

G4S Health Services (UK) Limited Grange Park SARC

Inspection Report

Building B Cobridge Community Health Centre
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Overall summary

We carried out this announced inspection on 29 and 30 January 2019 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 who was supported by a second CQC inspector.

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

Grange Park Sexual Assault Referral Centre (SARC) is in Cobridge, Stoke on Trent and provides forensic and therapeutic support to adults who have experienced rape or sexual assault recently or in the past. The service, provided by G4S Health Services (UK) Limited, (referred to throughout the report as G4S) is commissioned by NHS England to deliver adult sexual assault cases only from

the age of 18 years upwards. Young people aged between 16 to 18 years can request to be seen at this service for the physical examination, however all aftercare is provided by the local paediatric sexual assault services. The local paediatric SARC service is not part of this inspection.

The service is provided by G4S 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 at Grange Park SARC is the SARC manager.

This SARC is a nurse led unit with the back-up of a Forensic Medical Examiner (FME) for complex cases and rota coverage. At the time of our inspection the core team consisted of the SARC manager, SARC coordinator, one crisis worker and two forensic examiner nurses known as Sexual Offence Examiners (SOE) who worked on a 4 day on 4 day off basis. A third flexi nurse had been recruited and was undergoing an induction and training period. The nights were covered by flexi contract SOE nurses and crisis workers. The SARC manager and SARC coordinator were also both trained Crisis Workers.

Summary of findings

The service is available 24/7 to help people that have been affected by sexual abuse and sexual violence. Patients can be referred through the police or directly self refer using the self-referral 24 hour phone line.

There is level access for people who use wheelchairs and those with pushchairs. Car parking spaces, including spaces for blue badge holders, are available near the centre.

The SARC has two adult forensic examination suites.

On the day of inspection we spoke with the registered manager, the West Midlands regional SARC manager, two sexual offences examiners and a crisis worker.

We looked at 14 patient records, policies and procedures and other records about how the service is managed.

Patients spoke positively about the service and the quality of care that was provided. Inspectors read comments that told the team how patients had felt respected and one person described how the attitude of staff had helped them to stay engaged through the process and not walk away.

Our key findings were:

- The provider did not have suitable safeguarding processes and staff did not demonstrate an understanding of all their responsibilities for safeguarding adults and children.
- Risk assessments were not carried out on potential ligature points.
- Governance arrangements did not always identify issues and quality assurance systems did not always prevent non-compliance.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.

- The service had thorough staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment/referral system met patients' needs.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and patients for feedback about the services they provided.
- The staff had suitable information governance arrangements.
- The environment appeared clean and well maintained.
- The staff had infection control procedures which reflected published guidance.
- Systems were in place to support multi-agency working.

We found that this service was not protecting service users from abuse and improper treatment and we are taking enforcement action.

The provider must:

- Ensure that systems and processes to prevent the abuse of patients are operated effectively.
- Ensure effective safeguarding processes are in place.
- Ensure staff are trained in safeguarding adults and children according to the required national guidelines.
- Staff must review records to ensure any safeguarding risks are considered.
- Ensure that governance arrangements are established and fully embedded into the service including risk assessment, record keeping and audit procedures.

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?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

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 not providing well-led care in accordance with the relevant regulations.

Are services safe?

Our findings

We found a breach of requirements relating to safeguarding service users from abuse and improper treatment, in accordance with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not always ensure patients were protected from abuse and improper treatment and systems and processes did not operate effectively to investigate, immediately on becoming aware of, allegations or evidence of abuse.

The service's safeguarding policies for both safeguarding children and adults were out of date. Not all practitioners had attended training in safeguarding as set out in the national Intercollegiate Document - Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Although this was not on the service's risk register at the time of the inspection, the registered manager has taken action to remedy this, including arranging training dates for all staff.

Analysis and evaluation of safeguarding risk was under developed with no documentation regarding multi-agency case discussion post examination available at the time of inspection. There were missed opportunities to identify safeguarding risks for both children and vulnerable adults. Records reviewed had gaps in the identification, referral and follow up of safeguarding children and vulnerable adults concerns. Details of patients or children who may be at risk were not captured during the assessment process. There was a reliance on other agencies, particularly the Police, to complete safeguarding referrals. There was no evidence on file to show that discussions had taken place with either social care or the referrer to check if an earlier referral had been made and whether there was new information to share. We did not see a clear safeguarding pathway and therefore it was not clear what was expected from staff for referrals and follow up of safeguarding concerns.

We identified that there were a number of ligature points around the premises which staff had not identified and had not been risk assessed. The ligature points were hanging pull-cords for the purpose of alerting staff. The cords were alarmed so if used as a ligature point staff would become aware. The rooms the alarms were in could be locked by

patients from the inside, staff could override but this would add a time delay. Staff advised they did have a ligature cutter on site. We brought this to the attention of managers who acknowledged the risk and took steps to complete a risk assessment immediately.

Staff were recruited safely. The service had a staff recruitment policy and procedure to help them employ suitable staff. We looked at three staff recruitment records which showed the service followed their recruitment procedures. Staff had Disclosure and Barring Service (DBS) checks. DBS is a system used to check up on the criminal records of people who are applying to work in certain occupations. DBS checks are designed to protect vulnerable groups of people from being abused or harmed by people who have a criminal past. Staff also undergo Non Police Personnel Vetting (NPPV) every three years. NPPV checking is far more detailed than DBS, NPPV typically checks details of partners, adult children, or parents if an applicant still lives at home, plus details of the applicants financial past such as whether they've ever been to court over a debt or are in arrears on a loan. These checks build an overall picture of a person's character, with the aim of identifying any people who may be susceptible to being blackmailed or tempted to pass on information to criminals for financial gain.

The building and premises were appropriately managed by an external maintenance company. The provider rented the space to deliver the service. The service had the appropriate health and safety risk assessments in place and any issues identified from these had been actioned in a timely manner.

The environment appeared clean. Clinical and general waste were arranged as part of the rental agreement with the NHS, and cleaning schedules demonstrated daily weekday cleaning. There were comprehensive infection control procedures and audits in place. Forensic cleaning was commissioned by the police and was carried out as required.

There were processes in place to ensure equipment was used safely. This includes safe arrangements for specialist equipment used for recording intimate images during examinations including photographs and video. These records are used by forensic examiners to facilitate a review of findings and for second opinion. At Grange Park there were robust arrangements for obtaining consent for

Are services safe?

making a photographic record and for ensuring the safety and security of these records in accordance with national guidance issued by the Faculty of Forensic and Legal Medicine (FFLM).

Comprehensive assessment for post-exposure prophylaxis after sexual exposure (PEPSE), antibiotic and/or hepatitis B prophylaxis and the need for emergency contraception were in place and we saw these used effectively in a number of records.

Emergency equipment and medicines were available and staff kept records of their checks to make sure these were accessible, within their expiry date, and in working order. Staff knew how to respond to a medical emergency and completed training in emergency resuscitation and basic life support (BLS) every year. Medicines were stored and managed safely. Emergency adrenaline and airway support equipment was available on site and the team were able to access the defibrillator on the lower floor of the building (this was maintained by the NHS). Medicines fridges and room temperatures where medicines were stored were monitored and recorded. Records reviewed showed that there had not been any issues identified in the last three months.

The service's health and safety policies, procedures and risk assessments were up to date and reviewed regularly to

help manage potential risk. The service ensured that equipment was maintained according to manufacturers' instructions, including electrical goods. Records showed that emergency lighting, fire detection and firefighting equipment such as smoke detectors and fire extinguishers were regularly tested. The service had a business continuity plan describing how the service would deal with events that could disrupt the normal running of the service.

The service had policies and procedures to ensure clinical waste was segregated and stored appropriately and had appropriate risk assessments to minimise the risk that can be caused from substances that are hazardous to health.

The service learned and made improvements when things went wrong. The staff were aware of the Serious Incident Framework and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework. There were adequate systems for reviewing and investigating when things went wrong. One incident had been reported in the previous 12 months in relation to a sharps injury, we saw evidence of appropriate action taken, lessons learned and shared with staff with the implementation of safer procedures and regular auditing. There was a system for receiving and acting on safety alerts. The service learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The service had worked with local commissioners as well as other health providers in planning services and pathways to enhance service improvement and delivery for all victims affected by sexual abuse and assault within the population it served.

Staff followed clear, well-established pathways and protocols for different sexual assault situations. The service had systems in place to ensure patients attending Grange Park were thoroughly assessed according to relevant FFLM and National Institute for Clinical Excellence (NICE) guidance. Staff told us they had access to additional training for their continuing professional development where required. All staff had access to the policies and documents through the intranet.

Staff had the relevant experience and skills to assess health needs and deliver care and treatment in line with FFLM and British Association for Sexual Health and HIV (BASHH) standards and guidance supported by clear clinical pathways and protocols to include plans for immediate healthcare including emergency contraception, antibiotic or HIV/Hepatitis B prophylaxis. However, safeguarding needs were not always consistently considered for children or vulnerable adults.

Health promotion and preventative care were consistently offered. Patients were supported to access sexual health services. Information was shared with the GP for all clients who consented to this.

All clinical staff were involved in quality improvement initiatives including peer review as part of their approach in providing high quality care.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance. The service's safeguarding policies included information regarding consent and the Mental Capacity Act 2005. Where people are subject to the Mental Health Act (MHA), their rights are protected and staff have regard to the MHA Code of Practice. The team understood their responsibilities under the act when

treating adults who may not be able to make informed decisions. We saw one example where capacity was not clear and the nurse had liaised with the relevant agencies to support the patient and complete an assessment of capacity and make a best interests decision on care and treatment as set out in the MHA Code of Practice.

Consent was well-documented in case records. Practitioners recognised the importance of obtaining and recording patients' consent to treatment. Staff told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions.

Monitoring care and treatment

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored.

We saw that the service audited patients' medical care records to check that staff recorded the necessary information, however we found inconsistencies in record keeping. Patient records were not completed comprehensively. In records reviewed we found patient identifiers were not consistently recorded on each page and not all questions on the paperwork were answered. This means data collection may be inaccurate and the holistic assessment of patients' needs is not consistent.

Staff told us they had good relationships with other agencies, this was evidenced through case records where staff had interacted with social workers, GP's, carers and sexual health services to support patients. This was also confirmed through the positive feedback we saw from partner agencies such as the police.

Effective staffing

The service had sufficient staffing levels in place to meet its current capacity. Staff new to the service had a period of induction based on a structured role specific programme. A shadowing period was available and determined on an individual basis.

Clinical staff received in house training to meet the requirements of the Faculty of Forensic and Legal Medicine's Quality Standards in Forensic Medicine. Staff were competent in both forensic medical examinations and in the assessment and management of physical and

Are services effective?

(for example, treatment is effective)

emotional conditions that may or may not be related to the alleged sexual abuse. Crisis workers were trained and available to provide support to patients as their needs arise.

All staff received annual appraisals and we saw evidence in staff records. Staff told us they discussed training needs at annual appraisals and during supervision. There was a policy to outline how appraisals were to be conducted and defined how clinical and non-clinical staff were to be appraised. They discussed learning needs, general wellbeing and aims for future professional development. Staff had appraisals with their line manager that were meaningful and useful and had objectives set and training needs identified.

Staff mandatory training was not up to date, in particular safeguarding children training.

Co-ordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. There were clear and effective pathways into and from the SARC to clinical care including pathways to psychosocial, advocacy, counselling and ongoing support services.

Staff were proactive in promoting the service and building relationships with other agencies. For example one nurse had engaged with trainee health professionals at the local university to raise awareness of the SARC. Links had also been established with the local 'Helpline' charity resulting in an emergency pathway established for SARC patients to access emergency out of hours mental health support.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff were aware of their responsibility to respect people's diversity and human rights.

Patient feedback obtained by the service, commented positively that staff were respectful, welcoming and attentive. Patients told us staff were kind and helpful when they were in pain, distress or discomfort.

Patients had access to shower facilities after their examination. The service provided care bags for patients which contained, toiletries and perfumed items for males and/or females. Staff told us the patients appreciated this kind gesture.

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients.

Confidential records were stored and held securely to protect people's personal data and right to privacy. There was a separate office for staff and we observed that computer screens were not visible to patients and staff did not leave patients' personal information where other patients might see it. Patients paper records were securely stored in locked filing cabinets.

Involving people in decisions about care and treatment

Patients were empowered to make informed decisions about their treatment and care. The service gave patients clear information to help them make informed choices. When patients first arrived at the service staff discussed sensitively what was going to happen to help put them at ease. Staff described the conversations they had with patients to satisfy themselves they understood their treatment options and helped them to think about their treatment and aftercare.

Staff told us the importance of phrasing questions correctly and adopting good listening skills to ensure patients were involved in the decisions they made about their treatment and care. They explored all the options the service offered and told us that patients always had the choice of using or declining the service. When services had been declined, patients were given the appropriate information and the choice to return and use the service if they wished.

Interpretation services were available for patients who did not have English as a first language. Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Staff helped patients and their carers find further information and access community and advocacy services.

The service's website and information leaflets provided patients with information about the range of treatments available at the service.

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 patient needs and preferences, for example we heard a hairdryer had been purchased for clients to use after showering in response to a request from a client. Staff were clear on the importance of emotional support needed by patients when delivering care.

The service had been proactive in raising awareness of the SARC and its pathways to enhance service improvement and delivery for all victims affected by sexual abuse/assault. Examples of the service striving to meet the needs of more vulnerable members of society include bespoke prison training packages to support victims within custody having equity of access to SARC and the wrap around pathways required. Partnership working with a variety of services had led to raising awareness and developing referral pathways into the drug and alcohol services for clients from the SARC and substance misuse training for the SARC staff including implementing the 'Alcohol Audit C' for all patients attending the service.

Examples of this strong partnership approach included links with a local women's project for sex workers, 'SALT Box' which offers supported living for ex-offenders, the homeless hostel and rough sleeper's team as well as the learning disability services to raise awareness of Grange Park SARC and referral pathways. Staff had delivered a presentation to safeguarding champions at Royal Stoke Hospital on the role of the SARC and referral pathways and also attended fresher's week at the local university with promotional material to raise awareness of the service.

Patients described high levels of satisfaction with the responsive service provided.

The service had made reasonable adjustments for clients with disabilities. These included step free access, a hearing loop, and accessible toilet and shower facilities with hand rails and a call bell.

Timely access to services

The service displayed its opening hours in the premises, and included it in their service information leaflet and on their website. The service had an efficient appointment system to respond to patients' needs. Staff told us that patients requiring an urgent appointment were seen the same day. Appointments ran smoothly on the day of the inspection and patients were not kept waiting.

The service website, information leaflet and answerphone provided telephone numbers for clients during the working day and when the service was not open. Staff confirmed patients could make routine and emergency appointments easily and were rarely kept waiting for their appointment.

Records reviewed demonstrated that patients were seen in a timely manner, however there was not consistent documented evidence that follow up calls were made within 72 hours.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The service had a complaints policy providing guidance to staff on how to handle a complaint. Complaints information was available on notice boards in the waiting areas patients used.

The registered manager was responsible for dealing with these. Staff told us they would tell the manager about any formal or informal comments or concerns straight away so patients received a quick response.

The service had not received any complaints since April 2018 when G4S took over.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders at all levels were visible and approachable. Staff told us that they were able to access advice and support and that leaders made themselves available as and when concerns arose. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The registered manager told us how she had been supported to access training and development opportunities.

Leaders did not have a good understanding about the quality of the service provided. Monitoring arrangements arising from lessons learned from the provider's other locations had not been shared with this service. In addition auditing arrangements designed to identify shortfalls in quality had not identified those shortfalls. For example, gaps in information in records and safeguarding risks which we have already identified in this report.

Vision and strategy

We did not see documentation to support G4S's strategic vision for the service in the form of a strategic or operational plan.

Culture

The service had a culture of high-quality sustainable care. Staff stated they felt respected, supported and valued. Staff told us they felt involved in the development of the service and could bring things to the team meeting to discuss; they felt listened to and found managers were supportive and accessible. They were proud to work in the service.

The service focused on the needs of patients. Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour.

Governance and management

The registered manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

There were regular monthly team meetings. Not all staff were able to attend team meetings, due to working elsewhere. However, all team meeting minutes were circulated and easily accessible in the office. Managers sent email updates regularly.

Governance arrangements were not fully embedded. Managers did not establish and operate effective systems and processes to assess and monitor the service. Managers had not identified weaknesses in safeguarding recording or the potential impact on service delivery of all staff not being appropriately trained in safeguarding children. We found several policies, procedures and risk assessments that were either not in place or were out of date.

Appropriate and accurate information

The sample of case records we reviewed did not give assurance that staff always had appropriate and accurate information for patients.

Quality and operational information was used to improve service performance. Performance information was combined with the views of patients for commissioner reports.

Staff spoke confidently about the importance of protecting patients' personal information and the service had appropriate arrangements in place to support this.

Engagement with clients, the public, staff and external partners

The service involved patients, staff and external partners to support the ongoing development of services.

The service used comment cards and verbal comments to obtain staff and patients' views about the service. We saw examples of suggestions from patients and staff the service had acted on.

For example the service had purchased some make up removal wipes for patients to remove any makeup prior to having a shower following feedback from a patient.

The service gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

Are services well-led?

The registered manager showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff. Staff told us they discussed training needs at annual appraisals and during supervision and this was evidenced in staff records seen. There was a policy to outline how appraisals were to be conducted and defined how clinical and non-clinical staff were to be appraised. They discussed learning needs,

general wellbeing and aims for future professional development. Staff had appraisals with their line manager that were meaningful and useful and had objectives set and training needs identified.

Staff told us they completed training needed to perform their roles. This included undertaking medical emergencies and basic life support training annually.

All clinical staff completed continuing professional development. Staff told us the service provided support and encouragement for them to do so.

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

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider did not have suitable safeguarding systems and processes. Staff did not demonstrate an understanding of all their responsibilities for safeguarding adults and children. Staff were not trained in accordance with national safeguarding training guidance. Records were not reviewed to ensure safeguarding risks were fully considered and actioned.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not establish and operate effective systems and processes to assess and monitor the service. Governance arrangements were not fully embedded. The provider had not identified all risks. These included risk assessments not being considered for all risks such as ligature points and record keeping audits had not identified missing entries and areas where quality improvement was required.

This section is primarily information for the provider

Enforcement actions

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment A warning notice was issued on 18 February 2019 in relation to Regulation 13, section (1) (3), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.