

York Teaching Hospital NHS Foundation Trust

The North Yorkshire Child Sexual Assault Assessment Service

Inspection Report

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Ratings

Overall rating for this service

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Overall summary

We carried out this announced inspection over two days on 18 and 19 February 2020 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal

requirements in the Health and Social Care Act 2008 and associated regulations. Two CQC inspectors, supported by a specialist professional advisor carried out this inspection.

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

- Is it safe?

Summary of findings

- 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 North Yorkshire Child Sexual Assault Assessment Service (CSAAS) is situated in The York Hospital. The service operates from a discrete set of rooms accessed via a paediatric ward. The CSAAS is accessible for people who use wheelchairs.

The service is jointly commissioned by NHS England and the Police and Crime Commissioner for North Yorkshire and is provided by York Teaching Hospital Foundation Trust. The CSAAS offers health services and forensic medical examinations to children and young people, aged 15 and under, who have been sexually assaulted or abused. The service can also see older young people aged 16 to 18 who have additional vulnerabilities, this is decided on a case by case basis in conjunction with the local adult sexual assault referral centre. The service does not accept self-referrals. All referrals must be made by police or social care staff. The North Yorkshire CSAAS is available Monday to Friday from 9am to 5pm excluding bank holidays. Children and young people requiring care outside of these times are referred to other services in the region.

The unit is accessed via an intercom and consists of a waiting room, a forensic examination room, a bathroom and an office which is used by CSAAS staff as well as the hospital safeguarding team. The CSAAS is staffed by a full-time lead nurse, a part time nurse and a part time administrator. Four paediatric consultants cover the service on a rota basis. Play therapists, who are employed on the neighbouring paediatric ward, can offer support to children and young people who are attending the unit. The service does not employ Independent Sexual Violence Advisors (ISVAs) or counsellors directly and refers children and young people into these services. The ISVA and counselling services, therefore, were not part of this inspection.

During our inspection we spoke with staff members including the lead nurse, the lead play therapist and a Forensic Medical Examiner (FME). We looked at 14 patient records and three staff recruitment files. We looked at policies and procedures and other records about how the service is managed.

Our key findings were:

- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The clinical staff provided children and young people's care and treatment in line with current guidelines.
- Staff treated children and young people with dignity and respect and took care to protect their privacy and personal information.
- The service asked children and young people and their families and carers for feedback about the services they provided.
- The service had a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service staff dealt with feedback positively and efficiently.
- The staff had suitable information governance arrangements.
- The service appeared clean and well maintained

During our inspection, we found concerns that children and young people were at risk of having their forensic DNA samples compromised by cross-contamination. When we identified these issues, the provider took immediate action and decided it would no longer see children and young people in the North Yorkshire Child Sexual Assault Assessment Service (CSAAS) who required a forensic medical examination. We were satisfied that the actions the provider took removed this risk to children and young people.

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

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

Full details of the regulations the provider was not meeting are at the end of this report.

Summary of findings

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

- Offer, whenever possible a choice of gender of medical examiner.
- Complete the planned programme of mandatory training and level three children's safeguarding training, so that all staff have received the required amount of training in line with trust policy.
- Consider how the communication needs of children and young people of different ages and with learning needs are met.
- Improve multi-disciplinary documentation of care.

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?

At the time of our inspection we identified a concern that this service was not providing safe care in accordance with the relevant regulations. The service took steps immediately to rectify this. Now that the shortcomings have been put right the likelihood of them occurring in the future is low.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

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

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices section at the end of this report).

Are services safe?

Our findings

Safety systems and processes

The North Yorkshire Child Sexual Assault Assessment Centre (CSAAS) had systems and processes to keep children and young people safe. Staff received mandatory training on safety topics such as infection prevention and control, fire safety and adult and paediatric life support. The service had clear policies which were reviewed regularly and were in date during our inspection. Staff told us these policies were used daily in the unit.

Systems were in place to protect children from the risk of abuse. All children attended the service with a social worker, and we saw that information was shared appropriately with the social care team. A safeguarding strategy meeting was held for every child before they attended the service. Staff told us that, on occasion, they were not invited to strategy meetings. When this happened the Forensic Medical Examiner (FME) and the lead nurse liaised with police and social care colleagues to ensure all relevant information was obtained before the child arrived at the unit. The service used the Child Protection - Information Sharing (CP-IS) system to identify any child or young person who may be subject to a child protection plan or who is a looked after child. Hospital records were flagged to highlight any additional vulnerabilities the child had. We saw that staff attended initial child protection conferences to contribute their expertise or to discuss any disclosures the child or young person may have made while they were receiving care on the unit.

We found that 83% of staff were up to date with level three children's safeguarding and safeguarding vulnerable adults training in accordance with intercollegiate guidance. This was slightly below the trust target of 85% and plans were in place for staff members to attend the required training urgently. The trust level three safeguarding training consisted of at least 12 hours of classroom-based learning every three years. Staff had access to the hospital's safeguarding team should they need any advice or support on a safeguarding issue. The lead nurse obtained safeguarding supervision directly from the hospital's named nurse.

Staff

Staff were employed in line with the trust's recruitment policy. We reviewed three staff personnel files that

demonstrated two suitable references had been obtained and authenticated and any gaps in the applicant's employment had been explored. We noted that photographic identification was held on staff records. Disclosure and Barring Service (DBS) checks were conducted by the hospital trust when staff were initially recruited. In two staff personnel files we found that DBS checks had not been updated since 2004 and 2010 respectively. There was no additional police vetting of staff. We checked trust policy which indicated it encouraged all applicants to subscribe to the DBS update service, however this was not a mandatory requirement. Repeat checks were not undertaken by the trust unless staff moved to a new role.

Staff knew who to contact in the event of any emergencies and did not work alone in the service. There was a trust wide procedure that staff could follow if they felt unsafe in the unit. We saw an emergency call bell in the examination room which staff could use to alert hospital security if required. The trust had a conflict resolution policy, which was in date. All hospital staff were trained in de-escalation techniques.

We found that the trust Occupational Health and Wellbeing team checked employees' previous immunisation history and ensured immunisations required to protect patients and staff were up to date.

Risks to patients

Children and young people accessing the CSAAS were assessed for risks regarding their physical, mental and emotional health. However, we noted there was no specific safeguarding assessment which would prompt practitioners to further explore risks to the child or young person.

Children and young people were consistently assessed for clinical needs such as the need for post exposure prophylaxis after sexual exposure (PEPSE) to reduce the risk of HIV transmission and the need for emergency contraception.

Staff knew how to respond to medical emergencies. All staff had attended annual mandatory life support training appropriate to their role. There was emergency equipment available on site.

Premises and equipment

Are services safe?

During our inspection we identified some areas of concern regarding the forensic examination suite. The rooms were used for child protection medicals and follow up visits as well as the examination of children who had been sexually assaulted.

The waiting room contained many toys. Staff recorded that the toys were cleaned after each child attended the unit and kept a log of this cleaning activity. However, there were also books and posters on the wall which means that the waiting room could not be deep cleaned.

The waiting room did not connect to the forensic examination room. Children and young people had to enter a short corridor, pass an office and enter the separate forensic examination room. The examination room contained paper folders which staff agreed to remove immediately. The bathroom was not connected to the forensic examination room and the child or young person would have to leave the room, enter the corridor and enter the bathroom. There was a toilet brush and a sanitary waste bin in the forensic bathroom. Staff agreed to remove these items, which could increase the risk of DNA cross contamination, immediately. We were concerned that the corridor used by children and young people to access the bathroom was used by all visitors and office staff at the CSAAS and the hallway was not forensically cleaned. Furthermore, this issue had not been risk assessed.

We noted that there were records of daily cleaning as well as monthly and quarterly deep cleans of the forensic rooms. There were records of cleaning carried out before forensic examinations. The last environmental testing (carried out by the police) was in 2017. This testing had shown a concern in one area (the handle used to adjust the couch), the service addressed this by adding an instruction to the cleaning checklist to ensure this was thoroughly cleaned. We saw evidence that the lead nurse had contacted police staff to ask for repeat testing, however this had not occurred.

We asked the provider to consider these issues and the provider informed us that it no longer planned to see children and young people on the unit who required forensic samples to be taken from 24 February 2020. This issue is discussed further in the well led section of the report.

Staff were trained in the use of equipment in the CSAAS. The unit had a piece of specialist equipment, known as a

colposcope, available 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.

CSAAS staff were aware of their responsibilities regarding health and safety. Health and safety and building management issues were overseen by an estates team. We saw evidence that the unit had been assessed regularly. There was a trust wide Health and Safety policy, which was in date. We saw that the unit had been assessed for ligature risks, however we noted that some risks had not been identified. Staff immediately updated the assessment and took steps to mitigate these risks. Staff followed the trust's policy to ensure safe use and disposal of sharps.

Emergency equipment such as fire extinguishers had been checked and were up to date. There was a trust fire safety policy. There were signs in the unit to instruct staff on what to do in the event of a fire. Staff were aware of the fire safety procedures for the unit. Staff had completed the mandatory fire safety awareness training in accordance with trust policy.

Information to deliver safe care and treatment

Staff kept paper records which were stored securely in locked cabinets while in use on the unit and were transferred to the hospital records department when the child's care within the CSAAS was completed. There were effective arrangements for ensuring the safe storage and security of these records. Images taken with the colposcope were stored on the hospital IT system. Only CSAAS staff had access to these images and access was password protected.

The service used proformas to assist in the holistic assessment of each child who attended the service. The templates were based on documents from the Faculty of Forensic and Legal Medicine (FFLM) and the Royal College of Paediatrics and Child Health (RCPCH). The proforma prompted the practitioner to make a full assessment of the child's family details, their learning ability, health related behaviours and physical health, the record included space for a genogram to be completed and an age appropriate body map. We found that the child's voice was evident in all records we reviewed.

We saw that appropriate referrals were made to other health teams in a timely way. When consent was given by

Are services safe?

the child or young person or their parent or carer, staff referred young people onto sexual health services, mental health services and informed the child's GP. In one record reviewed we saw a FME had written to the local child and adolescent mental health service to request a review of a young person with an ongoing mental health need.

Safe and appropriate use of medicines

The CSAAS kept a very limited number of medicines on the unit, any other required medication could be obtained from the hospital pharmacy. We found that medicines were stored safely and securely. All medicines were prescribed by a doctor. We found that there was an appropriate stock control system for medicines on the unit.

Track record on safety

The unit reported on performance information including staffing levels, staff training compliance, patient demographics and when children and young people were seen by other services (due to being out of hours or due to staffing issues) at quarterly operational meetings attended by senior trust staff and commissioners.

Two safety issues had been reported; the gaps in the Forensic Medical Examiner (FME) rota, which meant the

service could not see children and young people, and the concern that the examination suite would not meet the Forensic Science Regulator's new guidelines. These issues were recorded on the trust's risk register; however, they were assessed as low risk. This is discussed further in the well led section.

Lessons learned and improvements

The unit used an incident reporting programme to record when things went wrong. Any issues were then reviewed by senior leaders within the trust and action was taken to prevent the issues from happening again. For example, staff told us they reported an issue with a faulty colposcope through this process which led to the equipment being swiftly repaired. Staff also used their regular peer review sessions to improve care. Following the review of one case; a multidisciplinary team including a play therapist, learning disability nurse, speech and language therapist and staff from the CSAAS developed a pathway to improve access to the service for children with learning disabilities.

Staff had an email cascade system in place so that they could be swiftly informed of any safety alerts including external safety, patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Staff at the North Yorkshire Child Sexual Assault Assessment Service (CSAAS) followed clinical pathways based on the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines to ensure the immediate healthcare needs of children and young people attending the service were identified and met. For example, the service assessed children and young people for the need for emergency contraception and HIV/Hepatitis B prophylaxis and provided medication when required.

All North Yorkshire CSAAS staff took part in regular peer review sessions. Sessions were held at least monthly within the service. Staff had also attended a regional peer review session, where paediatric staff from other sexual assault referral centres across the region met with each other to share learning and review each other's findings.

Systems were in place within the unit to ensure care was evidence-based and up to date with current guidelines. The lead nurse ensured any updates from CSA (Child Sexual Abuse) centre for excellence and the Faculty of Forensic and Legal Medicine (FFLM) were disseminated to all staff. The lead nurse also attended the local area's Rape Scrutiny Board and ensured unit staff were made aware of learning from case reviews from across the region. At the most recent panel the board reviewed what went well and what could have been better for cases involving under 16-year olds. This meeting was also used by the lead nurse to gain feedback on how well cases had proceeded through the criminal justice system and was an opportunity to obtain feedback on how to improve the service.

Consent to care and treatment

Staff sought consent to care and treatment in line with current legislation and guidance. We spoke with staff who demonstrated their understanding of the Gillick and Fraser guidelines when children under 16 consented to treatment and the Mental Capacity Act when vulnerable young people aged 16 and over used the service.

In the records we reviewed we found that treatment options were given and any risks were explained to the young person. We saw that consent to treatment and care was documented at each stage of the patient examination.

We found signed consent forms in every record we reviewed, and some forms were signed by the child as well as by their parent / carer. We saw that the play therapists worked as advocates for children and young people and helped them to express their views about their examination and treatment options. We saw that interpreting services were used in cases where the family's first language was not English.

Monitoring care and treatment

The service had an annual audit schedule which included a monthly cleaning audit of the CSAAS, and audits on record keeping, medicine management and safeguarding training compliance. In the documentation audit some gaps in record keeping had been identified. This issue had been raised with team members and a repeat audit was due to take place.

Effective staffing

We saw that the lead nurse had developed an effective CSAAS specific induction programme. This included shadowing opportunities, observations of forensic examinations and child protection medicals, training on the use of the colposcope and visits to other sexual assault referral centres (provided by other organisations) in the region. The induction also included how to manage telephone advice and local referral processes. The programme included regular competency checks to assess the new starters' learning and skills.

We saw that all staff had had an annual appraisal in line with trust policy. Staff were able to access training to ensure their continuing professional development, for example the lead nurse had completed a course on trauma informed care. Staff benefitted from clinical supervision and peer review activities. The lead nurse received clinical supervision from a Forensic Nurse Examiner employed by a neighbouring sexual assault referral centre as it was identified that no one in the trust could meet this need.

Three of the four Forensic Medical Examiners (FMEs) and the lead nurse had completed the Forensic and Medical Examinations in Rape and Sexual Assault (FMERSA) course to learn best practice in forensic examination and the care and treatment of patients who had been sexually assaulted. No member of CSAAS staff was a member of the Faculty of Forensic and Legal Medicine.

Are services effective?

(for example, treatment is effective)

Staff were required to undertake mandatory training in line with trust policy which included training on information governance and risk management. CSAAS leaders were aware the percentage of staff who had completed their training was at 83%, just below the trust target of 85%. Plans were in place to ensure staff attended the required training sessions.

Co-ordinating care and treatment

We saw that the service worked with other professionals to ensure the children and young people attending the service received effective coordinated care. Staff liaised repeatedly with social workers and police colleagues from the moment the child was referred to the unit to ensure all the child's medical and safeguarding needs were met. The unit had strong links with the local area's sexual health outreach team. This team was able to follow up young people aged 13 and over in their own home to provide further tests, results and treatment when required. Children under 13 who required a follow up appointment were seen by the paediatrician.

All children, young people and their families and carers were offered a referral to the local Independent Sexual Violence Advisor (ISVA) service. Staff told us there was no waiting list for this service. The service had recently trained three advisors to work specifically with children and

young people. However, there was no mechanism in place to ensure that the ISVA service had received the referral or to liaise with this service to ensure young people, parents and carers had been able to access this care. Children and young people were also offered a referral into the local area's counselling provision; however, staff were aware there were long waits for this service.

There had been variation in the routine monitoring of children and young people's care and treatment after they left the service in the six months prior to our inspection. CSAAS staff had noted their target of contacting young people or parents and carers two weeks following an appointment was not being consistently achieved. Staff had introduced a tracking mechanism to ensure every young person or parent or carer was contacted following their visit and we noted there had been attempts to contact all young people and their parents / carers in the month prior to our visit.

We saw that staff requested permission to share details of the child's visit with their GP and any other relevant services the young person was involved with. When permission was granted by the child's family or by the young person, CSAAS staff shared the information appropriately.

Are services caring?

Our findings

Kindness, respect and compassion

We found the North Yorkshire Child Sexual Assault Assessment Service (CSAAS) to be a caring service. Children and young people were treated with kindness, respect and compassion. Staff were aware of the emotional trauma those attending the service had experienced and described the actions they took to ensure children, young people and their families felt comfortable and in control in their service. Staff told us they allowed each child as much time as they needed to prepare for the examination. There was a variety of age appropriate toys and an electronic tablet for young people to use as a distraction while they were waiting. Play therapists were available to work with anxious or distressed children.

The unit had spare clean clothing in a range of sizes for children and young people to use if they did not want to or were unable to wear their clothing to return home in. The service had fleecy blankets which children and young people, who did not require a forensic medical, could use to make them feel more comfortable during their examination. We noted in feedback that a child had commented positively about the blanket being 'lovely and soft'.

Food and drink were offered to children, young people and their families when they visited the service. Staff told us they were able to access the hospital catering facilities which meant there was a range of food and drink available to meet all dietary requirements.

Privacy and dignity

The service respected and promoted the privacy and dignity of children and young people. The unit was accessed by a discreet entrance on a paediatric ward. Only one child accessed the service at a time, therefore visitors would not see who else used the service. Children and young people were able to wear dressing gowns or medical gowns during their examination and only showed one part of their body at any one time to preserve their dignity. There was a privacy curtain in the forensic examination room so that the young person could change behind this screen.

Patient records were securely stored in locked cabinets on the unit before they were moved to the trust's medical record department. Images were stored safely on the provider's IT system. Access to the images was restricted to CSAAS staff only and was password protected.

Involving people in decisions about care and treatment

Parents and carers were given information on what to expect during a visit to the CSAAS. The lead nurse had developed a leaflet regarding this which included pictures of the waiting and examination rooms. The trust website included a link to a video which described what to expect during a visit to a CSAAS service.

The service did not offer a choice of gender of care professional. All CSAAS team members were female. Staff told us they would refer any young person requesting a male member of staff to another service. However, this meant children and young people had to ask for this at a time when they felt vulnerable.

Parents and carers were provided with information folders when they left the service. This included a range of information and advice on topics such as the independent sexual violence advisor (ISVA) service, a parent's guide to keeping children safe on line, protecting your child from sexual abuse and child friendly and easy read feedback forms for children and young people to share their experiences of their treatment and care.

We left comment cards and a box for children, young people, parents and carers to leave us feedback on the service in the two weeks prior to our inspection, however we did not receive any completed cards. The service collected feedback and we reviewed comments from the previous 12 months. Most of the comments were positive. One parent had commented that the follow up care that they had received was second to none. A child commented that they could not think of anything to change and wanted to stay all afternoon.

We noted that there was a suggestion box in the waiting room, however there was no information to inform people that this is what the box was for. Staff immediately agreed to place a sign on the box. We noted there was a 'you said we did' board which demonstrated the providers response to feedback. One person had commented that the waiting room was not child friendly and the service had responded by adding child friendly decoration to the room and

Are services caring?

providing fleecy blankets. Information leaflets about the service offer were developed following a patient comment that they did not know what to expect when they arrived at the service. Hot chocolate was offered as a choice of drink after this was suggested.

The provider was meeting the accessible information standards. Information about the CSAAS could be obtained in a range of different languages and formats including, braille, large print, audio and electronic formats. However,

the service did not have any leaflets tailored to children and young people of different ages or different levels of understanding which meant that children and young people were reliant on others explaining information to them.

There was a range of leaflets on display for parents and carers to take with them including details about services which could support them in the community.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The North Yorkshire Child Sexual Assault Assessment Service (CSAAS) responded to the needs of the children, young people, parents and carers who attended the unit. The service was staffed by consultant paediatricians, registered nurses and play therapists who were knowledgeable about the emotional and physical needs of children and young people. The waiting area was decorated in a child friendly way and there was a variety of toys and activities suitable for children and young people of all ages.

There was a pathway for children and young people with a learning disability to ensure they had equal access to the service. Children and young people were encouraged to bring their hospital passports with them to the unit, the passport told staff what the child liked and disliked and explained the child's preferred method of communication. Information was displayed in the waiting room about the different communication methods that were available in the trust and hearing loops could be used if required. The service was accessible for people with physical disabilities, there were allocated car parking spaces for those with disabilities, step free access, an accessible toilet with hand rails and a wet room containing a shower. Staff told us a patient representative group had visited the service and assessed its suitability for wheel chair use. If required specialist equipment such as a hoist was available from the paediatric ward.

The provider sought feedback from professionals. One professional had commented that the 'staff in this process have been utterly amazing; the patient experienced an exemplary sexual healthcare network of very capable expert staff and hoped it would give [the patient] good confidence to seek help when this was needed'.

Staff at the CSAAS had recognised the number of children and young people using the service was low when compared to the number of reported incidents in the local area. In response to this the lead nurse visited local social care, health and police teams to promote appropriate referrals into the service and to encourage use of the what to expect in the CSAAS leaflet.

Timely access to services

The provider had received written feedback on the responsiveness of the service. The CSAAS was open 9am to 5pm weekdays, excluding bank holidays. One relative had commented that they would have liked the service to operate seven days a week, 24 hours a day. The feedback went on to say the professionals they met at the service were amazing and they were very grateful 'but wished that the service was available continually to support the emotional wellbeing of a child.'

We did note that other seven-day services were available in the region for children to attend.

We found that families of children and young people who did not require urgent appointments had left negative feedback about the length of time they had had to wait. One parent explained the distress they felt 'that this had become a safeguarding process' and had found this very distressing they then 'had to wait a few days for the CSAAS appointment'. Another parent expressed dissatisfaction when their child's appointment had been postponed on two occasions. Staff told us this had happened as two acute cases were referred into the service who had to be seen within an urgent timescale. Following this comment, a new protocol was developed where acute cases would be referred into another unit in the region and non-acute cases would not be rearranged.

Listening and learning from concerns and complaints

The provider had received no formal complaints in the last 12 months. Formal complaints about the service could be made via the patient advice and liaison service (PALS). Although the details of complaints process were provided in the patient information leaflet and on the provider's website, this was not displayed in the unit. When we pointed this out to staff, they agreed to display this information more prominently in the waiting room. Any feedback about concerns in the service were discussed with the team and were recorded in the annual report which was shared with staff, senior leaders and commissioners.

Are services well-led?

Our findings

Leadership capacity and capability

Staff working at the North Yorkshire Child Sexual Assault Assessment Service (CSAAS) had the skills to deliver high-quality care. However, staff shortages meant that care delivery was not consistent or sustainable. We saw staff rotas from the four months prior to our inspection which showed the service could not cover each clinical session with a Forensic Medical Examiner (FME). Children and young people cannot be seen on the unit when there is no FME cover as this means there is no doctor to perform the medical examination. We saw that in January 2020, there were seven sessions without FME cover and in February 2020 there were nine occasions of no FME cover. This situation had resulted in two children being referred to other units within the region.

Staff had recognised that the lack of forensic testing, which would assure them that the forensic areas were being properly decontaminated, was an issue and had requested testing to be carried out. Furthermore, staff understood that the set-up of the examination room and bathroom was a concern and could potentially lead to forensic samples being at risk of cross contamination.

These issues had been escalated to senior leaders and two issues (the staff shortage and the set-up of the forensic room) were featured on the trust risk register, however the issues were assessed as being low risk and had not been actioned further.

Prior to our inspection senior leaders had been in discussions with commissioners to consider the future of the service. It was probable that children and young people who required forensic samples to be taken would not be seen in the service after 31 March 2020. Immediately after our visit, the service decided to bring this date forward so that no children or young people who required a forensic medical examination would be seen in the service after 24 February 2020. This decision resolved our concerns about the lack of a program of testing to ensure decontamination procedures were effective and about the set-up of the forensic examination room and bathroom. The decision also reduced our concerns about staffing levels as children and young people requiring immediate care will no longer be referred to this unit.

We found that the systems and processes that were in place to ensure good governance in accordance with the fundamental standards of care were not effective. In some records we reviewed, we found sections of the documentation proforma were left blank, for example genograms and facts such as the child's faith and language were missing. This means that important details which could impact on the effectiveness of the child's assessment could be missed. We noted that play therapists did not always write directly into the patient record, instead the FME recorded retrospectively what the play therapist reported to them. This means the opportunity for the play therapist to record their important observations first hand was lost. In addition to this in we found gaps in the assessment of the child's safety, for example, a tool used to determine the child's risk of child sexual exploitation was not completed in three of the records we reviewed. This meant that systems and processes were not effectively monitored to assess the risks of patients who accessed the service.

The service had identified the need for succession planning. A nurse was employed part time on the unit in order develop the knowledge and skills required to lead the unit in the future.

The lead nurse represented the service at several meetings relevant to protecting young people from sexual harm including the CSA/CSE (Child Sexual Abuse & Child Sexual Exploitation) sub-group meetings and the local area's MACE (Multi-Agency Child Exploitation) meetings. This means that the service was promoted to relevant stakeholders.

Culture, Vision and strategy

All staff we spoke with were passionate about providing a caring, high quality service to children, young people and their families. Staff told us they felt able to raise concerns and any incidents or concerns were responded to openly. We were told that all team members were keen to learn to prevent issues from reoccurring. The trust had a policy relating to duty of candour called 'Being open with patients'.

Staff were committed to multi-agency and multi-disciplinary working. They recognised the children and young people attending the unit required a high level of joined up care from health colleagues and agencies such

Are services well-led?

as social care and the police to keep them safe. To achieve this CSAAS staff worked hard at liaising with other professionals to ensure information was obtained and shared appropriately.

The CSAAS was part of a larger 'care group' within the trust. The care group's vision was one of 'transformation and innovation'. CSAAS staff were good advocates for the children and young people who used their service and were committed to ensure the children received a high standard of care.

Governance and management

CSAAS staff were aware of their responsibilities and roles within the service. There were clear systems of accountability to support governance and management. Staff were aware of trust and CSAAS specific policies and procedures and described using them daily. The unit sat within a 'care group' and there was a clear line management structure. Staff on the unit knew who to escalate concerns to and stated they felt supported by their line managers. The lead nurse and her line manager had one to one conversations at least every six weeks.

There was an overarching trust business continuity plan in place, however this was not specific to the CSAAS. There was no plan in place to indicate where children would receive treatment and care if the unit could not operate in the event of an emergency, incident or disaster.

Appropriate and accurate information

The service collected a range of data and used this to monitor performance. The data was shared with senior leaders and commissioners during quarterly operational meetings and was used, alongside the views of children, young people, families and carers to populate an annual report which highlighted the service's strengths and areas for development.

The trust had an Information Governance policy which CSAAS staff adhered to. This meant that the creation, storage and use of patient information was managed in line with legislation.

Engagement with clients, the public, staff and external partners

The service invited feedback from children, young people, families, carers and professionals from other agencies in order to continuously improve. The lead nurse had spoken with an adult who had attended the unit as a child in order to ascertain if the service could have done anything better. Following on from this meeting the service ensured they spoke to all children alone at least once during their visit.

The lead nurse had produced a newsletter every six months which was sent to health partners and other agencies such as social care and the police. The aim of the newsletter was to promote the unit to new staff, to remind professionals of the services the CSAAS can offer and to dispel common myths about sexual assault referral services.

Continuous improvement and innovation

There were systems and processes in place in the CSAAS for learning, continuous improvement and innovation. We found that the service learned when things did not go as expected, for example the introduction of a pathway for children with learning disabilities.

Staff were able to access learning opportunities and training. Nursing staff had completed a training needs analysis and opportunities had been sought to meet identified learning needs, for example both nurses had visited other sexual assault referral centres in the region to learn from wider practice. Within the service staff engaged in regular peer review and supervision sessions.

The service was committed to staff wellbeing and recognised the emotional impact of working in the CSAAS. All staff were able to access individual sessions with a psychologist. Staff described these sessions as incredibly helpful.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) |