

University Hospitals Bristol NHS Foundation Trust Central Health Clinic

Inspection Report

Tower Hill
Bristol
BS2 0JD
Tel: 0117 342 6999
Website: www.thebridgecanhelp.org.uk

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Overall summary

We carried out this announced inspection on 5 & 6 November 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 health & justice inspector who was supported by a second health & justice 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 Bridge SARC is in Bristol and provides services to children, young people and adults. NHS England commission University Hospitals Bristol NHS Foundation Trust (UHB NHSFT) to deliver the paediatric pathway supporting children and young people up to the age of 18

years. A different provider was commissioned to deliver forensic medical examinations to over 18s. This inspection was of the paediatric pathway only delivered by UHB NHSFT.

The Bridge SARC provides services for children and young adults up to the age of 18 across a large geographical area. The SARC accepts referrals for children and young adults requiring a medical examination from the counties of Wiltshire, Gloucestershire, Avon & Somerset and Swindon.

The SARC is situated within the Central Health Clinic in the centre of Bristol with sexual health services delivered on the ground floor, and the SARC on the second floor. Access to the SARC is via a lift with secure entry to both the building and SARC on the second floor. The SARC offices are open between 9am and 6pm Monday to Friday, and between 10am and 4pm at weekends. Paediatric examinations may be carried out within these hours during the week, and between 12 noon and 4pm at weekends. A 24 hour telephone advice line is available for professionals 365 days a year.

The SARC facilities include two forensic medical examination suites with pre-examination, examination and bathroom facilities adjoining each other, and separate aftercare rooms. One suite is set up for adult patients and the second for children and young people. The provider has access to a loft space where forensic samples are stored, as well as a staff kitchen, staff shower and bathroom facilities and a disabled toilet. Staff work

Summary of findings

within a small office area and have access to a large meeting room which can be booked as required. Plans were in development to utilise a disused room on the same floor of the building as a shared staff comfort area.

The SARC team is led by a service manager and the paediatric pathway overseen and delivered by a consultant paediatrician. Three bank clinical sexual offence examiners are utilised to cover the rota with two substantive paediatricians due to join the team in January 2020. The provider's staffing structure includes five full time equivalent crisis worker posts, of which one is currently vacant. Recruitment has taken place and the role is due to be offered imminently. 10 crisis workers from the trust bank cover out of hours provision on zero hour contracts.

During the inspection we spoke with three managers and four crisis workers. Throughout this report we have used the term children and young people to describe people who use the service to reflect our inspection of the paediatric patient service.

We looked at policies and procedures and other records about how the service is managed, and sampled care records for 15 children and young people.

Our key findings were:

- The provider had systems to help them manage risk.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.

- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The clinical staff provided children and young people's care and treatment in line with current guidelines.
- Staff treated children and young people with dignity and respect and took care to protect their privacy and personal information.
- The appointment/referral system met children and young people's needs.
- The service had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The provider asked staff and children/young people for feedback about the services they provided.
- Staff followed appropriate information governance procedures.
- The provider maintained a clean and welcoming environment for children, young people and visitors.
- Infection control procedures reflected published guidance.

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

- Implement a formal audit programme to align with the trust audit calendar and support the service's culture of learning and development.

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 care 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 well-led safe care in accordance with the relevant regulations.

Are services safe?

Our findings

Safety systems and processes

The provider had clear systems to keep children and young people safe and safeguarded from abuse. Staff we spoke with were able to explain their responsibilities if they had concerns about the safety of children, young people and adults. All children and young people seen in the SARC were referred to local authority children's services, and SARC staff engaged in strategy planning meetings at the point of referral for all children and young adults they supported.

Safeguarding pathways had been developed between the trust and the three local authorities covered by the SARC; all safeguarding referrals were sent to the trust safeguarding team who forwarded these to the relevant authority ensuring they were actioned in a timely manner. The provider had safeguarding policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. All staff had received level 3 safeguarding training in line with the Intercollegiate guidance.

Children and young adult's care records were held separately from adult patient records within the SARC. Risk factors such as mental health issues, learning disability, and communication support needs were identified at the beginning of the care records, and a checklist was completed by crisis workers for each file to highlight the file contents and any gaps or immediate concerns.

Staff

The provider had a staff recruitment policy and procedure to ensure suitable staff were employed and trust whistleblowing procedures were in place. Professional registration checks were carried out by the consultant paediatrician, and bank staff used from within the trust were able to access all training relevant to the SARC services.

Staff were well supported by managers and received monthly managerial and clinical supervision. Additional monthly peer review sessions took place which out of hours and bank staff were invited to attend. Attendance was monitored by managers to ensure that all staff attended a minimum of three sessions per annum. The peer review sessions included an hour of education; Recent

examples of the education sessions included a presentation from a local HIV service, and a session on the use of anti-ligature equipment. These sessions all contributed to staff's continuing professional development (CPD).

A managers on call rota was in operation across the trust to ensure that staff were able to seek assistance in case of an emergency, or should they require advice out of hours.

Risks to patients

The provider had systems to assess, monitor and manage risks to patient safety. At the point of referral to the SARC immediate risks to the child or young person were identified during the initial strategy planning meeting, which SARC staff were involved in. All children and young people received a comprehensive risk assessment on arrival at the SARC; this included monitoring children and young people for signs of deteriorating health, mental health concerns, medical emergencies and learning disabilities however the risk assessment did not include prompts for practitioners to consider Female Genital Mutilation (FGM).

Staff identified children and young people at immediate risk of harm and took appropriate action to safeguard them. This included a comprehensive assessment for post-exposure prophylaxis after sexual exposure, antibiotic and/or hepatitis B prophylaxis, the need for emergency contraception and any physical injuries which required urgent treatment.

Staff we spoke with knew how to respond to a medical emergency and mandatory training records demonstrated basic life support and first aid courses had been completed by all staff. Emergency equipment and oxygen were available on the ground floor of the building which were maintained by the trust's sexual health service.

Managers had recently carried out a ligature point audit and found that there were a number of possible ligature points within the SARC such as coat hooks in toilets. A number of tasks had been escalated to the trust works department to remove these risks, however the work was still outstanding at the time of our inspection. Managers assured us that the work to remove these potential ligature points would be completed by 2 January 2020. Staff told us that a child or young person would never be left on their

Are services safe?

own whilst attending the SARC, with the exception of when they use the bathroom facilities. Staff had the ability to open locked bathroom doors if they needed to enter, and carried anti-ligature equipment on them at all times.

A high risk area had been identified within the building where a fire exit led to an open steep stair case which was accessible and could be dangerous for a child or young person. Staff told us that if a child had not been seen for more than five minutes, they would follow a new local operating procedure for 'Management of the missing person' to locate the child or young person and ensure their welfare. Staff we spoke with were clear of the process to follow to reduce this risk.

Premises and equipment

Building management arrangements were overseen by a central team within the trust. SARC managers completed annual premises risk assessments which were forwarded to a trust health & safety lead to action, and a system was available to report new concerns. The trust held health & safety policies and business continuity plans to manage events disrupting the running of the SARC.

All health equipment was safe and appropriate. Equipment was checked regularly and serviced as required. Colposcopes (a low-power microscope mounted on a stand, used to look at the cervix under magnification, with the ability to record the images) were used in the forensic suites and clinicians were trained to use these.

Waste management arrangements were satisfactory and organised centrally by the trust. Forensic samples were handed to police following a medical examination, and self-referral specimens were stored in a loft area. Whilst these specimens were stored and checks in place to monitor the freezer temperatures, these were carried out by visiting staff from the adult service and were not always carried out daily. This was highlighted to SARC staff who decided to take responsibility for ensuring these checks were completed and a system was implemented during our inspection to start this.

Staff followed appropriate infection control procedures and crisis workers completed forensic cleaning of clinical areas. Cleaning logs were held outside clinical rooms and were up to date with staff signatures and room tag details. An external company were contracted to carry out a monthly audit of the cleaning, and a deep cleaning schedule was also in place to maintain standards. Cleaning

equipment was stored securely and appropriately with relevant COSHH documentation. The forensic medical examination suite we viewed during the inspection met infection control standards.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. We talked to staff about how information was recorded and handled and reviewed a sample of patient records to confirm our findings. Care records we reviewed were detailed and legible and were stored securely in locked cabinets in a controlled access area. The records we reviewed in relation to safeguarding children and information sharing with local authorities was of a very high quality.

Photo documentation and intimate images were managed in line with guidance from the Faculty for Forensic and Legal Medicine (FFLM).

Referrals to other agencies were documented within care records and those we reviewed were made in a timely manner. Whilst the provider was not commissioned to follow up referrals, crisis workers sought confirmation of referrals being received from other agencies, and safeguarding referrals were managed and followed up by the trust's central safeguarding team.

Safe and appropriate use of medicines

The provider had reliable systems for appropriate and safe handling of medicines.

There was a suitable stock control system of medicines which were held on site with comprehensive record keeping to ensure that medicines did not pass their expiry date and enough medicines were available if required. Medicines were stored securely in lockable cabinets in a controlled access area. Fridge temperatures were monitored and recorded daily.

The provider had an appropriate range of patient group directions (PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) which were available if required. Clinical staff were trained and aware of their responsibilities in the use of PGD's.

Track record on safety

Are services safe?

The trust recorded all incidents on the electronic Datix system. Staff we spoke with were aware of their responsibilities and had access to report incidents as required. Managers could access full details of incidents and were alerted to any new incidents when they were reported. The SARC risk register was also recorded on Datix which included some risks arising from incidents reported, such as gaps in medical examiner provision due to staffing shortages and recruitment difficulties.

Since October 2018 when the provider took over responsibility for the paediatric pathway, 27 incidents had been reported regarding the paediatric service. The majority of these incidents were reported as gaps in the rota. Despite this, all children and young people referred to the service had been seen within the commissioned timescales. Several information governance and partnership working incidents had also been reported. Incidents were investigated by the SARC manager and consultant paediatrician, and each incident included a review of the lessons learned which were documented on

the investigation report. Managers had met with referring police and local authorities in order to build and strengthen partnership working and raise awareness of the SARC remit and referral processes.

Lessons learned and improvements

Themes arising from incidents reported were captured on Datix, and these were shared with SARC team members during team meetings. A serious incident framework was in place to report on and learn from such incidents; however there had been no serious incidents reported since the provider took over the paediatric pathway in October 2018.

SARC managers worked together to investigate incidents, and actions taken to improve safety were clearly highlighted within investigations. For example, a recording error had been identified and reported. When reviewed, managers were able to identify how the error had occurred and shared information with SARC staff on how to ensure the same mistake was not made again.

Safety alerts, including external safety, patient and medicine safety alerts were shared with staff electronically and through team meetings.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Clinicians assessed children and young people's needs and delivered care and treatment in line with guidelines from the Faculty for Forensic and Legal Medicine. Local operating procedures had been developed by the SARC manager and consultant paediatrician which provided clear pathways for staff to follow to ensure that treatment was delivered consistently and effectively. The provider's policies included plans for immediate healthcare interventions and contraception where clinically indicated, and referrals were made promptly to local sexual health services if appropriate.

The provider had systems in place to keep staff up to date with current evidence-based practice. Staff were invited to attend monthly peer review sessions which included an hour of educational information. This included information shared from training or networking events, and feedback from sector conferences which staff had attended. All staff including night workers and bank staff had the opportunity to attend these sessions. Staff were encouraged to attend relevant trust and sector events to continue their professional development. All crisis workers had the opportunity to spend time with the community paediatrician's team at the local children's hospital as part of their continuing professional development.

Staff we spoke with during the inspection had completed mandatory e-learning and demonstrated a good knowledge of the Mental Health Act (MHA) code of practice. A policy was in place to support children and young people subject to the MHA if required, and a pathway was established with the local children's hospital for children and young people with urgent mental health needs to be seen on the same day, regardless of their home address.

Staff shared information with children and young people and their responsible adults on where to seek further help and support should they require it after leaving the SARC. Information was available in an easy read format or different languages, and a 'young person's passport' was in development which would provide children and young people with age appropriate information about the SARC, how they may feel and what may help them at that time.

Consent to care and treatment

Staff sought children and young people's consent to care and treatment in line with the Mental Capacity Act 2005 and the Gillick competence for children under the age of 16. Staff we spoke with told us that treatment options and the associated benefits or risks were explained to children and young people prior to the examination, and consent was reviewed with the child or young person throughout the medical examination. This was corroborated in the records we reviewed during the inspection.

The SARC facilities meant that children and young people's relatives, parents or carers, and other professionals could be in attendance with them if the child or young adult wished them to be. The provider invited feedback from children and young people and those attending with them on how the service they had received could be improved. A number of compliments had been received and staff recorded these on the electronic data system Datix.

Monitoring care and treatment

Medical staff completed comprehensive forensic medical examination records, including details about any historic or current physical and mental health needs, and onward support required following the examination. Assessment and aftercare proformas from the Faculty of Forensic and Legal Medicine (FFLM) were used to ensure that children's needs were assessed in line with the FFLM guidelines. Some gaps had been highlighted by staff through using the proformas, for example the absence of reference to Female Genital Mutilation (FGM). The proformas were under review at the time of the inspection.

All care records were peer reviewed by a clinician within three working days to monitor the quality of care and ensure appropriate treatment had been given. Feedback from record audits was shared with staff during team meetings or taken to peer review sessions for discussion.

Children and young people's care and treatment, and their outcomes were monitored by managers within the SARC, and the data was submitted to commissioners on a quarterly basis through a performance report. Commissioners were well engaged with the provider and were working with the team to consider how an increase in demand could be managed within the location.

Are services effective?

(for example, treatment is effective)

Outcomes information was shared regionally to improve children and young people's care, and SARC managers engaged with colleagues in nearby locations to share experiences and learning to improve the quality of service delivery on a monthly basis.

Effective staffing

Staff who were new to the SARC received a structured induction programme including a range of mandatory training courses to be completed. All staff received an annual appraisal; during our inspection some staff appraisals were not due yet, but were scheduled to take place within their first 12 months of employment with the provider. Clinical staff held their own records of continuing professional development and revalidation; registration details were held by the provider's human resources department and were also monitored locally by the consultant paediatrician.

Staff qualifications and skills for the roles they were employed in were included within the recruitment process, and monitored through monthly managerial supervision sessions. Appropriate training was offered by the provider to ensure the holistic needs of children were met, and the consultant paediatrician was trained to undertake forensic medical examinations. Local paediatricians could be called to the SARC to cover staff shortages, and would be supported in line with FFLM guidelines for children's examinations.

Staff completed online mandatory training courses and attended face to face courses for life support and safeguarding. Mandatory training levels were monitored by managers and submitted to divisional trust managers to ensure compliance did not fall below an adequate level. In September 2019 the mandatory training completion rate for SARC staff was 72%. We spoke with staff and reviewed both individual training and supervision records, and we were assured that training had been completed and was effectively monitored through supervision, however due to a time lag in the provider's training system reports, it was difficult to see current compliance rates. We found that some staff had not received their update for child or adult resuscitation training; however dates had been scheduled and staff were booked to attend these courses imminently. Managers were alerted to any outstanding training for the team at the SARC through the provider's online training hub, and as a result all lapsed courses had been scheduled.

Monthly clinical group supervision sessions were led by an external clinician who had previously worked at the SARC, and staff spoke positively of the support they received in this forum. Staff also recognised the value of one to one supervision, telling us they felt very well supported and received monthly individual supervision with their manager to support them in their role.

Co-ordinating care and treatment

The team at the SARC had worked hard to develop working relationships and pathways with other providers. This was a particular challenge for the team given that the SARC was a regional centre covering four counties and their relevant local authorities. A log had been developed by the consultant paediatrician detailing all relevant services in each area to which the team may need to refer children, or make contact with, following their attendance at the SARC.

All children who were seen at the SARC were then referred to the relevant local safeguarding team, and crisis workers contacted named social workers if these were known to them. Referrals we reviewed during the inspection were of a very high standard with comprehensive and detailed information.

All children and young people were offered a referral to see a children and young people's sexual violence advisor (CYPSVA), and young people were offered a referral to either the children and young people's or adult Independent Sexual Violence Advisor (ISVA) service. Referrals were made within 24 hours and the services acknowledged referrals from the SARC within 24 hours. A gap had been identified in the follow up of children and young people following their time at the SARC. The provider and commissioner were aware of the gap and an action plan was in place to introduce follow up calls, however this was yet to be embedded.

Crisis workers completed referrals as required at the point of engagement with the SARC, including sexual health, mental health, counselling and community paediatrician services. The provider was not commissioned to coordinate the care and services for children and young people following their attendance at the SARC, and we were told that the sexual violence advisor services took on this role.

Are services effective?

(for example, treatment is effective)

The SARC operated a 24 hour, 365 days telephone advice line for professionals. Staff we spoke with during the inspection told us that this line had been well utilised and they had supported police and other professionals in managing sensitive cases with children and young people.

Are services caring?

Our findings

Kindness, respect and compassion

Interactions we observed during the inspection were caring and compassionate, and the five comment cards we reviewed from those attending the SARC in the two weeks prior to our inspection indicated that children and young people and their families felt they had been treated with respect and compassion during their time at the SARC. Comments we reviewed said that staff were very considerate and made them feel comfortable, staff were very respectful, and that they did not feel judged.'

Staff we spoke with during the inspection demonstrated respect for diversity and human rights, however the majority of referrals into the paediatric pathway were children and young people of a white British background. The provider was due to carry out an equality assessment of the service, and a black and ethnic minorities (BAME) lead role had been introduced within the team. A male crisis worker had recently been recruited which would enable any male children and young people attending the SARC to have the choice of a male crisis worker. Children and young people were offered a choice of gender for their medical examination, however we found that this was not routinely documented within care records.

Information for children and young people, their relatives or carers and professionals was available in aftercare rooms within the SARC. This included information in a child friendly format, as well as a number of age appropriate toys and distractions for children such as lava lamps, low lighting and artificial fish tanks.

Privacy and dignity

The service respected and promoted children and young people's privacy and dignity; a forensic examination suite including a pre-examination, clinical and aftercare room had been designed for the paediatric pathway and included space for parents or carers, as well as appropriate bathroom facilities adapted for smaller children. The layout

of the suite with adjoining rooms meant that children and young people's confidentiality could be protected, and the entrance to the SARC was discreet within a sexual health services building.

Children and young people's records were stored securely in locked cabinets close to the forensic suite, meaning that records were not moved around a large area and were not left out for other patients to see. Staff offices were separate to allow for confidentiality when making phone calls regarding children and young people, and staff we spoke with understood the importance of protecting children's information from unauthorised individuals or organisations. Electronic recording systems were password protected and computer systems were locked when not in use.

Involving people in decisions about care and treatment

Information was available for both children and young people, families and visiting professionals in the appropriate formats and was available in foreign languages. Easy read materials were available if required, and interpretation services were also available but were not regularly required.

Children and young people were provided with information to make informed choices; age appropriate pictures were used in leaflets to help children understand treatment. Feedback we received from children and their families during the inspection reflected this; comments we received said that people felt well-informed, they had plenty of details about what would happen and they felt in control at all times.

Further information and access to community and advocacy services were documented in literature displayed in the SARC. Staff that we spoke with told us that they discussed services available to children and young people with them and their families during appointments, and this was corroborated in care records we reviewed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider organised and delivered services to meet children and young people's needs in line with the service specification they were commissioned to. The provider's policies and local processes took account of individual children and young people's needs and preferences, and crisis workers had adopted lead roles with one crisis worker leading on paediatric care at the SARC.

The needs of vulnerable children and young people were assessed on arrival at the SARC prior to the forensic medical examination, and throughout the appointment. Additional needs such as a learning difficulty, homelessness, family concerns or substance misuse issues were documented within the assessment paperwork completed by crisis workers and clinicians, and records we reviewed evidenced that appropriate action was taken to support children and young people with vulnerabilities. Emotional support was provided to children using the SARC and those close to them through referrals to local sexual violence advisor services.

The SARC had facilities for people with physical disabilities including step free access, a lift and an accessible toilet with a call bell. Children and young people could be seen outside of the SARC in exceptional circumstances and a portable bag was prepared with equipment to facilitate this.

The provider sought feedback from children and visitors attending the SARC and had received numerous compliments on the services delivered. Feedback from CQC comment cards completed in the two weeks prior to our inspection were also positive about the service in general; people commented that the environment felt calm and safe, and that the quality of care was amazing with very kind staff.

Timely access to services

Children and young people were able to access care and treatment within acceptable timescales to meet their needs as well as the requirements of the FFLM guidelines. The provider was commissioned to deliver both a telephone advice line and forensic medical examinations; both of which had been operated to achieve 100% of this target over the last 12 months. Details of operating times for the SARC were available on the provider's website and information leaflets.

A clear booking system was in place for children and young people to be seen following strategy planning meetings for each referral. Staff we spoke with told us this worked well and one comment received in the two weeks prior to our inspection from a child's parent said how pleased they had been to have the telephone answered so quickly and to receive such good communication.

The provider had an easily accessible, clear and detailed website with translation options included on the homepage for anyone requiring a different language. The website included information such as what to expect, information about the range of treatments available, and organisations who are able to offer advocacy or further support following an appointment with the SARC. The SARC leaflets reflected the information available online, and the same information in a child friendly format was in development.

Listening and learning from concerns and complaints

The provider had a complaints policy in place, and information was made available to children and those visiting the SARC on how to make a complaint, however there had been no complaints or concerns received in the 12 months prior to the inspection when the provider took over the paediatric pathway. An electronic system, Datix, was available to log complaints and compliments, including an audit trail of investigations and outcomes of complaints should any be reported in the future. Compliments and complaints were standing agenda items for team meetings in order to share outcomes and feedback with the wider staff team.

Are services well-led?

Our findings

Leadership capacity and capability

The SARC manager was an experienced counsellor with many years experience working within the SARC. The manager was supported by a consultant paediatrician leading on the paediatric pathway who had extensive research and experience in working with children and delivering forensic medical examinations. The manager and paediatric lead spoke positively of their joint working at the SARC to establish and develop the paediatric pathway, and their combined experience and qualifications evidenced their capacity and skills to deliver high-quality, sustainable care.

The provider had faced a number of challenges in the 12 months prior to the inspection, in particular with regards to the recruitment of clinicians. Risks had been highlighted on the service risk register which was reviewed and actioned by the manager and paediatric lead, as well as the divisional manager within the trust. Risks were currently mitigated through the use of bank staff within the trust, and an arrangement for community paediatricians, or forensic medical examiners supporting the adult pathway at the SARC to cover the rota.

Staff we spoke with during the inspection were open and transparent regarding the difficulties they had faced. Since joining the team seven months ago, the priority for the paediatric lead had been to focus on the child's experience at the SARC. In partnership with the SARC manager, pathways and local operating procedures had been put in place to improve the quality of services, and further plans were in place to develop the service in the future, for example with the introduction of follow up support for children and young people, and possible restructuring of some roles to provide increased administration provision.

Leaders were visible throughout the inspection and staff told us that they saw leaders regularly who were very supportive to them. Leaders were involved in the delivery of services, and the consultant paediatrician conducted forensic medical examinations alongside managerial tasks to oversee and develop the paediatric pathway.

The trust had processes to develop leadership capacity and skills, including training options for staff as well as a review of roles within the staffing structure to consider alternative roles and expand recruitment opportunities.

Vision and strategy

With the development of pathways with local agencies and authorities ongoing, leaders' vision for the service was to now update governance systems for the paediatric care at the SARC, and to develop a strategy alongside commissioners to manage the increasing referrals they were receiving.

Quarterly contract review meetings with commissioners reviewed the delivery of services in line with the service specification in order to meet the needs of the population. Commissioners we spoke with prior to the inspection felt satisfied with the service delivered and were supportive of new initiatives the SARC requested funding for, such as a new rest room for staff.

Culture

Staff we met during the inspection showed passion and dedication for the work they do at the SARC, and leaders and team members consistently referred to the importance of a child's experience of the service. This gave a warm and welcoming atmosphere to the SARC which was reflected within the comments received in the two weeks prior to the inspection from children and their families.

Staff spoke positively of leadership within the service, and felt able to raise concerns should they need to. Whilst we did not see evidence of responses to staff concerns, staff told us they could be open and transparent with leaders in order to effect positive changes to service delivery.

Incidents were investigated with openness and the use of the Datix system ensured that investigations were completed consistently. The provider had systems in place on Datix and a policy to ensure compliance with the requirements of the Duty of Candour.

Governance and management

The provider had clinical governance arrangements in place including policies and procedures which were accessible to all staff and reviewed on a regular basis. Monthly team meetings were held and integrated governance meetings had recommenced in June 2019 following a gap after the takeover of the paediatric service.

The service manager had responsibility for the management and day to day running of the SARC, and the paediatric consultant took responsibility for the clinical

Are services well-led?

leadership of the paediatric pathway within the SARC. Staff were clearly aware of the managerial structure, their roles and responsibilities and there were clear systems of accountability.

The risk register showed that control measures were in place for risks identified, and the register showed that risks were added as they arose including those identified on incidents reported. The risk register was shared with commissioners and reviewed at contract meetings in order to monitor the impact of risks against performance.

Appropriate and accurate information

Quality and operational information was used to monitor and improve performance. Complaints, incidents and feedback were standing agenda items for team meetings and findings from audits of care records, ligature points and infection control were shared through these meetings as well as peer review sessions.

Children and young people's or visitors' views were taken on board to improve the service. The example we found of this when reviewing feedback was a young person suggesting ice could be available to have in cold drinks at the SARC; this was now available.

The provider had effective information governance arrangements and staff we spoke with were aware of the importance of adhering to these in order to protect children's personal information.

Engagement with clients, the public, staff and external partners

The staff team had carried out extensive networking to engage with the public and external partners since taking over the paediatric pathway. All activities undertaken were logged and included awareness sessions with local hospitals, local school safeguarding teams, The Greenhouse (counselling) service, Victim Support, and police constabularies the SARC serves.

Stakeholders and partners were invited to attend the SARC to share information about their services; The provider had hosted staff from local paediatric hospital services and the Sexual Violence Advisor services to learn more about the services delivered. In return, staff from the SARC had the opportunity to visit and spend some time shadowing local partner agencies, such as triage services at Bristol Children's Hospital.

Staff we spoke with during the inspection told us that they felt listened to and that they were able to share ideas and suggestions with leaders. Staff members had been involved in the development of local protocols and contributed to team meetings and networking events.

Continuous improvement and innovation

The provider had systems and processes for learning, continuous improvement and innovation, however some processes such as the rolling audit programme were in development. Audits had taken place on an ad-hoc basis in relation to infection control, ligature points, and health and safety, however the service was not yet signed up to the trust audit calendar to provide structure and ensure all areas requiring audits were covered. Quality assurance of care records took place for all cases and findings were shared in monthly peer review sessions with staff.

Staff told us that monthly team meetings provide opportunities to receive feedback from audits, as well as the chance to contribute to the development of the service, however team meetings were not scheduled regularly and minutes not always documented to evidence the discussions which had taken place around feedback and learning. The SARC manager acknowledged this during our inspection and put a timetable in place for monthly team meetings over the coming year.