Manchester University NHS Foundation Trust

Saint Mary's Hospital

Inspection report

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Overall summary

We carried out this announced inspection of Saint Mary's Sexual Assault Referral Centre (SARC) over three days on 7, 8 and 9 September 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. Four CQC inspectors carried out the inspection. To reduce the risks presented by Covid-19, we used a combination of remote and face to face interviews.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Background

Saint Mary's sexual assault referral centre (SARC) is located within Saint Mary's Oxford Road Hospital grounds with discrete sign posting. Patients are always met and accompanied to the suite by a staff member. The SARC is in an old building, access for anyone using a wheelchair needs to be managed, as there is no lift directly to the centre on the first floor of the building. Staff assist patients to the suite via the main hospital. There is parking available on site for patients although it is limited.

Summary of findings

The SARC services are a directorate of Saint Mary's Hospital Manchester which is a managed clinical service within Manchester University NHS Foundation Trust (MFT).

Saint Mary's SARC commissioning contracts are managed by the police and NHS England and Improvement (NHSE/I). They commission Saint Mary's SARC to provide a forensic service to all genders and all ages. People who access the service who live in Greater Manchester (GM) or have been sexually assaulted in GM also access aftercare services there. We will explain the aftercare services further on in this report. Saint Mary's is commissioned to provide a forensic medical service to Cheshire residents and those patients are referred to local services for aftercare.

Patients accessing the SARC can be referred by professionals or self refer, although children under 14 years of age must be referred by children's social care or police . Aftercare at Saint Mary's SARC includes advice regarding sexually transmitted infections (STI), specific paediatric STI clinics, access to crisis support workers, independent sexual violence advisors (ISVA's) and counsellors. The staff group are multi-disciplinary and are made up of forensic physicians, crisis support workers (CSW), ISVAs, a counselling team, administrative support and a children's team. The children's team consists of ISVA's, counsellors and a young person's advocate who specialises in child sexual exploitation.

There are three forensic examination rooms. Each of these has access to a forensically cleaned bathroom and waiting room. There are additional comfortable waiting areas and suitable rooms for counselling services.

There are 22 forensic physicians that undertake forensic examinations at the SARC. They are from a range of specialisms that cover general practice, paediatric and child health and obstetrics and gynaecology. SARC leaders appreciated the different skills and partnership benefits that the forensic medical examiners (FMEs) brought and they felt this contributes to good patient outcomes. Most FMEs have completed the Forensic Medical Examination in Rape and Sexual Assault (FMERSA) course and over half are members or fellows of the Faculty of Forensic and Legal Medicine (FFLM). Some FMEs teach on the FMERSA and some of those are examiners on the course.

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

During the inspection we spoke with nine staff. We looked at policies and procedures and other records about how the service is managed. We reviewed comments cards that we had asked patients to complete to get their feedback on the service.

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

Our key findings were:

- The service had systems to help them manage risk.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- Staff identified vulnerable patients and those assessments informed aftercare.
- 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 clients' needs.
- The service had effective leadership and a strong culture of continuous improvement.

Summary of findings

- Staff felt involved and supported and worked well as a team.
- The service asked staff and clients for feedback about the services they provided.
- There were suitable information governance arrangements.
- The service appeared clean and well maintained.
- The staff had infection control procedures which reflected published guidance.

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

- Be assured that the frequency of Disclosure and Barring Service (DBS) checks is proportionate to the work that SARC staff deliver

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Are services safe?

Our findings

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

Our review of the SARC's policies, interviews with staff and patient record reviews showed that Saint Mary's SARC had systems and procedures to ensure patients were safe. Policies relating to safe care and treatment were up to date and regularly reviewed. The responsibility for development and communication of the policies to staff was clear. This meant that all staff knew their role and responsibilities in relation to safeguarding.

Standard operating procedures (SOPs) provided staff with best practice guidance to ensure that patients continued to be safeguarded after their contact with the SARC. This included procedures for dealing with requests from external agencies as part of court processes. This meant that requests were responded to in a timely manner that was safe and maintained an audit trail to secure the SARC's accountability.

Saint Mary's SARC research identified that people who had learning difficulties (LD) who accessed the SARC were less likely to access aftercare services. To support improved uptake of aftercare services for this patient group, a validated LD screening tool was adopted. This was completed with all patients over eight years of age who accessed the SARC services. Aftercare leaflets for people who have LD had been co-produced. This means that all support can be adapted to meet the needs of the person.

The trust had safe recruitment procedures in place. This included assurance of consistent induction to the SARC for new staff members. The induction programme was regularly updated to ensure that all relevant and newer aspects of SARC roles were covered and that staff were aware of relevant trust policies. We were assured of the effectiveness of these processes through staff interviews. However, at the time of our inspection the trust hadn't considered whether on a risk assessed basis SARC staff would need regular DBS checks. DBS checks were completed on recruitment but not repeated.

All equipment in the SARC had been subject to regular testing so staff were assured it was safe to use. Staff were trained to use specialist equipment. This included FME's use of the colposcope. A colposcope is a piece of specialist equipment for making records of intimate images during examinatios, including high quality photographs. FMEs were also trained to meet patient need in settings other than the SARC, such as in a prison setting or care home if that was a more suitable environment for the patient.

There were effective systems to maintain assurance that cleaning met standards issued by the Forensic Sciences Regulator. Cleaning schedules were clear and there was accountability and an audit trail through a system of room tags. These were recorded in a local workbook that documented the SARC's assurance of infection control procedures. This included audit findings and leaders' spot checks to ensure that audit findings were valid.

Local audits of the SARC's compliance with trust policies provided assurance that staff understood and followed procedures. For example, clinical waste disposal and sharp disposal procedures, regular equipment testing, checks including environmental temperatures and staff knew how to access and use the range of emergency equipment.

Risks to clients

Trust safeguarding policies were comprehensive and gave clear direction to MFT employees at a strategic and operational level. The children's policy included advice for staff on 16 and 17-year-old young people and highlighted that staff should maintain professional curiosity. This supports the staff member to remain patient focused during their assessment.

All patients attending Saint Mary's SARC were screened for safeguarding issues. This was supported by mandatory training, supervision and local policies. This ensured that the patient's needs remained at the centre of the assessment. The safeguarding policy gave details of a number of local authority services which recognises the complexity of cross boundary working. This is important because the of the large geographical area that was covered by the SARC.

Are services safe?

Access to the SARC was by appointment only. Patients were kept safe when entering the SARC through an intercom system as staff were made aware who was entering the department. We saw through our review of evidence that staff at Saint Mary's SARC regularly reported concerns regarding the building. This included uncomfortable room temperatures, water leaking through a roof and lifts not working which limited wheelchair access to the SARC. These concerns were appropriately responded to by leaders keep patients safe.

Staffing levels and skill mix were planned to meet patient demand and ensure that staff had the right support. Covid-19 had an impact on the numbers of patients accessing the SARC and staff's availability to respond. Staff were flexible to meet the demand and continued to meet key performance indicators despite this challenge. However, leaders acknowledged that more FMEs would build resilience in the service and support staff wellbeing. The service operated 24 hours a day seven days a week and there were appropriate arrangements to ensure staff and patients were safe when the SARC was accessed outside of working hours. This included support from security staff on site at the hospital.

Patients benefited from a review of their care at the daily multi-disciplinary meeting. This meeting included forensic physicians, crisis support workers, ISVA and counsellors. Case discussions allowed critical reflection and challenge. They also ensured appropriate referrals were made based on needs identified at the holistic assessment. We saw how this meeting supported co-ordination of care and accountability for referrals. Particularly complex cases benefited from additional oversight and scrutiny through a complex care database.

Staff assessed patients for a range of risks or additional factors that may make them more vulnerable. This included learning difficulties, sex workers, children looked after, and poor emotional and mental health. We saw from our record review that this important information at the initial assessment resulted in appropriate referrals being made for aftercare. Joint work with the mental health provider had recently strengthened the SARC's response to patients who may be experiencing poor mental health. These pathways supported staff to know when and how to respond to urgent concerns.

Staff took action to address the risk of harm to patient's physical health. This included an assessment for the need for post-exposure prophylaxis after sexual exposure (PEPSE), hepatitis B prophylaxis and emergency contraception. Patients were able to choose a sexual health self screening option for use at home.

There was effective oversight of the departments training relating to safe practice such as safeguarding and health and safety. Our review of staff records showed that staff accessed relevant role training at the earliest opportunity. Staff's knowledge and skills were refreshed according to the trust's training schedule. There were some challenges in delivering mandatory training face to face due to Covid-19 however managers were aware and there were plans in place to ensure staff could access that training.

Information to deliver safe care and treatment

Staff used standardised forms to help in asking the right questions when assessing and examining patients. In our review of records, we saw fully completed assessment forms that helped staff to identify additional vulnerabilities such as multiple attendances and poor emotional health. The voice of the patient was strong, and we saw that this led to individualised comprehensive assessments.

Staff were trained and inducted to ensure they could use the colposcope. Staff were aware of local procedures to safely store images. All staff told us that they regularly receive FFLM updates relevant to their practice to ensure patients receive evidence-based care. St Mary's also had a procedure to ensure the integrity of images was maintained when sharing with external bodies, for example during legal processes. This supports upholding the confidentiality of the patients' information.

The SARC used paper records. Records were clear, ordered and legible. If a patient had attended the SARC more than once we saw that the records for the previous attendance were reviewed and appropriately informed the patient's current assessment including aftercare referrals. This ensured that there was a comprehensive assessment of the patients' needs.

Are services safe?

Leaders used audits to improve record keeping and multi-agency working. A recent audit of timeliness of GP letters had led to a standard template for GP communication. GP letters that we reviewed after the template was introduced were concise, of good quality and met expected timescales.

Safe and appropriate use of medicines

All medicines in use at the SARC were individually prescribed for each patient by the examining doctor. The SARC did not stock controlled drugs.

SARC staff used a locally agreed prescribing formulary to ensure that patients were treated in a timely way. The SARC had access to the trust pharmacy which was open 24 hours a day and this meant that there was timely provision of medication to meet patient's needs.

SOPs supported doctors to prescribe medication that reflected current best practice, for example prescribing of emergency contraception. Medicines were stored safely. We saw that there were appropriate stock checks and that these were recorded. Audits provided assurance to SARC leaders that medicines were being appropriately reconciled and stored. Prior to Covid-19 pharmacy staff had provided further assurance by completing quarterly audits. This had reduced during the pandemic however, SARC leaders increased their spot checks of medication to assure themselves that medication processes were keeping patients safe.

Fridges that stored vaccines were fitted with an alarm so that staff knew when temperatures had gone out of range. The alarm continued until it was disabled, and checks were frequent enough that staff were able to calculate whether the contents had been compromised. There were plans to further strengthen these processes as part of the SARC's relocation.

Track record on safety

SARC leaders had a good understanding of their performance. We saw examples of leaders proactively managing mandatory training to ensure staff were all up to date. This included ensuring that the quality of the training was not compromised in an effort to catch up. For a short period of time at the start of the Covid-19 pandemic the SARC had stopped seeing some cohorts of patients. However, they had developed a system to manage risks posed to these patients during their wait and this ensured that they were safe. For example safeguarding referrals were still made based on telephone assessments.

SARC leaders and staff were alert to national learning and were willing to consider how it informs practice. This was a standing agenda item at team meetings which ensured that all staff were involved.

Lessons learned and improvements

Staff told us they knew how to report incidents. We saw that incidents were regularly and appropriately reported. Staff knew how incidents were managed and they were updated on outcomes from reporting incidents.

The process for reporting incidents was robust. All incidents were reported on the trust's electronic system and were assessed to determine the level of risk. We saw that incidents that carried increased risks were regularly reviewed by senior leaders in the trust via divisional governance processes. Lower level risks are discussed and managed at departmental meetings. Nominated SARC leaders attended divisional risk meetings to ensure that they could be responsive when risk was identified. We were assured of the effectiveness of governance processes that surrounded risk management.

The SARC collected feedback from patients and families about the service and very few comments related to matters that the service could do better. However, the service was responsive whenever they got feedback. For example, we saw how reasonable adaptations had been made to make the environmental temperature more comfortable for staff and patients.

Are services safe?

Research based practice is embedded at the SARC. A number of research projects and peer reviewed clinical papers had led to changes in service. For example, aftercare leaflets for people who were learning disabled were co-produced by people with LD and included feedback forms to try to capture their experiences. This learning had been shared nationally with other SARCs to support engagement with important aftercare services such as ISVAs and counselling.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients' needs were systematically assessed. Care and treatment was delivered in accordance with clear clinical pathways that met national FFLM guidance.

Health needs identified at initial assessment at the SARC such as the need for PEPSE, for hepatitis B vaccination and for emergency contraception, followed guidance issued by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH). Patients had a choice as to whether they would prefer to complete their sexual health screen using a self-test kit. Exclusion criteria existed to ensure the patient was accessing the best service for them. Using this service had given the SARC some relevant data regarding access to GUM services and numbers who develop an STI because they were informed of the results. SARC leaders were hopeful they could use this to inform service development to meet patient need.

All health plans were comprehensive and took account of patient's physical, emotional and mental health. Staff we spoke with were aware of their responsibilities under the MHA Code of Practice. In records we reviewed, we saw that staff considered whether patients had additional needs. Staff were alert to the impact and trauma of the alleged sexual abuse and made appropriate referrals to mental health services. As we have identified previously, this assessment and referral process to identify mental health needs had recently been strengthened to ensure patients could access the right support at the right time.

A recent crisis support worker pilot had ensured that patients were supported at the earliest opportunity. A crisis support worker completed a joint initial home visit with the police to patients who had experienced a non-recent sexual assault. This meant that a holistic assessment was initiated at the start of the investigation to better support the patient.

The SARC leaders ensured the right training was available via the trust. The department had worked closely with the e-learning service to ensure that relevant additional learning modules were added to the training offer for SARC staff. This included LD and autism awareness and consent. This meant that staff were empowered to support patients with additional needs through their SARC journey.

Patients accessing the SARC had good access to a range of guidance to support their understanding of what may happen after they have accessed the SARC. This included leaflets and an augmented reality tool that clients could access by downloading an app. This meant that this information was available to patients in a range of different formats and was more accessible to a wider patient group.

Monitoring care and treatment

There was a multi-disciplinary approach to case management through the daily case review meetings where every case was discussed. This enabled FMEs and crisis support workers to reflect on their assessments and for their decisions to be tested. It was also an opportunity to identify if any further support was needed for the staff involved in the assessment and examination. Staff we spoke with told us they found the case review an important part of their professional development and valued the support that was offered.

Regular audit activity was scrutinised by SARC leaders. For example, when audit data suggested there was a reduction in performance there was further work to understand it before the issue was addressed. This meant that changes and efforts to improve patient outcomes were always measurable. However, the SARC did not have a data system that supported them to understand the patient journey, for example uptake of ISVA services. This may be particularly important because people can access different parts of the SARC in different ways. Not having this oversight limits the SARC's ability to adapt the model to better suit patients' needs.

Are services effective?

(for example, treatment is effective)

The service used a peer review process to monitor care and treatment and to ensure that forensic and clinical findings were consistent and reliable. Attendance at peer review and the role taken at peer review was considered as part of staff's appraisal. This meant that there was oversight to ensure staff attended the minimum number of peer reviews and that learning needs were followed up. Peer review includes learning and reflection topics such as trauma informed care. This has led to increased staff awareness ensuring they do not cause the patient further distress.

Effective staffing

Patients accessing Saint Mary's SARC were assessed and cared for by staff in a range of roles who were competent and had the right skills and knowledge for their role. The SARC followed trust processes to support staff in training. This ensured they had the right level of training and supervision.

There was enhanced training that was mapped to the staff members' previous knowledge, skills and experience. Training for medical examiners was wide ranging and included communication, pharmacology and neuro-disability for example. A wide ranging competency document included holistic assessments and safeguarding. We saw from our review of records this induction and training supported comprehensive assessment of patients' needs.

Staff learning needs were identified at the point of recruitment. There were opportunities for staff members to gain knowledge, skills and experience through access to training courses and supervision. This ensured that staff were able to develop skills to meet the demands of their work.

Regular appraisals, supervision and case management review meetings supported continuous improvement. We saw from our review of records that doctors were up to date with their appraisals. SARC leaders were assured of continuous professional development and that staff were able to meet the demands of the role.

Regular and spontaneous supervision was available and accessible to meet staff needs. Crisis support workers who work out of hours were encouraged to attend the monthly crisis worker facilitated group supervision. There were minimum attendance standards to ensure that all staff accessed regular supervision and reduced the risk of vicarious trauma. Counsellors reported compliance with supervision through a counselling dashboard, all other staff members kept their own record which is reviewed at annual appraisal.

Patients waited too long to access counselling services. The SARC leaders had been responsive and applied for additional funding to respond to demand. All staff that we spoke with described a challenge in meeting demands of the forensic medical examinations. Staff told us that they often complete additional shifts and the needs of the patients always come first. SARC leaders recognised that although they can cover the rota, additional staff would add physical and emotional resilience to better meet patient demand.

Co-ordinating care and treatment

The access pathway into the SARC for all patients was clear. The SARC's website walked patients through what different parts of the service were offered and why. This included access to videos that described the services. This meant that if patients wanted to, they could be fully informed of processes before making contact with professionals. Videos supported people who are not able to read to be informed of what may happen when they access the SARC.

Multi-disciplinary and multi-agency working at the SARC was strong, effective and patient focused. All staff that worked in the SARC had the opportunity to support the assessment and planning of patients' needs. All staff we spoke with shared the same commitment to ensure that care was patient centred. They did this through established multi-agency relationships, reflection and learning when care could be improved and through supporting each other. Effective joint working ensured the right decisions were made at the right time for patients.

Are services effective?

(for example, treatment is effective)

Wide ranging SOPs that were regularly reviewed and developed, supported staff to work together and meet a standard of care. GP letters were detailed in supporting the co-ordinated care of patients needing follow up and safeguarding referrals we reviewed appropriately articulated the risks to the patient. This meant that patients received joined up care from a range of different professionals.

Staff we spoke with all reported the high value they place on each other's skills to deliver the highest quality patient care. This included support to make the right referrals to the right agencies. Handover processes between shifts ensured that any outstanding needs were met.

Consent to care and treatment

Staff understood the importance of seeking informed consent and recording the consent.

Staff told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. The patient leaflets and website were uncomplicated in explaining how the patient could make decisions about their care. Signed consent was obtained in accordance with FFLM guidance.

Staff understood legal standards for obtaining consent from children. The trust's safeguarding children's policy included guidance on consent to care and the law for 16 and 17year olds and signposted staff to the Mental Capacity Act Policy when needed. SARC staff described that the safeguarding team were accessible and supportive when support was required with complex cases. This ensured that patients' consent to care and treatment was in line with legislation and guidance.

The provider had mechanisms in place to gather feedback from all clients about all parts of the SARC. The service had not received any complaints and feedback from patients was overwhelmingly positive. Feedback forms had been reviewed and adapted to make sure that they were capturing feedback from as many patients as possible to influence developments in patient care.

Are services caring?

Our findings

Kindness, respect and compassion

All staff at the SARC understood and respected patients' needs and showed compassion when providing the service. As we have already identified, this was reflected in the feedback that the SARC received from patients and multi-agency partners.

Interviews with staff, our review of records and feedback from patients showed staff were kind, respectful and compassionate to patients. All staff we spoke with were experienced and knowledgeable about the impact and trauma of sexual abuse and were considerate of this when providing care and support. For example, making reasonable adjustments for patients with additional needs.

The SARC has led work to understand what acts as a barrier to some patients accessing the service. For example, working with sex workers in Manchester to support them to understand the SARC and what is on offer.

Involving people in decisions about care and treatment

A choice of male or female FME was not offered to patients. All FMEs are female. Leaders had excluded the need to offer a choice of gender of examiner following an audit of patients' requests and wider research. Leaders reported that they could meet demand and patient need with a female FME workforce. We did not review any patient feedback that suggested otherwise. Patients were offered a male or female ISVA service through a Greater Manchester wide ISVA service that the SARC could refer on to.

Patients were empowered to make informed decisions about their treatment and care. The service gave patients clear information to help them make choices about their care. When patients first arrived at the service staff discussed sensitively what was going to happen to help put them at ease. As we have previously highlighted, this was also available on video so multi-agency partners could support patients at the earliest opportunity.

Staff had access to interpreters to support them in communicating with patients. After the medical examination, this was via telephone interpreting services. Our review of reported incidents showed that there were sometimes challenges in the interpreting service not being as responsive as staff would like for patients. This was mostly reported outside of normal working hours. Staff reported that it had not stopped an assessment but had meant that sometimes patients' appointments took longer than scheduled.

Privacy and dignity

All staff at Saint Mary's SARC respected and promoted patients' privacy and dignity. In our review of feedback, patients reported that they felt they were treated with dignity and respect despite the difficult circumstances. Our review of records showed that staff took account of individual choices about how patients identified and what they wanted to be called. This maintained patients' dignity.

Curtains maintained patients' privacy if they needed to undress in the forensic room. There were shower facilities with access to toiletries. Patients were offered refreshments throughout their time at the SARC. Clothes were available for patients who needed them. SARC leaders sought charitable monies to be able to offer clothes to all patients regardless of their age. This ensured patients were treated with dignity and respect.

Staff were aware of the importance of privacy and confidentiality. The layout of the waiting areas provided privacy when dealing with patients. There was a separate office for staff which ensured that patient confidentiality could be maintained. Access for anyone using a wheelchair needs to be managed, as there is no lift directly to the centre on the first floor of the building, patients are assisted to the suite via the main hospital. SARC leaders accept this compromised privacy and dignity. There were advanced plans to move to a new location.

Are services caring?

The SARC had a dedicated room that was a court room link for patients and staff to give evidence in trials. This reduced the trauma of the patient going into a court room and we heard that staff were more easily able to give evidence in court as they did not have to travel and take time out of clinical practice.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

Saint Mary's SARC was well organised to deliver services to meet patients' needs. Patients' wishes were taken account of throughout the SARC experience. Staff explained the SARC processes to all patients. This helped patients to feel informed and reassured and was reflected through patient feedback.

Aftercare leaflets called 'what happens next' had been designed to help patients remember discussions that have taken place during their examination. The leaflet had been co-produced with patients and had been designed to be inclusive and offer access to information in different ways. This removes barriers to the active participation of people with a disability in their own health outcomes as set out in the NHS accessible information standard.

There was a range of support services that staff signposted patients to. This was individualised based on the patients' assessment. Referrals were recorded in the patients' 'what happens next' leaflet so that patients had their own record. This included any dates that they may need to return to the SARC for follow up care.

Saint Mary's SARC was a well established service with experienced and highly respected staff. The SARC had established good working relationships with multi-agency local partners including vulnerable groups who may use the service. We saw that this led to a range of high quality referrals to other partners.

Leaders had taken account of the demographics of patients that accessed the SARC. They had used census data and compared that to patients who accessed the SARC. By doing this they had been able to work with community groups to raise awareness amongst those that were underrepresented. This work was discussed at multi-agency Rape and Serious Sexual Offence (RASSO) meetings. This meant that all partners considered actions to raise awareness amongst groups that did not access the SARC services.

Timely access to services

The service was available 24 hours-a-day seven days-a-week for acute and non-recent cases. Each patient's needs were individually assessed to ensure they accessed the SARC at the right time to meet their needs.

All examinations were by appointment only. There was not a defined timescale for what constituted recent or non-recent sexual assault. This was assessed on an individual patient basis.

Patients could self refer to the SARC and there were guidelines to support with this process on the Saint Mary's SARC website. Self referral examinations for children and young people aged over 14 years were assessed and offered on a case by case basis. We saw from our review of records that children who attended the SARC were referred to children's social care for safeguarding assessments. This ensured that all risks were considered to keep vulnerable patients safe.

Listening and learning from concerns and complaints

The SARC followed the trust's complaints policy, however, there had been no complaints to the SARC. Feedback was sought from all patients and this was positive.

Are services well-led?

Our findings

Leadership capacity and capability

Saint Mary's SARC Manchester was established in 1986. The leadership at the SARC has been stable and well established. We found mature multi-agency relationships which operated for the best outcome for the patient.

The SARC had effective clinical and operational leadership. The SARC services were overseen by a clinical director and a senior forensic physician. The directorate manager and deputy report to the local Saint Mary's Hospital leadership team. When we spoke with staff, they were clear about the differences in specific leadership functions. This meant that they knew who to speak with to understand and resolve issues or to raise learning opportunities. This visibility and clarity was valued by staff and this helped them to feel included.

Leaders and all staff at the SARC had a good understanding of their work and about what was important to patients. The skills of the multi-disciplinary team at the SARC were used to support staff as they needed it. Leaders were accessible and visible, and staff appreciated the access and responsiveness of all senior leaders at the SARC. This reduced the risk of vicarious trauma through the challenging work that the staff delivered.

Vision and strategy

Staff we spoke with were clear about the vision for the SARC. This included continuing to contribute to important research to improve outcomes nationally for people who experience sexual assault and moving to a new location that would better suit patient needs. All staff told us that the service was focused on the patient and that they worked tirelessly to deliver the best outcomes.

The behaviours and values that staff told us about clearly reflected the trusts values, vision and behaviours; Everyone Matters, Working Together; Dignity and Care, Open and Honest. We saw how staff treated each other in the same way they treated patients, and this was valued by all. The vision and successes of the service was not formally shared through an annual report. This limits the opportunities for staff to reflect on achievements.

Leaders were not complacent about the service's positive feedback. Feedback was reviewed monthly as part of a clinical governance report for the crisis worker team lead. SARC leaders have reflected that their feedback does not represent all of the different groups that attend the SARC. They had started to record demographics of those who responded. This would allow them to identify themes and be creative if they need to consider getting feedback in different ways for different groups.

Culture

There was a strong culture of putting patients first and treating patients compassionately. This was evident in patient feedback and our interviews with staff.

There was an open culture for reporting incidents. Leaders and staff regarded the incident reporting process and the frequency of reporting as a positive feature. This showed an open culture to learning from adverse events. Some staff we spoke to were not aware of what was currently on the department's risk register. This would further strengthen the mitigations in place to manage risks.

Staff wellbeing was important to leaders. A recent trust wide survey had prompted SARC leaders to do some further work to understand how well the survey reflected the feelings of the SARC staff.

Governance and management

There were clear governance processes that effectively monitored the performance of the SARC. A clinical director and directorate manager held overall responsibility for the management and clinical leadership of the SARC. Accountability for

taking issues from the floor to the board was clear. For example, the clinical director reported outcomes from audits by exception to the monthly SMH Quality and Safety Committee and monitoring frameworks assured leaders of progress and safety. These lines of governance assured us that staff and leaders understood their service and could account for their actions.

The range of meetings that managed the functions and operational oversight of the SARC was effective. These included the SARC business meeting, SARC operational meeting and a senior management team meeting. These meetings served to ensure accountability and that senior directorate managers were involved in discussions at the earliest opportunities to support staff.

The SARC was effectively supported through MFT's clinical governance processes. MFT's clinical effectiveness manager attended the monthly SARC clinical governance meeting to support communication between the SARC and the wider trust. Action logs ensured that issues were promptly addressed and that the SARC was able to access support from leads within the trust. We saw that this meant that the SARC received timely advice and guidance.

Leaders' roles in the SARC were reflected in minutes of meetings that we reviewed. For example, we saw that the SARC's Directorate Manager appropriately identified trust processes when issues needed further scrutiny. Staff we spoke to were aware of the policies and procedures that supported them to do their work including information governance.

Regular audit was a key quality and effectiveness measure for SARC leaders. Daily, weekly and monthly audits were recorded in the SARC Clinical Governance workbook which was reported at the monthly clinical governance meetings. An audit 'forward plan' identified upcoming audits which were supported by business management and business continuity plans. A regular directorate audit day ensured that all staff were involved in planning audits, completing actions from audits and understanding outcomes from audits.

Leaders in the SARC had clear action plans to manage issues. For example, action plans to address mandatory training that had not been possible to deliver to the desired standard during the pandemic. The response and processes assured us that problems were addressed at the earliest opportunity and the SARC was supported by the trust.

Appropriate and accurate information

The use of data to understand the patient journey was limited. St Mary's SARC collected data that provided oversight to leaders and commissioners of the numbers of patients seen by the multi-disciplinary team. However, the data was not available in a way that allowed leaders to understand the patient journey. This is important because patients can access the SARC at different points. For example, when patients are referred to the ISVA it was not possible to identify the numbers who do not access the service or who may disengage and at what point that is more likely to happen. This limits the ability of the SARC to be able to change their offer to better meet patient need.

Patient information was managed appropriately through clear consent processes at the start of the assessments.

Engagement with clients, the public, staff and external partners

The SARC was meaningfully engaged with multi-agency partners. We saw evidence of this through innovative work that had been developed jointly. This included joint working with the police from the first contact with non-recent sexual assault. SARC leaders are well respected and were often involved in developing new ways of joint working. Their involvement in multi-agency meetings such as Greater Manchester Violence Reduction meetings meant they were well placed to be involved in partnership working.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement, innovation and quality assurance. Action plans to secure improvements were regularly monitored, reviewed and updated.

Are services well-led?

There was a culture of learning and innovation at the SARC. Opportunities to learn and develop practice was a standing agenda item at team meetings. We saw that this allowed the SARC leaders to learn from others and also generate and share learning. The SARC had established a multi-agency non-fatal strangulation group after looking at international research and the numbers attending St Mary's. They developed specific proformas and referral pathways for use during a forensic medical examination. Through our record review we saw how these pathways met patient needs. In 2021 a research paper had been published on the subject and the information gained from the database had led to a change in the law on non-fatal strangulation.

Staff used research and audit to improve access to professionals. For example, they had recently been successful in making a bid for monies for an LD ISVA. This was following publication of research that identified there was more to do to understand and support their journey through the SARC. The SARC is supported by the University of Manchester to identify the most beneficial research points for SARC services. Leaders felt that this helped them to be assured they are prioritising the right research.

There was a wide range of training and network days available for all staff to attend. Staff had regular appraisals to ensure their training needs were identified. The comprehensive induction documentation set out expected standards and how to work towards them. Staff told us they valued the training and supervision that they had access to.