G4S Health Services (UK) Limited

South West SOE Service

Inspection report

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Overall summary

We carried out this announced inspection on 5th and 6th of April and the 12th April 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector, eight team inspectors and supported by a specialist professional advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for patients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

Are services effective?

Summary of findings

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

The South West (SW) Sexual Offence Examiners (SOE) service provides forensic medical examiners and forensic nurse examiners to six Sexual Assault Referral Centres (SARCs) across the South West of England. The SARCs are based within:

- Exeter
- Truro
- Plymouth
- Gloucester
- Bristol
- Swindon

The Police and Crime Commissioner commissions the SW SOE Service. The service is available 24 hours a day, seven days a week (including public holidays) to provide advice to police, agencies and the public. The service delivers acute forensic examinations and provides support following recent sexual assault and sexual violence. The G4S service is commissioned to see adults and children 24 hours a day, seven days a week. During working hours there are separate services working alongside G4S that are commissioned to see Children under 18 within working hours and some limited hours over weekend days. These separate services provide telephone advice for Children under 18 years 24 hours a day, seven days a week..

For the purpose of this inspection we inspected the South West SOE provision of doctors and nurses (who will be referred to as SOEs throughout the report) to perform forensic medical examinations only, and not the activity or staff that were based within the SARCs as the SARC staff were employed by different providers.

At the time of inspection there was a regional clinical lead doctor, 12 doctors (including four in the shadowing process) and 26 nurses (with four also in the shadowing process) across the SW SOE service providing forensic medical examinations. The regional clinical lead was a member of the Faculty of Forensic and Legal Medicine (FFLM) and five doctors had obtained membership by examination (MFFLM) of the FFLM and one nurse had completed the FFLM licentiate examination.

All six of the SARCs were situated in buildings that were accessible for wheelchair users, with disabled parking spaces provided outside. Lifts were available where the SARCs were not situated on one level. All SARCs contained discreet entrances. Some of the SARCs had one forensic examination area where others had two. All had separate forensic

Summary of findings

bathrooms with a toilet and shower. All had appropriate environments for the age range of patients who used the six SARC sites. In the Bristol SARC there was a separate room from those provided for adults, for children under 18 years old to receive their examinations. In Exeter SARC there was a separate room from the acute forensic room where children under 18 years old attending historic clinics, are examined separately.

During the inspection we spoke with the registered manager who is also the regional clinical lead, 21 SOEs (three of which were lead nurses for their area) two crisis workers and two SARC managers employed by external providers. We also spoke with a commissioner who commissions the SARCs but not the SW SOE Service. We also reviewed policies, reports and examined 45 patient records to learn about how the provider managed the service.

We left comment cards at each of the six locations the week prior to our visit and received six completed feedback cards.

G4S provide the forensic medical service, and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager for the SW SOE Service was the regional clinical lead for the provider.

Before we inspected the SW SOE Service, the provider informed us the contract to provide forensic medical examinations was due to end on 31st September 2022, and the provider would no longer be providing SOEs to perform forensic medical examinations from that date onwards.

Throughout this report we have used the term 'patients' to describe people who use the service to reflect our inspection of the clinical aspects of the SARC.

Our key findings were:

- The SOEs had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children. However, the SOEs did not always follow up safeguarding referrals to ensure the patients were appropriately safeguarded.
- Patients records mostly evidenced a holistic approach to assessing patients' needs. However, in some records examined there was a lack of the patients' voice to describe their journey through the service.
- The environments mostly appeared clean and well maintained, although we found the Bristol SARC to have forensic areas which were not clean.
- The provider had systems to help them manage risks presented to the service.
- SOEs provided patients' care and treatment in line with current guidelines.
- The staff had infection control procedures which reflected published guidance and had adapted to Covid-19 guidance to ensure services remained available to patients throughout the pandemic.
- The provider had thorough staff recruitment procedures.
- SOEs knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available in all the SARCs they worked within.
- SOEs treated patients with dignity and respect and took care to protect their privacy and personal information.
- The service had effective leadership and a culture of continuous improvement.
- SOEs felt involved and supported and worked well as a team.
- The service worked in partnership with external agencies and asked staff and patients for feedback about the services they provided.
- Patient feedback was positive about the support they received from the SOEs
- The service dealt with complaints positively and efficiently.

Summary of findings

- The service had suitable information governance arrangements.

We identified regulations the provider was not meeting. They must:

- Ensure that each SARC site they visit is forensically clean to reduce the risk of the spread of infection and contaminated samples. (Regulation 15 Premises and equipment).

Full details of the regulation/s the provider is not meeting are at the end of this report.

There were areas where the provider should make improvements:

- SOEs should follow up all safeguarding referrals to ensure the patient is appropriately safeguarded against harm.
- SOEs should improve the representation of the patients' voice within the patient records to ensure the patient's wishes would have been adhered to and the belief they have been listened to.
- All local team meetings should be minuted to ensure information flow from the floor level to board level.
- SOEs should be assured all SARC environments have been appropriately risk assessed for ligature risks.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**Requirements notice** ✖
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**No action** ✓

Are services safe?

Our findings

Safety systems and processes (including Staff recruitment, Equipment and premises)

SOEs understood how to protect adults, children and young people from abuse and the service worked well with other agencies to do so. SOEs had training on how to recognise and report abuse, and they knew how to apply it. SOEs considered safeguarding of adults and children at the earliest opportunity through multi-agency working, the use of information gathering tools and risk assessments.

SOEs we spoke with were familiar with the provider's safeguarding policies for children and adults and how to access it. They were aware of the procedure to follow if they had safeguarding concerns. Safeguarding policies and procedures were clear, up to date and SOEs we spoke with showed a comprehensive understanding of safeguarding issues.

We reviewed training records which showed all SOEs had the appropriate level three children and adult safeguarding training. SOE leads and the clinical lead monitored this to ensure compliance. SOEs updated their training every three years which was in accordance with the intercollegiate national guidance 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019).

SOEs completed safeguarding referrals for all children and on a case by case basis for adults. Doctors would see children under the age of 16 years referred to the service by social services. Children were therefore already known to the local authority. However, SOEs were clear that they would still report any further safeguarding concerns to the appropriate agencies. SOEs told us for all patients that, if a partner agency such as the police said they had already made a referral, they would check this. If there was any doubt, then they would make a referral as well. We saw evidence of safeguarding pathways being available to SOEs and followed for each local authority area covered by the six SARCs.

Out of the 21 SOE's with spoke with, three reported they would not follow up their safeguarding referrals and would ask the crisis worker who worked for an external provider to do this for them. This did not assure the provider that all SOEs consistently across the service followed up their safeguarding referrals which meant not all patients may have been safeguarded appropriately as the SOEs had not closed the referral 'loop'. The clinical lead reported they had identified this as a gap in the service. They had immediately implemented weekly meetings with the external SARC providers and NHS trust safeguarding leads to review all safeguarding referrals that had been made by the SOEs and their outcomes to ensure the patients had been effectively safeguarded and so update their own records accordingly.

SOEs reported, and we saw in the patient records, that they adapted the assessment process and examination to meet the needs of patients who required additional support, for example for patients with a learning disability or alcohol/ substance dependency. The provider had developed a comprehensive standard operating procedure for the management of substance misuse in SARCs.

From our review of 45 patient records we saw that SOEs clearly highlighted patient vulnerabilities as part of the referral and assessment process. This included, for example, risks relating to individual mental health, domestic violence, learning difficulties and child sexual exploitation.

SOEs were involved in multi-agency meetings where decisions were made in the patient's best interests. For example, in one record examined we saw that SOEs had completed a forensic medical examination in an elderly patient's care home as they were immobile and unable to attend the SARC in person. We also saw that SOEs had attended intensive care units within hospitals to complete examinations.

SOEs completed mandatory training, which included a range of topics including immediate life support, infection control and fire training. SOEs received an email reminder when their training was due, and the SOE leads and clinical lead had an overview of staff training via an electronic system. This assured the provider that SOEs fulfilled requirements for mandatory training.

Are services safe?

Four of the doctors and one nurse had completed and passed FFLM exams and the clinical lead sat on the FFLM board. This ensured the clinical lead and other staff were able to share updates regarding policies and guidelines produced by the FFLM.

The clinical lead arranged additional job specific training sessions which were virtual and recorded to ensure that all SOEs could access them if they could not attend the live event. Topics included; forensic examinations of the pregnant patient, non-fatal strangulation and emergency contraception updates. SOEs we spoke with told us they thought very highly of this additional training offer.

The service had a staff recruitment policy and procedure to ensure employment of suitably qualified staff. The police also vetted all SOEs yearly as an additional check. The provider's human resources department automatically requested DBS checks every three years. This ensured SOEs were subject to the appropriate ongoing checks.

The provider had a comprehensive whistleblowing policy. This provided staff with information about how to raise a concern confidentially should they not wish to do so at a local level. SOEs were aware of how and where to access this policy. Most SOEs we spoke with told us they felt comfortable to raise concerns with management.

The providers call centre was available 24 hours, 365 days a year for the SOEs to seek advice about patients if required. Additionally, SOEs reported the clinical lead was always available to answer concerns during the working day.

The provider did not hold responsibility for the buildings and their checks. All NHS providers who ran the SARC's, except for the Bristol SARC, sent in quarterly building risk assessments which included checks such as fire risks, health and safety responsibilities, slips, trips and falls and Control of Substances Hazardous to Health (COSHH) for example. This provided assurance to the provider that the NHS trusts had oversight of the SARC environments.

The provider mostly controlled infection risk well. SOEs used equipment and control measures to protect patients, themselves and others from infection. However, in the Bristol SARC we found the sealed forensic bathroom which linked into the forensic examination room, had a ceiling grill that was thick with dust and a swing bin on the floor without a bin liner, containing some empty equipment wrappers. This did not follow the FFLM guidance and did not assure the provider that the SOEs working within the Bristol SARC had oversight of the cleanliness of the forensic areas. This posed an infection risk as well as a risk of contaminated patient samples. We have issued the provider with a requirement notice to ensure the SOEs have full oversight of the cleanliness of all six SARCs.

We reviewed the cleaning schedules of the six SARCs inspected, which demonstrated external staff to the service cleaned forensic rooms before each patient entered the SARC. We saw cleaners had sealed the doors with plastic tags to demonstrate they were clean and recorded the log numbers in the cleaning schedules. All SARCs had forensic spot checks undertaken to determine the levels of DNA, therefore, this should assure the SOEs as to the forensic integrity of the rooms. However, the SOEs still had an overall responsibility to check the cleanliness of each six SARC environments.

The service completed infection control audits of each SARC on a monthly basis, which included handwashing audits, uniform checks and waste management, for example. In the last quarter, all six SARC areas received 100% compliance which met the providers compliance target.

We noted five out of the six SARC external providers had carried out ligature risk assessments of all buildings. However, we noted in four of the six SARCs that ligature risks still existed, and the clinical lead advised they would be requesting the external providers to undertake a comprehensive risk assessment of ligature risks. SOEs mitigated the ligature risks by having immediate access to ligature cutters and were able to open all bathroom doors from the outside.

SOEs and SARC staff accessed all forensic suites and offices with swipe cards or keypad codes which reduced the risk of unauthorised access.

Are services safe?

SOEs knew how to respond to an emergency and were up to date with their basic and immediate life support training. In each of the six SARCs, SOEs had access to emergency grab bags and in some SARCs an NHS trust's crash trolley or defibrillator. We checked the grab bags and found all the equipment to be appropriate for both adults and children and all consumables were in date. We also noted SOEs and external providers checked the emergency equipment routinely to ensure the equipment was fit for use.

All SOEs had received training in the use of a colposcope (A colposcope is a piece of specialist equipment for making records of intimate images during examinations, including high quality photographs) and we saw evidence SOEs managed forensic samples in line with FFLM guidelines. We saw evidence the external providers had maintained and serviced all colposcopes.

Risks to Patients

The provider had good systems in place to assess, monitor and manage risks to patient safety. Templates and proformas supported SOEs to recognise the deteriorating mental and/or physical health of the patient.

SOEs reported they discussed patient vulnerabilities with the police, crisis workers or the patient before the examination, including for example; patients with a mental health diagnosis, learning disabilities or alcohol dependency. This was to ensure their condition was stable enough for them to safely attend the SARC.

We saw evidence from patient records that SOEs assessed, monitored and managed risks to patients. During the initial referral, SOEs would complete a holistic assessment, including for example; the patient's mental health status, physical health and any substance misuse concerns. If the patient was acutely unwell then the SOE would advise the patient to attend the SARC, or in the case of an emergency, the SOE would call 999 and arrange for the patient to be taken to accident and emergency for treatment before attending the SARC.

SOEs assessed patient's needs for Post Exposure Prophylaxis after Sexual Exposure (PEPSE), emergency contraception, hepatitis B prophylaxis, antibiotics and referral for sexual health screening. This ensured the patient received a holistic assessment and continuing care when required.

We saw evidence of continuous risk assessments of patients throughout the patient journey. We also saw evidence in the patients notes of SOEs identifying risks to patients and taking the appropriate action. For example, referring the patient to sexual health services or mental health services.

There was mostly enough staff to cover the 24 hour nature of the service and the clinical lead told us existing staff would cover gaps in the rota by working additional hours or cover would be sourced from elsewhere within the provider. At the time of inspection, they were actively recruiting additional nurses and doctors to cover the rota and the SOEs we spoke with did not raise the rota cover as a concern and patients were seen within the required timeframes unless they requested specific appointment times.

From a review of the last three months rota's from across the service, we noted that in the 'north' area of the service there was a lack of forensic medical examiners. The clinical lead reported that this was due to the low numbers of children referred in this area; making staff training and competency maintenance challenging. If nurses required medical advice and there was no medical cover for the north, nurses were able to contact the call centre who would put them in touch with an on call forensic examiner. Information given by the provider showed patient care or response times had not been compromised from the lack of doctor cover on the rota.

The provider had a business continuity plan describing how it would deal with events that could stop the service running. This included utilising staff from out of area if required due to staff sickness.

Information to deliver safe care and treatment

Are services safe?

Patient records evidenced the safe delivery of care and assessment paperwork was in line with FFLM guidance. The records were accurate, complete, legible, contained completed body maps and SOEs stored them securely. SOEs were the only staff with access to the records where an information sharing agreement was not in place, which complied with data protection requirements.

SOEs stored photo evidence from the colposcopes securely. The service stored each image with a unique identifying number so as not to identify the patient.

SOEs made appropriate and timely referrals to other agencies such as the sexual health clinic, GPs and local authority social services, which was in line with national guidance.

All relevant polices and pathways were in line with the FFLM guidance and all SOEs reported to access guidelines and updates from the FFLM regarding forensic medical examinations.

Safe and appropriate use of medicines

SOEs stored medicines in locked cupboards or fridges and kept keys securely across the six SARCs. We reviewed the medicines at each SARC and noted they were all stored as per the providers policy and within their recommended expiry dates. SARC staff and the SOEs monitored the room temperatures of all stored medicines and were aware of the procedure to take if the room became too hot or cold.

SARC staff stored temperature sensitive medicines in a fridge and forensic evidence in freezers. The SARC staff and/or SOEs monitored fridge and freezer temperatures daily to ensure the medicines remained safe. SOEs we spoke with knew what procedure to follow if the fridge and freezer temperatures fell above or below recommended temperatures.

The provider had a comprehensive medicines management policy for handling and administering medicines within the SARC. SOEs we spoke with were confident in administrating medicines safely.

There was a range of Patient Group Directions (PGDs) in place (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). These were subject to regular organisational review and we saw evidence that all SOEs had signed the PGDs alongside the chief pharmacist, clinical nurse director and the regional clinical leads, which met national guidance for PGD's. Printed PGDs were available at each SARC for staff to access.

Track record on safety

The provider had reporting systems to capture incidents and errors that required investigation and any of the clinical lead and SOEs leads shared learning outcomes through team meetings. This demonstrated that if an incident occurred, the SOEs and provider would take appropriate action to ensure that similar incidents did not occur again.

SOEs were able to demonstrate they understood their responsibilities to report concerns and near misses.

Lessons learned and improvements

SOEs told us they discussed themes from incidents at their monthly team meetings and in peer review sessions. SOEs understood the importance of discussing incidents which reduced the risk of similar incidents occurring again and supported further learning.

SOEs received medicines and equipment safety alerts by email from the clinical lead. This ensured SOEs were aware of any medicines or equipment that needed removing from the service.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The service provided care and treatment based on national guidance and best practice. The clinical lead and lead SOEs checked to make sure the other SOEs followed guidance.

SOEs assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance, including the FFLM and National Institute for Clinical Excellence (NICE). We reviewed patient documentation which assured us SOEs had recorded a comprehensive health assessment as part of the forensic examination including past and current medical histories.

The provider produced evidence-based policies and procedures to provide guidance for SOEs and ensure SOEs identified risks to patients and improved patient safety. All SOEs we spoke with had access to the policies and procedures through the providers electronic system which they were able to access on their mobile phones. If the SOE had no mobile signal, they were able instead to contact the call centre who could provide them with the necessary information they required.

We noted that two of the provider's policies were due for a review as they were out of date. We spoke with the clinical governance team who provided assurances around their reviewing processes of all policies to ensure they were accurate and reflected current guidance and legislation. The out of date policies were undergoing the review process at the time of inspection.

The provider had developed and put in place clinical policies. These included for example; emergency contraception and HIV/Hepatitis B prophylaxis which, when reviewed, were up to date and in line with current guidance. In one record we reviewed, the SOE had followed the hepatitis B policy which showed evidence that the SOE had offered the patient appropriate care.

We saw evidence all SOEs had completed mental capacity act training and had regard to the Mental Health Act. We saw evidence in the patient records that all patients who attended for forensic medical examinations had their mental health status considered by the SOEs during the examination process.

Post examination, SOEs and the external provider staff provided patients with appropriate information with regards to access to additional support, in addition to referral onwards to other services such as the sexual health clinic or Independent Sexual Violence Advisors (ISVA).

Monitoring care and treatment

Both the clinical lead and SOE leads completed audit programmes which included, for example; notes audits, infection control, sharps, uniform and waste management audits. The service scored 100% in the infection control audits which assured the provider the SOEs were providing a safe service to patients, however we noted in the Bristol SARC the shower room had a dusty ceiling vent which the SOE leads had missed during the audits.

Across most areas of the service, SOE leads and the clinical lead audited five sets of the SOEs patient notes yearly if the SOE had previously scored above 95%. If they scored 93% and below it would be six monthly and any lower on a more frequent basis. All new starters had every set of notes audited. We reviewed the audits and found the auditors left appropriate feedback for the examining SOE to act upon.

However, from a review of the audits and from speaking to the SOEs, we found some areas audited patient notes on a monthly basis and others annually. This inconsistency contributes to our findings that, from the 45 patient notes we reviewed, we found a lack of documentation of the patient's voice particularly within the adult notes. The patient voice would ensure the patient's wishes would have been adhered to and the belief they have been listened to. Therefore the audit process required strengthening across the service.

Are services effective?

(for example, treatment is effective)

In one area of the service a consultant from the local NHS trust audited the notes and fed back to the clinical lead who then fed back to the individual SOE. This gave greater assurance to the provider that SOEs were completing their notes to a high standard.

Audits of the notes included a review of the examination and the aftercare form including, for example, reviewing areas such as the consent process, examination, forensic sample taking and recording and record legibility. The auditor scored each area using an electronic system which provided an overall percentage score of the notes audit. The auditor was able to leave constructive comments for the SOEs future development.

SOEs would record the outcomes of patients attending for forensic medical examinations within the confidential medical aftercare proforma. This included procedures undertaken, treatment provided (including medication issued) and communication or referrals (including safeguarding and GP's) made to other agencies for ongoing support.

All patient records had additional space to record any conversations the SOEs may have had with external partner agencies and conversations with the patient, for example; the local authority or the sexual health clinic. We saw evidence of contemporaneous record keeping which meant SOEs were completing notes in a timely manner with the expected detail required.

Effective staffing

The provider made sure SOEs were competent to undertake their roles safely. All SOEs had received an annual appraisal and attended supervision meetings to receive support and development. The leads identified training needs within the appraisal process.

We saw evidence SOEs had the right experience, skills, knowledge and management support to deliver good quality care. SOEs completed mandatory training as well as service specific training to ensure they understood what was expected of them. SOEs we spoke with talked about how much they valued the service specific training. We heard that the clinical and SOE leads offered training both formally and informally and the training sessions were predominantly multidisciplinary which offered a richer discussion on the holistic care of the patient.

New SOEs undertook the providers comprehensive induction programme which aligned to the FFLM and prepared them for their role to ensure they were skilled and well supported. For example, new SOEs would shadow four examinations and undertake specific training related to forensic medical examinations, such as colposcopy training and forensic swabs. The lead SOE or clinical lead observed new SOEs in practice before signing them off as competent practitioners.

The provider requested that SOEs attended at least four peer supervision sessions a year where SOEs discussed any individual cases and themes and shared learning with their peers. This was also an opportunity for SOEs to learn from other areas across the provider as well as being able to debrief about any difficult or upsetting cases in a safe supportive environment.

SOEs maintained their professional registration through continuous professional development and we saw evidence of SOE nurse leads and the clinical lead monitored this through monthly clinical supervision.

SOEs used a trauma informed based approach when assessing patients holistically. This ensured SOEs thoroughly assessed patients' needs whilst considering the trauma they may have suffered.

Co-ordinating care and treatment.

The provider's call centre received referrals from the police, other agencies and patients during the day and night, and then informed the SOE on call. The SOE then contacted the police officer or patient/crisis worker and arranged a mutually agreed time to attend the SARC for the examination, ensuring they kept within the forensic window which was in line with the FFLM guidance.

Are services effective?

(for example, treatment is effective)

We saw evidence of good working relationships between the SOEs and their co-located colleagues in all six SARCs. We saw evidence of joint meeting minutes where the SARC teams and clinical lead and lead SOEs discussed incidents, complaints/compliments and themes which contributed to improving the care and treatment to patients.

Health improvement and promotion

SOEs offered all patients who attended the SARC an appointment with an ISVA. With patients' consent, the service also contacted GPs with details of the patient's attendance at the SARC and made other referrals if appropriate. This could include, for example, referrals to sexual health clinics, counselling services, mental health teams and substance misuse teams.

Consent to care and treatment

SOEs supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. SOEs understood the relevant consent and decision-making requirement of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice should they need to.

All SOEs were able to describe what actions they would take if a patient lacked the capacity to consent. We reviewed one set of notes where the patient lacked capacity to consent, which demonstrated the SOE had provided a detailed capacity assessment with rationale explaining why the patient lacked capacity to give consent.

All SOEs were aware of the importance of gaining consent from patients before performing the forensic medical examination. We saw evidence of this from the notes we examined and SOEs also told us that consent was a continuous process where SOEs gave the patient the option to stop the forensic medical examination at any point should they so wish. This ensured the patient was central in managing their own experience and any sharing of their information.

We saw evidence in patient notes that SOEs discussed all risks and treatment options with patients. For example; PEPSE, hepatitis B vaccinations, and emergency contraception. Patients left the SARC with written information regarding onward referrals and non-fatal post strangulation advice, for example when to access medical advice.

For children up to the age of 16, there was a strong awareness across the SOE team of the requirement to understand Fraser guidelines and Gillick competencies when assessing if a child had the capacity to consent to treatment. Where the parent was in attendance, we saw they had signed the consent form along with the child which was in line with national guidance.

Are services caring?

Our findings

Kindness, respect and compassion

SOEs treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients who used the service was very positive. SOEs talked with care and compassion about the patients they saw and their role in advocating for them at a vulnerable time in their lives.

SOEs allowed patients time to control the examination and took time to explain processes and next steps. Interviews with SOEs and a review of records showed SOEs were kind, respectful and compassionate as well as knowledgeable about the impact and trauma of sexual assault.

NHS trusts collected patient feedback and shared the results with the SW SOE service. Feedback included; how well cared for they felt, how the SOEs clearly explained information and how they felt supported by the SOEs and crisis support worker team to make the right decisions. Patients commented on how relaxed the SOEs had made them feel.

The SARC staff offered patients clothing and care bags which contained toiletries which they could use on site or take away with them. Each SARC site also offered patients snacks and drinks.

Involving people in decisions about care and treatment

SOEs were sensitive to the diverse needs of patients and we saw evidence in the patient's records that the forensic medical examination was adapted to suit everyone. This allowed the patient to take control of the pace at which the examination was completed. At each step of the examination SOEs took time to explain and ensure the patient fully understood the process.

From our review of patient notes and from speaking with SOEs, we saw evidence patients were at the centre of their own care and treatment and were involved in decisions about each step.

SOEs had access to interpreters either by video, telephone or face to face to complete the initial assessment and would offer all patients, whose first language was not English, an interpreter. This ensured patients understood the treatment options available to them. British sign language interpreters were also available. We heard an example where a patient had brought their family member along who could sign and speak for them, but the SOE recognised this was not appropriate and arranged an external sign language translator to attend. This ensured the family member was not coercing the patient during the examination process and the sign language interpreter accurately translated the conversation between patient and SOE.

SOEs talked confidently about supporting patients with a learning disability but we noted there were limited resources available to support this work, although one SOE reported they had photographs of the SARC environment which could be used to explain the environment, and the service had produced a PEPSE advice leaflet in an easy read format.

SOEs gave patients discharged from the service leaflets which the SARC providers produced that included information about next steps and medication. This ensured the patient left the SARC informed about the next steps. SOEs could translate these leaflets using google translate before the patient attended the SARC. The service produced their own information leaflets on non-fatal strangulation, head injuries and easy to understand information regarding PEPSE medicine.

The six SARC sites that the SOEs attended all had their own independent websites which included information on what to expect when attending the SARC, contact numbers for the SARC and information regarding other support agencies.

Privacy and dignity

Are services caring?

SOEs showed respect for patients' privacy, allowing them to change their clothing in private and use the toilet and shower facilities alone. However, SOEs remained close by to ensure the patients were safe from harm. SOEs gave patients the option to wear a gown or keep items of clothing on during the examination process depending on the nature of the alleged assault.

SOEs stored patient notes securely in a locked cabinet within an office in each of the six SARC sites, and the provider collected them on a monthly basis. This prevented any unauthorised access to patients notes.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

The clinical and SOE leads planned and provided care in a way that met the needs of patients. The SOE and clinical leads worked in partnership with the local NHS Trusts, external agencies, police and local organisations to plan care and support.

Patients who self-referred into the service and chose not to involve the police were able to have their evidence stored at the SARC for up to seven years. This ensured that, should they wish to proceed with police involvement at a later stage, evidence of their attendance at the SARC would still be available.

All six SARCs that the SOEs worked within provided access for patients with disabilities, including accessible toilets with handrails and call bells. Patient feedback across the services clearly demonstrated a high level of satisfaction regarding the environments.

The SOEs paperwork included a confidential medical aftercare proforma which included; an assessment of the patient's mental health, learning disabilities, their home environment, whether a patient was homeless, if they had dependent children at home, drug and alcohol dependency and a detailed personal medical history. This ensured SOEs identified vulnerable patients and referred them onwards as appropriate.

We heard examples of where the SOEs worked in partnership with external providers by advertising the SARC services to emergency department staff, in gynaecology wards and local universities. We also saw that SOEs were involved in training newly qualified police staff. This helped to raise awareness of the SARCs and their function across the South West region of England.

Taking account of particular needs and choices

Most of the SARC's we visited provided age appropriate environments for the age range of patients that attended. For example, we saw access to wipe clean toys for younger children and appropriate environments for younger people and adults. However, some of the SARC environments were more clinical in appearance and less child friendly.

Before arrival to the SARC, the crisis worker alerted patients to the gender of the SOE which gave them the opportunity to request a different gender should they so wish. As most of the SOEs were female, if the patient requested a male SOE, the call centre would arrange a male examiner to attend from out of area. All SOEs we spoke with reported no patients they had seen had requested an alternative gender examiner.

SOEs worked in partnership with the crisis workers across the SARCs who were employed by an external provider. Crisis workers had access to the local NHS trust's computer system and were able to alert the SOEs if a patient had attended the SARC more than once. This ensured any previous history or attendances were known by all practitioners which could then better inform their interactions with those patients.

Timely access to services

All six SARC's websites displayed opening hours and contact numbers. The SOEs provided forensic medical examinations 24 hours a day 365 days a year. The provider monitored response times from the point of referral to the start of the assessment and produced quarterly reports for each area of the service for the police commissioners and NHS partners. The expected response time target was 90 minutes and the reports showed the service achieved the target 91% to 100% of the time across the service. The providers target was 100%. The reasons for the fluctuations were due to SOE's giving patients a choice of appointment times to suit their needs (within the forensic window) and staff sickness mainly due to the Covid-19 pandemic.

Are services responsive to people's needs?

As a result of the fluctuating response times across the service, the provider had implemented a recruitment drive for both medical and nurse examiners to ensure full cover of the rotas and to improve the 90 minute target response time.

Where the SARC only had one examination room, the call centre would ensure there were no cross over of cases which could compromise patient confidentiality. SOEs we spoke with reported that sometimes there may be a delay with patients being seen due to a lack of capacity within the SARC and that patients may have to travel to a SARC further away, but they reported to us, and we saw evidence, this had not happened during the last 12 months.

Listening and learning from concerns and complaints

SOEs were aware of, and followed, the providers complaint policy if patients wanted to complain about the service. SOEs reported to us that learning from complaints and incidents were a standing item on the team meeting agenda. We also saw evidence of this in meeting minutes examined.

SOEs used an electronic reporting system to log incidents and complaints to ensure a clear audit trail. This ensured the clinical lead could identify trends for quality assurance purposes. External providers shared complaints with the clinical lead who investigated, addressed and resolved the matter in a timely way, following provider policy.

We saw from the information request we made prior to our inspections that there had been one complaint received in the last year, which the clinical lead responded to in a timely and appropriate manner whilst following the provider's complaints procedure.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders demonstrated integrity, skills and the ability to run the forensic medical examination service. They understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service and supported SOEs to develop their own skills and practice.

A clear management structure was in place to provide day to day supervision and support to SOEs. A leadership team provided oversight of the SOEs and were available to support with any issues that required escalation. Leaders were visible and the SOEs spoke positively about the support they received. However, most SOEs reported leaders at levels above the clinical lead were less visible and supportive.

The registered manager who had extensive experience in forensic medicine for both adults and children, was the clinical lead for the service and had achieved accreditation with the FFLM. Further to this, they were an active member of the FFLM board.

SOE's told us they felt very well supported by the registered manager and reported they were confident to raise concerns with them should they need to do so. Additionally, SOEs told us they felt comfortable to raise concerns with the external providers and felt the two teams worked very well together and that it felt like they belonged to one, not two separate organisations.

Vision and strategy

The provider's values included integrity and respect. They were passionate about safety, security and service excellence. This was achieved through teamwork and innovation.

We observed the SOEs to be committed to their roles and saw evidence through patient feedback that they provided patients with good quality, safe care. SOEs we spoke with were able to demonstrate how they followed the providers values.

SOEs were passionate about their work and had a clear vision to improve the care for patients who had suffered sexual assault. This included working closely with NHS trusts, the police, and the SARC providers to provide education and promote the service.

From October 2022 the provider will no longer be providing the contract to provide forensic medical examinations to the six SARCs across the South West of England. However, we saw evidence of a clear business plan to continue to provide high quality provision of the examinations for patients until the contract ends.

Culture

SOEs reported they felt respected, supported and valued. We saw evidence that demonstrated how SOEs focused on the needs of patients in their care. The service promoted equality and diversity in daily work and provided opportunities for career development. The clinical lead actively encouraged doctors and nurses to complete the accreditation process with the FFLM. We saw the service had an open culture where patients could raise concerns without fear of repercussion.

The provider had a whistleblowing policy, of which the SOEs were aware. Most SOEs told us they could make comments and suggestions, talk freely and felt supported to drive any improvements forward.

The SOEs reported an open and honest culture and they mostly worked well together with the external SARC teams. We saw a no blame approach to peer review of patient notes and the clinical lead addressed any concerns though open and honest feedback. External provider staff we spoke with from the six SARC teams reported good working relationships with the SOEs and they also found them approachable.

Are services well-led?

SOEs told us the provider monitored their welfare and gave them debrief opportunities following complex or distressing cases. SOEs welcomed and supported this process and as it helped with reflection and improving their future practice.

The provider had a lone working policy, of which all SOEs we spoke with were aware. Out of hours, the provider requested SOEs contacted the call centre when they left the SARC and when they arrived home. If the call centre had not heard from the SOE they would call to complete a welfare check.

Governance and management

The provider had good clinical governance arrangements in place including; policies, standard operating procedures and risk assessments relating to the delivery of forensic medical examinations by the SOEs. The clinical governance team regularly reviewed and updated policies and shared policy or procedure updates with the SOEs by email.

A range of meetings across the service supported the governance structure including; the SOEs team meetings, patient safety meetings, team lead meetings and the monthly clinical governance meetings. Incidents, complaints and discussion of trends or themes took place at those meetings. This ensured outcomes were actioned and information was shared in a timely way. However, the clinical lead reported that local team meetings were not minuted and had immediately developed a standing agenda which they shared with all the team leads. This meant moving forwards following on from the inspection, information would be shared effectively from 'floor to board'.

Both the clinical lead and SOE leads attended quarterly external meetings jointly with providers of the SARCs and police commissioners. We reviewed the minutes of these meetings which showed effective monitoring and challenge regarding the performance of the SOEs and the quality of the forensic medical examinations.

Processes for managing risks, issues and performance.

The clinical lead identified and recorded risks to the SW SOE service on a risk register which the provider's senior SARC management team regularly updated and reviewed and the clinical lead discussed during the quarterly provider clinical governance meeting. Risks included; the upcoming contract end and the TUPE process for staff, rota cover due to the Covid-19 pandemic and recruitment and retention issues. All risks included detailed plans of action, who was responsible for the risk and when the action was required to be reviewed.

Some SOEs we spoke with reported risks around rota coverage. However, the provider assured us they were being proactive with recruitment and we noted minimal impact on patients with no patients in the last six months having to have their examination cancelled as a result of insufficient staff coverage.

The provider had a business continuity plan which was comprehensive. If any SOEs were unable to attend the SARC due to inclement weather for example, there was always availability from other SOEs from other SARC's that could attend.

Appropriate and accurate information

Information governance arrangements complied with the Data Protection Act. The clinical lead gathered quality and operational information which they used to ensure and improve outcomes for patients.

The clinical lead contributed to the Sexual Assault Referral Centres Indicators of Performance which provided assurance to police and NHS commissioners and helped SOEs to make improvements to patient care. The outcomes fed into a report produced by the SARC providers which they shared with NHS and police commissioners in addition to the provider.

Patients consented for the SOEs to securely store their records. This was part of their initial consent process. This demonstrated the providers compliance with the General Data Protection Regulation (GDPR) (2018). The service had not experienced any information breaches.

Engagement with Patients, the public, staff and external partners

Are services well-led?

The external SARC providers encouraged patients at all six SARC sites to leave written or oral feedback. The feedback was shared back to the SW SOE service so that the service could make improvements where required.

The clinical lead and SOE leads gathered staff feedback through staff meetings, appraisals and peer reviews. Most SOEs we spoke with reported how well the provider managed the service.

The SOEs, alongside the external six SARC teams, would often provide training for GP's, NHS staff, the police and sexual health clinics. We heard examples where the sexual health teams and the SW SOE service worked in partnership to deliver training to each other.

The clinical lead shared an example where they had provided the police with an update session regarding patients with learning disabilities and capacity concerns attending the SARC and, in addition, developed a police booklet to aid them to ask the right questions about non-fatal strangulation, therefore ensuring patients attended the emergency department in a timely manner.

SOEs were also available to provide advice and guidance to patients and professionals who called for advice regarding non-recent sexual assault. They could signpost them on to the most appropriate agency for additional support.

Continuous improvement and innovation

The service had effective assurance processes to encourage continuous quality improvement using peer reviews, training sessions and audits. SOEs talked positively of the opportunity for learning within their role. The clinical lead provided one to one support for SOEs when writing court statements which helped to ensure SOEs produced statements in a timely way and that they were of a high quality.

The service had developed a non-fatal strangulation staff and patient information leaflet which aided in the assessment of patients following strangulation. There was space on the leaflet for SOEs to detail specifics about the assault to the accident and emergency department which helped reduce the need for the patient to tell their story more than once, therefore reducing the risk of a traumatic response from the patient retelling their story.

The SOEs joined other SOEs across the provider network to have joint learning sessions. This was an opportunity for the SOEs to share good practice and learning.

One SOE we spoke with had joined a forum within the United Kingdom association of Forensic Nurses and Paramedics to discuss and become involved with future research projects.

SOEs had access to a comprehensive programme of learning and development opportunities through the provider. The provider also funded attendance at national conferences, such as the FFLM SARC best practice day.

During the pandemic the clinical lead introduced a dip sampling process which has continued as a regular monthly meeting alongside the police, NHS providers and SARC teams where they sample patient notes and reflect on the holistic journey of the patient and what improvements could be made. This has enabled the service to pick up themes of attendance and identify areas for development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider must ensure that each SARC site they visit is forensically clean to reduce the risk of spread of infection and contaminated samples.