Mountain Healthcare Limited

Solace Centre SARC

Inspection Report

Cobham Community Hospital
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Website: https://www.surreysolace.org/

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Ratings

Overall rating for this service	No action ✓
Are services safe?	No action ✓
Are services effective?	No action ✓
Are services caring?	No action ✓
Are services responsive?	No action ✓
Are services well-led?	No action ✓

Overall summary

We carried out this announced inspection over two days, 20 and 21 November 2018, 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.

Background

Summary of findings

The Solace Centre is based in Cobham and offers a range of support services to anyone aged 13 or over, living within the Surrey area who have experienced sexual abuse or sexual violence, either recently or in the past. The service is available 24/7 to help people that have been affected by sexual abuse and sexual violence. For those children aged 13 and under, the Solace Centre supports community paediatricians from Monday to Friday (9am – 5pm), offering paediatric examinations and support.

The service is provided by Mountain Healthcare 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 about how the service is run. The registered manager was the SARC manager.

The service is located on the first floor and has full access for people who use wheelchairs and those with pushchairs. Car parking spaces are available at the hospital including a number of spaces for blue badge holders.

On the day of inspection, we spoke with the registered manager, the nominated individual who is also the medical director, the director of integration and collaboration, a counsellor, two forensic nurse examiners, a medical practitioner with the local clinical lead and also with administration staff. We also looked at policies and procedures and other records about how the service is managed.

The paediatric services at this service are undertaken by a different provider which were not reviewed as part of this inspection.

Our key findings were:

- Staff knew how to deal with emergencies.
- Appropriate medicines and life-saving equipment were available.
- The service had systems to help them manage risk, however, they had not considered risks such as lone working.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service had thorough staff recruitment procedures.
- The clinical staff provided clients' care and treatment in line with current guidelines.
- Staff treated clients with dignity and respect and took care to protect their privacy and personal information.
- The service had effective leadership and a culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and clients for feedback about the services they provided.
- The service staff dealt with complaints positively and efficiently.
- The staff had suitable information governance arrangements.

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

- Review and update all the policies, procedures and risk assessments to ensure they are current, in date and meet local requirements.
- The service should develop a localised business continuity plan.
- The service should ensure that safeguarding training is increased from 75% of staff to 100%.

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. **No action** ✓

Are services effective?
We found that this service was providing effective care in accordance withthe relevant regulations. **No action** ✓

Are services caring?
We found that this service was providing caring services in accordance with the relevant regulations. **No action** ✓

Are services responsive to people's needs?
We found that this service was providing responsive care in accordance with the relevant regulations. **No action** ✓

Are services well-led?
We found that this service was providing well-led care in accordance with the relevant regulations. **No action** ✓

No action

Are services safe?

Our findings

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

Staff knew their responsibilities if they had concerns about the safety of children, young people and adults who were vulnerable due to their circumstances. The service had a lead for safeguarding as well as appropriate policies and procedures to provide staff with information about identifying, reporting and dealing with suspected abuse. We saw evidence that staff had received safeguarding training following the intercollegiate guidance. Data provided showed that 75% of all staff had received safeguarding level 3 training. Staff we spoke with knew about the signs and symptoms of abuse and neglect and how to report concerns, including notification to the CQC.

The provider's safeguarding processes ensured patients of all ages were protected from abuse and there was good oversight of practice by a lead nurse and a named doctor. The provider explained were they made referrals to the safeguarding adults team and recognised that some referrals may not always meet the safeguarding adult threshold. The lead nurse carried out a safeguarding notes audit for all records of patients who were referred from, or who were subsequently referred to the local authority social care team. These audits were effective in ensuring safeguarding practice improvement through feedback and learning.

The provider collated any safeguarding incidents via their national "Positive, Adverse and Irregular Events Reports" (PAIERs) system. The medical director reviewed all PAIERs weekly to identify themes and discussed them with the safeguarding lead and leadership team. This was shared with all other SARC locations and resulted in an annual thematic analysis of incidents and an associated action plan which enabled learning from incidents across the provider's SARC locations to be shared.

The service ensured that facilities and equipment was safe and that equipment was maintained according to manufacturers' instructions, including electrical and gas appliances. Records showed that emergency lighting, fire detection and firefighting equipment was regularly tested.

The medical equipment met standards, including forensic standards laid down by the Faculty of Forensic and Legal Medicine (FFLM). We saw evidence of regular calibration and servicing for the equipment. Staff regularly checked equipment to ensure it was within the servicing schedules.

Specialist equipment, known as a colposcope, was available for making records of intimate images during examinations, including high-quality photographs and video. The purpose of these images is to enable forensic examiners to review, validate or challenge findings from the examination and for second opinion during legal proceedings. At the Solace Centre, there were clear arrangements for obtaining and recording consent for making such photographic records. There were also effective arrangements for ensuring the safe storage and security of these records in accordance with national guidance issued by the FFLM.

Staff were recruited safely as the service had a staff recruitment policy and procedure to help them employ suitable staff. These checks reflected the relevant legislation. All the staff files were kept and maintained at the headquarters (HQ) in Essex and no personnel files were held at the location. The registered manager was not aware of the validity of the checks of the staff employed at Solace and acknowledged it may be useful for these to be kept locally also. We looked at two staff recruitment records which showed the service followed their recruitment procedures. Pre-employment safety checks included enhanced Disclosure and Barring Service (DBS) checks, an extensive interview process and validation of references and qualifications. Due to the nature of the work of the service within the criminal justice system, staff were also subject of additional vetting through the local police before being employed.

Risks to clients

There were systems to assess, monitor and manage risks to client safety. A health and safety policy was in procedure that outlined how the service would manage risks such as environmental and violence to staff. However, local risk assessments were not always in place in relation to some safety issues. For example, staff followed relevant safety regulations when using needles but a local sharps risk assessment had not been undertaken despite a health and safety audit being in place that checked the safe disposal of sharps.

No action

Are services safe?

The service did not have a localised business continuity plan (BCP). A BCP describes how the service would deal with events that could disrupt the routine running of the service. Staff told us they would contact other nearby SARC services, also managed by the same provider, and clients would be transferred to receive a service there in the event of flood, fire or other emergencies. Contact numbers of local services were displayed on the notice board, however the BCP protocol was not evidenced in the procedures we checked. The registered manager acknowledged this and agreed to action this.

Procedures were not fully in place to ensure staff were equipped with the information in the event of emergencies. Although staff knew who contact in an emergency, including for incidents of self - harm, violent behaviour and first aid, they did not carry mobile phones or panic buttons to enable them to call for assistance.

We checked the lone working policy and found this had not been updated for over a period of five years. The provider had a standard operation procedure outlining guidance of how the service would assess the risks associated with lone working, however these were generic and not specific to the location. This procedure advised the provider should ensure suitable communication was in place, to call emergency services if staff were at risk. We brought this to the attention of the registered manager who agreed a more thorough approach to assessing risks to lone working was required.

Staff knew how to respond to medical emergencies and completed training in emergency resuscitation and basic life support (BLS) with airway management. Immediate Life Support (ILS) training was also completed. Emergency equipment and medicines were available as described in recognised guidance. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. There was a well-stocked emergency bag that contained emergency items such as those for airway management. All the items were checked regularly.

We saw cleaning schedules for the premises. The service was clean when we inspected and had carried out infection prevention and control audits as well as environmental audits that showed the service was meeting the required standards. Policies and procedures in place to ensure clinical waste was segregated and stored appropriately in line with guidance.

Information to deliver safe care and treatment

Patient records were held in colour coded files which helped to reduce any misplacedfilesand to access information faster making personnel more productive. A review of the client care records showed that information was taken to ascertain as comprehensive background as possible using risk assessment templates. The initial triage confirmed any potential risks to clients such as safeguarding risks and findings from individual records were written and managed in a way that kept clients safe. Care records were noted to be accurate, complete, and legible and were kept securely and complied with data protection requirements. Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with service protocols and current guidance.

Where a client was identified as at risk of harm or urgent health concerns were identified, immediate and continuing action was taken to safeguard the client. This included an assessment for infection and for post-exposure prophylaxis after sexual exposure and for emergency contraception, as well as physical injuries that needed urgent treatment. Risks to people who use the services were assessed, monitored and managed. These included signs of deteriorating health, including mental health, medical emergencies, child sexual exploitation, FGM, domestic abuse or behaviour that challenged.

There were clear procedures adopted for the management of photo documentation and intimate images resulting from the assessment in line with FFLM guidance.

Safe and appropriate use of medicines

The service had systems for appropriate and safe handling of medicines and the clinical staff were aware of current guidance with regards to prescribing medicines. All medicines were ordered from an approved supplier and there was a suitable stock control system of medicines which were held on site.

All the medication we looked at was within the expiry date. The service held a limited formulary comprising of emergency contraception and post-exposure prophylaxis drugs (PEP). PEP is another name for emergency HIV treatment and is not a cure for HIV, but a form of prevention. The service only had five-day starter kits and

No action

Are services safe?

referred clients to the sexual health or genitourinary medicine (GUM) clinics for the remainder of the course and for further monitoring. The service stored and kept records of NHS prescriptions as described in current guidance.

The nurses supplied certain medication under a Patient Group Direction (PGD) which is a written instruction for the sale, supply and or administration of named medicines in an identified clinical situation. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation . There was an agreed formulary for the supply of PGDs. The PGDs were in date clear, appropriately signed off, complaint and in line with current best practice.

Track record on safety

The service monitored, reviewed, learned and made improvements following incidents or when things went wrong. Staff were aware of the incident reporting framework and recorded, responded to and discussed all incidents to reduce risk and support future learning in line with the framework. One incident had been reported in the previous 12 months in relation to damage caused by water causing disruption to the paediatric service. The incident was investigated, documented and the remedial work was completed by the landlord.

No action

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The service policies, procedures and pathways delivered care and treatment that followed evidence-based guidance such as clinical guidance from the National Institute for Health and Care Excellence (NICE). All Staff had access to the policies and documents through the intranet. We spoke to staff who found this extremely useful and informative. Any changes to national guidelines were discussed and disseminated to staff through newsletters, emails and team meetings. Staff were made aware of the policies and procedures during induction and staff we spoke with were aware of how to access the policies and where the pathways were located.

The service had worked with the authority, local commissioners, the local police force as well as other health providers in planning the services and pathways offered to the population it served, and considered individuals' needs. This was outlined in a contractual service level agreement.

Clinicians assessed needs in line with current legislation, standards and guidance supported by clear clinical pathways and protocols to include plans for immediate healthcare including emergency contraception, antibiotic or HIV/Hepatitis B prophylaxis.

Consent to care and treatment

The service's safeguarding policies outlined how consent and confidentiality would be managed in different circumstances, including in a forensic environment. Staff in the service obtained consent to care and treatment and understood the importance of obtaining and recording clients' consent to treatment.

The team understood their responsibilities under the act when treating adults who may not be able to make informed decisions. Staff told us how they assessed fluctuating capacity, particularly for clients with substance misuse, and how this could impact them making informed decisions about their treatment and care. They explained, when clients attended the service they were assessed using a consent proforma form to include a mental capacity flow chart to demonstrate that the client could make specific decisions about their day to day care.

The policy also referred to Fraser Guidelines and Gillick competence, by which a child under the age of 16 years of age can consent for themselves. The staff were aware of the need to consider this when treating young people between 13 and 16 years of age.

Clinical staff told us they gave clients information about treatment options and the risks and benefits of these so they could make informed decisions. Staff described how they involved clients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Consent to care and treatment was evidenced in the records we reviewed. One record demonstrated that a young person's views were acted upon when they were scheduled to attend treatment and made the decision for their parent not to be present as they felt more comfortable attending with their designated social worker.

Monitoring care and treatment

An audit strategy had been developed for 2018 to provide assurance that services met legislative requirements, CQC standards of compliance and to provide assurance where risk had been identified. We saw evidence of a core audit programme, which included Infection control, medicines management, safeguarding and health and safety. The audits were based on nationally recognised tools, and a schedule was in place to ensure they were being conducted. We reviewed a number of these audits that showed good overall compliance. The hand hygiene and safeguarding audits showed 100% compliance. The service was supported by the provider, Mountain Healthcare, in conducting some medical and governance audits. The staff were involved in quality improvement initiatives including peer review as part of their approach in providing high quality care. Each clinician audited 10 sets of notes for each other and provided feedback on the outcomes. The service audited clients' medical care records to check that the clinical staff recorded the necessary information.

Solace SARC was also monitored by the provider as part of a national programme and the outcomes were compared to other centres within the group. The service delivery was benchmarked with other centres such as those in Kent and Sussex.

Effective staffing

No action

Are services effective?

(for example, treatment is effective)

The service had sufficient staffing levels in place to meet its current capacity. The service had two suites where examinations were carried out. These were not usually used at the same time as the demand was not there. However, they allowed the staff to have a quick turnaround and see the next client to reduce wait times.

New starters followed a role specific induction process that covered information such as organisational structure, the vision and goals, common processes, standard operating procedures (SOP), information governance guidance and professional service standards. A shadowing period was available and determined on an individual basis. Staff maintained their competence through regular refresher training in key subjects essential to the effective running of the service and through peer review of their work.

Staff were trained or qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Forensic clinical staff received initial, specialist training in their role that met national requirements set by the FFLM. There was also a comprehensive, professionalised induction programme for each staff group; crisis workers and forensic clinicians. These were competency based and used national occupational standards set out by the 'Skills for Justice' national training organisation and by an organisation specialising in sexual violence. Staff we spoke with told us training opportunities were available and they were supported to develop. They gave us examples of education and training they had recently completed. Clinical staff completed continuing professional development and staff told us the service provided support and encouragement for them to do so. Staff told us they completed training as per national professional standards which included undertaking medical emergencies and basic life support training annually.

There was a strong approach to peer review and supervision for all staff. Forensic medical examiners (FMEs) received peer review feedback on their notes and video recordings every quarter to ensure they carried out examinations consistently and according to FFLM standards.

All staff received annual appraisals. There was a policy in place to outline how appraisals were to be conducted and defined how clinical and non-clinical staff were to be appraised. They discussed learning needs, general wellbeing and aims for future professional development. Staff had appraisals with their line manager that were meaningful and useful and had objectives set and training needs identified.

Staff were competent in both forensic medical examinations and in assessing and providing for the holistic needs of clients, including safeguarding from all forms of maltreatment and in the assessment and management of physical and emotional conditions that may or may not be related to the alleged sexual abuse.

Co-ordinating care and treatment

There was good team working with other agencies. Staff worked together and with other health and social care professionals to deliver effective care and treatment. There was direct access to an independent sexual violence advisor (ISVA) and child ISVA as well as support from counsellors.

There were clear and effective pathways into and from the SARC to clinical care that complied with the National Institute for Health and Care Excellence (NICE) clinical guidelines. These pathways included psychosocial, advocacy, counselling and ongoing support services. When clients received care from a range of different staff, teams or services, this was coordinated. We saw evidence of pathways from the SARC to other agencies such as the emergency department and to the sexual health or genitourinary medicine (GUM) clinics as well as pathways into the SARC such as those clients who wanted to self-refer.

Onward referrals were sent to the appropriate services when it had been identified that people required further treatment, care and support. This included a one-page proforma that highlighted what agency the referral had been made to and six week follow up calls were made to check the status and/or outcome of the clients wellbeing. For example, records showed where one client was at risk of harm, external support had been sought and received by the client to minimise risks. This was following discussion and referrals to the multi-agency safeguarding hub with completed child sexual exploitation (CSE) screening tool, the general practitioner (GP), sexual health clinic and the child and adolescent mental health service (CAMHS). The outcome of the client's wellbeing was followed up by the forensic medical examiner (FME) within the relevant timescale.

No action

Are services caring?

Our findings

Kindness, respect and compassion

Client feedback obtained by the provider commented positively that staff were welcoming, friendly and helpful. Staff explained that when clients arrived at the service they were greeted with empathy, respect and understanding. Staff explained the importance of using soft skills when talking with clients such as being non-judgemental and having awareness of their own body language to support them to feel welcomed and relaxed. Hot and cold drinks and snacks were offered to people on their arrival such as tea, hot chocolate and soup; staff commented that the toast was a popular choice.

Staff emphasised the importance of being kind and helpful when clients were in pain, distress or discomfort. We observed the children's waiting room had a range of games, toys and books as well as a "Vpod" unit which included 3D glasses for children and young people to watch and play age appropriate games. A Vpod is a 3D pain distraction unit which has been reported to play a pivotal role in helping reduce stress, encourage relaxation and provided for children receiving clinical treatments. The unit was could be wheeled to other areas with ease to ensure children and young people could access the equipment in other rooms within the service when receiving treatment.

Clients could access washroom facilities after their treatment and a change of clothes were made available for clients if this was required. The service provided care bags for clients to take away which contained, toiletries and perfumed items for males and/or females. Staff told us clients appreciated this kind gesture.

Information showed that most clients who used the service were female and received very few male referrals into the service. Staff told us although clients were offered a choice of a male and female professional this option may not always be possible to meet client's specific needs. The service could check if specific gender requested staff were available at the provider's other nearby centres, however this was dependent on availability. The provider explained they were recruiting for a male crisis support worker and male forensic medical examiner to ensure people's individual needs were being meet.

Privacy and dignity

The service respected and promoted clients' privacy and dignity. We saw that areas of the building were open and spacious and there were separate waiting rooms for adults and children. The rooms had appropriate décor so clients were made to feel relaxed. The layout of the rooms and waiting areas provided privacy when staff were dealing with clients. Staff told us that if clients asked for more privacy they would take them into another room. Additional facilities included an suite where achieving best evidence (ABE) interviews were carried out as part of criminal investigations with children and vulnerable adults. There was a separate locked monitoring room on site for the police that held their equipment including a fridge to store forensic evidence. This enabled the provider to work in close partnership with the police to support clients who had chosen to report the assault.

Confidential records were stored and held securely to protect people's personal data and right to privacy. There was a separate office for staff and we observed that computer screens were not visible to clients and staff did not leave clients' personal information where other clients might see it. Clients paper records were securely stored in locked filing cabinets. Staff password protected clients' electronic care records and backed these up to secure storage.

Staff were aware of the importance of privacy and confidentiality. There were two separate entrances so clients could access the service discreetly if they wanted to protect their anonymity.

All members of the staff team understood the importance of not disclosing information about the clients they supported with unauthorised individuals and organisations.

The provider worked in partnership with other agencies to deliver a confidential service to meet people's needs. Members of the staff team explained they carried anonymous health checks, when necessary, to ensure client confidentiality to minimise the risk of being exposed and/or fear of reprisals.

Involving people in decisions about care and treatment

Staff helped clients and their carers find further information and access community and advocacy services. Counselling services were available and staff explained that clients could access up to 15 to 20 sessions. There was a

Are services caring?

counselling room onsite which was bright, clean and comfortable where clients were helped and asked questions about their care and treatment. At the time of the inspection the registered manager told us there was no waiting list for the counselling service.

Clients were empowered to make informed decisions about their treatment and care. The service gave clients clear information to help them make informed choices. When clients first arrived at the service staff discussed sensitively what was going to happen to help put them at ease. Staff described the conversations they had with clients to satisfy themselves they understood their treatment options and helped them to think about their treatment and aftercare.

Staff told us the importance of phrasing the questions correctly and adopting good listening skills to ensure clients were involved in the decisions they made about their treatment and care. They explored all the options the service offered and told us that clients had full 'choice and control' about using or declining the service. When services had been declined, clients were given the appropriate information and the choice to return and use the service if they wished.

The service's website and information leaflets provided clients with details about the range of treatments available at the service. Clinical staff described to us the methods they used to help clients understand treatment options discussed. These included for example, photographs, models, videos, shown to the client to help them better understand examination and treatment.

Clinical records confirmed this and clearly outlined the steps the practitioners had taken as well as all the information discussed with the client.

Although the provider was aware of the accessible information standards these requirements were not always met. Interpretation services were available for clients who did not have English as a first language. We saw notices in the communal areas, informing clients this service was available. However, information about the service was not available in an easy read format and communication aids were not available for clients with visual and hearing impairments. We had raised this issue with the registered manager who stated that they planned to amend and update their information and provide aids to ensure the service met the requirements to the accessible information standard.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service organised and delivered services to meet clients' needs. It took account of client needs and preferences. Staff were clear on the importance of emotional support needed by clients when delivering care.

Psychological therapies were available for clients who experienced symptoms of trauma and post-traumatic stress. Clients could be seen at the Solace centre or a location of their choosing. For example, for one client who had mobility issues and difficulty traveling to the service the psychologist had agreed to see them at their local GP.

Clinical staff informed us they would encourage clients to visit with their families during the first initial sessions and when they would feel more at ease, the would be invited for one to one sessions. A trauma based model was used and the psychologist supported clients to talk through their feelings of guilt, stigma and shame because of abuse. Clinical tools were in place to measure the patient outcomes. As the service had been in operation since June 2018 the psychologist explained it was too early to assess to effectiveness of this.

The crisis support worker informed us they ordinarily supported people with complex needs. They shared examples of how they engaged in sensitive conversations with patients who accessed the service to support them with advice, treatment and care for patients in the most difficult circumstances, such as sex workers.

Staff told us that they currently had no clients for whom they needed to adjust the service for them to receive treatment. The service had made reasonable adjustments for clients with disabilities such as step free access and bathroom facilities with hand rails.

Timely access to services

Clients could access care and treatment from the service within an acceptable timescale for their needs. The service displayed its opening hours in the premises, and included it in their service information leaflet and on their website.

Referrals were made into the service by a range of external agencies, the provided also accepted self-referrals. Data showed most referrals were received from the police and self-referrers. Clients were given the option to make their own referrals to the service without involvement from the police. An emergency screening tool was used to assess all aspects of clients mental and physical health needs.

There was a one hour response time for all referrals to be seen. Information we checked demonstrated the response times were met to ensure that people received timely access to the service. The provider had an appointment system to respond to clients' needs. Appointments were scheduled by a contact centre that was based off site. Staff described some of the initial difficulties they faced when they first began using the contact centre, for example, overlapping appointment times leading to clients not having enough time between appointments. There was a consensus by the staff team that the call centre required a better understanding of the service and the protocols that should be followed. Because of this, staff explained their plans for key staff members in the service to be based at the contact centre to share best practice and provide guidance on how the service operated to ensure systems ran more effectively.

Records showed when a client required an urgent appointment they were seen on the same day. We observed that an appointment ran smoothly on the day of the inspection and the client was not kept waiting. Staff confirmed clients who required urgent appointments would prioritised and seen within 24 hours and were rarely kept waiting for their appointments. They explained they would coordinate appointment times based on the information they received to ensure that male and females; adults and children are seen on separate dates to make certain that clients were placed not at risk.

Listening and learning from concerns and complaints

Complaints and concern leaflets were displayed on notice boards and provided guidance about how to make a complaint, concern or query. Staff told us they would speak with the registered manager immediately if any formal or informal complaints were raised and ensure clients received a timely response. The registered manager explained if any complaints or concerns arose they would discuss outcomes with staff to share learning and improve the quality of the service.

No action

Are services responsive to people's needs?

(for example, to feedback?)

Systems were in place for recording and managing complaints. The provider had not received any complaints over the last 12 months. Staff told us they took complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

We checked the complaints policy and noted this was not up to date and required a review; the registered manager acknowledged this and explained the policy was in the process of being updated. The complaints policy contained a clear procedure for acknowledging and investigating complaints, with scope for complaints to be escalated by external organisations that clients could contact if not satisfied with the way the service dealt with their concerns.

No action

Are services well-led?

Our findings

Leadership capacity and capability

Leaders at the service had the experience, capacity and skills to deliver high-quality, sustainable care. They were visible, approachable and worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. The leaders understood the challenges and were addressing them.

The service had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The service was knowledgeable about issues and priorities relating to the quality and future of services.

Succession planning was embedded in the service and strategies such as talent management, to provide leaders from within the organisation, had been put in place to plan for future growth.

Vision and strategy

There was a clear vision and set of values. The vision and aim was to "provide the best possible standard of healthcare, through innovative and efficient service design".

The service had a realistic strategy and supporting business plans to achieve priorities. The service strategy was acknowledged by staff from ground level to the leadership teams. The strategy was to "enable a continued focus on the quality of care ensuring safe, effective and efficient service delivery, which is compliant with CQC standards and meeting the governance principles, but remains innovative with a compassionate model of leadership, ensuring we continue to 'do the right thing'. The service planned its services to meet the needs of the service population and this was reinforced by the multiagency delivery plan which stated "The success of the SARC is crucial to all service users and stake holders. During the past year 2017-2018 the SARC has had the opportunity to make significant changes that will have the most impact on its clients, colleagues and commissioners".

The quality strategy focussed on implementing and operating quality systems that supported a culture of empowerment, quality management, shared learning and continuous improvement. Within the strategy and assurance framework were clear accountabilities, structures and systems for reporting and monitoring. Clinical leaders worked alongside and in partnership with service managers.

Culture

The service had a culture of high-quality sustainable care. Staff stated they felt respected, supported and valued and were proud to work in the service. Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

The service had a clear set of principles which were quality, integrity, respect, kindness, ambition, courage, innovation and enjoyment. We observed that staff reflected these values in their behaviour and their approach used when caring for clients.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the Duty of Candour. Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance and management

Solace SARC had a clear governance structure that fed up to the provider, Mountain Health Limited, through their monthly meetings. There were clear responsibilities, roles and systems of accountability to support good governance and management. The nominated individual had overall responsibility for the management and clinical leadership of the service. The registered manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

There were systems in place for providing assurance to the Board about the safety and quality of the services provided. Data collated as part of the assurance and governance framework was used to drive service improvements.

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis.

No action

Are services well-led?

There were clear and effective processes for managing risks, issues and performance. The service had a risk register that was used effectively locally and at Board level. High scoring risks were escalated to the Governance Committee and upwards to the executive team.

We found several policies, procedures and risk assessments that were either not in place or were out of date. We also found localised polices were not fit for purpose at Solace SARC. We found that the provider's audits had not identified issues in relation to policies and procedures for lone working, the business continuity plan and the complaints procedure. Policies and procedures had not been reviewed to ensure there was a consistent approach to compliancewith laws and regulations and guidance for clear decision-making to reinforce the expected standards of employees. Information and communication aids did not meet the accessible information standard to support needs of clients, carers and relatives with a disability, impairment or sensory loss.

Appropriate and accurate information

The service acted on appropriate and accurate information. Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of clients.

The service had information governance arrangements and staff were aware of the importance of these in protecting clients' personal information.

Engagement with clients, the public, staff and external partners

The provider sought regular feedback from clients and used questionnaires to gauge if clients who used the service were satisfied. These included questions about whether support was appropriate they received from health professionals, police officers and medical practice and whether staff behaved with kindness and professionalism. We reviewed 13 questionnaires completed by adults and children and found that clients had not expressed any concerns about the service, and described high levels of satisfaction about the experience of their care.

Staff spoke positively about how the service was managed and how they worked collaboratively as a team. A staff member commented, "The service is well led, the team work effectively together they do a great job. I love my work; no two days are the same."

The service gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. We saw evidence of a staff survey which included questions in areas such as employee satisfaction, efficiency and facilitation recognition, support and opportunities and hours and rates of pay. Over 100 responses were received with mostly positive results. One positive statement was "Nearly all of our employees experience the feeling of looking forward to going to work. They are also enthusiastic about their jobs and time passes quickly for most of them".

Continuous improvement and innovation

The service had many projects in place to help improve the outcomes and to improve the running of the service. The registered manager and nominated individual described plans to develop leadership training, electronic peer review systems as well as establishing a research group.

Quality improvement projects had been undertaken in the service to drive improvement such as a quality initiative to gather forensic evidence for each forensic nurse examiner and to make the decontamination process more efficient after an examination.