Surrey and Borders Partnership NHS Foundation Trust

Trust Headquarters

Inspection report

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Overall summary

We carried out this announced inspection on 31 May 2022 and 16 June 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 conducted by two CQC inspectors.

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.

Background

This sexual assault referral centre (SARC) is located at Cobham Community Hospital. The SARC comprises a suite of rooms on the first floor of the hospital site and is occupied by this provider, Surrey and Borders Partnership NHS Foundation Trust (SABP) and another provider.

Summary of findings

The other provider is responsible for the SARC service for adults, for children aged 13 and over and for children under 13 who have recently experienced sexual assault (the under 13 'acute' pathway). The other provider is also responsible for the premises, the environment and the equipment used in the centre. We have previously inspected and reported on the service provided by the other provider.

SABP is responsible for the SARC service for children aged under 13 whose experience of sexual assault is regarded as 'non-recent'; that is where the type of assessment would not need to include a forensic examination due to the amount of time elapsed following the assault and usually described as being over 72 hours. This inspection was solely of that service. This report focuses just on the pathway and the clinical assessment of children in this group. All other aspects of the centre that relate to the sexual assault pathway for adults, children aged 13 and over, the under 13 acute pathway and for the premises and environment can be found in our report of the other provider.

Assessments of this small number of children are carried out in a 'non-forensic' examination room; the room is not used for collecting forensic samples. Children visiting this this service also used other, non-forensic waiting and reception rooms located in the centre.

Each examination and assessment is carried out by two consultant paediatricians who are more usually employed in other paediatric medicine services provided by SABP. The service operates during the daytime every Thursday, with paediatricians selected from a rota for that day. This rota runs alongside the daily paediatric rota for child protection / non-accidental injury medicals.

The other provider supports SABP paediatricians with some administrative and record keeping functions. All children requiring this service are seen by virtue of an appointment scheduled for this clinic and so there is no out-of-hours or emergency function associated with the service.

As the service is provided by SABP, the trust is responsible for meeting the requirements of the Health and Social Care Act 2008, and the associated regulations about how the service is run.

Prior to our inspection we reviewed a range of policies, procedures, data and other records that the provider had sent to us in advance. On the day of our visit we spoke with two paediatricians and with two members of a therapeutic and advocacy service to whom children are referred following their visit to the centre. Whilst visiting the centre we reviewed the records of six of the 22 children whom had used the service provided by SABP in the last year. Subsequent to our visit we held a meeting with two members of the trust's senior leadership team.

Our key findings were:

- Staff carried out safe, effective and comprehensive assessments of children.
- The service had good systems to help them manage risk.
- The staff used safeguarding processes effectively and knew their responsibilities for safeguarding children.
- The service had effective recruitment and staff training and development procedures.
- Doctors provided children's care and treatment in line with current guidelines.
- Staff treated children with dignity and respect and took care to protect their privacy and personal information.
- The appointment / referral system met children and families' needs.
- The service had effective leadership and a culture of continuous improvement through peer review.
- Staff felt valued and supported and worked well as a team.
- The staff had suitable information governance arrangements.

Summary of findings

There was an area where the provider could make improvements. They should:

- Develop ways to obtain feedback from children and families in order to better understand their experience and make improvements as necessary.
- Ensure that all children are offered a choice of the gender of clinician prior to the examination.

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?	**No action** ✓
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)

Our review of information supplied by the provider and our interviews with staff showed there were systems and processes to ensure children using the service were kept safe. Policies about safe practice, such as health and safety, information governance and infection prevention and control were up-to-date and regularly reviewed. Staff knowledge and skills about safe practice was refreshed according to a mandatory training schedule. All staff were up to date with this training.

The trust safeguarding children policy was detailed and up-to-date. Our review of records and interviews with staff demonstrated they were very competent and knowledgeable about local safeguarding arrangements. A culture of continuous professional development meant that staff had received regular safeguarding training and learning opportunities that exceeded the standards set out at level three of national, intercollegiate guidance for healthcare staff.

Staff also had a positive approach to sharing safeguarding information with relevant partners. For example, every child's assessment resulted in a referral and detailed report being made to local safeguarding partners regardless of where the initial referral emanated from. This meant that other professionals working with the child and family had a clear understanding of safeguarding risks.

Staff were safely recruited according to the provider's recruitment policy. This included enhanced checks with the Disclosure and Barring Service that were renewed every three years. Staff were actively recruited from a very small pool of paediatric colleagues that had previous experience of child sexual abuse examinations.

There were sufficient staff available on the rota to ensure that every assessment was carried out by two paediatricians. Safeguarding documentation was signed off by each doctor to ensure consistency and clarity of findings before being sent to safeguarding partners.

Monitoring data sent by the provider indicated that paediatricians were often not invited to strategy discussions where the prospect of a sexual abuse examination was being considered, and this varied across each of the four local geographic areas served by the SARC. This meant there could be inherent delays in arranging such examinations or that the question of whether a medical examination was appropriate could not be addressed by partners in an informed way. Staff acknowledged this and explained they had made numerous efforts over time at an operational level, including during training for other partners, to encourage local area safeguarding teams to involve medical expertise in such discussions. The provider had escalated this at a strategic level with partners but this had not yet led to significant improvements.

Risks to clients

Staff used templates to help in assessing and examining patients, including paediatric assessment forms that were based on templates recommended by the Royal College of Paediatrics and Child Health (RCPCH). Body maps were used to document marks and injuries. The use of standardised forms ensured staff asked relevant and consistent questions to ensure accurate assessment.

Records showed a comprehensive record of the assessment of a range of risks for each child such as safeguarding risks, physical and mental health risks and risks of sexually transmitted infections (STI). Professional curiosity was clear and was strongly demonstrated in records we looked at which resulted in an extensive understanding of the risks for each child.

Are services safe?

Where risks were identified, appropriate action was taken through follow-on referrals to other services. For example, children were offered the opportunity to provide a sample of urine to test for chlamydia and were referred to another partner for blood to be taken to test for blood borne infections. In each case the results of these were followed-up as part of the after-care process so that children could be recalled and seen by the doctors in respect of any genito-urinary issues.

We have reported on risk arising from the safety of the premises, environment and facilities in our inspection report for the other provider who was responsible for this aspect of the location.

Information to deliver safe care and treatment

Information from children's assessments was recorded in hard-copy, paper format. These records were comprehensive, legible and well-ordered. All information relating to the examination and to children's safety was clear and easy to understand. Records also contained hard copies of email chains with other professionals both before and after the examination so decisions made about the need for the examination and for follow-on care were all accountable.

Specialist equipment, known as a colposcope, was available at each site for making records of intimate images during examinations, including high-quality photographs and video. The purpose of these images is to enable clinicians to review, validate or challenge findings and for second opinion to be considered during legal proceedings. The video recording of each examination was stored securely along with the documentary record, in a double locking system maintained by the other provider.

Relevant information about the child's examination was transferred safely and securely to other services providing follow-on care as well as to the child's GP and the child's parents or carers. For example, the outcome of every examination was routinely shared with safeguarding partners using the local area's safeguarding documentation.

Safe and appropriate use of medicines

As part of this, 'non-recent' sexual abuse pathway, clinicians did not issue children with post-exposure prophylaxis following sexual exposure (PEPSE) medicines or with emergency contraception. We have reported on the use of medicines for children using the 'acute' sexual abuse pathway and their access to PEPSE and emergency contraception in our report for the inspection of the other provider.

Any medicines that children required arising from follow-up consultations with the doctors was prescribed according to the provider's prescription policy and was not administered on-site.

Track record on safety, lessons learned and improvements

The provider had a system in place for reporting incidents to the trust's leadership team through the trust's incident management process and a template designed for this purpose However, the very low number of children seen by the service in the last year had not resulted in any safety incidents.

Staff we spoke with demonstrated a strong safety culture, with a commitment to ensuring all assessments of children were carried out safely and all outcomes reported through safeguarding procedures. At the fore of this culture was the peer review process. Every assessment of a child was subject of scrutiny by colleagues at a formal peer review meeting every two months. Each staff member was required to attend five of the six meetings held each year. This meant that findings in respect of each child could be checked for accuracy and consistency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Examinations and assessments were carried out in accordance with the providers' protocol for this patient group, which met national guidelines. For example, the protocol in relation to assessing for the risks of STIs and blood borne viruses referenced and met the guidelines issued by the British Association of Sexual Health and HIV (BASHH).

Children's needs were assessed according to a template that met guidance issued by the RCPCH for this type of examination. All of the children's records we reviewed showed a clear, holistic and thorough assessment of their needs and each of the records was of a high standard. This included an assessment of their physical and emotional health needs as well as their development and their social situation. This resulted in a clear plan to meet the child's needs which was documented in the record. Children's needs were met either by way of referral to other services or the child's GP, or by seeing children in later routine paediatric clinics for follow-up. This enabled follow-up care and treatment to be delivered in a consistent way by a doctor who understood them well.

Monitoring care and treatment

The number of children using this service was very low. Therefore, clinicians monitored the quality of children's assessments on an individual basis through the peer review process. The records and video recording of every child's examination were reviewed to check the quality of the assessment, the validity of the findings and the timeliness of follow-up activity.

The notes of peer review meetings showed that discussion took place and that actions were taken to follow up where required.

Effective staffing

There were effective arrangements to ensure clinicians were properly trained and supported to carry out their role.

Doctors were recruited to this particular role from a pool of paediatricians employed by other paediatric services in the trust and where they had developed experience of carrying out safeguarding medical examinations. All clinicians received nationally recognised training in the examination of child sexual abuse from established centres. Staff also had a collaborative arrangement with paediatricians from Kent and Sussex to jointly commission and participate in specialist learning events.

There was a comprehensive induction process that included a staged approach to skill development. This included shadowing and observing examinations, taking part in peer review meetings and supporting examinations as the second doctor. New doctors were mentored by existing staff during this period so that both they and senior colleagues could be confident of their readiness to lead a sexual abuse examination.

The trust had an extensive mandatory training programme and all clinicians on the rota were up to date with this schedule of training.

In addition to the peer review process, all clinicians were regularly supported by a strong clinical supervision regime led by the clinical lead, which considered developmental opportunities as well as support in managing their feelings arising from this stressful area of work.

Co-ordinating care and treatment

Staff worked well with other services supporting children after their visit to the centre. Records we looked at showed that every child was followed-up with an appropriate referral to other services depending on needs identified during their assessments. This included referrals to, for example, the child and adolescent mental health services provided by this

Are services effective?

(for example, treatment is effective)

trust and the school nursing service. The outcome of every child's examination was communicated to the child's GP to enable further care to be coordinated in the community. All children visiting the centre were followed up in paediatric clinics and the outcome of every child's examination was communicated as a safeguarding matter to children's social care.

Doctors routinely referred children to the Sexual Trauma and Recovery Service (STARS) regardless of the outcome of the examination. Through the STARS, children could access therapeutic services as well as sexual violence advocacy from a children's independent sexual violence adviser.

Consent to care and treatment

We observed very strong practice in relation to consent to care and treatment, which was obtained in every case in line with the law and relevant guidance.

Our interviews with staff and review records showed that consent was obtained in every case from the outset and was revisited dynamically throughout the examination. Information was conveyed to children in a way that they and their parents or carers could understand and this was helped through the use of written materials. Children's understanding of what was happening to them was tested in accordance with established standards and examinations proceeded no further if any child withheld their consent at any time.

Staff from the STARS service told us that the SARC's positive and considerate approach to obtaining consent was an area that was frequently remarked upon by parents of children they saw.

Are services caring?

Our findings

Kindness, respect and compassion

Staff at this service understood and respected children's needs and showed compassion and empathy whilst engaging with them.

Our interviews with staff, our review of records and feedback we received from staff in the STARS service showed that paediatricians provided a child focused service. Examinations were led by the needs of the children at all times and proceeded at a pace that they were comfortable with. Children were enabled to stop, or pause their examination at any time and in some cases if children were not ready to be seen or to continue they could be brought back at another time.

Staff were experienced and knowledgeable about the impact and trauma of sexual assault and abuse and were considerate of this when providing care and support. Clinicians took their time to get to know the child well and establish a strong rapport. Good use was made of toys and of an interactive television that provided calming and distracting media to enable children feel at ease.

Involving people in decisions about care and treatment

Children were given sufficient information to enable them to be involved in decisions about their assessment and follow-on care. The staff used child friendly information in the form of leaflets to enable children to understand what would happen throughout their visit and afterwards.

The STARS service told us about feedback they had received from children and families about the SARC. This feedback had been positive and reflected the fact that children were treated well whilst at the centre and that they were kept informed.

Children's voices were prominent in the records we reviewed and it was clear that clinicians had taken steps to ascertain and act upon children's wishes and feelings at every stage of their experience in the service.

Children could choose who accompanied them into the examination room, and staff made sure that they used language to describe body parts that were recognised by families when examining children. This helped to ensure children knew they were in control.

Privacy and dignity

Staff at the SARC respected and promoted children's privacy and dignity.

Children were enabled to maintain their dignity through the examination by making sure they were comfortable and informed throughout the examination.

Staff ensured children felt comfortable during the examination by using child focused language about the conduct of the examination; for example, by asking the child to think about the body shape of an animal or a toy they were familiar with, to enable them to feel less overwhelmed.

Children were also told about how their examination and their information would be held privately and would only be shared with those who needed to know.

Records were held securely in the centre under a double lock system.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

The service was responsive to the needs of children who had experienced non-recent sexual assault of abuse. This was evidenced by a child-focused pathway, the conduct of the assessment and continuity of care from referral into the service, to the provision of follow-up care to services we have referred to earlier in this report.

Records showed assessments were comprehensive where all children's needs were explored, identified and responded to, including those relating to communication or disability.

Children who could not speak English well were given access to interpreters who had experience of communicating with distressed children and families. We also learned of one example when a child had been offered the use of an intermediary to support the child's understanding of the assessment. An intermediary is a person whose role is described in law that supports children to communicate during criminal justice processes.

The location itself was subject of the risk registers for this provider and the other provider as they were considered to be too small for use for the children's clinic, with a corresponding risk that other patients may be using the SARC service of the other provider. There was a plan to relocate this service in the near future but this had not yet occurred at the time of inspection.

Taking account of particular needs and choices

The service responded to a range of needs and choices and children's wishes and feelings were clearly evident in the records we reviewed. The choice of the gender of the examining clinician was not always available as all paediatricians who provided this service were female, and this has been the case for the last three years. However, there was a male clinician available through the other provider if a child expressed a preference. The provider should ensure that all children are offered a choice of the gender of clinician prior to the examination.

The premises were accessible for children and families including ready access for wheelchairs and pushchairs.

Timely access to services

The service was coordinated alongside the pathway for recent, or acute sexual assault examinations offered by the other provider. Crisis support workers employed by that provider facilitated access to the location.

This clinic for children whom had experienced non-recent sexual assault was available by appointment on one day for each week. This was appropriate for the nature of this type of clinical need and the characteristics and requirements of the assessments, which were undertaken outside of the window for forensic opportunities. Children whose experience meant they needed immediate access to forensic medical services were seen through the acute pathway delivered by the other provider.

This service was offered mainly to children whom were referred through local safeguarding processes or by other health professionals. There was clear information available on the website of the other provider for services at this location in relation to families who wished to self-refer although there had been no such children's cases in the last year.

Listening to and learning from concerns and complaints

There was a clear complaints policy and an information leaflet available for families who might wish to raise concerns. There had been no complaints or concerns raised in the last year.

Any issues of concern arising during an examination were addressed during the peer review meeting for each child although there had been no concerns raised in these circumstances.

Are services responsive to people's needs?

Feedback was often received in an informal way from other services who saw children after their visit to this service. For example, we received some highly positive feedback from the STARS service who reported to us things they had been told by children about the SARC. However, there was no formal mechanism for children or families to provide feedback other than an evaluation form that was not generally used. Staff told us that it was usually not appropriate to seek children's views on their satisfaction with the service at the point that they left the centre. Nonetheless, staff agreed that this was an area they ought to address.

The provider should develop a way to obtain feedback from children and families in order to better understand their experience and make improvements as necessary.

Are services well-led?

Our findings

Leadership capacity and capability

Clinicians working in this service were supported by highly visible, responsive and knowledgeable senior leaders including the clinical lead for the service, the director of children and young people's services and the clinical director of children's services.

Leaders visited the centre occasionally but had direct contact with staff through their work in other parts of the paediatric services for which they were also responsible. This was done through weekly catch-up meetings with each doctor.

Leaders responsible for this service had a direct link with and were accountable to the trust board and also with the Children and Families Health Surrey (CFHS) partnership. The CFHS is a collaboration between this provider and two other providers of community paediatric services in Surrey that had some shared governance processes.

Vision, strategy and culture

The provider had a clear set of values that underpinned the trust's vision. These values were to treat people well, involve and not ignore, create respectful places and be open, honest and accountable.

These values were strongly evident throughout our interviews with clinicians and leaders and our review of records. Staff and leaders described the values as helping to build an empowering culture and good staff morale.

Staff were enthusiastic and motivated to provide the best caring service for children whom had experienced trauma and were committed to supporting each other to achieve this.

Staff told us they felt able to escalate any issues of concern. They understood their duties in respect of the duty of candour and related potential situations where this duty might be required. No incidents requiring a response in this respect had occurred within the last year.

Governance and management

There were clear governance structures and lines of accountability between the service, trust board and the CFHS oversight processes. There were clear mechanisms for reporting and action planning.

The weekly catch-up meetings between clinicians and the clinical director as well as weekly formal reports by the lead clinician ensured there was good leadership oversight of the work of the service.

All policies used by the service were those in place for the trust as a whole. The relevant polices we reviewed that applied to this service were all clear, up-to-date and well-understood by staff.

Processes for managing risks, issues and performance.

There are a number of internal and external quality assurances processes in place for this service. This includes senior representation at the quarterly CFHS quality and performance oversight group, which examined performance and risk data for the three paediatric service providers in the partnership. In this way, issues could be considered in terms of their impact on the delivery of the SARC service, such as staffing levels and waiting times in paediatric services. Leaders told us any staff shortfalls in other paediatric services has had limited impact on staffing the SARC rota as this service was prioritised. This was reflected in the staff rotas for the SARC clinic, which were always fully staffed, and children were always seen on time.

Are services well-led?

This service also had senior representation at the Surrey Sexual Assault Management Board (SAMB), a multi-agency strategic group that monitored the performance of this service and the services offered by the other provider from the same location. A review of minutes of these meetings showed the board to be active in addressing shortfalls although there were no such shortfalls identified for this service.

Due to the low numbers of children seen as patients on this pathway, much of the assurance for individual cases was done through the peer review process that we have already reported on above. This was an effective means of scrutinising the quality and depth of assessments as well as overseeing the performance of clinicians.

Staff were also involved in the developmental paediatric service weekly catch-up meetings, a forum that enabled low level issues to be identified and addressed dynamically.

Continuous improvement and innovation

There were processes in place to learn from incidents through the trusts' reporting system. However, there were very low numbers of children using this service and so there had been such incidents to report in the previous 12 months.

Doctors told us they felt the peer review process offered lots of opportunities to improve their practice as a result of learning from each other's experiences. This was demonstrated in the minutes of those peer review meetings we looked at, which showed action points to take forward for further learning and improvement.

As well as peer review, staff were well supported through supervision. Doctors received monthly supervision from the clinical director and this provided opportunities to reflect on their practice.

Staff and leaders were active participants in assurance and improvement strategic groups such as the SAMB set out above. For example, as part of this board's forward action plan we noted an action for staff at this service to raise concerns about children's support services with commissioners.

Staff carried out audits as part of their routine improvement activity. For example, a SARC notes audit carried out by the lead paediatrician in April 2022 considered the records of 28 children who had used the service in the previous year. This audit examined a number of features of the notes, such as attendance at strategy discussions; whether a child had undertaken an evidential interview prior to their visit; the follow up of STI screening and the general quality of the notes. There were a number of actions for improvement within the audit and a schedule for a further notes audit to check on whether those improvements had been made.