Commissioning Brief
16/117 – The effectiveness of Sexual Assault Referral Centres (SARCs)
Closing date: 12 January 2017 (two stage – outline to full)

1. Remit of this call

This call is concerned with the assessment of the effectiveness of Sexual Assault Referral Centres (SARCs): these centres provide one-stop integrated clinical and forensic medical examination services, responding to the medical and psychological effects of recent and non-recent rape and sexual assault, limiting the health consequences and empowering victims to take back control. In particular, this call looks to assess the differences in models of delivery, interventions and outcomes, as well as differences between the treatment of recent and less recent cases and between adults and minors. Only health and health service outcomes are of interest; prosecution rates and associated measures are out of remit. This call is limited to SARCs in England, but could include comparison and learning from other countries in the UK and internationally.

As the number of centres has risen from three in the 1990s to 43 currently, with further services also providing some elements of SARC services, there is now a sufficiently large evidence base to permit new research to focus entirely on the impact and outcomes of SARC interventions and delivery models. SARCs models vary; from those provided within hospital services, community services, and on a hub and spoke model. Some services, particularly counselling, are provided by specialist third sector charities, and Victim Support and Independent Sexual Violence Advisers (ISVAs) provide services in the criminal justice system. SARCs mainly provide services for those above 11-13 years but there is local variation. Younger children are mainly seen in paediatric services and on a regional basis, with a Nordic model (Child House) being implemented in two centres in London and one in Durham.

Research required

Particular areas have been identified as priority areas of research need; whilst applicants may wish to address more than one area in their proposal, these are the only topics in remit of this call:

i) What comparative evidence on SARCs is available from an evidence review? There is not a current and comprehensive review which brings together all of the evidence to date. An evidence synthesis of international research may provide evidence as to which intervention/models work best for which service users (age, gender), in response to what circumstances (recent or non-recent sexual assault and rape) and under what conditions (size of centre, access, in-house services, workforce, linked services). This could include the gains or losses in not providing an integrated service in terms of crisis management, medical care, and forensic consultation, independent sexual violence advisory support and advocacy, and any subsequent psychological therapy. The call is open to a range of review methods.

ii) What are the most effective health interventions delivered via SARCs, compared to other models which may rely on mainstream public health services (sexual health, Genito-Urinary Medicine, drugs and alcohol) and NHS services (e.g. Emergency Departments), and how does this vary between children and adults? What are the health benefits for survivors of non-recent[1] child sexual abuse (CSA) to attend a SARC compared to alternative services? Despite a national commissioning framework, there is known to be variation in the scope of provision, the role of the third sector in specialist rape and sexual assault, and of the role of GUM and Mental Health services. New forms of service model are being tested for child-focused services. Effectiveness may be user-centred, e.g.; physical and sexual health, mental health, well-being and resilience, user and family defined outcomes, or service-centred, e.g.; cost-effectiveness, staff roles, efficient transition to mainstream services.

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[1]***Non –Recent*** *refers to those outside the 7 day period where forensic evidence post sexual assault is possible. Although often referring to much longer time periods, the term "historic" is a term many survivors' organisations believe is less acceptable*

iii) What psychological interventions do SARCs and child specific services undertake directly or refer on to mainstream services, and are post crisis trauma-focused interventions best provided by specialist third sector providers or by mainstream mental health services? Research might use contrasting case studies of services (including the perspectives of service providers, users and commissioners, the health outcomes, cost to commissioners, and safety of services) to provide prospective evaluation of promising models.

iv) How can commissioning the voluntary sector to provide services, within SARCs and as alternatives to mainstream provision, be improved? It is known that some centres have extensive links to third sector support organisations that may provide on-going counselling and similar services, or the SARC itself may be run by voluntary staff. The impact of this organisational model on health service, health and user-centred outcomes is of interest. Third sector provision is well regarded by survivors, but may pose challenges for commissioners compared to mainstream providers. Similarly, the voluntary sector may face particular challenges in meeting these requirements. For example, it would be of interest to understand the circumstances, including how services can be funded, in which the third sector might provide trauma-focussed IAPT services for sexual abuse and rape survivors.

v) How can self-referral and equality of access to SARCs be improved? SARCs are estimated to serve only 20% of those who might be eligible for SARC services, and use is proportionately lower by BME and LGBT groups. Research using for example social marketing and communication theories to develop and evaluate interventions to improve potential access to SARCs would be of interest.

vi) Workforce: What are the contributions of specialist professionals in SARCs to health outcomes, how can the roles be developed and assurance be provided for safe practice, and what are the costs and benefits of these roles? Research is needed to ascertain the comparative contributions of forensic medical examiners and nurse forensic practitioners, and the training and clinical governance requirements for their safe practice. It is important to evaluate if there are discernible impacts on outcomes and costs within the co-commissioned services. Similarly, it is important for service commissioners to have evidence of the contribution of ISVAs to patients' health outcomes, ISVAs' training needs, and how safe practice might be assured.

2. Scope

Primary and secondary research is required to look at how well the SARC model is working across the 43 SARCs in England, and how this may vary according to the age and gender of the user. SARCs are known to provide care for children over the age of 13, but might also care for younger children. Since children and adults who have been subjected to sexual assault will require immediate medical attention as well as on-going or long-term emotional support, effective access and transition to relevant health services from a SARC is an important factor and a welcome focus for this call. Variation in the staffing of, and delivery of care in centres is also of interest, by whom and when, and how this affects outcomes for the centre-user. This includes the role of third sector organisations providing this care in and alongside SARCs.

In recent years there has been an increase in the reporting of sexual assaults that occurred many years ago, often in childhood or adolescence, and therefore provision within SARCs may need to assist these adults, as well as people who have been assaulted recently. This provision by SARCs, and alternatives to SARCs, is within the scope of this call, including whether SARCs or other models such as in the third sector, or new models combining with public health services such as open sexual health clinics, GUM clinics or A&E departments, are the most effective service models.
Teams are advised to both consult and include as co-applicants or advisers the NHS and third sector providers, commissioners of health and social care services, and users of services in their proposals.

3. Purpose of call

NHS England are the co-commissioners of SARCs with Police and Crime Commissioners. CCGs have responsibility for the commissioning of long-term therapeutic care for people with mental health issues. Such commissioning models are always subject to review to ensure that the best model is utilised to get the best outcome for patients. Research that establishes what form of provision works best for immediate and long term health outcomes, for which client group, in what circumstances, to inform

future commissioning and service improvement, is therefore of importance in England and in other countries of the UK.

4. Notes to Applicants

The NIHR Health Services and Delivery Research (HS&DR) programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes in order to improve health and health services. It is focused on research to support decisions by frontline managers and clinical leaders on the appropriateness, quality and cost-effectiveness of care.

The NIHR HS&DR programme is funded by the NIHR, with contributions from Health and Care Research Wales, the HSC R&D Division, Public Health Agency in Northern Ireland, and case by case contributions from the CSO in Scotland.

The programme operates two funding streams; researcher-led and commissioned. Researchers in England, Wales and Northern Ireland are eligible to apply for funding from either workstream under this programme. Researchers in Scotland may apply to the researcher-led workstream but are not eligible to respond to the commissioned workstream and should contact the CSO to discuss funding opportunities for healthcare delivery-type research.

5. Application process and timetable

Please ensure you have read the supporting documents and application guidance notes provided to support this call.
Should you have any questions or require any further clarification please refer to the NETSCC FAQs at HS&DR programme - FAQs; if the answer to your question cannot be found please email your query to hsdrinfo@soton.ac.uk with the title for the call for proposals as the email header. Applicants should be aware that while every effort will be made to respond to enquiries in a timely fashion, **these should be received at least two weeks before the call closing date.**

The process of commissioning will be in **two stages** and applicants should submit **outline proposals** via the HS&DR website by **1pm on 12 January 2017**. All proposals will initially be checked for remit and competitiveness[1]. No late proposals will be considered. No paper-based only submissions will be considered.

Applicants will be notified of the outcome of their outline application in late April 2017.

Shortlisted applicants will be invited to submit a full proposal via the HS&DR website (a link will be sent to shortlisted applicants). Applicants will be notified of the outcome of their full proposal application in late October 2017. Please note that these dates may be subject to change.

Transparency agenda

In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at:

http://transparency.number10.gov.uk/
http://www.ogc.gov.uk/policy_and_standards_framework_transparency.asp
http://www.contractsfinder.businesslink.gov.uk/

[1] '***Non-Competitive***' means that a proposal is not of a *sufficiently high* standard to be taken forward for further assessment in comparison with other proposals received and funded by the HS&DR programme because it has little or no realistic prospect of funding. This may be because of scientific quality, cost, scale/duration, or the makeup of the project team.