Mountain Healthcare Limited

Suffolk SARC – The Ferns

Inspection report

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Summary findings

We carried out this announced inspection on 15 March 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 who 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.

Are services safe?
We found that this service was providing safe care in accordance with the relevant regulations.
Are services effective?
We found that this service was providing effective care in accordance with the relevant regulations.
Are services caring?
We found that this service was providing caring services in accordance with the relevant regulations.
Are services responsive to people's needs?
We found that this service was providing responsive care in accordance with the relevant regulations.
Are services well-led?
We found that this service was providing well-led care in accordance with the relevant regulations.

Background

The Ferns is a sexual assault referral centre (SARC) commissioned by NHS England and the Suffolk Police and Crime Commissioner for patients of all ages. The SARC service is available 24 hours a day, seven 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) and children's independent sexual violence advisors (CHISVA) in the Suffolk area.

Mountain Healthcare Limited (MHL) are commissioned to deliver forensic medical examinations to men, women and children, which are undertaken by Forensic Nurse Examiners (FNE) and Forensic Medical Examiners (FME). For the purpose of this inspection we inspected Mountain Healthcare Limited's provision of Forensic Examiners to perform the forensic medical examinations for all ages within The Ferns SARC. At the time of inspection there were five FNEs providing forensic medical examinations and two FMEs.

Patients aged 13 and above can refer themselves via the 24hour advice line that is supported by Suffolk Police between the hours of 9-5 Monday to Friday and Mountain Healthcare (MHL) out of hours and weekends. Children under 13 are seen at the SARC Mondays and Thursdays, in conjunction with social care and police. Outside of these times the service made provision for children under 13 to be seen at alternative locations.

The SARC is located on the outskirts of Ipswich in an industrial estate with parking for police colleagues and patients outside. The building is in two units and on two levels. Patients can access the ground floor where there is a clinic room for adults in unit 10 and a clinic room for children in unit 11. There is a patient bathroom accessed via the adult clinic room and a family room with toys next to the children's clinic room. Each side has a small kitchen area and storage rooms. There is a lift, should anyone need to access the upper floor. There is also an ABE (achieving best evidence) suite which is used by the police for video interviews and court link.

During the inspection we spoke with the associate head of healthcare who is a FNE, a clinical director who is a FME and three FNEs. We looked at policies and procedures, reports about the service, and ten patient records to learn about how the service was managed.

Three of the medical examiners employed by MHL for this location are members of the Faculty of Forensic and Legal Medicine.

We left comment cards at the location the week prior to our visit and received one comment, stating staff made them feel comfortable, were kind and supported them through the process.

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

Our key findings were:

- The service had systems to help them manage risks presented to the service.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service had thorough staff recruitment procedures.

- Clinical staff knew how to deal with emergencies and had access to life-saving equipment.
- Clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment/referral system met patients' needs.
- The service had effective leadership and culture of continuous improvement.
- Staff felt involved, supported and worked well as a team.
- The service asked staff and patients for feedback about the services they provided.
- The service dealt with complaints positively and efficiently.
- The service had suitable information governance arrangements.
- The environment appeared clean and well maintained.
- The service 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.

Are services safe?

Our findings

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

There were embedded systems and practices that kept patients safe. The Forensic Examiners (FEs) 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.

FEs we spoke with were familiar with the provider's policies for safeguarding children and adults and could access these online when required. FEs we spoke with had a comprehensive understanding of safeguarding issues and staff had a manager they could immediately report to should they have any concerns. There was a safeguarding lead within the wider organisation.

FNEs and FMEs made safeguarding referrals directly to the local authority and followed these up appropriately. Staff attended meetings with the local authority and shared information regularly. The FEs made follow up calls to patients to ensure their needs were addressed.

We reviewed training records which evidenced the appropriate level three safeguarding adults and children training for all FEs. Training was monitored by the registered manager via an online portal and was updated every three years in line with intercollegiate national guidance.

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

FNE and FMEs were invited to multi-agency meetings for their patients and had developed good local relationships with agencies including the police, social services and sexual health.

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.

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

The FEs at the SARC received additional support from the associate head of healthcare who covered the East of England and MHL medical directors. At the time of inspection MHL were recruiting to a new position, a clinical co-ordinator, who would evaluate and assess service delivery, implement changes in practice and offer support to all MHL staff within the Suffolk SARC. This post would ensure there was a manager in position to cover day to day tasks.

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

The provider operated a 24 hour call centre for referrals, and lone working procedures were in place to support staff safety. There were alarms installed within the SARC for staff safety and these were checked regularly by police who were responsible for the premises.

Suffolk Constabulary were responsible for the maintenance and upkeep of the SARC building and carried out regular maintenance checks such as fire alarm testing, emergency lighting checks and health and safety risk assessments. Premises documentation was stored in the building foyer in a locked cabinet which MHL had access to so that they could assure themselves checks had been completed.

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 these risks and enabled the service to stay open throughout the pandemic.

We saw evidence MHL staff completed daily or weekly checklists including cleanliness, emergency equipment and medicines checks. All checklists were fully completed.

Infection control audits were carried out every six months in line with the providers audit schedule. The last audit took place in September 2021 and actions had been addressed. FNEs worked closely with the SARC manager and crisis workers to manage the risks.

Suffolk Constabulary were responsible for the SARC building and the SARC manager completed a risk assessment of the SARC environment, however not all fixed ligature points such as handrails, were identified on the document. MHL staff mitigated such risks by not leaving patients unattended within the SARC and locked bathrooms could be opened from the outside.

Both MHL and crisis workers for the SARC accessed all forensic suites and offices with swipe cards which reduced the risk of unauthorised access.

The police commissioned a cleaning team that were responsible for the decontamination process of deep cleaning the forensic rooms. MHL managers could request the deep cleaning audit from the SARC manager to ensure themselves that the cleaning had been done.

The FEs used a colposcope (a colposcope is a specialist piece of equipment for making records of intimate images during examinations, including high-quality photographs and video). We saw evidence forensic samples were managed in line with Faculty of Forensic and Legal Medicine (FFLM) guidance.

Suffolk police authority serviced the colposcopes yearly and informed MHL manager. All FEs received in house training on use of the colposcope and were assessed by their clinical mentor until signed off as competent.

FEs and the SARC team disposed of clinical waste appropriately. Suffolk police authority held the contract for waste disposal.

Risks to Patients

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

We saw evidence from patient records that FNEs and FMEs assessed, monitored and managed risks to patients. During the initial referral FEs 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 FE would advise the patient to attend or be taken to accident and emergency to be treated before attending the SARC.

FEs assessed patient injury, needs for post exposure prophylaxis after sexual exposure (PEPSE) and emergency contraception at the SARC, and made referrals for sexual health screening. This ensured the patient received a holistic assessment and continuing care.

Sexually transmitted infection testing was offered for children under 13 years. FMEs offered baseline and repeat testing after treatment, they worked with local acute services to support patients treatment.

FEs used the Glasgow modified alcohol withdrawal scale and clinical institute withdrawal scale when patients with drug and alcohol withdrawal symptoms were identified. There were clear pathways for FEs to follow if patients were too intoxicated to be able to consent to the examination.

The FEs continued to risk assess patients throughout the patient journey. We also saw evidence of FEs identifying risks to patients and taking the appropriate action. For example, referring the patient to sexual health services or completing a domestic abuse safeguarding referral. The FEs attended the Multi-Agency Risk Assessment Conference (MARAC), where they shared information of concern to other agencies and social services.

FEs 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 used a Positive or Adverse Incidents and Events Reporting System (PAIERS) 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. We saw where an incident had occurred, staff reported this appropriately on the incident system then apologised to the patient under the Duty of Candour.

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

Information to deliver safe care and treatment

We saw patient records completed by the FEs were to a high standard and the assessment paperwork was in line with FFLM guidance. FEs completed 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. The records were accurate, complete, legible and contained completed body maps.

All patient records were stored securely on the SARC premises in locked metal filing cabinets within the FEs room. Only MHL staff had access to the records which complied with data protection requirements. Photographic digital evidence was also stored securely alongside patient records. Each image was stored with a unique identification number so as not to identify the patient.

We noted from a review of the patients' notes, staff made appropriate and timely referrals to other agencies such as the sexual health clinic, GP and local authority social services. This was in line with national guidance and each referral was appropriately followed up.

MHL ensured that all policies and standard operating procedures were in line with the FFLM guidance. Managers ensured staff read and signed any new and updated versions.

Safe and appropriate use of medicines

Medicines were stored in locked electronic cupboards and could only be accessed by MHL clinicians. We reviewed the cupboards and noted they contained medicines that were within their expiry dates. FNEs also monitored the room temperatures where all medicines were stored.

The provider had a comprehensive medicines management policy for handling and administering medicines within the SARC. FEs 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 FNEs had signed the PGDs alongside the medical director and pharmacist.

Forensic evidence was stored elsewhere in the premises in a freezer which was maintained by the police and the temperature checked daily by police SARC staff.

Track record on safety and lessons learned

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

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

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

shared with SARC police colleagues and reviewed during partnership meetings where appropriate.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients attending the SARC were greeted by a SARC crisis worker and the FE who jointly assessed the patient to avoid duplication of questions. A matrix document was in place between Suffolk Constabulary and the provider to outline the responsibilities of each staff member due to the separate contracts for crisis workers and nurses.

FNEs assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance including the FFLM and National Institute for Health and Care Excellence (NICE). Patient records reviewed during the inspection evidenced that FEs completed a comprehensive health assessment including past and current medical histories as part of the forensic medical examination.

We saw staff included any strategy meeting discussions, referrals and captured any social care involvement in patient records. For children under 13 years, we saw where possible staff attended the strategy meeting before the examination took place, or on the same day. However, staff said this was not always possible, as meetings went ahead without SARC involvement. Lead FEs reported such incidents and were developing relationships to improve the meeting schedule.

The provider had a range of evidence-based policies to assist FEs in their work, these were accessible online and offered guidance to staff in identifying and managing risks to patients and improving patient safety. FEs we spoke with knew how to access MHL 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, HIV PEPSE and over the counter remedies such as paracetamol, records we reviewed showed that patients' needs were assessed in line with these policies.

Monitoring care and treatment

The provider had an audit programme including audits of health and safety, infection prevention and control, and safeguarding. The programme included the frequency of each audit, and managers documented the dates of completion. Recent audits included an environmental ligature risk assessment audit in February 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 for every child under 13 and on randomly selected files for adults. Feedback was shared with FEs during one to one sessions. We saw evidence that individual cases were taken to peer review staff forums to share learning and best practice, which FNEs felt was valuable.

FEs recorded the procedures undertaken, treatment provided (including any medication issued) and relevant outcomes, including onward referrals and liaison with other agencies such as the GP or sexual health services. FEs completed follow up calls with patients 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 FEs were competent to carry out their roles within the SARC. All FNEs received an annual appraisal. Regular management and clinical supervision had been implemented. Due to some current changes in the clinical lead structure, supervisions and line management meetings were being re-scheduled for the year.

Training records evidenced that FEs had the right experience, skills, knowledge and support to deliver good quality care. MHL had developed a training programme for all nurses with varying levels of experience to develop and refine their skills within the forensic nursing field. This in-house training module included how to use the colposcope, writing a witness statement for court and allowed staff to have direct observation and feedback. In addition, the online training system used by the provider issued notifications to staff when a course was overdue, or a new course became available.

Newly recruited FNEs 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. Regional managers were available during weekdays for support, and the provider's 24 hour call centre provided access to clinical or medical advice if required. New FEs competence was assessed through observation by a senior clinician prior to sign off for them to work independently.

Co-ordinating care and treatment

There was clear referral criteria online and in the service information leaflets at the SARC. MHL staff worked with Suffolk Constabulary to promote the SARC in the community, and 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 the FEs and their police colleagues in the building. Despite working to separate contracts, FNEs were seen as part of the SARC team and there was a close working relationship with the SARC manager including regular meetings to share information.

FEs attended strategy meetings with the local authority and made safeguarding referrals or liaised with existing social workers to ensure appropriate information was shared. The outcome of safeguarding referrals was followed up by FEs themselves and documented within patient records. Any outstanding outcomes were addressed on a weekly basis with phone calls to the local authority to gather further information.

All patients attending the SARC were offered a range of referrals, including to the Independent Sexual Violence Advisor (ISVA) service or Child Independent Sexual Advisor (CHISVA), counselling and social services. The FEs wrote directly to the GP (where patient consent was given) to advise of the patient's attendance at the SARC and any concerns to be followed up by the GP. If appropriate, a referral would also be offered to sexual health, substance misuse or mental health services where required.

Consent to care and treatment

FEs 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 FEs 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.

Proformas completed by FMEs included patient consent to sharing information and a signed declaration from the patient or responsible adult. The Gillick competence framework was used to assess capacity for young people where appropriate, and FEs recorded details of capacity assessments they completed with their patients. FEs we spoke with during the inspection clearly understood their responsibilities with regards to patient consent and the Mental Capacity Act 2005.

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

Are services caring?

Our findings

Kindness, respect and compassion

FEs 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 FEs, who showed great care and consideration for their patients and their family or carers. Staff told us that the assessment and examination were based around each patient's individual needs and adapted to suit their wishes.

Comment cards were available in the waiting area for patients or visitors to leave feedback and suggestions. Any comments received were logged by the provider and overall, patients left very positive feedback about staff and their experience.

Managers within MHL collated a log of qualitative feedback from patients. We saw the feedback overall was positive about staff and the examination process within the SARC. There was a whiteboard in the main waiting room where staff recorded any patients' comments for all to read. Examples of notes left on the board included how staff supported patients through the journey, and although they did not know what to expect they were grateful for staff's kindness and understanding.

Involving people in decisions about care and treatment

The police used a telephone and face to face interpretation service which was available for patients who did not speak English as a first language. 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 contained useful information for professionals, patients, and their carers or families on what to expect when attending the SARC. Information was also available in the post examination waiting areas and interview rooms, including in easy read formats, to support patients in making informed decisions. 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 building was situated in an industrial estate and consisted of two units. There was plenty of parking outside for patients and visitors and the discrete entrance gave some privacy to those attending. There was a separate entrance, waiting room and examination area for both adults and children. This meant that staff could treat two cases at one time privately.

Prior to the examination, patients over the age of 13 could change in the bathroom facilities which was off the examination room. The bathroom had two entrances so forensic standards could be met. Patients' 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 FEs remained close by to keep patients safe from harm.

There was not a shower available for children under the age of 13, however staff said they could arrange for the use of the adult shower if needed.

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 whilst at the SARC.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

FEs delivered care and treatment to their patients according to their individual needs. FEs worked in partnership with crisis workers to plan and coordinate the patients' care and ensured 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 2 years in case they should wish to involve the police at a later stage.

The SARC had access for wheelchair users and facilities were all on one level. Patients with a hearing or sight impairment were identified from the point of referral by the providers call centre

and adaptations could be made to support the patient during their time at the SARC, such as a sign language, language interpreter and access to a hearing loop system.

A forensic or holistic examination is carried out at the SARC by a Forensic Nurse Examiner (FNE) (for patients 13 years and over) and by a Forensic Medical Examiner (FME) (for patients under 13) alongside a crisis support Worker who is there to be an advocate for the patient and support them through the process.

Taking account of particular needs and choices

Staff at the SARC had a range of clothing and toiletries which they offered to patients. There were kitchen facilities maintained by the police, this meant patients could be offered a drink and/or snack while at the SARC. There was a family room on one side of the SARC which had a range of child appropriate toys. On the other side of the SARC there was a comfortable room with soft furnishings which was nicely decorated.

The provider aimed to offer all patients a choice in gender of the FE providing their treatment. Should a patient request a male examiner, MHL arranged for one to cover the SARC. There was now a new male FE who was about to start in the service.

Timely access to services

FEs provided the forensic medical examination 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. Patients aged 13 and above could refer themselves via the 24hour advice line that is supported by Suffolk Police, between 9am and 5pm, Monday to Friday and MHL out of hours and weekends. The call would be transferred to a crisis worker or if needed a nurse who gave advice on next steps and options available.

Children aged under 13 years were seen at the SARC at the dedicated clinics on Mondays and Thursdays. Children under 13 were seen in conjunction with social care and/or the police and were referred to the SARC using the locally agreed referral pathway. Outside of the clinic times, 24/7 telephone support and advice was available to professionals who required specialist knowledge from the FME or FNE. Staff also participated in strategy discussions for all children accessing the SARC.

Referrals to FEs were received by the provider's call centre who then notified the FNE on shift to attend the SARC. Patients were seen within the required 60-minute timescale from the point of referral to the call centre. This target had been consistently met in recent months. Response times and performance targets were monitored by area managers and were reviewed with police during regular contract review meetings.

Listening and learning from concerns and complaints

A complaints policy was in place outlining the procedure for the investigation process and sharing lessons learned. Complaints received either directly or via the SARC manager were recorded on the provider's PAIERS system. We saw one complaint had been raised around the poor attitude of staff in relation to the process of booking an examination, this had been investigated and managers shared with staff the booking process and guidance with social services involvement. The provider's governance framework indicated that themes identified from complaints would be discussed in the quality assurance board meetings.

Are services well-led?

(For example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership capacity and capability

The lead FNE had the appropriate skills to run the forensic examination service and was supported by the associate head of healthcare and area manager who clearly understood the local area, priorities and issues the service faced. A recent change in area managers had left some staff feeling unsure as who their line manager may be, but recent changes outlined the staffing structure which included FEs supervising staff. More frequent visits to the SARC were planned by managers as COVID-19 restrictions were lifted.

The provider had a clear management structure; new regional managers were in the process of embedding regular line management supervision for the lead FNE and a structure for the lead to supervise other FNEs. On-call support was available to FNEs from the 24 hour call centre, and the area manager was also available to offer telephone support. FNEs told us they felt incredibly supported and find the whole supervision and peer review processes a great source for development. Managers also reported to us that they felt supported by senior staff within the wider organisation. Staff reported there were good working relationships between them and police SARC colleagues.

Vision and strategy

All staff reported they put patients first and strive to offer the best care possible. The provider had worked alongside police colleagues to develop a responsibilities matrix which ensured the treatment journey for the patient was seamless and all staff were aware of their responsibilities.

Culture

FEs we spoke with were focused on ensuring patients received the best experience possible when they attended the SARC. Staff said they felt proud of the work they do and have opportunity to practice with high standards. There were opportunities for development with specialist training, regular peer reviews and information sharing evidenced a learning culture.

The provider had a whistleblowing policy in place and all 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 forensic medical examination service. Senior clinical staff within the organisation ensured that policies were regularly reviewed and updated, and staff were alerted to any changes in a timely manner.

Monthly quality assurance and team meetings were scheduled, this gave staff the opportunity to raise and discuss any issues as well as share learning and best practice. The monthly meetings

ran alongside the national quality assurance meetings 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 provider's PAIERS system by FEs to be investigated and addressed at a local level. Incidents and complaints were also reviewed at a regional and national level to identify themes and share learning.

The associate head of healthcare and contract manager attended regular contract monitoring meetings with police colleagues who commissioned the service. Managers prepared a performance report in advance of the meeting, and overall there was good oversight of the service's performance.

Risks relating to the forensic examination service were reported on a local risk register, which was overseen by the associate head of healthcare and area 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

Service outcomes were reported monthly by the police SARC manager into the Sexual Assault Referral Centre Indicators of Performance (SARCIP) too,l 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 while at the SARC and again during a follow up call with a nurse. 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 FEs with the opportunity to share feedback regarding the service. FEs we spoke with gave positive feedback about collaborative working with colleagues at the SARC. Staff said they had a good relationship with all staff within the SARC, which gave them opportunity to develop ways of working to improve the service.

Suffolk Constabulary and MHL FE's promoted the SARC within the community. We were told that FEs had delivered some training to local police and social services to help raise awareness of the SARC. Information leaflets were available at the SARC for other professionals or visitors to take away.

Continuous improvement and innovation

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