G4S Health Services (UK) Ltd

Horizon SARC Castle Vale

Inspection Report

Castle Vale Primary Care Centre
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Overall summary

We carried out this announced inspection on 11 & 12 June 2019 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 second CQC inspector and 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

The Horizon SARC Castle Vale is located in the Castle Vale area of Birmingham and provides services to adults aged 18 and over. Children aged 16 or 17 may be seen at the centre upon request.

The service is accessible 24 hours a day, 7 days a week but only opens on request. Staff are based at another Sexual Assault Referral Centre (SARC) and attend this location should a patient request to be seen here. The location is secure and only SARC staff can access it.

The service is delivered from within a primary care centre and the provider leases a part of the building. The building is accessible for patients with disabilities. The accommodation includes one forensic suite with an adjoining shower room and a separate waiting room.

The team includes a service manager, two full time forensic nurse examiners (FNEs) and four FNEs who have flexible contracts. There are 14 crisis workers, two of whom cover administrative duties in the office. The service manager is also a FNE and trained as a crisis worker and can provide cover if required. There are four Forensic Medical Examiners (FMEs) who provide cover should an FNE not be available or if particular skills and expertise are required.

The service is provided by G4S Health Services (UK) Limited and as a condition of registration they 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 regarding how the service is run. The service is commissioned by NHS England in the West Midlands.

Summary of findings

During the inspection we spoke with five staff members, and looked at policies, procedures and other records about how the service was managed. We reviewed care records for 26 patients who had accessed the SARC within the last 12 months. During the period between April 2018 – March 2019, 179 patients had accessed services at Horizon SARC Castle Vale. We were unable to speak with any patients during this inspection. 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:

- There were suitable safeguarding processes and staff understood their responsibilities for safeguarding their patients.
- The service had appropriate systems to help them manage risk.
- The service had thorough staff recruitment procedures.
- Systems were in place to support staff to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- Care and treatment was provided in line with current guidelines and staff asked for patients' consent.
- The service appeared visually clean and well maintained.
- Staff had access to a wide range of training and felt supported.
- Patients were treated with dignity and respect and their privacy and personal information were protected.
- Patients were seen quickly following their referral or an appointment was made for an appropriate time.
- There was a process in place for patients to complain about the service.
- The service had effective leadership and there was a positive culture which encouraged continuous improvement.
- There was a strong ethic of teamwork and openness.
- Patients and staff were asked for their feedback about the service.
- There were good clinical governance arrangements in place which supported staff to provide patients with a high quality service.

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

- Review all policies and procedures to ensure they are up to date.
- Implement an effective system for monitoring staff training.
- Ensure that the complaints process is accessible to all patients and contains relevant details about escalation of complaints.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

We asked the following question(s).

Are services safe?

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

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing 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.

Are services safe?

Our findings

Safety systems and processes

There were appropriate systems in place to safeguard patients from the risk of abuse. Staff had received the appropriate level of safeguarding training and our discussions with staff showed that they understood the signs of potential abuse. Staff also received separate training in safeguarding children, as the service saw 16 and 17 year olds. There were clear systems in place for the safeguarding of any children that used the service and there was a designated child safeguarding lead to oversee this.

The assessment of patients carried out by staff highlighted vulnerabilities such as existing safeguarding concerns, people with a learning disability or a mental health condition or patients who had been physically injured. Staff were also trained to recognise the signs of modern slavery and Female Genital Mutilation (FGM).

During the assessment of patients staff ensured that any required referrals to the local authority safeguarding team had been made. Staff were clear that they would always check that a referral had been made by a partner agency such as the police and if there was any doubt, they would make the referral themselves.

The provider had safeguarding policies and procedures in place which gave staff guidance in identifying, reporting and dealing with suspected abuse. Multiple local authority areas were covered by the SARC and the safeguarding pathways were displayed in the office for each local authority.

Staff

The provider had a whistle blowing policy in place which was displayed prominently in the staff office. This provided staff with information about how to raise a concern confidentially should they not wish to do so at a local level. However, it was clear that staff felt comfortable raising any concerns they had with the service manager.

There was a recruitment process in place which was managed centrally by the provider. New staff were subject to police and criminal records checks as well as obtaining satisfactory references from previous employers. The checks were renewed every three years.

Clinical staff were expected to maintain their professional registration through continuous professional development. Staff at the provider's head office checked that clinical staff registrations remained valid.

Risks to patients

The systems in place to assess, monitor and manage risks to patient safety were effective in assessing risks to patients. Crisis workers carried out an assessment with the patient as soon as they arrived at the SARC. This included checking their physical health, mental health and the risk of suicide or self-harm. There were clear processes to follow should there be a medical emergency or other concerns about a patient's wellbeing. Staff were never alone with a patient in the SARC as they would ensure that two members of staff were present before greeting the patient.

Should a patient be identified as being at risk of harm or if there were urgent health concerns, staff took swift action to ensure that they received the support or treatment required. There was also an assessment for post-exposure prophylaxis after sexual exposure, antibiotic and/or hepatitis B prophylaxis as well as the need for emergency contraception.

The provider had a health and safety policy which was up to date having been recently reviewed and this supported local management to manage potential risk. A monthly health and safety risk assessment of the building was carried out which ensured that avoidable risks to staff and patients were well managed. In addition, the service manager had carried out a suicide and self-harm audit which identified potential risks to patients and steps that should be taken to manage each type of risk.

Crisis workers had completed training in basic life support and knew how to respond to a medical emergency. Clinical staff were trained to intermediate level in life support. Emergency equipment and medicines were available and checked on a regular basis to ensure they were within their expiry date and in working order.

Premises and equipment

The equipment used for patient examinations was regularly checked and serviced annually to ensure it remained safe to use. There was a business continuity plan

Are services safe?

in place which was relevant to this location and described how services could continue to be provided during an adverse event, although it required review to ensure that the details remained up to date.

Forensic samples were managed in line with guidance from the Faculty of Forensic and Legal Medicine (FFLM). There were appropriate infection control procedures in place which were followed by staff. Crisis workers carried out forensic cleaning after each patient had left the premises. In addition, a quarterly deep clean of the forensic areas was carried out by an external contractor. A monthly infection control audit was carried out as well as a bacterial environmental check to ensure that the cleaning was of the required standard. Sharps bin audits and clinical waste audits were also carried out. Work was underway jointly with commissioners and the Police to develop DNA environmental checking.

The relevant staff were trained to use a colposcope (specialist equipment used for making records of intimate images during examinations, including high-quality photographs and video). Images were recorded onto compact discs and stored securely.

The provider did not own the premises and was not responsible for carrying out building safety checks such as fire alarm tests. However, staff checked that fire alarm tests and other safety checks were routinely carried out. Safety checks of the area of the building the SARC was located in were carried out by staff and any issues reported to the landlord for action.

The provider had appropriate policies and guidance in place relating to infection control and staff were provided with infection control training. The facilities were appropriately cleaned in order to comply with the guidance issued by the Faculty of Forensic and Legal Medicine (FFLM). Staff maintained the cleanliness of the forensic and general areas after each patient had been seen. There was an adequate supply of personal protective equipment and clinical waste was managed appropriately.

Information to deliver safe care and treatment

Staff told us that they had access to the information required to provide safe care and treatment to patients. Our review of patient records showed that staff gathered information from the attending police officer (where appropriate) and patient upon arrival at the SARC. All patients records sampled were legible, clear and easy to read as well as being fully completed. Care records were held securely and complied with data protection requirements.

There were robust procedures in place to assist staff in managing photo documentation, including intimate images resulting from the assessment. This was in line with guidance from the Faculty for Forensic and Legal Medicine (FFLM).

Any referrals staff made to other service providers were fully documented in the patient record. These demonstrated that referrals were made promptly. Staff made follow up phone calls to patients to check on their welfare and also to remind them and encourage them to attend any follow up appointments.

Safe and appropriate use of medicines

There were adequate systems in place for the safe management of medicines. Only a small amount of the required medicines were kept on site and there were systems in place to ensure that these were regularly checked. This ensured that medicines did not pass their expiry date but also that there was always a sufficient supply available. Medicines were kept in a lockable cabinet which was securely attached to a wall. The temperature of the area that medicines were stored in was checked on a regular basis and the records we saw confirmed that temperatures remained within an acceptable range. A small amount of medicines were stored in a fridge which was located in the staff office. There had been a two week period where the fridge temperature was not monitored due to staff using a faulty thermometer instead of the inbuilt thermometer in the fridge. This issue had been addressed prior to the inspection and staff instructed to use the inbuilt thermomter.

The Patient Group Directions (PGD) (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) in place were appropriate for the medicines to be supplied. However, not all nursing staff had signed to confirm they had read the PGDs at this location. They had, however, signed the same PGDs at another location operated by the provider. The service manager agreed to rectify this by asking all nursing staff to sign the PGDs at this location as well.

Are services safe?

Track record on safety and lessons learned and improvements

There was a robust system in place for staff to report adverse incidents that happened in the service. Incident forms were submitted by the relevant staff member and the service manager logged these on a central database. An appropriate person carried out an investigation if required and actions were assigned to ensure that improvements were made. Learning from incidents was shared with staff by email communication and also at staff meetings. There had been two incidents reported since October 2018 and these had been appropriately acted upon.

There was a provider-wide system for the dissemination of patient and medicines safety alerts and we saw an example of this system working in practice during the inspection. We also saw examples of the provider ensuring that staff learned from any incidents that happened at other locations.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients' needs were effectively assessed firstly by a crisis worker and then by a clinician when they arrived at the SARC. The care and treatment provided reflected the guidelines from the Faculty of Forensic and Legal Medicine (FFLM). The patient record template and supporting flowcharts provided a clinical pathway which ensured that patients' immediate healthcare needs were met. This included provision of emergency contraception and treatment of physical injuries. Referrals were made to the local genito-urinary medicine services should patients require HIV/Hepatitis B prophylaxis and antibiotics.

Staff told us about quality improvement initiatives such as regular peer review sessions which formed part of their approach to provide high quality care. These sessions were used as an opportunity for staff to constructively challenge colleagues and offer support and advice. The provider had a system to provide staff with relevant updates from agencies such as NICE and the FFLM.

Patients were provided with food and drink as needed. Water, tea, coffee and a limited range of food was available for patients if required. Should the need arise then staff would attempt to meet any specific dietary or cultural needs that patients had.

Patients were provided with appropriate advice about where to seek more help and support, such as local sexual health and counselling services. Staff provided leaflefts which signposted the various services that were available and made a follow up phone call to each patient to check on their wellbeing and encouraging them to attend any appointments that had been made for them.

Consent to care and treatment

Staff were provided with training in the Mental Capacity Act (2005) (MCA) and consent and understood the importance of getting and recording patients' consent to treatment. Staff we spoke with told us that patients were provided with information about their choices and what would happen during their examination. This enabled patients to give informed consent which they could choose to withdraw at any time. The patient records that we viewed during the inspection confirmed this.

The provider had policies regarding consent and the MCA. There were clear processes in place should staff doubt a patient's capacity to make an informed decision about their care and treatment. We saw examples within patient records where staff had carried out and appropriately recorded a mental capacity assessment.

Some patients attended the SARC with a relative or carer and, where appropriate, staff involved them in the decision making process. There was only a limited amount of space within the SARC so generally patients were asked to bring only one relative or carer with them. However, staff took account of patients' individual needs and accommodated these as far as possible. Staff received training in working with 16 and 17 year old patients during their induction which covered appropriate ways to gain consent. At the time of the inspection only clinicians and the service manager worked with 16 and 17 year old patients and there was a system in place to verify their competency to do so.

Monitoring care and treatment

Detailed information was recorded about patients' current physical and mental health needs as well as relevant information about their medical history. Staff were aware of any patients who had received services at the SARC before and were sensitive to their needs. The patient record forms that staff used followed a standard format which ensured that staff asked patients relevant questions to capture their past and current medical needs.

The provider had systems in place for the auditing of patients' records which ensured that clinical staff recorded the necessary information. An audit schedule was in place for staff to regularly peer review records completed by their colleagues and provide feedback where it was felt improvements could be made. The service manager monitored the results of the audits and staff told us they had found it to be a helpful development tool.

Within the patient record, staff were recording the outcome of their appointment at the SARC, such as whether any onward referrals had been made or partner agencies contacted. Staff made a follow up phone call to every patient that attended the SARC the following day to check on their welfare. This call also allowed staff to remind patients of the importance of attending any appointments that had been booked for them. The provider monitored patient outcomes and reported these to their commissioner on a regular basis.

Are services effective?

(for example, treatment is effective)

Effective staffing

New members of staff were given an induction which combined structured, classroom based learning with self-directed reading and e-learning modules. In addition, new staff were able to shadow more experienced colleagues who supported them during their probationary period. Clinical staff carried out their own continuing professional development and revalidation. There was an annual appraisal system in place and while not all staff had received their most recent appraisal, these were scheduled to take place shortly after the inspection.

The system that the provider used to monitor training compliance was not effective and this caused frustration to the staff and service manager. It did not accurately reflect all of the training that staff had undertaken and did not provide timely reminders to staff when a training course was due to be refreshed. A local training record was maintained by the service manager which showed that the majority of staff had received the training considered mandatory for their role. Further training was booked for the weeks following the inspection to address any remaining gaps.

Staff received important training which was tailored to their role, this covered areas such as safeguarding, infection control and basic/intermediate life support. Staff were able to access further training to develop their knowledge base, such as alcohol and substance misuse awareness training. Clinical staff received training in working with the victims of sexual offences, including carrying out a forensic examination, which met FFLM standards. This training ensured that staff were able to carry out forensic medical examinations as well as assessing and meeting any other needs patients may have.

The provider had policies relating to clinical and managerial supervision which were followed in practice. There were regular group clinical peer review sessions which staff told us they found to be helpful and supportive.

Staff could also access one to one clinical and managerial supervision. This was offered once per quarter as a minimum, but staff could request supervision whenever they felt they needed it. The service manager told us that often staff received informal supervision when they were in the office but that these conversations were not always recorded. Staff felt that they were part of a supportive team and that they could speak with the service manager if they needed to.

Co-ordinating care and treatment

There was effective working between staff at the SARC and also with the police. Patients could either self-refer or the police made referrals to the service. A crisis worker and forensic examiner would then arrange to meet the patient at the location along with a police officer (should it be a police referral). There was effective coordination between staff to ensure that the patient's journey through the service was as smooth as possible and allowed the patient to be in control of the process.

The service had good links with partner agencies such as local sexual health services, mental health teams and GP practices to ensure that patients received follow up care and treatment. Patient records demonstrated that staff explained what services were available to them and obtained their consent to make a referral. Staff also offered to make referrals to the local Independent Sexual Violence Adviser (ISVA) service and we saw that many patients accepted this service.

Within the SARC patients could access leaflets providing information and contact details of the various services available to them. This meant that, even if they did not accept a referral at the time of their attendance at the SARC, they could choose to make contact with various services at a later date. Staff had access to interpretation and translation services to support their communication with patients who did not speak English or who had other communication needs.

Are services caring?

Our findings

Kindness, respect and compassion

Staff were aware of the diverse nature of the population that they served and had undertaken work to engage with the different communities in the locality and better understand different cultures. The provider had access to translation and interpretation services so that they could communicate more effectively with all patients. Where patients requested to see a clinician of a specific gender, every effort was made to accommodate this, such as by booking an appointment time when an appropriate member of staff would be available.

We reviewed patient feedback forms that had been received recently and these were very positive. One patient indicated that staff had treated them in a respectful and dignified way. Patients could access the bathroom facilities after their examination and any treatment they required. Patients were offered a care bag which contained various toiletries which could be used at the SARC and also to take away.

Privacy and dignity

The facility was in a discreet location within a primary care centre and staff made efforts to ensure that patients were afforded privacy and respected their dignity. When staff had finished seeing a patient their records were securely stored and not left where other patients might see them. Patients did not have access to the office so could not view any confidential records kept in this area or on the computer.

Staff received training in information governance and there were clear systems in place to protect confidential patient information. Staff only disclosed information to other organisations that was necessary to allow the continuation of patients' care and treatment.

Involving people in decisions about care and treatment

Staff told us that patients were fully involved in decisions about their care and treatment, along with their relative or carer where appropriate. Patients, including 16 and 17 year olds, were involved in decisions about referrals to other services and staff provided information to inform patients' choices. Staff also discussed with patients about making a safeguarding referral where it was appropriate to do so, including when it was a 16 or 17 year old. Patient involvement in decision making was confirmed by staff entries into patients records.

Efforts were made by staff to communicate with patients in the most effective way. Interpretation services were available for patients who did not have English as a first language. Patients received written information about what to expect at the SARC upon arrival and also about what would happen next. The service's website also provided information which supported a patient's decision making about whether or not to contact the SARC service.

The staff we spoke with told us that they frequently checked that the patient was happy to continue throughout the process. Should there be any doubt about a patient's understanding of what was happening or the patient decided they no longer wished to continue, this decision was respected. Relatives of patients attending the SARC could also be referred for counselling should it be required. The patient records that we viewed demonstrated that appropriate and timely referrals were made in all cases.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service manager had recognised that there were difficult to reach groups within their community and had carried out targeted work to promote the SARC service. Staff were provided with training in Equality, Diversity and Human Rights and were committed to providing an equitable service to all members of their community.

Staff were passionate about the importance of providing patients with emotional support throughout their appointment at the SARC. Crisis workers were seen as being pivotal to the service as they were the main point of contact for patients. The records we viewed confirmed the support that had been offered to patients at the SARC as well as liaison with other professionals such as ISVAs and local authority social workers, to ensure that ongoing support was provided.

The SARC was accessible to patients with physical disabilities by way of a lift, otherwise access was by staircase. The bathroom was accessible for a wheelchair and there were suitable adaptations to meet the needs of patients. The crisis worker would remain outside the bathroom and keep in regular communication with the patient so they would be alerted to anything untoward that might happen.

Staff would arrange to meet the patient at an agreed place in the building and escort them to the SARC so that they did not have to ask for directions. Patients who could not attend the SARC for any reason could be seen at an alternative location such as a hospital or care home. A portable colposcope was available to use outside the service and staff knew how to access it.

Feedback was invited from patients and other professionals who had contact with the service. The feedback that we received from the one CQC comment card gathered in the two weeks prior to the inspection was positive. We also reviewed feedback that the provider had gathered from patients who had attended the SARC in the previous 12 months which indicated a high level of satisfaction with the service. The feedback from professionals was also very positive and individual members of staff had received praise for their responsive and caring approach.

The service manager had recognised that patient's may not always provide the most meaningful feedback immediately after the conclusion of their appointment. The provider was working on creating an online portal for patients to provide feedback at their own pace. It was hoped that this approach would encourage patients to think about any areas of the service that could be improved.

Timely access to services

Patients could access the service 24 hours a day, seven days a week and the service was available 365 days a year. When a referral was received, staff checked whether the patient was still within the timescale for a forensic examination and gathered other information about the nature of their needs. There was a target response time of 60 minutes from receipt of a referral which had been agreed with local commissioners. Data received prior to the inspection showed that the vast majority of patients were seen within this timescale.

Some patients requested to be seen at a specific time and an appointment was offered for them to attend at a later time or date to facilitate this. The service also saw patients who reported historic sexual abuse to provide support and referrals on to counselling services. The provider displayed information about accessing the service on their website and in their service leaflet.

Listening and learning from concerns and complaints

There was a complaints policy in place which gave information to staff about dealing with any complaints that patients may have. Staff attempted to resolve any issues with patients while they were still at the service. If this was not possible then patients could take a leaflet which detailed how to make a complaint. The complaints procedure was displayed by the entrance, however it was in very small print and was not immediately obvious when entering the SARC. This was rectified during the inspection.

There was a system in place for recording and managing complaints, but no complaints had been received in the 12 months prior to the inspection so we were unable to fully assess how complaints were investigated and responded to. The complaints process provided patients with information about how to escalate their complaint to more senior management within the provider organisation. However, it did not provide information about external agencies that a complaint can be escalated to. This was rectified during the inspection.

Are services well-led?

Our findings

Leadership capacity and capability

The service manager was also the registered manager for this location as well as being the regional SARC lead for the provider. They were also a forensic nurse examiner and a trained crisis worker. They attended relevant conferences and training events to further broaden their knowledge as well seeing patients which underlined their commitment to demonstrating good practice. They shared this knowledge with other practitioners so they could learn and staff provided positive feedback about their leadership.

The staff we spoke with felt that the service was well-led and that the service manager provided clear leadership. There was a team structure in place which enabled the service to continue functioning normally when the service manager was not on site.

The main challenge facing the service was relating to the suitability of their premises. This was in the process of being resolved with service commissioners with the provision of a new facility which would have two self-contained 'pods' each having forensic examination rooms. Staff were fully appraised of these developments and had been involved in the process.

Vision and strategy

The provider had a clear vision within their SARC services and this was shared locally. There was a committed and stable team of staff and the service manager ensured that messages from the senior management team were shared with staff at team meetings and through other communications. The strategy to develop and improve the service was centered around the upcoming move to a new building.

Culture

A recruitment process was ongoing to fill an important role which was soon to become vacant and the service manager had elicited the views of staff to support the recruitment process. This demonstrated that there was an inclusive culture among the staff team and this was encouraged by the service manager. The staff we spoke with felt involved and included in the development of the service and felt that their views were respected and listened to. During our inspection we saw that staff were comfortable and confident talking to each other and the service manager. Support mechanisms were in place for staff to talk through any challenging cases they had been involved with.

The provider had a policy relating to the Duty of Candour and whenever any incidents occurred consideration was given as to whether the patient needed to be informed. Staff were aware of their responsibility to report any adverse events and were encouraged to do so. The provider's whistle blowing policy was displayed in the staff office and also available to staff electronically.

The service commissioners also told us that they had an open and transparent relationship with the provider and local team. Any issues were discussed with commissioners either informally or during more formal contract review meetings.

Governance and management

During our inspection we identified some policies required updating and reviewing, such as the local business continuity plan. The provider had already identified this and was in the process of reviewing and updating all of their policies and procedures. Most of the policies and procedures that we reviewed had been updated in the months prior to the inspection. The local team had also set up a comprehensive series of flow charts for the processes that staff were expected to carry out in their role, such as medicines and infection control related tasks. These acted as a reminder to staff of all of the steps required to fully complete each process.

Clinical governance meetings took place regularly which involved service managers from other SARCs as well as representatives of the senior management team. This supported the clinical governance arrangements in place at this location as lessons learned and ideas for improvement were shared as well as findings from inspections. Managers also shared information and updates from conferences that they had attended.

The service manager had the overall responsibility for the management and clinical leadership of the service as well as the day to day operation. Staff knew the management arrangements and their roles and responsibilities. The service manager was available by telephone should they not be on site and there was always on-call support available to deal with any challenges.

Are services well-led?

The central system for managing and recording the training undertaken by staff was not effective, although work was underway to rectify this. As an interim measure, the service manager had developed their own local training matrix which identified the training that all staff had completed and what training needed to be refreshed. We were told that local monitoring of training would continue until the provider had rectified the issues with its central training system. This concern was recorded on the service risk register and was being closely monitored and training was discussed at clinical governance meetings.

Appropriate and accurate information

Staff maintained detailed and appropriate records about the patients that used the service and these were stored securely. Data about the performance of the service was shared with commissioners on a monthly basis as part of the contract monitoring arrangements. The findings of audits were shared with individual staff and at team meetings to ensure that there was a culture of continuous improvement.

The views of patients were important to the development of the service. Each patient was asked to provide feedback before they left the SARC and we saw that the comments received had been very positive and complimentary. The service manager and provider were developing an online feedback portal which they hoped would encourage patients to reflect after their appointment and provide more in depth feedback.

Engagement with clients, the public, staff and external partners

The service manager and staff had undertaken work with their police partners to encourage a greater understanding of SARC services and, in particular, the importance of the crisis worker role. There had also been an emphasis on placing patients' privacy and dignity at the forefront of the service. During the 'in-hours' period, police officers would leave the site whilst a patient was receiving their examination and return to collect them later. During the 'out of hours' period, police officers would remain on-site.

The service manager had oversight across four SARC services in their geographical area and had carried out engagement with key partners such as ISVA services and local authorities to encourage closer joint working. They had also sought to raise awareness of what a SARC service can provide by engaging with local universities and community centres.

Staff were encouraged to provide their feedback through their group and individual supervision sessions as well as during team meetings. The minutes of meetings that we reviewed evidenced that staff were able to fully contribute to the discussions. Staff were also encouraged to put forward ideas for the improvement and development of the service. For example, one member of staff had suggested and then implemented the 'Crisis Worker Voice' scheme which aimed to give crisis workers across all sites a greater say in how services were operated. This feedback could be provided anonymously if desired.

Continuous improvement and innovation

There were systems and processes in place for learning, continuous improvement and innovation. Staff had access to a comprehensive range of training and a peer review system which encouraged constructive feedback and continual improvement. There was programme of regular audits of various aspects of the service and, where any issues were noted, the focus was on learning and improving the service provided. For example, record audits were carried out to check that staff were completing records appropriately and the findings shared with the individual staff member. Other audits carried out included medicines storage temperature checks, health and safety and infection control audits.

There was a robust system in place for staff to receive an annual performance appraisal, which sat alongside the regular supervision meetings. This encouraged staff to set objectives for the year ahead and set tasks for their development. Staff told us that they could request additional training on top of the mandatory that they all had to complete. This demonstrated that the provider was committed to developing their staff and improving the skill and knowledge base in order to improve the service that patients received.

The provider had acted upon concerns raised during a recent inspection of a different registered location and we saw that those concerns had also been addressed at this location.