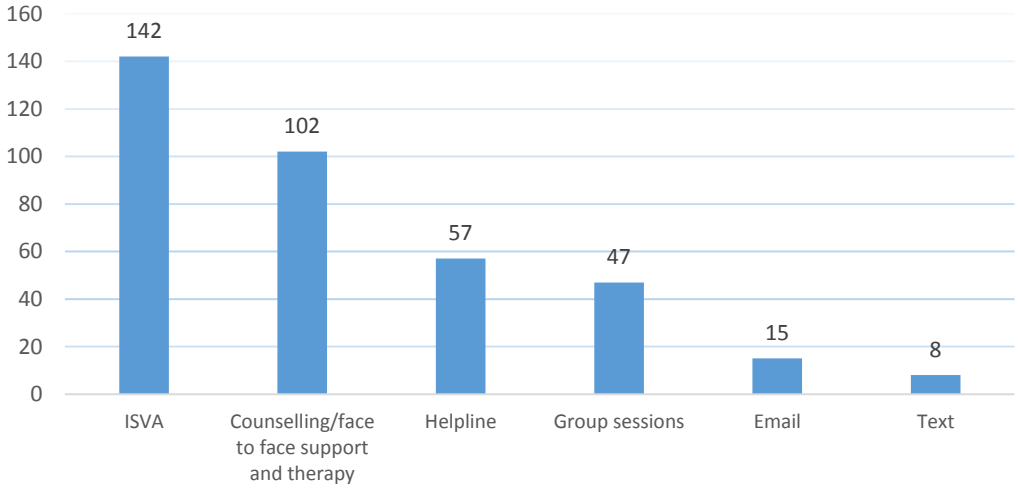


Rape Crisis (Wycombe, Chiltern and South Bucks)

4.99 In the 12-month period y/e Sept 2015 the Rape Crisis service (Wycombe, Chiltern and South Bucks) supported a total of 371 victims. This is an increase of 22.4% compared with the previous 12 months (up from 303, y/e Sept 2014).

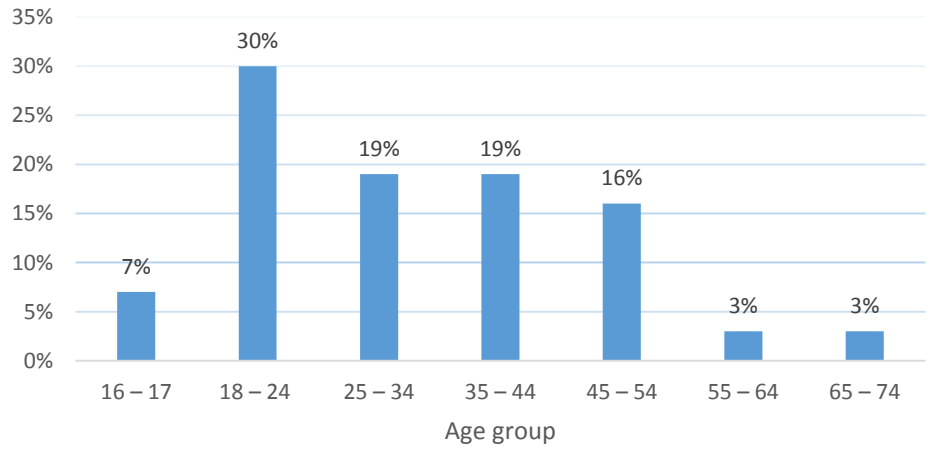
4.100 Of the 371 victims supported, 142 were supported through advocacy services (ISVA service), 102 through ongoing support (counselling, face to face emotional support, therapeutic support and telephone support), 57 support through helpline, 47 supported through group sessions, 15 supported through email and 8 supported through text services.

Chart 44: Type of Support Offered, Rape Crisis (Wycombe, Chiltern, South Bucks) y/e Sept 2015 (Source: Rape Crisis (Wycombe, Chiltern, South Bucks) Data y/e Sept 2015)



4.101 The following demographic data was provided combined for the two-year period from October 2013 to September 2015[77]. This shows almost all were female victims (96%). The chart below shows the age profile of victims, 37% were aged under 25 (7% aged 16-17 and 30% aged 18-24).

Chart 45: Age Profile, Rape Crisis (Wycombe, Chiltern, South Bucks) October 2013 – 2015 (Source: Rape Crisis (Wycombe, Chiltern, South Bucks) Data Oct 2013 – Septt 2015)



[77] Demographic data relating to victims seen between October 2013 and September 2015 has been provided in percentages only

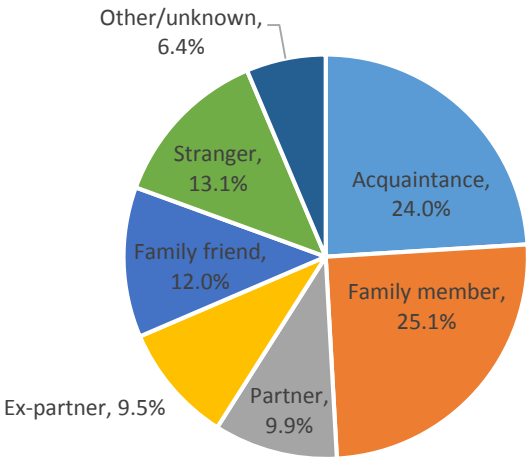
4.102 The table below shows the ethnic profile of the victims seen by the Rape Crisis service between October 2013 and September 2015. This shows a higher proportion of victims from BME populations in comparison to the overall BME population across Thames Valley (18% and 15.4% respectively). This is a reflection of the more diverse ethnic profile within the areas this service is located.

Chart 46: Ethnic Profile, Rape Crisis (Wycombe, Chiltern, South Bucks) October 2013 – 2015 (Source: Rape Crisis (Wycombe, Chiltern, South Bucks) Data Oct 2013 – Septt 2015)

Ethnicity	Thames Valley (population)	Rape Crisis (Wycombe, Chiltern, South Buck) (victims)
White	84.6%	78%
Mixed/multiple ethnic group	2.5%	4%
Asian/Asian British	9.2%	8%
Black/African/Caribbean	3.0%	4%
Other ethnic group	0.7%	2%
Total BME population	**15.4%**	**18%**

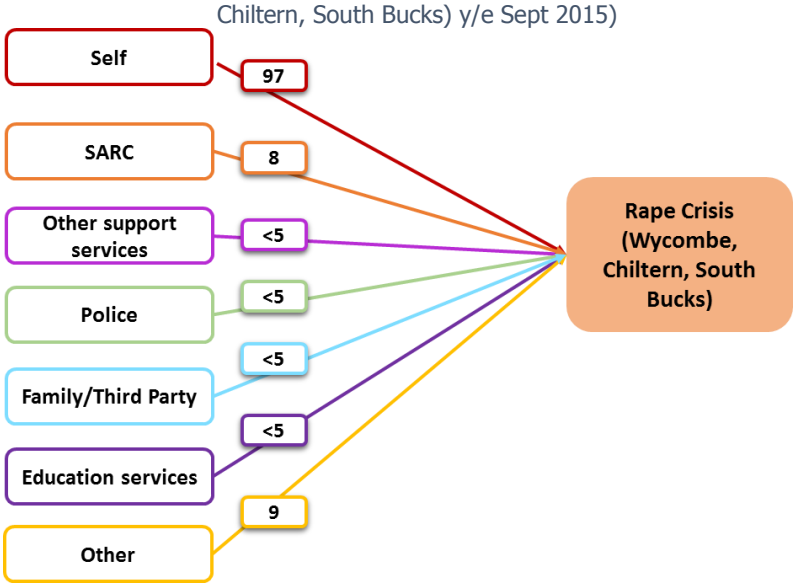
4.103 The chart below shows the victim and assailant relationship, 80.6% of victims were assaulted by someone they knew (24.0% acquaintance, 25.1% family member, 12.0% family friend, 9.9% partner, 9.5% ex-partner) the remaining 13.1% were strangers and 6.4% other or unknown.

Chart 47: Victim, Assailant Relationship, Rape Crisis (Wycombe, Chiltern, South Bucks) y/e Sept 2015 (Source: Rape Crisis (Wycombe, Chiltern, South Bucks) y/e Sept 2015)



4.104 The chart below shows referral sources for those victims new to the services in the 12-month period (y/e Sept 2015, 124 new referrals). The majority, eight out of ten were self-referrals or referrals from the friends or third party (78.2% self, 3.2% friend or third party). The remaining were SARC (6.5%), police (2.4%), education services (1.6%) and other (7.3%).

Chart 48: Referrals, Rape Crisis (Wycombe, Chiltern, South Bucks) y/e Sept 2015 (Source: Rape Crisis (Wycombe, Chiltern, South Bucks) y/e Sept 2015)



4.105 In summary, data recording activity and support for victims of sexual assault or rape is varied and therefore it is not possible to build an accurate picture of the extent of support delivered through specialist services. However, based on the data provided, collectively around 1,100 children, young people and adult victims of sexual assault or rape were supported in the 12-month period y/e Sept 2015. With almost all services experiencing an increase in the number of victims they have seen in the latest 12-month reporting period compared to the previous 12-month period (y/e Sept 2014), despite cuts in funding, during 2015-16.

4.106 The nature of the sexual assault was not provided for all services to draw comparisons with police recorded sexual offences or comparisons to the numbers seen by the SARC. However, 1,100 victims would account for just over one fifth of all police recorded sexual offences and are almost three times the amount seen by the SARC over the same period.

4.107 Victims in contact with support services accessed a range of services including counselling, group therapy, ISVA support, play therapy and helpline, email and text support. In addition to this many more victims and concerned others have been supported through helpline, email and text contact.

4.108 Around 14% of all victims were children aged under 18. On average 93% of all victims supported were female (ranging between 87% and 100% by service). The majority of referrals to specialist support services were through self-referrals (20%), police (17%) and SARC (6%).

5 Existing services offering care and support

5.1 NHS England's recommended service model[78] for meeting the needs of victims who have been sexually assaulted, raped or abused is to deliver through a managed clinical network. This will have the acute forensic examination and care delivered at a SARC "hub" with referral pathways in place to local paediatric and adult services for support and follow-up care where these are identified as a need.

5.2 The acute medical examination process needs to identify any physical health issues, safety and safeguarding issues and forensic issues. The examination can also lead to provide immediate access to emergency contraception, post-exposure prophylaxis after sexual exposure (PEPSE), first aid or other acute mental health or sexual health services where indicated. Either during the initial presentation or at follow up appointment, the medical consultation may identify unmet health needs or further safeguarding issues.

5.3 These needs include a risk assessment of harm/self-harm, together with an assessment of vulnerability, safeguarding and sexual health needs; and further follow-up may be required to address these issues.

5.4 The recommended service model describes more than the medical examination: it includes access to crisis workers (support staff) trained to work with victims and in the case of children, child advocates (or advocates/independent sexual violence advisors trained to work with children). Case assessments can also lead to further support which may include counselling and/or practical support for the victim/survivor. The importance of liaison with other health providers, social care, education and some local third sector providers of practical support and resilience-building cannot be overestimated.

5.5 The availability of this range of support, delivered in a seamless manner, is vital. Within Thames Valley there are a range of services for victims (children, young people and adults and their families and carers), that directly aim to address and support their needs. The table below sets out these services as a broad service pathway experienced by victims and their families and carers.

Table 18: Key Services available for Children, Young People and Adults as victims of Sexual Assault in Thames Valley 2015.

Provider	Service Description	Funding Source /Commissioner
Thames Valley Children, Yong People and Adult SARC	• There are two SARCs in Thames Valley, one located in the North (Bletchley) and the other in the south (Slough) both are provided through a contract with Care UK • The centres provide specialist medical and forensic services and health advisors for child, young people and adult victims of sexual assault and their families and carers • Forensic physicians provide comprehensive medical examination of victims (children, young people and adults)	NHS England and Thames Valley Police

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

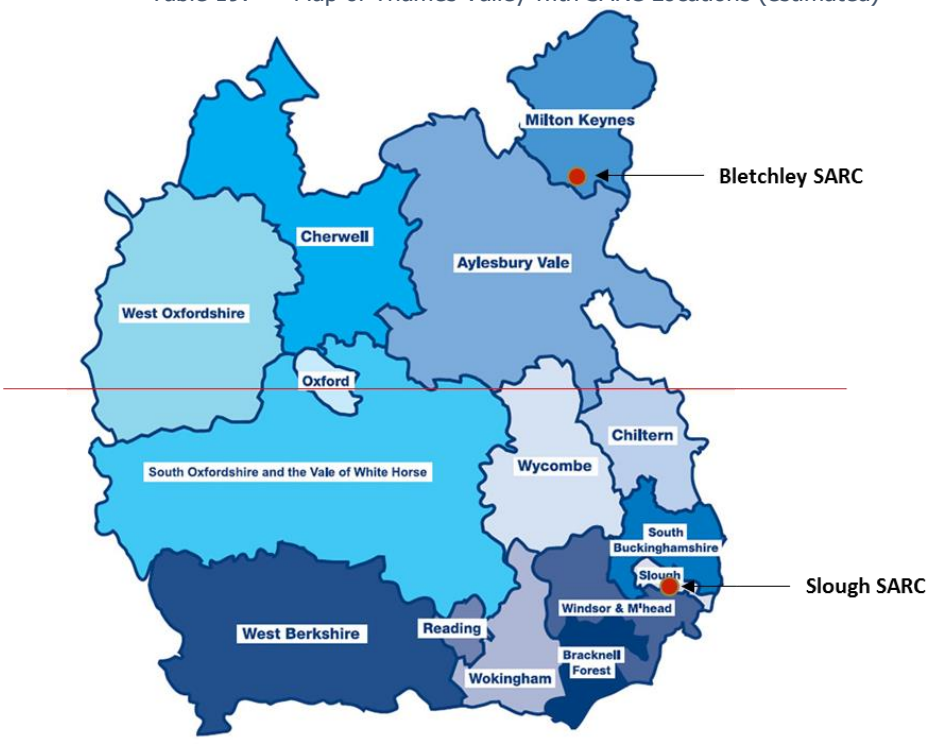
Provider	Service Description	Funding Source /Commissioner
Independent Sexual Violence Advisors (ISVAs) for men and women aged 16 and over	• ISVA provision for adults age 16 and over is provided through Refuge for men and women across Thames Valley • Team of 5 ISVAs of which 1 ISVA specialist ISVA for young people aged 16-21 • There are an additional 4 ISVAs based with support services	OPCC Varied: OPCC/MoJ/LA/Other
Mental Health Services	• Child and Adolescent Mental Health Service (CAMHS) and Adult Mental Health Service provision exists across all areas in Thames Valley. However, as is the case for many SARCs, high thresholds for accessing this service provision mean victims of sexual assault are not considered unless there is a predefined trauma that meets the thresholds	CCG/NHS
Third Sector Providers Counselling and therapeutic support	• Aylesbury Vale Rape Crisis, support service for women aged 16 and over. Provide one to one counselling, helpline (open to all ages), text and email support and ISVA support. • Trust House Reading, support service for children (4-11), young people and adults. Provide one to one counselling, helpline and email support, play therapy or children aged 4-11 and ISVA support • Oxford Sexual Abuse and Rape Crisis Centre, support service for women and girls • Rape Crisis (Wycombe, Chiltern and South Bucks), support service for women aged 16 and over. Provide counselling, weekly self-help groups, telephone and email support, Asian and youth outreach work and ISVA support • SAFE project, support for children aged 8-16 across Thames Valley (launched in July 2015)	Varied: OPCC/MoJ/LA/Other
Oxfordshire Health	• Horizon: Supporting Young People and Families Affected by Sexual Harm • This service was set up in January 2016 by Oxfordshire HNS Foundation Trust, supporting professionals involved in the care of young people (aged under 18) affected by sexual abuse and their families.	
Police	• Thames Valley Police, STOs support victims aged 16 and over. There are around 15 full time equivalents STOs in Thames Valley. • STOs offer support and are a single point of contact for victims, staying in contact with victims from the time of reporting and throughout the criminal justice process.	Thames Valley Police

Provider	Service Description	Funding Source /Commissioner
Social Care	• There are 13 Social Services providers in the 13 authorities with Social Service provision. Some Social Services have MASH arrangements in place whilst other have not. The local authorities with social care provisions: • West Berkshire • Reading • Wokingham • Bracknell, Windsor and Maidenhead • Slough • Chiltern and South Buckinghamshire • Wycombe • South Oxfordshire and the Vale of White Horse • Oxford • Cherwell and West Oxfordshire • Aylesbury Vale • Milton Keynes	Local Authorities

Specialist provision

5.6 There are two **Sexual Assault Referral Centre's** run by Care UK, located in the North and South of Thames Valley (Bletchley in the north and Slough in the south). The location of the two SARCs is marked with a red dot on the map below. People living north of the line through Oxford generally access the Bletchley SARC and those living in south of the line generally access the Slough SARC.

Table 19: Map of Thames Valley with SARC Locations (estimated)



Note: Map is not to scale, simply illustrative of the approximate location of the SARCs

5.7 Bletchley SARC is situated on the grounds of Bletchley police station but with an entrance that is separate from the main entrance of the police station. Slough SARC is situating on the grounds of Upton hospital and benefits from being next door to the GUM clinic.

5.8 Both SARCs will see children, young people and adults that have been a victim of sexual abuse/sexual assault. Referrals of child victims come through the police or social services and adults can self-refer.

5.9 Each SARC offers victims of sexual abuse/sexual assault, forensic medical examinations that are carried out by forensic physicians (male and female doctors), crisis support and follow up assistance and telephone advice, referral to the ISVA service for support with practical matters and other support services such as rape crisis or victims support, including access to rape crisis counselling based at the SARCs.

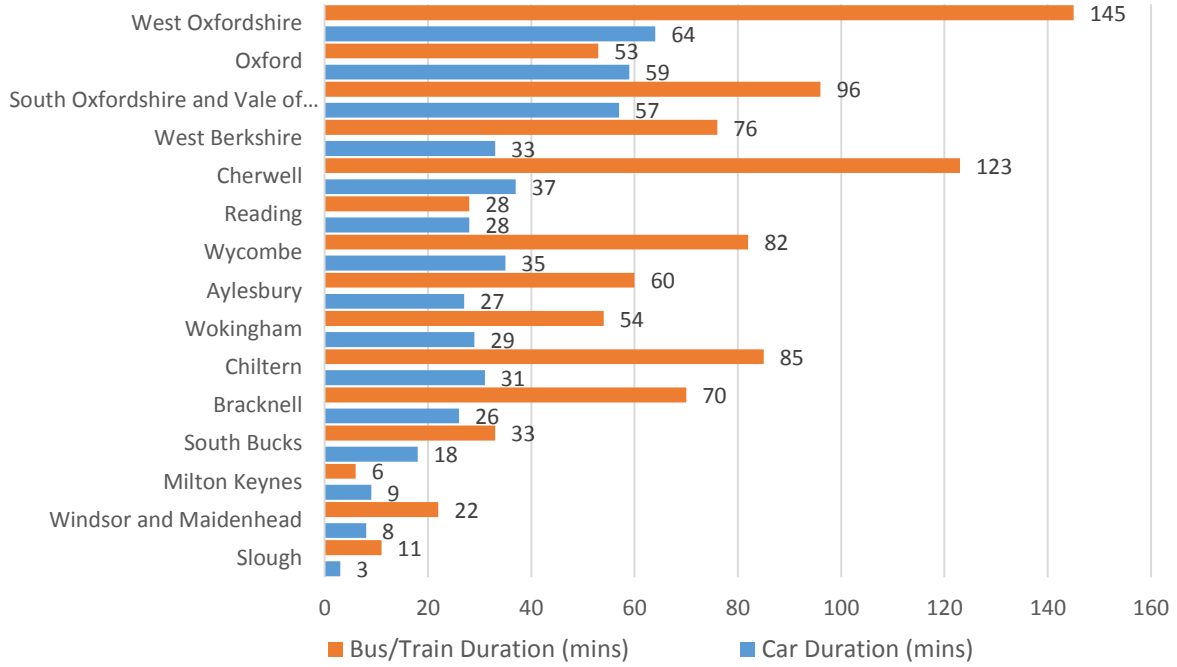
5.10 Distances and Travel Times for different parts of the Thames Valley location are set out in the table below.

Table 20: Distances and Travel Times to the Nearest SARC IN Thames Valley

Place	Miles to/from SARC	Car Duration (mins)	Bus/Train Duration (mins)	Nearest SARC
Slough	0.6	3	11	slough
Windsor and Maidenhead	3.1	8	22	Slough
Milton Keynes	4.2	9	6	Bletchley
South Bucks	7.1	18	33	Slough
Bracknell	12.9	26	70	Slough
Chiltern	15.4	31	85	Slough
Wokingham	15.6	29	54	Slough
Aylesbury	16.9	27	60	Bletchley
Wycombe	18.4	35	82	Slough
Reading	20.3	28	28	Slough
Cherwell	24.6	37	123	Bletchley
West Berkshire	28.4	33	76	Slough
South Oxfordshire and Vale of White Horse LPA	37.2	57	96	Slough
Oxford	38.9	59	53	Slough
West Oxfordshire	43.1	64	145	Bletchley

5.11 The chart below sets out the travel times by car and bus and public transport to the nearest SARC from the locations plotted in the table above.

Chart 49: Car and Public Transport travel time to SARC in the Sub region



5.12 Both SARCs operate on the same model, with the exception of SARC manager overseeing both SARCs, the staff complement is the same at each venue. Each SARC is staffed by a team of seven crisis support workers (two crisis workers covering 8am – 6pm and the remaining five work a rota system to provide out of hours' coverage). Currently 11 (with capacity of 12) forensic physicians work a rota system covering both SARCs. Administrative support for both SARCs is through a part time administrator based in Bletchley. The SARCs have a Clinical Director.

5.13 The role of the Forensic Physician is to conduct a holistic comprehensive forensic medical examination (FME) with a dual purpose, to attempt to prevent any physical or psychological sequelae and to gather forensic evidence both in the form of forensic swabs, documentation of injury and gathering other forensic evidence, which can be multitudinous especially in historic cases.

5.14 Emergency contraception is given when needed. Prophylaxis for HIV is given when needed; prophylaxis/active immunisation for hepatitis B and referral on for STI screening is arranged when needed. STI screening of children aged 12 and under takes place at the SARC. This service includes a comprehensive examination of victims (both acute and historic); recording injuries and taking, where necessary, samples and evidence that can contribute to building a case for prosecution. In addition, injuries should be treated and screening arranged for sexually transmitted infections as appropriate. The forensically trained pediatricians would also consider and prescribe emergency contraception if appropriate, Hepatitis B vaccination and HIV post-exposure prophylaxis, as necessary.

5.15 Currently there are 11 **forensic physicians** on a rota system providing cover to the SARCs 24/7, 365 days a year. The majority are trained in paediatric examinations and will undertake the forensic medical examination for all children aged under 18 across Thames Valley. In some cases, the forensic medical examination will be undertaken jointly between the forensic physician and **community pediatricians**. Out of hours it is the acute paediatrician on duty who

the forensic physicians will, on occasion, carry out joint examination with; such examinations are always carried out at the hospital. In Oxfordshire and East Berkshire, on occasion, an examination is done jointly with the community paediatrician in the hospital.

5.16 Within a 24-hour period there are three, 8-hour shifts (5am to 1pm, 1pm to 9pm and 9pm to 5am), each day, 365 days per week. Each forensic physician is now expected to be available for 4 hours post shift, in order to attend an end of shift call out for an examination. This model replaced the old 12-hour shifts to minimise the delays in examinations if the victim presented toward the end of one shift which would have meant waiting until the next forensic physician started their shift. This still presents challenges and delays in examinations being carried out as it relies on only one forensic physician on duty at any one time, in some cases the forensic physician is already examining a victim and further delays take place where travel between the two SARCs is required.

5.17 The Crown Prosecution Service policy requires the Forensic Practitioner to be included at the conference with the prosecutor, trial advocate and the investigating officer unless there are particular reasons for not doing so. Clearly this work has resource implications especially as more cases are being brought forward for prosecution.

5.18 **Sexual Assault Crisis Work** is delivered on site with each victim assigned a crisis worker who helps and represents the victim (all ages) or the parent/supporter of a child victim through the process and explains the process with them to ensure victims have all the information they need to make informed decisions about their options. The crisis worker signposts and refers victims to other support services including GUM clinics and ISVA services to support victims through the criminal justice process where necessary.

5.19 From October 2014, local **Police and Crime Commissioners** became responsible for commissioning new emotional and practical support services for victims of crime in their area. Across the country, local commissioning is replacing the old system of grant funding by the Ministry of Justice, although some services will still be commissioned nationally, including the witness service, homicide service, trafficking service, rape support and some victims' helplines.

5.20 The Police and Crime Commissioner evidenced through this process a commitment to:

- Ensuring local commissioning priorities are based on a comprehensive picture of victims' needs in Thames Valley.
- A consultative approach, involving potential providers especially voluntary and community sector organisation.
- Invested in the capacity of the provider base, particularly those working with victims of the most serious crime, those persistently targeted or vulnerable and intimidated victims.
- Focusing clearly on the key outcomes of helping victims to "cope" and "recover".
- Ensuring that funding decisions are accountable, transparent and well-informed.

5.21 **Thames Valley Independent Sexual Violence Advisors (ISVA)** prior to July 2015 the ISVA service provision was delivered through a number of ISVAs based within the SARCs and rape crisis centers and specialist support services across Thames Valley. In July 2015, the Thames Valley OPCC commissioned and launched the Thames Valley ISVA service. This service now delivers ISVA services across the whole of Thames Valley for men and women aged 16 and over that have been victims of sexual assault, rape or childhood abuse regardless of whether the crime is reported to the police or not. The service is also offered to those who do not wish to report the crime to the police. The ISVA service is located in Wendover and Slough, however victims can be seen by the ISVAs in any location that is most convenient for the victim.

5.22 There are five ISVAs, of which one provides specialist emotional and practical support to victims aged 16-21. The ISVA service develops a support plan to meet the needs of victims of sexual assault or rape. Offering a range of services that include access to legal advice and support to contact the police, practical support such as housing and financial management and support for those considering going to court and access to counselling services. Currently there is no dedicated ISVA service for children and young people aged 16 and under, for children referrals are made to the SAFE project that provides support services to child victims of sexual assault under the age of 16 across Thames Valley.

5.23 In addition to this ISVA provision, each of the four rape crisis services have retained their ISVAs for 2015-16 (financial year), adding a further 4 ISVAs (one per service).

5.24 There is a wide range of counselling and therapeutic provision across Thames Valley, this includes:

5.25 The **Aylesbury Vale Rape Crisis** service provides support to women aged 16 and over, that have been the victim of sexual assault, rape or child abuse. Support is also provided to the victim's friends and family members. The support offered includes counselling, helpline, email and text support and ISVA support and befriending. All counsellors are qualified and receive training in supporting women who have experienced abuse. AVRC deliver in house specialist sexual violence for all counsellors covering all aspects from trauma through to court process.

5.26 **Trust House Reading** is a rape and sexual abuse support centre that provides specialist support to women, men and children living in Berkshire who have been affected by rape or sexual abuse. Support is also provided to the victim's friends and family members. Trust House Reading is a subsidiary of the Survivors Trust and launched the service in February 2014. The service offered includes one to one counselling, telephone and email helpline support, ISVA support and play therapy for children (aged 5-11).

5.27 **Oxford Sexual Abuse and Rape Crisis Centre** (OSARCC) is a support services for women and girls aged 16 and over that have been a victim of a sexual assault, rape or sexual abuse. The services offered includes support group where victims can work towards recovery, email, helpline (open to females of any age), ISVA support and support to access other services such as counselling or alternative

health practitioners. In November 2015 OSARCC launched their face to face counselling services.

5.28 **Rape Crisis (Wycombe, Chiltern and South Buckinghamshire)** is a support service for women (aged 16 and over) that are victims of sexual assault, rape or sexual abuse living in the Wycombe, Chiltern and South Buckinghamshire areas. The services offered include counselling, weekly self-help group for victims, ISVA support, telephone and email support, befriending service and Asian and youth outreach work.

5.29 The **SAFE Project**, is a support service for children and young people (aged 8-24) in Oxfordshire who have been victims of crime and bullying and who are finding it hard to recover from their experiences. The crimes experienced by young people referred to the project can include bullying, robbery, hate crimes, sexual assaults, violent offences, or witnessing domestic violence. The project works with children and young people to help them to feel safe, recover their confidence and develop their resilience.

5.30 The newly developed service, **Horizon: Supporting Young People and Families Affected by Sexual Harm**, has been set up by Oxfordshire HNS Foundation Trust. The service aims to support professionals involved in the care of young people (aged under 18) affected by sexual abuse and their families. Offering advice and information to professionals concerned about young people and sexual abuse and support professionals through the provision of comprehensive assessments of recommendations of need. The service will take referrals from all professional and partner agencies. In addition, the service is developing therapeutic provision for young people in partnership with the SAFE project. In the initial period the service will look to assess the flow of referrals and the nature of support required to determine the full service being offered.

5.31 In July 2015, through funding from the Thames Valley OPCC, the SAFE project launched its support services for children (aged 8-15) who are victims of sexual abuse/sexual assault across the whole of Thames Valley. In addition, the OPCC are developing a specialist **counselling service** for victims of crime (including victims of sexual assault) across Thames Valley.

5.32 In addition, the OPCC are developing an on-line web based directory of statutory and non-statutory services that are available in Thames Valley to support the needs of victims of sexual assault. This directory will provide advice and information on what services are available locally.

5.33 **Mental Health Services** through the **Children and Adolescent Mental Health Service (CAMHS)** and **Adult Mental Health Services** provide a service to meet the therapeutic needs of children, young people and adults. However, in most cases these people will have had to have a predefined Mental Health diagnosis/need in order to access this provision. It is often very difficult for victims to meet thresholds to access mental health services.

5.34 **Social Services** (Adult and Children and Young People) have both a safeguarding responsibility and a key role to play in addressing sexual assault and sexual violence. Within social services the targeting of provision for 'Looked after

children', multi-agency safeguarding hubs, safeguarding of young people and vulnerable adults, targeted crisis provision for older people and the delivery of the troubled families' agenda, all have direct and indirect associations with sexual exploitation, violence, assault and rape.

5.35 In Thames Valley there are a number of **Local Safeguarding Children's Boards** (LSCB) in Oxfordshire, Buckinghamshire, Milton Keynes, Windsor and Maidenhead, Reading, Wokingham, Bracknell Forest and Slough. These are the key statutory mechanism for agreeing how the relevant organisations in Thames Valley will cooperate to safeguard and promote the welfare of children and ensure the effectiveness of what they do and provide strategic oversight. The LSCBs across Thames Valley are different but are essentially made up of statutory and voluntary partners including representatives from Health, Education, Children's Services, Police, Probation, Children and Family Court Advisory and Support Service (Cafcass), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

5.36 Not all areas in Thames Valley have **Multi Agency Safeguarding Hubs** (MASH). In West Berkshire the MASH is currently being developed and will be in place by June 2016. All cases of child sexual abuse are referred to the front door services in West Berkshire social care where cases are referred. The front door services also deliver interventions to children and young people and their families and carers who have been affected by sexual abuse through family support work delivering keep safe work.

5.37 The Oxfordshire County Council's MASH acts as the single point of contact where all referrals are triaged and cases of sexual abuse are investigated, all acute cases are referred to the SARC. The MASH refer cases to the assessment team and an investigation will commence, under section 47 of the Children Act 1989, where children are considered at risk of significant harm and where these inquiries indicate the need, to decide what action, if any, it may need to take to safeguard and promote the child's welfare. Safeguarding strategy meetings are held between social care and the police and other agencies including health and education. At present health are not always part of the safeguarding strategy meetings as often they are convened at short notice, going forward the MASH are considering teleconferences with health professional to ensure they become a consistent party to the discussions.

5.38 There are 3 clinical commissioning groups (CCG) with **CCG safeguarding leads** (adult and children) across Thames Valley, based across the three counties; Oxfordshire, Berkshire and Buckinghamshire. Each CCG within these counties has a safeguarding responsibility and a designated nurse and GP safeguarding lead.

5.39 **Domestic and Sexual Abuse** coordinators across Thames Valley play a key role in coordinating local activity to support statutory and voluntary agencies by delivering training, best practice and help to develop preventative measures, protect and provide support for victims of domestic abuse and for those of sexual violence. There is a network of domestic and sexual abuse coordinators with a strategic responsibility that cover Oxfordshire, Buckinghamshire and Berkshire and a number of Independent Domestic Violence Advisors and Independent Trauma

Advisors who support victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children.

5.40 **Thames Valley Police** cover 13 local police areas in Thames Valley (Milton Keynes, Aylesbury Vale, Cherwell and West Oxfordshire, Oxford, South Oxford and the Vale of White Horse, Wycombe, Chiltern and South Buckinghamshire, Slough, Windsor and Maidenhead, Bracknell, Wokingham, Reading and West Berkshire). The police force has a central role in tackling serious sexual assault and rape, sexual violence and sexual assault. Victims aged 16 and over are supported by a dedicated team of Specially Trained Officers (STOs) whose only role is to deal with victims. Thames Valley Police is the only totally victim focused unit in the force.

5.41 STOs support the victims from the time they report the offence through to court and remain the victims primary single point of contact. STOs are usually involved in the first 72 hours of the investigations, beyond this they work closely with the investigating unit CID or DAIU (Domestic Abuse Investigation Unit). The STOs are managed by two Detective Sergeants, one in the North and one in the South of the Force.

5.42 However, for child victims of sexual assault aged under 16 there are no STOs to support the victims and their families. Cases involving sexual crimes against children are dealt with by the Child Abuse Investigation Unit (CAIU) where interfamilial abuse is alleged and all other cases are dealt with by the force CID. This means, cases dealt with by the CID (other than having their medical and VRI completed by an officer from CAIU) are not provided any other dedicated victim support for the duration of the case, this would fall to the CID officer running the investigation.

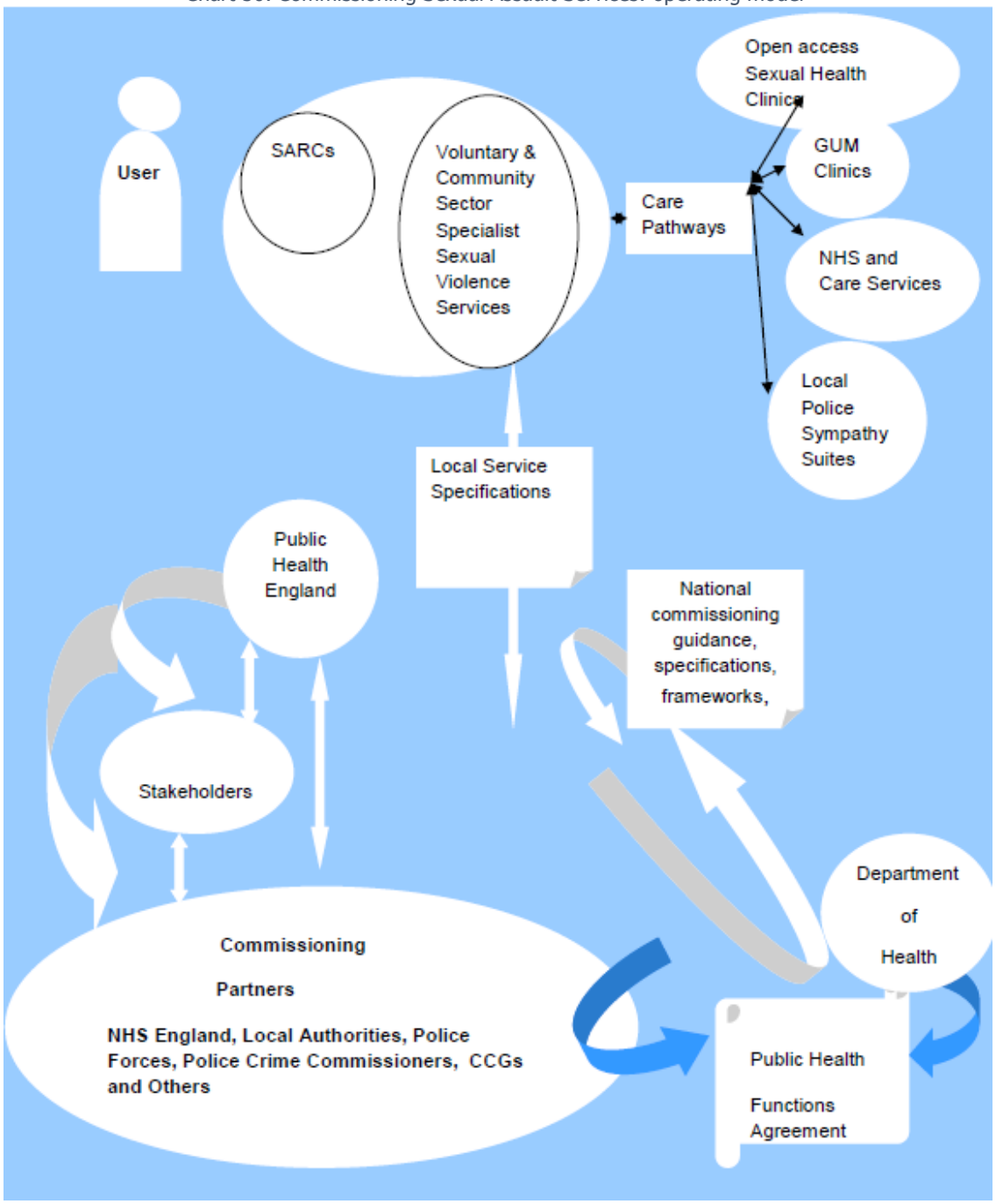
5.43 Thames Valley police run an in house intensive bespoke training course for all STOs over five days which incorporates all aspects of STO roles and responsibilities.

5.44 The **Crown Prosecution Service** (CPS) has responsibility for decision making in relation to the prosecution of alleged perpetrators. The CPS does not make referrals with regard to the health needs of victims', this would usually be carried out by the CISVA service. Nonetheless the CPS is reliant on an efficient and effective SARC and CISVA service and as such will continue to be part of the wider SARC partnership.

Commissioning Sexual Assault Services

5.45 In its recently published guidance (August 2015) NHS England sets out a process for the commissioning of sexual assault services. This is shown diagrammatically below.

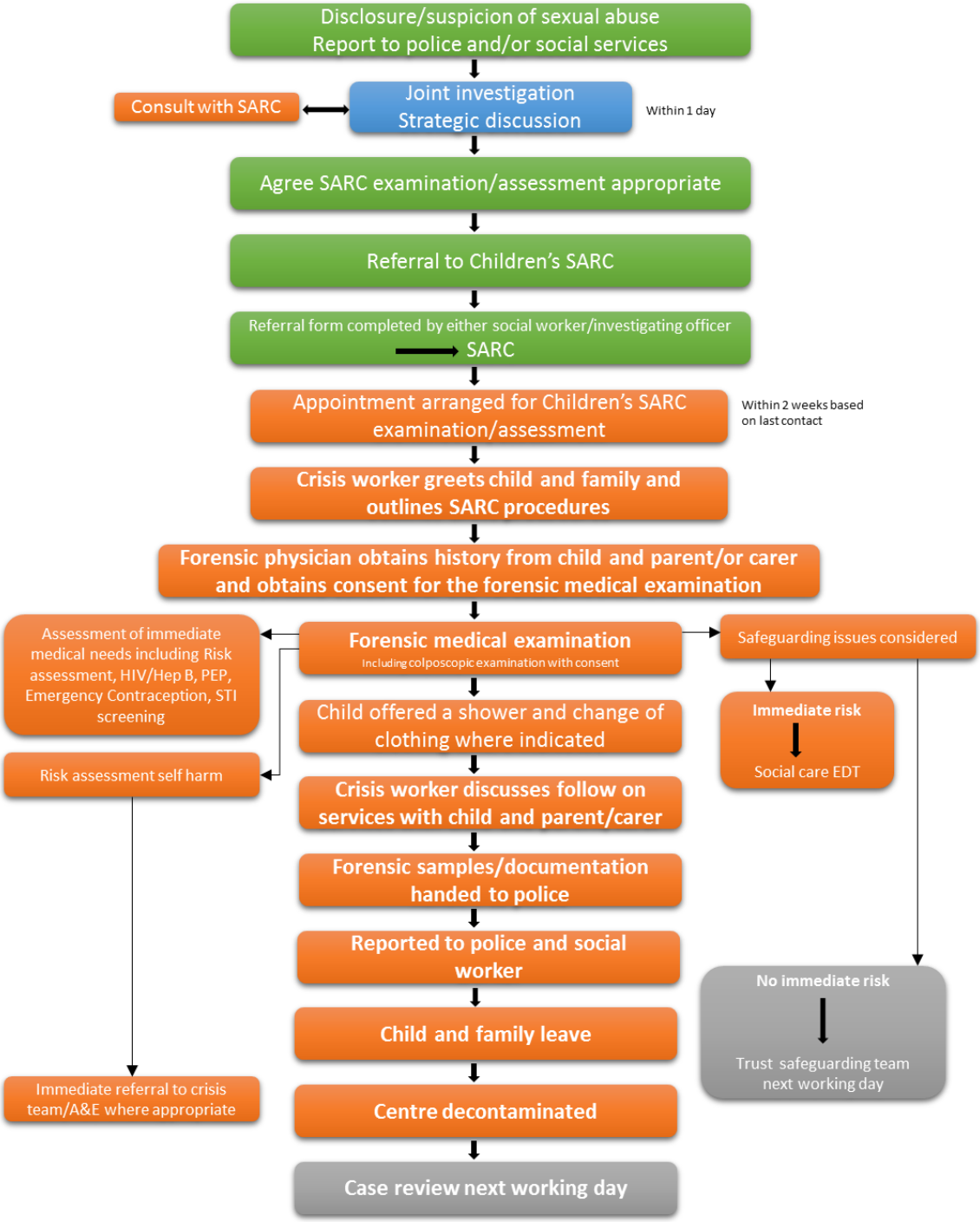
Chart 50: Commissioning Sexual Assault Services: operating model



Referral Pathways Adult

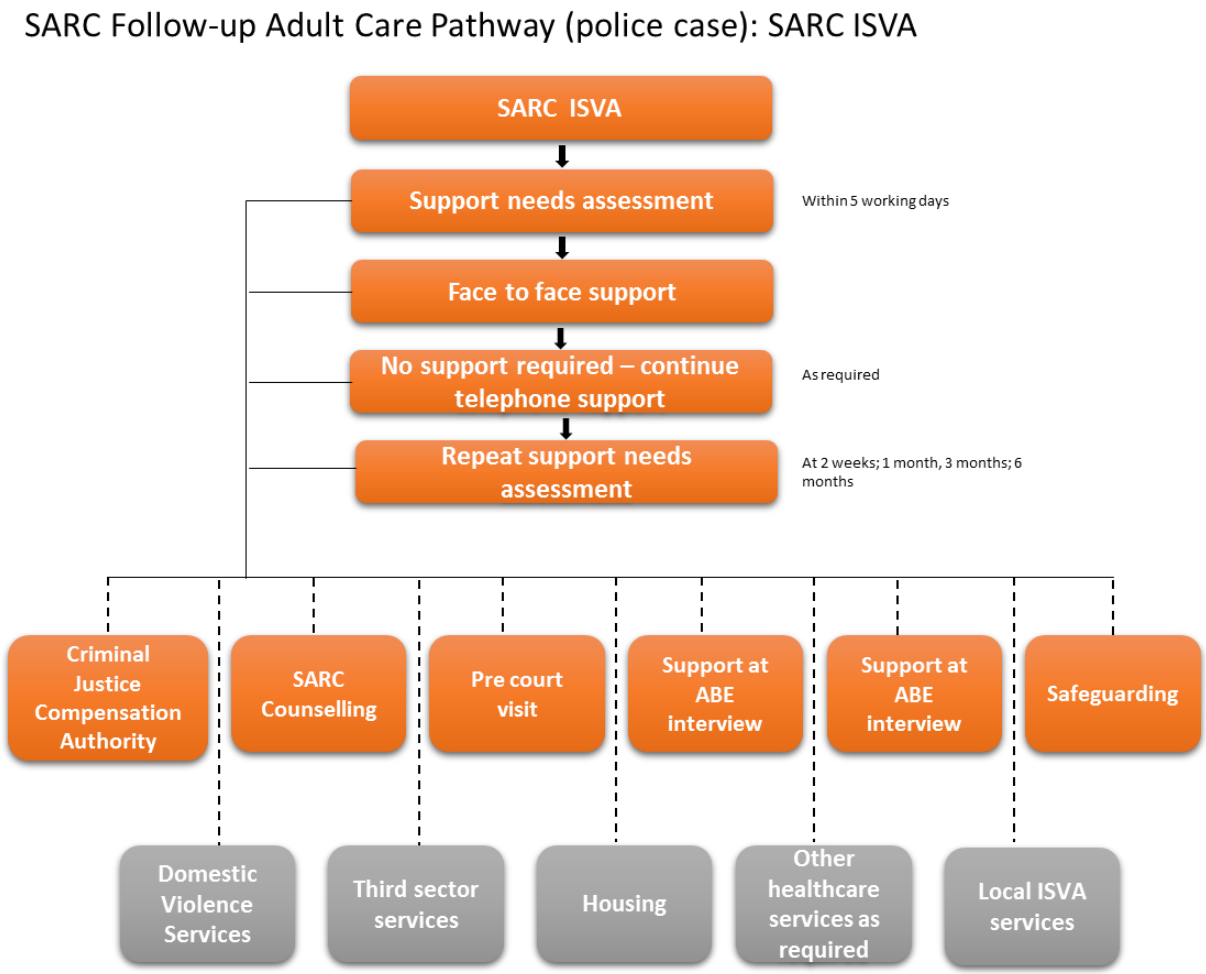
5.46 Within their Guidance NHS England sets out adult care pathways for cases of sexual assault reported to the Police and for those cases that are self-referral. Each care pathway addresses, initial attendance at the SARC, follow up, a range of support services, and access to counselling provision. The table below refers to the initial attendance Adult care pathway for Police reported cases of sexual assault.

Chart 51: SARC Adult Care Pathway (Police Case): Initial Attendance at SARC



Follow up Adult Care Pathway (Police case): SARC ISVA

Chart 52: NHS England Guidance Follow up Adult Care Pathway (Police case): SARC ISVA

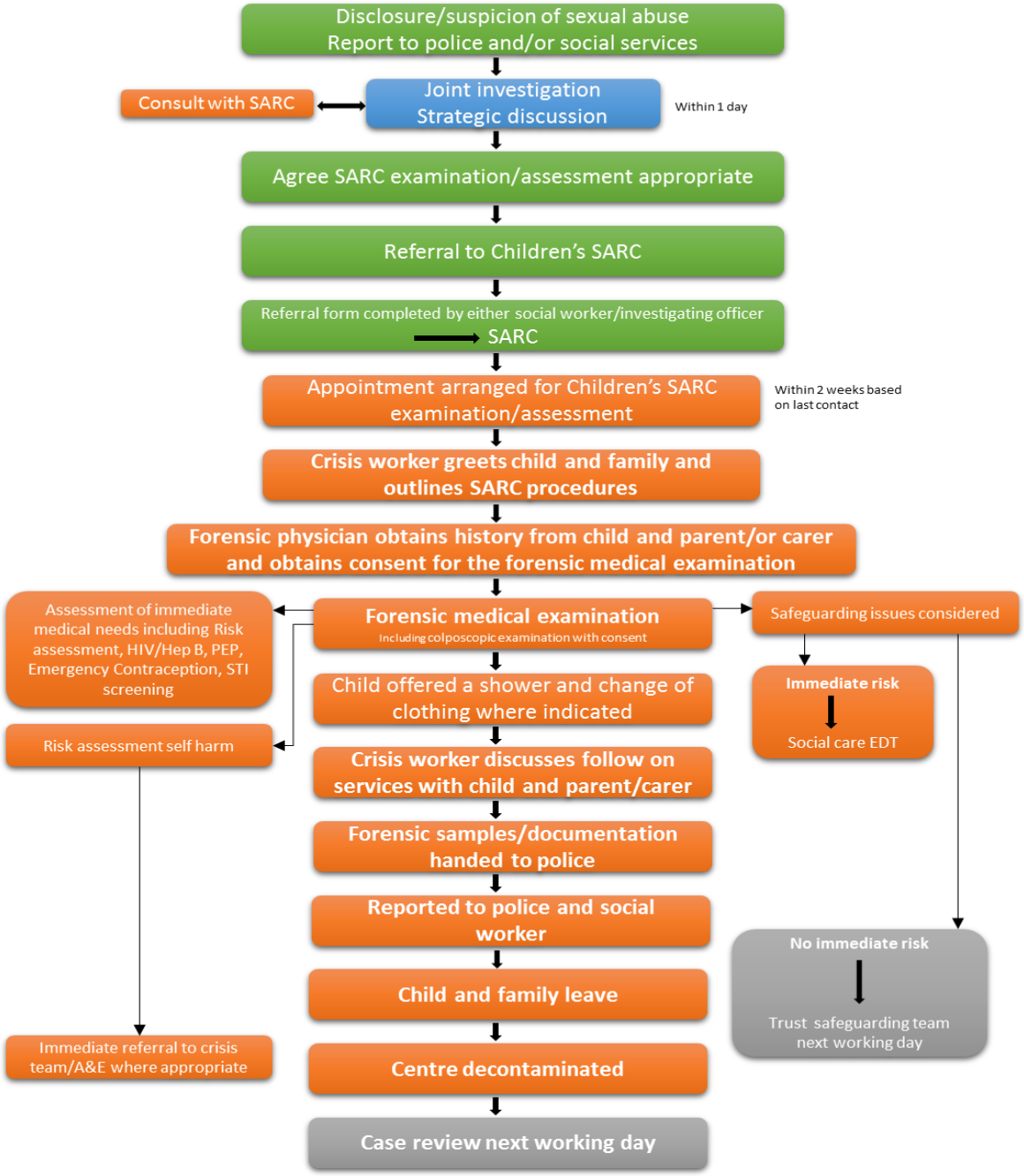


Referral Pathways Children

5.47 Within their Guidance NHS England sets out a child SARC pathway for joint investigations. This pathway is a multi-agency pathway with support from, in particular, the police and social services and then the services provided by the SARC, forensic physicians, pediatricians and crisis workers and onward referrals to key therapeutic and counselling services. The table below relates solely to the investigative pathway and the protocols/process to address the immediate case of sexual assault.

Chart 53: NHS England Guidance for Child and Young People Joint Investigation Pathway

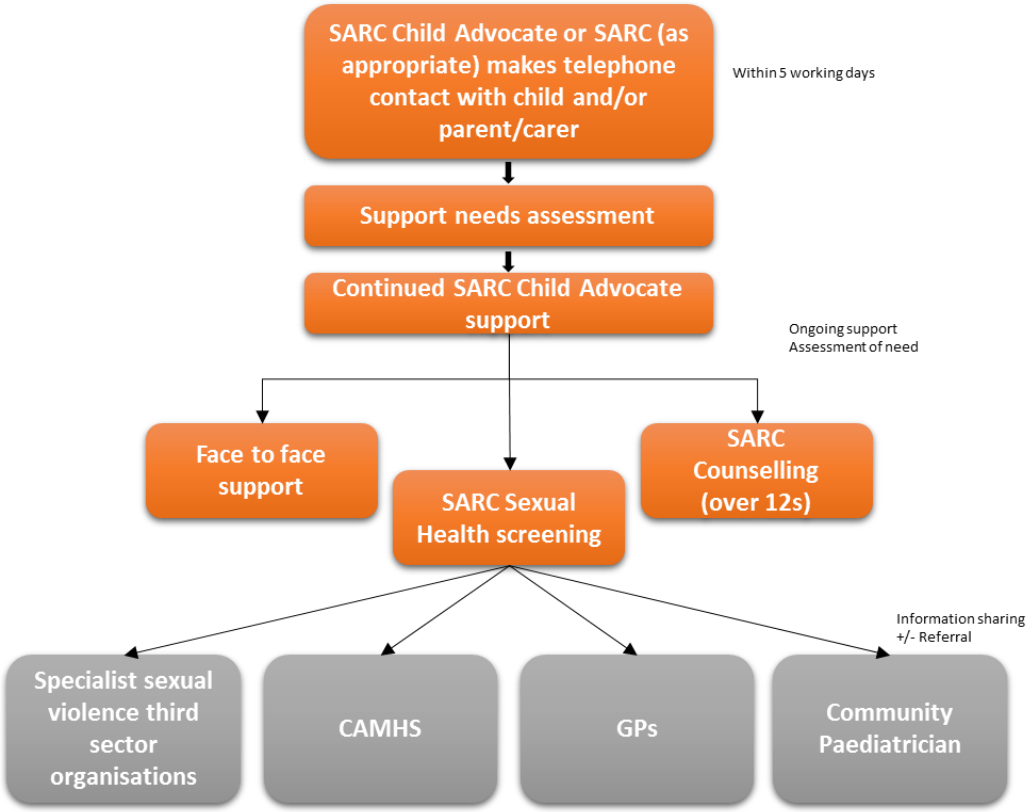
SARC Child Care Pathway (joint investigation): Initial attendance at SARC



5.48 Beyond the initial investigation NHS England recommend the onward referral to Child ISVA services and or the SARC as well as referral to other key agencies.

Chart 54: SARC Follow Up Pathway (NHS England Guidance)

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

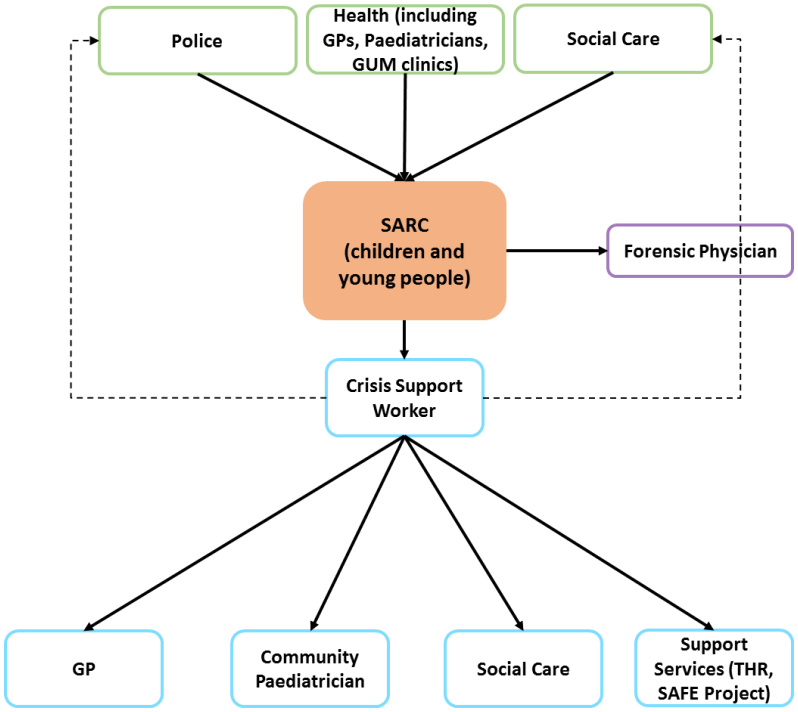


5.49 Through our interviews and review of existing providers it is clear that the direction of travel as set out in these two pathways is being delivered in Thames Valley. Indeed, the pathway itself seems to be well established and that it is delivering for all children, young people and adults engaged within it. However, there is equal acceptance that the pathway may not be feeding through the true volume of potential cases.

Thames Valley Pathway (Paediatric) based on Current Service Activity

5.50 The chart below shows the current referral pathway to the SARC for children and young people aged under 18 and onward referrals.

Chart 55: Sexual Assault Services Children and Young People - Victim Pathway to Address Health Needs



5.51 Primarily there appears to be only formal routes into the Paediatric SARC, in the main through the police and social care, representing 95% of all referrals (children, young people and adults). This does limit the opportunity to engage with children and young people who choose not to report the sexual offence to the police, where they may be fearful of police and social services intervention but who nonetheless have a health need that can be supported through the SARC.

5.52 In some parts of the country there are paediatric self-referral options provided into third sector organisation who support the needs of the young person and in some cases referrals to the police and social services take place. Indeed, there are more children aged under 18 seen by support services (SAFE Project and THR) than children aged under 18 seen by the SARC.

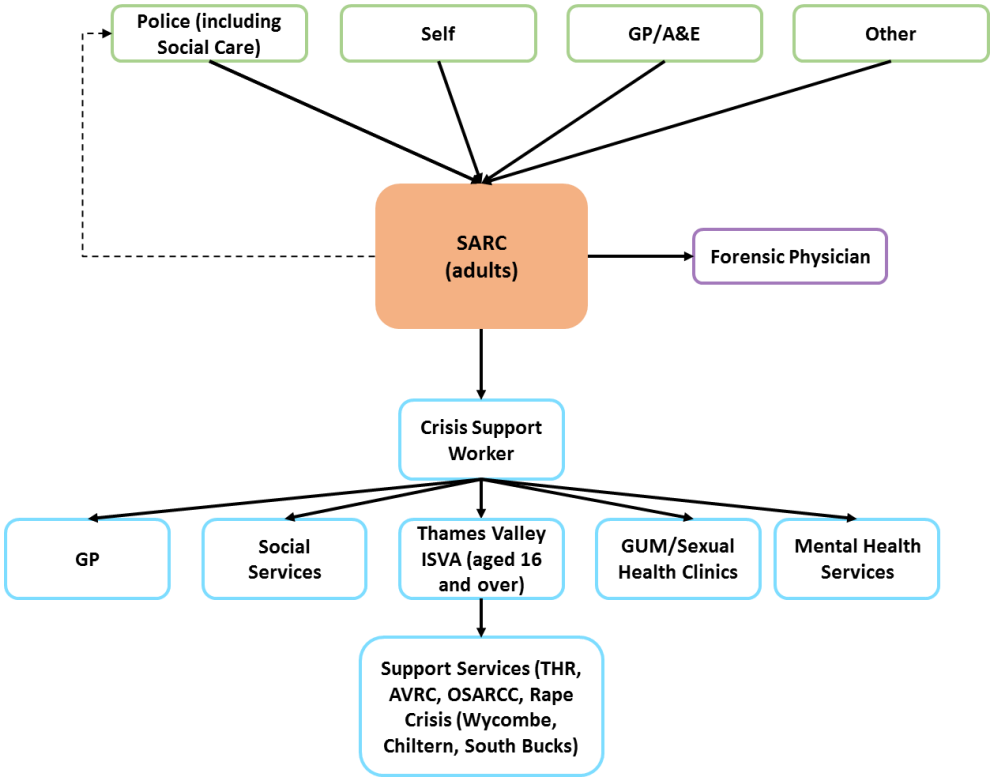
5.53 Often health is not included in all safeguarding strategy meetings and in some cases of child sexual abuse and decisions are being made without the advice of health. In Buckinghamshire, involving health in safeguarding strategy meetings via teleconference is being piloted. The SARC Board may wish to consider to widen the scope for children and young people to access the SARC.

Thames Valley Pathway (Adult) based on Current Service Activity

5.54 The chart below shows the current referral pathway to the SARC for adults aged 18 and over and onward referrals. The main source of referrals to the SARC is the

police (including social care) with 5% being made up of self-referrals, A&E, GP and other.

Chart 56: Sexual Assault Services Adults - Victim Pathway to Address Health Needs



5.55 Collectively there are more victims seen by the specialist support services than there are seen through the SARC and these services are a potential source of referrals to enable victims of sexual assault to access immediate health and forensic health needs.

5.56 The need to enable as many victims of sexual assault to have access to therapeutic counselling is important, evidence shows this has a beneficial impact on victims and helps to reduce symptoms of stress, anxiety, fear. In addition, group therapy sessions offered by support services helps to address the emotional, mental health and psychological wellbeing of victims.

5.57 The Thames Valley ISVA service now acts as the main referral from SARC to therapeutic support services for victims. This service will assess both practical and emotional support needs of victims and refer or signpost to appropriate support services. However, there are waiting lists for both counselling and group support.

5.58 Onward referrals to other services for adults such as GUM or sexual health clinics, social services, GPs and mental health services

5.59 In summary, referral pathways into the SARC are predominantly through the police and social services with few victims self-referring or referrals from specialist sexual assault or rape services. The referral pathway between police, social services, the SARC and specialist support services will need to continue to be developed to

ensure that every opportunity is afforded to enable children and young people to benefit from the sexual assault services in place.

5.60 The referral pathway between police, social services, the SARC and specialist support services will need to be further developed to ensure that every opportunity is afforded to enable children and young people to benefit from the sexual assault services in place. Therefore, continually improving the effectiveness of the referral pathway is critical. This is equally important as all the elements for an effective pathway are in place, not only does it meet the national guidelines it also has clear successes for those engaged into services. Respondents to the stakeholder survey felt the location of the SARCs was an issue and in some cases made them inaccessible, this was a particular concern for those who choose not to report the assault to the police and those who lived in Oxfordshire.

6 Perceptions of stakeholders, service providers and victims of sexual assault

6.1 A programme of primary research, using a range of methodologies and with diverse participants, has been undertaken to inform this needs assessment. The scope of the primary research has been to understand people's knowledge of and attitudes towards sexual assault alongside their experience, expectations and thoughts on improved sexual assault services in Thames Valley.

6.2 There were three separate research strands to this HNA as detailed in the table below.

Table 21: Primary research undertaken

Primary research project	Interview method	Profile of participants	Number of participants
Stakeholders	Semi-structured face to face and telephone interviews	Commissioners, providers of sexual health services, other health professionals, police, office of the police and crime	31
Wider Stakeholders	E-Survey distributed through Ottaway and NHS England	Commissioners, providers of sexual assault support services, other health professionals, police, office of the police and crime commissioner, sexual health services, social care	43
Service users	Telephone interviews	Victims of Sexual Assault Primary research undertaken by support services	2 victims + various victim surveys and reports

6.3 Summary findings of the **stakeholder interviews**

6.4 Perspectives emerging from stakeholder interviews are set out below, the views have been themed and where relevant presented for children and adults separately.

6.4.1 Overall state of sexual assault service provision in Thames Valley:

Adults

- There is pressure on all services with the rise in number of victims accessing support services, including those that are and those that are not reporting sexual crimes to the police
- This is evidence of the increase in the number of reported sexual crimes to the police and the increase in the number of people accessing the SARC and support services.
- The increase in the number of victims coming forward to report sexual crimes has had an impact of the volume of cases assigned to STOs, the recommended level of STO caseload is around 20-25 but in recent times STOs can carry a caseload of up to 40, significantly greater than the recommended level.
- Many services, particularly counselling services have long waiting lists for victims that need specialist counselling services.

- The SARC has been operating for five years and there is a good relationship and pathway between the police and SARC, in part this is due to relationships that have been forged over time between the police and SARC.
- The relationship with wider services is varied within the different localities across Thames Valley.
- Strong support and commitment to providing universal coverage and support across Thames Valley from the Office of the Police and Crime Commissioner, particularly through the commission of the single young people support service and adult ISVA services

Children

- There are concerns with perceived of lack service provision for children, for example there is no equivalent STO provision and or a dedicated ISVA service for victims aged under 16 and their families or carers, this was considered a significant gap for this group.
- Whilst children aged 8-16 are referred to the SAFE project there is no dedicated support services for those aged under 8, other than the support offered through Trust House Reading.
- The need for play therapy was considered a gap in meeting the therapeutic needs of children.
- Access to counselling for children and young people is a concern, the only provision is through CAMHS, however child victims of sexual abuse/sexual assault often do not meet the high thresholds and there do not access this provision.
- The varied response across Thames Valley social care was a concern, often cases where child sexual abuse is identified or suspected are not being referred to the SARC. It was felt health, through paediatricians and forensic physicians need to be included in safeguarding strategy meetings and case discussions.
- Decisions being made in relation to the need for forensic medical examinations are often made either by police alone or social services alone, or both and this can result in potential referrals not making it to the SARC for forensic medical examinations.
- Information sharing was considered a barrier to meeting the needs of child victims of sexual abuse, particularly where full medical records and or history of the assault is not shared with local community paediatric services or GPs.

6.4.2 Awareness of services:

- Generally, there is a lack of awareness of what services were available for the victims of sexual abuse, sexual assault and rape
- The lack of awareness, compounded by the fact that the area is diverse and vast, and navigating services and accountable bodies across Thames Valley was perceived to be problematic.
- In some instances, support services felt their organisational name was misleading, for example some victims when contacting rape crisis perceived the services catered for victims of rape only and not wider sexual assaults.

- Some parties engaged felt that services were not that well known and that a more effective communications effort was needed, particular since services being offered vary across Thames Valley, for example some services are for women only, others will see men and women and some services offers group therapy whilst others offer counselling only and many are locality focused rather than pan Thames Valley
- There was a sense that if professionals are unable to decipher services provision then how would a victim know where and who to approach for help.
- It was felt that an overarching Thames Valley sexual assault strategy was needed to shape the direction of sexual assault services.
- Referrals to the SARC from sexual assault and rape support services are exceptionally low as are referrals from the SARC to sexual assault and rape support services. There was a perception that the referrals pathways from SARC to support services were not as effective.
- Domestic violence services working with victims of domestic and sexual violence across Thames Valley considered they were not engaged with the SARC.
- Some social care services consider the pathway for referrals to the SARC are developed but the model is in need of reviewing to ensure there is consistent approach and understanding of each other role and responsibility.

6.4.3 Therapeutic services

- Therapy, in particular counselling either in group or one to one settings was considered a serious health need by many, in particular the need for specialist sexual violence counselling.
- It was felt that most if not all victims require long-term ongoing therapeutic support and that such therapy cannot be time limited.
- Ongoing therapeutic support is critical, thresholds for adult mental health services and CAMHS are too high and unless there is a predisposed mental health need, victims are often denied access to this service
- Waiting times are a concern, with victims waiting around 6-12 months before being able to access specialist one to one specialist counselling support
- Where group therapy is being offered, this too is operating a waiting list.
- There was a common concern with the lack of perceived support services offered to children.
- Whilst there was expressed support and optimism as the SAFE project develops its reach across Thames Valley to meet the therapeutic needs of children, there were concerns that this was limited to children aged 8-15. Moreover, there is concern that no provision exists in Thames Valley for children aged under eight, apart from that provided through Trust House Reading (play therapy for 4-11 year olds).
- It was also considered that there is little provision for men to access support services and a concern that the needs of male victims of sexual assault are not being met.

6.4.4 ISVA service in Thames Valley

- The new ISVA provision in Thames Valley is currently being developed for male and female victims of sexual assault aged over 16. This started in July 2015 and the services is currently developing pathways with the SARC, police and support services.
- The SARC and police felt this provision and the benefits of a single ISVA service and a single point of contact was positive. Whilst others felt the separation of ISVA from therapeutic services is likely to lead to victims "jumping though more hoops and undergoing more assessments"
- It was felt there is a need for "more joined up work" to ensure there is no duplication of service offer between police STOs and ISVAs and protocols will need to be developed so that both services complement one another.
- Similarly, there was more developmental work required between the Thames Valley ISVA service and rape crisis centres and Trust House Reading ISVA provision.
- The lack of dedicated ISVA provision for children under 16 was a concern, however protocols and pathways are being developed with the SAFE project to address this.

6.4.5 Funding

- There is confusion over the longer term funding, around the therapeutic support for victims of sexual assault. Most sexual assault and rape support services have confirmed funding until March 2016 but expressed concern around the uncertainty of funding beyond this financial year.

6.5 Summary findings of the **stakeholder e-survey**

6.5.1 This survey was designed in partnership with NHS England Commissioners and the HNA Working Group. Its aim was to enable as many stakeholder and partners as possible to engage in this HNA. The survey was distributed by NHS England and the link for the survey was encouraged to be shared by respondents to enable wider dissemination to other local stakeholders and practitioners. The survey went live on 3rd November and closed on 30th November 2015. Forty-three stakeholders across Thames Valley participated in this survey. The key findings of the survey are set out below.

6.5.2 Respondent's engagement with sexual assault services:

- The profile of respondent by place of work was:
    - Voluntary/third sector (31%)
    - Community Safety (13%)
    - Sexual Health Service (10%)
    - Heath Trust (10%)
    - Social Services (8%)
    - Police (5%)
    - Public Health Commissioning (5%)

- Non-NHS Health Providers (5%)
- Primary Care (3%)
- NHS Commissioning (3%)
- Other (10%) local safeguarding children boards, housing and substance misuse treatment

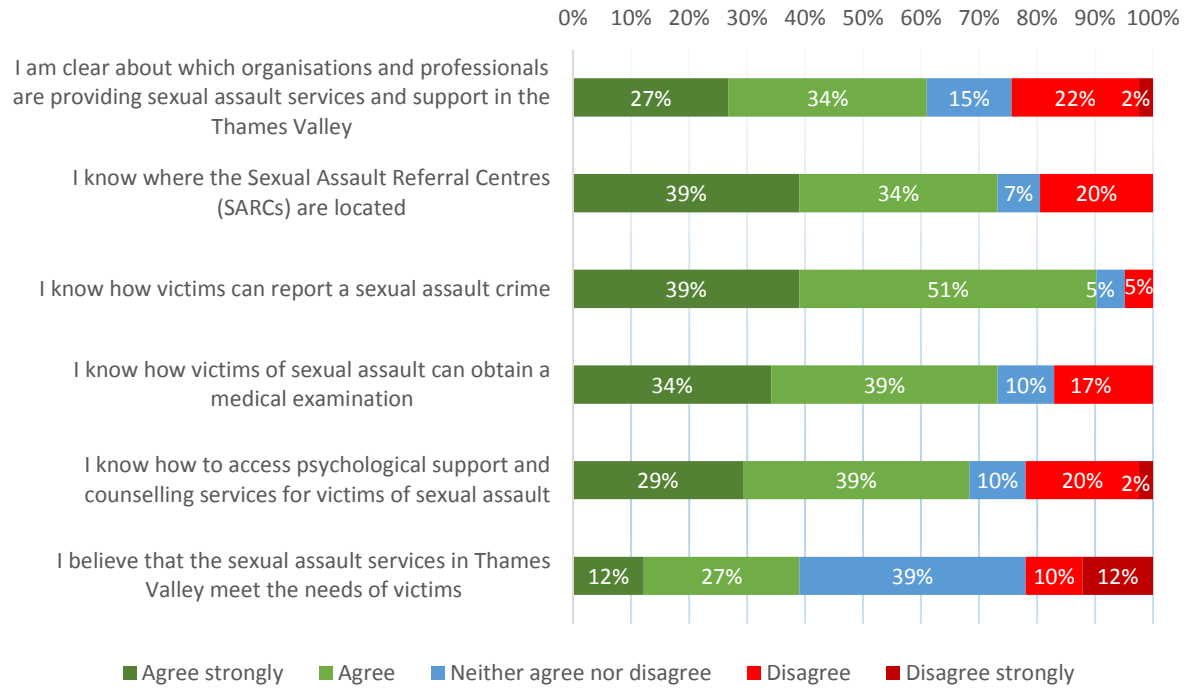
6.5.3 Work area in relation to sexual assaults and victim support:

- The profile of the role the respondents work area involved was:
  - Victim support (33%)
  - Frontline sexual assault work (15%)
  - Sexual health provision (13%)
  - Policy and planning (5%)
  - General health provision (3%)
  - Other (20%), including local safeguarding children's board, substance misuse treatment, housing services and mental health

6.5.4 Respondent's awareness of sexual assault services:

- 61% agreed or agreed strongly that they 'were clear about which organisations and professionals are providing sexual assault services and support in the Thames Valley'
- 73% agreed or agreed strongly that they 'know where the Sexual Assault Referral Centres (SARCs) are located'
- 90% agreed or agreed strongly that they 'know how victims can report a sexual assault crime were'
- 73% agreed or agreed strongly that they 'know how victims of sexual assault can obtain a medical examination'
- 68% agreed or agreed strongly that they 'how to access psychological support and counselling services for victims of sexual assault'
- 39% agreed or agreed strongly that they 'believe that the sexual assault services in Thames Valley meet the needs of victims'

Chart 57: Awareness – Would you agree or disagrees with the following statements (Q3, Stakeholder e-survey 2015)

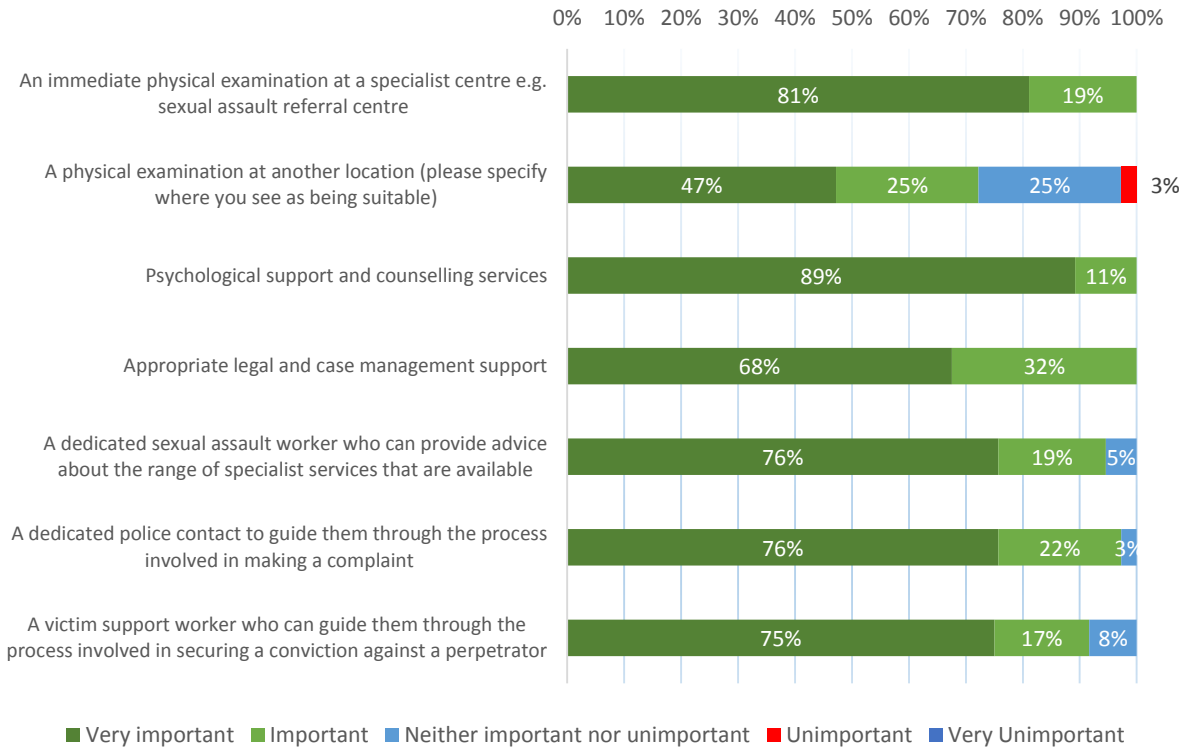


6.5.5 Respondent's views of the need for victims to access specific services:

- 100% felt it was important or very important that victims of sexual assault had access to 'an immediate physical examination at a specialist centre e.g. sexual assault referral centre'
- 72% felt it was important or very important that victims of sexual assault had access to 'a physical examination at another location' several respondents felt the location of the Bletchley SARC being next door to the police station was not suitable "a person may not be comfortable attending a police linked location [Bletchley] for an examination" more general views expressed around the geographic location of the SARCs and the distance required "often puts people off" location for examinations could be based "at a hospital or health centre"
- 100% felt it was important or very important that victims of sexual assault had access to 'psychological support and counselling services' views expressed by respondents were around the "lack of specialist support or counselling services for under 16 year olds." In addition, it was felt "there is a serious lack of therapy for children under 13 and children older than 13 who are vulnerable." Other comments around psychological support and counselling services included the need for a better understanding the importance of "on-going counselling and support services [for victims] as well as recognition that "majority are victims of non-recent sexual abuse and will not engage with the SARC" and "do not wish to engage with the criminal justice system".
- There were statements around the lack of provision for children and young people aged under 16. It was also felt that "greater priority should be given to the planning and provision of services, especially to male survivors."

- 100% felt it was important or very important that victims of sexual assault had access to 'appropriate legal and case management support'
- 95% felt it was important or very important that victims of sexual assault had access to 'a dedicated sexual assault worker who can provide advice about the range of specialist services that are available'
- 97% felt it was important or very important that victims of sexual assault had access to 'a dedicated police contact to guide them through the process involved in making a complaint'
- 92% felt it was important or very important that victims of sexual assault had access to 'a victim support worker who can guide them through the process involved in securing a conviction against a perpetrator'

Chart 58: Meeting Needs – How important do you think it is to provide the victims of sexual assault with the opportunity to access the following services in Thames Valley? (Q4, Stakeholder e-survey 2015)



6.5.6 Respondent's views of the priorities to support victims of sexual assault:

- 95% felt they would like to see more being done to 'encourage victims to get support for their physical and emotional health needs,
- 94% felt they would like to see more being done to "encourage victims to report sexual assaults to the police' some respondents felt that more needs to "more done to tackle the stigma [attached to sexual assault" to encourage more reported of sexual crimes to the police.
- 100% felt they would like to see more being done to "increase conviction rates against perpetrators of sexual assault" others felt "Prevention requires ongoing

work to tackle attitudes towards (mainly) women & especially women more vulnerable to assault." There was a sense that more prevention work needs to be undertaken with particular groups or communities "we should also be doing much more for BME Communities where disclosing sexual violence is a huge taboo; including FGM"

- 15% felt 'enough is being done to prevent the incidences of sexual assault' most respondents felt that there needs to be more targeted education and awareness raising particularly among children through schools "more education in schools and colleges" and generally within the community.
- 100% felt that there were things that they felt 'could improve the experience of victims of sexual assault' some respondents expressed the need for more work needs to be done to bring about "a more collaboration [working] between the complex services within Thames Valley to agreed guidelines" in order to "avoid the current confusion around what is available and where"
- 17% felt they there is currently "adequate support/information for the families/carers of victims? (Parents, partners, guardians, or children etc.)

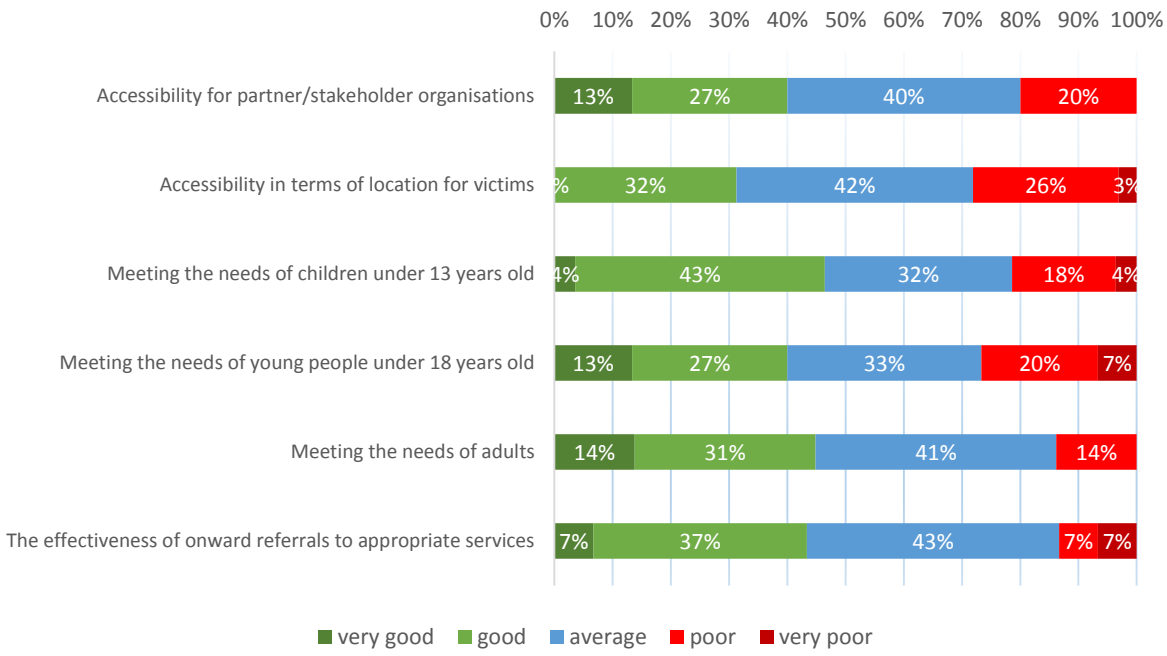
6.5.7 Respondent's views on whether a whole population or targeted approach is required the design of sexual assault services in order to be appropriate to specific groups of people:

- Over half of respondents felt a targeted approach is required in the design of services for children under 13, young people age 13-17, looked after children, people for BME communities and people from particular faith groups.

6.5.8 Respondents were asked to rate aspects of the SARC:

- 40% gave the SARC a good or very good rating for 'accessibility for partner/stakeholder organisations'
- 32% gave the SARC a good or very good rating for 'accessibility in terms of location for victims'
- 46% gave the SARC a good or very good rating for 'meeting the needs of children under 13 years old'
- 40% gave the SARC a good or very good rating for 'meeting the needs of young people under 18 years old'
- 45% gave the SARC a good or very good rating for 'meeting the needs of adults'
- 43% gave the SARC a good or very good rating for 'the effectiveness of onward referrals to appropriate services'
- It is worth noting, between 32% and 43% in all aspects gave the SARC an average rating.

Chart 59: Perceptions – How would you rate the following aspects of the SARCs in Thames Valley (Q7, Stakeholder e-survey 2015)



6.5.9 Respondent's suggestions for areas where the SARC could improve:

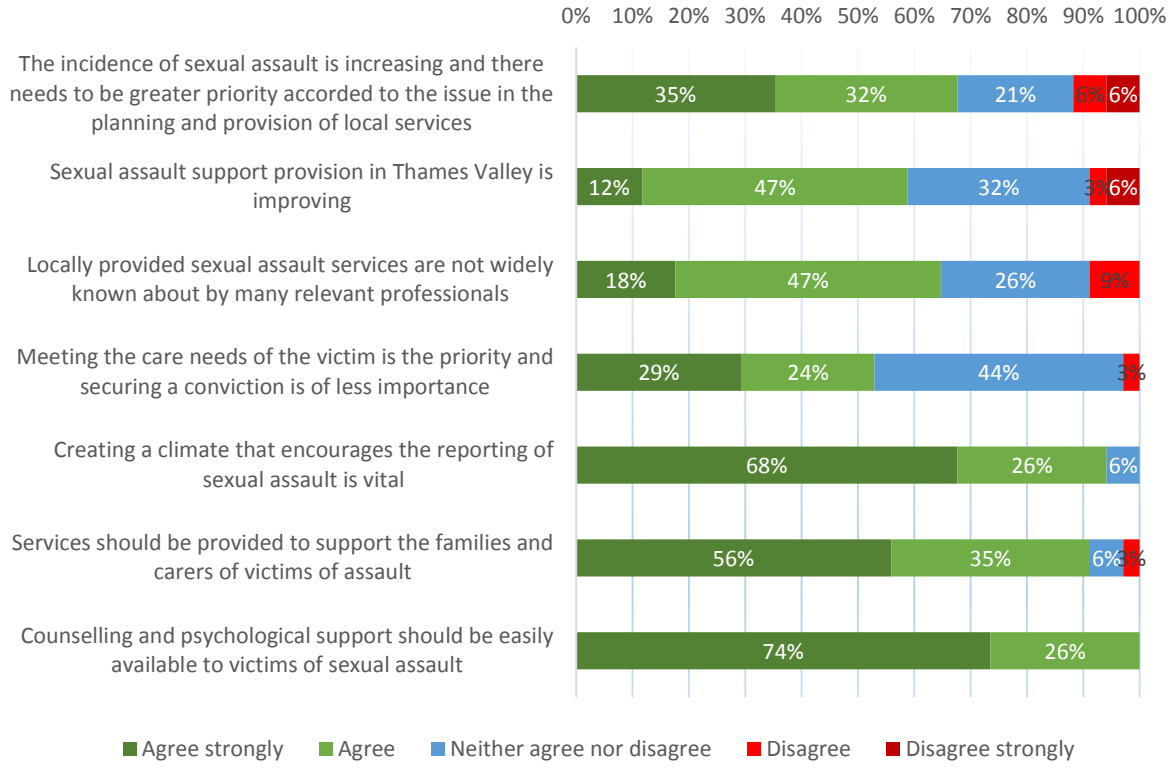
- "Provision does not meet demand. Locations of SARCs are inequitable and prevent the most vulnerable from accessing and therefore reporting. Feedback from clients reporting to police station has been very negative."
- "If it is a matter of funding then obviously more money - the services need to expand and cover different areas of the Thames Valley - particular areas appear to have no support services at all which means either they are unsuccessful or in deed in lacking. Trained workers and volunteers recruited and specific buildings that are discreet and yet accessible - I am certain with all the brain power within the NHS/Government something can be proposed that does not look at votes/targets and/or money saving!!!!"
- "There is very little information coming from the SARC or partnership working. They may do a good job but we never hear anything about them, although some anecdotal feedback from potential service users has not been positive. Although I am a Sexual Violence lead and sat on the working group to establish the SARC I was not even aware it had changed to another organisation. In my view it is an extension of the police. They should be more engaged with local strategic partnerships and transparent in what they are doing and encourage reporting that does not involve the police."
- "After assaults possibly the coordinator at the SARC could phone the sexual Health clinic and speak to a Health advisor about the client, to try to encourage uptake of post assault screening and care. Currently we receive faxes, but when we try to contact the victim we don't always get contact and follow up."
- "Accessibility is an issue."

- "Engagement with the specialist voluntary sector working in the Thames Valley is critical and needs to be improved."
- "Strongly feel that the therapeutic needs of children are not met. Spending resources on this now will prevent a whole host of difficulties and ruined lives later, and also be extremely cost effective for the country."
- "We need a more central location. Bletchley has never been a good location as it is at the edge of the area covered. Aylesbury would be much better. As Bletchley site is being sold then another site has to be found.
- "usual lack of mental health services."

6.5.10 Respondent's views on wider perceptions of sexual assault:

- 68% agreed or agreed strongly that 'the incidence of sexual assault is increasing and there needs to be greater priority accorded to the issue in the planning and provision of local services'
- 59% agreed or agreed strongly that 'Sexual assault support provision in Thames Valley is improving'
- 65% agreed or agreed strongly that 'Locally provided sexual assault services are not widely known about by many relevant professionals'
- 53% agreed or agreed strongly that 'Meeting the care needs of the victim is the priority and securing a conviction is of less importance'
- 94% agreed or agreed strongly that 'Creating a climate that encourages the reporting of sexual assault is vital'
- 91% agreed or agreed strongly that 'Services should be provided to support the families and carers of victims of assault'
- 100% agreed or agreed strongly that 'Counselling and psychological support should be easily available to victims of sexual assault'

Chart 60: Perceptions – Could you please indicate the extent to which you agree/disagree with the following statements (Q8, Stakeholder e-survey 2015)



6.5.11 Respondents were asked to comment on how well they felt their organisation responds to sexual assault services and what could be done by their organisation to improve:

- I believe there has been a much greater focus and awareness on this topic. Moving forward I feel we can make the information available to the wider community.
- Better use of data to understand, monitor and evaluate outcomes of all sexual assault and sexual abuse services.
- Sexual assault fits into a number of areas of our work (policies and procedures, training and awareness raising) and this survey has highlighted that we could do more in terms of signposting to services in particular for parents / carers and children.
- Greater knowledge of this service and provision
- It would be great if a SARC worker was a Healthwatch Champion and liaising with us about what services worked well and what could be improved
- We are a relatively new organisation and unfortunately it has been difficult for me personally to engage with certain areas in order to access their support for some of my young clients! As i mentioned earlier i am appalled with the treatment shown, it has been shameful to some victims and their families. There is much more needed and at some point it should be recognised that it is a priority - surely to look at savings in the long run try and support now before a

person's life spirals so far out of control their support will need to be increased tenfold!

- Better links between stakeholders. Named job roles to be able to report issues to (both client related and process related)
- We have a dedicated team that looks after the victims from report to court and good training for front line officers and Investigators. One concern for the police is due to the increase in reported SSA we may have capacity issues which the Force are aware of so working with our partners is of great importance to maximise the service and response we give to victims.
- When an assault comes to light we will assist in referrals to appropriate agencies. We could consider advertising it more within this service.
- I would like to have closer ties with local services, possibly a yearly meeting where all relevant services meet to work on improving the ways we work together and also a chance to update each other on new developments.
- The Office of the Police and Crime Commissioner for Thames Valley has commissioned services to support victims of crime and with regard to sexual violence this includes a Thames Valley wide ISVA service. Much more work needs to take place to encourage and develop dialogue with partner agencies and statutory bodies to ensure duplication is minimised, best use of existing funds within the current financially challenging landscape is utilised and a more unified approach is enabled.
- We would be happy to use our extensive experience of all aspects of rape/sexual abuse, the needs of Survivors/Victims and service provision to help improve all aspects of service provision in the Thames Valley.
- I would like to see two doctors on duty at any one time as the geographical area covered is very large and sometimes one is not enough.
- I definitely want to see better therapy for children

6.6 Summary findings of the **telephone interviews, support service research with victims of sexual assault**

6.6.1 The interviews focused on understanding the victims' perceptions of their general and specific health needs, their knowledge of, and experience of services relevant to sexual assault and their ideas for what would best help future victims.

Reporting the assault

6.6.2 Victims who had reported the assualt to the police felt they had been fully supported by the police. Having a dedicated police officer that could be contacted from the time the assault was reported to the time the case went to trail was a positive experience.

"Just knowing that I can contact her [specially trained police officer] at any time, she has been really great"

6.6.3 Victims also reported being extremely fearful of the consequences that they may suffer as a result of police involvement; worrying that they may suffer additional abuse from their perpetrator. For such victims the

prosepect of reporting the assualt to the police was frightening and scary.

6.6.4 Particpants felt victims are sterotyped as a certain 'type' or 'class' of women to whom this happens and they are often seen as being less worthy and looked down upon.

"was it me, did I make this happen, is this all in my mind?"

6.6.5 Going through the criminal justice process is a stressful ordeal, not having the knowledge or information about what is supposed to be happening. It was scary knowing that the perpetrator was still out there.

"Not having a clue, what my rights are, never really knew what was going on, where to find things out…a massive open space"

Mental health need

6.6.6 There was acknowledgment of the significant, long-term and multi-faceted impact that sexual assault has on victims. The major health need reported was the impact on the mental health and well-being. This was described as being enormous. Feelings of being anxious, depressed, isolated and alone. Being in an abusive relationship meant that there was constant fear and worry about being contacted an organisation for help might lead to the abusive partner finding out. Participants that are in abusive relationships are forced to relocate leaving behind their jobs, their friends and social networks.

"I was diagnosed with post traumatic stress syndrome"

"I moved to Thames Valley after the assault"

6.6.7 As a result of the multiple and complex emotional pressures experienced by the victims it was felt very strongly that victims must have access to specialist and ongoing professional counseling services that should be readily accessible.

"I didn't know about services, or what was available"

"I got a counsellor privately, paid for it myself"

Listening services

6.6.8 Having someone to talk to about the assaut, the case and being able to share is very important. This had come out strongly from the interviews and from research carried on the impact of specialist sexual assault support services in Thames Valley. Emotional one to one counselling and support through group therapy where experiences are shared with other victims has been vital in starting to deal with their mental health. The quality of the staff and volunteers working in services was highly commended, and it was seen to be of huge value.

"She was excellent. I've done a lot of thinking and working and she's given me the tools to think in a different way about what

happened to me."

6.6.9 It was also felt that services need to be open at times other that 9-5pm, Monday to Friday, if you work you can only contact the service during work time. This experience was seen as very isolating.

"If you need to speak to someone you do it at work and then carry on as though nothing has happened"

6.6.10 In the absence of professional emotional support there was widespread concern that victims were unlikely to be able to have any chance of coping.

"I can see why so many victims give up…you can't take this on alone"

6.6.11 There was recognition too that the 'burden' on society could as a consequence be enormous and long-lasting.

"If victims don't get the right kind of help then it could cost the NHS a lot of money. They could have lots of long-term health problems, become alcoholics or drug addicts, not be able to work, be destructive."

"If I didn't get the counselling support or attend group sessions, I would have probably turned to drugs and alcohol"

6.6.12 Research undertaken by the specialist sexual assault support services on understanding the impact their service is having on victims showed that many felt attending group therapy sessions had a positive impact on them as they did not feel alone through meeting other victims who shared similar experiences. There was a positive impact on victims feeing more in control of their lives, with a better understanding of their situation, knowing and understanding what to do about the assault, it increased confidence and the ability to have normal relationships.

6.6.13 Participants to this research experienced an improvement in their health and wellbeing.

Support through the SARC

6.6.14 Victims with experience of the SARC, reflected on the time they spent there and recall it being a positive experience at a time when they felt their most vulnerable. The environment was clean and the staff were kind and supportive. This was important especially since the examination was quite invasive.

"I remember feeling really cold and they [SARC staff] put the heating on and offered me a cup of tea"

ISVA support

6.6.15 Victims also felt having a single person to talk to about the criminal process is important, especially when a trial date has been set and every

so often there is an update. The ISVA support was perceived to be having a positive impact, someone to talk to on a practical level.

"It is really helpful having someone to go with me to interviews or meetings with the police"

"It took four months to be referred to the ISVA, I wish I knew about the ISVA service before"

6.6.16 However, it was felt the ISVA is too busy, and often victims are waiting for a response from them and often a lot of waiting around 'left hanging with tension.' Or if they are away for any length of time, this involves more waiting around. There was also an understanding and appreciation that staff were busy and that they were doing the best they can.

6.6.17 Going through the investigation and court process was felt to be the time when it was especially important to have emotional support. Without support it is felt to be unrealistic to expect someone to cope with the experience.

"If it wasn't for the support I have through my ISVA and IDVA then I would have dropped the case, I would not have been able to go through with it"

6.7 In summary, there is an understanding among stakeholders that the demand on services through more victims reporting sexual offences and seeking support has increased and this demand is having an impact on the capacity of police supporting victims and services provided psychological support. There is strong commitment to support the emotional and practical needs of victims of sexual assault and their families. It is recognised that there is a lack of therapeutic input and support for children aged under 16 and while the SAFE project develops its services across Thames Valley, there is still a need for those aged under 8.

6.8 The lack of understanding of the services available through the SARC and the available services to support victim's psychological health needs. A renewed marketing and communications strategy to promote services among stakeholders as well as victims and their families is essential.

6.9 Victims feel, the impact of the assault on their mental health and wellbeing is huge and that there is little information out there about services. Victims feel counselling support and group therapy have been instrumental in helping them to deal with their situation. Practical and emotional support through ISVAs has helped victims to cope during the criminal justice process.

7 Sexual assault health needs assessment findings

Estimated Need

7.1 Estimates from the CSEW indicate in 2013-14, 2.2% of women and 0.7% of men (aged 16-59) stated they had been a victim of a sexual offence (including attempts) in the previous 12 months. Applying these percentages to the population of Thames Valley it can be estimated that around 20,150 have been a victim of a sexual offence (around 4,900 men and 15,250 women) in the last year.[79] In the 12-month period y/e Sept 2015 there were 2,801 police recorded sexual offences of this 1,083 were rape cases (adults aged 16-59). Over the same period there were 273 adult (aged 16 and over) attendances at the SARC.

7.2 National estimates suggest that 16% of children aged under 16 in the UK experience sexual abuse during childhood. Applying this percentage to the Thames Valley population aged under 16 would indicate this is around 76,400 children. In the 12-month period y/e Sept 2015 there were 1,043 police recorded sexual offences, of this 445 were rape cases (children aged under 16). Over the same period there were 68 children and young people (aged under 16) attending the SARC.

Convictions

7.3 National data from the Rape Monitoring Group relating to 2014-15, indicates the low level of rape cases resulted in convictions. During this period there were 1,085 police recorded rape cases in Thames Valley (adult and children), 311 rape cases were referred by the police to the CPS, 217 defendants were charged by the CPS resulting in 178 prosecutions and 112 convictions. Whilst the figures are not directly comparable, this does illustrate the around 10% of reported rape cases end up in convictions.

SARC

7.4 The SARC has been operating since 2011 and is well established. Over time there has been an upward trend in the number of victims seen by the SARC, 342 victims in the latest 12-month period (y/e Sept 2015). The profile of victims seen by the SARC; most were female (94%), around two thirds were aged under 24 (21% of aged under 16), the majority assault type reported by victims seen by the SARC was rape (96%), the ethnic profile of SARC victims is broadly similar to the total population of Thames Valley.

7.5 Forensic medical examinations take place at the two SARCs (Slough and Bletchley). There are 11 forensic physicians providing cover to both SARCs 24/7, 365 days a year. Forensic physicians work an 8-hour shift rota and are required to stay for an additional 4 hours where a victim presents toward the end of one shift. With only one forensic physician on duty at any one time this creates long delays, where there are multiple victims requiring examinations and where travel between SARCs is involved. One in five victims waited 3 hours or longer to be examined.

Services

7.6 In July 2015 the local Office of Police and Crime Commissioner (OPCC) for Thames Valley, commissioned the Thames Valley ISVA service to provide practical and emotional support to male and female victims aged 16 and over. In addition, the

[79] Using Mid-year population estimates 2014, ONS

OPCC commissioned the SAFE project (based in Oxford) to provide services to children and young people (aged 8 to under 16). The OPCC are currently developing a counselling service in order to provide victims of sexual assault or rape a similar level of consistent and standardised service across Thames Valley.

7.7 In the 12-month period y/e Sept 2015, among specialist sexual assault support services around 1,100 victims of sexual assault, rape and child sexual abuse were supported (1,000 adults aged 16 and over and 100 children aged under 16). These support services have dedicated locations in Oxford, Aylesbury, Wycombe and Reading and provide services to victims in and around these locations.

7.8 Collectively, between the main specialist rape and sexual assault center's a range of services are available for victims. Services include specialist sexual assault counselling, group therapy, ISVA services and targeted therapies to support child victims including play therapy.

7.9 However, the services offered vary in each centre. As such not all services are available to all victims across Thames Valley. Specialist sexual assault support services are predominately providing services to women only and are for victims aged over 16. The only service offering play therapy for children aged as young as four is located in Reading.

7.10 Oxfordshire health in January 2016 launched their new service; Horizon: Supporting Young People and Families affected by Sexual Harm. This service aims to support professionals involved in the care of young people (aged under 18) and their families affected by sexual abuse.

Victim views

7.11 Coping with the short and long term effects of sexual violence can be devastating, overwhelming and confusing. Whether victims have reported their assault to police or not they often need someone who can help them through their various demands at this traumatic time and or how to go about getting them met. Victims can become distressed, they may want to 'hide away' from the world, express anger, sadness, experience loneliness and desperation, as well as many other emotions.

7.12 Overall victims felt their experiences of reporting the assault to the police and the SARC were positive and specialist sexual assault services had a positive impact on their mental health and wellbeing. It was clear that emotional and practical support is critical to help victims deal with the trauma of the assault and for those who prosecute the perpetrator.

Referral pathways

7.13 The relationship between the police and SARC is well established and almost all referrals to the SARC are from the police (95%), many of which involve social care and health, few victims self-refer or are referred to the SARC by specialist support services (such as rape crisis center's). Despite referrals from police, social care and health only 68 children (aged under 16) attended the SARC and an additional 40 attended the historic paediatric clinic (aged 18 and under) in the same period when

445 police recorded child rape cases (y/e Sept 2015), this is the equivalent of around 75% children reporting rape not attending SARC.

7.14 The referral pathway between police, social services, the SARC and specialist support services will need to be further developed to ensure that every opportunity is afforded to enable children and young people to benefit from the sexual assault services in place. Therefore, continually improving the effectiveness of the referral pathway is critical. This is equally important as all the elements for an effective pathway are in place, not only does it meet the national guidelines it also has clear successes for those engaged into services. Respondents to the stakeholder survey felt the location of the SARCs was an issue and in some cases made them inaccessible, this was a particular concern for those who choose not to report the assault to the police and those who lived in Oxfordshire.

Demands placed on services

7.15 It is clear the increase in the number of victims reporting sexual offences to the police, accessing the SARC and specialist sexual assault support services is placing pressure on services, with Specially Trained Officers (STOs) carry caseload of around 40, and counselling and support groups operating long waiting lists. Cuts in funding and uncertainty of funding beyond March 2016 among the voluntary sector specialist sexual assault and rape services has further reduced capacity to deliver services to victims.

Support services for children

7.16 There was a collective concern among stakeholders that the needs of child victims of sexual abuse were not being met, in the same way that support exists for victims aged over 16. Stakeholders felt there was a lack of counselling provision and child therapy available across Thames Valley.

7.17 Many stakeholders expressed the need for a dedicated ISVA provision for children and young people under 16 particularly for those reporting child sexual offences where there is no police STO support available (in cases where the assault was not interfamilial).

ISVA provision

7.18 As the new pan Thames Valley ISVA service continues to embed and become fully established there remains some confusion among stakeholders over the current arrangements between Thames Valley ISVA service, the role of the police STOs and the relation with the ISVA provision among support services. ISVA support provision across Thames Valley will need to develop a cohesive service and clear protocols and pathways between the collective ISVA support available.

Awareness of services

7.19 Findings from the stakeholder survey suggest 61% were clear about the organisations and professionals that are providing sexual assault services, 68% knew how to access psychological support and counselling for victims of sexual assault and 73% knew where the SARCs were in Thames Valley.

Communications

7.20 Across Thames Valley there is a need to develop a communication strategy that promotes the services available for victims of sexual abuse, assault and rape. The

communications strategy should promote the SARC and provide clarity of the work it undertakes to support victims at the early stages, particularly as this will vary if the victim is a child, young person or adult. Equally important is communicating the role of the other support services in the region and the services they provide.

7.21 It is important the communication strategy is developed to increase awareness and understanding of existing and new services provision. It is critical that the communications strategy promotes the full range of sexual assault services available for children, young people and adults. The OPCC are developing a directory of services to provide information concerning services to support victims of crime that are available across Thames Valley.

7.22 The communications strategy should also provide clarification of the roles and responsibilities of different parts of the sexual assault care pathway to enable a better understanding among professionals of the processes and protocols surrounding the work of sexual assault services across Thames Valley.

8 Recommendations

8.1 The recommendations from this needs assessment are set out below. The recommendations are derived from the desk, data and primary research completed as part of this health needs assessment. The focus of these recommendations are to identify what needs to be delivered and by whom, set priorities and enable the onward review of progress and where relevant link to other partner activity.

8.2 The recommendations have been broken down as strategic and operational recommendations. The operation recommendations are set out in order of short term, medium term and long term priorities.

Strategic Recommendations

- Develop a Thames Valley Sexual Assault Strategy addressing prevention, immediate and post event response to acts of sexual violence.
- Plan for the likely growth in demand for services, reflecting the growing levels of victims reported sexual assault, rape or child sexual abuse (including historic cases), as well as the increasing number of victims seen by the SARC and support services.
- Develop a comprehensive communication strategy for victims to raise awareness of and promote services available to them and for professional to secure the pathways for referral between sexual assault services.
- Deploy innovative approaches to marketing and communications that include prevention and education.
- Communicate the roles and responsibilities of the Thames Valley ISVA service, rape crisis's and specialist support ISVA services and services offered through police STOs to promote the best possible care for victims.
- Review the capacity and capability of the current provision of forensic medical examinations to meet the needs of victims within agreed timescales.
- Review the funding arrangements for the support services particularly if referrals and service take-up increases.
- Work with partners to maintain and build the current community paediatric arrangements with the SARC
- Ensure that all victims, where the need is identified, have access to sexual assault services, in particular the therapeutic needs of children
- Develop safeguarding strategy meetings with mandatory health involvement to ensure the health needs of children and young people are routinely considered when child abuse cases are reviewed.
- Work with local children safeguarding boards and social care to build links and care pathways for referrals to the SARC and from the SARC to social care.

Operational Recommendations

Short Term

- Continue to develop clear pathways with partner agencies to enable ease of referrals into and onto relevant victim support services, setting guidelines for timely referral.
- Establish a commissioning framework to ensure a coherent set of victim support including counselling and therapeutic support services.
- Establish a clear marketing and communications campaign to ensure that partners, stakeholders and victims are aware of and able to access all sexual assault services (including SARC and rape crisis centres).
- Target awareness campaign with partners including, GP's, practice staff and pharmacists, sexual health practitioners, A&E departments and mental health teams, drugs and alcohol services, adult and young people's social care and commissioners across Thames Valley.
- Agree and set the baseline data collection arrangements with commissioned and partner services to monitor information and build a profile of victim need.
- Establish a data sharing agreement between service providers and partners, in order to make effective use of local intelligence.

Medium Term

- Develop training material for stakeholders in police, social care and health care services to support referrals of children, young people and adults to sexual assault services.
- Develop psychological interventions, in particular counselling and trauma therapy for victims meeting current and potential demand.

Long Term

- Establish ongoing health need reviews of victims as they move through the services by ensuring that referral partners are signed up to report outcomes.
- Carry out annual Health Needs Assessment 'refresh' and review sexual assault services in advance of future re-commissioning/procurement exercises.
- The needs of child and adult victims vary, and future HNA's should be undertaken separately for children and adults.

9 Appendix 1: Glossary of acronyms

Abbreviation	Description
AVRC	Aylesbury Vale Rape Crisis Centre
CCG	Clinical Commissioning Group
CPS	Crown Prosecution Service
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
CSEW	Crime Survey for England and Wales
FME	Forensic Medical Examination
FP	Forensic Physician
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
HMIC	Her Majesty's Inspectorate of Constabulary
IDVA	Independent Domestic Violence Advocate
ISVA	Independent Sexual Violence Advocate
LSCB	Local Safeguarding Children Board
MoJ	Ministry of Justice
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
ONS	Office for National Statistics
OPCC	Office of the Police and Crime Commissioner
OSARCC	Oxford Sexual Assault and Rape Crisis Centre
PEPSE	post-exposure prophylaxis after sexual exposure
PFA	Police Force Area
PTSD	Post-Traumatic Stress Disorder
SARC	Sexual Assault Referral Centre
STO	Specially Trained Office
SCR	Serious Case Review
THR	Trust House Reading

10 Appendix 2: Stakeholder interviewees

Name	Organisation/Role
Alan Doherty	SARC Manager
Alison Chapman	Designated Nurse & Safeguarding Lead, Oxfordshire Clinical Commissioning Group
Ammara Kanwal	Service Manager, Thames Valley ISVA
Chloe Purcell	SAFE Project
Christina	Director, Rape Crisis (Wycombe, Chiltern, South Bucks)
Claire Short	Director, Aylesbury Vale Rape Crisis
Dave Wraight	Chair CSE Operational Group, West Berkshire
Dr Carmen Chan	Clinical Psychologist and Services Lead, Horizon: Supporting People and Families Affected by Sexual Harm, Oxfordshire
Dr Sheila Paul	Clinic Director, (SARC) Care UK
Edward Fitzpatrick	Policy Development Officer, Partnership and Commissioning, Office of Police and Crime Commissioner
Faye Maxted	CEO, Survivors Trust
Fiona Pearce	Thames Valley Police
Jan Collins	Crisis Worker, Slough SARC
Janet Donaldson	Interim Strategic Lead, Child Sexual Exploitation, Oxfordshire
John Travains	Assistant Director of Nursing, Patient Experience & Safeguarding, NHS England South (Central)
Karen Atalla	Service Manager, Front Door Services, West Berkshire Social Services
Lara Patel	Area Social Manager, Oxfordshire MASH
Linda Stent	Public Health England
Lisa Ward	Director, Oxford Sexual Assault Rape Crisis Centre
Liz Jones	Domestic and Sexual Abuse Co-ordinator, Oxfordshire City Council
Marilyn Read	Health and Justice Commissioner (L&D, Police and SARCs) NHS England South
Matilda Moss	Business Manager, Buckinghamshire Safeguarding Children's Board
Michael Wallen	Thames Valley Police
Michelle Dexter	Volunteer Coordinator, Trust House Reading
Namita Prakash	Manager, Trust House Reading
Sharon Erdman	Strategic Lead, Thames Valley ISVA
Siriol Davies	OSARCC
Sophie Jarpmyr	ISVA, Aylesbury Vale Rape Crisis
Sue Lemon	ISVA, Rape Crisis (Wycombe, Chiltern, South Bucks)
Sue Staddon	Head of Health and Justice, NHS England South Central
Victoria Kurrein	Regional Service Manager, Bucks Prisons Cluster & SARCs, Care UK

11 Appendix 3: Policy Drivers and National Guidance

11.1 National guidelines and policy drivers for the development of SARCs were introduced around 10 years ago. Since this time there have been a number of policy documents and reviews that have had an important impact on the direction and development of SARCs and wider SAS. It is vital to have an understanding of the key policy drivers and national guidance that have influenced the development of SARCs and wider SAS. Equally, it is important to be aware of the national documents that outline the standards of health and social care to be provided to sexual assault victims.

11.2 This is in no way an exhaustive list but some of the key documents for adults, young people and children are summarised below.

- **National Service Guidelines for Developing SARCs (2005)[80]** - The intention of these guidelines was to highlight the SARC as a model of good practice in the provision of immediate aftercare to victims of serious sexual violence. They were produced jointly by the Home Office and Department of Health because:
  "…they are relevant to the police and health services in equal measure. Partnership working between these agencies, and with the voluntary sector, is crucial in the provision of services to victims of sexual violence, and in particular, to the success of SARCs".

- **A Resource for Developing SARCs (2009)[81]** - Published jointly by the Department of Health, Home Office and the Association of Chief Police Officers this guide replaced the 2005 *National Services Guidelines for Developing SARCs*. It highlighted the minimum elements essential for providing high-quality SARCs for victims of sexual violence and sexual abuse, including forensic medical examination. It also highlighted opportunities for partnership working with SARCs to improve availability of services and to raise the standards of care for children and young people who were sexually abused.

- **NHS Taskforce report by Sir George Alberti, "Responding to violence against women and children - the role of the NHS (2010)"**[82] – This report highlighted the need for access to high quality services. It recommended that Forensic Physicians should be employed by the NHS with better access to high-quality training, be an integrated part of the NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of victims of rape.

- **The Stern Review (2010)**[83] - This Review looked at the response of public authorities to rape complaints and considered how the response could be

[80] National Service Guidelines for Developing Sexual Assault Referral Centres (SARCs) (October 2005) Home Office, Care Services Improvement Partnership, National Institute for Mental Health in England, Department of Health
[81] A Resource for Developing Sexual Assault Referral Centres (SARCs) (27 October 2009) Department of Health, Home Office and the Association of Chief Police Officers
[82] Department of Health (2010) Responding to violence against women and children- the role of the NHS. The Report of the Violence Against Women and Children Taskforce, London: DH
[83] The Stern Review A Report by Baroness Vivien Stern CBE of an independent review into how rape complaints are handled by public authorities in England and Wales (2010) Home Office and Government Equalities Office

improved so that more victims might report what had happened to them; more cases would end with prosecution and conviction; and victims would receive better treatment. **The report recommended that SARCs be put onto a firm basis as part of mainstream provision and expanded further in the future.** It also recommended that every victim who so wishes should be supported by an Independent Sexual Violence Advisor.

- **Call to End Violence against Women and Girls (2010)[84]** – This is a Cross-Government Action Plan on Sexual Violence and Abuse, which brought together all the work to address all aspects of sexual violence and set out the roles and responsibilities of key agencies. It focused on the further value that Government could add on preventing violence and challenging attitudes and behaviours; providing support for those who have experienced sexual violence; working in partnership with public bodies and community groups; reducing the risk to women and girls and bringing perpetrators to justice. The Action Plan[85] affirmed the role of SARCs in making healthcare, including forensic examination choices and the criminal justice system more accessible to those who have experienced sexual violence.

- **Transfer of Commissioning Responsibility from the Police to the NHS (2011)[86]** - This evidence base report supported the Impact Assessment that emerged from a feasibility study carried out between September 2010 and February 2011. The Impact Assessment proposed that funding and commissioning responsibility for forensic examinations for sexual offences work should transfer from the police to the NHS, with improved quality standards.

- **Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence (CAHVIO) (2012)** - The obligation to provide accessible and integrated services to victims of sexual violence is affirmed in Articles 24 and 25 of the Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence (CAHVIO). The UK Government became a signatory of the Convention in June 2012 and is obliged to observe other international obligations to take actions to mitigate violence against women and children, including the United Nations Conventions on the Rights of the Child (UNCRC) and on the Elimination of all Forms of Discrimination against Women (CEDAW). These are also reflected in the Government's strategy, Call to end Violence against Women and Girls.

- **Victims' Services Commissioning Framework (2013)[87]** – The development of this commissioning framework forms part of the commitment the Government made in the consultation Getting it right for victims and witnesses to provide a

[84] Call to End Violence against Women and Girls (November 2010) HM Government
[85] A Call to End Violence against Women and Girls Action Plan 2013 (March 2013) HM Government
[86] Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS: Evidence Base to Support the Impact Assessment (March 2011) Tessa Crilly, Gill Combes & Deborah Davidson: University of Birmingham; Olivia Joyner & Shaun Doidge: Tavistock Institute
[87] Victims' Services Commissioning Framework (May 2013) Ministry of Justice

systematic framework for commissioners of victims' services. The framework has a number of purposes: to help provide clarity about securing outcomes for victims; to establish performance monitoring so that commissioners can be held to account by the public for the funding decisions they have made while providers will be accountable to commissioners for the services they are providing; and overall to provide advice and information on commissioning to those involved with victims' services.

- **Child sexual exploitation and the response to localised grooming (2013)[88] -** The Home Affairs Committee published their original report *Child sexual exploitation and the response to localised grooming* on 10 June 2013. The Committee made 36 recommendations for the Government to consider. This document set out the Government's approach to tackling child sexual exploitation together with the response to each of the Committee's recommendations.

- **Health Working Report on Child Sexual Exploitation (2014)[89]** – This report was produced by an independent group chaired by the Department of Health. It focuses on improving the outcomes for children by promoting effective engagement of health services and staff. The report responds to the commitment in the Tackling Child Sexual Exploitation Action Plan 2011, that the *"Department of Health, as part of its work programme on violence against women and children, will work with its partners to see whether more can be done to highlight the particular needs of children who have been sexually exploited."*

- **Child Protection All Party Parliamentary Group (APPG) (2014)[90]** – The APPG was concerned that children were not receiving the support they needed and opportunities to prevent problems occurring in the future were being missed. The APPG has therefore outlined six key recommendations for the Government, to bring the focus back to all aspects of sexual abuse, and to promote a clear and consistent approach to protecting children and young people. This is set in the context of greater inter-ministerial working which sets action plans for all areas of sexual abuse to ensure that every child who has experienced sexual abuse gets the support they need.

- **Sexual Violence against Children and Vulnerable People National Group (2015)** - Following the Savile case and other high profile cases, the Government established a programme of work through this National Group to prevent sexual abuse happening in the first place; to protect children online; to make sure the

[88] Child sexual exploitation and the response to localised grooming. The Government response to the second report from the Home Affairs Committee Session 2013-2014 HC 68 (September 2013) Presented to Parliament by the Secretary of State for the Home Department by Command of Her Majesty

[89] Health Working Group Report on Child Sexual Exploitation. An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff Executive Summary (January 2014)

[90] Child Protection All Party Parliamentary Group Seminar Series on Child Sexual Abuse. Recommendations for the prevention of child sexual abuse and better support for victims (April 2014) NSPCC

police can identify and deal with abuse; and ensure victims are at the heart of the criminal justice system. The work of this National Group links in with the broader agenda on violence against women and girls. In March 2015, the Government published a report on its work over the past five years[91].

- **Cross Government Child Sexual Abuse (CSA) Directors' Group (2015)** In March 2015, the Home Office established the CSA Directors' Group which is looking to create a whole system cross-government strategy. The Government Departments involved in include the Crown Prosecution Service (CPS), Ministry of Justice (MoJ), Home Office, Department for Education (DfE), Department of Health (DH) and Department of Communities and Local Government. The Group has commissioned work within each Department, with the following three main areas of focus:

    - Aggregating research to demonstrate what works across the spectrum of abusers and victims - to prevent abuse, build resilience and stop perpetrators;

    - Mapping the system across health, local government, children's services, education, the voluntary sector, the police, prosecutors and criminal justice system. Seeking to identify costs and levers at every stage;

    - What could be done to create a central engine to produce tangible change focusing on reducing abuse and supporting victims and their families? The aim is to help understand the key intervention points, costs and numbers of child sexual abuse cases. Clear common aspirations have emerged from this work to date: focusing more on upstream interventions – preventing abuse before the harm is done; taking a multi-agency, multi-disciplinary approach at every level; efforts to improve the quality of frontline practice; and building the evidence of what works through research, analysis, pilots, evaluations.

- **The Goddard Inquiry (2015)** - Justice Lowell Goddard was appointed to Chair the Independent Panel Inquiry into Child Sexual Abuse. The statutory Inquiry into Child Sexual Abuse has been set up to consider whether, and the extent to which, public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse in England and Wales.

- **Commissioning Framework for Adult and Paediatric SARC Services (2015)[92]** - This document is primarily for commissioners of SARC services and aims to summarise the key deliverables for sexual assault services that all stakeholders and partners including NHS England are encouraged to deliver across the care pathway.

Management of Victims: Health implications of sexual assault and violence

[91] A Call to End Violence against Women and Girls Progress Report 2010 – 15 (March 2015) HM Government
[92] Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services (10 August 2015) NHS England

11.3 In the aftermath of a rape or sexual assault victims and their families and carers have a number of main care needs:

Safeguarding including possible place of safety – Medical – Forensic - Social - Psychological - Legal

Risk Factors associated with Sexual Assault and Exploitation of children and young people [93]

11.4 NHS England in their Commissioning Framework clearly state the risk factors for Children and Young People, these include:

- Parental or carer drug or alcohol abuse.
- Parental or carer mental ill health.
- Intra-familial violence or history of violent offending.
- Parent with learning difficulties.
- Previous child maltreatment in members of the family.
- Known maltreatment of animals by the parent or carer.
- Vulnerable and unsupported parents or carers.
- Pre-existing disability in the child, including learning disability.

Crime and Forensic guidance

11.5 The CPS has produced legal guidance[94] to support Crown Prosecutors. In cases of rape and sexual offences the guidance sets out the roles of forensic, scientific and medical evidence. The guidance focuses on the role of forensic physicians, the collection of forensic evidence and physical evidence from the scene. It states that the forensic medical examination should take place with informed consent once urgent medical treatment has been administered. The role of the forensic physician (FP) is both therapeutic and forensic and ideally the FP should ensure appropriate treatment for any injuries, arrange screening for sexually transmitted infections as appropriate, and consider and prescribe emergency contraception and post-exposure prophylaxis (if necessary). In addition, the FP should conduct a top to toe forensic examination and record all injuries, however minor, and other findings on a detailed body chart and in note form using correct medical terminology.

11.6 With respect to forensic evidence the guidance offers clear parameters:

- Ensure the Police are aware of the need to preserve the evidence and avoiding cross-contamination, particularly where there is a named suspect for the offence
- Forensic examination of damage to clothing may provide support for whether or not sexual activity was non-consensual
- Body fluids, DNA, fibres, hairs, lubricants, toxicology, marks and traces are all capable of revealing useful evidence

[93] NHS England: Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres (SARC) Services. August 2015

[94] http://www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/consent/

- Due to the rapid development of new forensic techniques and scientific methods advice/training from forensic providers should be sought to ensure nothing is missed
- The forensic provider needs to receive copies of medical examination papers including body diagrams of victim and suspect where appropriate

11.7 Guidance is also set for managing the physical evidence from the scene. It is good practice for prosecutors to be involved in compiling the forensic strategy. Exhibits or samples sent for examination should be accompanied by a summary of the victim and suspect interviews. This will assist scientists to understand the sequence of events even before full statements or interview summaries are available.

Revised Protocol between the Police Service and Crown Prosecution Service in the Investigation and Prosecution of Allegations of Rape 2015[95]

11.8 In 2008 the first joint protocol for investigating and prosecuting rape set out a framework for the Police and CPS to work in partnership and this edition recognises further developments including the introduction of dedicated CPS Rape and Serious Sexual Offences (RASSO) Units across the CPS. The objectives of this protocol are to reflect National Police and CPS policy, to achieve improved and consistent performance in the investigation and prosecution of rape and to improve the service to victims of rape and increase public confidence in the Police and CPS.

11.9 The protocol states that the Police will appoint a Rape Champion and the CPS will appoint a RASSO Unit Head who together can ensure coordination between the agencies. Early investigative advice, or consultation, between the police and the CPS is regarded as essential in rape cases and is a requirement of the Director's Guidance on Charging[96].

Safeguarding

11.10 The Children Act 2004 places a duty on every Local Authority to establish a Local Safeguarding Children Board (LSCB). The Government's Statutory Guidance, Working Together to Safeguard Children (2015) defines safeguarding and promoting the welfare of children as: Protecting children from maltreatment; Preventing impairment of children's health or development; Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; Taking action to enable all children have the best life chances.

Commissioning Guidance[97]

11.11 Key consideration in designing service response to young people include:

- Specific consideration of capacity and consent is required for children and young people.

[95] Protocol between Police Service and CPS in the Investigation and Prosecution of Allegations of Rape (Jan 2015)

[96] The Director's Guidance On Charging 2013 - fifth edition, May 2013 (revised arrangements)

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

- Confidentiality and autonomy can require careful negotiation between the child or young person, family and safeguarding requirements.
- Their safety is of paramount importance

11.12 Key Service model, care pathway and quality issues

- The service model recommended is of a SARC "hub" serving a number of authorities, linked through clear referral pathways and managed clinical networks to a range of local "spoke" services.
- The model and pathways need to reflect local needs assessments and encompass both immediate and longer term assessment, treatment and support and liaison with other agencies.
- Paediatric SARCs have an important educational role, promoting awareness of the signs and symptoms of sexual assault and of the services available and how others can refer in as victims can present in many settings.
- Important dimensions of quality include patient experience as well as the timely availability of appropriate expertise.

Children's Commissioner: Protecting Children from Harm; A critical Assessment of child sexual abuse in the family network in England and priorities for action.[98]

11.13 In July 2014, the Children's Commissioner launched an Inquiry into child sexual abuse in the family environment. Based on data examined by the Commissioner, it is likely that only 1 in 8 victims of sexual abuse come to the attention of the police and children's services. Up to two thirds of all sexual abuse happens in and around the family. Our evidence shows that children are sexually abused from a very young age, but most victims do not come to the attention of the police or children's services until they reach adolescence. Accessing help from the police and children's services is largely dependent on a child telling someone that they have been abused, but evidence examined by the Commissioner clearly demonstrates that most victims of sexual abuse in the family do not report it until they have the knowledge to recognise abuse and the words to describe it.

11.14 The Commissioner established a series of recommendations:

- A National Strategy for the prevention of child sexual abuse, in all its forms
- That the Government explores how to strengthen the statutory responsibilities of organisations and professionals working with children, to ensure that all professionals work together more effectively to identify abuse
- That the Government recognises the importance of and coordinates all sources of support for children and families where there is a particular risk of sexual abuse, to ensure that victims are more effectively identified and targeted
- That all schools equip all children, through compulsory lessons for life, to understand healthy and safe relationships and to talk to an appropriate adult if they are worried about abuse.
- That all schools take the necessary steps to implement a whole-school approach to child protection, where all school staff can identify the signs and symptoms of

[98] http://www.childrenscommissioner.gov.uk/sites/default/files/publications/Protecting children from harm - executive summary_0.pdf

abuse, and are equipped with the knowledge and support to respond effectively to disclosures of abuse.

- That all teachers in all schools are trained and supported to understand the signs and symptoms of child sexual abuse.
- That all Achieving Best Evidence interviews are undertaken in the presence of an intermediary or a suitably qualified child psychologist, and that appropriate provision for this is made by the Ministry of Justice and police forces.
- That, from the moment of initial disclosure, children receive a holistic package of support, tailored to their needs, including therapeutic support to help them recover from their experiences
- That Government reviews the process of inter-agency investigation of child sexual abuse, including the role of the police and children's social workers, to ensure that the process minimises the potential for re-traumatisation, whilst maximising the possibility of substantiating abuse and taking effective protective action and taking the views of the child into account.
- That the Home Office amend and update the Annual Data Requirement to ensure that all police forces record this aspect of child sexual abuse-related crimes
- That children and young people with harmful sexual behaviour receive proportionate and timely intervention to reduce the risk of this behaviour continuing into adulthood