Kings College Hospital NHS Foundation Trust

Kings College Hospital (The Havens sexual assault referral service)

Inspection Report

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Overall summary

We carried out this announced inspection of The Havens sexual assault referral service over two days on 21 and 22 May 2019. We conducted this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements of the Health and Social Care Act 2008 and associated regulations. Two CQC inspectors, supported by a specialist professional adviser, carried out this inspection.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Background

The Havens sexual assault referral service is provided by Kings College NHS Foundation Trust at three sexual assault referral centres (SARC) in London; one site close to Kings College Hospital in Camberwell, one site close to St Mary's Hospital in Paddington and one site close to the Royal London Hospital in Whitechapel.

Each of the centres has a dedicated entrance with separate pathways for patients who use the forensic service and for those using only the follow-up services. All three centres follow the same common processes and procedures and, although there are local managers in place, each centre is subject of the same central governance and oversight.

Each of the buildings occupied by the centres is configured differently, although each centre has dedicated forensic examination rooms and associated waiting rooms for children and for adults.

Summary of findings

NHS England (NHSE) and the Mayor's Office for Policing and Crime (MOPAC) jointly commission The Havens, which is the only sexual assault referral service in London. The service provides forensic medical examinations and related health services to people living in all of the London Boroughs (the Metropolitan Police area) who have been sexually assaulted. This includes the offer of an independent sexual violence adviser (ISVA) to co-ordinate follow-up care and support for patients. The service also provides a range of additional follow-up psychology services for children and adults although these were not in the scope of our inspection

The Havens is an 'all-age' service; that is, adults aged 18 and over, children aged13 and above and children under the age of 13. The service is accessible to male, female and transgender patients.

The service is available 24 hours each day with patients directed to the most appropriate centre where they can be seen quickly. Patients are referred through the police (or child protection processes for patients under 13). Patients aged between 13 and 17 may be brought to the centres by police or a social worker but can also self-refer subject to safeguards in relation to their capacity to consent. Patients aged 18 and over can self-refer without police involvement.

The Havens has an integrated central management structure comprising a service manager and medical and nursing leads. Each centre has a service delivery manager together with doctors who are sexual offence examiners (SOE), forensic nurse examiners (FNE), and nursing staff and duty crisis workers who carry out the role of crisis worker.". There are specialist paediatric and psychology staff, as well as ISVA workers for both adults and children, nurses who provide crisis support, forensic nurse examiners (FNE) and business support staff who perform a variety of roles. Most staff members work from their base site, although clinical staff may be called to any of the three sites. There are also some medical, paediatric and crisis worker staff who carry out sexual offence examinations on an on-call, sessional basis at any of the sites.

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

During our inspection we spoke with the service manager, the service delivery managers for each of the sites, both consultant co-clinical leads, a lead doctor from each of the three Havens sites and a specialty doctor. We also spoke with the interim lead nurse and senior forensic nurse examiner, a senior nursing sister (who is also a crisis worker), a senior crisis worker, an adult ISVA, a young person's ISVA, the family nurse advocate and the child clinical support worker. We looked at records of eight patients. Two of these were children under 13, two were young adults over 18 and four were older adults. Six were female patients and two were male.

We left comment cards at the location in the two weeks prior to our visit and received 29 responses from people who had used the service in that period. We also spoke directly with three people who had used the service recently.

We looked at the policies and procedures that were used commonly across all three sites and examined performance and quality monitoring information and training data.

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:

- Staff knew how to deal with emergencies.
- Appropriate medicines and life-saving equipment were available.
- The service had systems to help them manage risk.
- The staff had effective safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service was clean and well maintained.
- The staff had infection control procedures which reflected published guidance.
- The service had thorough, safe, staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines issued by the relevant professional bodies.
- There were processes for monitoring the standard and quality of care.
- Staff treated patients with dignity, respect and compassion and took care to protect their privacy and personal information.

Summary of findings

- The single point of access referral system met patients' needs.
- The service had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and clients for feedback about the services they provided and acted on this.
- The service dealt efficiently with adverse incidents, complaints and feedback.

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

- Complete first stage risk assessments fully for each patient.
- Account accurately for medicine stocks used.
- Provide written information about the service and its procedures, and in a suitable format, for younger children, patients with a learning disability and patients whose first language is not English.
- Provide information to all patients about the gender of the clinician.

Summary of findings

The five questions we ask about services and what we found

We asked the following question(s).

Are services safe?
We found that this service was providing safe care in accordance with relevant regulations.

Are services effective?
We found that this service was providing effective care in accordance with relevant regulations.

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

Are services responsive to people's needs?
We found that this service was providing responsive care in accordance with relevant regulations.

Are services well-led?
We found that this service was well-led in accordance with relevant regulations.

Are services safe?

Our findings

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

Our review of the KCHFT policies and procedures and our interviews with staff showed that The Havens had systems and processes to ensure patients were safe. Policies relating to safe care and treatment were up-to-date and were subject of regular reviews.

In support of the trust's policies, staff were trained in topics relating to safe practice, such as health and safety, resuscitation, information governance and infection control. Staff knowledge and skills in these areas were refreshed according to the trust's mandatory training schedule. Compliance with this was monitored by the senior management team. The service manager was actively working with some individual sessional staff members to verify training they had acquired with other NHS trusts, and which we noted as a small number of shortfalls in the training data.

Staff had received training in safeguarding both adults and children that met level three of national, intercollegiate guidance for healthcare staff. Staff reported they were confident and competent to identify safeguarding risks and respond appropriately and this was evident in our review of records. Identified concerns were reported through safeguarding processes of the relevant London Borough in line with the trust's procedures and progress was followed up using a tracker system.

Children under 13 could not self-refer to The Havens. All referrals always came through local safeguarding processes. Children under 18 could self-refer but they were rigorously assessed and their capacity considered. Children under 18 who self-referred were routinely referred to local safeguarding partners

The trust's clear employment processes ensured staff were safely recruited. This included enhanced checks with the Disclosure and Barring Service that were renewed every three years, the validation of all professional qualifications, the take-up of all references, an interview and simulated role play assessments.

External contractors provided maintenance checks and repairs for equipment at all three sites. Resuscitation equipment was in working order and subject to weekly checks to make sure it was safe to use. Fire safety equipment had been inspected and was up-to-date at each site.

Staff followed infection control processes to prevent patients and staff from acquiring healthcare-associated infections. There was a clear infection control policy and good signage and an audit process in relation to hand washing and infection prevention. Clinical waste and sharps were disposed of safely according to the trust's schedules.

Each forensic examination room was stringently cleaned after each use to prevent the cross-contamination of contact evidence. The cleaning, checking and labelling of these facilities met guidance issued by the Faculty of Forensic and Legal Medicine (FFLM). Staff confirmed they had been trained in cross-contamination and infection control.

Risks to patients

The manager acknowledged that the frequent turnover of permanent specialist staff had presented some recent challenges. For example, staffing levels of crisis workers and of paediatric staff were short of the assessed establishment need. However, the management team were aware of the shortfall and were taking steps to mitigate risks arising from this through a recurring recruitment programme, the use of staffing rotas and the employment of sessional staff on a daily basis.

Every environmental space in each site had been assessed for ligature risks and action taken to mitigate this. Patients were supervised by staff members throughout their initial episode of care and this helped staff to monitor such risks, except for a short time when showering following their examination. However, there were no obvious ligature points in the shower facilities we looked at.

Staff assessed patients for a range of risks including mental ill-health, substance misuse, domestic abuse, child sexual exploitation (CSE – mandatory for all patients under 18), deliberate self-harm, potential suicide and sexually transmitted infections (STI) using a two-stage risk assessment. A first assessment (RA1) was completed at the initial appointment at the service (typically at forensic examination), with the use of a follow-up risk assessment form (RA2) to evaluate risks at follow-up appointments. Second stage risks assessments were comprehensive and

of a high quality. However, some of the information in the first stage assessment in two of the patients' records we sampled was incomplete, and this meant that some risks might be overlooked.

Staff took action to assure the safety of patients identified as being at risk of harm or with urgent health concerns. For example, the examination included a full assessment for the need for post-exposure prophylaxis after sexual exposure (PEPSE) or the need for emergency contraception. In such cases appropriate medicines were supplied.

Patients were routinely asked about risks of domestic abuse and this was repeated at each successive contact by the ISVA workers. The service used domestic abuse and sexual harm (DASH) risk assessments to fully understand these risks and these were fed into multi-agency risk assessment conferences.

Staff and managers discussed safeguarding risks at daily and weekly multi-disciplinary team meetings to ensure everyone was clear about risks to individual patients and that actions taken had been appropriate. A social care liaison officer employed by the service offered guidance and advise on individual issues. This was enhanced by good access to the trust's safeguarding team and by regular individual and group supervision sessions.

Patients were routinely asked about alcohol and drug use. Those who were withdrawing from alcohol or opiates were assessed and supported according to specific protocols. This ensured the safety and follow-up of people who misused substances or where the use of alcohol or drugs had been a feature of the sexual assault

Information to deliver safe care and treatment

Staff used standard forms to help in asking the right questions when assessing and examining patients, including paediatric forms for children. These forms were based on those recommended by the FFLM. Body maps were used to document marks and injuries. The use of standardised forms ensured staff asked relevant and consistent questions to ensure accurate assessment.

Records were clear, legible and accountable. Hard copy records made during examinations were scanned and stored electronically and securely. Records made by ISVA workers were also comprehensive and showed they had gathered sufficient information from patients to accurately assess their needs and risks.

Managers carried out an annual clinical notes audit which involved a high-level scrutiny of clinical notes of around 8-10% of new patients. This provided a picture of the performance of the service in relation to the completeness of notes and compliance with the trust's record keeping standards.

Specialist equipment, known as a colposcope, was available at each site for making records of intimate images during examinations, including high-quality photographs and video. The purpose of these images is to enable forensic examiners to review, validate or challenge findings and for second opinion during legal proceedings. There were effective arrangements for ensuring the safe storage and security of these records in accordance with guidance issued by the FFLM.

The service used a single electronic record system for the whole service which meant that information about patients could be accessed at each site. This supported accurate monitoring and audit and ensured staff in different parts of the service understood a patient's case.

Information about patients was transferred safely and securely to other providers and services across London. For example, all information about children was routinely shared with safeguarding partners in each Borough using the same safeguarding documentation and this ensured consistency.

ISVA workers who were supporting children routinely attended and shared information at meetings held under local safeguarding processes. This approach helps other agencies to better understand children's experiences.

Safe and appropriate use of medicines

All medicines in use at the Havens were individually prescribed for each patient by the examining doctor or by nurses who were qualified to prescribe.

Each site stocked a range of medicines, including antibiotics, emergency contraception, PEPSE for HIV, hepatitis vaccination and analgesic medicines. There were also emergency medicines located with the resuscitation equipment. The service did not stock controlled drugs.

Are services safe?

All medicines were stored securely in cabinets with controlled access by designated staff members. Those that were temperature sensitive were stored in fridges. Fridge and ambient temperatures were monitored daily to ensure medicines remained safe to use.

The trust's pharmacy team carried out random assessments to ensure medicines were stored appropriately. However, during our check of stock at the Paddington site we noted that numbers of medicines were not accurately reconciled. We were advised that medicines were re-ordered when the stocks were running low but there was no mechanism in place to account for each unit of medicine as it was used. In which case the service was not assured of the accuracy of its stock of medicines against medicine that had been issued. We brought this to the attention of the service manager who undertook to immediately introduce a system to account for individual units across all sites.

Track record on safety

The Havens used a programme of checks and audits to monitor safety practices. These included daily, weekly and monthly checks carried out by the nurses at each site, for example, medicine storage temperatures, environmental cleanliness and hygiene and self-referral forensic samples. This ensured each site operated safely and enabled depleted equipment and consumable material to be replenished. Rigorous records were maintained of this activity.

The integrated management team and the service delivery managers had a good understanding of their safety performance as was demonstrated in monthly performance report to the trust's Planned Medicine Management Board and 6-monthly reports to the Risk and Governance Committee of the trust's Post-Acute and Planned Medicine care group. These included updates on current risks from the service risk register that were currently being managed, any new or escalating risks, serious and adverse incidents and complaints. This showed consistently safe performance and activity to mitigate any shortfalls. For example, an issue relating to changes to police email addresses had been noted. The report to the risk and governance committee showed this was being addressed through dialogue with the Metropolitan police so that service managers and the trust could be assured of the safe electronic transmission of patient sensitive material.

Quarterly monitoring of the service risk register showed that organisational risks were actively worked upon so that they did not drift or have a negative impact on patient safety. For example, the business continuity plans for each site were managed through the service risk register. This ensured that significant events affecting the operation of the sites were discussed at the most appropriate management level and action taken to ensure risks to patients were minimised.

Lessons learned and improvements

The service learned and made improvements from incidents and safety alerts.

There was a robust adverse incident reporting and learning process. All adverse incidents were reported through the KCHFT incident reporting system and were assessed to determine the timescale for investigation and response.

Root cause analysis was used to identify learning and ensure action to address shortfalls was appropriate. For example, we noted an incident relating to incorrect submission of samples from the examination of a patient who had self-referred. The analysis of the incident identified shortfalls in the quality and practice regarding documentation in records of such patients. This had led to a series of actions related to reconciling the electronic and paper records of self-referral patients.

Staff we spoke with told us they received feedback on incidents they had reported and that learning from incidents was shared at staff meetings.

We discussed with the manager examples of recent adverse incidents and were assured of the rigour of governance processes and the effectiveness of learning.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients' needs were holistically assessed, and their care and treatment was delivered according to standards and evidence based guidance.

Staff carried out thorough assessments of all patients needs in accordance with clear clinical pathways that met national FFLM guidance. Health needs arising from exposure to unprotected sexual activity, such as the need for PEPSE, for hepatitis vaccination and for emergency contraception, were identified through assessment that met guidelines issued by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) respectively.

All health plans were holistic and took account of patients' physical, emotional and mental health, in particular, the impact or trauma of the alleged sexual assault. This enabled staff to make referrals straightaway to The Havens' in-house psychology service where required or to local mental health providers. This work met guidelines issued by the National Institute for Health and Care Excellence (NICE) and enabled patients to experience good health outcomes.

Patients who were seen as part of follow-up services by the ISVA workers, were also continually assessed using nationally recognised toolkits developed by a specialist sexual violence organisation. This gave rise to the production of a 12-month care plan which included pre- and post- trial support where this was required.

Monitoring care and treatment

Managers monitored the care and treatment of all patients through daily and weekly multi-disciplinary team meetings where every person's case was discussed. This enabled clinicians to sense-check their assessments and their care plans with other specialists employed by the service across a range of physical and psychological disciplines.

There was also a robust peer review process that the service used to monitor care and treatment and to ensure that forensic and clinical findings from examinations were consistent and reliable. One in every five forensic examination records was peer reviewed by a member of the senior medical team, and there was a monthly in-house review of video recordings of examinations. Clinicians also attended four group peer review sessions each year to help standardise their approaches and interpretation. There was a weekly review of all cases involving children under 13, with most of these examinations peer reviewed in-house. Some examinations were taken to Pan-London Paediatric Peer Review meetings to standardise the interpretation of paediatric findings.

The service delivery managers for the three sites collected data for a weekly assurance report to the service manager. The data gathered included information on waiting lists for the psychology and counselling services, medical staff coverage, safeguarding referrals, adverse incidents and the number of forensic samples in storage. This provided the manager with an at-a-glance picture of activity in each site and fed into the risk and governance processes. In addition, a monthly 'Perfect Ward' audit had recently begun to be carried out by the senior nurses for each site. This examined compliance with basic standards such as, for example, the quality of care and treatment plans, documentation and confidentiality, equipment and supplies.

Effective staffing

Patients using The Havens were assessed and cared for by staff in a range of roles who were competent and had the right skills and knowledge for their role.

Staffing at the three sites comprised a broad skill mix of SOEs, paediatric staff, crisis workers, ISVAs, psychology staff and sessional clinicians. Clinical practice at each site was led by a senior doctor who was a member of the FFLM. In addition to this just over half of the substantive medical team were also members of the FFLM as a result of their experience and training.

Each staff group took part in a comprehensive professionalised induction programme based on national occupational standards relevant to their role. For example, ISVA workers were assessed against standards issued by an organisation specialising in the impact of sexual violence.

Medical staff received training on a range of topics appropriate to their role that met requirements of guidance issued by the FFLM, such as forensic skills, assaults on children, photography and court room skills. Newly appointed doctors took part in an induction process that led towards their competency. This involved shadowing,

Are services effective?

(for example, treatment is effective)

observation, mentoring by a senior doctor, notes audit and peer review. Doctors were 'signed off' before being enabled to carry out independent examinations subject of the usual peer review process.

Nurses who carried out the role of crisis worker received bespoke forensic training and were also mentored by senior staff before being signed off as competent against an assessment tool.

Staff maintained their competence through regular refresher training in key subjects essential to the effective running of the service and through peer review of their work. For example, ISVA staff had received training in sexual health and the impact of trauma; the focus on trauma was evident in the records we looked at. Staff also had the opportunity for training in mental health first aid and this supported initial identification of mental ill-health.

The culture of peer review and regular clinical supervision supported practice improvement. Doctors we spoke with regarded their work, particularly peer review, as continuous learning and development.

We have commented on the governance of the service's learning, development and research strategy in Well-Led below.

Co-ordinating care and treatment

Multi-disciplinary working in The Havens was noted to be strong and effective. Professionals from a range of health disciplines had opportunities to support the assessment and planning of patients' needs. This approach was taken either at the time a patient presented, through daily and weekly multi-disciplinary meetings or during follow-up care, and this was evident in records we reviewed.

Due to the complexity of London's local authority and health provider landscape, the service had developed consistent protocols and agreements to ensure information about patients was shared with appropriate services in different areas. This included, for example, local authority or mental health services for children, and mental health or counselling services for adults. This was supported by detailed and diligent record keeping on the electronic system and effective information exchange with other services. For example, we saw detailed letters to GPs that were consistently completed in each case we looked at. This supports health partners outside the trust to deliver safe and effective care by way of follow-up.

We noted an effective relationship with the Metropolitan Police in relation to both the planning of forensic examinations where they were involved and the exchange of information arising from those examinations.

Health improvement and promotion

Patients were routinely screened for sexually transmitted infections including HIV. Prophylactic medicines were supplied to patients at risk of HIV and hepatitis to ensure they were protected.

Patients also received effective advice and guidance about sexual health both from the staff at the location and also in the form of written information and posters that were overtly displayed throughout each of the sites.

Consent to care and treatment

Staff understood the importance of seeking informed consent and followed relevant guidance and standards for doing so from different patients according to their age and level of understanding.

Our review of records and interviews with staff showed that staff communicated with patients of different ages and provided them with clear information about the services they would receive. There was written information available to support practitioners to provide explanations to facilitate them seeking consent.

Patients or their advocates or carers provided signed consent in accordance with FFLM guidelines at the beginning of, and throughout their visit. Verbal consent was repeatedly obtained throughout their visit for each part of the examination. If there was doubt that a patient had not understood what was happening, the examination did not proceed.

Staff had received training in the Mental Capacity Act and knew how to identify patients where capacity to consent to a forensic examination would need further exploration. The assessment forms used by the service supported staff to consider this question. Our review of records showed that this process was followed in every case although we did not review any examples where a patient was thought not to have capacity.

Staff understood the legal standards for obtaining consent from children. Staff used the standard for obtaining informed consent from a young person, known as 'Gillick competence'. Staff also followed particular guidelines,

Are services effective?

(for example, treatment is effective)

known as 'Fraser guidelines', before providing contraception and sexual health advice to children. The use of these standards was evident in the records of children we reviewed and in our interviews with staff.

Are services caring?

Our findings

Kindness, respect and compassion

Staff at The Havens understood and respected patients' needs and showed compassion when providing a service.

Interviews with staff, our review of records and feedback from patients showed that staff were kind, respectful and compassionate to people who had experienced sexual assault. Staff were experienced and knowledgeable about the impact and trauma of sexual assault and abuse and were considerate of this when providing care and support. For example, crisis workers were calm and compassionate when enabling patients to provide their history.

Forensic examiners allowed time for patients to control the pace of the examination. Examiners and crisis workers took time to explain to patients the next steps in a supportive way following their examination and before they left the centre.

We received 29 completed comments cards from patients who had used the service in the two weeks prior to our inspection. Most of these comments were positive and highlighted that staff were caring, supportive, warm, welcoming and friendly. Some patients told us they felt safe and were not judged.

The service routinely collected feedback from patients through a feedback questionnaire form and published this in a summary document. Our review of the summary document for the period April 2018 to March 2019 showed that patients regarded staff as kind, compassionate and supportive. Many patients said that they had felt comforted by their visit.

We spoke directly with three patients who had recently used The Havens.

All three people we spoke with told us that the staff had been very kind, caring and compassionate and had helped them deal with their experience.

One person told us that their life had changed in a positive way since using the service as the support they had received exceeded their expectations.

Involving people in decisions about care and treatment

Patients were given sufficient information to enable them to be involved in decisions about their care and treatment.

The Havens website was easy to access and information was presented well, and in a way that patients could understand. There was also a service user guide and leaflets were available about what to expect at the centres and about medicines.

Staff told us that they explained to patients what would happen during their initial visit and provided information about their options for the examination. Records we looked at showed that patients had been empowered to make decisions and there was evidence of the 'child's voice' in the records of children we reviewed.

Family and friends of patients were encouraged to provide support to their relatives using the service. We were advised of occasions when, at the request of patients, relatives were allowed to be present for much of the initial consultation in order to provide support and this enabled the patient to feel more comfortable with the process.

Patients who self-referred had a choice about whether to involve the police or not, including whether or not to provide forensic samples so they could make that choice later if they wished. Samples were retained for up to one year after their examination in agreement with the patient who could ask for them to be destroyed at any time before that. This means patients who self-referred remained in control of the outcome of their visit.

Four of the comment cards from patients we reviewed said that they had been listened to. One patient commented that they felt in control of the process.

In the provider's summary feedback document, a common comment was that patients felt listened to and that everything was explained well and made clear. 97% of patients said they could make decisions and were given choices at The Havens while 98% said they had the opportunity to discuss their care.

One patient we spoke with directly told us about a support group they had attended organised by the ISVA service which had been led by patients. They told us they had felt supported by others who had had a similar experience.

Another patient we spoke with directly told us that the feeling of being in control was one of the most important things that helped them come to terms with the process.

Are services caring?

Privacy and dignity

Staff at The Havens centres respected and promoted people's privacy and dignity.

Patients were enabled to prepare for their examination by undressing behind screens in the examination rooms. Patients were also offered toiletries and a shower after the examination in private and they were provided with clean clothes if they needed these. Clinicians explained their approach to preserving patients' dignity during examinations. Gowns were available for patients to wear during the examination to enable them to expose only those parts of the body that were being examined at any one time.

All staff we spoke with told us how they tried to make patients feel comfortable from the moment they presented at the service. This involved sensitive conversation and explaining that their privacy and dignity was important. The Havens' website stressed that staff would believe and support patients and would treat them with respect.

Patients who left comments cards were positive about their experience. Two patients told us that their privacy and dignity had been respected. One patient commented that they trusted the staff. Another patient said that the service had been a life-saver.

One patient, however, commented that they felt there was a lack of privacy in the reception area at the Whitechapel centre as the window had been open and some people were outside who they felt were in a position to over-hear their conversation.

Patients we spoke with directly were also positive. One patient said the staff were very respectful, even when asking questions about their mental health.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The Havens was well organised to deliver services to meet patients' needs. The service took account of patients' needs and preferences and was responsive to the needs of London's population.

KCHFT has been providing a well-established SARC service for London for a number years and are an experienced provider. The service used data to understand the prevalence of sexual assault in London and had developed a positive relationship with the Metropolitan Police with whom they worked closely. The service also worked with other paediatric health services who provided child protection medical examinations across London when a sexual assault on a child was recent enough to warrant a forensic examination. The Havens also received patients' referrals from other providers such as GPs or sexual health services.

The service was open 24 hours-a-day and seven days-a-week and there were a number of responsive pathways. These depended on the patient's age, whether they had, or wished to report their assault to the police or were involved in safeguarding processes, the time elapsed since their assault, or whether they wished to access psychology or therapeutic services only.

The locations of the three sites enabled the service to be delivered equitably across the geography of London, although some of the feedback collected by the service suggested the centres were sometimes difficult to find. In most cases patients attended the centre closest to them, subject to the availability of staff, but in any event, they could choose which centre they visited.

The Havens website was easy to navigate and had clear information about how to make an appointment, what patients could expect when they arrived at the centres and what their follow-up care might consist of. The website also signposted patients to other services that they might find helpful. There was an emphasis on patients' choice.

Children under the age of 13 were always referred through local safeguarding processes. There were facilities at each site for supporting and examining children and those at Camberwell and Paddington were welcoming and child focused. The waiting areas for children at the Whitechapel site were not child friendly but we were advised that children referred to Whitechapel were usually seen at the Paddington centre.

Records we looked at showed that all patients, including those who had self-referred, were offered the ISVA service for ongoing care and to facilitate access to therapeutic or other health services. There were specific ISVA workers who had been trained in supporting children.

Feedback from patients collected by the service showed that over 96% of patients were satisfied with the service. Comments recorded on the service feedback spoke positively about the way the service met patient's needs. Comments typically noted that the environment was comfortable and clean, and that the staff were professional and supportive. One comment noted that the service was person centred.

Patients remarked on CQC comment cards the service had met their needs. All three patients we spoke with directly told us that the service was accessible and their needs had been met. One patient told us about their follow-up care plan and the way this had supported them and helped them meet their emotional needs.

The service was promoted through leaflets and information in relevant health provider locations across the city whilst the service training and awareness team undertook regular open days for health professionals. The service also participated in numerous events and conferences across London to promote the service.

Taking account of particular needs and choices

Staff from The Havens responded to people with particular needs to ensure they had equal access. Each of the centres was accessible to patients using wheelchairs with adapted access and examination facilities on the ground floor.

Patients who were injured and in hospital were seen there by a forensic examiner through the use of portable equipment to ensure their medical treatment was not hindered. Similarly, on rare occasions, patients who could not get to any of the centres due to disability could be seen at the place where they lived although we did not review any records of such patients.

Due to London's diverse population, interpreters (and 'signers' where appropriate) were commonly used to facilitate communication with patients whose first

Are services responsive to people's needs?

(for example, to feedback?)

language was not English. However, we noted that there was no information or leaflets translated into foreign languages for patients to refer to or take away with them. There was also limited information available that was specifically aimed at younger children or patients who had a learning disability - In these cases, involving children or patients with a learning disability in decision making, including obtaining consent, relied on the explanation of the practitioner.

The service was accessible to male and female patients as well as patients who identify as transgender. The Havens was staffed with female practitioners and the service's website explicitly refers to examiners as being female. This reflects the national picture of staffing in this type of service and the issues in recruiting male practitioners. This was a long-standing item on the service risk register although reports to the trust risk and governance committee have suggested that there is no evidence of requests from patients for male clinicians. Whilst the service employs one crisis worker who is male, we were advised that patients are not offered a choice of the gender of the clinician and this was supported by our review of records. This meant that patients were not fully informed they would be examined by a female clinician and were not able to choose whether or not to decline the examination on this basis.

Timely access to services

Patients could access the service within an acceptable timescale to meet their needs, whether they were referred by the police or through safeguarding processes or had self-referred. All examinations were by appointment. Patients brought to the centre by the police were seen immediately. Patients who self-referred made an initial call to The Havens and, depending on whether the call was in a forensically viable timeframe, they were directed to one of the three centres. Where a forensic examination was indicated and if the patients chose this then they were seen immediately.

The Havens kept data on patient satisfaction to response times. The data showed that patients who made initial contact within a forensically viable timescale were seen straightaway.

Listening and learning from concerns and complaints

The Havens had a complaints policy which called for each complaint to be acknowledged within five working days and responded to after investigation within 25 days. The service's data on complaints for the last quarter showed that four complaints had been received and all had met these timescales. In each of these instances the complaint was recorded and managed diligently and where appropriate, apologies had been offered to the complainant.

The service took learning from complaints and communicated this to staff through individual communications and team meetings. Those that were significant were managed as an adverse incident and were added to the service's improvement action log and we saw examples of this in our review of documentation.

Are services well-led?

Our findings

Leadership capacity and capability

KCHFT are the sole provider of the sexual assault referral service for London having acquired the Whitechapel and Paddington sites in 2013 from other providers. As such the service has become well established and with a clear line of accountability to the trust board. Leaders, managers and clinical staff had a good understanding of this area of health service and had developed experience and expertise in providing a full integrated sexual assault service using the current three-site model.

Leaders understood the diverse demographics of London and the challenges faced by a single provider with 32 local authorities as was evident in the range of strategic risks set out on the service risk register.

Capacity of clinical staff was an ongoing challenge to the service but leaders were working to actions directed from the risk register to increase the use of sessional forensic examiners, improve the capacity of the ISVA service and to streamline the process for triaging self-referral patients.

Leaders were accessible and visible and knew their staff well. Staff spoke positively about the style of leadership from the service manager, the service delivery managers and the clinical leads and said they felt well supported.

Vision and strategy

Staff we spoke with were unsure whether the service had a specific vision and values. Managers acknowledged that a formal set of values was something they intended to produce but this had not yet happened.

However, staff told us that they put patients first, listened to what they had to say and, worked hard to improve and always tried to deliver a first-class service. These views reflected the KCHFT, trust-wide overarching values.

The service's strategic direction was established as part of the rationale to make the sexual assault referral service for London a single provider service in 2013; said to be a 'harmonised' service. Leaders acknowledged that since that time there remained challenges in relation to consistent practices across all three sites, adequate resourcing of permanent staff and communication technology. These challenges formed the service improvement plan and were the first item on the service risk register, so work was actively focused on addressing those. For example, daily multi-disciplinary meetings had been established to promote the 'one service' approach, and a common IT system had been implemented to improve communications across the three sites with further development planned to reduce the hard-copy documentation used.

At the time of the inspection the service was planning to relocate one of the sites to another hospital and plans were already well advanced for this.

Culture

There was a strong culture of putting patients first and taking a compassionate approach to their needs with a desire to work towards excellence. This was evident in our interviews with staff, our review of records and the views of patients who provided feedback. Staff told us they felt valued by leaders, felt a part of the team and wanted to do well.

There was an open and transparent process for reporting adverse incidents and working constructively with feedback from patients to improve services. An open 'no blame' culture and an effective approach towards peer review and of discussing cases at multi-disciplinary meetings promoted this ethos of practice improvement.

Staff had received training in the management of their own adverse feelings arising from the trauma experienced by patients (known as vicarious trauma) and the impact of patients' experiences on staff was addressed as part of regular supervision.

Governance and management

The Havens had clear lines of accountability to the trust board through a monthly performance report to the trust's Planned Medicine Management Board and a 6-monthly report to the Risk and Governance Committee of the trust's Post-Acute and Planned Medicine care group. The service was responsible for the commissioned provision of the sexual assault referral service for London as part of the joint commissioning arrangements between NHSE and the Mayor's Office for Policing and Crime. Accountability was maintained through quarterly meetings attended by commissioners and the leadership of the Havens.

Operational oversight was provided by an integrated management team comprising the service manager, a service delivery manager for each site, and psychology,

clinical and nursing leads. There was an active presence of the senior leadership team at each site to provide support and direction in addition to the monthly site business meetings.

The service used a range of supervision processes in addition to peer review of cases. ISVA and psychology staff groups had mandatory clinical supervision, with clinical supervision also available to, and regularly accessed by, all other staff groups. Staff also had safeguarding supervision and ISVA staff received supervision from an external facilitator. This ensured clinical and safeguarding practice was up-to-date and that staff had plentiful opportunities to share concerns about their work or their wellbeing.

During our inspection we found a small number of minor areas for improvement that we have reported on above. These were acknowledged by managers and we are confident that these would be addressed immediately following the inspection.

Appropriate and accurate information

The Havens had a range of sophisticated data collection methods to assess their performance, including baseline data known as Sexual Assault Referral Centre Indicators of Performance (SARCIPS). Managers at The Havens used this data well and had a holistic view of their service. Data was used to populate reports to the trust and to commissioners and to generate improvement activity where this was required.

The implementation of a single IT system across the service had improved the ability to gather information about the service and to standardise record keeping practice. Record keeping, on the whole, was diligent and comprehensive.

Engagement with clients, the public, staff and external partners

The Havens routinely gathered feedback from patients through questionnaires after their visit. The service had also begun to carry out 'Service user quality interviews' with patients to elicit more qualitative data and we reviewed examples of these. Along with complaints, this feedback was used in reports to the trust and commissioners and led to learning and improvement actions. We looked at several examples of suggestions made by patients through this medium that were under consideration by the service; for example, wider engagement and the creation of a Havens ambassador.

Managers held meetings with the Metropolitan Police to discuss 'quality service reports' submitted by either Havens staff or police staff in relation to operational concerns or areas of good joint practice. Examples of these that we looked at showed that this worked effectively and ensured any operational problems were resolved quickly enabling each service to learn from good practice.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation, and quality assurance. These included a comprehensive educational plan and an audit programme.

The Havens developed their education and audit plans through the Havens Education Audit Research and Training (HEART) group. The HEART group, consisting of a clinical lead and members from each staff group, met quarterly to determine training needs and planned training events and to agree the audit schedule. For example, the group were in the process of planning a two-day learning and networking conference aimed at Haven practitioners and a wider multi-agency audience, including police and prosecutors.

As well as weekly assurance reports and the 'Perfect Ward' audit, the service had carried out a range of audits over the previous year, such as a notes audit and a safeguarding audit. Of particular note was the mental health needs audit based on a retrospective sample of patients' files. This audit showed the broad range of mental ill-health presentations of patients at the centres and noted other social characteristics that were common to presentations, such as domestic abuse. The audit made recommendations about confirming referral to external agencies and about making records of relationship status in risk assessments, a feature we noted to be consistent in records we looked at.