Hull University Teaching Hospitals NHS Trust

Hull Royal Infirmary

Inspection Report

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Overall summary

We carried out this announced inspection on 29 and 30 January 2020 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 and a specialist professional advisor.

To get to the heart of children and young peoples' 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

Hull University Teaching Hospitals NHS Trust (HUTHT) is commissioned by NHS England, to provide a Child Sexual Assault Assessment Service (CSAAS) for the Humberside Police area in East Yorkshire, Hull, North Lincolnshire and North East Lincolnshire, for children under the age of 16 and for 17 to 18-year old young people with vulnerabilities. The CSAAS covers core hours, outside of these hours, the service is provided by other organisations.

The service provides medical and forensic assessment for sexual abuse at the request of Humberside Police and Local Authorities' Children's Services. The holistic medical examination includes sexual health assessment, contraception if required, sexual health screening and treatment where clinically indicated.

The service is delivered from within a standalone building in the grounds of Hull Royal Infirmary. The building is accessible for children and young people with disabilities. The accommodation

includes one forensic suite, with an adjoining shower room and waiting room. In addition, there are also more comfortable interview rooms and a children's play room.

The team includes a service manager, a clinical lead nurse two full time registered nurses, four doctors and one administrator.

During the inspection we spoke with five staff members, the service manager, the Deputy Director - Quality Governance and Assurance, and the Clinical Director. We looked at policies, procedures and other records about how the service was managed. We reviewed care records for seven children and young people who had accessed the CSAAS within the last 12 months. During the period

Summary of findings

between April 2018 to March 2019, 91 children and young people had accessed services at the Anlaby Suite CSAAS. Throughout this report we have used the term children and young people to describe people who use the service to reflect our inspection of the clinical aspects of the CSAAS.

Our key findings were:

- The trust had suitable safeguarding processes in place and staff understood their responsibilities for safeguarding children and young people.
- The service had appropriate systems to help them identify and report incidents.
- The trust had thorough staff recruitment procedures.
- Systems were in place to assist staff when dealing with emergencies. Appropriate medicines and life-saving equipment were available.
- The service appeared visually clean and was well maintained.
- Clinical staff provided children and young people with care and treatment in line with current guidelines.
- Staff asked for children and young peoples' consent and supported children to provide consent where possible.
- Staff felt well supported by managers and each other.
- Staff were caring and compassionate and children and young people were treated with dignity and respect.
- Children and young peoples' privacy was respected and their personal information was protected.
- There was a trust wide process in place for children, young people and their carers to complain about the service.
- There was effective local leadership and support at a senior manager level.
- Children, young people and staff were asked for their feedback about the service.
- The culture was positive and open, which encouraged continuous improvement.

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

Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

There were areas where the provider should make improvements. They should:

- Implement a service specific self-harm or suicide risk assessment for the premises.
- Demonstrate they have offered, where possible a choice of gender of forensic examiner to all children and young people.
- Consider how the communication needs of children and young people with learning disabilities are met.
- Implement a service specific competency assessment for all staff.
- Provide an effective system to monitor and maintain appropriate room temperatures in areas where medicines stored out of a fridge
- **Full details of the regulation the provider was 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. We asked the following question(s).

Are services safe?
We found that this service was 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?
At the time of this inspection we found the provider was not providing well-led care in accordance with the relevant regulations. We have taken enforcement action in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded. (see full details of this action in the Enforcement Actions section at the end of this report).

Are services safe?

Our findings

Safety systems and processes

Children and young people were safeguarded from the risk of abuse because there were appropriate systems in place to identify and report safeguarding issues. Staff had received the appropriate level of safeguarding training in accordance with intercollegiate guidance. There was a named safeguarding lead within the trust and for the Child Sexual Assault Assessment Service (CSAAS). The staff we spoke with demonstrated a clear understanding of the signs of potential abuse and the action they were required to take.

The trust's Safeguarding Children and Young People annual report 2018 – 2019, highlighted the key improvements the trust had taken. For example, the quality of referrals to children's Social care had improved by ensuring a named nurse or doctor reviewed all serious incidents that involved a child. Safeguarding supervision arrangements in line with the Trust policy were in place.

Assessments of children and young people highlighted vulnerabilities such as existing safeguarding concerns, their age, learning disability, mental health conditions or any physical injuries. Staff were also trained to recognise the signs of modern slavery and female genital mutilation (FGM). Safeguarding referrals were made for all children that were in contact with the service. All of the children were referred to the CSAAS by the police or relevant social services team and therefore were already known to the local authority; however staff were clear that they would still report any safeguarding concerns and share information about the child or young person.

The trust had safeguarding policies and procedures in place which gave staff guidance in identifying, reporting and dealing with suspected abuse. Additional child protection support and advice was available via the on-call consultant paediatrician so that there was cover 24 hours, 7 days a week. The safeguarding pathways for each local authority the CSAAS covered were available for staff reference. The trust was working to develop their engagement with each local authority to increase a shared understanding of what a CSAAS service offers and the vulnerability of children and young people.

The trust had assurances in place which were used effectively to monitor staff practice. For example, there were regular safeguarding supervision and peer review sessions where staff discussed cases they had handled recently with their manager and colleagues. The safeguarding supervision sessions were led by a member of staff that had undertaken an accredited safeguarding supervision course. In addition, a safeguarding audit was carried out monthly. This involved checking a sample of records to ensure that staff had taken the appropriate action to safeguard the child or young person any concerns raised were discussed during supervisions.

Staff

The trust had a whistle blowing policy in place which was available to all staff. This provided staff with information about how to raise a concern confidentially should they wish to do so. The staff we spoke with confirmed they would feel comfortable raising a concern with the service manager and felt that the directors were approachable and willing to listen and resolve any issues.

There was a recruitment process in place which was managed centrally by the trust's human resources department. Police and criminal records checks were carried out for new staff before they could commence working. The provider also obtained references from previous employers and a character reference where this was not possible. The checks were repeated every three years.

Clinical staff were expected to maintain their professional registration through continuous professional development and we saw that this was regularly monitored through staff supervision. The service manager carried out regular checks to ensure that clinical staff registrations remained valid.

Risks to patients

There were effective processes in place to assess, monitor and manage risks to children and young people's safety; staff understood how to use these to assess risks. Before a child came to the service staff met with police and social services to discuss the child's risks and started to formulate an assessment plan. Nurses at the CSAAS carried out an assessment with the child when they arrived at the CSAAS. This included a check of their physical and mental health and the risk of suicide or self-harm, as well as questions relating to potential child sexual exploitation. The records we reviewed confirmed that staff completed all relevant

sections of the assessment or gave a reason if something was not relevant. Staff continued to maintain contact and sent updated information to partner agencies to reduce any remaining risks to a child's well-being.

Children and young people were taken directly to hospital by the police and social services if there was a medical emergency or concerns for their wellbeing. The service manager had worked with colleagues in the accident and emergency department to ensure that staff there understood that the children and young people's health took priority over attendance at the CSAAS. Staff also carried out an assessment for post-exposure prophylaxis after sexual exposure, antibiotic and/or hepatitis B prophylaxis as well as the need for emergency contraception.

The trust had an up to date health and safety policy which was reviewed frequently, and this supported local management to identify and mitigate potential risks. An annual health and safety risk assessment of the building and external areas was carried out which ensured that avoidable risks to staff and children were well managed. Any areas of the building requiring attention were reported to the maintenance contractor for action, however there was no suicide and self-harm risk assessment specifically for the CSAAS premises. Managers said they would adapt the children's hospital and trust assessment to identify potential risks to children and young people and steps that should be taken to manage each type of risk within the CSAAS. Older children were given privacy in the bathroom, as staff remained outside of the bathroom if wished. Staff did not see children alone and they would ensure that two members of staff were present before greeting the child or young person.

Training records showed staff had completed the appropriate level of life support training for their role and knew how to respond to a medical emergency. Appropriate emergency equipment and medicines were available and checked on a regular basis to ensure they were within their expiry date and in working order.

Premises and equipment

The equipment used for examinations was regularly checked by staff to ensure it remained safe to use. There was an annual service agreement with the provider for the colposcope (specialist equipment used for making records of intimate images during examinations, including high-quality photographs and video), and we saw evidence that they had carried out software updates which included the second back up colposcope.

There was a wider trust business continuity plan in place that included the CSAA service. The service had moved premises in 2018, and managers followed a contingency plan during the service move which ensured there was no impact on children or young people.

Forensic samples were managed in line with guidance from the Faculty of Forensic and Legal Medicine (FFLM). There was an adequate supply of personal protective equipment and clinical waste was managed appropriately.

We found the waiting room was cluttered with books and some toys that could not be wiped to meet forensic standards. This meant that we could not be assured that the facilities were forensically clean to comply with the guidance provided by Faculty of Forensic and Legal Medicine (FFLM). During the inspection, managers removed books from the examination suite, which mitigated some risk.

The provider carried out regular infection control audits of the premises and staff practice, and action was taken to rectify any issues found.

Designated staff carried out essential building safety checks such as fire alarm tests. The maintenance contractor also carried out a series of regular and annual tests. These included portable electrical appliance testing and infection control measures to prevent the development of legionella in the water system.

Information to deliver safe care and treatment

Staff told us that they had access to the information required to provide safe care and treatment to paediatric patients. The records we reviewed showed that staff obtained the necessary information from the attending police officer, Section 47 meetings (a strategy meeting held by police and social services to discuss a child's welfare), from the children and young people or the adult that accompanied them to the CSAAS. All records we sampled were legible, clear and easy to read as well as being fully completed. Care records were held securely and complied with data protection requirements.

Are services safe?

There were effective procedures in place to assist staff in managing photo documentation, including intimate images resulting from the assessment. This was in line with guidance from the Faculty for Forensic and Legal Medicine (FFLM).

Any referrals staff made to other service providers, such as Child Independent Sexual Violence Advisors (ChISVA) were fully documented in the child or young person's record. These demonstrated that referrals were made promptly, and the benefits of such referrals were explained to children and young people and carers. Staff made follow up phone calls to children and young people two weeks after their attendance at the CSAAS to check on their welfare and also to remind them about and encourage them to attend any follow up appointments.

Safe and appropriate use of medicines

There were effective systems in place for the safe management of medicines. Only a small amount of the required medicines were kept on site and there were systems in place to ensure that staff regularly checked these. The checks made sure that medicines did not pass their expiry date and also that there was always a sufficient supply available. There was no standard operating procedure in place for stock rotation, however one was being developed. Medicines were kept in a lockable cabinet which was securely attached to a wall in a room which only staff could access.

The temperature of the medicines stored in the fridge was checked on a regular basis and the records we saw confirmed that temperatures remained within an acceptable range. Staff knew how to report out of range temperatures and escalated any concerns to the Trust on site pharmacy. The room temperature was not being recorded at the time of our inspection, but managers had ordered a room temperature thermometer for recording the temperature of any medicines that were stored out of the fridge.

The Patient Group Directions (PGD) (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) in place were appropriate to the patient group. Clinical staff had signed to confirm they had read the PGDs and told us that they felt comfortable administering the medicines covered by the PGDs.

Track record on safety and lessons learned and improvements

There was a clear and easily accessible system in place for staff to report adverse incidents that happened in the service, as well as positive events. An incident report was submitted by the relevant staff member to the Trust for action and investigation where required. An appropriate person, usually the service manager, carried out investigations and actions were assigned to ensure that improvements were made. Learning from incidents was shared with staff by email communication, as there had been few team meetings held over the past year. We saw examples where details of an incident had been shared immediately with staff. All staff were aware of this incident.

Staff also reported incidents that involved the wider pathway between social services and the CSAAS. We saw one example where an email from CSAAS staff that contained confidential information was sent to the wrong department. Managers responded in line with the trust's information governance policy and immediately acted which prevented this from occurring in future.

There was a trust wide system for the dissemination of patient and medicines safety alerts. Such alerts were distributed by senior staff to the service manager who in turn alerted staff. Managers of the service also worked with the trust pharmacy team to ensure correct medicines were used.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

We saw that all children and young people attending the CSAAS received a full medical assessment in line with the Faculty of Forensic and Legal Medicine's (FFLM's) guidelines. Medical staff told us they assessed each child or young person on a case by case basis.

Forensic Medical Examiners (FMEs) assessed children or young people for health needs arising from sexual assault. The service provided emergency contraception and prophylaxis. Medical staff told us they followed the recommendations of the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) to assess and meet their needs.

Doctors were involved in quality improvement initiatives such as regular peer review sessions which were used to provide professional challenge and sharing of best practice. This formed part of the team approach to providing high quality care. Staff told us that they found these sessions helpful in encouraging their professional development and team working. The provider had a system to provide staff with relevant updates from agencies such as National Institute for Health and Clinical Excellence and the Faculty for Forensic and Legal Medicine to ensure they were working to the current guidelines.

Staff were knowledgeable about the impact of sexual assault on children and young people's emotional wellbeing and mental health and referred them for ongoing psycho-social support.

Children aged 13 and under were able to return to the CSAAS if any further treatment was required. Young people aged 14 and over were referred to the local sexual health service for follow up if this was necessary. Staff told us they were flexible and would see an older young person for treatment in the CSAAS if they were unable to access community services. The nursing staff followed up on every child and young person within 14 days, which gave them an opportunity to check their clinic attendance and offer additional advice to them or their carer.

Consent to care and treatment

Staff understood the importance of seeking informed consent. Signed consent for examination, treatment and the taking and storing of images was obtained in accordance with Faculty of Forensic and Legal Medicine guidelines in every record we reviewed. Staff used legislation such as the Mental Capacity Act, 2005 (MCA) to determine ability to consent in 16 -18-year olds and Gillick competence and Fraser guidelines for under 16s. Staff told us they explained the process of the examination to the child or young person and their families before they entered the forensic examination room. If any treatments were required, doctors took time to explain treatment options and any associated risks. Staff told us they requested verbal consent repeatedly during the examination from the children and young people and we found that written consent was obtained from parents in most cases. In one record reviewed we noted that the views of a seven-year-old was not clearly documented when parental consent was obtained in place of the child.

The provider had policies regarding consent and the MCA as well as Gillick and Fraser guidelines. There were clear processes in place should staff have any doubts about a child or young person's capacity to make an informed decision about their care and treatment. New staff worked through the subject of consent and the relevant legislation as part of their induction package. Staff understood the importance of seeking and recording the child or young person's consent to treatment.

Monitoring care and treatment

An annual audit schedule was in place; however, managers had only completed one audit of nursing case records in the last year. This audit had helped managers identify some learning needs that were discussed with staff on a one to one basis, for example, staff had fully completed all areas for the records, but some information was duplicated, which was not necessary. There had been one audit of medical examination records in the last year and the lead physician had identified areas that the other doctors could improve upon. The newly appointed clinical lead had recognised re-establishing clinical audit was a priority and more regular audits were required. The staff we spoke with felt they were provided with constructive and valuable feedback, and they could contribute ideas on how to improve.

Are services effective?

(for example, treatment is effective)

Staff had just begun to monitor the outcomes of children and young peoples' care and treatment, by introducing a follow up call two weeks after the child or young person attended the service. Data from this call had not yet been collated or used to improve care.

The trust submitted quarterly performance data to commissioners, which demonstrated managers had made some improvements to the CSAAS service by ensuring staff recorded all telephone contacts. Managers were aware they needed to develop more of an understanding of the demographic trends within their region to assist with promoting their service.

Effective staffing

The trust did not have a specific induction or competency programme for any new staff joining the CSAAS team. Any new starters completed the formal trust induction, but this did not include any CSAAS specific information. New staff completed shadowing opportunities and did not carry out any tasks that they felt they lacked confidence in. All staff were up to date with their mandatory training and level three safeguarding children training, and all staff had received an annual appraisal in the last 12 months. We saw records of staff attending group safeguarding supervision on a two-monthly basis. Clinical staff took responsibility for their own continuing professional development and revalidation.

One physician had completed the Forensic and Medical Examination for Rape & Sexual Assault (FMERSA) course. We spoke with another doctor who completed training equivalent to FMERSA. No member of permanent staff was a member of the Faculty of Forensic and Legal Medicine (FFLM).

We found that there was a lack of formal mechanisms to share learning in the CSAAS. Regular team meetings had not been held in the 12 months prior to our inspection, but managers had scheduled this year's team meetings in advance. Staff did not attend any formal CSAAS related refresher training throughout the year, however doctors told us they received updates from the FFLM and the Royal College of Paediatrics and Child Health and disseminated new learning to all staff via email.

Forensic Medical Examiners at the service took part in local and regional peer review activities. This meant that staff were able to share learning and experience with FMEs from this service and across the region. This also contributed to the continued professional development for medical examiners.

Co-ordinating care and treatment

Staff at the CSAAS worked effectively with other professionals to co-ordinate care and treatment. Before any child or young person arrived at the service, the forensic medical examiner took part in a strategy discussion with social care and police colleagues to determine the appropriate plan of treatment and care for that child. Children and young people were seen by one nurse and one doctor which meant they received continuity of care while accessing the service. If ongoing health needs were identified staff could refer to other services (such as sexual health) or offer the child further appointments at the CSAAS. If ongoing referrals were made, information was shared by post or secure email.

All children and young people attending the service were referred to the local Children and Young People's Independent Sexual Advice (ChISVA) service. Who made onward referrals to other agencies such as drug and alcohol services. In one record reviewed, we saw that a young person had disclosed substance use, this information was not passed over to the ChiSVA service, so no advice, signposting or referral was made to support this young person.

There were effective partnership working arrangements between staff at the CSAAS and the police who referred children and young people. The police force had a lead officer who was responsible for liaison between the force and CSAAS staff. We saw that staff raised any issues through this route and they were effectively resolved.

The service had well established links with local GP practices to ensure that children and young people received follow up care and treatment if required. It was evident from their records that staff explained what services were available to children and young people and obtained their consent to make a referral.

Are services caring?

Our findings

Kindness, respect and compassion

We found that staff at the Hull Child Sexual Assault Assessment Service (CSAAS), treated children and young people with kindness, respect and compassion. We interviewed staff members who told us how important it was that children and young people were made to feel comfortable and in control during their visit. We left CQC comment cards for children and young people who used the service in the two weeks before our inspection; however we did not receive any responses. We saw feedback the service had collected over the previous year which consistently mentioned how kind and caring the staff were. Comments we saw were very positive and complimentary.

Staff told us they recognised the impact of sexual abuse and assault on the whole family and showed us a leaflet they give to parents and carers explaining what to expect next and exploring common reactions and feelings following a family member being assaulted.

The service had a selection of food and drink available to offer to children, young people and their families. All dietary requirements could be met as the service had access to the adjoining hospital's facilities.

Children had access to a selection of toys and books and the crisis worker could spend time engaging with and reassuring children before any interviews or examinations took place. Every child and young person was given a donated toy or game when they left the service.

Privacy and dignity

The service respected and promoted children and young peoples' privacy and dignity. The suite was located in a standalone unit on hospital grounds and had its own entrance. The service only accepted one child or young person at any one time by appointment therefore they could attend the service discreetly.

Staff told us how they protected the dignity of the child or young person. For example, the service had clinical garments children and young people could wear during their examination. Staff told us they only uncovered one part of the child's body at a time and examinations were conducted behind a curtain in the forensic room.

Children and young people were able to shower after their examination and there was a range of clean clothing available in a variety of sizes that children and young people had something to wear to travel home in if they could not or did not wish to wear their original clothes.

Paper records were kept securely in the unit in a locked filing cabinet. Colposcope images were encrypted and stored on the trust's electronic system, which was password protected. Hospital notes were flagged to note the child had attended the service, but the documentation of the visit was not added to the main hospital record keeping system to ensure its sensitive content was only shared on a 'need to know' basis.

Involving people in decisions about care and treatment

Staff ensured there was enough time for each appointment so that children could get to know the nurse and doctor who would be caring for them and so that the examination could go at a pace the child or young person was happy with. Staff took time to make sure each child, parent and carer fully understood their options regarding examination and treatment and that the child agreed to each element of their care. Any children or young people who did not speak English were provided with a face to face interpreter. There was no information written in other languages readily available, however managers said they could source this from contacts in other sexual assault services and the Trust.

Nursing staff told us they gave every young person the opportunity to speak to the Forensic Medical Examiner without their parent present. This meant the young person was able to speak to the doctor freely about their past medical and sexual history. In notes reviewed we saw that medical staff made a holistic assessment of each child or young person, including their cognitive abilities, emotional and mental health needs. We saw that explanations of treatments were tailored to each child or young person abilities.

We noted the service did not have any leaflets for those children and young people who preferred information in a written format. Furthermore, there was no easy read information or leaflets tailored to children and young people of different ages. The trust had a general communication book containing pictures to help people with communication difficulties, but this was not CSAAS

specific. The service did not have any pictures of the forensic examination room or the equipment they used in this room, which could have been used to reduce anxiety before the child or young person entered the room for the first time.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service was decorated with child friendly images and there were toys, games and books available for children and young people of all ages. The service used paediatric equipment and its facilities were used exclusively by children and young people. We reviewed records and noted that children and young people's immediate health needs were met, and referrals were made for ongoing care.

Feedback was collected from the children and young people and other professionals who had contact with the service. We reviewed feedback that the provider had gathered from children and young people, parents and carers who had attended the CSAAS from 2018 to 2019. This indicated a high level of satisfaction with the service. Feedback received from professionals was also very positive and individual members of staff had received a thanks for their caring approach.

Taking account of particular needs and choices

The service offered some access to people in wheelchairs. There was a ramp to the main door, which was wider to provide access. There was no hoist in the service and staff had not conducted an assessment to determine what support disabled children and young people would need to use the environment safely. The service did not have any mobile equipment and did not offer any outreach assessments for children who could not attend the building. However, a new children's outpatient room fitted with hoists was being built, and staff planned to use these rooms if hoisting equipment was required.

Staff routinely recorded each child or young person's religion and ethnicity. Staff told us they asked all children, young people and their families what they could do to meet their religious and cultural needs. All staff had completed mandatory equality, diversity and human rights training.

The trust employed both male and female doctors to work in the CSAAS however there was no record that children and young people accessing the service were routinely asked what gender of examiner they would prefer before they attended the service. We were told that the doctor attended the strategy meeting where the gender of physician would be discussed, and staff told us children and young people were asked if they were happy to be examined by the doctor when they arrived for their appointment at the CSAAS. This practice meant that children and young people's choice of gender of forensic examiner was not clearly evidenced.

Timely access to services

The Hull Child Sexual Assault Assessment Services (CSAAS) was commissioned to deliver its service during office hours Monday to Friday. Under the terms of their contract, all referrals into the service were made by police or social workers in the local area. Any young people requiring urgent appointments outside of these times were seen in other sexual assault referral centres (SARC) in the region. The trust could not accept a referral into the service if they were not able to see the child or young person within the recommended time scale for their forensic needs. In such cases, managers discussed alternative options with the Police and if required would facilitate an appointment at another service.

Listening and learning from concerns and complaints

Staff told us they would follow the trust complaints policy in the event of receiving a complaint; however, there were no patient information leaflets or posters in the CSAAS explaining how a complaint could be made. Staff told us there had been one complaint in the previous 12 months which had been investigated in line with trust policy. The organisation had an incident reporting system where any complaints were logged, which would enable service leaders to identify risks and trends.

Anyone receiving care at the CSAAS was asked to complete a feedback form. We saw feedback forms from the last 12 months, all of which were very positive. One theme had been identified from the comments; children and young people told staff they sometimes did not know why they had been brought to the service before they arrived. In response to this CSAAS staff developed a training package to increase external professionals' understanding of what care children and young people would receive during their visit. Staff had recently delivered this training to a local social work team however It was too soon to assess its impact.

Are services well-led?

Our findings

Leadership capacity and capability

There was a trust nominated individual, a service manager and a newly appointed nurse lead overseeing the Child Sexual Assault Assessment Service (CSAAS). The nurse lead had begun implementing some changes and processes for the CSAAS, such as an audit cycle and ensuring staff had access to service specific policies. Staff told us that managers were always available to provide support and direction.

The trust's director of nursing was contactable for support informally as well as offering structured support to forensic medical examiners. There was effective dissemination of messages from board level to local staff through the service managers.

The staff we spoke with felt that the service was well-led with good support from the lead physicians. The staffing structure that was in place meant that the service could continue functioning normally when the service manager was not available.

Vision and strategy

The trust had clear values: 'great staff, great care and great future'. The CSAAS staff demonstrated they were always striving to improve the service by developing relationships with other sexual assault referral centres to share practice and learning. Staff received and acted upon feedback from commissioners, key stakeholders, colleagues and the children and young people using the service.

The trust was supporting the new clinical lead nurse to undertake further qualifications in forensic examination and was developing training packages to upskill the nursing staff. Managers had identified that they would need to implement CSAAS specific competencies for newly appointed staff to ensure staff developed essential expertise in paediatric forensic care.

The service manager was committed to bringing about improvements to the paediatric care pathways. This involved developing a training package for the police, social services and partner agencies to establish a formal treatment pathway for children seen at the CSAAS. Staff had carried out some training using this package and had scheduled the next training opportunities.

Culture

The trust managers told us that staff morale was good and that staff worked well together. Staff said they worked well as a team, not only supporting each other, but offering support to other professionals they worked with. Staff spoke highly about the physicians they worked with and valued the expertise amongst the team.

The staff we spoke with felt their views were considered in the development of the service and that their views were respected and listened to. During our inspection we saw that staff were comfortable and confident talking to each other and other managers within the trust.

The Trust had a policy relating to the Duty of Candour which guided staff about what action would need to be taken whenever any incidents occurred, including considering whether the child and their family needed to be informed. Staff were aware of their responsibility to report any adverse events and told us they knew how to do so.

The service commissioner also told us that they had an open and transparent relationship with the provider and local team. We were told that any issues were discussed with commissioners either informally or during more formal contract review meetings.

Governance and management

During our inspection we reviewed the provider's policies relating to the CSAAS service and saw that these were up to date and kept under review. Trust clinical governance meetings took place regularly which involved the service managers. This supported the local clinical governance arrangements because lessons learned and ideas for improvement were shared. We saw managers met with peers from other sexual assault assessment centre to share practice, training and any initiatives.

At the time of our inspection managers had not provided staff responsible for decontaminating the examination suite and waiting room with guidance on how to meet the Forensic Science Regulator guidance – 207.Anti-contamination – Forensic Medical Examination in Sexual assault Referral Centres and Custodial Facilities. Staff were clear of their role and responsibilities for forensic cleaning and when asked, they could describe the process and had access to appropriate cleaning chemicals. During inspection there were no additional instructions, guidance

or standard operating procedures in place to ensure consistency of forensic cleaning. A cleaning log was in place for the room but there was no cleaning log for toys. This meant that there was no assurance that staff were appropriately cleaning the examination areas to meet the standards set out by the Forensic Science Regulator and the trust could not be assured that the relevant areas of the CAAS were forensically clean. Following the inspection, a Standard Operational Procedure for forensic cleaning was implemented. Managers also implemented a toy cleaning policy and a cleaning log for all toys.

During inspection inspectors highlighted some risks to cross-contamination that had not been identified by managers, such as books and toys in the examination suite. These were removed by managers when we raised our concerns.

At the time of inspection, we found there were no arrangements in place to monitor or audit the effectiveness of decontamination of the forensic suite or waiting room in line with the Forensic Science Regulator guidance. Since moving to the premises in 2018, there had not been a DNA sampling check carried out to ensure that the forensic cleaning was effective. Managers had requested, but had not successfully commissioned or facilitated, a programme of testing rooms or equipment to check the effectiveness of decontamination procedures. This meant that children and young people were at risk of having their forensic samples cross-contaminated.

At the time of inspection managers did not have processes in place for assessing and maintaining the on-going competency of staff undertaking decontamination procedures. This meant that they could not be assured that staff were practising correctly, in accordance with the guidance set out by the Forensic Science Regulator. However prompt action was taken to address this after inspection.

Staff we spoke with knew the procedure for using the backup colposcope and for managing medicines safely. They also knew where to seek advice and support should they need it. However, managers had not provided staff with guidance or a standard operating procedure for using the backup colposcope or for the management of medicine stock rotation, but they had developed an action plan to implement these for staff.

The service manager had the overall responsibility for the management and clinical leadership of the service as well as the day to day operation. Managers had reviewed and made some changes to the audit cycle to improve oversight on clinical outcomes and records. There were plans in place to ensure clinical audits were carried out more frequently.

A service risk register was maintained which covered risks pertinent to the CSAAS. This demonstrated that the service manager was proactive in reporting any matters of concern so that the trust or commissioner could take the required action. Although the clinical lead had identified there was limited guidance and no standard operating procedures in place, this was not on the risk register. The risk register was also used to document any issues that were not directly under the control of the service, but which impacted upon the children and young people. For example, the lack of referrals made by some social services due to limited awareness, was being addressed as managers were offering training to those services.

Appropriate and accurate information

Staff maintained detailed, legible and appropriate records about the children and young people who used the service, and these were stored securely. This meant that, should computer systems not be available, staff could still refer to a paper record.

Data about the performance of the service was shared with commissioners quarterly and reviewed as part of the contract monitoring arrangements. The commissioners reported that the data quality from the CSAAS had improved over the last year. We saw that commissioners had identified that there had been some gaps in reporting demographic data, but this had improved since the contract began.

The trust had secure arrangements for the management of data, records and systems, which ensured managers validated and protected confidential information. Managers developed secure referral pathways and processes for sharing information within the trust, and with police and other partner agencies.

The findings of audits were shared with individual staff and at team meetings to ensure that there was a culture of continuous improvement.

Are services well-led?

Engagement with clients, the public, staff and external partners

The service manager and staff had been involved in engagement work with their police partners to give a greater understanding of child sexual assault assessment services. It was identified that the trust would deliver training and awareness to social services and local authorities in order to improve awareness and referral rates. However, due to staff shortages in 2019 this objective was not yet fully achieved.

The provider was also keen to improve the experience of children whilst at the CSAAS. To help achieve this, they collected feedback and submitted a summary of responses to commissioners, to inform service improvement.

Staff were encouraged to provide their feedback through their group and individual supervision sessions as well as during team meetings. There were plans to implement monthly full team meetings. Staff were also encouraged to put forward ideas for the improvement and development of the service.

Continuous improvement and innovation

There were some systems and processes in place for learning, innovation and continuous improvement. The new clinical lead nurse was embedding some CSAAS specific training and competency assessments for staff. Staff had access to a wide range of relevant training and a peer review system which encouraged constructive feedback and continual improvement. Managers had implemented a programme of regular audits of various aspects of the service. If any issues were noted, these were fed back to staff with the focus being on learning and improving the service provided.

Managers used the trust system for appraisals which ensured that all staff received an annual performance appraisal, which sat alongside the regular supervision meetings. This encouraged staff to set objectives for the year ahead and as well as tasks which contributed towards their development. Staff told us that they could request additional training on top of the required mandatory training. This demonstrated that the provider was committed to developing their staff and improving the skill and knowledge base to improve the service that children and young people received.

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 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The systems and processes in place did not ensure the effectiveness of decontamination procedures.