HCRG Medical Services Limited

Lincolnshire SARC

Inspection report

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Overall summary

Background

Spring Lodge is a sexual assault referral centre (SARC) commissioned by NHS England and the Police and Crime Commissioner for adults. The SARC service is available 24 hours a day, 7 days a week (including public holidays) to provide advice to police and patients, deliver forensic medical examinations, provide support following recent and non-recent sexual abuse, and offer onward referrals to independent sexual violence advisors (ISVA) in the Lincolnshire area.

Lincolnshire police commission the forensic medical examinations which are undertaken by Forensic Medical Examiners (FME) who are employed by HCRG Medical Services Limited (the provider). For the purpose of this inspection we inspected HCRG Medical Services Limited's provision of FMEs to perform the forensic medical examinations. At the time of inspection there were five FMEs providing forensic medical examinations.

The SARC is located on the outskirts of the city at the back of a business park. There was parking for police colleagues and patients outside the SARC, and a side entrance through a small garden to provide separate access to staff. The building is on one level and accessible to wheelchair users. There were two forensic medical rooms which included forensic showers and toilets. The building also had a pre examination waiting room, an aftercare room, a staff shower and toilets, a kitchen area, staff offices, store rooms, and a medical room utilised by the forensic medical examiner.

During the inspection we spoke with the clinical lead who is the registered manager at the Lincolnshire SARC, and two of the five FMEs. We looked at policies and procedures, reports, and eight patient records to learn about how the service was managed.

We left comment cards at the location the week prior to our visit but did not receive any feedback cards.

HCRG Medical Services Limited provide the forensic medical service and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager at Lincolnshire SARC is the area manager for the provider.

Summary of findings

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

Our key findings were:

- The service had systems to help them manage risks presented to the service.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- FMEs 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 was effective.
- The FME service had a culture of learning and continuous improvement.
- Staff felt supported and had good joint relationships with co-located colleagues at the SARC.
- The provider encouraged staff and patient feedback about the services they provided.
- Complaints were managed and investigated efficiently.
- The provider had suitable information governance arrangements.
- The SARC environment was welcoming, appeared clean, and was well maintained.
- Infection control procedures reflected published guidanceand had been adapted with Covid-19 guidance to ensure services remained available to patients throughout the pandemic.

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

- Ensure that a system is in place to be assured that safeguarding concerns have been reported and followed up in a timely manner.
- Ensure that patient records are complete and contemporaneous, and evidence the discussions with patients and/or their responsible adult to explain the clinicians decision making and the rationale for care and treatment provided.

We identified areas for improvement. The provider should:

- Ensure that all patients have the option to be examined by a female clinician.

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

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?

Our findings

Safety systems and processes

FMEs understood how to protect adults, children and young people from abuse and received training on how to recognise signs of abuse and report it. FMEs we spoke with were familiar with the provider's policies for safeguarding children and adults and could access this via the provider's online portal. FMEs we spoke with had a comprehensive understanding of safeguarding issues. Safeguarding referrals made directly by the FME were recorded on the provider's electronic reporting system, however this did not include safeguarding referrals made by the crisis worker. Safeguarding referrals to the local authority were monitored by the SARC, but not specifically followed up by FMEs, and we were told that the referral process was verbal only, which meant the provider did not have adequate records to monitor the outcome of safeguarding referrals.

A process was in place for the FME to complete a handover form for the crisis worker to identify any concerns and actions taken or required following their interaction with the patient. The provider did not retain a copy of the handover form for their own records, and therefore no handover of safeguarding concerns or actions taken by the FME were evident in records we reviewed during the inspection. This was raised with the provider during the inspection, who acknowledged the need to retain their own copy to evidence concerns raised and actions taken.

We reviewed training records which evidenced the appropriate level three safeguarding adults and children training for all FMEs. Training was monitored by the registered manager via an online portal, and was updated every three years in line with intercollegiate national guidance.

The SARC accepted referrals from the police or other agencies with the patient's consent, and patients could also choose to self refer. The source of referral was documented within the forensic examination notes, including onward referrals made by the FME such as the GP.

Patient records highlighted some vulnerabilities such as mental health and substance misuse issues, and FMEs told us that the crisis worker handed over any relevant issues prior to the examination, and that the examination process would be adapted to suit the patients preference, however additional vulnerabilities such as learning difficulties and domestic abuse were not routinely recorded by FMEs. This was highlighted during the inspection and immediate action was taken by the provider to implement an additional form highlighting any patient vulnerabilities, and relevant actions taken.

Staff

Staff completed mandatory training covering a number of topics such as health and safety, basic life support, infection prevention and control, and information governance. Training was provided via an online portal which all staff could access, and the system prompted staff when a course was due to expire. The system also generated a report for the manager to maintain oversight of completion rates and address any non-compliance.

The provider had a staff recruitment policy which ensured only suitably qualified staff were employed. Vetting was also completed by Lincolnshire police for the FMEs working at the SARC. Three yearly DBS checks were required by the provider, and were recorded on the provider's online staff portal which meant the manager could run a report to ensure all staff were up to date with their checks.

The provider was currently recruiting two FMEs to provide resilience within the rota. FMEs covered both the SARC and Lincolnshire custody during shifts, and performance was monitored by Lincolnshire police force. Despite some staff vacancies, performance and patient care had not been adversely affected.

The provider had an up to date whistleblowing policy in place which was available to staff on the online portal. FMEs we spoke with told us that they felt able to raise concerns with managers.

Are services safe?

The provider operated a 24 hour call centre for referrals, and lone working procedures were in place to support staff safety. Alarm strips were installed within the SARC for staff safety, and were checked regularly by police who were responsible for the premises.

Risks to patients

The provider had systems in place to assess, monitor and manage risks to patient safety. Forensic medical examination records reviewed during the inspection evidenced the identification of risk during the FMEs contact with the patient through a holistic assessment including aspects such as physical health, mental health and substance misuse. FMEs we spoke with told us that should a patient present with significant health concerns, they would be encouraged and supported to attend accident and emergency prior to continuing treatment at the SARC.

FMEs completed an assessment with patients for post exposure prophylaxis following sexual exposure (PEPSE), emergency contraception and hepatitis B prophylaxis. Consideration was also given to whether the patient required any antibiotics, and referrals were made for sexual health screening where appropriate.

The alcohol withdrawal scale and clinical opiate withdrawal scale tools were used to assess a patient's intoxication levels where substance misuse concerns were identified. FMEs we spoke with were clear that they would assess both risk and a patient's capacity to consent to treatment dynamically throughout their time with the patient, and would not proceed if they felt patients were too intoxicated to undergo the medical examination. We saw evidence in care records that examinations did not take place where the patient declined, or the risk was too high due to a physical health issue, however this was not recorded on the record but on a provider call centre database.

FMEs completed basic and intermediate life support training and knew how to respond in case of a medical emergency. An emergency response bag (including emergency drugs), defibrillator and oxygen were stored in the FMEs medical room which had restricted access, and we saw evidence that the equipment was checked regularly to monitor stock levels and expiry dates.

The provider used their online staff portal for the reporting of incidents and complaints which included details of the investigation completed. Lessons learned were identified and shared with staff as notifications on the portal.

Premises and equipment

Lincolnshire police were responsible for the maintenance and upkeep of the SARC premises and carried out regular maintenance checks such as fire alarm testing, emergency lighting checks and health and safety risk assessments.

Infection control measures were in place and the provider worked closely with the SARC manager and crisis worker team to manage the risks from COVID-19. Additional safety measures were in place to protect patients and staff from infection, such as additional hand sanitiser and social distancing arrangements. FMEs would only attend the SARC for contact with a patient, however the SARC manager and crisis workers completed daily checks of equipment, and the police managed a contract to ensure examination rooms were forensically cleaned to the appropriate standard. FMEs disposed of clinical waste in secured external bins, and Lincolnshire police managed the contract for all waste disposal.

The provider's registered manager attended the SARC on a monthly basis as a minimum to oversee checks to the premises and equipment and ensure these had taken place correctly. A medicines audit including for controlled drugs was also completed by the registered manager during these visits. Any concerns identified could be raised locally with the SARC manager, or during regular performance meetings with the police.

The provider did not complete their own ligature risk assessment despite a number of ligature risks being visible to inspectors. This was actioned by the registered manager to obtain a copy of the SARC manager's ligature risk assessment for their own records. Bathroom facilities had been fitted with anti ligature pulls for both the disabled alarms and light switches, and we were told that patients would never be left unattended outside of bathroom areas. Locks to bathrooms could be opened by staff externally should they have cause to do so.

Are services safe?

Forensic suites and staff offices were accessible to staff with a swipe card which reduced the risk of unauthorised access. All staff accessing forensic areas had provided DNA samples for elimination purposes.

FMEs had access to, and received appropriate training in the use of, the colposcope at the SARC (a colposcope is a piece of specialist equipment for making records of intimate images during examinations). Lincolnshire police were responsible for the maintenance of equipment including the colposcope, and forensic samples were managed in line with the Faculty of Forensic and Legal Medicine (FFLM) guidelines.

Information to deliver safe care and treatment

Forensic medical examination proformas from the FFLM were completed by FMEs alongside additional forms to provide additional information regarding safeguarding and onward referrals. Records reviewed as part of the inspection were not consistently legible, and included significant gaps. This issue was known to, and being addressed by, the provider in line with their supervision policy.

FME records were stored securely in locked metal filing cabinets within the FMEs medical room. Only FMEs and the provider's registered manager had access to the records which complied with data protection requirements. Photo evidence was also stored securely alongside patent records.

Referrals were made by crisis workers following a handover from the FME with the exception of GP referrals which were completed by the FME. Crisis workers were responsible for following up onward referrals, and due to their limited time on site, FMEs would often not be aware of the referral outcomes for patients.

Safe and appropriate use of medicines

Medicines were stored in a locked fridge or locked medicine cabinet which were situated in the temperature controlled FME medical room. The fridge and cabinet keys were held in a key safe with restricted access. Room and fridge temperatures were recorded daily by crisis workers and audited monthly by the registered manager to ensure the integrity of medicines had not been compromised. We saw evidence from checks that there had not been any recent issues where this had happened, and the expiry dates of medicines we checked on site were within date.

Forensic evidence was stored elsewhere in the premises in a freezer which was maintained by the police and the temperature checked daily by crisis workers.

Track record on safety and lessons learned

FMEs reported incidents using the provider's online portal and those we spoke with during the inspection understood their responsibility to report concerns. All incidents were reviewed by the registered manager and themes identified were shared with staff using notifications on the portal. Incident themes were also shared with the SARC manager and reviewed during performance meetings with Lincolnshire Police.

Feedback from incidents was used to inform discussions with FMEs in supervision, appraisal and peer review.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients attending the SARC were assessed by a crisis worker on arrival, whilst the attending police officer provided a handover to the FME. The crisis worker then completed a handover with the FME before the forensic medical examination took place. This arrangement was in place due to a separate contract for crisis workers and FMEs. The FME then assessed the patient prior to commencing the forensic medical examination.

FMEs assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance including the FFLM and National Institute for Clinical Excellence (NICE). Patient records reviewed during the inspection evidenced that FMEs completed a comprehensive healh assessment including past and current medical histories as part of the forensic medical examination.

FMEs had access to a range of evidence based policies from the provider's online portal which offered guidance to staff in identifying and managing risks to patients and improving patient safety. The FMEs we spoke with during the inspection had access to the online portal when on site at the SARC and knew how to access the provider's policies and procedures. The provider had a clinical governance lead who had oversight of all policies to ensure they remained up to date and in line with current legislation and guidance.

Clinical policies were in place for the administration of emergency contraception, HIV PEPSE and hepatitis B prophylaxis, and care records we reviewed showed that patients' needs were assessed in line with these policies.

Consent to care and treatment

FMEs sought patient consent to care and treatment in line with national guidance, and told us they would continue to review patient consent throughout the medical examination. Training records evidenced that FMEs had completed mandatory training in the Mental Capacity Act 2005, and those we spoke with were able to describe the appropriate actions they would take if a patient lacked capacity.

While FMEs were aware of the importance of gaining consent from patients prior to the examination taking place, patient records did not evidence the capacity assessment carried out by the FME. We raised this with the provider who implemented a new form immediately to document the capacity assessment which had been carried out.

FMEs documented patient consent prior to sharing information with external agencies, such as the GP.

Monitoring care and treatment

A SARC audit was carried out by the registered manager on an annual basis, however this was currently under review and a number of smaller audits for specific areas were in the process of being implemented. This meant that a rolling programme covering areas such as infection control, safeguarding, health and safety, and record keeping would be introduced rather than one long ongoing audit of all aspects within the SARC. Audit reports were completed for police performance reviews, and the registered manager was working with the SARC manager to share relevant audits for learning and best practice purposes.

The provider operated a national peer review programme for FMEs working across police custody and SARC services. We saw evidence that individual cases were taken to peer review for learning and best practice, which FMEs felt was valuable. Patient records were randomly selected for audit by the registered manager who identified learning and best practice which was then raised within one to one supervision sessions with staff.

Are services effective?

(for example, treatment is effective)

FMEs recorded the treatment provided and follow up required within their assessment forms. FMEs would not routinely follow up with patients following their attendance at the SARC, however the crisis workers did do this and would liaise with the FMEs for advice should any further medical concerns arise.

Effective staffing

The provider had policies and procedures in place to ensure FMEs were competent to carry out their roles within the SARC. All FMEs received an annual appraisal and were offered regular management and clinical supervision.

Training records evidenced that FMEs had the right experience, skills, knowledge and support to deliver good quality care. Service specific training was provided such as how to use the colposcope and writing a statement. Service specific training was flagged to FMEs alongside mandatory training requirements on the provider's online portal, and staff were notified when a new course was available, or one became due/overdue for completion.

Newly recruited FMEs received a comprehensive induction in line with the provider's policy. The induction procedure included more frequent supervision, and shadow shifts to observe experienced staff. A manager was on call daily to offer additional support if required. New FMEs competence was assessed by the registered manager prior to sign off for them to work independently.

Co-ordinating care and treatment

Patients could self refer to the SARC or may be referred by another professional or agency such as the police. The SARC manager and crisis workers promoted the SARC in the community, and FMEs had access to information about local services available to paients.

We saw evidence of good working relationships between the FMEs and their co-located colleagues in the SARC. Despite working to separate contracts, the FMEs felt part of the SARC team and there was a close working relationship with regular meetings to share information between the SARC manager and the provider's registered manager.

Crisis workers would most commonly refer patients to the local authority where safeguarding concerns were identified, with some FMEs choosing to do this themselves. We were told that the local authority accepted only verbal referrals and did not provide a follow up to the referral, therefore this was not included in patient records and was a missed opportunity to liaise directly with social workers.

All patients attending the SARC were offered a referral to the ISVA service. FMEs wrote directly to the GP to advise of the patients attendance at the SARC where patients consented to this, and if appropriate a referral would also be offered to sexual health services. Crisis workers offered patients onward referrals to substance misuse and mental health services where required.

Are services caring?

Our findings

Kindness, respect and compassion

FMEs treated patients with compassion and kindness and were respectful of patient privacy and dignity. This was reflected in patient records we reviewed and interviews with FMEs. Staff told us that the forensic medical examination was based on a patient's individual needs and the patient was at the centre of the process. FME' were sensitive to individual needs, explaining each step of the process and allowing the patient to have control of the pace of their examination.

The SARC had a process for collecting feedback from service users which was displayed within the SARC. FMEs did not seek specific feedback regarding the forensic medical examinations, but overall patients were positive about the service they received from the SARC.

Involving people in decisions about care and treatment

From our review of patient records we found evidence that the patient's voice was documented.

Patients who did not speak English as a first language were offered an interpreter over the phone. Language needs were identified by crisis workers prior to a patient's arrival at the SARC, and an interpreter arranged by police colleagues if required. FMEs did not routinely document whether an interpreter had been used if English was not the patient's first language, however managers made an amendment to the recording template which was implemented immediately when this was raised with the provider.

The SARC website contained useful information for patients, staff and their carers or families on what to expect when attending the SARC. Information was also available in waiting areas and interview rooms, including in alternative languages and easy read formats, to support patients in making informed decisions.

Patients received information leaflets when leaving the SARC, however these were given out by crisis workers who completed an aftercare assessment with patients following the forensic medical examination. The FMEs liaised with crisis workers prior to the patient leaving to ensure that any medical information and actions required were included in discharge information.

Privacy and dignity

The SARC building was discreet at the back of a business park with a side entrance via a gate for patients offering them privacy. A small enclosed garden area was welcoming and offered private outside space for patients, their carers or families and visiting professionals.

Patients' privacy and dignity was protected throughout the forensic medical examination. Patients were able to change behind a curtain in the forensic examination room, and the curtain would be drawn during the examination. Patients were able to use bathroom and shower facilities alone although crisis workers and FMEs remained close by to keep patients safe from harm.

Patient records were stored within locked rooms accessible only by SARC staff to prevent unauthorised access to confidential information, and all patient areas were accessed via swipe card to protect patient privacy while at the SARC.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

FMEs delivered care and treatment to their patients according to their individual needs. FMEs liaised with crisis worker and police colleagues to plan and coordinate the patients care, and crisis workers provided follow up support to patients to ensure address any umet needs following their time at the SARC.

Patients who self referred to the SARC and did not wish to pursue a police investigation were able to have evidence stored at the SARC for 2 years in case they should wish to involve the police at a later stage.

The SARC offered clothing and toiletries to patients attending the SARC free of charge, and crisis workers also offered patients a drink or food while at the SARC. Staff told us that children had attended the SARC with family members and so some childrens toys were available in the aftercare room where families or professionals may care for children while the patient received treatment.

The provider aimed to offer all patients a choice in gender of the FME providing their treatment, however due to ongoing staff recruitment, a female FME was currently unavailable. The SARC manager was due to qualify as an Sexual Offence Examiner in the near future and planned to make herself available across the service if a female SOE was requested. The offer to patients in choice of gender was not routinely recorded on the FME proformas however this was added to FME documentation when raised with the provider during the inspection.

The SARC provided access for wheelchair users and was on one level. Patients with a hearing or sight impairment were identified from the point of referral by crisis workers and adaptations made to support the patient during their time at the SARC.

Timely access to services

FMEs provided forensic medical examinations 24 hours a day, 365 days a year and access to service information was clearly documented in the SARC patient leaflets and on the SARC website. Referrals to FMEs were received by the provider's call centre who then notified the FME on shift to attend the SARC. Patients were seen within the required 60 minute timescale from the point of referral to the call centre, and despite some staff shortages this target had been consistently met in recent months. Response times and performance targets were reviewed by police during contract review meetings.

Listening and learning from concerns and complaints

A complaints policy was in place outlining the procedure for investigation and sharing lessons learned. Complaints received either directly or from the SARC manager's complaints system were recorded on the provider's online portal which provided an audit trail and gave the registered manager oversight to investigate complaints and identify common themes. Complaints records we reviewed indicated two complaints had been received in the last 6 months relating to the SARC FME provision. The provider's national clinical governance forum provided an opportunity to share learning and best practice across the organisation's clinical sites.

Are services well-led?

Our findings

Leadership capacity and capability

The clinical lead had the appropriate skills to run the forensic examination service, and clearly understood the local area, priorities and issues the service faced. The clinical lead was visible within the SARC spending time with colleagues on a regular basis and colleagues spoke positively of the joint working relationships at the SARC.

The provider had a clear management structure; the provider offerred line management supervision and day to day support to the FME', who told us they felt well supported and could approach managers for support. Similarly, the clinical lead felt well supported by senior managers within the organisation.

Vision and strategy

The provider had worked hard to build relationships to manage the FME service within the SARC, building relationships with police and co-located SARC colleagues to offer a seamless service to patients. Staff we spoke with demonstrated passion for their work and showed commitment to improving the experience for patients who attended the SARC.

Culture

Staff we spoke with were focused on ensuring patients received the best experience possible when they attended the SARC. The provider gave opportunities for development with specialist training, and we observed an open culture where concerns could be openly reported by staff or patients without fear of retribution.

The provider had a whistleblowing policy in place and FMEs were aware of how to raise concerns should they wish to. FMEs told us they felt able to approach managers and were keen to receive feedback to improve the service.

Governance and management

The provider had a good clinical governance framework in place with policies, standard operating procedures and risk assessments for the delivery of the forensic medical examination service. Clinical governance staff within the organisation ensured that policies were regularly reviewed and updated, and staff were alerted to any changes in a timely manner.

Monthly meetings were in place providing an opportunity to raise and discuss any issues as well as share learning and best practice. The monthly meetings ran alongside the national clinical governance meetings in which learning was shared across the organisation, and common themes around incidents and complaints were discussed.

Any incidents relating to the SARC were reported by FMEs who all had access to the provider's online portal. Incidents and complaints were also reviewed between the clinical lead and SARC manager to address concerns and share learning.

The clinical lead attended regular contract monitoring meetings with police colleagues who commissioned the service, which provided good oversight of the service's performance.

Risks relating to the FME service were reported on the provider's online portal, which was overseen by the clinical lead. A business continuity plan was in place and the provider was able to evidence responsive and flexible working with adaptations made alongside colleagues at the SARC during the COVID-19 pandemic.

Appropriate and accurate information

Information governance arrangements we observed complied with the Data Protection Act 2018. Performance data was collated by the clinical lead to monitor and improve outcomes for patients attending the SARC.

Are services well-led?

Patient records were stored securely in line with patient's consent which was sought at the beginning of the forensic medical examination. There had not been any information governance breaches, and the provider demonstrated compliance with the General Data Protection Regulation (GDPR) 2018.

Engagement with patients, the public, staff and external partners

Patients were encouraged to share their feedback with the SARC, however the provider recognised that this is not always appropriate to ask at the time of treatment. Patients could complete feedback forms before leaving the SARC, or share feedback during a follow up call with a crisis worker. Any feedback relating to the FME service would then be fed back to the clinical lead.

Supervision and team meetings provided FMEs with the opportunity to share feedback regarding the service, as well as the incident reporting tool on the online portal. FMEs we spoke with gave positive feedback about collaborative working with colleagues at the SARC, and support from the clinical lead.

Promotion of the SARC was done by colleagues in the crisis worker team with FMEs only on site when needed for a forensic medical examination. Information leaflets were available to share with other professionals, or for anyone visiting the SARC to pick up whilst there.

Continuous improvement and innovation

The provider had processes in place to promote continuous improvement including peer reviews, supervision, audits and staff training. FMEs were encouraged to be innovative and share learning and best practice with peers to improve the patient experience. FMEs could access a substantial training package from the provider.

The clinical lead and FME engaged in national meetings with other FMEs working for the provider which was a good opportunity to share learning and best practice to improve services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Regulation 17: Good governance** 17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The provider must ensure that a system is in place to be assured that safeguarding concerns have been reported and followed up in a timely manner. 17(2)(c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; The provider must ensure that patient records are complete and contemporaneous, and evidence the discussions with patients and/or their responsible adult to explain the clinician's decision making and the rationale for care and treatment provided.