Care and Custody (Health) Limited

Juniper Lodge, Leicestershire

Inspection report

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Date of inspection visit: 5th and 6th October 2021
Date of publication: 17/11/2021

Overall summary

Summary Findings

We carried out this announced inspection on 5 and 6 October 2021 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector and a second inspector and was supported by a specialist professional advisor.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Background

Juniper Lodge is a sexual assault referral centre (SARC), which is commissioned by NHS England and the Police and Crime Commissioner. The SARC service is available 24 hours a day, seven days a week, including public holidays, to provide advice to police and patients, deliver acute forensic examination, provide support following recent and non-recent sexual assault and sexual violence. It also offers referrals to Independent Sexual Violence Advisors (ISVA) and counselling to people over 18 in the Leicester, Leicestershire and Rutland areas.

Summary of findings

Leicestershire police commission the forensic medical examinations which are undertaken by Forensic Practitioners (FPs), who are nurses employed by Mitie Care and Custody (the provider). For the purpose of this inspection we inspected Mitie Care and Custody's provision of FPs to perform the forensic medical examinations. At the time of inspection there were three FPs providing forensic medical examinations.

The service is approached via a discreet side road. There was ample parking outside for patients. The building is on one level and accessible for wheelchair users. There were three forensic pods which included a forensic changing area, forensic toilet and shower and the forensic examination room. One of the pods was slightly larger with adaptations to accommodate wheelchair users. At the time of inspection only one pod was in use. The building also included tastefully decorated meeting/interview suites which created a pleasant environment for patients, a staff shower, toilet and changing rooms, staff kitchen, offices and storerooms. In addition, there were facilities for patients to appear in court via video link.

During the inspection we spoke with the registered manager, two FPs (one of which was the lead nurse), the contract manager, the SARC manager, the medical director for Mitie care and custody and two crisis support workers. We also looked at policies and procedures, reports and nine patient records to learn about how the service was managed.

We left comment cards at the location the week prior to our visit and received three feedback cards. We also spoke to commissioners of the service.

Mitie care and custody provide the forensic medical service and as a condition of registration must have a person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager at Juniper Lodge was the lead sexual assault nurse examiner (FP) for the provider.

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.
- The FPs had suitable safeguarding processes and knew their responsibilities for safeguarding adults and children.
- Case records evidenced a holistic approach to assessing patient's needs.
- There were effective working relationships with the co-located police colleagues.
- The provider had thorough staff recruitment procedures.
- FPs knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The FPs provided patients' care and treatment in line with current guidelines.
- FPs treated patients with dignity, respect and kindness and took care to protect their privacy and personal information.
- The service had effective leadership and we saw a culture of continuous improvement.
- FPs felt involved and supported and worked well as a team.
- Patient feedback was positive about the support they received from the FPs and there had been no complaints.
- The service had suitable information governance arrangements.
- The environment was clean and welcoming.
- The provider had infection control procedures which reflected published guidance and had adapted to Covid-19 guidance to ensure services remained available to patients throughout the pandemic.

There was one area where the provider should make improvements:

Summary of findings

- Patient leaflets should be readily available in other languages and easy read formats for patients with English as a second language and learning difficulties.

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

FPs understood how to protect adults, children and young people from abuse and the service worked well with other agencies to do so. FPs had training on how to recognise and report abuse, and they knew how to apply it.

FPs we spoke with were familiar with the provider's safeguarding policies for children and adults and how to access it. They were aware of the procedure to follow if they had safeguarding concerns. Safeguarding policies and procedures were clear, up to date and FPs we spoke with showed a comprehensive understanding of safeguarding issues.

We reviewed training records which showed all FPs had the appropriate level three children and adult safeguarding training which the lead nurse and contract manager monitored. Training was updated every three years which was in accordance with the intercollegiate national guidance.

The SARC accepted referrals from agencies and the police with the patient's consent and patients were able to self-refer. We saw evidence of clear referral criteria and evidence in patient's notes of onward referrals to other agencies, for example social services, GPs and the SARC inhouse mental health nurse.

We saw from a review of patient records; FPs clearly highlighted patient vulnerabilities as part of the referral and assessment process. This included risks, for example, mental health, domestic violence, learning difficulties and honour-based violence.

Patients who required additional support, for example patients with learning difficulties or alcohol dependency were flagged at initial referral to the FPs so the assessment process and examination could be adapted to meet the patient's needs. All referrals and assessments were over the phone due to Covid-19, we were given an example where a patient with English as a second language was seen face to face for their initial assessment using an interpreter on the telephone.

FPs were involved in multi-agency meetings where decisions were made in the patient's best interest. For example, a forensic medical examination was completed in an elderly patient's care home as they were immobile and unable to attend the SARC and FPs would be invited to strategy meetings where children were involved in the patient's life.

The FPs followed up all safeguarding referrals with the local authorities within two weeks, and we saw evidence of documented safeguarding outcomes in the patient records.

The lead FP met with the SARC manager on a weekly basis to discuss patients who had attended to ensure all safeguarding referrals had been followed up. This also captured any further safeguarding issues that may have been identified following patient follow up calls made by the crisis workers.

Staff

Staff completed mandatory training, which included a range of topics including basic life support, infection control and fire training. Staff received an email reminder when their training was due, and the contract manager and lead FP had an overview of staff training via an electronic system. This assured the service FPs fulfilled requirements for mandatory training.

Two of the three FPs had completed part one of the licentiateship of the Faculty of Forensic and Legal Medicine (FFLM) and the lead FP was currently completing level two and three.

The service had a staff recruitment policy and procedure to ensure employment of suitably qualified staff. Leicestershire police also vetted FPs as an additional check. The provider's human resources department automatically requested DBS checks every three years. This ensured FPs were subject to the appropriate ongoing checks.

Are services safe?

The provider had a comprehensive whistleblowing policy and FPs were aware of how and where to access this policy. FPs we spoke with told us they felt comfortable to raise concerns with management.

The provider had on call consultants that FPs could contact out of hours in case of an emergency such as self-harm or violent behaviour. Alarm buttons were installed in all non-forensic rooms and were tested weekly. The providers call centre was also available 24 hours, 365 days a year for FPs to seek advice. Additionally, FPs reported the medical director and contract manager were always available to answer concerns during the working day.

Risks to clients

The provider had good systems in place to assess, monitor and manage risks to patient safety.

We saw evidence from patient records that FPs assessed, monitored and managed risks to patients. During the initial referral FPs would complete a holistic assessment, including for example, the patient's mental health status, physical health and any substance misuse concerns. If the patient was acutely unwell the FP would advise the patient to attend, or be taken to, accident and emergency to be treated before attending the SARC.

FPs assessed patient's needs for post exposure prophylaxis after sexual exposure (PEPSE), emergency contraception, hepatitis B prophylaxis, antibiotics and referral for sexual health screening. This ensured the patient received a holistic assessment and continuing care when required.

FPs used an alcohol withdrawal scale and clinical opiate withdrawal scale when patients with drug and alcohol withdrawal symptoms were identified. However, there were clear pathways for FPs to follow if patients were too intoxicated to be able to consent to the examination.

We saw evidence of continuous risk assessments of patients throughout the patient journey. We also saw evidence of FPs identifying risks to patients and taking the appropriate action. For example, referring the patient to sexual health services or completing a Domestic Abuse, Stalking and Honour based Violence (DASH) assessment and referring onwards for a Multi-Agency Risk Assessment Conference (MARAC). Two FPs told us they were in the process of working with the local MARAC co-ordinator to implement more of a direct referral route.

FPs knew how to respond to an emergency and were up to date with their basic and immediate life support training. We saw emergency medicines and equipment were regularly checked to ensure equipment and medicines required in a resuscitation emergency were available.

The provider had reporting systems to capture incidents and errors that required investigation and any learning outcomes were shared with the FPs through team meetings. This demonstrated that if an incident occurred, the FPs and provider would take appropriate action.

The service had a business continuity plan describing how it would deal with events that could stop the service running. This included a mutual agreement with another local SARC to use their premises and the provider could use FPs from within the business to cover for sickness and annual leave.

Premises and equipment

The service controlled infection risk well. FPs used equipment and control measures to protect patients, themselves and others from infection. We saw FPs kept equipment and their work areas visibly clean.

Leicestershire police maintained the SARC building, including fire and safety checks. We saw evidence that all checks had been completed and all schedules were up to date.

We saw evidence the provider, along with the police commissioners, had risk assessed the SARC environment for Covid-19 safety precautions and had successfully managed risks from Covid-19 and enabled the service to stay open throughout the pandemic.

Are services safe?

We saw evidence FPs completed daily checklists including cleanliness, oxygen, emergency equipment and medicines checks. We saw fully completed checklists and if there were any gaps a reason had been given.

The provider completed a risk assessment of the SARC environment however, we noted neither the FPs nor the SARC manager had completed ligature risk assessments. We saw evidence in all the bathrooms of ligature risks and when we raised concerns during inspection, the FP and SARC manager immediately introduced a risk assessment and advised ligature cutters were on order and were able to provide us with risk mitigating actions.

FPs and SARC staff accessed all forensic suites and offices with swipe cards which reduced the risk of unauthorised access. Bathroom doors were fitted with anti-barricade doors which meant FPs could open the door from the outside.

The SARC team were responsible for the decontamination process of deep cleaning the forensic rooms. DNA elimination had been taken from all who accessed the forensic rooms and monthly environmental swabs showed 100% cleaning compliance. This assured the FPs of the forensic integrity of the forensic examination rooms.

FPs received medicines and equipment safety alerts by email or by messages left on a white board in their office. This ensured the FPs were aware of any medicines or equipment that required to be withdrawn from the service.

FPs used a state of the art colposcope (A colposcope is a piece of specialist equipment for making records of intimate images during examinations, including high quality photographs). We saw evidence forensic samples were managed in line with FFLM guidelines.

Leicestershire police ensured the colposcopes were serviced yearly. FPs received training in the use of the colposcopes from an external provider and were assessed by the lead FP until signed off as competent.

FPs and the SARC team disposed of clinical waste which was placed in an external locked bin and stored out of public view. Leicestershire police held the contract for waste disposal.

Information to deliver safe care and treatment

FPs completed patient records to a high standard and the assessment paperwork was in line with FFLM guidance. The records were accurate, complete, legible, contained completed body maps and were stored securely in locked metal filing cabinets. FPs were the only staff with access to the records which complied with data protection requirements.

Photo evidence from the colposcopes were stored securely. Each image was stored with a unique identifying number so as not to identify the patient.

FPs made appropriate and timely referrals to other agencies such as the sexual health clinic, GP and local authority social services, which was in line national guidance and each referral was appropriately followed up.

Safe and appropriate use of medicines

Medicines were stored in locked cupboards or fridges and keys could only be accessed by nurses. Keys were locked in a key safe and the combination was changed every three months. We reviewed the cupboards and noted they contained medicines that were within their expiry dates. FPs also monitored the room temperatures where all medicines were stored.

FPs stored vaccinations that were temperature sensitive in the fridge and forensic evidence in the freezer. FPs monitored fridge and freezer temperatures daily (when on site) to ensure the medicines remained safe. The fridge and freezer were fitted with an alarm to alert staff if the temperatures have gone over or under the optimal range. All FPs we spoke with knew what procedure to follow if the fridge and freezer alarmed.

FPs checked the emergency medicines boxes daily to ensure the medicines had not expired and when we checked we noted the emergency medicines were in date.

Are services safe?

The provider had a comprehensive medicines management policy for handling and administering medicines within the SARC. FPs we spoke with were confident in administrating medicines safely.

There was a range of Patient Group Directions (PGDs) in place (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). These were subject to regular organisational review and we saw evidence all FPs had signed the PGDs alongside the medical director and pharmacist.

Track record on safety

The provider used an electronic system to report incidents. FP clinical leads would be notified of an incident and record it on the system. All logged incidents were reviewed by clinical leads and any themes identified were shared within team meetings both by the providers and jointly with the co-located SARC team.

FPs were able to demonstrate they understood their responsibilities to report concerns and near misses.

Lessons learned and improvements

FPs told us themes from incidents were discussed at their monthly team meetings but would also be shared in the whole SARC team meetings. Incidents were also discussed through peer review of the notes and appraisals. FPs understood the importance of discussing incidents therefore reducing risk and supporting further learning.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The service provided care and treatment based on national guidance and best practice. The lead FP checked to make sure the other FPs followed guidance.

FPs assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance including the FFLM and National Institute for Clinical Excellence (NICE). We reviewed patient documentation which assured us FPs had recorded a comprehensive health assessment as part of the forensic examination including past and current medical histories.

The provider produced evidence-based policies and procedures to provide guidance for FPs and ensure risks to patients were identified and managed to improve patient safety. All FPs we spoke with had access to the policies and procedures through the electronic system.

We spoke with the clinical governance team who provided assurances around their reviewing processes of all policies to ensure they were accurate and reflected current guidance and legislation.

Due to the Covid-19 pandemic, FPs and the crisis support workers jointly assessed patients prior to the forensic medical examination over the telephone. FPs reported this worked well and were planning on introducing video calls so the patient could physically see the FP and crisis worker before they arrived at the SARC. The crisis worker told us patients had fed back they found the joint phone call useful to prepare them for the forensic medical examination as well as enabling them to stay at home for longer which helped with childcare etc.

The provider had developed clinical policies. These included for example, emergency contraception, HIV/Hepatitis B prophylaxis and antibiotics policy which when reviewed were up to date and in line with guidance. In one record we reviewed the hepatitis B policy had been followed which showed evidence the patient had been offered appropriate care.

Consent to care and treatment

FPs supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. FPs understood the relevant consent and decision-making requirement of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice.

We saw evidence all FPs had completed mental capacity act training. All FPs were able to describe what actions they would take if a patient lacked the capacity to consent.

All FPs were aware of the importance of gaining consent from patients before performing the forensic medical examination. We saw evidence from the notes and were told that consent was a continuous process with the patient being given the option to stop the forensic medical examination at any point.

We saw evidence in patient notes that FPs discussed all risks and treatment options with patients for example, PEPSE, hepatitis B vaccinations, emergency contraception and antibiotics, and patients left the SARC with written information.

Monitoring care and treatment

The clinical governance team completed a yearly audit programme which included for example, infection control, medicines management, safeguarding, and the environment. The SARC scored 100% in the audit and therefore no action plan was required. This assured the provider the FPs were providing a safe and effective service to patients.

Are services effective?

(for example, treatment is effective)

FPs completed peer to peer reviews on all patient records within a 72-hour period to ensure medical records were completed to a safe standard, and to improve the quality of care provided. We reviewed the peer reviews and found appropriate feedback had been left for the examining FP to act upon.

The providers clinical governance team performed a yearly audit on a sample of the FPs case notes and we saw evidence there were minimal improvements required. Additionally, the lead FP would complete a monthly record keeping audit and dip sample two records per FP – examples we saw received completion scores of above 90%. The providers target was 85%.

Following the record keeping audit, the lead FP recognised early evidence kits were not always utilised early in the assessment process (early evidence kits include urine collection and mouth swabs). The lead FP created a flow chart of when to use the early evidence kit and offered training to all agencies who may use them.

FPs would not routinely follow up patients however the crisis workers did. If there were any continuing health concerns the crisis workers would liaise with the FPs for advice and further onward referral options if required.

FPs would record the outcomes of patients attending for forensic medical examinations within the medical examination pack. This included procedures undertaken, treatment provided (including medication issued) and communication or referrals made to other agencies for ongoing support.

All patient records had additional space to record any conversations the FPs may have with external partner agencies for example the local authority, sexual health clinic or the patient. We saw evidence of contemporaneous record keeping.

Effective staffing

The provider made sure FPs were competent for their roles. All FPs had received an annual appraisal and attended supervision meetings to receive support and development.

We saw evidence FPs had the right experience, skills, knowledge and management support to deliver good quality care. FPs completed service specific training to ensure they understood what was expected.

New FPs undertook the providers comprehensive induction programme that prepared them for their role and ensured they were skilled and supported. For example, new FPs would shadow several examinations and undertake specific training related to forensic medical examinations such as colposcopy training, forensic swabs and statement writing. New FPs were observed in practice by the lead FP and finally the medical director before being signed off as competent practitioners.

We saw evidence FPs completed a training needs assessments every six months to ensure their training needs and requirements were met by the provider.

FPs attended peer case discussions bimonthly, where individual cases and any themes arising were discussed and learning shared. The case discussions followed the syllabus from the FFLM sexual offences examiners qualification. FPs also had access to safeguarding leads within the provider if they required specific safeguarding advice. Co-located SARC staff were also invited to the case discussions and therefore ensured learning was shared across the service.

Co-ordinating care and treatment

Referrals into the SARC were made from any professional or agency or by self-referral. The lead FP had liaised with GPs and the local accident and emergency department to raise the profile of the SARC. The lead FP had created flow charts with information on what action should be taken when a patient disclosed sexual assault, including forensic timescales, patient choice and referrals at night. FPs offered training sessions to new rotational doctors within accident and emergency as well as nursing staff and GPs.

Are services effective?

(for example, treatment is effective)

The lead FP and SARC manager had worked together to produce small laminated credit card sized cards for staff in prisons, GPs and accident and emergency departments as a reminder of questions to ask patients when they disclose sexual assault. The cards also included forensic timescales information and the phone numbers to call to refer patients to the SARC.

We saw evidence of excellent working relationships between the FPs and their co-located colleagues in the SARC. We saw evidence of regular joint monthly meetings with the SARC team, where any incidents, complaints/compliments, results of audits and themes were discussed and updates to the service were shared. The FPs and SARC team met every morning by video link to discuss any upcoming referrals, and activity and actions required from the day before.

The FPs had strong links with the local authorities which ensured safeguarding concerns and information was shared promptly and named social workers could be contacted where appropriate.

FPs and crisis workers offered all patients who attended the SARC an appointment with an ISVA. With patients consent all GPs were contacted with details of the patient's attendance at the SARC and referrals were made if appropriate to sexual health clinics, counselling services, the onsite mental health nurse, and substance misuse teams.

Are services caring?

Our findings

Kindness, respect and compassion

FPs treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients who used the service was very positive.

FPs allowed patients time to control the examination and took time to explain processes and next steps. Interviews with FPs and a review of records showed FPs were kind, respectful and compassionate as well as knowledgeable about the impact and trauma of sexual assault.

FPs and SARC staff jointly collected patient feedback and displayed it on a notice board in the waiting area. Patient feedback included how well cared for and safe they felt, how information was clearly explained, and how they felt supported by the FPs to make the right decisions. Patients commented on how clean and comfortable the rooms were and how relaxed the environment made them feel.

FPs were sensitive to the diverse needs of patients and we saw evidence in the patient's records, that the forensic medical examination was adapted to suit each individual, which allowed the patient to take control of the pace at which the examination was completed. At each step of the examination FPs took time to explain and ensure the patient fully understood the process.

Privacy and dignity

The SARC was situated off a side road with a discreet entrance and parking available directly outside for patients. The premises were large, on one level and could be accessed through three entrances, one main entrance and two further entrances. This helped with the patient flow and confidentiality.

FPs showed respect for patients' privacy allowing them to change behind a curtain and use the toilet and shower facilities alone. However, FPs and crisis workers remained close by to ensure the patients were safe from harm. Patients were given the option to wear a gown or keep items of clothing on during the examination depending on the nature of the assault.

All forensic rooms within the SARC were accessible with swipe cards and computers were password protected. FPs stored patient notes securely in a locked cabinet within their office which was accessed by FPs and the SARC manager only. This prevented any unauthorised access to patients notes.

Involving people in decisions about care and treatment

From our review of patient notes and speaking with FPs, we saw evidence patients were at the centre of their care and treatment. It was clear all patients were involved in decisions about each step of their care and treatment and saw the patients' voice recorded in their notes.

FPs had access to interpreters either by video or over the telephone to complete the initial assessment and would offer all patients whose first language was not English an interpreter. This ensured patients understood the treatment options available to them. We saw an example where a patient had refused an interpreter but acknowledged they had difficulties in reading English, the FP had clearly written in the patients notes and sexual health referral, that they needed an interpreter in attendance to help them to understand any written information.

The SARC website included information on what to expect when attending the SARC and feedback from patients we reviewed, described how well the FPs and SARC team had explained the process to patients upon attendance.

Are services caring?

FPs discharged patients from the SARC with information leaflets regarding medication or tests that had been taken. This ensured the patient left the clinic informed about the next steps. However, the SARC did not have leaflets readily available in different languages or easy read formats. FPs reported they were aware of the gap and were in the process of working with the SARC team to produce leaflets in alternative languages.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

The service managers planned and provided care in a way that met the needs of patients. Managers worked with agencies and local organisations to plan care. FPs followed up outcomes of patient referrals to identify and address any unmet needs.

The SARC accepted self-referrals and referrals from other agencies. Patients who self-referred and chose not to involve the police were able to have their evidence stored at the SARC for up to two years, should they wish to proceed with police involvement later.

FPs, crisis workers, a mental health nurse, police and ISVAs all worked within the one building. FPs were able to advise patients about access to onsite facilities, for example, their mobile phone information could be downloaded, ensuring the patient was never without their phone and access to a direct video stream to court so patients could give evidence from the SARC. Patients also had access to food, drink, bedding and clothing free of charge.

FPs offered patients a choice in gender of the FP and crisis worker. As all the staff were female, an agreement was in place with a local SARC for male or female patients to attend there if they preferred to have a male FP.

The SARC was on one level with step free access. One of the forensic pods had been designed and adapted for the use of wheelchair users and a hearing loop was installed for patients with hearing impairments. Patient feedback clearly demonstrated a high level of satisfaction regarding the environment.

FPs and the SARC staff visited the local prisons to perform forensic medical examinations. Previously prisoners were taken out from prison to visit the SARC, however feedback from the prison user group showed prisoners preferred to be seen in prison The FPs and SARC staff responded and had mobile colposcopes to enable a full forensic medical examination to take place within the prison environment. The FPs also provided regular updates and training for the prison governors.

The FPs would also use the mobile colposcope to visit patients in the intensive care unit in hospital who required a forensic medical examination, or patients who were unable to leave their home environment, for example a patient who may be immobile or who has a severe learning disability.

Timely access to services

The service's website and information leaflet displayed opening hours and contact numbers. FPs provided forensic medical examinations 24 hours a day 365 days a year and referrals could be made to the providers call centre. The call centre would liaise with the FPs to schedule appointments and the FPs worked closely with the SARC team to ensure patients were seen within a 90-minute referral window.

Response times from the point of referral to the start of the assessment were monitored by the provider's contract manager and police colleagues. We saw evidence the 90-minute target had been achieved for all patients seen in the SARC for the last four months. Commissioners of the FPs reported they were satisfied with performance data.

Listening and learning from concerns and complaints

The SARC followed the providers complaint policy however FPs reported there had been no complaints received. Although no complaints had been received, FPs reported and we saw evidence of in meeting minutes, that learning from complaints and incidents were a standing item on the team meeting agenda. This included regional and national learning from across the providers clinical sites.

Are services responsive to people's needs?

Staff used an electronic reporting system to log incidents and complaints to ensure a clear audit trail. This ensured trends could be identified for quality assurance purposes. Complaints would be flagged to the clinical lead who investigated, addressed and resolved the matter.

Are services well-led?

Our findings

Leadership capacity and capability

Leaders had the integrity, skills and ability to run the forensic examination service. They understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service and supported FPs to develop their skills and practice.

A clear management structure was in place to provide day to day supervision and support to FPs. A leadership team provided oversight of the FPs and were available to support with any issues requiring escalation. Leaders were visible and the FPs spoke positively about the support they received.

The lead FP was a registered nurse, and health visitor and had completed level one and two of the FFLM qualification with full completion due by December 2021. They were also near completion of the first part of a masters in sexual offence medicine. The lead FP was also in the process of applying to be a CQC registered manager for Juniper Lodge.

The lead FP was knowledgeable about the local area and led a team of two FPs who were also experienced in forensic medical examinations and were working towards their part one and two of the FFLM qualification.

FPs told us they felt very well supported by the clinical lead and contract managers. Both FPs we spoke with reported they felt confident to raise concerns with the co located SARC team and felt the two teams worked as one 'family' and not two separate organisations.

Vision and strategy

The provider had values including integrity, trust and believed their diversity made them stronger. They believed that their customer's business was also their business.

We observed the FPs to be passionate and committed to their roles and saw evidence they provided patients with good care.

The FPs and SARC team were working together to achieve accreditation from the forensic services regulator which was due for completion in 2023.

FPs were passionate about their work and had a clear vision to improve the care for patients who had suffered sexual assault. This included attending events at universities, PRIDE and planned to attend rugby events to promote awareness of the SARC and the roles of the FP.

Culture

FPs reported they felt respected, supported and valued. We saw they were focused on the needs of patients. The service promoted equality and diversity in daily work and provided opportunities for career development. We saw the service had an open culture where patients could raise concerns without fear.

The provider had a whistleblowing policy which the FPs were aware of. FPs told us they could make comments and suggestions, talk freely and felt supported to drive any improvements forward.

The FPs reported an open and honest culture and worked well together with the co-located SARC team. We saw a no blame approach to peer review of the notes and the lead FP addressed any concerns though open and honest feedback.

Staff from the co-located SARC team told us they felt very supported by the FPs and found them approachable. They reported the FPs shared learning and knowledge across the whole team which enhanced the team's knowledge.

Are services well-led?

We noted a staff recognition board in the staff kitchen which showed the FPs had been recognised and received the chief constable's award for outstanding work for their part in a successful prosecution case and were recognised for the good work they did in partnership with the military.

Governance and management

The provider had good clinical governance arrangements in place including policies, standard operating procedures and risk assessments relating to the delivery of forensic medical examinations by the FPs. Policies were regularly reviewed by the clinical governance team and policy or procedure updates were shared with the FPs.

A range of meetings supported the governance structure including the FPs monthly team meetings and the monthly clinical governance meetings. Incidents, complaints and discussion of trends or themes, such as local concerns around sex workers or trafficking took place at the meetings. This ensured outcomes were actioned and information was shared.

FPs flagged concerns or incidents relating to the SARC building or equipment to the SARC manager whose responsibility was to investigate, address and resolve the matter. FPs reported issues were resolved in a timely way.

The lead FP and contract manager attended quarterly contract meetings which were joint meetings between the provider and commissioners. We reviewed the minutes which showed effective monitoring and challenge regarding the performance of the FPs and the quality of the forensic medical examinations.

Risks to the FPs service were identified and recorded on the local health and custody risk register which was regularly updated and reviewed by the clinical leads and contract managers. An example on the risk register was the Covid-19 pandemic, staffing and potential breach of data security. The provider documented clearly how all 'live' risks could be mitigated. The local risk register informed the provider's overall risk register.

All staff we spoke with recognised only having three FPs on the rota was a risk, however we were assured the provider was being proactive with recruitment and FPs from other SARC's were available to provide cover for annual leave and sickness.

Appropriate and accurate information

Information governance arrangements complied with the Data Protection Act. Quality and operational information was gathered by the lead FP and contract manager and were used to ensure and improve outcomes for patients.

The lead FP reported service outcomes monthly into the Sexual Assault Referral Centres Indicators of Performance (SARCIPS) which provided assurance to commissioners and helped staff to make improvements to patient care. The outcomes fed into a report produced by the SARC manager which was shared with NHS, police commissioners, the ISVA team and the provider.

Patients consented for the FPs to securely store their records. This was part of their initial consent process. This demonstrated the providers compliance with the General Data Protection Regulation (GDPR) (2018). The service had not experienced any information breaches.

Engagement with clients, the public, staff and external partners

Patients were able to leave written or oral feedback and FPs offered patients a leaflet which detailed how to make a complaint if the situation arose.

Staff feedback was gathered through staff meetings, appraisals and peer reviews. FPs spoke highly about how well the service was managed.

The FPs, alongside the co-located SARC team, provided training for GPs, prison governors, new and established police officers, accident and emergency staff, military staff, and provided the crisis workers with clinical updates. The FPs and SARC had produced information leaflets for professionals to promote and raise awareness of the SARC as well as educate professionals about forensic timescales and any updated FFLM guidelines.

Are services well-led?

Although it was not part of the commissioned service, FPs were available to provide advice and guidance to patients and professionals who called for advice regarding non recent sexual assault.

Continuous improvement and innovation

The service had effective assurance processes to encourage continuous improvement using peer reviews, training sessions and audits. FPs talked positively of the opportunity for learning within their role. FPs wrote practice statements for court once a month which were peer reviewed. This helped to ensure FPs court statements were of a high quality.

The lead FP had identified a gap in patient information regarding non-fatal strangulation and developed a patient information leaflet with advice on what action to take and assessment tools for FPs to use during the examination. This had been shared across the provider.

The FPs joined other FPs across the provider network to have joint learning sessions. This was an opportunity for the FPs to share good practice and learning.

FPs had access to a comprehensive programme of learning and development opportunities through the provider. The registered manager and lead FP were developing a SARC update day for the whole of the provider. It will include learning from real life examples and external speakers to raise the profile of the FPs, SARCS and forensic medical examinations.