Sussex Community NHS Foundation Trust

Brighton General Hospital

Inspection report

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Overall summary

We carried out this announced inspection over two days on 24 and 25 August 2021 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. Two CQC inspectors carried out the inspection, supported by 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

The Sussex children's sexual assault referral centre (CSARC) is provided by Sussex Community NHS Foundation Trust (SCFT). The CSARC is situated on the site of Brighton General Hospital and is clearly signposted with the service name, without reference to the type of service to ensure discretion. Dedicated parking is available directly outside the CSARC.

Summary of findings

NHS England and Improvement (NHSE/I) and the Sussex Police and Crime Commissioner (PCC) commission the CSARC. NHSE/I is the lead commissioner for the CSARC. The Sussex PCC is the lead commissioner for the children's independent sexual violence advocate (ChISVA) service, which is provided by The Survivors' Network, a community and voluntary sector organisation. The CSARC refer children to the ChISVAs for support throughout the court process, where appropriate. The Survivors' Network was not in the scope of this inspection.

The CSARC provides a service to children in Brighton & Hove, East Sussex and West Sussex, up to and including the age of 13 years, who have experienced or are suspected of having experienced recent (within 21 days) or non-recent (longer than 21 days) sexual abuse. In addition, they see young people aged 14 to 18 years if they have additional needs that would make the CSARC the best place for them to be seen. The CSARC provides holistic health assessments, including forensic medical examinations when required.

The CSARC is open between 9am and 5pm for referrals, with doctors available between 10am and 4pm, 365 days of the year. Access is via police or social worker referral only. The staff team is led by a non-clinical service manager and a consultant paediatrician who is the clinical lead doctor. A vacancy for lead nurse had been recruited at the time of the inspection. There are a further 12 doctors, including ten paediatricians, one genito-urinary medicine (GUM) speciality doctors and one GUM consultant; and six nurses from the children in care (CiC) nursing team, fulfilling the CSARC rota. Each child is assessed by at least one doctor, plus a nurse who also offers crisis support, on weekdays and two doctors on bank holidays and weekends.

SCFT is responsible for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

During the inspection we spoke with the service manager, the clinical lead, the general manager, the head of nursing and governance, two doctors, two nurses and a ChISVA. No children or young people accessed the CSARC during the time we were onsite.

We examined the records of 10 children, all of whom were under the age of 14 years.

We left comment cards at the location in the week prior to our visit. No children had accessed the service during that time, so no comments were received. We reviewed feedback from a range of stakeholders, received by the CSARC.

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

Throughout this report we have used the term 'patients' to describe children and young people who use the service, to reflect our inspection of the clinical aspects of the CSARC.

Our key findings were:

- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding children and adults.
- The service had systems to help them manage risk.
- The service had thorough staff recruitment procedures.
- The clinical staff provided support, care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- Established policies and procedures ensured effective multi-agency and multi-disciplinary working.
- The service had effective leadership and a culture of continuous improvement.

Summary of findings

- Staff felt involved and supported and worked well as a team.
- The service asked staff, patients and stakeholders for feedback about the services they provided.
- The service staff had effective processes in place to deal with complaints positively and efficiently.
- The staff had suitable information governance arrangements.
- Areas seen during our inspection were clean and well maintained.
- The staff followed infection prevention and control procedures, which reflected published guidance.

The provider could make improvements. They should:

- Strengthen arrangements for onward referral to external services and follow-up, including emotional well-being and mental health support.

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

Our review of policies, procedures and audit findings; as well as interviews with staff and leaders, showed how systems and processes were embedded in practice, to keep patients safe. Policies were up to date in accordance with scheduled review dates and were fit-for-purpose. Interviews with staff demonstrated knowledge and understanding of policies and procedures. Practice was regularly reviewed and monitored to ensure compliance with expected standards.

Patients were cared for in the CSARC by staff who were trained in safeguarding children in accordance with intercollegiate guidance for healthcare staff. Clinicians were trained to at least level three, with some staff trained to level four and five. We saw examples in records of clinicians' analysis of risk. This was clearly articulated through effective and regular liaison with multi-agency partners. This meant that patients were safe during their visit to the CSARC and had their safeguarding risks promptly and appropriately responded to.

Our review of patient records demonstrated a clear understanding of safeguarding risks and effective contribution to multi-agency safeguarding arrangements. For example, there was an expectation that strategy discussions were held for all patients requiring a CSARC service, with a representative from the CSARC in attendance. As well as being an essential forum to safeguard children, these discussions also provided an opportunity to inform and engage colleagues in the benefits that a CSARC assessment could provide. This was documented in CSARC guidance and corroborated in the records we sampled.

All referrals to the CSARC were via the police or a social worker. This was in accordance with the Sussex multi-agency Child Sexual Abuse (CSA) pathway. Self-referrals were not accepted.

There were flags on the electronic patient record that alerted staff to additional vulnerabilities. For example, if a child was looked after by the local authority, had attended the SARC previously, or had learning disabilities. This meant that staff were sensitive to additional needs and risks to the child before they attended the CSARC and could plan their care accordingly.

Staff

There was an open culture in the CSARC where staff could raise concerns, and reported they felt confident to do so if required. SCFT was ranked 9th nationally in the 'Freedom to Speak Up' index. This enabled any unsafe or discriminatory issues to be quickly identified and addressed.

Staff were employed in line with the SCFT's safer recruitment policy. Pre-employment safety checks included, enhanced Disclosure and Barring Service (DBS) checks, an extensive interview process and validation of individual references and qualifications. SCFT updated these safety checks every three years. This provided assurance that staff were still safe to deliver care and treatment to vulnerable patients.

Risks to patients

Patients accessing the CSARC benefited from a holistic health assessment that fully incorporated their medical, physical, emotional, mental and sexual health needs. Staff assured the safety of patients that were identified as being at risk of harm or with urgent health concerns. For example, the health assessment included a full physical examination and consideration of the requirement of post-exposure prophylaxis after sexual exposure (PEPSE), Hepatitis B vaccination, emergency contraception and sexual health screening.

Are services safe?

The assessment reports we reviewed as part of the sampling were detailed, comprehensive and demonstrated analysis of risk, and the impact of the patient's experiences on their health and well-being. They also followed the format of a court report in the event this might be needed in the future. This meant that practice was child-focused, responded to the child's initial needs and identified appropriate next steps.

Premises and equipment

There was an SCFT infection prevention and control (IPC) policy and the lead nurse, supported by the IPC champion, was responsible for ensuring staff at the CSARC complied with it. This was achieved through regular audit. Personal protective equipment (PPE) was available for both staff and patients to reduce the risk of transmission of infectious illnesses and we saw staff using PPE consistently. Appropriate governance procedures were in place to ensure that used PPE was disposed of safely.

All information displayed in the CSARC was laminated, toys and surfaces were wipeable to allow effective cleaning in line with IPC guidance. This reduced the risk of viral transmission in the CSARC to protect both patients and staff.

SCFT was responsible for the cleanliness and safety of the environment. This included the disposal of general, confidential and clinical waste, as well as the stringent cleaning of the forensic examination and waiting rooms to prevent the cross-contamination. The cleaning arrangements met the Faculty of Forensic and Legal Medicine (FFLM) guidance. The manager of the CSARC liaised regularly with the Trust's head of nursing and governance to identify and mitigate potential risks arising from the environment and this arrangement was effective.

We identified during our inspection however, the serial numbers on forensic room seals were not recorded or monitored. This did not provide complete assurance that the forensic room had not been entered and resealed, thus risking contamination. We raised this with leaders at the time, who responded quickly by developing and implementing a recording system to eliminate this risk.

The manager carried out environmental risk assessments, including fire safety and ligature points in areas used by patients and families. Patients were always accompanied by a social worker and a parent/carer during their time at the CSARC, unless assessed by the nurse as safe to access the bathroom unaccompanied. There were agreed procedures in place to reduce risks if the safety of a patient in the bathroom became a concern. Furthermore, the nurses completed additional environmental checks in line with SCFT's policies and procedures. This provided an audit trail and meant that patient safety was maximised.

There are two fire exits in the CSARC, one at the front which is the main entrance and one at the rear of the building. There are a small number of steps at the rear exit, which would hinder someone with mobility difficulties exiting the building this way in an emergency. This risk was reduced by staff ensuring patients and families only used the front of the building, therefore exiting via the main entrance.

The CSARC staff had access to three automatic external defibrillators (AED) at different locations within Brighton General Hospital. In view of the patient group accessing CSARC being assessed as low risk, the CSARC policy was to call 999 in the event of an emergency.

SCFT had an effective business continuity plan, which incorporated Covid-19. Staff at the CSARC had continued to deliver a service to patients throughout the pandemic, and all patients had been able to access assessments, treatment and support.

Information to deliver safe care and treatment

Staff at the CSARC recorded on paper during the health assessment, to remove the physical barrier of a computer. All information on paper records was both scanned then destroyed and transcribed onto an electronic patient record (EPR).

Are services safe?

Some paper records we reviewed were difficult to read and there was sometimes a short delay in hard copies being scanned. This risk was mitigated however, through timely dictation and transcription after each patient had left the CSARC. Clinicians told us they had dedicated time to complete all work for each patient. This meant that the 'next practitioner' using the EPR had access to a comprehensive record in one place.

The EPR was also used by local GPs, public health nurses and the CiC health team, allowing multi-disciplinary health professionals access to appropriate information in children's multi-disciplinary records. This meant that staff at the CSARC could prepare for appointments using a fuller picture of needs and risks. Staff were also able to communicate through the EPR and this strengthened liaison and follow-up of required actions.

We saw effective use of body maps to support accurate documentation. Genital body maps were stored in every patient's records, with full body maps also used if further non-accidental injury was suspected, or otherwise deemed appropriate by the assessing clinician.

Relevant research articles were available for staff at the CSARC to access on an electronic system. A newsletter with updated guidance and news was circulated within the CSARC by the clinical lead. This ensured that staff were aware of new guidance and that practice was informed by up to date national guidance and protocols.

Staff used specialist equipment, known as a colposcope for making records of intimate images during health assessments, including high-quality photographs and video. There were effective arrangements for ensuring the safe storage and security of written and video records that met guidance issued by the FFLM.

Safe and appropriate use of medicines

The CSARC had a standard operating procedure (SOP) for the management of medicines. This SOP was explicit to the CSARC and specified that all medicines had to be prescribed by doctors for individual patients.

The CSARC held a stock of medicines in a locked cupboard which was reconciled weekly, these included emergency contraception and antibiotics. All medicines were in date with the quantity and type clearly documented. The CSARC followed trust guidance to ensure that medicines were stored safely.

Track record on safety

Leaders in both SCFT and the CSARC had a clear understanding of CSARC performance. There was effective oversight of training compliance through reporting systems and governance arrangements.

The SCFT electronic incident reporting system was robust. All incidents, many of which related to the CSA pathway not being followed properly by partners; were reported, responded to, and monitored in line with expected procedures.

Lessons learned and improvements

Staff and leaders identified children who were inappropriately referred to the CSARC, after GPs had incorrectly suspected a common childhood condition to be a symptom of sexual abuse. In collaboration with GPs, paediatricians and children's social care, staff at the CSARC developed a process for children to be swiftly reviewed by a paediatrician to rule out the common condition, before commencing the CSA pathway. Such cases have since been audited and the number of inappropriate referrals has reduced. This meant that children and families were less likely to unnecessarily experience safeguarding and CSARC processes which caused undue distress. Instead, they received the correct care and treatment at the earliest opportunity.

Leaders have carried out single and multi-agency audits including the effectiveness of the Sussex CSA pathway, CSARC service provision for children in care and a review of non-attendance. Findings from these audits led to improvements, such as changing the language used from 'medical examination' to 'health assessment'. This led to a decrease in the numbers of patients not brought to CSARC appointments.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients attending the CSARC had their needs thoroughly and holistically assessed, and their care and treatment delivered, in line with evidence based, FFLM guidance. Nurses contacted all patients prior to attending the CSARC for a pre-assessment, to ensure the child and the family were sufficiently prepared.

Staff appropriately considered patients' health needs arising from exposure to unprotected sexual contact, such as the need for post-exposure prophylaxis after sexual exposure (PEPSE) and emergency contraception through close liaison with the GUM service. These processes were in line with guidelines issued by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) respectively.

All patients' records we reviewed were detailed and clearly articulated medical, physical, emotional, mental and sexual health needs. Staff followed a trauma informed model of care and records reflected how they were sensitive to individual patient experiences.

Monitoring care and treatment

The designated doctor and GUM specialty doctor, overseen by the clinical lead, undertook an audit on hepatitis B vaccinations recommended for CSARC patients compared with the number administered. The findings identified many GPs had a lack of understanding regarding the need for vaccinations and had not arranged administration. This led to awareness raising for GPs and a plan to bring hepatitis B vaccinations into the CSARC.

Peer review and clinical supervision sessions were accessible, effective and well attended. They included a review of the latest guidelines, as well as a review of recent cases. Staff also benefited from emotional support, including vicarious trauma and a safe space for reflection, acknowledging the sensitive and challenging nature of working in a CSARC. Monthly sessions were facilitated by a psychotherapist and highly valued by staff. These sessions provided learning and reflection time for staff to develop their practice. In addition, there were also regular audits to provide assurance that record keeping met the expected standards. We saw that this meant that staff were able to deliver effective, evidence based and compassionate care.

Effective staffing

The CSARC was staffed by committed professionals who received thorough induction and training corresponding to a competency framework. This included doctors undergoing a period of shadowing for as long as necessary, to ensure competence and confidence. This meant that patients accessing the CSARC, received a service from skilled, dedicated and competent clinicians, to ensure the best possible experience and outcome during distressing and difficult circumstances.

All health assessments were completed by a consultant paediatrician, supported by a nurse and/or a second doctor. In the event of recent abuse when forensic samples were required, a crime scene investigator (CSI) was also present to take the samples from the doctor and securely manage the transport and storage on behalf of the police. The CSI was out of the scope of this inspection.

Staff knowledge and skills was supported by regular mandatory training in key safety topics; including safeguarding children and adults, immediate life support, health and safety, and infection prevention and control. All staff were up to date with, or booked to attend, mandatory training at the time of our inspection.

All CSARC clinical staff had received specialist training including the Royal College of Paediatrics and Child Health (RCPCH) and the FFLM forensic courses for doctors; and The Havens: Introductory Training Course in Sexual Offences Medicine for both doctors and nurses.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

Collaboration between the CSARC and partners was effective and child focused. We saw examples in records of consistently strong relationships with a range of multi-disciplinary and multi-agency professionals. For example, staff at the CSARC had developed a strong working relationship with the GUM service and as a result, onward referral and liaison for patients requiring sexual health screening and treatment was timely and effective. This was further strengthened by having GUM doctors on the CSARC rota.

We saw evidence in records of how staff routinely liaised with multi-disciplinary professionals. The ChISVA was positive about the working relationship with staff at the CSARC. Furthermore, CSARC staff were important members of the multi-agency team responding to safeguarding needs and risks, including strategy discussions and where appropriate, child protection conferences. This ensured that specialist knowledge informed decision making and care planning.

There were some patients however, who did not benefit from such a co-ordinated approach to meet all their needs. For example, patients requiring emotional well-being or mental health support had to be referred and followed-up via the social worker due to local arrangements. This limited the opportunity for patients to receive the support they needed in a timely manner, such as, if children's social care assessed a child as being safe from further risk of harm and closed the case.

Consent to care and treatment

Staff understood the legal standards for gaining consent from children and young people, as well as the adult with parental responsibility. All staff explained a clear and thorough process of obtaining consent using the 'Gillick competence' standard. Consent was sought and documented for assessment, examination, treatment and information sharing. This was evident in the records we sampled. This meant that patients retained control over what happened to them in the CSARC as much as possible. Patients and their families were empowered to stop assessments at any time.

Are services caring?

Our findings

Kindness, respect and compassion

Staff at the CSARC understood the significant impact of sexual, emotional and often physical trauma on patients and were compassionate when providing the service. Interviews with staff, our review of records and feedback collected by the service from patients and families; showed staff to be kind, caring, empathic and respectful.

Nurses discussed the patient's preferred gender of clinician during the pre-assessment call and fulfilled specific requests.

One patient told the CSARC how they were very nervous and anxious but felt welcomed and reassured by the staff.

Parents told the CSARC that staff were excellent and sensitive to all children, including siblings and those with special needs.

Privacy and dignity

Patients were given a choice about where they got changed, and privacy and dignity were respected and maintained through the appropriate use of curtains. The CSARC allowed only one patient and family onto the premises at a time. This provided privacy for the patients and flexibility for clinicians to respond to patient's needs.

Patients were also given a choice about who accompanied them in the examination room during assessment. We found however, that social workers or police officers were routinely present behind a curtain during forensic examinations. Leaders of the CSARC recognised that this was unnecessary and immediately took action to rectify this practice.

Involving people in decisions about care and treatment

Records we reviewed captured the voice of the child well. Children's likes, dislikes, wishes and feelings were clear, which supported their involvement in making decisions about their care.

Leaflets about the service and what to expect were available for children and parents. They were clear, concise and a single page. Information about the CSARC is available on the SCFT website. It does not provide the address, contact details or the name of the service to protect confidentiality. It clearly states that referrals must be made via children's social care or the police.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

The CSARC was well organised and delivered services to meet patients' needs. We found through our interviews with staff, review of records and the physical environment that staff considered patients' varying needs and responded well to meet them. The range of skills and knowledge within the staff team meant that patients with additional and complex needs were cared for sensitively. A particular benefit was the expertise that paediatricians could bring for children with neurodevelopmental needs and learning disabilities and the experience that CiC nurses could bring regarding trauma and adverse childhood experiences.

There was excellent support for patients and families to attend the CSARC. Staff collected information from other professionals about patients' needs and required communication methods for example, prior to contacting the family. They had also created a video and social stories as alternative ways to prepare children for what to expect at the CSARC.

The CSARC was a child-friendly environment. In response to direct feedback and findings from a quality assurance audit, this was further adapted to better meet the emotional and social needs of older children as well as younger children. It was clear from regular feedback the service had sought and received, that they did everything they could to make attending the CSARC as comfortable an experience as possible under distressing circumstances.

The entrance to the CSARC and all rooms used by patients and families had step-free access, ensuring those with physical disabilities could attend the service.

The positive external working relationships have enabled a better awareness of the services provided by the CSARC. Open days and education for multi-agency professionals, as well as careful use of language, has allowed a deeper understanding of how attending the CSARC can be a therapeutic experience for children who have been sexually abused.

Timely access to services

The CSARC was open for referrals between 9am and 5pm, 365 days of the year. It was the view of commissioners and the provider that it was not in the best interests of children to be seen 'out of hours', and the 'forensic window' of 72-hours could still be met for recent cases. Access to the CSARC was via police or social worker referral only, to ensure the child's safeguarding needs were assessed and responded to by the right professionals. All assessments were by appointment, with the patients accompanied by a parent or carer as well as a social worker. There was full cover of doctors and nurses on the rota and all patients who have requested a service has received one.

Patients identified as needing hepatitis B vaccinations were referred to the GP. This increased the risk of additional unnecessary delay in accessing additional treatment. The clinical lead had already identified this as an area for improvement following an audit and was developing a plan to maintain a stock of vaccinations at the CSARC.

Listening and learning from concerns and complaints

The CSARC followed SCFT's complaints policy, however, there had not been any complaints to the service.

Are services well-led?

Our findings

Leadership capacity and capability

The CSARC was led by a stable team. Strong relationships were evident between the CSARC manager, clinical lead, SCFT's safeguarding children team and SCFT's senior leadership. The general manager of SCFT child development services and the head of nursing and governance had oversight of the service through regular meetings with the CSARC manager and knew its staff well.

Leaders and staff at the CSARC had a thorough understanding of the needs of children and young people who had experienced trauma, including sexual abuse. The strong links with the safeguarding team meant there was always additional support in dealing with complex cases and opportunities for reflection.

Vision and strategy

CSARC staff had a clear understanding of SCFT's values of 'compassionate care', 'working together', 'achieving ambitions' and 'delivering excellence'. Our review of records and the feedback the service received demonstrated how these values were embedded in the care they provided to patients and families.

Culture

Staff told us that they felt well supported by the CSARC manager, clinical lead, as well as each other. They stated that leaders and managers both in the CSARC and in the wider Trust, were visible, accessible, approachable and open to challenge. They reported to feel confident to raise concerns if they needed to. We were told that staff morale remains high, with children remaining firmly at the centre of everything they do, despite a challenging 18-months due to the pandemic.

Governance and management

There was a clear accountability and governance structure between the CSARC and SCFT. The governance processes effectively monitored performance and leaders were proud of the CSARC having such positive feedback from all stakeholders, as well as there being no serious incidents and no risks or complaints.

Our interviews with staff showed a clear understanding of their roles and responsibilities in the CSARC. They knew how to raise concerns and reported that they felt confident in doing so if required. Staff well-being was important to leaders, which was evidenced by the psychotherapy sessions they provided to support staff due to the emotional impact of working in a CSARC, which we thought was an excellent example of good practice. All staff said they valued this and felt listened to.

Areas for development we identified during our inspection were either already known by staff and leaders with work underway to develop a plan of improvement, or they were rectified immediately, such as the forensic room seal log. This reflected the culture of continual improvement.

Appropriate and accurate information

The CSARC collected a range of data on their performance in line with the NHSE/I commissioning framework. This ensured that commissioners had oversight of the CSARC's monitoring and improvement processes. Commissioners told us they were confident in the service the CSARC provided as well as leaders' quality assurance and governance arrangements.

Patient information was managed safely and appropriately in line with SCFT's information governance arrangements. Consent to share information was discussed with patients and families at the start of assessments and clearly documented in records.

Are services well-led?

Engagement with clients, the public, staff and external partners

Leaders at the CSARC regularly collected feedback from patients, families, social workers and the police, with very few suggesting improvements that needed to be made. They were responsive when suggestions were made, such as the introduction of digital tablets, table-football and a pool table for older children and young people. Staff also considered IPC safety with these items, which were cleaned and locked away until required when an appointment was made for a young person.

Continuous improvement and innovation

The CSARC had a rolling audit calendar, the findings of which were shared, and actions identified and implemented where necessary. They also had an annual improvement plan, with actions to fulfil objectives identified in the annual report. On the latest plan all actions were complete with a RAG rating of green, except for one which was rated amber. This was an action that required support from external partners including all the local safeguarding children partnerships (LSCP) across Sussex and the work to achieve this was continuing.

NHSE/I had commissioned a quality assurance audit of the CSARC. The findings were positive and the recommendations relating to the area rated requires improvement have been implemented.

Contract monitoring meetings with NHSE/I were replaced during the pandemic with weekly 'situation report' meetings which continued at the time of our inspection.

As stated above, staff were up to date with mandatory and role specific training and could access additional training to enhance practice that suited their specific interests.