Nottingham University Hospital Trust

# Queen's Medical Centre (Sexual Assault Referral Centre)

## Inspection Report

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## Overall summary

We carried out this announced inspection of East Midlands Children and Young People's Sexual Assault Service (EMCYPSAS) over two days on 26 and 27 November 2019. We conducted this inspection 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 of the Health and Social Care Act 2008 and associated regulations. Two CQC inspectors, supported by a specialist professional adviser, carried out this inspection.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

### Background

The East Midlands Children's and Young People's Sexual Assault Service (EMCYPSAS) was provided from two regional hubs. The Serenity Suite in Northampton (inspected in 2018) and The Children and Young People's Suite at the Queen's Medical Centre, Nottingham. This inspection looked at the paediatric sexual assault referral centre (SARC) services provided from The Children and Young People's Suite at Queen's Medical Centre (QMC), Nottingham University Hospitals NHS Trust (NUHT).

The service had been delivered by NUHT since April 2018 when there was a change in provision of paediatric and adult SARC services in the East Midlands. The regional model allowed better support for staff and sharing of knowledge and skills to benefit the patient experience. The children and young people's suite at the Queen's Medical Centre accepted referrals from children and young people who had been a victim of rape or serious sexual assault and reside in Derbyshire (including Derby City), Lincolnshire and Nottinghamshire (including Nottingham City) or if the assault had been committed in

# Summary of findings

that area. In cases that were close to the regional border, care of the patient and patient preference is paramount. If a patient chose to access a different service, staff told us that they were happy to manage the onward referrals and ensure the patient could access local aftercare services if they want to.

The SARC saw children and young people up to 18years and 18-24year olds with additional needs. There was an on-call out of hours rota for telephone advice and strategy discussions.

The centre was within a wing of the Queen's Medical Centre. Families and the police had dedicated parking so that they could access the centre via the most direct route. Access to the SARC was via a video intercom. A staff member from the SARC had to attend the entry door to allow access.

The suite was designed and refurbished to deliver paediatric SARC services with a dedicated forensic waiting and examination room. There was also a non-forensic waiting room. The areas had been made as child and young person friendly as possible. They were bright and secure. There was ongoing work and refurbishment to add a police suite and non-recent clinical space.

Nottinghamshire Sexual Violence Support Services (NSVSS) delivered a single point of access (SPA) for the regional service and provided crisis workers 24 hours a day to the Nottingham Hub.

Self referrals were not accepted for children and young people aged 13yrs and under. With appropriate assessment young people aged 14-17yrs could self refer. All forensic examinations were completed by doctors. The suite was staffed by doctors, specialist nurses and crisis support workers.

The hub had a rota of medical staff who completed the forensic examinations. This included Forensic Physicians and Paediatric Consultants. There was a Clinical Lead who was a member of The Royal College of Paediatrics and Child Health (RCPCH) who represents The RCPCH on the academic committee of The Faculty of Forensic and Legal Medicine (FFLM). In addition to being on the rota, the clinical lead provided staff support and had been instrumental in the setting up of the SARC. There were three specialist nurses who supported in examinations, referrals and day to day running of the SARC Monday to Friday. One nurse has a dual role providing clinical support and managing the SARC processes. In total the nursing establishment was 1.2 whole time equivalents. There were seven crisis support workers, a lead crisis support worker and a crisis support worker service manager.

On the day of inspection we spoke with 10 members of staff. We reviewed eight patients' records and seven safeguarding referrals. We left comment cards at the SARC in the two weeks prior to our visit and received 3 responses from patients who had used 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’.

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

**Our key findings were:**

- The service used systems to help them report risk.
- The service had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service had thorough staff recruitment procedures.
- 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 clinical leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and clients for feedback about the services they provided. The feedback was overwhelmingly positive.
- The staff had suitable information governance arrangements.
- The service appeared clean and well maintained.
- The staff had infection control procedures which reflected published guidance.

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

# Summary of findings

- Ensure that local leadership capacity means that all risks are identified.
- Ensure that governance and management systems support local leaders to identify, address and manage risks.
- Ensure a clear line of accountability through NUHT governance structures from the local SARC leaders to the trust board. This includes the use of locally agreed performance measures.
- Ensure there is a clear system in place so that the service is continually improving in relation to staff learning plans and job role priorities.

**Full details of the regulation/s the provider was/is not meeting are at the end of this report.**

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

- Identify competency frameworks for all staff groups.
- Ensure ligature assessments are updated when there are changes to the physical environment.
- Offer examination information for patients, families and carers to take away with them or have prior to the examination.

# Summary of findings

## The five questions we ask about services and what we found

We asked the following question(s).

**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.

**Are services caring?**
We found that this service was providing effective care in accordance with the relevant regulations.

**Are services responsive to people's needs?**
We found that this service was providing responsive care in accordance with the relevant regulations.

**Are services well-led?**
We found that this service was not providing well-led care in accordance with the relevant regulations. The impact of our concerns, in terms of the safety of clinical care, is minor for clients using the service. Once the shortcomings have been put right the likelihood of them occurring in the future is low. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report). We will be following up on our concerns to ensure they have been put right by the provider.

# Are services safe?

## Our findings

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

Staff followed NUHT safeguarding processes to ensure that patients were safe. During staff interviews and patient record reviews, we were provided with evidence that safeguarding processes were well understood and followed. Each morning case records were reviewed from the previous day. We saw evidence that when processes were not followed, this was reported through NUHT's incident reporting system. This allowed individual training needs to be identified and addressed.

In adherence with trust policies, all staff had accessed their mandatory training via the trust induction programme. This included information governance, infection control and fire and safety. Oversight of staff training and timelines for updates were monitored by the network co-ordinator. However, some trust guidelines were out of date. For example, the Information and Security Risk policy should have been reviewed in May 2019. The Post Exposure Prophylaxis after Sexual Exposure (PEPSE) guidelines should have been reviewed in July 2018. It is not clear what the SARC managers were doing to mitigate the risk created by guidance being out of date. All staff we interviewed told us how the clinical lead shared updates to national guidance and this was reflected in records we reviewed.

The provider did not have a competency schedule for nursing staff and crisis support workers. We saw through our review of staff records that staff members were inducted to the trust via the trust's corporate induction programme as well as having a local induction within the SARC service. Crisis support workers told us that they valued their induction and felt well supported and that they were shown how to carry out specific tasks. However, there was no written record that they had achieved competence. This is important because the service was just about to induct its first new nursing recruit and there was no SARC specific competency or skill pack for them to complete. This means that leaders may not be able to provide assurance that all SARC staff have reached an appropriate level of competency according to their role.

Most referrals to the SARC were from police. In these circumstances, referrals to children's safeguarding services were already made. We were assured through our review of records that if there was doubt as to whether the referral had been made or whether it captured the risks, SARC staff completed a new referral.

The trusts employment processes ensured that staff were safely recruited. All staff have enhanced checks with the Disclosure Barring Service (DBS) and these were renewed every three years. All new staff members were also subject to the Police Vetting System (PVS) before they are officially recruited. Confirmation of a satisfactory PVS check comes via email to the SARC nurse manager so leaders were assured that the appropriate processes had been followed prior to staff starting.

All staff are up to date with NUHT safeguarding training. How staff accessed the training was different according to their role. The crisis support workers accessed level three online. The nurses and doctors accessed level three through the trust induction and most staff had accessed additional sessions such as Prevent training.

Clinical waste, sharps disposal and daily cleans of non forensic areas were managed according to the trust's schedules and policies. Cleaning rotas and systems, such as signed sheets on the entrance to rooms, verified that areas have had the expected level of cleaning and the suite appeared clean.

All staff had completed infection control training however the service did not take part in infection control audits to be assured of the effectiveness. For example staff told us that they had not taken part in the trust hand washing audit as this would mean additional persons in the forensic areas.

Decontamination was being carried out in accordance with FFLM guidance however there were no swabs to assure that the decontamination was effective. Plans were in place to train the crisis support workers to complete regular DNA swabs of the forensic suite as part of future audit but this was not happening at the time of the inspection.

The unit opened 18 months ago and was designed specifically for use as a SARC. The entrance to the unit is accessible by persons in a wheelchair and further improvements continue to be made as a result from patient feedback.

All equipment had the appropriate maintenance checks within timescales. Resuscitation equipment was in working

order and subject to weekly checks to make sure it was safe to use. We identified a shortfall in the way that the checks were signed for that meant that the person doing the check was not identifiable. The service were going to rectify this through having a signing sheet that identified the staff member and their signature.

**Risks to patients**

Risk to patients was well managed by the staff and the service. The team of staff at the SARC had been stable since the service was established in April 2018. There were enough doctors on the rota to meet service demand.

There was a comprehensive risk assessment for every patient that used the service, including those who don't come into the SARC, for example if a 17year old young person chooses to access an adult service closer to home, EMCYPSAS would still complete the assessment when they took telephone details. They reported that this allowed them to advise on paediatric issues when needed and suggest appropriate referrals. If they lived in the East Midlands region then NUHT offered them or the professional making the call, advice or follow up referrals to local services.

The comprehensive risk assessment included child sexual exploitation risks, mental health and substance misuse. Through our review of records we saw these risks were all followed up by referrals to other services or a review of the risk with the child or young person. Staff also spoke about their ongoing assessment of risk during the examination. For example, a recent examination was not finished because they assessed the young person as needing urgent medical care via the accident and emergency department.

The daily team meeting at the start of the day meant that risks to patients could be followed up or follow up from phone calls could be handed over from the on-call crisis worker. The handover and actions from the team meetings were documented in the patients' records. There was also a handover to the on-call crisis worker at the end of the day shift.

A ligature risk assessment had been carried out but did not include the shower curtain rails. Ligature risk assessments are carried out every 12 months. At the time of inspection, there was no updated assessment if the environment was altered which means there were unassessed ligature risks in the forensic environment. The SARC risk register was out of date at the time of the inspection and staff we spoke to were unaware of who was responsible for updating it.

**Information to deliver safe care and treatment**

All staff used templates for assessments of patients. This supported staff in asking the right questions. Body maps were consistently used by doctors to support their examination of the patient. The use of standardised forms ensured staff asked relevant and consistent questions when they were assessing the patient.

At the time of inspection, all records were hand written and scanned on to a secure computer system. In some cases the handwriting was illegible. The service was imminently moving to an electronic record keeping system to mitigate the risks involved with not being able to read handwriting. Despite the difficulty in understanding handwriting at assessment stages, in all records reviewed, appropriate risk assessments and onward referrals were completed and followed up. The crisis support worker manager completes a weekly review of some records. However, there was no regular holistic audit of records to allow managers to identify areas that staff need more training or areas of strength.

There had been ongoing challenges regarding the availability and functioning of specialist equipment known as a colposcope. A colposcope is a piece of specialist equipment, available for making records of intimate images during examinations, including high-quality photographs and video. The purpose of these images is to enable forensic examiners to review, validate or challenge findings and for second opinion during legal proceedings. There had not been a maintenance contract for the equipment and there was not enough storage capacity on the devices for images. These issues had been reported by SARC staff using the trust incident reporting system because at times it meant that the service has had to delay non-recent referrals. At the time of the inspection the service had issued guidance, as recommended by the FFLM, regarding storage of images from colposcopes. A new colposcope was on order and there was a maintenance and repair contract in place. However, because there was not appropriate representation and ownership of the SARC through NUHT governance structures, it had taken longer than expected to resolve the challenges. This will be reported on further in the Well Led section.

# Are services safe?

There was ongoing work to look at safe cloud storage options for the images to address the storage challenges and make the images more accessible for peer review.

Relevant information was shared with appropriate agencies. This was supported by a comprehensive local information sharing agreement which covered all the geographical locations that patients accessed the SARC from. Staff had attended the various Local Safeguarding Partnership meetings to promote the service and establish important relationships with multi-agency partners. This had been important work because the service is new and serves a geographically large area. Some of this outreach work had been challenged recently due to nurse shortage and clinical work was prioritised. The opportunity to contribute to multiagency intelligence discussions, helped partners understand patients experience.

All staff at the SARC were clear about the way that they are kept informed of updated FFLM guidance. The clinical lead shared updates six monthly. Staff told us that they felt able to ask questions to better understand guidance which meant they were confident in their practice.

**Safe and appropriate use of medicines**

All medicines in use were individually prescribed by doctors. The SARC stocked medicines that were subject to regular checks to ensure that all stored medication was within date. This practice reflected learning from a recent incident. All medicines were securely stored in locked cabinets. There was a fridge to store medication that required cooler temperatures. Fridge temperatures were monitored during week days. We noted that there was no mechanism to alert the staff if the temperature in the fridge had gone above or below the recommended levels in between checks. The staff contacted pharmacy and had rectified this issue before we left site by having a data logger in the fridge.

**Track record on safety**

There were appropriate safety checks of equipment, staff knew their responsibilities and there were logs to show when staff had completed checks. Spot checks of the logs during the inspection provided assurance that the checks were being carried out in line with trust and SARC guidance.

**Lessons learned and improvements**

There was an open and transparent approach to reporting and learning from incidents. We saw this through our review of reported incidents over the last 12 months. The SARC used the trust incident reporting system to record and rate the incidents. The trust Caldicott guardian supported the SARC in managing an information breach. To avoid a repeat of the incident the clinical lead was reading all reports before they were sent to patients. This was planned to continue until the SARC implemented the electronic record keeping system which was imminent. However, the trust had no formal mechanism for ensuring that the interim process in place to mitigate the risk was effective and proportionate.

Learning from incidents was shared at the operational team meetings that are attended by all SARC staff. Staff we spoke to were aware of how to report incidents and how learning was shared and we saw this reflected through local minutes of meetings.

A strong learning culture was evident throughout the inspection. All staff were able to access further advice to get assurance or additional support. This was well evidenced through prompt action taken during the inspection. For example obtaining a device from pharmacy to record fridge temperatures and advice from estates as to how they access the back-up electricity supply in the event of a power failure.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment, care and treatment**

Patient's needs were assessed and their care and treatment was delivered in accordance with national FFLM guidance and local clinical pathways. Staff carried out thorough and holistic assessments for every patient that accessed the service which ensured an appropriate standard of care.

If there were additional health needs identified during the assessment the doctor made the ongoing referral. Specialist nurses made and followed up sexual health referrals and the appropriate crisis support worker followed up any other referrals needed. In records we reviewed, we saw seven children's safeguarding referrals that were all good quality. They were timely and allowed the receiving professional to have the right amount of detail and to understand who else is supporting the patient following the examination. This facilitates effective multi-agency working.

Referrals are managed through an action plan that was generated at the end of the examination so that staff know which services they need to follow up on for the patient.

The initial assessment allowed staff to identify appropriate referral pathways, for example to children's social care and sexual health services. There were clear chronologies recorded and all patients were followed up within 72 hours of their attendance. This included calls to the patients and calls to follow up referrals that had been made.

Access to Children and Young People's Independent Sexual Violence Advisors (CHISVA's) across the local areas is timely. We spoke with a CHISVA who confirmed that the referrals that they received were appropriate and timely and contained the necessary information. This means that the service can be delivered at the right time for the client.

**Monitoring care and treatment**

The care and treatment of patients was routinely monitored through daily handover meetings and a follow up phone call to the patient. This was recorded in the patients' records and enabled staff to follow up on referrals to ensure that patients had access to services that would support them.

The SARC had completed an audit to review which geographical area patients are accessing the service from. This also included reviewing the age, gender and nationality of patients that accessed the SARC. Staff planned to use the data to target their next phases of outreach work for example to males and particular ethnic groups who accessed the service less than national data predicts.

Outcome data was not routinely recorded and monitored by the SARC. We saw from individual record reviews that referrals were followed up, but at the time of the inspection there was no oversight of the outcomes of referrals. This limits the opportunity to understand the effectiveness of patient pathways.

The clinical lead from the SARC contributed to development of national guidance. For example, attending the FFLM scientific committee to review guidelines regarding; sample collection, the SARC environment and equipment; development of the two-day paediatric forensic training course delivered through Royal College of Paediatrics and Child Health (RCPCH). The clinical lead also attended the RCPCH safeguarding committee and was involved in the updating of the purple book. The purple book is RCPCH best practice guidance to aid clinical decision making in examining children referred for evaluation of possible sexual abuse. This means the SARC staff received timely updates regarding national care and treatment pathways.

**Effective staffing**

Patients accessing the SARC were assessed and cared for by a range of staff who had the right skills and knowledge to deliver their care, this included doctors, nurses and crisis support workers. Staff we met with consistently spoke about their ability to share knowledge and ask for support to deliver care when they needed it.

Examinations were only carried out by doctors because it is a paediatric SARC. There were male and female doctors on the clinical rota. The service reported that there were no challenges in meeting requests for a male or female examining doctor and there had been no occasions when they were unable to fulfil the patient request for a particular gender of doctor.

Doctors covering the rota had a variety of backgrounds including Paediatrics, General Practitioners and Forensic Physicians. They had a range of qualifications including

# Are services effective?

## (for example, treatment is effective)

Forensic and Medical Examinations in Rape and Sexual Assault (FMERSA) training, the RCPCH forensic examination course and some had obtained or were working towards FFLM membership.

Doctors attended peer review at least four times per year to support consistent interpretation of clinical findings. If Doctors did not attend the minimum number of peer review sessions, they were removed from the doctor's rota. Nurses felt that the support and supervision for their role met their needs and they were able to access peer review as needed.

Staff accessed regular supervision to support them in their role. Crisis support workers had one to one independent clinical supervision four to six weekly when they could talk about any topic and they had four to six weekly management supervision where they could talk about cases and safeguarding issues if needed. Attendance at the supervision was monitored by the crisis support worker manager and there was management oversight of staff participation which allowed them to identify if there were staff missing regularly. This was followed up by the crisis support worker manager.

Safeguarding nurses accessed safeguarding supervision every six weeks via the NUHT safeguarding team. Opportunistic supervision was available for staff when they had seen difficult cases and a business case had recently been approved for staff to be able to access supervision through an external provider from January 2020. Staff can also access a dedicated 24 hour occupational health helpline provided by NUHT.

Crisis support workers had been able to access appropriate accredited training through an external agency to facilitate them in feeling confident and competent to deliver the role. Although as highlighted earlier in this report, there was not a competency schedule to assure managers that staff had acquired the necessary skills. An emotional health and wellbeing day had recently been offered to all staff at the SARC. This included sessions about meditation and head and hand massage to support them in managing their wellbeing as staff. Staff spoke positively of the session.

**Co-ordinating care and treatment**

A clear EMCYPSAS sexual health referral pathway offered a consistent service for all patients accessing the SARC. This included follow up if the patient was not brought to the appointment. There was a clear paediatric referral process and identification of who the resulting report needed to be shared with.

Multi-disciplinary working was well embedded. All staff told us there was an open culture built on trust and that they felt able to ask questions and challenge one another. Staff from the range of disciplines working in the SARC contributed to the assessment of the patient. This supported appropriate referrals following an examination.

The SARC had a clear system to manage and co-ordinate onward referrals. This was supported by an information sharing agreement with each of the local areas the SARC served. The phone call by the crisis support worker made 72hours after the patient had visited the SARC meant that there was opportunity to take any additional action to support the patient should this be requested or identified as needed.

The SARC served a large geographical area and the staff had worked hard to try and engage with the key professionals across those areas. We reviewed positive feedback that the SARC had received from partners since the regional service opened.

**Health Improvement and promotion**

Onward referrals for sexual health services and CHISVA's were offered to all patients who encounter the service, even if they were not seen at the service. This offered patients timely access to appropriate services to meet their needs.

An audit of the assessment and prescribing of contraception led to a teaching session for all staff. This was aiming to provide a more consistent assessment for all patients accessing the SARC by improving staff confidence and knowledge. A re-audit was due shortly after the inspection to measure the impact of the training.

**Consent to care and treatment**

Records seen evidenced that patient consent was obtained in accordance with FFLM guidance throughout the patient's journey, including a full explanation of the examination. Staff understood the importance of obtaining informed consent and followed relevant guidance and legal standards for doing so according to the age of the patient and their level of understanding. Doctors mostly obtained face to face consent from the patient. Staff were familiar

# Are services effective?

## (for example, treatment is effective)

with how to apply the "Gillick competence" standards when obtaining consent from a young person and also used the Fraser Guidance when providing contraceptive advice to their patients.

EMCYPSAS had developed clear guidance for staff regarding parental responsibility in relation to consent. This gave staff clarity as to who had parental responsibility in different care arrangements. If staff were unsure who had consent they are advised to get support from NUHT legal team.

Verbal consent was obtained for each part of the examination. If there was doubt as to whether the patient was comfortable to continue then the examination was paused. Staff spoke about adapting their communication styles and methods of examining to optimise the outcome for the patient.

Staff had received Mental Capacity Act training at their trust induction. Any ongoing mental health needs including support being accessed or required, were part of the comprehensive initial assessment which facilitated multi-agency working.

# Are services caring?

## Our findings

**Kindness, respect and compassion**

All staff understood and respected patients needs and this was reflected in patient and carer feedback. All staff consistently spoke about taking individuals needs into account when they were carrying out an examination. Feedback from patients on comments cards and through the SARC's feedback mechanism consistently reported how kind, compassionate, calming and reassuring staff were in a difficult situation. One patient had contacted the Patient Advice and Liaison Service (PALS) to report how reassuring and professional the staff were during their contact with the SARC.

NUHT had accessed a voluntary project so that they can offer patients a quilt to take away with them after their examination. These were intended to provide some comfort after their experience. We were told this was positively reviewed by a child in care who otherwise had few belongings of comfort. Staff had developed toiletry bags for males as the donated toiletry bags contain mostly feminine products. Snacks were also available for patients if they wanted them.

Patients and their families were signposted to support services and these were diligently and sensitively followed up with the patient and their family when appropriate. If follow up was unsuccessful we saw evidence of crisis support workers contacting children's social care if appropriate.

**Privacy and dignity**

Staff respected and promoted people's privacy and dignity.

The environment had been designed for use as a SARC which meant that the room space had been well thought out. Patients were able to dress and undress behind a curtain to maintain their dignity. The rooms and space were accessible by wheelchair. There were shower facilities and clean clothes and toiletries were available for patients after the examination had been concluded.

All staff spoke about how they made patients feel comfortable and that patients privacy and dignity was important. Changes had been made to the waiting room to allow the patients to have more of a private space but still allow staff to have a view of the room should any additional support be required.

The clinical lead for the SARC supported doctors in ensuring that sharing of images followed FFLM guidance and in writing reports for court. This means the service is effective whilst maintaining patient dignity.

**Involving people in decisions about care and treatment**

Staff described how they communicated with the children, young people or an appropriate adult to help them understand their treatment and they told us how they would adapt their communication styles. Interpreters were available through the police or social care.

Patients and their carers who accessed the SARC did not have written information to take away with them to explain the stages of the SARC processes. At the time of inspection there was an examination leaflet in draft form and the SARC was also planning to develop a pre-examination leaflet.

Feedback from patients and their families and carers reflected that they felt listened to. Changes had been made to the environment following feedback from patients and families The service had also purchased an electronic tablet to help distract patients while they were waiting . This was also following feedback from patients and had subsequently been positively reviewed in family feedback.

Patients who self-referred and were assessed as able to make that decision had a choice as to whether to involve the police at that time. This also included whether to provide forensic samples which could be stored by the SARC according to FFLM guidance. At the patient's discretion they could be destroyed or used any time in the next year. This meant that those who self-referred remained in control of the outcome of their visit.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

Most parts of the EMCYPSAS service operating from QMC were meeting the needs of the region. Parents and carers commented on how positively they experienced the service as well as patients.

A gap in access to therapeutic services was being addressed through a business plan so that access to those services can be more equitable for patients. Feedback collected by the SARC from patients showed that patients were satisfied with the service and appreciated the compassion that the staff showed. Staff had been able to respond to the feedback about the visual appearance of the SARC through provision of pictures in the non-forensic waiting room and an electronic tablet.

Staff gave examples of how they had been able to contribute to contextual safeguarding discussions through attending Multi-Agency Sexual Exploitation (MASE) meetings with SARC intelligence however, as previously discussed, they had been unable to prioritise this work.

Patients were empowered to manage their care from the start of the examination. This was described by all staff and was reflected in the feedback that the SARC has received since it had opened. For example, staff gave examples of listening to children and young people and using the interests of the patient or a favourite toy to engage and communicate with them.

**Timely access to services**

Local SARC leaders have worked hard to raise awareness of the SARC since it opened in April 2018. Some of this work had been providing assurance to multi-agency colleagues as the service was being moved away from smaller, locally delivered sites. Despite some initial apprehension, feedback from professionals, patients and their families have all commented on how accessible the service was. The SARC staff had engaged with multi-agency colleagues through Local Safeguarding Partnerships, MASE meetings, GP meetings and putting up posters in key places. A key positive feature was for staff and patients to have one number to contact 24 hours a day.

All examinations at the SARC were via an appointment which is accessed via a single point of contact. Data showed that the SARC had been able to see all patients within agreed timescales despite not being a 24hour service. The crisis support workers used assessment templates to support them in prioritising examinations which means that patients can be seen within agreed timescales and forensic windows when appropriate. During the inspection we were not made aware of any examinations that had to be cancelled since the SARC has been open.

There is an on-call element to the service which was operated by the crisis support worker with access to the on-call doctor. Although the SARC had not had any need to deliver an 'out of hours' examination. This suggests that the current model of operating hours can meet the needs of the clients.

Our review of records showed that patients receive timely referrals to services that supported them following the examination. Timely referrals were also made to services to meet patients' emotional needs, however access to therapeutic support for patients after they have accessed the SARC is not equitable across the geographical boundaries that the SARC is commissioned to provide a service for. Some children and young people were waiting too long. As mentioned previously, there is business planning underway to address this gap.

**Listening and learning from concerns and complaints**

The service had not received any formal complaints since it opened. Any incidents of concern were raised and managed appropriately through the trust systems and with the person affected in order to provide assurance and apologies as appropriate.

PALS leaflets were on display as you walked into and out of the SARC and the SARC had received positive feedback through PALS.

# Are services well-led?

## Our findings

**Governance and management**

We found some shortfalls in the governance of NUHT EMPCYPSAS. Due to these findings we have issued a requirement notice.

Governance arrangements and board assurance on the safe and effective operation of the SARC were underdeveloped. The responsibility for the SARC was within the trust's family health division. The division's "challenges and opportunities" document did not accurately reflect the SARC's risk spreadsheet. Local SARC managers were unable to tell the inspectors who had responsibility for ensuring that risks in the SARC were appropriately recorded and escalated.

At the time of the inspection the risk spreadsheet did not fully reflect all the service's risks. For example, fulfilment of DNA swabs of the forensic suite. Due to contracting issues, this was not being completed at the time of the inspection and was not recorded on the risk register.

During the inspection, service managers and leaders recognised that more could be done to review the sub-contracting of crisis support workers and whose responsibility it was to ensure their training was up to date and how that was reported. Although there had not been any concerns raised about the level that crisis support workers were operating at or the care that they were providing.

**Leadership capacity and capability**

Leaders of the SARC were visible, accessible and approachable. This was valued by SARC staff and staff knew what they needed to do to deliver a safe service. They knew who to access if they had concerns or needed advice. However, as we have reported above in 'safe' there was no clear line of accountability to the trust board for safety and performance with the SARC risk register not being subject to executive scrutiny and no means of assuring the effectiveness of plans made after lessons learned following safety incidents. This includes the absence of a regular data set or audit reports that are delivered and reviewed by the trust board.

**Vision and strategy**

Staff we spoke with were unsure whether the service had a specific vision and values which means they would be limited in contributing to the longer term vision of the service. As the service had developed, some key roles had changed such as the nurse manager. Although there was a job description, this role was not underpinned by an approved job plan. This challenged the ability to know what was being prioritised and limited the ability of the board to accurately ascertain whether the service is delivering its own objectives. For example, results of audits or work to improve aspects of the service.

Leaders were clear about future developments for the SARC and some of these were well developed. This included expansion of the estate to include a police suite and non-recent clinical space and implementation of the electronic record. However, at the time of the inspection there was not a vision or plan that was owned and reviewed by the SARC staff and reported to the trust board.

**Culture**

Staff repeatedly told us they felt supported and valued and felt able to raise concerns and ask questions. They described a culture that was open and transparent and felt that this helped them to learn and put the patient experience first. Staff appeared to be proud of the work that they did and the organisation that they worked for.

Staff had accessed an Emotional Health and Wellbeing day that was delivered by the trust. Staff described this as important to them. Staff spoke of accessing additional support through informal debriefs with colleagues after a difficult case or by accessing additional supervision. They felt that this supported them to deliver their role well and promote practice improvement. Leaders spoke of accessing training days and sharing learning with the team.

**Appropriate and accurate information**

The service was imminently moving to an electronic record keeping system and staff were hopeful this would support their journey to continue to use data to inform service delivery.

There were robust arrangements for ensuring the confidentiality of patients was maintained when records or parts of records needed to be transferred and advice could be sought from the trust's information governance and legal teams as needed.

# Are services well-led?

**Engagement with clients, the public, staff and external partners**

EMCYPSAS NUHT regularly gained patients feedback through questionnaires and PALS. As mentioned earlier, this feedback had been used to make proportionate and safe alterations to the environmental space.

The SARC had been involved in learning from other inspection programmes such as the JTAI (Joint Thematic Area Inspections) into Child Sexual Abuse in the Family Environment. They had welcomed engagement in the action plan from the JTAI and had engaged with the designated doctor from the local authority area. The SARC staff reported that they noticed a positive difference in how they were invited to strategy discussions in that area following the JTAI.

**Continuous improvement and innovation**

As we have identified earlier in this report, audit and plans to deliver continuous improvement must be developed further. This includes staff learning plans and job roles and identifying which SARC staff member has capacity to have oversight of short and longer term plans and how this is reported to the trust board.

The SARC staff have been involved in work completed in Nottinghamshire by an external agency. This was a needs assessment for Sexual Violence and Abuse Survivors in Nottinghamshire. Although this is only one area that is covered by the regional SARC, staff were keen to use the report to further understand a part of the patient group that accessed the service.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**<br><br>**There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:**<br><br>• There was insufficient capacity in local leadership to ensure that all risks were identified.<br>• Governance and managements systems did not support local leaders to identify, address and manage risks.<br>• There was not a clear line of accountability through NUHT governance structures from the local SARC leaders to the trust board. This included the absence of locally agreed performance measures.<br>• There was not a clear system in place to secure continuous improvement in relation to staff learning plans and job role priorities. |