

## PFCC Decision Report

Please ensure all sections below are completed

<b>Report reference number: PCC059/18</b>
<b>Classification</b> Not protectively marked
<b>Title of report:</b> Talking Therapies funding
<b>Area of County/Stakeholders affected:</b> Countywide
<b>Report by :</b> Greg Myddelton
<b>Date of report:</b> 26 <sup>th</sup> April 2018
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**1. Purpose of report**

- 1.1. To approve the allocation of a 'pass-ported' grant from NHS England to Southend-on-Sea Rape Crisis Centre (SoSRC) for the delivery of a talking therapies pilot service to victims of rape and sexual abuse

**2. Recommendations**

- 2.1. Approve the pass-ported of a £72,500 grant from NHS England to Southend-on-Sea Rape Crisis Centre (SoSRC) to deliver a talking therapies service for victims of sexual abuse.

**3. Benefits of Proposal**

- 3.1. This pilot service is intended to;
- provide immediate and short term psychological interventions to support male and female adults and children in the immediate aftermath of a sexual offence, whether the incident is subject to criminal justice proceedings, or not. The pilot service is for victims and survivors who have disclosed within the last 12 months.
  - support improved mental health outcomes through early access to talking therapies promoting stabilisation, safety and recovery.
- 3.2. The service will align with, and complement, the PFCC-commissioned ISVA and community based sexual abuse support services

**4. Background and proposal**

- 4.1. NHS England East of England Team is responsible for commissioning the public health services elements of Sexual Assault Referral Services (SARS), and the co-commissioning of services within the wider Sexual Assault Services (SAS)

pathway. NHS England is piloting a 2-year talking therapies service across the Eastern region.

- 4.2. The expected maximum number of treatment sessions delivered in Essex is 2,400 in Year one of the pilot. The service provider will need to achieve the identified quality standards in order for the funding to be released for Year Two of the pilot following agreement with NHS England.

**5. Police and Crime Plan**

- 5.1. This grant ensures that victims are given the chance to cope and recover from their experience, and have the support needed to engage in the criminal justice system, where appropriate.
- 5.2. This grant will ensure that vulnerable adults and children are protected from harm.

**6. Police Operational Implications**

- 6.1. There are no direct operational implications of this new service for Essex Police.

**7. Financial Implications**

- 7.1. The PFCC will 'passport' a £72,500 grant from NHS England to Southend-on-Sea Rape Crisis Centre.

**8. Legal Implications**

- 8.1. This funding will be transferred to Essex PFCC under the existing Sexual Abuse collaboration agreement between NHS England and PFCC

**9. Staffing and other resource implications**

- 9.1. Employment of staff or sessional workers will be the responsibility of CARA. No liabilities will be placed on the PFCC as a result of this grant funding.

**10. Equality and Diversity implications**

- 10.1. There are no direct equality and diversity implications.

**11. Background documents**



NHSE Talking  
Therapies Pilot Service

- 11.1.



**Decision and Final Sign Off**

I agree the recommendations to this report;

Sign: ..... *[Handwritten Signature]* .....

Print: ..... *R. C. Hines* .....

**PFCC/Deputy PFCC**

Date signed: ..... *2/5/18* .....

I do not agree the recommendations to this report because;

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.....  
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Sign: .....

Print: .....

**PFCC/Deputy PFCC**

Date signed: .....

<b>Service Specification No.</b>	2017SARC001P
<b>Service</b>	Talking Therapy Services Local Pilot – Sexual Assault Referral Services
<b>Commissioner Lead</b>	NHS England
<b>Provider Lead</b>	Synergy Essex Rape Crisis Partnership
<b>Period</b>	This is a 2 Year Pilot
<b>Date of Review</b>	End of Year One

## 1. Population Needs

### National/local context and evidence base

NHS England East of England Team is responsible for commissioning the public health services elements of Sexual Assault Referral Services (SARS), and the co-commissioning of services within the wider Sexual Assault Services (SAS) pathway.

There are currently 6 Sexual Assault Referral Services across the East of England region. They are located within each of the police force areas that make up the East of England.

- Bedfordshire (The Emerald Centre)
- Cambridgeshire (The Elms)
- Norfolk (The Harbour Centre)
- Suffolk (The Ferns)
- Essex (Oakwood Place)
- Hertfordshire (The Sunflower Centre).

The pathway for each individual service user will commence from the point at which they are referred to the Sexual Assault Referral Service or present themselves. For adults this may be via a self-referral, police referral or referral made by another professional, while for children and young people it will be through a safeguarding referral to social services or the police.

Sexual Assault Referral Services should provide around the clock support to victims of sexual assault and rape, including health care and onward referral to other health and social care services. They should deliver services to both acute and non-acute survivors and offer the opportunity to assist in a police investigation if the survivor so chooses. The services provided are:

- Crisis care
- Forensic medical examinations
- Health care that includes emergency contraception, Post-Exposure Prophylaxis after Sexual Exposure (PEPSE), testing for sexually transmitted infections
- Access to Independent Sexual Assault Advisor (ISVA) support
- Referral for psychological therapies including pre-trial and post-trial therapy and specialist sexual violence support, including advocacy.

Talking therapies have not previously commissioned as part of the Sexual Assault Referral Services for survivors who wish to access support in the period after the incident(s). It is expected that survivors would access such services within their own communities on referral from a GP.

Despite this expectation it is believed that a significant proportion of survivors do not access such services. This may be because they do not wish to disclose the matter to their GP, or because there is pressure on services, or because services specific to this need have not been commissioned (or other reasons).

Additionally, consultation with Sexual Assault Referral Services and specialist sexual violence service providers on the existing pathways reported significant waiting lists of between two and six months for talking therapies, indicating a true demand for these services. While local Improving Access to Psychological Therapies (IAPT) services may achieve shorter waiting times in accordance with national standards, national evidence suggests IAPT services will frequently refer clients to specialist sexual violence services rather than provide a service to them, since therapists working in IAPT services do not feel appropriately equipped to deal with victims of sexual violence, and their service is not appropriate to respond to this need.

NHS England Health and Justice Commissioners in the East of England Team propose to pilot direct access to short term psychological interventions and evaluate their utility to survivors before taking future commissioning decisions.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

<b>Domain 1</b>	<b>Preventing people from dying prematurely</b>	
<b>Domain 2</b>	<b>Enhancing quality of life for people with long-term conditions</b>	
<b>Domain 3</b>	<b>Helping people to recover from episodes of ill-health or following injury</b>	<b>x</b>
<b>Domain 4</b>	<b>Ensuring people have a positive experience of care</b>	<b>x</b>
<b>Domain 5</b>	<b>Treating and caring for people in safe environment and protecting them from avoidable harm</b>	<b>x</b>

## **2.2 Locally defined outcomes**

The Provider will collect and provide to commissioners the following key performance indicators (KPI), reporting them each quarter:

- I. Monitoring equality of access across protected characteristics
- II. Total number and proportion of clients assessed within 1 week of referral
- III. Total number and proportion of clients entering treatment (defined as a first therapeutic session) within 2 weeks of assessment
- IV. Total number and proportion of referrals entering treatment
- V. Total number and proportion of service users entering treatment who complete treatment
- VI. Total number and proportion of service users completing treatment
  - a) Adults with reliable improvement indicated by a decrease GAD7 by 4 or more points or PHQ9 by 6 or more points or IESR by 9 or more points.
  - b) Adults with no reliable deterioration indicated by either an increase of; GAD7 score by 4 or more, PHQ9 score by 6 or more, or IESR by 9 or more.
  - c) Children and Young People with reliable improvement indicated by a decrease in Revised Children's Anxiety and Depression Scale (RCADS) total by 16 or more points. N.B providers are not expected to use age adjustments available for this scale.
  - d) Children and Young People with no reliable deterioration indicated by an increase in Revised Children's Anxiety and Depression Scale (RCADS) total by 16 or more points. N.B providers are not expected to use age adjustments available for this scale.
- VII. Total number and proportion of service users completing treatment provided by same therapist.
- VIII. Total number and proportion of service users who complete treatment and provide 'Client feedback'
- IX. Total number and proportion of 'client feedback' provided that identify a 'positive' service was experienced by service user
- X. Total number and proportion of 'client feedback' that identify a negative service was experienced.

The Provider must have an appropriate way of capturing and reporting this each quarter.

### **3. About the Service**

#### **3.1 Aims & objectives of service**

To provide immediate and short term psychological interventions to support male and female adults and children in the immediate aftermath of a sexual offence, whether the incident is subject to criminal justice proceedings, or not. The pilot service is for victims and survivors who have disclosed within the last 12 months.

To support improved mental health outcomes through early access to talking therapies promoting stabilisation, safety and recovery.

#### **3.2 Service description/care pathway**

In delivering the service, the Provider must work with the providers of other services within the SARC, and particularly, the provider of the SARC service itself.

##### **Access**

Access to the talking therapy service will be via the Sexual Assault Referral Service only. The Provider will not accept referrals from any other source. It is acknowledged that not all survivors wish to use the services of a SARC, and there is no intention or expectation that all should or will. This limitation on access will be reviewed within the evaluation of the service, at its conclusion after 2 years.

##### **Assessment**

The Provider will ensure that waiting times are minimal, with assessment of the service user within a maximum 1 week of referral and interventions to commence within a maximum of 2 week after assessment. The timing of referral will be made according to the preferences of the survivor and their circumstances.

Assessment will include clinical measures; PHQ9, GAD7, Impact of Event (IES-R) for those over the age of 13 to determine the level of intervention to meet the service user's individual needs.

For children under the age of 13 the clinical measure that should be included at Assessment should be Revised Children's Anxiety and Depression Scale (RCADS) including sub-scales.

Assessment should also include a full risk and needs assessment of all children and adults to determine how best to deliver support to meet the individual's requirements. The outcome of the clinical measures and risk and needs assessment must be used to develop a bespoke plan of therapeutic support for the individual service user.

Review will take place after sessions 4, 8 and 12 have been delivered or by request of the therapist or clinical lead at any time.

- The purpose of review is to monitor the progress of the service users by
- Assessing clinical scores
- Monitoring Risk and Needs Assessments
- Agreeing continued support plan (and need to provide further sessions at session 4 and 8 only)
- Determining any onward referral needs



Each review will involve all therapists delivering the intervention for the service user and the Provider's clinical lead. Decisions taken and any agreed actions shall be recorded.

### **Onward Referral**

Where it is determined at assessment or review that an onward referral to another (more appropriate) agency is required in order to better meet the individual needs of the service user, continuity of care should be facilitated wherever possible. The Provider must give consideration to the transfer of information about the service user to reduce the risk of re-victimisation wherever possible. External integration and partnership working is important in sharing knowledge and information to facilitate a seamless and timely transfer to:

- ISVA Services - for emotional support, practical advice and assistance in accessing support for the criminal justice process and other services,
- Specialist Sexual Violence Services - for longer term therapeutic support, and advice about sexual violence.
- Specialist mental health services (such as Child and Adolescent Mental Health Services (CAMHS), Crisis Intervention Teams) - for clients presenting with severe and enduring mental health problems,
- IAPT services - for clients presenting with depression and anxiety disorders who would suit a generic (non-specialist sexual violence) mental health service.

The Provider will be required to identify, as far as they are able, any indications which survivors may show of having communication difficulties which could be supported through referral to speech and language therapy services. This is especially relevant for children and young people but could also be required by adults. Where such a need is identified, the provider must make an appropriate onward referral to a community speech and language therapy service. The Provider will then either continue with the course of therapy, or suspend it pending the initiation of speech and language therapy, and the decision regarding whether to continue will be informed by the survivor's preferences and by an assessment of the likely benefit of continuing before speech and language therapy has been initiated.

### **Choice**

The Provider should consider the service users' preferences for a particular therapist.

Interventions should be tailored to meet the needs of the service through ongoing assessment (including assessment) and regular review after session 4 and 8.

For adults, the Provider should deliver evidence-based interventions using trauma-informed integrative approaches. Interventions will include:

- Trauma-focused Cognitive Behavioural Therapy (CBT)
- Eye Movement Desensitisation and Remodelling (EMDR)
- Integrative or multi modal approach of therapy is best suited to meet the diverse needs of this client group
- Psycho-education to normalise reactions to abuse.

(Where any other form of counselling is offered by the service, the Provider must inform the service user that there is as yet no convincing evidence for a clinically important effect of this treatments on common mental health problems) .

For children and young people, the Provider will need to meet the short term practical and therapeutic needs of the child/young person's family following sexual violence. This could be done in liaison with a Child ISVA (within an integrated service).

The Provider must offer children and young people who have been sexually abused a course of psychological therapy adapted appropriately to suit their age, circumstances and level of development. Where appropriate, families should be involved in the treatment of children and young people.

The Provider should deliver evidence-based interventions using trauma-informed integrative approaches to children and young people. Interventions will include:

- Trauma-focused Cognitive Behavioural Therapy (CBT)
- Eye Movement Desensitisation and Remodelling (EMDR)
- Psycho-education to normalise reactions to abuse.

For younger children, interventions should include creative techniques and play-informed approaches. However, when considering treatments for children and young people, the Provider must inform parents and, where appropriate, children and young people, that, apart from trauma-focused psychological interventions (CBT and EMDR), there is at present no good evidence for the efficacy of widely-used forms of treatment for common mental health (depression, anxiety disorders and PTSD) such as play therapy, art therapy or family therapy or counselling.

### **Pre-Trial Therapy Considerations**

The Provider should ensure that all staff delivering psychological therapies are cognisant of, and adhere to, the current Crown Prosecution Service (CPS) Guidance relating to 'pre-trial therapy' as many of the service users will be involved in criminal proceedings (or may choose to report to the police at a later date).

The provider must ensure that all staff delivering psychological therapies to a service user whilst they are awaiting a court case could impact on the reliability, actual or perceived, of the evidence of the service user who is witness in the court proceedings. Therefore, it is crucial that all psychological therapists adhere to the current guidance in order to reduce the risk of allegations of coaching and, ultimately, the failure of the service user's criminal case. This may include avoiding reprocessing of material relating to the sexual assault itself, unless it is in the clients 'best interests' to do so.

Where the therapist believes it to be in the best interests of the individual service user to provide a therapeutic intervention that is not in line with the Pre-trial therapy guidance, the Provider will ensure that the rationale for this decision can be clearly articulated, documented and shared with the police and CPS where necessary. The Provider will ensure that any such decisions are taken with agreements from the service's clinical lead and not by individual therapists in isolation.

The Provider must ensure that all staff providing psychological therapies must keep contemporaneous notes relating to each individual service user. As the therapist may be called to court as a witness in relation to any therapy undertaken prior to a criminal trial, it is crucial that the Provider recognise their responsibilities and obligations relating to disclosure of notes as part of court proceedings.

The Provider should maintain and review clear policies around pre-trial therapy including disclosure of therapy notes.

### **Sessions**

For adults - The Provider will deliver a maximum of 12 sessions for adults.

The duration of trauma-focused psychological therapy for adults should normally be 8 –12 sessions, but where the treatment starts in the first month after the sexual assault, fewer sessions (according to NICE, about 5) may be sufficient. However, review of clinical scores must be used to determine the number of sessions required for each service user.

Treatment should be regular and delivered at least once a week. Treatment should be delivered by the same therapist.

For children and young people - the Provider will deliver a maximum of 12 sessions children and young people. The duration of trauma-focused psychological treatment for children and young people should normally be 8–12 sessions.

Treatment should be regular and delivered at a frequency of no less than every 2 weeks (to facilitate normal school and family life alongside the therapeutic work). Treatment should be delivered by the same person.

Involving a non-abusing parent in therapy is associated with an improved outcome for children and the Provider will ensure that parents are able to be involved in the sessions if appropriate.

### **Measurement**

The Provider will ensure that for each service user over the age of 13:

At assessment, there are measures of

- PHQ9/GAD7
- Risk and Needs Assessment

At the beginning of the course of treatment, there are measures of:

- PHQ9/GAD7
- Risk and Needs Assessment

At each session, there are measures of:

- PHQ9/GAD7
- Risk and Needs Assessment

At conclusion of the course of treatment, there are measures of:

- PHQ9/GAD7
- Client feedback

The Provider will ensure that for each service user under the age of 13:

At assessment, there are measures of

- Revised Children's Anxiety and Depression Scale (RCADS)
- Risk and Needs Assessment

At each Session, there are measures of:

- Risk and Needs Assessment
- Revised Children's Anxiety and Depression Scale (RCADS) subscales

At conclusion of support, there are measures of:

- Revised Children's Anxiety and Depression Scale (RCADS)
- Client (and non-abusing parent) feedback.

### **Workforce**

The Provider must ensure that all their staff have appropriate DBS Clearance that are recorded and reviewed by the Provider. These should be available for inspection on request from Commissioners.

All therapeutic staff should be fully qualified with relevant post-qualification experience of working with people who have experienced sexual violence.

All therapeutic staff should have relevant post-qualification experience of working with the age range that they will support.

All therapeutic staff should be accredited members of the appropriate professional body for the intervention they deliver (such as BACP or BABCP). Registration only will not be sufficient.

The provider must ensure that volunteers or therapists-in-training will not deliver any therapeutic interventions to any service users.

The provider will ensure that appropriate clinical supervision arrangements will be in place for all therapeutic staff to prevent vicarious trauma and promote a resilient workforce.

The provider will ensure that appropriate management supervision arrangements will be in place for all staff, and will produce records of supervision on request.

### **3.3 Population covered**

The population will be those covered by the identified Sexual Assault Referral Service located in each police force area; Bedfordshire (The Emerald Centre), Cambridgeshire (The Elms), Norfolk (The Harbour Centre), Suffolk (The Ferns), Essex (Oakwood Place), Hertfordshire (The Sunflower Centre).

### **3.4 Any acceptance and exclusion criteria and thresholds**

The talking therapy service will accept referrals for all adults and children who have disclosed and attended the Sexual Assault Referral Service within the previous 12 months, whether the incident is subject to criminal justice proceedings, or not. The service does not respond to the needs of those who have experienced sexual assault at other times in their lives.

The talking therapy services will not apply any exclusion criteria for assessment. However, following initial assessment where the adult or child does not consent to receive a talking therapy service, it will be acceptable not to provide any therapeutic service.

Following assessment or review, where the Provider considers the needs of the individual service user are better met by another service, a referral can be made and it will be acceptable not to provide any therapeutic service (at referral) or not to continue to provide a therapeutic services (at review). Decisions should be documented.

### **3.5 Interdependence with other services/providers**

The provider will demonstrate integration and pathways to facilitate referrals to

- ISVA services
- Specialists Sexual Violence Providers for longer term support or advocacy
- Specialist Mental Health Providers (such as CAMHS and Crisis Intervention Team)
- IAPT services
- Primary Care
- Police
- Crown Prosecution Service

## **4. Applicable Service Standards**

### **4.1 Applicable national standards (eg NICE)**

- NICE Guidance Post Traumatic Stress Disorder
- NICE Guidance Anxiety
- NICE Guidance Depression

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

- BACP Ethical Framework or equivalent professional body
- CPS Pre Trial therapy guidance

## 5. Quality Standards

### 5.1 Applicable Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Staff will have documented Clinical Supervision on a monthly basis.	100%	Locally defined reporting / Provider report	The pilot will end at Year One
Therapies provided will be compliant with the Service Specification	100%	Locally defined reporting / Provider report	The pilot will end at Year One
Number of clients assessed within 1 week of referral	90%	Locally defined reporting / Provider report	The pilot will end at Year One
Number of clients entering treatment within 2 weeks of referral	90%	Locally defined reporting / Provider report	The pilot will end at Year One
Adults with reliable improvement indicated by a decrease GAD7 by 4 or more points or PHQ9 by 6 or more points or IESR by 9 or more points	75%	Locally defined reporting / Provider report	The pilot will end at Year One
Provider is fully compliant with NHS England Serious Incident policy and process, as amended from time to time	100%	Locally defined reporting / Provider report	The pilot will end at Year One
Reporting requirements will be fully submitted in line with contractual requirements	100%	Locally defined reporting template	The pilot will end at Year One

### 5.2 Applicable CQUIN goals

None

## 6. Location of Service Provision

The Provider should consider co-locating with the Sexual Assault Referral Service to facilitate access for users of the SARS. However, consideration should be given to the possibility that service users may not wish to return to the SARS, particularly those who accessed the service in the immediate aftermath of a sexual assault. For those who do not wish to return to the SARS, if possible, a range of alternative locations in the community, which can be easily accessed, should be made available for the talking therapy service.

The Provider should locate the service to promote equality of access across the identified Sexual Assault Referral Service area and facilitate access across protected characteristics.

## **7. Service Activity & Funding**

To ensure funding is equitable, each county will receive a flat amount of £72,500 in Year One to initiate the pilot. The service provider will accept referrals for all adults and children who have accepted the offer of a course of talking therapy and have disclosed and attended the Sexual Assault Referral Service within the previous 12 months, whether the incident is subject to criminal justice proceedings, or not. The service provider will deliver a maximum 12 sessions for all adults and children.

The service provider is not required to deliver a service for those who have experienced sexual assault at other times in their lives. In Year One there will be no other minimum required number of referrals, assessments or sessions in order to prevent service providers being penalised if uptake is low. The expected maximum number of treatment sessions delivered per county is 2,400 in Year One. The service provider will need to achieve the quality standards outlined in section 5.1. Provided these quality standards are met throughout Year One of the pilot then the service provider can continue to Year Two of the pilot following agreement with NHS England.

