Mountain Healthcare Limited

Oakwood Place SARC

Inspection report

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Overall summary

Summary findings

We carried out this announced inspection on 17–18 May 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by two CQC inspectors and a specialist professional advisor.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Background

Oakwood Place is a Sexual Assault Referral Centre (SARC), which is commissioned by NHS England and NHS Improvement (NHSEI) and the Police and Crime commissioner. Although the SARC provides services to patients of all ages, for the purpose of this inspection we reviewed the care and treatment provided by Mountain Healthcare to children under 13 years old.

Summary of findings

The under 13 year old service is available Monday to Friday 9-5pm. NHSEI commission Mountain Healthcare and two NHS Foundation trusts, to provide a paediatrician or Forensic Medical Examiner (FME) to undertake recent and non-recent alleged sexual assault examinations on different days. Mountain Healthcare provides an FME on a Friday only. They also provide paediatric crisis support workers (PCSWs) who work alongside the paediatricians and FME's Monday to Friday 9-5pm. Mountain Healthcare take overall responsibility of the governance and administration of the service. However, they do not manage or oversee the activities provided by the NHS foundation trust paediatricians. NHSEI have commissioned Mountain Healthcare to provide a Sexually Transmitted Infections (STI) screening service for the under 13 year olds, although this was not part of this inspection.

Mountain Healthcare FMEs saw 13 children for recent and non-recent examinations over the period of April 2021 – April 2022. At the time of inspection there were three FMEs who were covering Oakwood Place SARC on a Friday and two PCSWs with a SARC manager overseeing both the adult and children's services.

Oakwood place is a fully accessible building which is situated in the grounds of a community hospital with plenty of parking, including spaces for those with disabilities. The building is on one level and accessible for wheelchair users. There were two forensic examination suites, but one was used predominantly for children and was separate from the adult area. There was a child friendly non-forensic waiting room with lots of wipe clean toys and activities for a variety of ages. The forensic area had a separate waiting area with a working television and the examination room included a forensic shower room. The building also included a staff shower and changing area, an office with a kitchen area, storage rooms and interview rooms.

During the inspection we spoke with the registered manager who was also the regional contract director, the national SARC director, the medical director for Mountain Healthcare, the associate head of healthcare, the SARC manager, three FMEs and two PCSWs. We also looked at policies and procedures, various reports and five patient records to learn about how the service was managed.

We left comment cards at the location two weeks before our visit, but we did not receive any completed feedback cards. We also spoke with the commissioners of the service from NHS England.

Mountain Healthcare provide the forensic medical service, and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager at Oakwood place was the regional contract director for Mountain Healthcare.

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

Our key findings were:

- The provider had systems to help them manage risks presented to the service.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding children and adults.
- Case records evidenced a holistic approach to assessing patient's needs.
- There were effective working relationships with the paediatricians from the external NHS trusts.
- Staff provided patients' care and treatment in line with current guidelines.
- Patient feedback was positive about the support they received from staff. Staff dealt with complaints positively and efficiently.

Summary of findings

- The service had effective leadership and we saw a culture of continuous improvement.
- The provider had infection control procedures which reflected published guidance and had adapted to Covid-19 guidance to ensure services remained available to patients throughout the pandemic.
- The provider had thorough staff recruitment procedures.
- Staff knew how to deal with emergencies. Appropriate life-saving equipment were available.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The service had suitable information governance arrangements.
- Staff felt involved and supported and worked well as a team.
- The environment was clean and welcoming.

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

- FMEs should improve the representation of the patients' voice within the patient records to evidence the FME listened to the patient and understood and met their needs.
- Staff should be assured that all areas in the SARC have been appropriately risk assessed for ligature risks.
- Ensure that patients have a choice of gender of the doctor they are examined by.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**No action** ✓
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**No action** ✓

Are services safe?

Our findings

Safety systems and processes (including Staff recruitment, Equipment and premises)

Staff understood how to protect children, young people and adults from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff considered safeguarding of children and adults at the earliest opportunity through multi-agency working by attending strategy meetings, the use of information gathering tools and risk assessments.

Staff we spoke with were familiar with the provider's safeguarding policies for children and adults and how to access them. They were aware of the procedure to follow if they had safeguarding concerns. Safeguarding policies and procedures were clear, up to date and staff we spoke with showed a comprehensive understanding of safeguarding issues.

We reviewed training records which showed all staff had the appropriate level three children and adult safeguarding training which the SARC manager monitored. This was in accordance with the intercollegiate national guidance 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019). Staff updated their training every three years.

Social workers or the police were the only agencies that could refer patients into the service. We saw evidence of clear referral pathways and evidence in the patients notes of onward referrals to other agencies including for example GPs, community paediatrics and Children's Independent Sexual Violence Advisors (CHISVA).

In most cases, before a patient was referred to the SARC, a multi-agency strategy meeting was held to decide the best pathway for the patient. The FMEs attended these meetings where they could, to ensure input from the SARC was available. Occasionally the strategy meetings were held after the examination and the FMEs would either try to attend or would hand over to the incoming on call FME to attend.

Staff reported, and we saw in the patient records, that staff adapted the assessment process and examination to meet the developmental needs of patients who required additional support, for example for patients with a learning or physical disability. The provider had developed comprehensive standard operating procedures for many areas of the SARC including children and family focused care, consent to medical examination and maintaining young people's safety.

From our review of five patient records, we saw that FMEs and PCSWs clearly highlighted patient vulnerabilities as part of the referral and assessment process. This included, for example, risks relating to individual mental health, learning disabilities and existing safeguarding concerns.

Staff completed mandatory training which included a range of topics, including basic life support, infection control and preventing radicalisation. Staff received an email reminder when their training was due, and the SARC manager and clinical director had an overview of staff training via an electronic monitoring system. This assured the provider that staff fulfilled requirements for mandatory training.

Staff knew how to respond to an emergency and were up to date with their basic and immediate life support training. Staff followed the providers policy and we saw evidence they checked all emergency equipment on a weekly basis to ensure the equipment was intact and in working order.

One of the FMEs had received the Faculty of Forensic and Legal Medicine (FFLM) training in forensic medical examinations and were a member of the FFLM. Two other FMEs were undergoing their training. These FMEs were able to share updates regarding policies and guidelines produced by the FFLM with the rest of the team.

Are services safe?

The medical director and head of safeguarding arranged additional paediatric master classes which were virtual and recorded to ensure that all staff could access them. Topics included: courtroom training, emotional development in children and medical conditions that may mimic child abuse. Staff we spoke with valued this additional training and described an example where they identified further learning needs in the area of STIs. The provider arranged for a forensic nurse examiner to provide topic specific training around STIs.

The service had staff recruitment policy and procedures in place to ensure employment of suitably qualified staff. The local police force also vetted all staff every three years as an additional check. The provider's human resources department automatically requested DBS checks every three years. This ensured staff were subject to the appropriate ongoing checks.

We reviewed the cleaning schedules of the SARC, which demonstrated an external cleaning service cleaned the forensic rooms before each patient attended. We saw the cleaners had sealed the doors to the forensic rooms with plastic tags to demonstrate they were clean, and this practice was recorded on the log. We saw evidence, in a recent spot check of cleanliness performed by the police, that the report identified contamination on many touch points. The provider closed the forensic area for 24 hours and had the rooms deep cleaned. The provider then held a meeting between the police forensic lead, the SARC manager and the cleaning service regarding the quality of the cleans. Two further rounds of testing found the rooms to be forensically clean.

We also reviewed the cleaning schedule of the toys which were all wipe clean and found staff had signed the cleaning schedule appropriately.

The service completed infection control audits every six months, which included hand hygiene, sharps and waste safety, and this included clinical equipment for example. In the last audit dated 29th March 2022 we saw that it was compliant. However, we did note the children's waiting area was carpeted which meant the area would be more difficult to keep clean. We raised this with the SARC manager who advised the external cleaners would clean any bodily fluid spills with an appropriate spill kit which they stored within the SARC. Immediately after the inspection the provider shared with us evidence that they had requested with the building owner for the carpet to be replaced with hard flooring.

We found all consumables were in date and stored appropriately above the ground. This assured the provider all forensic swabs and consumables were fit for purpose and not contaminated.

The provider had a ligature and suicide risk audit policy and procedure which contained a report of the risk assessment for the SARC. The SARC had been risk assessed as a medium risk. The buildings provider fitted all doors in the forensic areas with locks that staff could open from the outside. Although staff had completed a ligature audit, we found a bucket in the forensic bathroom that a patient could overturn and use as step to self-harm and we raised this with the SARC manager who immediately removed it from the bathroom.

All SARC staff accessed all rooms and offices with swipe cards which reduced the risk of unauthorised access.

All FMEs had received training in the use of a colposcope (a colposcope is a piece of specialist equipment for making records of intimate images during examinations, including high quality photographs) and we saw evidence FMEs managed forensic samples in line with FFLM guidelines. We saw evidence an external provider maintained and serviced the colposcope.

The provider had a health and safety folder which included, for example; when portable appliance testing was next due, guidance around the secure disposal of clinical waste and the storage and control of substances hazardous to health.

Risks to clients

The provider had good systems in place to assess, monitor and manage risks to patient safety. Templates and proformas supported FMEs to recognise the deteriorating physical and/or mental health of the patient.

Are services safe?

The FMEs reported that they discussed patient vulnerabilities with the police and social workers or the patient and/or their carer before their examination, including for example; any learning disabilities or health/ mental health concerns or injuries. This was to ensure the patient's condition was stable enough for them to safely attend the SARC.

We saw evidence from patient records that FMEs assessed, monitored and managed risks to patients. During the initial examination, FMEs would complete a holistic assessment, including for example; the patient's physical health and family tree as well as details of the alleged assault. If the patient required further medical treatment, they would advise the patient and their parent/carer to attend accident and emergency, or in the case of emergency would call 999 for emergency care themselves.

Additionally, we saw evidence in the patients notes of FMEs identifying risks to patients and taking the appropriate action. For example, referring the patient to community paediatrician clinics or Emotional Wellbeing and Mental Health Service (EWMHS).

FMEs assessed patient's needs for Post Exposure Prophylaxis after Sexual Exposure (PEPSE), emergency contraception, hepatitis B prophylaxis and STIs. This ensured the patient received a holistic assessment and continuing care when required. FMEs would refer patients back to their own GP for hepatitis B prophylaxis and they assessed and treated STIs within the SARC.

We saw evidence of the last three months rota for both PCSWs and FMEs which showed there was enough staff for the provider to cover the service. If there was any short notice sickness, managers informed us that the SARC manager would arrange cover from elsewhere within the provider. Managers told us they had never not been able to cover staff sickness absence.

Information to deliver safe care and treatment

The FMEs completed patient records to a good standard and the assessment proformas were in line with FFLM guidance. The records were accurate, complete, legible, contained completed body maps and stored securely in locked metal filing cabinets. The SARC staff were the only staff with access to the records and had information sharing agreements with the NHS trusts who provided paediatrician cover, which complied with data protection requirements

Staff securely stored photo evidence from the colposcopes. Staff stored each image with a unique identifying number so as not to identify the patient.

Staff made appropriate and timely referrals to other agencies such as GPs and local authority social services, which was in line with national guidance. PCSWs appropriately followed up referrals and ensured social workers and/or the family were aware of each referral, and where appropriate, checked the patient had attended appointments.

All relevant polices and pathways were in line with the FFLM and the National Institute for Health and Care Excellence's (NICE) guidance, and all FMEs reported to access guidelines and updates from the FFLM regarding forensic medical examinations.

Safe and appropriate use of medicines

Staff stored medicines in locked cupboards and they also locked keys away securely. We reviewed storage cupboards and noted they contained medicines that were within their expiry dates. Staff also monitored the inside temperature of the medicines cupboard where all medicines were stored.

Staff stored STI samples in a fridge and monitored the temperature of the fridge daily. The provider had fitted the fridge with an inbuilt thermometer which sent the temperature records to a computer. This ensured staff were aware of the temperature ranges during weekends and bank holidays when staff were not in the building.

The provider had a comprehensive medicines management policy for handling and administering medicines within the SARC. FMEs we spoke with were confident in administrating medicines safely.

Are services safe?

Track record on safety

The provider emailed incident forms to their governance department and the records were saved and monitored from a digital spreadsheet, which the SARC manager and the regional contract director reviewed. Any identified themes were shared within team meetings for future learning.

Staff we spoke with were able to demonstrate they understood their responsibilities to report concerns and near misses and that they understood the incident reporting processes and were able to give examples of when they had reported an incident.

Lessons learned and improvements

Staff told us they discussed incidents and themes from incidents at their team meetings. Staff also discussed incidents through peer review and appraisals. Staff understood the importance of discussing incidents, therefore reducing risk and supporting further learning.

If an incident occurred while a paediatrician from one of the NHS trusts was performing an examination within the SARC, the provider would take the lead in the initial investigation and work closely with the NHS trust to come to an appropriate outcome.

Staff received medicines and equipment safety alerts by email from the provider. This ensured staff were aware of any medicines or equipment that required to be withdrawn from the service.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The service provided care and treatment based on national guidance and best practice. The clinical leaders checked to make sure staff followed published guidance.

FMEs assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance, including the FFLM and NICE. We reviewed patient documentation which assured us FMEs had recorded a comprehensive health assessment as part of the forensic examination, including past and current medical histories.

The provider produced evidence-based policies and procedures to provide guidance for staff and ensured staff identified risks to patients and improved patient safety. All staff we spoke with had access to the policies and procedures through the providers electronic system.

We saw evidence all staff had completed mental capacity act training and had regard to the Mental Health Act which was relevant when talking with parent/carers. We saw evidence in the patient records that all patients who attended for forensic medical examinations had their mental health status considered by the FMEs during the examination process.

Post examination, FMEs and PCSWs provided patients and their parent/carers with appropriate information with regards to access to additional support, in addition to referral onwards to other services such as their GP or CHISVA.

Monitoring care and treatment

The SARC manager, medical director and head of safeguarding completed audit programmes which included, for example; notes audits, infection control, ligature assessments and safeguarding audits. The SARC manager reviewed and recorded the results of the audits on an action log and ensured they completed all actions.

The medical director and head of safeguarding audited 10 sets of the FMEs patients notes each year and PCSWs would have 20 sets of notes audited by the SARC manager. We reviewed a sample of the FME audits and found the auditors had left appropriate feedback for the FME to act upon. Feedback from the audits also informed one to one discussion as well as peer review and appraisals. However, from a review of the five patient records, we found FMEs could strengthen the documentation of the child and parent/carer's voice. This would provide stronger evidence the patient felt listened to and the FMEs met and understood their needs.

A multi-disciplinary case review meeting was held daily, and attended by the SARC manager, FMEs and the medical director. The case review ensured that all referrals relating to every patient's case were processed in a timely manner and PCSWs checked to ensure that each patient accessed the services they needed. The case review enabled professionals to challenge decisions made by other organisations and demonstrate aspects of safeguarding practice such as professional curiosity, contextual safeguarding, and professional challenge.

FMEs would record the outcomes of patients attending for forensic medical examinations within the confidential medical aftercare proforma. This included procedures undertaken, treatment provided (including medication issued) and communication or referrals (including safeguarding and GP's) made to other agencies for ongoing support.

All patient records had additional space to record or store any conversations the FMEs or PCSWs may have had with external partner agencies and conversations with the patient or carer, for example; the local authority or GPs. We saw evidence of contemporaneous record keeping which meant FMEs and PCSWs were completing notes in a timely manner with the expected detail required.

Effective staffing

Are services effective?

(for example, treatment is effective)

The provider made sure all staff were competent to undertake their roles safely. All staff had received an annual appraisal and attended one to one supervision meetings to receive support and development. Training needs were identified within the appraisal process

New staff undertook the providers comprehensive induction programme which prepared them for their role to ensure they were skilled and well supported. For example, new staff would shadow examinations and undertake specific training related to forensic medical examinations, such as colposcopy training and forensic swabs.

The provider requested that FMEs attended at least four peer review sessions a year where FMEs discussed any individual cases and themes and shared learning with their peers. This was also an opportunity for FMEs to debrief about any difficult or upsetting cases in a safe supportive environment. PCSWs and the NHS paediatricians were also invited to attend the peer reviews for learning.

FMEs maintained their professional registration through continuous professional development and this was monitored through monthly clinical supervision.

Co-ordinating care and treatment

The providers pathway and support service received referrals from social workers or police who then liaised with the PCSWs. The PCSWs informed the on call FME or paediatrician of the time and place of the strategy meeting and/or liaised with the patient and their carers to arrange a mutually agreed appointment time at the SARC.

We heard evidence of strong working partnerships between the PCSWs, FMEs and the paediatricians who attended from the external NHS providers. From speaking with the individual practitioners, we heard evidence that the patient was always their priority.

Health improvement and promotion

Staff offered all patients who attended the SARC an appointment with a CHISVA. The service also contacted GPs with details of the patient's attendance at the SARC and made other referrals if appropriate. This could include, for example, referrals to CAMHS, community paediatricians, and dermatology clinics.

Consent to care and treatment

FMEs supported patients and their carers to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. FMEs understood the relevant consent and decision-making requirement of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice should they need to.

All FMEs were able to describe what actions to take if the parent was unavailable to provide appropriate consent. We saw in one set of patients notes an example where a parent had been arrested but the FME was still able to gain consent verbally over the telephone. We heard other examples of where the child was under a care order and so the FME sought appropriate consent for STI treatment from the social worker involved in the case.

There was a strong awareness across the team of the requirement to understand Gillick competencies when assessing if a child had the capacity to consent to treatment, which was in line with national guidance.

Are services caring?

Our findings

Kindness, respect and compassion

The service collected feedback from patients and their families and displayed this on a feedback tree so all staff and visitors to the SARC could see. Positive feedback included: how well cared for they felt, how clearly staff explained information to them and if and how they felt supported by the FME and crisis support worker team to make the right decisions. Patients commented on how relaxed the staff had made them feel.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff talked with care and compassion about the patients they saw, and their role in advocating for them at a vulnerable time in their lives.

Staff told us they allowed patients time to control the examination and took time to explain processes and next steps using age appropriate language. Interviews with staff and a review of records showed staff were kind, respectful and compassionate as well as knowledgeable about the impact and trauma of sexual assault.

The PCSW had introduced a 'cuddle buddy' which was a hand knitted toy, patients could take with them through the examination process and then take home to keep. Staff told us the patients feedback showed they really appreciated the gesture.

Involving people in decisions about care and treatment

Staff were sensitive to the diverse needs of patients and we saw evidence in the patient's records that the forensic medical examination was adapted to suit everyone. This allowed the patient or their carer to take control of the pace at which the FME completed the examination. At each step of the examination staff took time to explain and ensure the patient fully understood the process.

From our review of patient notes and from speaking with staff, we saw evidence patients were at the centre of their own care and treatment. It was clear all patients and carers were involved in decisions about each step of their care and treatment.

It was the social work or police team who had responsibility for arranging interpreters for patients and their carers when required. We heard one example where the carer of the patient was deaf, and the police wanted to bring them to the SARC without an interpreter. We heard the PCSW advocated on their behalf and insisted an interpreter was booked before they attended the SARC, as the carer was unable to lip read through masks and would therefore be unable to communicate during the examination.

Staff talked confidently about supporting patients with a learning disability. We saw evidence of pictorial guides for children who may have a learning disability regarding the SARC journey and PCSWs reported they would gather as much information about the patient before they arrived so they could make reasonable adjustments.

Oakwood place has its own website that included information on what to expect when attending the SARC, contact numbers, opening hours and information regarding other supporting agencies.

Privacy and dignity

Staff showed respect for patients' privacy, allowing them to change their clothing in private and use the toilet and shower facilities alone if appropriate to do so. However, staff remained close by to ensure the patients were safe from harm. Staff gave patients the option to wear a gown or keep items of clothing on during the examination process depending on the nature of the alleged assault. Staff also ensured the use of a privacy screen which made the room seem slightly smaller and less daunting for the patient and their carers.

Are services caring?

Staff stored patient notes securely in a locked cabinet within an office. This prevented any unauthorised access to patients notes.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

Staff planned and provided care in a way that met the needs of patients. The SARC team worked in partnership with local NHS Trusts, external agencies, police and local organisations to plan care and support.

The providers assessment paperwork included a confidential medical aftercare proforma for under 18s which included; an assessment of the patient's mental health, learning disabilities, their home environment, whether there were any safeguarding concerns, contraceptive assessments and a detailed personal medical history. This ensured FMEs identified vulnerable patients and referred them onwards as appropriate.

The SARC provided access for patients with disabilities, including accessible toilets with handrails and call bells. Patient feedback demonstrated a high level of satisfaction regarding the environment. The SARC also had a hearing loop which the staff could use for patients or their carers with hearing loss.

The SARC manager had introduced regular meetings with the local authority social work teams across Essex, to raise the profile of the SARC and awareness of their functions The aim of this was to improve the communications between the police and the social work team to ensure the FMEs and paediatricians were included in strategy discussions and referrals of recent alleged sexual assault cases to ensure patients were referred to the SARC in a timely manner.

Taking account of particular needs and choices

The SARC provided an age appropriate environment for children under the age of 13. They had access to a wide range of wipe clean toys and access to TV screens and computer consoles.

Staff did not offer the patients a choice of gender of the FME before the appointment, although the PCSWs did inform the families of the gender of the FME's before they arrived at the SARC.

Staff had access to their computer system where they recorded all patients who attended at the SARC or who they gave verbal advice about. This ensured they were aware if a patient had attended the SARC before and were able to advise the strategy meeting attendees. This knowledge would better inform their interactions with re-attending patients and their carers.

Timely access to services

The SARC was open from 0900 – 1700 Monday to Friday. The provider monitored response times from the point of referral to the start of the assessment and produced monthly reports for each area of the service for the police commissioners and the NHS England commissioners so they could be assured of the timeliness of service provision.

The PCSWs ensured that there was never a cross-over of children's cases but sometimes there may be an adult case in the SARC building at the same time. However, the service saw adult cases in a separate part of the SARC building so it was unlikely that the two cases would meet.

We saw evidence that, due to lack of cover provided from the external providers across the week, there had been two separate incidences where patients who had suffered non-recent abuse had needed to attend an out of Essex SARC instead. Although the provider was not commissioned to cover the service apart from on Fridays, they told us they do their upmost to gain permission from the commissioners to cover the service with their own FMEs to prevent patients from travelling out of area, but this was not always possible.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

Staff were aware of, and followed, the providers complaint policy if patients or their carers wanted to complain about the service. Staff reported to us that learning from complaints and incidents were a standing item on the team meeting agenda. We also saw evidence of this in meeting minutes examined.

Staff used an electronic reporting system to log incidents and complaints to ensure a clear audit trail. This ensured the SARC manager and senior managers could identify trends for quality assurance purposes.

We saw from the information request we made prior to our inspections that there had been one complaint received in the last six months, which the regional contract director responded to in a timely and appropriate manner whilst following the provider's complaints procedure.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders demonstrated skills and the ability to run the under 13 year old forensic medical examination service. They understood and managed the priorities and issues the service faced, for example the lack of daily paediatrician cover. Leaders were visible and approachable in the service and supported staff to develop their own skills and practice.

A clear management structure was in place to provide day to day supervision and support to staff. A leadership team provided oversight of the staff and were available to support with any issues that required escalation. Leaders were visible and the staff spoke positively about the support they received from them.

Staff told us they felt very well supported by the registered manager and SARC managers and reported they were confident to raise concerns with them should they need to do so.

Vision and strategy

The provider had a clear vision and strategy of continuous learning and improvement within their SARC services and staff embedded this within their practice.

We observed the staff to be committed to their roles and saw evidence through patient feedback that they provided patients with good quality, safe care. Staff we spoke with were able to demonstrate how they followed the providers guiding principles.

There was a committed and stable team of staff and we saw that overall staff turnover was low. The SARC manager shared messages from the senior management team with staff at team meetings and through other communications, such as the staff noticeboard and by email.

Culture

Staff reported they felt respected, supported and valued. We saw evidence that demonstrated how staff focused on the needs of patients in their care. The service provided opportunities for career development.

Staff reported an open and honest culture and worked well together with the external NHS paediatricians. We saw a no blame approach to peer review of patient notes and the contract lead and SARC manager addressed any concerns though open and honest feedback.

The provider had a comprehensive whistleblowing policy. This provided staff with information about how to raise a concern confidentially should they not wish to do so at a local level. All staff we spoke with told us they felt comfortable to raise concerns with their direct line management in addition to more senior managers.

Staff told us the provider monitored their welfare and gave them debrief opportunities following complex or distressing cases. The provider had dedicated well-being ambassadors for the SARCs who were mental health first aiders. Staff welcomed and supported these processes as it helped with reflection and improving their future practice.

The service commissioner also told us they had a good working relationship with the provider. The regional contract director discussed any issues with commissioners either informally or during more formal contract review meetings.

Governance and management

The provider had good clinical governance arrangements in place including; policies, standard operating procedures and risk assessments relating to the delivery of forensic medical examinations by the FMEs.

Are services well-led?

A range of meetings across the service supported the governance structure. These included; team meetings, safeguarding case reviews, monthly paediatric meetings, an incident review board, and weekly regional contract meetings. Incidents, complaints and discussion of trends or themes took place during team meetings. This ensured outcomes were actioned and information was shared in a timely way. There was a clear flow of information from board level down to floor level and back up again, with all team minutes and action logs being available for the appropriate leads to review, action and escalate as necessary.

The registered manager who was also a regional contract manager attended quarterly meetings with NHSEI and police commissioners where actions on the providers risk register for the service were discussed, in addition to the service's overall performance.

Processes for managing risks, issues and performance.

The regional contract lead and SARC manager identified and recorded risks to the service on a risk register which the provider's senior SARC management team regularly updated, reviewed and discussed during monthly paediatric meetings. Risks included; even though it was not the providers responsibility to cover the gaps in the service where there was no cover from external providers they had acknowledged it as a risk to the overall service, the need to meet the forensic regulator standards to achieve accreditation and lack of a separate entrance for children into the building. All risks included; detailed plans of action, who was responsible for the risk and each risk scored for the level of severity and when the action was required to be reviewed.

The provider had a business continuity plan which was comprehensive. If any staff were unable to attend the SARC due to Covid 19 sickness for example, the provider aimed to provide staff from other SARC's.

Appropriate and accurate information

Information governance arrangements complied with the Data Protection Act. The SARC manager, contract lead and governance lead gathered quality and operational information which they used to ensure and improve outcomes for patients.

The regional contract director provided Sexual Assault Referral Centres Indicators of Performance which provided assurance around the activities of the service to police and NHSEI commissioners and helped staff to make improvements to patient care.

Patients consented for the service to securely store their records. This was part of their initial consent process. This demonstrated the providers compliance with the General Data Protection Regulation (2018). The service had not experienced any information breaches.

Engagement with clients, the public, staff and external partners

The staff encouraged patients to leave written or oral feedback before they left the service and they then used this feedback to improve service provision. For example, we saw feedback from an older child who had requested more age appropriate activities to be made available. The service responded by providing a computer console with age appropriate games.

The SARC manager and clinical director gathered staff feedback through staff meetings, appraisals and peer reviews. All staff we spoke with reported how well they felt the managers listened and acted upon their concerns.

Continuous improvement and innovation

The service had effective assurance processes to encourage continuous quality improvement using peer reviews, training sessions and audits. Staff talked positively of the opportunity for learning within their role. The medical director provided one to one support for FMEs when writing court statements which helped to ensure FMEs produced statements in a timely way and that they were of a high quality.

Are services well-led?

Staff had access to a comprehensive programme of learning and development opportunities through the provider. The provider also funded attendance at national conferences, such as the FFLM SARC best practice day.

The provider, alongside the HIV nurse consultant from a local NHS trust, developed guidelines for advising on and issuing HIV PEPSE in children aged under 13 years old. This had resulted in an agreement where the FME and paediatricians could refer all children living within or outside of Essex, who required HIV PEPSE treatment, to the NHS trust's clinic for assessment and treatment if required. This ensured the patient received treatment in a timely way.