G4S Health Services (UK) Limited

Hodge Hill Primary Care Centre

Inspection report

Roughlea Avenue
Birmingham
B36 8GH
Tel: 01217767744

Date of inspection visit: 31 May 2022
Date of publication: 26/08/2022

Overall summary

Summary findings

We carried out this announced inspection on 31 May 2022 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector supported by a second CQC inspector.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Background

Summary of findings

Hodge Hill Primary Care Centre is a sexual assault referral centre (SARC) commissioned by NHS England. The SARC service is available 24 hours a day, 7 days a week (including public holidays) to provide advice to police and patients, deliver forensic medical examinations, provide support following recent and non-recent sexual abuse, and offer onward referrals to independent sexual violence advisors (ISVA) in the area.

G4S Health Services (UK) Limited are commissioned to deliver the SARC service, including forensic medical examinations, to patients aged 18 and over, which are undertaken by either a Forensic Nurse Examiner (FNE) or a Forensic Medical Examiner (FME).

The SARC is located in a residential area of Birmingham within a primary care centre. The SARC has a separate entrance to the rear of the building to give patients some privacy, and there is ample parking available for patients and visiting professionals. The SARC facilities are newly designed with two forensic pods- each including a pre-examination room, bathroom and medical examination room. There are additional rooms used for aftercare sessions, family waiting areas and visiting professionals such as counsellors. The facilities also include a staff bathroom, changing area, medicines room, several storage rooms and cleaning cupboards, as well as two staff offices and access to a training room. Kitchen facilities and visitor bathroom facilities are also available as well as office space and a room to develop into an ABE (achieving best evidence) suite for police video interviews.

During the inspection we spoke with the registered manager, team manager, two forensic nurse examiners and two crisis workers. We looked at policies and procedures, reports about the service, and eight patient records to learn about how the service was managed.

We left comment cards at the location the week prior to our visit but did not receive any feedback from patients.

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

Our key findings were:

- The provider had systems to help them manage risks presented to the service.
- Staff received appropriate training to respond to emergencies. Appropriate medicines and life-saving equipment were available.
- Staff provided caring and compassionare 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 was effective.
- Staff felt well supported by peers and managers.
- The provider encouraged staff and patient feedback about the services they provided and shared examples of where changes had been made as a result of this feedback.
- The provider had suitable information governance arrangements.
- The newly designed and renovated SARC environment was welcoming, clean, and offered excellent facilities for patients, visitors, professionals and staff working on site.

Infection control procedures reflected published guidance and had been adapted with Covid-19 guidance to ensure services remained available to patients throughout the pandemic.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Are services safe?

Our findings

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

Staff understood their responsibilities to protect adults, children and young people from abuse and received training on how to recognise signs of abuse and report it. Staff we spoke with knew how to access the the provider's policies for safeguarding children and adults and understood the requirements for their roles. Staff we spoke with had a comprehensive understanding of safeguarding issues, which was evidenced in patient records we reviewed.

Safeguarding referrals were made within 24 hours and were followed up appropriately with the local authority. Safeguarding referral information was clearly documented within patient records.

The provider monitored staff compliance with safeguarding training; all staff had received level three safeguarding adults and children training via the online portal, and this was updated every three years in line with intercollegiate national guidance.

Patients could refer themselves via the 24hour call centre operated by the provider, and police or other professionals also used the call centre line to make their referrals. The referral source was documented within patient records, and we saw evidence that staff made onward referrals to appropriate agencies such as the GP, sexual health and social services.

Patient vulnerabilities identified during the assessment process, such as mental health, substance misuse, learning difficulties and domestic abuse, were clearly highlighted in patient records we reviewed. This meant that additional needs were flagged at an early stage so that the patient's treatment could be adapted as required.

The provider had a staff recruitment policy which ensured only suitably qualified staff were employed. Three-yearly Disclosure and Barring Service (DBS) checks were required by the provider, and were recorded within staff HR records, with prompts issued when any checks were due to expire.

Two substantive nurses covered daytime shifts at the SARC, and a team of flexi nurses covered the out of hours rota as well as extra shifts when the substantive nurses took leave. Two crisis workers had moved on and one was on maternity leave which left some challenges, however office staff and the team manager were trained crisis workers and able to assist with any shortfalls in the rota.

The provider had an up-to-date whistleblowing policy in place which was available to staff on the online portal. Staff we spoke with told us that they felt able to raise concerns with managers.

Staff operated the service 24 hours a day and the provider had appropriate lone working procedures in place to support staff safety when working out of hours.

The NHS were responsible for the maintenance and upkeep of the primary care centre which the SARC was situated in, and regular maintenance checks such as fire alarm testing, emergency lighting checks and health and safety risk assessments were carried out and shared with the provider. Premises documentation was stored in the centre for the provider to access so that they could assure themselves checks had been completed.

Infection control audits were carried out every 6 months in line with the provider's audit schedule, and there were no outstanding actions. The provider had developed additional safety measures and worked closely with the SARC manager and crisis workers to manage the risks from COVID-19 with additional safety measures such as hand sanitiser and social distancing to protect staff and patients from infection.

The NHS managed the contracts for the general cleaning of the SARC facilities and clinical waste disposal. Crisis workers were trained to carry out forensic cleaning of medical examination rooms, and a contract was in place for a forensic deep clean to take place monthly.

Are services safe?

An environmental ligature point risk assessment had been completed, however there were no outstanding concerns and the facilities had been designed with anti-ligature bathroom facilities which had been fitted with anti-ligature pulls for both the disabled alarms and light switches. Staff told us that patients would never be left unattended outside of bathroom areas. Locks to bathrooms could be opened by staff externally if required and anti-barricade doors had been used for the bathrooms.

Forensic suites and staff offices were accessed by staff with swipe cards, which reduced the risk of unauthorised access.

FNEs had access to, and received appropriate training in the use of, the colposcope at the SARC (a colposcope is a piece of specialist equipment for making records of intimate images during examinations). G4S were responsible for the maintenance of equipment including the colposcope, and forensic samples were managed in line with the Faculty of Forensic and Legal Medicine (FFLM) guidelines.

Risks to patients

The provider had systems in place to assess, monitor and manage risks to patient safety. Patient records evidenced that staff carried out holistic assessments with their patients to identify risk factors such as physical or mental health concerns, substance misuse and safeguarding. If a patient presented as acutely unwell, staff told us they would encourage and support patients to attend accident and emergency prior to continuing treatment at the SARC.

Staff completed an assessment with patients for post exposure prophylaxis following sexual exposure (PEPSE), emergency contraception and hepatitis B prophylaxis. Referrals were made for sexual health screening where appropriate.

The alcohol withdrawal scale and clinical opiate withdrawal scale tools were used to assess a patient's intoxication levels where substance misuse concerns were identified. FNEs we spoke with were clear that they would assess both risk and a patient's capacity to consent to treatment dynamically throughout their time with the patient, and would not proceed if they felt patients were too intoxicated to undergo the medical examination.

Clinical staff had received up to date life support training and knew how to respond in case of a medical emergency. An emergency response bag and defibrillator were stored on site and were checked regularly to monitor stock levels and expiry dates.

The provider used the Ulysses system to record incidents, complaints and compliments. The system was overseen by managers who investigated incidents and complaints, recorded outcomes and shared any lessons learned with the team.

Information to deliver safe care and treatment

Staff used assessment and forensic medical examination proformas developed by the provider and based on the template from the FFLM. Additional proformas were completed in patient records to document safeguarding concerns, actions taken, follow up information and outcomes. Patient records reviewed during the inspection were legible, contemporaneous, and comprehensive. Records were subject to regular peer review by senior clinicians; evidence of the review and subsequent discussion with staff was stored within patient records.

All patient records were stored securely within the SARC facilities in locked metal filing cabinets within the FNEs room. Only SARC staff had access to the records which complied with data protection requirements. Photo evidence was also stored securely alongside patient records.

Any onward referrals made by staff for their patients were documented within patient records and a copy of referral documentation stored in the patient file.

Safe and appropriate use of medicines

Are services safe?

Medicines were stored in a locked medicine cabinet within a temperature controlled clinical room accessed by SARC staff only. The cabinet keys were held in a key safe with restricted access. Room temperatures were recorded daily and audited by the team manager to ensure the integrity of medicines had not been compromised. The expiry dates of medicines we checked on site were within date.

Forensic evidence was stored in dedicated areas with temperatures monitored daily by SARC staff.

Track record on safety and lessons learned

Staff reported incidents using the Ulysses system and nurses we spoke with during the inspection understood their responsibility to report all incidents, accidents and near misses. All incidents were reviewed by managers, and themes identified were shared with staff in supervision and team meetings. Incident and complaint themes were shared with SARC police colleagues and reviewed during partnership meetings where appropriate.

Feedback from incidents was used to inform discussions during team meetings, staff supervision, appraisal and peer review sessions.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients attending the SARC were greeted by a crisis worker and the FNE who jointly assessed the patient. Patients' needs were assessed, and their care and treatment delivered, in line with current legislation, standards and guidance including the FFLM and National Institute for Clinical Excellence (NICE). Patient records reviewed during the inspection evidenced that FNEs completed a comprehensive health assessment including past and current medical histories as part of the forensic medical examination.

The provider had a range of evidence-based policies to assist nurses in their work which were accessible online and offered guidance to staff in identifying and managing risks to patients and improving patient safety. FNEs we spoke with knew how to access the provider's policies and procedures, and the provider's governance framework ensured that policy review dates were monitored to prevent them becoming outdated.

Clinical policies were in place for the administration of emergency contraception and HIV PEPSE, and records we reviewed showed that patients' needs were assessed in line with these policies.

Monitoring care and treatment

The provider had an audit programme in place to ensure regular audits took place for health and safety, infection prevention and control, and safeguarding. Audits were overseen by the team manager and registered manager to monitor compliance and completion of actions. It included an environmental ligature risk assessment audit in January 2022, and an infection prevention and control audit in September 2021. Audit reports were completed for police performance reviews, and the provider regularly met with the SARC manager to share relevant audits for learning and best practice purposes.

Senior clinicians carried out peer reviews of patient records which were randomly selected. Feedback was shared with FNEs during one to one sessions. We saw evidence that individual cases were taken to weekly peer review meetings to share learning and best practice, which staff told us was valuable.

FNEs recorded the procedures, treatment, and any medication issued to patients as well as the relevant outcomes, including onward referrals and liaison with other agencies such as the GP or sexual health services. Crisis workers completed follow up calls with patients to monitor their well-being following attendance at the SARC, as well as follow ups with the local authority to monitor the outcomes of safeguarding referrals and identify any outstanding needs.

Effective staffing

The provider had policies and procedures in place to ensure FNEs were competent to carry out their roles within the SARC. All FNEs received an annual appraisal, and access to regular management and clinical supervision.

Staff completed mandatory training in line with the provider's policy which covered topics such as health and safety, basic life support, infection prevention and control, and information governance. Training was provided via an online portal which all staff could access, and the system prompted staff when a course was due to expire. Training completion was monitored by managers and a report could be generated to review and identify any non-compliance.

Training records evidenced that FNEs had the right experience, skills and knowledge to deliver good quality care. Service specific training was provided such as how to use the colposcope and writing a witness statement for court. Local training opportunities were available however staff were not always able to attend at short notice.

Are services effective?

(for example, treatment is effective)

New staff joining the SARC team received a comprehensive induction in line with the provider's policy. The induction procedure included more frequent supervision, and shadow shifts to observe experienced staff. The provider's 24 hour call centre provided access to clinical or medical advice if required, and both the team manager and registered manager were available to support new recruits during working hours. Competency assessments were completed with nurses by a senior clinician prior to sign off for them to work independently.

Co-ordinating care and treatment

Clear referral criteria was available online and in the service information leaflets for patients or any other professional agency wishing to refer to the SARC. The team had worked hard to promote the SARC at the new location, and had held an open day for all local partner agencies and stakeholders to visit the facilities and learn more about the service offered. A wide range of literature and information was displayed within the SARC to inform patients and staff of local services available in the area to provide additional support.

We saw evidence of good working relationships between police and SARC staff. Police colleagues were not co-located but would call in to collect samples. Although there were facilities available to them in the new premises, they did not always remain on site while patients they brought to the SARC were seen.

All patients attending the SARC were offered a referral to the ISVA service. FNEs wrote directly to the GP (where patient consent was given) to advise of the patients attendance at the SARC and of any concerns to be followed up by the GP. A referral would also be offered to sexual health, substance misuse or mental health services where required.

Consent to care and treatment

FNEs sought patient consent to care and treatment in line with national guidance, and told us they would continue to review patient consent throughout the medical examination, which we saw evidence of in patient records. Training records indicated that all FNEs had completed mandatory training in the Mental Capacity Act 2005, and those we spoke with were able to describe the appropriate actions they would take if a patient lacked capacity.

Assessment and medical proformas included sections to document patient consent to sharing information and a signed declaration from the patient. FNEs we spoke with during the inspection clearly understood their responsibilities with regards to patient consent and the Mental Capacity Act 2005.

Staff documented patient consent prior to sharing information with external agencies, such as the GP.

Are services caring?

Our findings

Kindness, respect and compassion

Staff treated patients with compassion and kindness and were respectful of patient privacy and dignity. This was reflected in patient records we reviewed and interviews with staff, who showed compassion and consideration for their patients. Staff told us that the assessment and examination were based around each patient's individual needs and adapted to suit their wishes.

The provider kept a box and comment cards in the waiting area for patients or visitors to leave feedback and suggestions. Any comments received were logged by the provider, and although brief, overall feedback was positive. One patient who had attended the SARC services at the previous location had commented on the improvement to the facilities at the new SARC premises.

Managers shared one example of a patient who fed back after their assessment how cold they felt, and following this the SARC now have a stock of blankets which patients can choose to have after the examination and take with them if they wish.

Involving people in decisions about care and treatment

From our review of patient records and speaking with staff, we saw evidence that patients were in control of their care and we saw the patient's voice documented in care records.

A telephone interpretation service was available for patients who did not speak English as a first language, and patient's communication needs were documented at the point of referral to ensure appropriate arrangements could be made prior to the patient arriving at the SARC.

The SARC website offered detailed information for professionals, patients, and their carers or families on how to refer, services available, and what to expect when attending the SARC. Information was also available at the SARC, including in easy-read formats, to support patients in making informed decisions and promote other local services offering aftercare support. Service leaflets were available in different languages if required.

Patients received information leaflets about the service and treatment they had received as they left the SARC, as well as the offer of leaflets detailing additional local support options.

Privacy and dignity

The SARC facilities were situated in a primary care centre in a residential area. The SARC had a separate entrance at the rear of the centre which was discreet to afford privacy to patients, and had ample parking for staff, patients, police and family members. Although situated within the primary care centre, SARC areas were restricted so that only SARC staff could access them.

New facilities included a private area for patients to change and have their weight taken prior to the examination. Adjoining pre-examination rooms, bathroom facilities and examination room allowed confidentiality for the patient receiving treatment, and their privacy and dignity was protected by a screen used throughout the forensic medical examination. Patients were able to use bathroom and shower facilities alone although crisis workers and FNEs remained close by to keep patients safe from harm.

Patient records were stored within locked rooms accessible only by SARC staff to prevent unauthorised access to confidential information, and all patient areas were accessed via swipe card to protect patient privacy while at the SARC.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

Staff delivered care and treatment to their patients according to their individual needs. Crisis workers and FNEs worked in partnership to plan and coordinate the patient's care, and ensure that follow up support was in place for patients following their time at the SARC.

Patients who self referred to the SARC and did not wish to pursue a police investigation were able to have evidence stored at the SARC for two years in case they should wish to involve the police at a later stage. Work was also under way with police colleagues to offer drug testing for patients self-referring to the SARC who may have been spiked prior to assault.

The SARC provided access for people with restricted mobility with facilities across one level. Patients with a hearing or sight impairment were identified from the point of referral by the provider's call centre so that adaptations could be made to support the patient during their time at the SARC.

Taking account of particular needs and choices

The SARC had a good stock of clothing and toiletries available for patients attending the SARC. There were facilities for patients to have a drink and/or snack while at the SARC, and a family room for any visitors attending with the patient. There was a range of child appropriate toys should a child come to the SARC with an adult.

The provider aimed to offer all patients a choice in gender of the FNE providing their treatment, however there was no male FNE currently working for the service. Should a patient request a male nurse, this could be requested via the provider's call centre.

The SARC had a well established relationship with the Wolverhampton Alliance LGBTQ+ and plans were in place for members of the group to visit the SARC to offer their advice on how it may be made more accessible.

Patient feedback following the move to telephone assessments during the COVID-19 pandemic had indicated some patients felt more at ease speaking over the phone rather than face to face. This learning was taken into account by the team, and patients could now choose whether to attend in person for the pre-examination assessment, or whether they would prefer to complete this over the phone.

Timely access to services

Staff delivered the SARC service 24 hours a day, 365 days a year. Contact details and information about the SARC was clearly documented in the SARC patient leaflets and on the SARC website.

Referrals to the SARC were received by the provider's call centre and where a referral was made out of hours, the call centre notified the crisis worker and FNE on shift to attend. Patients were seen within the required 60 minute timescale from the point of referral to the call centre, and despite some staff shortages this target had been consistently met in recent months. Response times and performance targets were monitored by the team and registered manager, and were reviewed with commissioners during regular contract review meetings.

Listening and learning from concerns and complaints

A complaints policy was in place outlining the provider's procedure for investigating concerns and complaints and sharing lessons learned with the team. All complaints were logged on the Datix system and assigned to the appropriate manager to commence the investigation. Common themes from complaints were reviewed during team meetings to ensure that lessons learned were shared with staff.

Are services well-led?

Our findings

Leadership capacity and capability

Managers had the appropriate skills to run the SARC service. The team manager was an experienced crisis worker and the registered manager an experienced clinical forensic nurse examiner. Staff we spoke with told us they felt well supported by managers and were able to contact a manager or clinician for advice when needed. Staff also spoke highly of the peer support between nurses and crisis workers.

The provider had a clear management structure in place with both managerial and clinical supervision embedded for all staff. On-call support was available to staff from the 24 hour call centre, and the registered manager was also available to offer telephone support. The provider had a governance framework in place to support managers working within SARC services, and managers told us they felt supported by the organisation.

Vision and strategy

The SARC team had worked hard to relocate the service to a new premises in the last six months, and had undertaken significant service promotion work to ensure all stakeholders were aware of the changes. Work was ongoing to encourage police colleagues to use the facilities allocated for them, which included an ABE interview suite, shared kitchen and separate office space.

Managers told us that their vision for the service now that they had moved to a new premises was to increase the face to face training and development opportunities for staff, and to explore new ways of gathering patient feedback. A room was available for the provider within the primary care centre which would be ideal for hosting training sessions, and the team hoped to work on new ways of gaining more detailed and qualitative feedback from patients to continue improving the service.

Culture

Staff we spoke with demonstrated passion and commitment to ensuring patients receive the best experience possible when attending the SARC. Both peer and managerial support were highly regarded by staff we spoke to, and regular peer reviews and information sharing evidenced a learning culture. We observed an open culture where staff were able to speak with managers and access advice and support via various methods 24 hours a day.

The provider had a whistleblowing policy in place and staff were aware of how to raise concerns should they wish to.

Governance and management, including processes for managing risks, issues and performance

The provider had a robust clinical governance framework in place with policies, standard operating procedures and risk assessments for the delivery of the service. Senior clinical staff and the organisation's governance manager ensured that policies were regularly reviewed and updated, and staff were alerted to any changes in a timely manner.

Regular team meetings provided staff with an opportunity to come together and discuss any issues as well as share learning and best practice. These meetings fed into a national meeting for SARC managers, in which learning was shared across the organisation, and common themes around incidents and complaints were discussed.

Any incidents relating to the SARC were reported on the Ulysses system and were investigated locally by managers. Learning from incidents and complaints was also reviewed at national level within the organisation to ensure that lessons learned and best practice identified could be shared between services, and any themes identified.

The team and registered managers had good relationships with commissioners and engaged in regular contract monitoring meetings with NHSE/I. Overall there was good oversight of the SARC's performance.

Are services well-led?

Risks relating to the SARC service were reported on a local risk register, which was monitored and reviewed by the registered manager. The provider had an up to date business continuity plan, and we saw evidence of responsive and flexible working with adaptations made alongside police colleagues at the SARC during the COVID-19 pandemic.

Appropriate and accurate information

Information governance arrangements we observed during the inspection complied with the Data Protection Act 2018. Patient records were stored securely in line with patient's consent which was sought at the beginning of the assessment process and throughout the forensic medical examination. Patient areas and offices containing patient information were restricted to SARC staff only and accessed via a swipe card system. There had not been any information governance breaches, and the provider demonstrated compliance with the General Data Protection Regulation (GDPR) 2018.

Service outcomes were reported monthly into the Sexual Assault Referral Centre Indicators of Performance (SARCIP) tool which provided assurance to commissioners, and was used to monitor and improve outcomes for patients.

Engagement with patients, the public, staff and external partners

Patients were given the opportunity to share their feedback and suggestions with the SARC both during their time there, and during a welfare call with a member of staff the following day. Information was displayed in the SARC to explain how patients, visitors or other professionals could raise a concern, leave a compliment, or escalate a complaint.

Supervision and team meetings provided staff with the opportunity to share feedback regarding the service. Staff told us they felt supported and able to share their suggestions and ideas to improve the service. One staff member had shared details of a feedback system used at a different SARC which had been effective in getting more detailed feedback from patients. Managers had listened to this suggestion and were due to trial the new feedback system imminently.

The team had links with a number of local stakeholders, including a pathway to work alongside the student support services within Birmingham University where patient consent was agreed.

Continuous improvement and innovation

The provider promoted a culture of learning and continuous improvement through peer reviews, supervision, audits and staff training. Staff had access to a comprehensive induction and training package, and were encouraged to be innovative and share learning and best practice with peers to improve the patient experience.