Mountain Healthcare Limited

The Emerald Centre SARC

Inspection report

The Emerald Centre SARC
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Date of inspection visit: 22 and 23 January 2019
Date of publication: 23/04/2019

Overall summary

We carried out this announced inspection of this sexual assault referral centre (SARC) over two days on 22 and 23 January 2019. We conducted this inspection 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 of the Health and Social Care Act 2008 and associated regulations. Two CQC inspectors, supported by a specialist professional advisor, carried out this inspection.

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

• 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.

We found that this service was providing safe care and treatment in accordance with the relevant regulations.

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

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

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

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

Our key findings were:

- Staff knew how to deal with emergencies.
- Appropriate medicines and life-saving equipment were available.
- The service had systems to help them manage risk.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service was clean and well maintained.
- The staff had infection control procedures which reflected published guidance.
- The service had thorough, safe staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.

Summary of findings

- There were processes for monitoring the standard and quality of care.
- Staff treated patients with dignity, respect and compassion and took care to protect their privacy and personal information.
- The single point of access referral system met patients' needs.
- The service had effective leadership and culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and clients for feedback about the services they provided.
- The service dealt efficiently with positive, adverse and irregular events and learned lessons.
- The staff had suitable information governance arrangements.

The Emerald Centre SARC

Detailed findings

Background to this inspection

Background

The Emerald Centre is a SARC situated in the Bedford Health Village in the north of the centre of the town of Bedford. The SARC provides forensic medical examinations and related health services to people who have been sexually assaulted who live in the local authority areas of Bedford, Luton and Central Bedfordshire (referred to collectively in this report as Bedfordshire). The service is an 'all-age' service; that is, for adults aged 18 and over, children and young people aged 13 and above and children under the age of 13. The service is also accessible to male, female and transgender patients.

The service is provided by a limited company and as a condition of registration they 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 at the Emerald Centre was also the medical director for Mountain Healthcare Limited.

NHS England and the Bedfordshire Police and Crime Commissioner jointly commission this SARC. This is the only SARC in Bedfordshire although the location shares some of its functions with the SARCs in the neighbouring local authority and police areas covering Hertfordshire and Cambridgeshire. These include the sexual offence examiner (SOE) staff rotas and the single point of access known as the pathway support service.

The service is available 24 hours each day and has a one-hour call-out time throughout the day and night. Patients can be referred to the service through the police, or children's social care for children and young people. Patients aged 13 and over can self-refer but subject to safeguards for younger patients as we have set out below.

The staff team includes a centre manager, pathway support staff and SOEs. The provider sometimes refers to SOEs as forensic nurse examiners (FNE) and paediatric forensic medical examiners (FME). We have used the term FNE and FME in this report for consistency There is one full-time crisis worker who also carries out business support functions, and three crisis workers on an on-call rota. There are also two independent sexual violence advisers (ISVA) attached to the service but who are based off site.

During our inspection we spoke with the registered manager who is also the provider's medical director. We also spoke with the centre manager, a crisis worker, both ISVA workers, two FNEs and a paediatric FME. We looked at the records of 12 people who had used the crisis and forensic examination service (four of these were children under 13 and two were young people aged 13 and over) and a further four records of people who had used the ISVA service.

We left comment cards at the location in the week prior to our visit and received four responses from people who had used the service in that period.

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.

Are services safe?

Our findings

Safety systems and processes (including staff recruitment, Equipment & premises)

There were systems and processes in place at the Emerald Centre to ensure patients were safe.

Mountain Healthcare Limited had developed and implemented policies relating to safe care and communicated these to all staff. All policies were up-to-date with clear, scheduled review dates. These were supported by regular, mandatory training in key safety topics such as immediate life support, health and safety, and infection control. Staff were up-to-date with this training and those we spoke with demonstrated their knowledge and understanding of policies and systems.

The provider's safeguarding processes ensured patients of all ages were protected from abuse and there was good oversight of practice by a lead nurse and a named doctor. The lead nurse carried out a safeguarding notes audit for all records of patients who were referred from, or who were subsequently referred to the local authority social care team. These audits were effective in ensuring safeguarding practice improvement through feedback and learning.

All staff had received safeguarding training for adults and children that met national, intercollegiate guidance on safeguarding roles and competencies for healthcare staff. Two staff members were out of date but had been booked on to forthcoming courses. Training included online programmes and frequent multi-agency training events with practitioners from local partners. This enriched their learning and the provider considered attendance as mandatory. Recent training included child sexual exploitation (CSE), modern slavery, female genital mutilation (FGM), so called honour based violence (HBV), domestic abuse and PREVENT (understanding radicalisation).

The provider required staff to attend four safeguarding group supervision sessions each year to maintain their competence and the manager monitored attendance. This ensured staff understood risky situations experienced by their patients and their families and could act appropriately.

Records we reviewed showed that staff were aware of risks to children in families where there had been physical or sexual violence. Staff made referrals without delay to the Bedfordshire Multi-Agency Safeguarding Hub (MASH), which contained good information to support decision making.

The service did not take self-referrals from children and young people under 13 years of age; all sexual assault referrals for children under 13 and some of those for young people under 16 came from the local authority through safeguarding processes. We saw diligent practice for referrals to the service for young people made by GPs. GPs were advised to re-route child safeguarding referrals through the MASH and such calls were flagged in the SARC to enable staff to follow up if the referral was subsequently not made as expected or in a timely way.

Staff were employed in line with the provider's recruitment policy. Pre-employment safety checks included enhanced Disclosure and Barring Service (DBS) checks, an extensive interview process and validation of references and qualifications. Due to the nature of the work of the service within the criminal justice system, staff were also subject of additional vetting through the local police before being employed. The provider updated these safety checks for each staff member every five years so was assured of the safety of the workforce at any point in time.

The Emerald Centre had processes to ensure all equipment was safe to use, that staff were trained to use it safely, that it was regularly checked and that disposable parts of the equipment were within their expiry dates. This included an automated external defibrillator and specialist equipment used for recording intimate images during examinations. Fire safety equipment had been inspected and was up-to-date. All portable electrical equipment had been checked and labelled to show that it was safe.

There were processes in place to prevent patients and staff from acquiring healthcare-associated infections. There was a clear and up-to-date infection control policy in place, a designated lead staff member and good signage in relation to hand washing and infection prevention. Clinical waste was disposed of safely according to the provider's schedules.

As the location was used solely as a SARC, there were stringent cleaning arrangements for the waiting and examination rooms to prevent the cross-contamination of contact evidence. These met the guidance issued by the Faculty of Forensic and Legal Medicine (FFLM). Staff

confirmed they had received training on cross-contamination and infection control and we observed the waiting and examination room being deep-cleaned following their use by a patient during our visit.

The manager had commissioned an independent audit of the forensic facility within the previous six months. This assured the provider that the forensic cleaning arrangements were effective. One patient who left us a comment card stated that the building was safe and very clean.

There were processes in place to support people withdrawing from alcohol or opiates who were identified using established assessment tools. This ensured the safety of people who misused substances or where the use of alcohol or drugs had been a feature of the sexual assault. In such cases staff referred patients to hospital or to their GP to ensure their care was followed up.

Risks to patients

There were sufficient staff available to meet patients' needs. This included forensic examiners and crisis staff working with patients on an acute basis and ISVA workers carrying out longer term work. Safe staffing was maintained through the use of rotas. Recent recruitment activity had resulted in these rotas being fully-populated. This meant patients were mostly seen within one hour at any time of the day or night as set out in the provider's offer.

The provider checked staff numbers and response times as part of their quarterly monitoring process and we noted that there were sufficient staff to ensure patients were cared for safely. This enabled patients to receive close support from staff throughout their episode of care at the centre, apart from a short period of time when they used a dedicated shower room following their examination. There were no obvious ligature points in the shower room, which was in accordance with the provider's assessment of this facility.

Staff assessed risks to patients on an ongoing basis, from the point of receiving the call in the pathway support services, to follow-up activity after an acute visit. Patients were comprehensively assessed for a range of risks during the reception process including for the risks of CSE, deliberate self-harm and potential suicide. Patients for whom there was an identified additional risk of CSE, and every patient aged 17 and under, were subject of a further, more detailed assessment using a nationally recognised assessment tool. This resulted in referrals being made through local safeguarding procedures and this was evident in our review of records.

Where a patient was identified as being at risk of harm or with urgent health concerns, action was taken to assure their safety. The examination included a full assessment for the need for post-exposure prophylaxis after sexual exposure (PEPSE), the need for emergency contraception and an assessment of physical injuries needing urgent treatment. Whenever a person had been taken to Bedford Hospital Emergency Department (ED) for serious injuries arising from a violent incident, Emerald Centre staff attended the ED to provide the forensic response.

Patients were re-assessed for risks when they accessed the ISVA service and these were reviewed at each successive contact. Our review of ISVA records showed that patients were assessed for risks such as, exposure to domestic violence, relationships and places of safety. The extensive assessment tool used by the ISVA workers used criteria that were in accordance with practice guidance issued by a recognised national specialist sexual violence and safeguarding organisation. The assessment also covered the patient's physical and mental health, coping mechanisms, drug and alcohol abuse, safeguarding, education and employment, finance, accommodation, immigration and issues relating to the criminal justice system or other agencies.

The ISVA workers acted on any identified risks and made referrals to other services where necessary, including for risks that were not necessarily associated with the initial sexual assault. For example, one patient was referred to the local Child and Adolescent Mental Health service (CAMHS) to participate in an emotional well-being development group. Another patient had been offered information for Gamblers Anonymous. This showed that ISVA workers supported patients to remain protected from ongoing or recurring risks.

All patients were subject of a six-week follow-up by the forensic nurses - three weeks for children - in addition to the ISVA service. The purpose of this was to consider risks identified during the initial examination and to check on patients' health and wellbeing. Referrals to other services were made or repeated at this follow-up to ensure patients were receiving appropriate support.

Are services safe?

Information to deliver safe care and treatment

Records we reviewed showed that staff used templates to help in assessing and examining patients. These were based upon templates recommended by the FFLM with specific forms for either children and young people under 18 or adults. Staff completed these thoroughly, which ensured they asked relevant questions and recorded their answers to facilitate accurate assessment. Staff made effective notes of their work, including body maps to accurately document injuries. Records were clear, legible and accountable.

Records made by the ISVA workers were also comprehensive and showed they had gathered sufficient information from patients to accurately assess their needs and design their support plan.

Staff made records in hard-copy format and these were held in locked facilities with controlled access. This meant that patients' personal information was secure.

Specialist equipment, known as a colposcope, was available for making records of intimate images during examinations, including high-quality photographs and video. The purpose of these images is to enable forensic examiners to review, validate or challenge findings from the examination and for second opinion during legal proceedings. At the Emerald Centre, there were clear arrangements for obtaining and recording consent for making such photographic records. There were also effective arrangements for ensuring the safe storage and security of these records in accordance with national guidance issued by the FFLM.

Forensic staff and crisis workers shared information internally with the ISVA workers to ensure they understood a patient's case. Staff also shared Information with other health professionals such as GPs, the community paediatric team, mental health services and the GUM and sexual health services. This supported health partners to continue to deliver safe care by way of follow-up. ISVA workers shared information directly with mental health services and this helps those services to support patients with emotional wellbeing and mental ill-health.

ISVA workers routinely attended and shared information with child in need (CiN) meetings and team around the family (TAF) meetings for children they were supporting. CiN and TAF meetings are part of local safeguarding processes that enable children and young people to receive targeted and coordinated support from partner agencies.

Safe and appropriate use of medicines

The Emerald Centre routinely used a limited number of medicines; PEPSE and oral contraception as outlined above, and paracetamol. None of these were temperature sensitive so they were not refrigerated. Staff administered medicines under a patient group direction (PGD). That is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation. The PGD in use in this SARC was up-to-date, which meant staff could administer prophylactic and contraceptive medicines safely and legitimately.

The provider had begun to regularly audit the use of prophylactic medicines and oral contraception. The initial audit showed that the assessments of patients for these medicines were accurate and that the medicines were provided safely in accordance with guidelines issued by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) respectively.

During our visit we reviewed the medicine systems. We found that medicines were stored safely and securely, and that there was an effective system for reconciling the medicines through weekly checks. Stock and administration records were accurate.

Track record on safety

Safety systems and practices at the Emerald Centre were monitored, such as staffing levels and call-out times. Monitoring data was reported quarterly to the provider's senior team and the local commissioning performance monitoring group (which includes NHS England, the Police, the local authority and a former service user). Managers had a good understanding of their safety performance. This was borne out in our review of the four quarterly reports for the previous year, which showed consistently safe performance and activity to mitigate any shortfalls over this period.

Are services safe?

The provider, managers and staff routinely used audit and action planning to improve safety performance. For example, the safeguarding notes audit, medicines audit and forensic cleaning audit, helped the provider to understand their practice in managing risks to safety.

The provider's monitoring activity and approach to patient safety also led to the actions set out in their risk register. For example, the risks to children aged under 13 years from the absence of a formal pathway for sexually transmitted infection (STI) screening was identified as a high risk for the service. Managers at the Emerald Centre had worked with the service lead at the Genito-Urinary Medicine (GUM) department at Luton and Dunstable Hospital to rectify this in the short term, and had continued to work with commissioners to resolve the issue formally.

Lessons learned and improvements

The service learned and made improvements when things went wrong but also learned from things that went well.

The provider had developed an incident reporting and learning programme known as PAIERs – positive, adverse and irregular events reports. Staff we spoke with told us they were aware of the process and provided examples of when they had reported and learned from such incidents. We have commented on this process in more detail under 'Well-Led' below.

Staff took immediate action to rectify safety issues as soon as they were identified. We saw that a small pair of nail scissors had been taped to the high point of the door to the patient waiting room; a work-around to facilitate the removal of the plastic seal that is placed there after cleaning. On our advice, the manager immediately removed these and ensured they were held in a place that was accessible to staff but not to patients. This was also recorded by the manager as a PAIER so that it could be shared as a learning point and so there was an accountable record.

Incidents categorised as 'serious' were investigated thoroughly and resulted in detailed action plans to correct shortfalls. This had happened on only one occasion at this location in the last year and we reviewed the incident records. The action plan called for initial assessment documentation to be reviewed and for staff training. Staff we spoke with were all aware of the incident and the outcome, which showed that the process was effective in ensuring practice improvement.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients attending the Emerald Centre were thoroughly assessed according to national FFLM guidance. This was the case for people who accessed the service through the police or local safeguarding processes, and those who self-referred. Patients who were followed-up by the ISVA workers were also continually assessed using nationally recognised toolkits developed by a specialist sexual violence organisation. Our review of records for all parts of the patient's journey showed that assessments were holistic and took account of physical health, emotional resilience, mental health and a range of social attributes to ensure their needs were thoroughly identified.

Plans accurately reflected the assessments so that staff could deliver care and support to meet those needs. For example, the ISVA workers used an 'Impact of Events Scale' to help identify Post-Traumatic Stress Disorder and patients were referred to psychological therapy services to support their management of this. In this way, patients could be assured of a service that met guidelines issued by the National Institute for Health and Care Excellence (NICE) and enabled them to experience good health outcomes.

Crisis workers in the Emerald Centre had received training in the use of a psycho-educational programme to support survivors of sexual assault with emotional resilience. This was developed by charitable organisations specialising in support for survivors of violent crime and was part of a 'talking therapies' pilot the provider was participating in. The programme had already been delivered in some of the provider's other SARC locations but it had just begun in Bedford at the time of our inspection and so we cannot yet evaluate its impact.

Staff followed clear, well-established pathways and protocols for different sexual assault situations. These ensured patients were seen quickly, by the right person and at the most appropriate location. On those few occasions when patients were still in hospital as a result of injuries sustained during a sexual assault, clinicians attended the hospital to carry out the initial examination and liaised with hospital staff to ensure it was conducted with due regard to their current physical health. Staff occasionally attended the children's outpatients' clinic where this had been deemed to be the most appropriate place to examine a child and was in their best interests.

Staff we spoke with were knowledgeable about different types of sexual assault and in providing care for patients with injuries they might have sustained or the effects of alcohol and drugs. For example, practitioners used established pain assessment tools to ensure they fully understood patients' experiences there and then and ensure they had appropriate medical follow-up. Staff also followed guidelines for assessing the need for and the use of PEPSE or contraceptive medicine.

Monitoring care and treatment

Managers and staff at the Emerald Centre participated in a range of quality monitoring activities and audits to ensure the service was effective and operated within guidelines, such as audits in the use of PEPSE medicines and emergency contraception. These provided managers with assurance that patients experienced the best and most effective outcome from these medicines.

The provider hosted monthly clinical review meetings for managers of their other SARC locations in the East of England. This helped managers to benchmark their performance against other SARCs and to share good practice. This ensured that this location and others provided by Mountain Healthcare delivered a consistent service across its footprint.

The provider had commissioned external organisations to support their monitoring activity. This included a 'secret shopper' exercise of the pathway support services carried out by an independent group representing survivors of sexual assault. The provider also commissioned an organisation specialising in sexual violence to carry out a review of the ISVA service. Both of these exercises led to new ways of working and some additional staff training to support this. In the latter case, this also led to the introduction of a regular audit of the effectiveness of the ISVA service, which had shown significant improvements over time.

Effective staffing

Forensic clinical staff received initial, specialist training in their role that met national requirements set by the FFLM. There was also a comprehensive, professionalised

induction programme for each staff group; crisis workers, forensic clinicians and ISVA workers. These were competency based and used national occupational standards set out by the 'Skills for Justice' national training organisation and by an organisation specialising in sexual violence. As well as online and face-to-face training programmes, staff received structured learning from exposure to workplace experiences so they could be 'signed-off' as competent. Staff records we looked at for each staff group showed that all staff had completed these programmes.

The provider had introduced a preceptorship programme to develop senior FNEs supported by a licensed training course and against FFLM quality standards. This two-year programme had been successful in another of Mountain Healthcare's locations and had enabled the provider to increase the level of clinical and forensic expertise in its workforce. The provider had just introduced the programme at this location at the time of our inspection and so we could not evaluate its success.

Staff maintained their competence through regular refresher training in key subjects essential to the effective running of the service and through peer review of their work. For example, recent training had included a court skills course which supported staff to understand the importance of accurate note-taking and their role in the criminal justice process.

There was a strong approach to peer review and supervision for clinical staff and the ISVA workers. One set of notes and four video recordings made by each FNE were peer reviewed by an allocated FME every quarter. This ensured that FNEs carried out examinations consistently and according to FFLM standards and enabled them to check the accuracy of their work. FMEs peer reviewed each other's records quarterly and participated in peer review activity with clinicians from other providers. This supported consistency in this SARC and contributed to practice improvement across the SARC network outside this provider.

ISVA workers received one-to-one monthly supervision from the centre manager, which included a review of patient records of cases that they held. They also received group, six-weekly clinical supervision from a consultant psychologist from another local health provider. This ensured patients of the ISVA service were supported by competent staff who had good, clinical oversight.

Co-ordinating care and treatment

Crisis workers, clinical forensic examiners and ISVA workers at the Emerald Centre worked effectively together to assess, plan and deliver care and treatment. The patient's journey began with a call to the pathway support services who then ensured a crisis worker was available to meet the patient and a forensic examiner called out to undertake the examination within agreed timescales. Crisis workers and forensic examiners worked closely together to accurately assess patients prior to their examination and this supported continuity of care. This was continued for those patients (most) who were referred onwards to the ISVA workers for follow-up.

Staff also worked with multi-agency professionals to ensure the examination and follow-on care met patients' needs. Staff met with police investigators or children's social workers, before the examination began to agree the scope and extent of the examination for each individual patient.

Children and young people were also referred to other agencies, including the local authority, to broker additional, targeted support through early help or child in need processes. We reviewed an example of this that demonstrated the ISVA worker's key role in establishing a child's wishes and feelings to support a 'team around the family'. The ISVA workers also made referrals to local services for adults, such as the community mental health team. In one case we noted how the ISVA advocated for a patient who was undergoing trauma focused work and supported them to make a claim to the criminal injuries compensation authority.

Health improvement and promotion

The provider ensured patients were routinely screened for sexually transmitted infections including HIV. Prophylactic medicines were supplied to patients at risk of HIV and hepatitis to ensure they were protected from these.

Records we reviewed showed that staff wrote to patients' GPs to enable them to receive follow-up health advice in the community.

Patients received effective advice and guidance about sexual health both from the staff at the location and also in the form of written information and posters.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

Staff understood the importance of seeking informed consent. Crisis workers were trained in communicating with people of different ages and provided patients with clear information about the SARC's services, both verbally and in written form. Staff used differentiated story-boards and leaflets aimed at young people, younger children and their parents. This information was easy-to-understand and was supported by staff who took time to explain to patients the purpose of the examination to ensure they understood what they could expect. Signed consent was obtained from patients and their advocates or carers in accordance with FFLM guidelines and this was revisited throughout the clinical examination.

We spoke with staff about the legal standards for obtaining consent from children and young people in their own right. The process of providing information and establishing the child or young person's understanding before obtaining consent is a standard known as 'Gillick competence'. Staff followed particular guidelines, known as 'Fraser guidelines', before providing contraception and sexual health advice to young people. Staff knew the difference between both standards, which demonstrated a good understanding of the situations when they would be applied.

If there was doubt that a patient had not understood what was happening, the examination did not proceed. In one record we noted that an adult patient who spoke another language but who said they understood English well had given consent. Staff became aware that the person might not have fully understood their explanation and so the procedure did not go ahead. The examination was rescheduled for later the same day when an interpreter had been booked. This enabled the person to provide valid consent at a time that was still within a forensically viable timeframe.

Staff also understood the provisions of the Mental Capacity Act 2005 for establishing a person's capacity to consent where such limited capacity was suspected. During our interviews with staff we were assured that they knew how to assess a person's capacity using the relevant code of practice, and whom to involve in the process to ensure decisions could be made in the person's best interest. However, we did not review any examples of this in the records we reviewed.

Are services caring?

Our findings

Kindness, respect and compassion

Staff were kind, respectful and compassionate to patients who had used the service as a result of their experience of significant sexual, emotional and often physical trauma. We found that the Emerald Centre was a patient focused service.

All staff members working at the Emerald Centre were experienced practitioners. They were knowledgeable about the nature of sexual assault and understood well the impact of such abuse. Staff told us that people's emotional wellbeing was their priority and said they treated people with compassion having regard to their abusive experience. This was borne out in patients' feedback.

Four people who left comments cards for us to collect provided positive feedback. One person noted that they felt safe, and that they were treated with dignity and respect. Another person used an easy-read comment card to advise us they thought they had been treated with respect.

A parent of a child patient who had been examined and had received support from the ISVA workers wrote extensively about the feelings of frustration and emotional pain experienced by their child and family. In expressing their thoughts about how the service had helped them they said that it had provided significant mental, emotional and practical support for them and their child.

The provider collected patient feedback and published this in their monthly newsletter. One patient comment stated that the staff had done a really good job and made them feel very comfortable.

Staff allowed patients time and space so that the forensic examination could go ahead at their own pace, including time for them to shower afterwards. Staff offered patients light refreshments whilst they discussed the next steps with clinicians and crisis workers before they left the centre. This was offered to support them to regain some comfort and self-esteem after their examination.

The registered manager told us that staff demonstrated the provider's vision of 'doing the right thing' and knew that staff wanted to 'go the extra mile' for all patients who were traumatised. This meant that staff always displayed empathy and kindness to patients of all ages.

Involving people in decisions about care and treatment

People were given plentiful information about the SARC, its function and what to expect during their visit and follow-up. This was prominent on the location's website which made it clear that patients could stop any process whenever they wanted. This was mirrored in the information leaflets provided to patients when they attended. Staff took their time to ensure patients understood what was going to happen to them before seeking consent for an examination to go ahead. Staff explained to us that it was very important for people who had experienced a traumatic event in which they had had no choice, to have control over what happened to them at the SARC. We were assured that patients were cared for by sensitive, patient-focused practitioners.

One person's feedback about the examination process that the provider had reported in their quarterly report to commissioners stated that the staff made them feel comfortable even though they had no intentions of going through the medical. They said they thought all the staff were very kind, caring, supportive and that they were given all the time they needed.

Feedback about the ISVA workers the provider had published in their newsletter stated that both workers were very helpful and made them feel very comfortable by explaining everything very well.

The operating processes for the ISVA workers followed guidance on the essential elements of the ISVA role, issued by the Home Office in relation to ensuring the service was focused on, and led by, patients' individual needs. Our interviews with the ISVA workers confirmed they followed this principle implicitly when advocating on behalf of patients. Our review of ISVA records showed that decisions about accessing follow-up services were led by patients.

Patients who self-referred had a choice about whether to involve the police or not. They could also choose if they had forensic samples taken and whether to pass these to the police up to seven years after their examination. This means patients remained in control of the outcome of their visit.

Are services caring?

The voice of the child was prominent in records relating to children who used the service. Records we looked at showed that staff engaged children in discussions and took account of their wishes and feelings in relation to the conduct of examinations

Patients whose main language was not English had access to interpreters who attended centre to translate key information to patients to ensure they had a good understanding of the process. However, during our visit we did not see any posters or leaflets in easy-read format to provide information to people with a communication difficulty.

Privacy and dignity

Staff at the Emerald Centre respected and promoted people's privacy and dignity.

Staff examined patients with sensitivity given the intrusive nature of the process. Screens in the examination room enabled patients to undress at their pace. Suitable clinical garments were available for patients to wear during the examination to enable them to expose only those parts of the body that were being examined at any one time.

Crisis workers took time to build trust and rapport to ensure patients were aware their privacy and dignity would be respected during the intimate examination. Feedback from one person recorded in the provider's newsletter stated that the SARC had made them feel comfortable throughout and that they were relieved there were people they could talk to alleviate their worries.

The provider's website explained what patients might experience during their visit and there was an overarching message of respect, dignity and compassion. The website had a specific section on the ISVA service, which explained that the service was independent, private and confidential (save for any safeguarding concerns that might be identified). This means patients could approach the ISVA, confident that the information they shared would remain in confidence.

Patient records were held confidentially in secure storage and computerised records relating to calls to the service were held on a discrete system accessible only to staff at the centre. This included records of the medical examination and video recordings taken with the colposcope.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patients' needs and preferences. The service was responsive to the needs of the local population.

The provider understood the prevalence of sexual assault in Bedford and neighbouring local authority areas of Cambridgeshire and Hertfordshire. They collected and used data to ensure the service was resourced to meet the local need and this was set out in their offer and their contract.

Patients had access to a 24 hour-a-day service through a responsive pathway. The provider's website had clear information about how to access the service and what patients could expect. The location also accepted referrals, with patient consent, from other professionals such as GPs or sexual health clinics.

Children and young people under the age of 13 were always referred to the service through local child protection processes. There was no facility for children under 13 to self-refer or for child protection procedures to be by-passed. Children and young people had access to specific paediatric clinics at this location or at either of the providers other two SARCs in neighbouring Hertfordshire or Cambridgeshire on a shared daily rota.

After the initial examination, adult and child patients were referred to the ISVA part of the service for follow-up procedures and to facilitate access to other health or psycho-therapeutic services. The provider had ensured the ISVA workers were trained to support both adults and children so they could respond to patients of all ages.

The Emerald Centre was staffed exclusively with female practitioners. This means that patients could not generally choose the gender of the clinician that carried out the examination. The registered manager was aware of this issue but explained this was reflective of the national picture where male clinicians, historically, rarely apply for such positions and so were uncommon, despite the equity of recruitment processes. This limited the choice of patients who might prefer to be seen by a male clinician although we were not advised of any occasions when this had arisen. The provider had plans in place to mitigate this, such as extending the use of Male Quality Standards, developed by an organisation specialising in sexual violence to this location. In addition, the provider's Hertfordshire SARC with which the Emerald centre shared a rota, had a special interest area relating to male patients and were available for consultation.

The Emerald Centre used paediatric equipment to facilitate the examination of children. However, the registered manager acknowledged that the facilities were not child focused. There was only one examination suite and the nature of its use meant that it was brightly lit and clinical. It had no other decorative or 'softening' characteristics to make it friendly to young children. The provider and commissioners understood this issue and there were long-term plans to address it including the relocation of the centre to another site that would enable child focused facilities to be part of the design. In the meantime, other opportunities to examine children in children's outpatients' clinics were sometimes taken following a risk assessment and in the best interests of the child.

The Emerald Centre's responsiveness was illustrated in feedback comments we received and those collected by the provider. One comment in the provider's quarterly report explained how staff had been understanding and how the patient had been put at ease through much reassurance. Another person wrote to us about their child's experience at the SARC and praised the way the ISVA workers had advocated for them with multi-agency partners.

Since taking on the role in the previous year, the centre manager had begun to raise awareness of the service with local groups. This had included some training and discussion on prioritising medical treatment in sexual assault cases, delivered to a small group of nursing staff at Bedford Hospital. This resulted in a request being made to repeat the training on a regular basis for the hospital's medical and nursing staff. The manager also delivered training to the local CAMHS service and had raised the awareness of the SARC to around 50 members of the CAHMS staff.

The manager had delivered some information sessions to staff at the Department of Work and Pensions (DWP) in Bedford. This was in response to an increase in sexual assault disclosures made to DWP staff and the need for them to understand what steps to take in. SARC practitioners had staffed a stall at the Luton and Bedford

Are services responsive to people's needs?

(for example, to feedback?)

Colleges Freshers' Fair to raise awareness of the centre and its services to the large student population in the area. In this way, the centre had promoted awareness of its services among a number of vulnerable populations. The number of increased referrals had not yet been measured and so we cannot evaluate its impact.

This SARC, along with three other of the providers SARCs in the East of England, have individual responsibility for particular groups. The Emerald Centre is responsible for promoting the service to black and minority ethnic groups as part of a quality improvement initiative. The manager had plans to engage faith groups to move this forward. This is a recent initiative and so we cannot yet assess its impact.

Taking account of particular needs and choices

Staff from the Emerald Centre responded to people with particular needs to ensure they had equal access to the service. Patients who were injured and in hospital were seen there by a forensic clinician to ensure their medical treatment was not hindered. Senior staff confirmed that they had, on rare occasions, visited the place of residence of people with complex needs to carry out an examination where this was in their best interests and following a risk assessment. This enabled people to receive an examination where it was not possible for them to be seen in the centre, although we did not review any records of such patients.

The service was accessible for people who use wheelchairs with full, level access through the wide, main door into the centre and throughout the location.

The provider's data indicated that children and young people, men, women and people who identify as transgender used the SARC in the last year. The data also showed that patients who identify as belonging to one of 20 minority ethnic, racial or cultural categories have used the service in the last year. This is reflective of the cultural diversity of people in Bedfordshire.

The data showed that people with certain vulnerability characteristics have also used the centre. This includes patients with a history of domestic abuse, substance misuse, mental ill-health, self-harm, learning disability and those who are sex workers. Staff told us they make referrals to appropriate services, with consent, for patients who are vulnerable. This includes mental health and substance misuse services and this was borne out in our review or records.

People who do not wish the involvement of police or criminal justice processes could self-refer to the SARC and access any of the services offered; including a forensic examination, a holistic health assessment, STI screening, emergency contraception and the ISVA service. The centre kept all forensic samples of people who self-refer for a period of seven years to ensure patients could have the opportunity to involve the police at a later time if this was what they decided.

The exception was for children aged 12 and under who could not self-refer. An extensive discussion took place with young people aged between 13 and 15 who self-referred to establish their competence to consent. This was subject to the young person's understanding that staff would make safeguarding referrals to the local authority where risk or abuse was suspected.

There were processes for identifying patients who used the centre more than once although the manager advised us this had not happened at this location since the provider had been running it.

Timely access to services

Patients could access the service within an acceptable timescale for their needs, whether they were referred by the police or through safeguarding processes, or had self-referred. This included patients who visited within a forensically viable timeframe and those who reported their experience much later. Such patients were involved in discussions about their extent of the forensic examination but in any event, could access the rest of the centre's services and health care.

The pathway support service used the crisis worker, FME and FNE rotas to ensure that patients who called out of normal hours could be provided with a service within one hour of their call.

Listening and learning from concerns and complaints

The provider had a complaints policy which called for each complaint to be thoroughly investigated and responded to as a positive, adverse or irregular events report (PAIER). This meant complaints were reviewed by the registered manager within seven days. The provider had no recorded complaints for this location.

Are services responsive to people's needs?

(for example, to feedback?)

Themes from PAIERS, including complaints, were identified and fed back to staff during team meetings. PAIERS were also fed back to staff through the provider's newsletter. Significant learning, or evolving themes, resulted in an action plan for changes to procedure or training.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership capacity and capability

Mountain Healthcare Limited almost exclusively provide SARC services in different parts of the country. Our discussions with the medical director and the director of nursing, supported by our review of information, indicated that the senior team had a good understanding of this field of health care. The provider had built, and was continuing to develop, expertise in this area of work.

Leaders at the Emerald Centre had a good understanding of their local area and had tailored the service to meet local needs, particularly in relation to adequate resourcing of the FNE rotas.

The provider's senior leadership team were accessible and visible, and frequently visited this SARC. The medical director was also the registered manager of this and a number of other locations operated by the provider. They had a good understanding of the comparative strengths of each location. This supported practice development across the provider's SARC estate.

The provider had experienced a period of growth over the two years prior to the inspection with the acquisition of a number of SARC locations. As a result, their business plan was evolving to take account of the growing estate and workforce. Senior leadership roles had been increased with leaders taking on new areas of accountability. Although this was a period of change and growth, we found the delivery of the service at this SARC had remained effective and consistent. This was evident in our review of information and interviews with managers and staff at the Emerald Centre.

Vision and strategy

The provider's vision of 'being kind to each other' and to 'always do the right thing' was well understood by the manager and staff at the Emerald Centre. This was evident in the kind and compassionate ways of working that we outlined above in 'caring' and in our interviews with staff.

The provider understood local areas of concern affecting their practice as they had registered these as organisational risks and were using a targeted action plan to address them. For example, the provider was in dialogue with the safeguarding children partnership about risks relating to not being invited to safeguarding strategy meetings. This had a timescale of April 2019 to be resolved.

Supervision processes and the peer review of practitioner's work showed that the provider and local managers were committed to practice improvement. The nature of case discussions and review promoted the involvement of all staff in the providers' vision and strategy. The provider had used a variety of communication methods, such as briefings and the quarterly newsletter, to ensure staff in all their SARCs understood their purpose and direction. This meant that staff supported changes and understood their role in relation to practice improvement.

The provider had formed a research group, in collaboration with a university, to help them understand the importance of national developments and to be clear about the purpose of their own projects. The aim of this was to embed quality improvement from those projects into practice in each of their locations. For example, the group had begun a project to consider how best to implement an accessible SARC service in prisons, an area or work that is relevant to Bedford.

Culture

Our interviews with staff showed that there was a good culture of providing high quality, compassionate and effective care and this was supported by the positive feedback from patients we reviewed. Staff told us they felt valued by the provider and felt positive about their work.

There was an emphasis on openness and candid reporting of incidents through the PAIERS process. The thematic analysis of PAIERS showed that the Emerald Centre was a 'high reporter' in comparison with the provider's other SARCs. Staff understood the process well and provided examples of when they had reported such incidents. This showed that staff at this location had a good insight into the incident reporting process and understood its value to practice improvement.

The provider promoted a culture of continuing professional development. For example, crisis workers could access additional training courses with recognised qualifications, such as the Royal College of Nursing care certificate, and were given paid study leave to do so.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Staff worked well with each other to ensure patients received the best possible service. This extended to the ISVA workers, who were not based at the location but whom were considered to be very much part of the team and the service.

The provider promoted dialogue and collaboration across all of its SARC locations through its quarterly newsletter, which kept staff in touch with corporate developments. The newsletter also celebrated success stories through publishing feedback from positive PAIERS.

Mountain Healthcare had carried out a staff survey in 2018 to understand the staff view of the services. The survey findings informed an action plan, directed by the communication and information governance group, to address issues raised. One of the plans was to provide opportunities for staff to show initiative in their role by integrating quality improvement into each person's personal development plan. For example, the centre manager for Bedford had been allocated the role of improving engagement with black and minority ethnic communities as we reported above in 'responsive'.

Governance and management

There were clear responsibilities, roles and systems of accountability to support good governance and management. This SARC continued to receive positive feedback with quality reports showing it had performed well.

There was a clear governance structure with senior leaders having portfolio responsibility for key areas of business, such as communication and information governance, education, financial governance, call centre and safeguarding. These reported quarterly to an integrated governance group that had overall accountability for decision making and the provider's strategic direction.

Staff numbers and response times were checked as part of the provider's quarterly monitoring process. Those few occasions when the response time had exceeded one-hour were raised as an issue for management action and was reflected in the provider's performance data. This had led to the provider identifying the need for an additional, dedicated FNE rota solely for the Emerald Centre. This had resulted in a bid for further funding to recruit staff to this rota as opposed to the existing FNE rotas shared with neighbouring SARCs at the time of our visit.

The provider had recently introduced a paediatric governance framework for each of its regions, developed by the provider's paediatric forum meeting. This was designed to develop practice through identification of risks and action planning. We saw examples of the effectiveness of this oversight, such as the previously mentioned risk relating to safeguarding strategy meetings.

Overall, we found that the governance processes for Mountain Healthcare and for this location were strong, and enabled accountable decision making.

Processes for managing risk, issues and performance

As previously reported in 'safe', the provider had good processes for identifying and managing risks and issues through the PAIERS process and its governance framework. This was supported by a regular audit programme of key aspects of the business such as the safeguarding notes audit, the ISVA audit and the audits for prophylactic and contraceptive medicines.

There was also an effective performance management process and we were provided examples of when this had been effective in Bedford.

Appropriate and accurate information

The provider understood it's area of business well through its diligent data collection against national criteria and quarterly reports to commissioners. Information was accurate and enabled the provider to have a holistic overview of its performance.

Quality and sustainability were key features of the provider's workplan given their recent expansion and increase in workforce and premises. The provider's commitment to quality was evident in our review of governance documents and our interviews with leaders.

There were firm arrangements in place to ensure the availability, integrity and confidentiality of identifiable data and to identify any occasion when there might have been a data breach.

Engagement with clients, the public, staff and external partners

The SARC involved patients, staff and external partners to support high-quality sustainable services.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

External partners were engaged in daily dialogue with the service on an operational, individual service user level. Partners were also involved in monitoring the performance of the SARC through the operational performance meetings.

A service user that sits as part of the operational performance meeting had also contributed to the design of outward facing patient information and had suggested changes to the way language was used to describe certain aspects of sexual assault and abuse.

The Emerald Centre routinely collected feedback from patients through a feedback form on the location's website and this feedback was published as part of the provider's newsletter. This, too, supported the service to understand areas where it was performing well and where it needed to develop through a 'you said – we did' approach.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation, and quality assurance. This included the previously mentioned PAIERS process, the centre's range of audits and the quarterly data reporting.

The provider's medical director reviewed all PAIERs weekly to identify themes and discussed them with the safeguarding lead and leadership team. This resulted in an annual thematic analysis of incidents and an associated action plan which enabled learning from incidents across the provider's SARC estate to be shared with each location.

The staff team had regular, one-to-one clinical supervision and case load supervision. Staff discussed learning needs, general wellbeing and aims for future professional development at their annual appraisals and we saw evidence of completed appraisals in the staff folders.