G4S Health Services (UK) Limited

The Shores - Dorset SARC

Inspection Report

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Ratings

Overall rating for this service	No action ✓
Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive?	No action ✓
Are services well-led?	No action ✓

Overall summary

We carried out this announced inspection of this sexual assault referral centre (SARC) over two days on 03 and 04 March 2020. 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?

Summary of findings

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

Background

G4S Health Services (UK) Limited provide forensic and criminal justice services in different parts of the country, including a number of SARC services such as The Shores.

The Shores is situated in the centre of Bournemouth adjacent to the police station. The police station and the SARC occupy the same building although the SARC is accessible through a separate front door to the main road and through a dedicated entrance at the side. The centre is fully accessible to people using wheelchairs.

The building is owned by the police and has two forensic examination rooms and associated waiting rooms. One room is used mostly for adults and young people aged 16 and over and the other is used mostly for children.

NHS England and the Dorset Police and Crime Commissioner jointly commission this SARC. This is the only SARC in Dorset. As such, the SARC provides forensic medical examinations and related health services to people living in Dorset who have been sexually assaulted. The SARC is also sometimes used by people who live just outside the county of Dorset for whom it is the closest service of this type. This is an 'all-age' service; that is, all adults aged 18 and over, children and young people aged 13 and above and children under the age of 13.

The SARC is available 24 hours each day with a one-hour call-out time outside office hours. Adult patients can be referred through the police or they can self-refer. Children's are referred through children's social care. Children aged under 16 can self-refer subject to certain safeguards as set out in this report although all children under 13 must be referred through safeguarding processes.

The staff team includes a centre manager, crisis support workers (CSW), sexual offence examiners (SOE) and administrative support. The service is a 'nurse-led' service and so all SOEs, including the SARC manager, are registered nurses or midwives. The SOEs carry out examinations of all adult patients at the centre. Community paediatricians employed by the local hospital trust are separately commissioned to lead on the acute (within 72 hours of an incident) forensic examinations of children alongside the SOEs at the SARC. Children who do not require an acute forensic medical examination are seen as part of safeguarding medical examination procedures by the paediatricians at the local hospital, and this was not part of our inspection.

All patients are referred to a follow-up independent sexual violence adviser (ISVA) service provided by a local advocacy and advice organisation, which also provides a children's ISVA (or ChISVA) service for children under 18. Although part of the ISVA service is subcontracted by G4S Health Services, the service itself is not provided by G4S so is not in scope for this inspection.

One of the forensic suites is made available for one day each week for use by the Dorset's sexual health service as a bespoke sexual health clinic for people who are LGBTQ+. The provider of this service is also not in the scope of this inspection.

The service is provided by a limited company and as a condition of registration they must have a manager registered with the Care Quality Commission. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager at The Shores is also the centre manager who is on-site during weekdays. We have used the term 'manager' below for simplicity.

During our inspection visit we spoke with the registered manager, two of the SOEs, two CSWs, and the SARC co-ordinator. We also spoke by telephone with a community paediatrician from the local hospital. We looked at the records of six patients. Two of these were children under 13, and four were adults.

We left comment cards at the location in the two weeks prior to our visit but received no responses from people who had used the service in that period.

We also looked at the policies and procedures that were used at the location.

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:

- Staff knew how to keep patients safe.
- Appropriate medicines were available.
- The service had systems to help them manage risk.

Summary of findings

- Staff were well trained.
- There were sufficient staff to meet patients' needs.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service was clean and well maintained.
- The staff had infection control procedures which reflected published guidance.
- The service had thorough, safe staff recruitment procedures.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- There were processes for monitoring the standard and quality of care.
- Staff treated patients with dignity, respect and compassion and took care to protect their privacy and personal information.
- There was sufficient information available to ensure patients were informed of the service.
- The single point of referral system met patients' needs.
- The service had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and patients for feedback about the services they provided.
- The service dealt efficiently with positive, adverse and irregular events and learned lessons.
- The staff had suitable information governance arrangements.

There were no areas where we felt the provider should make improvements

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

No action

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

No action

Are services caring?
We found that the SARC was providing caring services in accordance with relevant regulations.

No action

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

No action

Are services well-led?
We found that this service was providing well-led care in accordance with the relevant regulations.

No action

No action

Are services safe?

Our findings

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

The Shores – Dorset SARC had systems and processes to ensure patients were safe.

G4S Health Services (UK) Limited had clear, up-to-date policies relating to safe care with scheduled review dates and these policies had been communicated to all staff. Staff had received mandatory training in key safety topics. This was either through the provider's in-house training or through verifiable training events provided by other organisations and logged on the learning management system. Records showed that staff were up-to-date with this training and those we spoke with demonstrated their knowledge and understanding of policies and systems.

Staff followed effective safeguarding processes to ensure patients of all ages were protected from abuse. Automatic referrals for every child or young person were made to the local authority to share information to support safeguarding procedures using standard multi-agency forms.

All staff had received training in safeguarding adults and children that met national, intercollegiate guidance on safeguarding roles and competencies that applied to their role. Staff also attended and logged regular supervision sessions facilitated by the provider's lead doctor that included safeguarding discussion. Safeguarding cases were discussed at team meetings to support practice improvement. Effective safeguarding practice was very well evidenced in patient records with a good attention to detail and analysis of risks.

All children and young people under 16 who used the SARC were referred to the service through local safeguarding procedures. Some self-referrals were accepted for children under 16 but over 13. These instances were rare and subject of rigorous risk assessment and referrals made where risks were evident.

The provider's recruitment policy was clear and ensured staff were subject of pre-employment checks. These included enhanced Disclosure and Barring Service (DBS) checks, an extensive interview, validation of references and qualifications and additional checks made directly with the police. The manager had good oversight of this with access to the provider's HR database.

All equipment was safe and staff were trained to use it safely. The manager carried out checks of safety systems through a weekly health and safety premises tour which included a check of electrical equipment and hazardous substances. All equipment was safe to use. This included specialist equipment used for recording intimate photographic and video images. There were good stocks of single use equipment and there was an effective monitoring system to ensure they were always within expiry dates.

There were processes in place to prevent patients and staff from acquiring healthcare-associated infections. A clear and up-to-date infection control policy, a designated lead staff member and good signage in relation to hand washing and infection prevention supported safe practice. Clinical waste and sharps bins were disposed of safely according to the provider's schedules.

Stringent cleaning arrangements for the forensic rooms to prevent the cross-contamination of contact evidence met guidance issued by the Faculty of Forensic and Legal Medicine (FFLM). These arrangements were carried out by a separately commissioned independent contractor and were monitored by monthly swab tests to ensure they remained effective.

Risks to patients

All sexual offence examiners (SOE) were registered nurses or registered midwives who were regularly employed in various nursing roles with other providers but who were employed by this provider in the role of SOE through an on-call rota. The manager checked staff numbers and response times as part of their quarterly monitoring and reporting process. There were sufficient SOEs and crisis support workers (CSW) available to meet patients' needs and to ensure that call out times remained under one hour for every patient. The workforce was well-established, stable, experienced and comprised a range of specialities such as emergency nurse practitioners and midwives with safeguarding expertise.

Staff assessed risks to patients throughout their episode of care, from the first call to the service, during and

immediately following their examination. Patients were comprehensively assessed for a range of risks, including sexual exploitation, deliberate self-harm, potential suicide and safeguarding risks using templated assessment tools.

Staff assured the safety of patients identified as being at risk of harm or with urgent health concerns. For example, the examination included a full assessment for the need for post-exposure prophylaxis after sexual exposure (PEPSE) or the need for emergency contraception.

The service was not commissioned to carry out screening for sexually transmitted infections (STI) but the risks of these were still assessed and patients referred to the adult or adolescent genito-urinary medicine (GUM) services, their GP or to community paediatricians in the case of children.

All patients were subject of a 48 to 72-hour follow-up call by a CSW to consider risks identified during the initial examination and to check on their health and wellbeing. Referrals to other services were made or repeated at this follow-up to ensure patients received appropriate support.

There was a corporate business continuity policy covering the provider's work. However, there was no specific business continuity plan for this location, other than arrangements for the building and for maintaining the power supply that was the responsibility of the police. The manager acknowledged that the location had no specific plan. During our inspection the manager arranged for a member of the provider's central team to visit the following week to develop a continuity plan for the service.

There were processes to support people withdrawing from alcohol or opiates who were identified using established assessment tools. This ensured the safety and follow-up of people who misused substances or where the use of alcohol or drugs had been a feature of the sexual assault.

Information to deliver safe care and treatment

Staff used templates to help in assessing and examining patients. These were the templates recommended by the FFLM with specific forms for adults and for young patients under 18. The templates used for patients under 18 met criteria set out in guidelines on paediatric forensic medical examinations issued by the FFLM and the Royal College of Paediatrics and Child Health (RCPCH), including age-appropriate body maps. This helped staff to ask relevant questions to facilitate accurate assessment. Staff made effective, detailed records of examinations that were clear, legible and accountable and included good notes of professional safeguarding discussions between the SOE, CSW and attending police officer or social worker.

Staff made records in hard-copy format and these were held in locked facilities with controlled access ensuring that patients' personal information was secure. Specialist equipment, known as a colposcope, was available in each suite for making records of intimate images during examinations, including high-quality photographs and video. There were effective arrangements for ensuring the safe storage and security of written and video records including monthly collection and secure transport to the provider's storage facility in another county. These arrangements met the guidance issued by the FFLM.

With consent, staff also shared information with other health professionals such as GPs, the community paediatric team, mental health services and sexual health services. Good quality referrals were made for independent sexual violence adviser (ISVA) or Children's ISVA support. This supported health partners to deliver safe care by way of follow-up.

Safe and appropriate use of medicines

The Shores routinely used a limited number of medicines; PEPSE and oral contraception as outlined above, paracetamol and emergency medicines. All SOEs administered medicines under a patient group direction (PGD) according to the provider's protocol. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation. The PGD in use in this SARC was up-to-date and had been signed by each staff member to verify they had read and understood the contents. This meant staff could administer prophylactic and contraceptive medicines safely and legitimately.

The manager reviewed the records of every patient within 24 hours, including where medicines had been administered, so was assured that assessments of patients for these medicines were accurate and that medicines were provided safely.

During our visit we reviewed the medicine systems. We found that medicines were well catalogued and that they were stored safely and securely. There was an effective system for reconciling the medicines through weekly checks. Stock and administration records were accurate.

No action

Are services safe?

Track record on safety

Safety systems and practices at The Shores were monitored, such as staffing levels, call-out times and decontamination processes. All monitoring data was reported quarterly to the provider's senior team and to the commissioners.

The manager had a good understanding of the SARC's safety performance as was demonstrated in our review of the SARC's monitoring systems, the risk register, the incident reporting system and team meeting minutes. This showed consistently safe performance and actions taken to address any shortfalls. For example, an issue with an apparent failure of one of the colposcopes to switch on properly had led to the introduction of a trouble-shooting guide to support staff to identify how to resolve such problems there and then.

The manager understood risks to patients arising from the environment and the impact of their experience and had implemented simple solutions to reduce those risks. Patients were not left unsupervised except for a short time when showering following their examination. There were no obvious ligature points in the shower facilities but the provider had carried out a self-harm and suicide prevention risk assessment. The assessment had identified potential risks due to the shower door being locked from the inside and so the manager had installed 10p pieces on each shower door frame to ensure staff could unlock the doors from the outside in an emergency.

Lessons learned and improvements

The service learned and made improvements when things went wrong but also when things went well. The provider used an incident reporting and learning system called 'clinical incident and positive information' (CIPI). All CIPI reports were overseen by the provider's central team and resulted in feedback or action plans for the service. For example, a root cause analysis (RCA) had been carried out in relation to a serious adverse incident in respect of a patient. The RCA did not identify any failings in practice but resulted in instructions being issued to staff about completing blank fields in records.

The manager's audit of each set of case notes within 24 hours of the patient attending resulted in feedback to staff about the record's completeness and the level of detail. This helped maintain the good standard of records that we noted during our inspection and ensured staff learned from dynamic feedback and discussion.

Staff were kept informed of any learning taken from incidents, not just at The Shores but arising from other G4S Health Services locations. This was by way of team meetings and bulletins. Staff told us they were well informed of the outcome of incidents and that this led to improvements in practice.

The service also learned from audits and health and safety checks. A legionella audit at the location in the previous summer had resulted in the introduction of a water supply flushing protocol. Flushing was monitored so the provider and manager were assured that the risks were minimised for every patient.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

All patients were thoroughly assessed in accordance with national Faculty for Forensic and Legal Medicine (FFLM) guidance. Staff followed clear, well-established pathways and protocols for different sexual assault situations, including those instances where patients had self-referred.

Patients' health needs were also assessed during the examination, including those arising from exposure to unprotected sexual activity. The assessment for post-exposure prophylaxis after sexual exposure (PEPSE) and emergency contraception met guidelines issued by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH) respectively. In the case of PEPSE the assessment also included a telephone consultation, there and then, with the genito-urinary medicine (GUM) consultant at the local hospital for every patient where such risk was identified. This ensured patients were not given powerful medicines unless they really needed it.

Our review of records for all parts of the patient's journey showed that assessments were holistic, taking account of physical health, emotional resilience, mental health and a range of social attributes to ensure their needs were thoroughly identified. This also facilitated the onwards referral to the independent sexual violence adviser (ISVA) service.

Monitoring care and treatment

The manager and staff at The Shores participated in a range of quality monitoring activities and audits to ensure the service was effective and operated within guidelines. These included the manager's weekly checks and the reviews of each set of case notes produced by both sexual offence examiners (SOE) and crisis support workers (CSW). The case notes reviews provided assurance about compliance with relevant guidance and protocols and the focus on patient centred care. This helped to ensure patients experienced the most effective outcomes from their episode of care.

Follow-up calls made to patients after their visit helped staff to check on their welfare and to ensure patients were referred to the most appropriate follow-on service. Records of attendance also helped staff to be aware of patients who had used the service before and so they were sensitive to their needs.

The service produced quarterly reports for commissioners and these were also submitted to the G4S Health Services central leadership team for oversight. The manager reported on trends against previous quarters and this ensured that resourcing of the SARC month-on-month reflected the evolving demands on the service.

Effective staffing

There was a competency-based induction programme for CSWs and SOEs. These were based on competencies set out by the FFLM and national occupational standards for people working with survivors of sexual assault. New staff undertook a comprehensive induction programme and for SOEs this also included a four-day training course in carrying out forensic examinations. Staff undertook supervised, reflective learning from workplace experiences so they could be 'signed-off' as competent. Records we looked at for each staff group showed that all staff had completed these programmes.

Staff maintained their competence through regular refresher training in key subjects essential to the effective running of the service and through peer review of their work. CSWs and SOEs were encouraged and funded to attend special interest conferences related to their work. The provider tracked the development and the workflow of each of the staff through a six monthly and annual education and development review (EDR) so that they were assured of their experience and their level of competence.

Peer review documents were completed by the manager and also by staff in respect of each other's work; these were used to generate discussion and reflection. Staff also undertook four clinical supervision sessions each year when their work was peer reviewed by the provider's lead forensic clinician. Staff told us that this supported their practice improvement and this was evident in the good quality of work we noted in patient records. However, although the manager had planned to record peer review documents as part of the EDR process this was not yet in place.

Co-ordinating care and treatment

Are services effective?

(for example, treatment is effective)

All staff at The Shores worked effectively as a multi-disciplinary team to assess, plan and deliver care and treatment. The CSWs and SOEs as well as paediatricians from the local hospital in relation to children, all worked closely together to ensure continuity of care.

The manager and staff reported that they had good relationship with the Dorset police and that they worked well together in the best interests of patients and this level of cooperation was borne out in the records we reviewed. For example, staff met the police investigators, children's social workers and paediatricians before the examination began to agree the scope and extent of the examination for each individual patient. For every young person aged 16 but under 18, the paediatricians were consulted by telephone to provide their expertise to this discussion.

Children and young people were referred to other agencies, including the local authorities in Dorset and the Children's ISVA service, to broker additional, targeted support through early help or child in need processes. Every examination of children and young people resulted in an automatic referral to safeguarding processes to ensure information was properly shared.

Health improvement and promotion

Records we reviewed showed that staff routinely wrote to patients' GPs to enable them to receive follow-up health advice in the community. This was the case for every patient unless the patient requested for this not to be done.

Patients received effective advice and guidance about sexual health both from the staff at the location and also in the form of written information and posters.

The provider had enabled an examination room in The Shores to be used as a sexual health clinic by an organisation known as 'Over the Rainbow' who were specifically for people who are LGBTQ+. Although this clinic was not provided directly by The Shores, the service worked closely with the organisation for patients who used both services.

Consent to care and treatment

Staff understood the importance of seeking informed consent and used a range of different information to support them in communicating with people about the SARC's processes. Staff used written information and leaflets aimed at children, young people and their parents to help them explain the purpose of the examination and ensure they understood what to expect. Interpreters were used whenever there was doubt about a patient's understanding due to their use of a language other than English.

Signed consent was obtained from patients or their advocates or carers in accordance with FFLM guidelines at the beginning of their visit. Verbal consent was repeatedly obtained throughout their visit for each part of the examination. If there was doubt that a patient had not understood what was happening, the examination did not proceed.

Staff also demonstrated their understanding of the legal standards for obtaining consent from children and young people in their own right. Staff used the process for obtaining informed consent from a young person, a standard known as 'Gillick competence'. Staff also followed particular guidelines, known as 'Fraser guidelines', before providing contraception and sexual health advice to young people. The use of these standards was evident in records we reviewed.

Staff records showed that they had received training in the Mental Capacity Act (MCA) 2005. During our interviews with staff we were assured that they knew how to assess a person's capacity using the relevant code of practice, and whom to involve in the process to ensure decisions could be made in a patient's best interests. We did not review any records of patients who had limited capacity.

Are services caring?

Our findings

Kindness, respect and compassion

Our interviews with staff and the records we reviewed showed the service to be caring and patient-focused. Staff spoke passionately about the care, support and compassion they offered to patients who had experienced significant sexual, emotional and often physical trauma. One staff member told us they felt honoured to care for patients at such a distressing and highly emotional time in their lives.

Staff described how they extended their kind and respectful approach to those people supporting the patient so that they, too, could have their worries addressed. The location's website had a separate section for friends and family and this contained clear, easy-to-understand information about the procedures and the emotional impact of the experience on their friend or relative. Through the single telephone number, the SARC offered advice and guidance to professionals in other agencies who may be supporting people who had experienced sexual assault.

Staff were knowledgeable about the impact of sexual assault and said they tried to develop a trusting relationship with patients. Feedback comments obtained from patients between throughout 2019 said that staff had treated them kindly and they had felt safe, welcomed and made to feel at ease. Other comments mentioned that staff were reassuring and friendly.

The service enabled patients to have a choice of the gender of the staff member that supported them during their visit. A male crisis support worker (CSW) and a male sexual offence examiner (SOE) were part of the staff rota. Their shifts were organised so that they worked opposite each other to increase the time when a male staff member would be on duty. People were offered this choice at the point of call-out. Staff told us they felt it was important not to assume what patients might want and so this was always discussed at first contact with the patient. The patient notes templates did not have a section to record that this offer was made, so it was monitored by the manager on a spreadsheet. This showed that the choice of gender of clinician was offered to every patient.

Involving people in decisions about care and treatment

People were given sufficient information about The Shores and about what to expect during their episode of care. The SARC's website was clear and easy to navigate with separate sections for men, women and LGBTQ+ patients as well as for friends and family. A prominent message about confidentiality ensured patients understood how they could choose what would happen with their information. The website also explained patients could choose how much of the service they used and that they were in control throughout their experience. This information was duplicated in the different types of patient information leaflets and written material available in the SARC itself and which staff used during their contacts to help explain what would happen. There was also written information available about follow-on care and advocacy services that patients could choose to access after their visit to the SARC.

Interviews with staff showed that they had a shared vision to ensure patients had control over decisions about their care and that the examination was carried out at their pace. Staff told us that patients' wishes were paramount and they were actively involved in decisions about the care they received. This included children and young people, for whom specific written information was available that was age appropriate and child-friendly.

Staff explained that ensuring patients understood that they could stop during any part of the process was a key message as it enabled patients to regain control after experiencing an event that they had no control over. Staff reinforced the importance of continually assessing, not only what the patient said, but also reading their body language for any signs of distress or discomfort.

Patients' voices were evident in records we reviewed, including the voice of children who used the service. Records we looked at showed that staff took account of the wishes and feelings of children in relation to the conduct and progress of examinations.

Patients who self-referred had a choice about whether to involve the police, including whether to provide forensic samples so they could make that choice later if they wished. Samples were retained for up to two years after their examination in accordance with guidance on self-referral sample timescales issued by the Faculty for Forensic and Legal Medicine (FFLM). This means patients

who self-referred remained in control of the outcome of their visit. People who had not yet used the service could also call the centre anonymously and speak to a CSW for advice about what they might choose to do next.

Patients whose main language was not English had access to interpreters who attended the centre to translate key information to ensure they had a good understanding of the procedures. There were leaflets and written information in Polish and Romanian, two of the largest minority languages used in Dorset.

There were also materials available in easy-read and pictorial format to provide information to people with a learning disability. There was a communication box that contained paper and pens for patients to write on and pictures to aid communication. For example, there were signs for patients to point at saying 'stop', 'don't touch' and 'no' to tell staff if they did not want to continue with the examination. There was also a communication book for patients who were visually impaired or had hearing loss. This included Makaton signs and a page with emoticons to indicate levels of pain.

Privacy and dignity

Staff understood the importance of respecting people's privacy and dignity and this was evident in our conversations with them during our visit. For example, staff told us patients who had attended the centre on more than one occasion before, would be treated as if it was their first time so that they would be offered a consistent level of support.

The layout of the building and equipment and facilities also supported people's privacy and dignity, particularly following a forensic examination. Examination suites included bathrooms to allow patients to shower after examination. Comfort packs containing toiletries that were provided by a national charity were available to patients. Post examination waiting rooms contained sofas and soft furnishings for patients to relax in and were used by crisis workers to speak with patients in a softer, less clinical environment. People were provided food and drinks to make them feel more comfortable and there was a small, secure garden area where patients could sit, take time out and have a break.

During the examination itself, staff promoted people's dignity by enabling patients to get undressed at their own pace behind screens before putting a gown on. Staff helped patients to keep covered those areas of their body that were not being examined and only essential people were allowed in the examination room. Crisis workers told us they would ask the patient where they would like them to stand during the examination and the importance of understanding and supporting their cultural values and beliefs.

An intercom with CCTV ensured access to the building was controlled and so only people who were using the service could enter. On those days when the service hosted the 'Over the Rainbow' sexual health clinic, privacy screens were used to section off different areas of the service and corridors.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs.

The service and staff had a good understanding of the needs of the local population and was proactive in identifying and supporting those needs. The service collected and analysed data of the patients who attended, which allowed them to provide effective staffing resources, information leaflets and tailored support. These were discussed at regular meetings with the commissioner, Police, paediatricians and the ISVA service.

This provider's data showed that a range of vulnerable patients used the service, including children and young people, patients with mental ill-health, disabilities and learning disabilities and those whom had reportedly consumed drugs or alcohol. The data also showed that there was a 17% increase of referrals to the centre in the last financial year (2018-2019). Almost 18% of people using the service were children and young people and 4% were men.

Meetings with the commissioners and partners also enabled the SARC to determine how the service should be promoted locally. There were clear aims and goals agreed to promote the service to all groups within the local area. The provider employed two engagement workers who had a good understanding of their local population and actively sought opportunities to promote the service to a number of different groups. These initiatives had led to the service being offered to new patients who might not otherwise have been identified. Following are some examples:

- Engagement with a local domestic abuse support group for victims resulted in three people requesting support and advice from the service.
- Links with a local user-led charity supporting people with learning disabilities had enabled the service to take feedback about how to improve their communication for people with learning disabilities. This had led to the charity's monthly newsletter being made available in the SARC reception area and the identification of another patient who needed support from the service.
- Work was underway by one of the team designated as a 'male engagement' worker to engage with local military establishments to promote the service offer.
- The male engagement worker had also attended a local prison and met with the mental health team and nursing staff to advise how the service could offer support to their patients.
- A meeting with managers responsible for student housing, resulted in increased awareness of the way the service could support students who had experienced sexual assault.

There was a strong culture amongst staff to engage with the community and other partner agencies. One afternoon each week the service held an open day to encourage people and professionals to attend and have a tour and learn more about the service. Staff took this opportunity to inform people of the services offered and to encourage them to raise awareness amongst their own colleagues. Engagement workers told us these sessions were proving useful and some of the people who had attended had been nurses, midwives, probation staff and students from the University of Bournemouth.

Taking account of particular needs and choices

The service was also undergoing an accreditation programme with a nationally recognised organisation that had devised standards for male victims. The service had produced evidence of their activity for male victims and this accreditation was due to be signed-off in the month following our visit.

As well as the strong links with the 'Over the Rainbow' sexual health service, the SARC had also recently begun to host another local transgender and questioning support group. The group used the building to run weekly sessions. The manager told us this was intended to promote the service to transgender and questioning men and women in Dorset to ensure they had equitable access to sexual assault services.

The building had good access for wheelchair users and one of the bathrooms had special adaptations for patients who were disabled. Examination couches could also be lowered to assist patients with mobility difficulties.

One of the examination suites was tailored to meet the needs of children and there were plentiful supplies of age appropriate single use equipment. A family lounge area with toys and child friendly décor supported families to relax following their child's examination.

Are services responsive to people's needs?

(for example, to feedback?)

There were useful contact links to signpost people to local and national support groups. This also included information for patients who required mental health support. In the service reception there were various support group leaflets for patients to take away and posters displaying contact details. These included, LGBTQ+, youth support, female genital mutilation, ChildLine and honour-based violence and substance misuse support groups and the ISVA service.

Parents of children who had experienced sexual abuse were actively referred to a local charity who provided support for protective carers in their position. This enabled those families to experience continuity of support to help them cope with the psychological impact of the abuse on their child.

Timely access to services

People who had experienced sexual assault had access to a 24-hour, seven-day service through a responsive pathway. Patients could be referred through the police or they could refer themselves. Children were referred through local safeguarding processes.

The provider's website prominently displayed the single contact telephone number for the provider's call centre. Staff rotas ensured patients could receive support day or night from a sexual offence examiner (SOE) and crisis support worker (CSW). The service met the agreed timescales for responding to urgent patient need within one hour and appointments were available for patients to attend outside of the forensic timescales where their experiences were more historic.

All patients received a timely follow-up call from a CSW and were routinely referred, with their consent to the ISVA service for further advocacy and therapeutic care.

The SARC was warm and welcoming to people and food and drinks were available with comfortable furnishings in the waiting rooms to help patients feel more relaxed. The main examination room, whilst needing to be a clinically clean area, was light and spacious and the adjacent bathrooms had been designed and furnished to make them more relaxing for people to use and shower in.

Listening and learning from concerns and complaints

The provider had a complaints policy which staff were aware of. Information on how to make a complaint was displayed around the building and on the provider's website. There was an online form if patients wanted to complain or give feedback.

The manager told us there had been no complaints received in the last year however, during the welfare call made to patients up to 72 hours after attending the service, they were asked for feedback. Any concerns expressed were recorded in the crisis workers' notes and discussed with the manager. The provider also provided patient feedback forms and staff would be updated during team meetings or the weekly email of any concerns identified.

Feedback we looked at was overwhelmingly positive with service users stating that the service had met their needs and more. One service user had commented that the SARC had worked hard to meet their particular emotional needs and had gone above and beyond their duty. Another commented that the service had made them feel safe and cared for.

Are services well-led?

Our findings

Leadership capacity and capability

The provider's senior leadership were visible and approachable and visited this SARC occasionally as part of their assurance duties. Senior leaders were also available for, and had regular contact with, the manager. In particular, the provider's lead forensic clinician regularly visited The Shores as part of the supervision and peer review arrangements to provide direct support to all the staff.

The registered manager was an experienced midwife and a sexual offence examiner (SOE) with extensive safeguarding experience. Systems and processes had been implemented by the manager to ensure that performance in relation to patient safety and the effectiveness of the service were well monitored. The manager had good oversight of all of the work carried out at the SARC and this was evident during our inspection.

The manager had recently enabled greater resilience in the management role. The role of three of the SOEs had been changed so they could become embedded as daytime staff for three days each week. This meant they could manage referrals during the day to create time for the manager to perform managerial functions and improve the monitoring and oversight arrangements. We saw evidence of this improvement activity planning during our inspection.

Vision and strategy

The provider's values of 'acting with integrity and respect', 'being passionate about safety, security and service excellence' and 'achieving through innovation and teamwork' were well understood by the staff team. During our inspection, and arising from interviews with staff and the manager and our review of records, we noted plentiful evidence of these values in action. For example;

- the views and approaches of staff to record keeping and the level of detail in those records showed their desire for excellence
- the drive to promote the service locally through engagement workers was well planned and targeted and demonstrated innovation

The service strategy was aligned with the NHSE service specification governing services of this type. This was monitored through quarterly performance meetings with commissioners and partners such as the paediatric team at the local hospital, the ISVA service and the police. This was also achieved through the provider's quarterly clinical governance meetings. The SARC's performance data was used to inform these processes.

Culture

There was a positive culture of providing high quality, compassionate and effective care as shown through our interviews with staff and the good quality of their records. Staff told us they felt valued by the provider and that they considered it a privilege to provide care to vulnerable people through this service.

Staff told us they were well supported by the manager, whom they held in high regard. There were good processes in place to ensure they maintained a culture of improvement. This was achieved through six-monthly EDRs, through the peer review process that was yet to be fully linked with the EDR, through regular team meetings and through the provider's briefings and bulletins.

There was a good ethos of incident reporting though the clinical incident and positive information (CIPI) process. Staff understood the process and provided examples of when they had raised incidents that had led to improvement actions; for example, the apparent failure of a colposcope as outlined in 'safe' above.

Multi-disciplinary work was well established in The Shores with a culture of collaboration across the staff roles in the centre and with staff from other services and agencies such as the paediatricians and the police. This ensured patients achieved the best possible outcomes.

Governance and management

There were quarterly clinical governance meetings which involved service managers from other SARCs and the provider's senior team. The manager also took part in monthly conference calls with managers from different SARCs. This created the mechanism for disseminating decisions and learning across the provider's SARC estate and we saw examples of this during our inspection. For instance, improvements had been made to the records templates in use at The Shores as a result of learning from a CQC inspection at another SARC location.

Are services well-led?

Local management of the SARC was effective with well-developed systems and processes for monitoring quality, performance and staff development. Staffing was well managed and the service had sufficient capacity to meet the contract it was commissioned to deliver.

The registered manager had the overall responsibility for the management and leadership of the service as well as its day-to-day operation. Staff knew the management arrangements and their roles and responsibilities.

There were regular three-monthly team meetings which most staff were able to attend. These facilitated communication with staff about key issues arising from governance meetings and about local matters affecting The Shores.

There was a good system for enabling the provider and the registered manager to have oversight of risks and incidents. This was through the provider's and the location's risk registers which formed part of the discussion at the provider's clinical governance and the commissioner's performance meetings. These registers derived from the CIPI process and through the regular programme of audits and weekly checks.

Appropriate and accurate information

There were firm arrangements in place to ensure the availability, integrity and confidentiality of identifiable data and to identify any occasion when there might have been a data breach. All staff were clear about their role in protecting sensitive information about patients.

The provider understood its area of business well through its diligent data collection against national criteria and its quarterly reports to commissioners. Information was accurate and enabled the provider to have a holistic overview of its performance.

Engagement with patients, the public, staff and external partners

The focus on capturing patients' voices in individual records extended to the engagement with service users by way of feedback. Feedback from patients was used as part of the SARC's quality assurance process.

Staff contributed ideas to service improvement at team meetings as well as information about performance and daily operation of the service. Examples of this included improvements to patient record templates to allow more room for narrative and a request to procure a blood pressure machine for examinations.

External partners were engaged in daily dialogue with the service on an operational, individual patient level and this was reported by staff to be effective. In particular, relationships with the local police were said to have improved significantly over the previous two years to the extent that patients received a well-co-ordinated service with each agency working in the patient's best interests.

Commissioners advised us that the service was responsive to feedback from partners and other agencies through the quarterly performance meetings. This was echoed by the paediatric service at the local hospital who described the service as one that listens well and always follows advice and guidance from consultation.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation, and quality assurance. This included the previously mentioned CIPI process, the centre's range of audits and the quarterly data reporting. Forms and templates used by staff were routinely and regularly kept under review to ensure they reflected current guidance issued by the Faculty for Forensic and Legal Medicine (FFLM) and health standards bodies.

Individual staff development and learning needs were managed through six-monthly EDRs. Staff told that this was effective and meaningful and we saw evidence of completed appraisals in the staff folders.

Of significance though, was the innovative programme of engagement and outreach activity with different groups as we have commented in 'responsive' above. As reported above, this is an unusually extensive programme of engagement and demonstrates that this SARC is an integral part of the Dorset health and criminal justice service community.