G4S Health Services (UK) Limited

The Solace SARC - Bicester

Inspection report

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Overall summary

We carried out this announced inspection on 22 and 23 March 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. The inspection was led by a CQC inspector who was 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.

Are services safe?

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

Are services effective?

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

Summary of findings

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 providing well-led care in accordance with the relevant regulations.

Background

G4S Health Services (UK) has managed The Solace Sexual Assault Referral Centre (SARC) since April 2019. There are currently 2 sites, Slough and Bicester. This report relates to our inspection of The Solace Bicester SARC.

The SARC covered the whole of the Thames Valley Region. From April 2019 the SARC received calls from 789 patients requiring assistance, including onward referrals, and carried out 554 forensic examinations.

The service is commissioned by NHS England.

Bicester SARC is based in the grounds of the Bicester police station in the old "police house". There was a separate, lit, walkway from the main road to the front door so a patient could choose to park away from the SARC and walk in, or they could park free in the police car park.

The service operated 24 hours a day 365 days a year for police referrals. They provided a service for both children and adults. Self-referral patients could be booked out of hours to facilitate their examination, but consideration would be made to their mode of transport to and from the SARC with last appointments usually agreed by 8pm to maintain their safety. The service took referrals from police, self-referrals, social services and other health professionals.

The service was provided by G4S Health Services (Limited) 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 The Solace was the service manager.

In Bicester, there were always at least two members of staff on site during the hours of 9 to 5. Staff lived close by to attend the SARC between 5pm and 6am if needed to conduct a forensic examination. These staff are forensic medical examiners (FME), forensic nurse examiners (FNE), doctors, crisis workers and administrators.

Within G4S Health Services (Limited) there are three clinical leads who are members and registered with the Faculty of Forensic and Legal Medicine.

During the inspection we spoke with seven staff and reviewed eight patient records. 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 people who use the service to reflect our inspection of the clinical aspects of the SARC.

Summary of findings

Our key findings were:

- The provider had systems to help them manage patient risk.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service had thorough staff recruitment procedures and an effective buddy system to ensure staffing levels were maintained during recruitment.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The clinical staff provided patients' 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.
- The appointment/referral system met patients' needs.
- The provider had effective leadership and culture of continuous improvement.
- The provider asked staff and patients for feedback about the services they provided.
- The staff had suitable information governance arrangements.
- The provider appeared clean and well maintained.
- The staff had infection control procedures which reflected published guidance.

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?

Our findings

Safety systems and processes

Patients including children and young people were safeguarded from the risk of abuse because there were appropriate systems in place to identify and report safeguarding issues. We saw evidence that staff had received safeguarding training that followed Intercollegiate Guidance; Safeguarding Children and adults: Roles and Competencies for Healthcare Staff. Data showed all staff had received safeguarding level 3 training, with the exception of one new member of staff who was booked onto a session within the next month.

There was a named safeguarding lead as well as appropriate policies and procedures in place to provide staff with information about identifying, reporting and dealing with safeguarding issues.

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable. Some staff we spoke with demonstrated that they were aware that a child may not always discuss or disclose a sexual assault, so gathering as much information about a child's situation was important.

Assessments of children, young people and adults highlighted vulnerabilities such as existing safeguarding concerns, their age, learning disability, mental health conditions or any physical injuries. If the patient was undergoing a physical examination, staff offered the patient a choice of having having a parent, carer or chaperone accompany them. Staff were also trained to recognise the signs of modern slavery, female genital mutilation (FGM) and other forms of 'honour based' violence. Safeguarding referrals were made for all children that were in contact with the SARC. All of the children were referred to the SARC by the police or relevant social services team and therefore were already known to the local authority. Staff were clear that they would still report any safeguarding concerns and share information about the patient.

The provider had effective systems in place to monitor staff practice. For example, there were regular safeguarding supervision and peer review sessions where staff discussed cases they had handled recently with their manager and colleagues. The safeguarding supervision sessions were led by a member of staff that had undertaken an accredited safeguarding supervision course. We were told that staff had the opportunity to discuss cases at any opportunity. We saw records of informal one to one discussions. In addition, managers carried out a safeguarding audit to ensure that staff had taken the appropriate action to safeguard the person if any concerns were raised.

The provider had recently introduced a database to monitor the number of children accessing the service. This was supporting the provider to have oversight of the children attending and the offered onward care from the SARC. Managers were working with partner agencies and commissioners to improve forensic medical examiners' inclusion in child protection strategy meetings.

Managers monitored all staffs mandatory training records to ensure they were up to date. Managers had been proactive in reviewing and managing compliance with immediate life support (ILS) training that had been impacted on by COVID-19 restrictions.

Staff

At the time of inspection, a manager from another SARC was in a temporary role to assist whilst recruitment was taking place. There had been a turnover of staff that covered the Thames Valley SARCS. We were told that this was for various reasons, such as travel commitments, pay and personal reasons. G4S were actively recruiting and there were two new forensic nursing staff and one crisis worker about to commence induction. During this period, staff from other areas had covered shifts at the SARC, which ensured that no patients went without treatment.

Are services safe?

There was a recruitment process in place which was managed centrally by the human resources department. All the staff files were kept and maintained at the provider headquarters in Essex. The registered manager had access to a data base where the recruitment process was monitored.

G4S policy was for staff's Disclosure and Barring Service checks (DBS checks search an applicant's criminal history to identify any convictions, warnings and reprimands) to be carried out every three years. We were advised all DBS and Non-Police Personal Vetting clearances are monitored on the internal system and the details are shared with the line manager via the monthly audit report shared by the workforce compliance team to ensure oversight.

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

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

The provider had a lone worker policy and consideration had been given to staff safety in relation to the SARC. The call centre logged staff activity including when they arrived home. Staff understood the arrangements for out of hour working and told us they felt safe at work.

Risks to patients

Managers had an up to date health and safety policy which was reviewed frequently, and this supported local management to identify and mitigate potential risks. An annual health and safety risk assessment of the building and external areas was carried out which ensured that risks to staff and patients were well managed. Any areas of the building requiring attention were reported to the maintenance contractor for action. We saw that any actions, such as ensuring the lighting was adequate, was carried out promptly.

There was a self-harm risk assessment specifically for patients visiting the SARC which ensured staff were aware of any anchor ligature points that a patient may be able to harm themselves on. Staff had access to ligature cutters in case of emergency.

No patients were left unattended in any of the rooms in the building. Adults and older children were given privacy in the bathroom, as staff remained outside of the bathroom if wished. Staff did not see children alone and they ensured that two members of staff were present before greeting the child or young person.

The provider had a business continuity plan describing how they dealt with events that could disrupt the normal running of the service. This included reducing impact on patients by using alternative SARCs if incidents arose such as severe weather, staffing capacity and a pandemic. The G4S national distribution of SARC sites was seen by leaders as a strength in managing the service for patients at times of major incidents.

Staff had access to all policies via a G4S internet microsite and hard copies were available on site. Due to the high level of homebased working, staff had also been given permission to have key documents available in hard copy, a number spoke positively of the benefit of access to them in this way. The site manager was responsible for ensuring documents printed were current.

Staff knew how to respond to medical emergencies and immediate life support training was mandatory for nurses and doctors. Emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. There was a well-stocked emergency bag that contained emergency items, and the items were checked regularly and in date.

Are services safe?

Risks to people who use the services were assessed, monitored and managed. These included signs of presenting and deteriorating mental health, medical emergencies, child sexual exploitation, female genital mutilation, and domestic abuse. Staff we spoke with were aware of the additional vulnerabilities of children and young people who might have special educational needs and disabilities or be a child looked after under the care of the local authority as 'corporate parents'. In records examined, we saw that that staff recorded what those risks and needs were so that they were considered during any examination process.

We reviewed procedures and saw in records that the assessment for post-exposure prophylaxis after sexual exposure (PEPSE), antibiotic and/or hepatitis B prophylaxis and emergency contraception was well managed. Staff were aware how to look for and support patients with any physical injuries. Where PEP medication was given, we saw in patient records examined that the name of the medication was clearly documented along with batch numbers, batch pack numbers and expiry dates. The staff member administering the medication then signed the record by way of confirmation.

Staff gave patients clear documentation to take away with them about any further appointments or care needed. Staff also sent a letter to the GP explaining about the care the patient had received. These were seen in the records we reviewed, which demonstrated that the provider recognised the patient may not be able to absorb all clinical information given at the centre during a time of increased stress.

Premises and equipment

There were decontamination protocols in place to ensure high quality forensic integrity. We saw complete cleaning schedules for the premises. The SARC was clean when we inspected and staff had carried out infection prevention and control audits as well as environmental audits that showed they were meeting the required standards.

Staff had access to an adequate supply of personal protective equipment. There was a record book for logging all visitors' temperature as part of monitoring signs and symptoms of COVID-19.

Managers were responsible for maintaining the safety of facilities and equipment including meeting the standards laid down by regulatory bodies. We saw that staff carried out regular checks of gas and electrical appliances, emergency lighting, fire detection and firefighting equipment such as smoke detectors and fire extinguishers.

Processes were in place to ensure all equipment was safe to use and records showed staff were fully trained in its use. Portable electrical equipment was checked and labelled to show it was safe to use.

The medical equipment met the manufacturers standards. Staff regularly checked equipment to ensure it was within the servicing schedules.

Clinical staff were trained to the appropriate level to operate medical equipment including use of a colposcope. A colposcope is used to make a digital recording of the genitalia. The clinical director was able to discuss how medical examiners training was delivered, which assured us staff were competent in the use of the colposcope. There were procedures for the management of photo documentation and intimate images which ensured patient confidentiality.

There were effective arrangements for managing waste, forensic specimens as well as forensic samples in acute cases that met the code of practice for forensic services. The clinical and non-clinical waste was managed by an external contractor and hospital led processes were in place for the prompt safe disposal of waste from the SARC premises.

Information to deliver safe care and treatment

Staff had access to up to date relevant information about each patient to deliver safe care. The initial triage by the crisis worker identified any potential risks such as safeguarding, before a detailed assessment by the forensic medical examiner. As part of the telephone assessment patients were asked about risks regarding COVID-19. Patient records included the decisions taken after initial triage for staffs use of PPE and the appropriateness of face-to-face meetings. This important additional information helped to keep both patients and staff safe at the time of the COVID pandemic.

Are services safe?

We found individual records were written and managed in a way that kept patients safe. In one record examined we saw that a patient was identified as living with a disability that impacted on their interactions with other people and their decision making processes. We saw that this was well documented along with the patient being reminded several times that they could stop the examination process at any time should they so wish. The quality of patient records was good, with clearly written notes that were complete.

Any referrals staff made to other providers, such as child independent sexual violence advisors (ChISVA), independent sexual violence advisors (ISVA), independent domestic violence advisors, genitourinary medicine, housing, mental health and local university safeguarding teams (for the benefits of students attending the SARC), were fully documented in the patients record. However, in one record we reviewed it was not clear what the difference was between a referral being made for mental health concerns or a notification being sent to inform the mental health service of a patient's attendance at the SARC. At the time of inspection, managers identified they would review the referral documentation so staff could add details of an attendance or details for a referral. Overall, staff made referrals promptly, and we saw evidence that the benefits of such referrals were explained to patients, children and young people.

All staff used proformas that were regularly updated in line with the faculty for Forensic and Legal Medicine guidelines. Care records were noted to be accurate, complete, and records were clearly legible. The care records included body maps. Staff kept records securely and complied with data protection requirements.

Safe and appropriate use of medicines

The provider had systems for appropriate and safe handling of medicines and the clinical staff were aware of current guidance with regards to managing medicines. Medication was stored in a locked cupboard or locked fridge, in a clinical storeroom. Systems were in place to monitor fridge and room temperatures. Staff ordered medications from an approved supplier and there was a suitable stock control system of medicines which were held on site.

G4S had a comprehensive medicines management operational code and standard operating procedures for handling and administering medicines within SARCS. Staff said that they always provided patients and carers with the relevant advice and guidance when administering any medications. There was a signatory sheet staff had signed to confirm they read and understood the Patient Group Directions for the medication they were allowed to offer patients.

The provider held a limited formulary comprising of emergency contraception and post-exposure prophylaxis drugs (PEP). PEP is another name for emergency HIV treatment and is not a cure for HIV, but a form of prevention. Patients were given printed advice on specialist medication prescribed to support its safe use.

Track record on safety, lessons learned and improvements

There was a clear and easily accessible system in place for staff to report adverse incidents that happened in the service, as well as positive events.

An incident report was submitted by any staff member to managers for action and investigation where required. An appropriate person, usually the manager, carried out investigations and actions were assigned to ensure that improvements were made. Staff had recorded 25 incidents in the last 12 months, between the two SARCS in the Thames Valley area. They had reported a wide range of issues. Learning from incidents was shared with staff by email communication. We saw an example which put a patient's forensic sample at risk, when at the start of the COVID-19 pandemic, staff had guided a patient with COVID symptoms to self-swab. However, this was immediately identified, and the incident reviewed. Managers highlighted the likely cause for concern and shared learning with staff, which demonstrated the provider's responsive approach and G4S staff's ability to make prompt improvements.

There was a G4S newsletter, where all managers could share learning nationally. There had been few face to face team meetings held over the past year. We saw examples where details of an incident had been shared immediately with staff. All staff were aware of this incident.

Are services safe?

There was a provider level system for the dissemination of medicines safety alerts. Such alerts were distributed by senior staff, clinical leads and to managers who in turn alerted staff. The clinical leads attended a weekly national meeting as part of working with the Royal College of Child and Paediatric Health (RCPCH) and the FFLM, where they had prompt access to updates and information to share with the wider organisation.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The provider had policies, procedures and effective clinical pathways for staff to follow that ensured they delivered care and treatment in line with evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies. G4S clinical leads had delivered a staff awareness training package where they shared the new UK Guidelines for the use of Post Exposure Prophylaxis 2021, which informed staff as to how the new guidelines affected the use of PEP treatment in SARC services. This ensured staff kept up to date with current treatment requirements and achieved effective outcomes.

We saw that all patients including children and young people attending the SARC received a full holistic medical assessment in line with the Faculty of Forensic and Legal Medicine's (FFLM's) guidelines. We reviewed documentation which assured us that a comprehensive health assessment had been undertaken as part of the forensic examination.

Forensic medical examiners (FMEs) assessed patients, children or young people for health needs arising from sexual assault. Medical staff told us they followed the recommendations of the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) to assess and meet their needs.

Staff we spoke with understood the rights of people subject to The Mental Health Act 1983 and the Mental Capacity Act 2005. They followed the MCA code of practice, staff said they always explored patient's capacity.

Staff made appropriate referrals to other agencies if a patient needed additional support. We saw evidence that the substance misuse standard operating procedure had been followed and facilitated a patient assessment and onward care.

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

Consent to care and treatment

The provider had policies regarding consent in line with the requirements of the MCA and the use of the Gillick competency assessment and Fraser guidelines. There were clear processes in place should staff have any doubts about a child or young person's capacity to make an informed decision about their care and treatment. New staff worked through the subject of consent and the relevant legislation as part of their induction package. Staff understood the importance of seeking and recording the child or young person's consent to treatment. In files we reviewed, we saw evidence of the young persons voice.

Staff understood the importance of seeking informed consent. Signed consent for examination, treatment and the taking and storing of images was obtained in accordance with Faculty of Forensic and Legal Medicine guidelines in every record we reviewed. Staff used legislation such as the Mental Capacity Act, 2005 to determine ability to consent in 16 to 18 year olds and Gillick competence and Fraser guidelines for under 16s. Staff told us they explained the process of the examination to the child or young person and their families before they entered the forensic examination room. If any treatments were required, doctors took time to explain treatment options and any associated risks. Staff told us they requested verbal consent repeatedly during the examination from the children and young people and we found that written consent was obtained from parents in conjunction with the child.

In two paediatric records examined, we saw that consent was obtained that pertained to various aspects of the SARC examination process. This included, for example, obtaining consent for information to be shared with GPs, sexual health services and any other relevant health services.

Monitoring care and treatment

Are services effective?

(for example, treatment is effective)

The provider had a core audit programme, which included infection control, medicines management, safeguarding and health and safety. The audits were based on nationally recognised tools, and a schedule was in place to ensure they were being conducted. We reviewed a number of these audits that showed good overall compliance. Managers we spoke with said that it was easy to carry out the clinical audits as G4S had ensured they accessed all systems remotely.

Data detailing patients' care and treatment and outcomes were shared with NHS England through the Sexual Assault Referral Centre Indicators of Performance to inform service delivery.

At Solace Bicester SARC the responsiveness overall for examinations taking place or planned within 90 minutes was between 95% and 97%, marginally over the targets set by NHS England. This indicated that the responsiveness of the service for patients was adequately managed by G4S. We reviewed three examples where managers had looked into why the response rate was lower. The reasons varied from staff being caught in traffic, adverse weather slowing travel time, the police holding a patient and the team already dealing with another patient's case.

Staff gathered information about the outcomes of patients' care and treatment (both physical and mental where appropriate) by calling patients after two weeks and obtaining follow up information.

Clinicians were involved in quality improvement initiatives such as peer review sessions which were held quarterly and used to provide professional challenge and sharing of best practice. This formed part of the team approach to providing high quality care. G4S sent out peer review invitations so that anyone could access the sessions regardless of where the location was. Staff told us that they found these sessions helpful in encouraging their professional development and team working. The provider had a system to provide staff with relevant updates from agencies such as National Institute for Health and Clinical Excellence and the Faculty for Forensic and Legal Medicine to ensure they were working to the current guidelines.

Effective staffing

Staff were employed on both permanent and flexible contracts. We were told this enabled cross cover and to manage staffing capacity to ensure availability of the service to the community they serve. G4S had a buddy system for cross site working, as staff accessed systems remotely this helped ensure staff shortages were managed to reduce impact on patients.

Staff we spoke with were competent in both forensic medical examinations and in assessing and providing for the holistic needs of patients, including where maltreatment was identified, and the management of physical and emotional conditions that may or may not be related to the alleged sexual abuse.

Staff had a structured role-specific induction programme overseen by the appropriate manager. Modification had been made to the training approach to meet with COVID-19 restrictions while still ensuring staff had access to a comprehensive programme.

We saw evidence of completed and 'in progress' training matrices for staff, which showed oversight by a linked lead, for example the clinical director for examiners. New staff completed shadowing opportunities and did not carry out any tasks that they felt they lacked confidence in. All staff were up to date with their mandatory training and level three safeguarding children training, and all staff had received an annual appraisal in the last 12 months. We saw records of staff attending group safeguarding supervision on a two-monthly basis. Clinical staff took responsibility for their own continuing professional development and revalidation.

Within G4S there were three physicians who had completed the Forensic and Medical Examination for Rape & Sexual Assault (FMERSA) course and were members of the Faculty of Forensic and Legal Medicine (FFLM). The lead clinicians formed part of a national network where they met regularly and offered guidance and support to other national SARCS.

Staff were given training and opportunities to develop. Clinical staff completed continuing professional development appraisals and revalidation. Staff we spoke with told us they had support to do so.

Are services effective?

(for example, treatment is effective)

Co-ordinating care and treatment

Staff at the SARC worked effectively with other professionals to co-ordinate care and treatment. However, clinicians were not always invited to attend strategy meetings with social care and police services to discuss the appropriate plan of treatment for each child, young person or vulnerable adult. Commissioners told us that they were aware of this issue and had set up new partnership board meetings, where they could continue to monitor strategy meetings and ensured SARC partners were included.

There were clear and effective pathways into and from the SARC for clinical care that complied with the national standards. These pathways included psychosocial counselling and ongoing support. When patients received care from a range of different staff, teams, or services, this was coordinated, and the patient kept informed of actions taken. We saw evidence of pathways from the SARC to other agencies such as the emergency department and to the sexual health or genitourinary medicine (GUM) clinics as well as pathways into the SARC such as those patients who wanted to self-refer.

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

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

Records examined demonstrated that staff were considering other multi-agency partners that were available to provide additional care and support to patients and making those patients aware of them by way of leaflet or other contact information. For example, packs given to patients on leaving the SARC contained relevant 'self-help' contact information regarding sexual health, substance misuse, mental health and housing support. This information could then be reviewed by the patient at a time and place that better met their needs.

Are services caring?

Our findings

Kindness, respect and compassion

We found that staff at the Solace SARC treated patients with kindness, respect and compassion. We interviewed staff members who told us how important it was that all patients were made to feel comfortable and in control during their visit. We left CQC comment cards for people who used the service and had a positive comment back about the SARC and its staff.

We saw feedback the provider had collected over the previous year which mentioned how staff were understanding and caring without judgment. Comments we saw were very positive and complimentary. Managers we spoke with said that the provider was looking into how they can obtain further feedback from patients' carers and family members to improve their service.

Staff told us they recognised the impact of sexual abuse and assault on patients and their family. Staff provided family and carers with information about what they could expect next and where they could obtain further help.

Young children that accessed the service had a selection of toys and books to play with and the crisis worker who spent time engaging with and reassuring children before any interviews or examinations took place. However, there were limited games and age appropriate activities for older children that visited the SARC. Overall, the site was not very stimulating for a child and this was something the provider was looking into.

Staff sought to be responsive to patient needs, for example, a number of individualised toiletries were available to take from the site if they wished to shower at home rather than use site facilities, recognising the individual needs of the patient.

Records seen showed that due consideration was given to patients' religious beliefs, language needs or cultural diversities. We saw that staff recorded when a patient had, for example, a disability that might impact on their understanding of processes undertaken at the SARC.

Staff ensured that patients received food and drink as needed; there was a small kitchen where staff made hot or cold drinks. Staff maintained a food stock check to ensure that all food was fit for consumption.

Privacy and dignity

Staff respected and promoted patient privacy and dignity. The site was located in a standalone unit on the grounds of the police station and had its own entrance. The service only accepted one patient at any one time by appointment therefore they attended the service discreetly.

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

There was a shower facility where patients were able to shower after their examination and there was a range of clean clothing available in a variety of sizes, so adults, children and young people had something to wear to travel home in if they needed.

Although the building was not purpose-built, there was one room that was used by the counselling services that was furnished to help provide a relaxed environment. Additional facilities included a room where police undertook achieving best evidence (ABE) interviews as part of criminal investigations with children and vulnerable adults. This enabled the provider to work in close partnership with the police to support patients who had chosen to report the assault.

Are services caring?

Paper records were kept securely in the unit in a locked filing cabinet. Colposcope images were encrypted and stored on the provider's electronic system, which was password protected. Computer screens were not visible to patients and staff did not leave patient personal information where other people may find it.

Involving people in decisions about care and treatment

Staff ensured there was enough time for each patient to talk with the examiner, each examination went at a pace the patient was happy with. Staff took time to make sure each patient fully understood their options regarding examination and treatment to ensure that they agreed to each element of their care. Any patients who did not speak English as a first language, were provided with a face-to-face interpreter if the police had arranged this, or they used a translation telephone service. The provider had in draft, information in other languages and were sourcing as much information from contacts in other sexual assault services.

Staff told us they gave every patient and young person the opportunity to speak to the examiner without their parent present. This meant the patient was able to speak to the doctor freely about their past medical and sexual history.

Staff supported patients with accessing community and advocacy services. Staff provided patients with information as to how they could access these. Crisis workers called patients for a welfare check after they had attended the SARC, they used this opportunity to provide further help and advice on the other community care available.

In notes reviewed we saw that medical staff made a holistic assessment of each patient, including their cognitive abilities, emotional and mental health needs. We saw that explanations of treatments were tailored to individual patient ability including any known learning disabilities or mental health conditions.

The provider had a range of leaflets for patients, children and young people who preferred information in a written format. Managers had recently undertaken a review of the information available and were adapting more leaflets for young people, people with a learning disability and general information about the services.

The provider had a general communication book containing pictures to help people with communication difficulties, but this was not specific to the Bicester SARC. Managers did have a newly developed information leaflet for children that contained photographic pictures of the forensic examination room and some of the equipment they used in this room. Staff used this to inform the child of the process and reduce anxiety before the child or young person entered the room for the first time.

The provider's website and information leaflets provided patients with details about the range of treatments available at the SARC, this included an online 'frequently asked questions' section.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

The building was decorated with comfortable furnishings in the therapy room, this helped staff to provide patients with therapeutic space and some emotional support. However, there were no posters or decorations for children.

Staff reviewed the patient's immediate health needs and made referrals to other professionals for ongoing care. Managers, clinical leads and examiners referred children to appropriate paediatric physicians if needed.

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

Staff discussed how they were responsive to the needs of patients with disabilities. The service did not have a hearing loop or a hoist, however all of the examiners and workers travelled to the patient and or another appropriate facility, when the patient required supportive aids or equipment.

Taking account of particular needs and choices

The provider employed both male and female examiners. Staff in the G4S call centre and at the SARCS offered a choice of gender of examiner during the first call that patients or professionals made. Managers had some time to arrange the preferred examiner when possible.

We were told that in the few cases the doctor attended the strategy meetings the gender of physician was discussed, and staff told us patients were asked if they were happy to be examined by the doctor when they arrived for their appointment at the SARC. This practice meant that patient's choice of gender of forensic examiner was considered.

G4S had employed a male engagement officer as they had recognised and wanted to raise the profile of the service across genders and within the lesbian, gay, bisexual, and transgender community. We spoke with the recently appointed male engagement officer who explained part the role was to promote the services of the SARC to young males and females who might otherwise be hesitant to seek care and support from the service. They would engage with the male survivor partnership network to develop multi-agency relationships. This was important work to ensure that those sometimes hard-to-reach groups of potentially vulnerable young people are aware of the support and care available at The Solace Centre SARC. This role will form part of the provider's work towards Lime Culture male survivor accreditation, which is a quality standard awarded to services which support male victims and survivors of sexual violence.

The clinical lead for the Thames Valley and Bicester SARC regularly undertook training sessions for clinicians and the police raising awareness and knowledge of the sexual assault services. We saw the providers annual report which outlined how they intended to increase SARC awareness once COVID restrictions are lifted. The commissioners we spoke with stated this was a key part of the commissioning agenda.

Psychological therapies were available for patients who experienced symptoms of trauma and post-traumatic stress. Patients could be seen at the Bicester SARC or a location of their choosing. Staff logged all referrals, however staff and managers told us that they did not always hear back in relation to the patient referral. Managers identified that staff could follow up on referrals, which would then give them an idea of the usefulness and appropriateness of the referral.

Timely access to services

Managers at the SARC ensured that services were delivered to meet patients' needs. Patient assessments and appointments were provided to them in line with national guidance for pathways for acute and non-recent sexual abuse.

Are services responsive to people's needs?

Patients could self-refer into the service by calling the main number. The provider's website and answerphone provided opening times and contact details for patients. Other agencies could refer patients to the SARC. Data showed that most referrals were from the police.

Patients over the age of 16, were given the option of attending the SARC service without police involvement. We saw comprehensive records for the self-referred patients. The provider offered safe storage for forensic evidence should they wish to proceed with police involvement later.

Patient care was coordinated from the initial contact with the service through a central G4S call centre, and the information gathering undertaken by the crisis worker. The crisis worker used a structured format to gather patient information and to support consideration of forensic timescales in discussion with the forensic examiners and police when they were the referrers. The provider's appointment system to respond to patients' needs included contingency arrangements as part of the business continuity plans. Patients could be seen at an alternative SARC if unexpected issues arose with staff availability or issues with the forensic suite or at the patients' request.

Children needing examination for acute or non-recent sexual abuse were seen by forensic medical examiners. The provider was able to meet demand, however there were challenges as numbers had been much higher than originally expected from when the service was commissioned. G4S was implementing a process for forensic nurse examiners (FNE) who have received training and reached competency standards to undertake examinations of non-complex young people aged 16 to 17 years, once full staff capacity had been reached. Specific training had been provided and a training matrix compiled to evidence competency and knowledge for when this starts. Forensic examiners already had access to peer review through the clinical director to support professional learning and development. At the time of inspection, managers had created a form which linked the cases discussed at peer review to the online record management system. This ensured there was a clear audit trail for individual patient records.

Data confirmed that overall patients' access to the service was timely, although there had been 11 incidents recorded in the past year that related to patients delay to the service. We looked at one incident record, where managers had carried out a root cause analysis of what went wrong when a patient was delayed for three hours before having the forensic examination. In this case, managers identified that staff needed to be aware that they may need to work extended shifts to complete their duty. Managers discussed how staff could streamline the telephone consultation to reduce the time patients were needed on site when they arrived for an appointment. An apology was given to the patient which was accepted and appreciated. Commissioners of the service were satisfied with performance data and felt that managers were open and responsive to patient needs.

Listening and learning from concerns and complaints

The provider's complaints policy contained a clear procedure for acknowledging and investigating complaints, however management reported they received very few complaints from patients or professionals.

Staff spoke with the registered manager immediately if any formal or informal complaints were raised and ensured patients received a timely response. The registered manager explained if any complaints or concerns arose, they discussed outcomes with staff to share learning and improve the quality of the service.

The providers website provided information about the range of treatments available onsite and post attendance it also included a plainly worded section of 'frequently asked questions' to help individual's understanding of the service. The site could be enhanced with information about feedback from complaints to the service. The site included guidance on how to hide your internet browsing to protect individual's safety.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders of the service had the experience and skills to deliver high-quality, sustainable care. At the time of inspection there was a new registered manger acting for the service at Bicester. The provider's lead SARC manager was available for all staff to contact and offered support to staff informally as well as structured support to forensic medical examiners.

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

Leaders recognised the importance of employing staff with the right skills and attributes to the service. The provider had faced some staffing capacity issues since G4S were commissioned to take on the service in April 2019. At the time of inspection, a new crisis worker had started, and two new staff were about to commence induction.

The provider had recorded recruitment as an organisational risk and commissioners were aware.

Vision and strategy

The provider had a clear organisational vision and values statement ''*we act with integrity and respect, we are passionate about safety, security and service excellence, we achieve that through innovation and teamwork*.' Staff demonstrated they were always striving to improve the service by developing relationships with other sexual assault referral centres to share practice and learning. Staff received and acted upon feedback from commissioners, key stakeholders, colleagues and the children and young people using the service.

During the COVID-19 pandemic, managers had implemented more informal meetings via internet calling. Staff said this was a good initiative as it allowed staff to engage from any location, was a more productive use of time and ensured managers were kept up to date and discussed performance more easily.

Culture

At the time of inspection staff morale was low, for a variety of reasons, such as a turnover of staff, staff feeling tired from working throughout the pandemic and staff having some personal commitments. However, we were told that staff worked well together, supported each other and staff enjoyed their place of work and wanted the best for their patients'. Staff said they worked well as a team, not only supporting each other, but offering support to other professionals they worked with. Staff spoke highly about the physicians they worked with and valued the expertise within the team.

The staff we spoke with felt their views were considered in the development of the service. Some staff had concerns about the turnover of staffing, which meant that commitments were stretched. During our inspection we saw that staff were comfortable and confident talking to each other and other managers within the organisation.

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

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

Governance and management

Are services well-led?

The provider had a clinical governance framework in place which included policies, protocols and procedures that were accessible to all members of staff. There were clear responsibilities, roles and systems of accountability to support good governance within the service. The manager was new to the Solace SARC in Bicester, however they knew their roles and responsibilities for the management of the service.

The Solace manager was responsible for the day-to-day running of the service and was well supported by the registered manager and clinical lead. Staff knew the management arrangements and their roles and responsibilities.

There was a systematic programme of clinical and internal audits to monitor quality, operational and financial processes. Managers had reviewed and made some changes to the audit cycle to improve oversight on clinical outcomes and records. There were plans in place to ensure clinical audits were carried out frequently.

The national head of SARC services feeds into the G4S Clinical Governance structure to ensure oversight at a higher level. The SARC Manager meetings also enables the service to benefit from peer support from the wider management team. Clinical leads ensured staff were kept up to date with any changes in guidance and assisted staff with developing the new process.

Managers maintained and reviewed a service risk register which covered risks pertinent to the SARC. This demonstrated that the service manager was proactive in reporting any matters of concern so that the provider or commissioner could take the required action.

Appropriate and accurate information

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

Data about the performance of the service was shared with commissioners quarterly and reviewed as part of the contract monitoring arrangements. The commissioners reported that the data quality from the SARC had improved over the last year. We saw that commissioners had identified that there had been some gaps with the number of patients using the service since the start of the contract, but managers and the provider had been proactive with ensuring they met the needs of the patients.

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

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

Engagement with clients, the public, staff and external partners

The service manager and staff had been involved in engagement work with their police partners to give a greater understanding of sexual assault assessment services. It was identified that the provider would deliver training and awareness to social services and local authorities in order to improve awareness and referral rates. However, due to COVID restrictions and staff shortages in 2020, this objective was not yet fully achieved.

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

Staff were encouraged to provide their feedback through their group and individual supervision sessions as well as during team meetings. During the last year, staff were invited to attend wider SARC team meetings that took part nationally via internet calls. Staff said this was a good opportunity to meet other staff within SARCS. There were plans to implement monthly full team meetings. Staff were also encouraged to put forward ideas for the improvement and development of the service.

Are services well-led?

Continuous improvement and innovation

There were some systems and processes in place for learning, innovation and continuous improvement.

The service manager was committed to driving improvement on paediatric care pathways. This involved developing a training package for the police, social services and partner agencies to establish a formal treatment pathway for children seen at the SARC. Commissioners were on board with this and had started to arrange partnership board meetings to ensure that children's services invited medical examiners to strategy meetings.

The building environment did not meet the standards for the service to have UK accreditation that was being set for SARCS in the United Kingdom. However, NHSE had employed a consultancy firm to look at the buildings to bring them up to accreditation standards.