Mountain Healthcare Limited

Millfield House SARC

Inspection report

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Overall summary

We carried out this announced inspection on 7 & 8 December 2021 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by two additional CQC inspectors 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

Millfield House is a Sexual Assault Referral Centre (SARC) for Derbyshire residents aged 18 years and over. The service is available 24 hours a day and seven days a week, including public holidays. Patients can self-refer although most referrals were received from the police. Calls were triaged by a crisis worker and patients who had been recently sexually abused were transferred to a Forensic Nurse Examiner (FNE) to complete an initial screening.

The SARC building is located on a busy road, however it is discreetly signed and with parking available for patients to use. There is level, ground floor access to the areas used by patients. There are three forensic suites available which

Summary of findings

included a forensic bathroom and examination area as well as a small room with seating used to carry out the initial assessment. One of the forensic suites was adapted for patients with additional accessibility needs. At the time of the inspection, all three suites were available for use, however only one patient would be seen at a time. There were also facilities for staff to shower and change, court video link interview rooms and a tastefully furnished family room.

The SARC services are commissioned jointly by NHS England, the Police and Crime Commissioner and local authority. Mountain Healthcare Limited (MHL) employ FNEs to deliver the forensic examinations at Millfield House. Crisis Support Workers (CSWs) are employed by SV2 (a local third-sector organisation). For the purpose of this inspection we inspected MHL's provision of FNEs to perform the forensic medical examinations.

Patients who accessed the SARC were offered contraception, Hepatitis B vaccination and injury checks. Access to these services is available at Millfield House for patients who don't wish to have forensic samples taken.

SV2 staff make onward referrals with the support of MHL staff and with patient consent, for ongoing support such as Independent Sexual Violence Advisors (ISVAs), counselling, mental health support and safeguarding. Safeguarding (urgent and routine) and any other urgent referrals needing action at the time of the examination were completed by the FNE. SV2 staff are also responsible for the forensic cleaning of the suites.

MHL employed one SARC manager and four FNEs at Millfield House. During this inspection we spoke with the SARC manager, two FNEs, MHL's SARC director and safeguarding lead and SV2's SARC Delivery Manager.

We left patient comment cards at the location the week prior to our visit and received four completed cards. We also looked at policies and procedures, reports and eight patient records to learn about how the service was managed. We also spoke with commissioners prior to the inspection.

The service is provided by a limited company 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 at Millfield House was the SARC manager for this and one other location, as well as covering shifts as an FNE.

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

Our key findings were:

- The service had systems to help staff manage risks to patient safety, although we found that not all ligature risks had been identified.
- There were appropriate safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service had thorough staff recruitment procedures.
- Staff knew how to deal with emergencies and had received relevant training. Appropriate medicines and life-saving equipment were available and regularly checked.
- The FNEs provided care and treatment to patients in line with current guidelines. Patients were asked for their consent at various stages during the assessment and examination.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.

Summary of findings

- The service had effective leadership and a culture of continuous improvement. Staff felt supported and able to contribute to the development of the service.
- Staff felt they received the required training and were supported with continuous professional development.
- Staff and patients were encouraged to provide feedback about the quality of the service.
- There were effective governance processes in place and good joint working with partner agencies.
- The service appeared clean and well maintained.
- Infection control procedures reflected published guidance.

There was one area where the provider should make improvements:

- The ligature risk assessment should be further reviewed to ensure it accurately reflects risk levels at Millfield House.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?	**No action** ✓
Are services effective?	**No action** ✓
Are services caring?	**No action** ✓
Are services responsive to people's needs?	**No action** ✓
Are services well-led?	**No action** ✓

Are services safe?

Our findings

Safety systems and processes (including Staff recruitment, Equipment and premises)

The FNEs we spoke with clearly understood how to make a safeguarding referral for adults and children, and when this would be required. The provider had policies and procedures in place to support staff with their decision making and was in the process of updating the safeguarding adults policy. Staff were guided to complete an online safeguarding alert form and inform their senior managers if they had concerns. The safeguarding policy also referenced the Mental Capacity Act so that staff could support patients to make decisions.

Staff had received appropriate safeguarding children and adults level 3 training which ensured they had the required level of knowledge and skills for their role. Training was updated every three years, in accordance with the intercollegiate national guidance.

Whilst patients under the age of 18 were not seen at the SARC, we saw that staff still identified any potentially vulnerable children that their patients may have and made appropriate referrals. The provider's policy gave staff guidance as to the outcome of a good quality child safeguarding referral, including the timeliness of the referral and the response from staff. There was clear guidance and escalation process to support staff in dealing with professional disagreements.

Audits were completed by local safeguarding champions and staff were able to join regular discussions and safeguarding supervision sessions. This meant there were opportunities to improve practice and discuss cases with colleagues in other locations. MHL staff followed up safeguarding referrals with the local authority to ensure they had been received. We also saw evidence of involvement in multi-agency risk assessment conferences (MARAC).

The SARC accepted referrals from a variety of sources and patients could self-refer, although most referrals were received from the police, with the patient's consent. MHL staff identified when patients would benefit from onward referral to other services, such as mental health teams and ISVAs. These referrals were made by SV2 staff, but MHL monitored this to ensure the referrals were made.

Assessments were carried out face to face, with appropriate COVID-19 precautions put into place in line with national guidance. During the initial assessment staff identified any patients that had additional needs such as a learning disability or language barrier. Interpreter services were available for anybody with English as a second language.

There was a whistle blowing policy in place which supported staff to raise concerns confidentially, should they not feel comfortable doing this locally. Staff told us that they would feel comfortable raising any issues with the registered manager.

The provider had safe recruitment processes in place which were followed. Staff had a police vetting check to identify known risks posed by the applicant or anyone associating with them. In addition, all applicants underwent an enhanced Disclosure, Barring and Vetting System (DBS) check on recruitment. These checks were also repeated every three years which ensured that any new risks that were not known at recruitment, were identified and patients were kept safe.

The provider recognised the importance of staff having access to continuing professional development. All staff completed a six month induction programme. More recently, staff were able to complete FNE training as a preceptorship programme. This aimed to provide the key skills that staff needed in the first 18-24 months of their employment. Training topics included relevant subjects such as alcohol and substance misuse, mental health and mental capacity training.

Staff had access to 24 hour on call support from a suitably qualified doctor and the provider's contact centre and told us they knew how to access this. In addition, during regular working hours staff could also speak with the registered manager or colleagues working in other locations, for advice and support.

Are services safe?

Derbyshire Police maintained the SARC building and carried out essential safety and maintenance checks. MHL staff logged any requests for building works or alterations with the police. The building was well maintained, and we saw MHL staff had made requests for building works as required, such as the fitting of new door handles in the forensic bathrooms. Staff accessed the building using a swipe card which reduced the risk of unauthorised persons gaining access.

Infection control standards were maintained by staff who undertook regular training in infection prevention and control. There was access to personal protective equipment (PPE) for staff and this was available in different sizes. SV2 staff were responsible for general and forensic cleaning and we saw where any issues were noted, these were escalated by the registered manager. For example, there had been some failures in environmental swab testing which could affect the admissibility of evidence. Additional training had been provided to staff who carried out the cleaning. This had resulted in improvements and continued to be monitored by the registered manager.

The provider had carried out a COVID-19 risk assessment and incorporated relevant guidance from the FFLM into their practices, to enable face to face services to continue to be provided.

FNEs completed daily checklists of emergency equipment, medicines and cleaning and action was taken should any issues be found. There were arrangements in place for the collection of clinical waste at regular intervals.

The provider had completed a risk assessment of the SARC environment which included ligature risks in the areas that patients accessed. Not all potential ligature points had been identified, and the level of risk before and after mitigating actions, was not recorded. We raised this with the provider during the inspection and they took immediate action to update the ligature risk assessment, although this still required further review to ensure it was fit for purpose. Staff told us they would either be with a patient or in the next room during their time at the SARC, and frequently assessed the level of risk a patient presented. The forensic bathroom doors had recently been fitted with anti-ligature handles and the doors could be opened from the outside if necessary.

Staff were trained to the appropriate level to use a colposcope (a colposcope is a specialist piece of equipment for making records of intimate images during examinations, including high-quality photographs and video.) There were three colposcopes for use on site and a mobile colposcope was available to take off site where a patient was not able to attend the SARC. Forensic samples were managed in line with FFLM guidelines. The provider kept forensic samples for up to two years if patients did not want a Police investigation to progress at that stage.

SV2 maintained service agreements for the colposcopes. New staff received support from the senior FNE in the use of colposcopes and would be signed off as competent as part of the induction process. There were arrangements in place for the peer review of images taken on colposcopes, with patient's consent.

There was a COSHH inventory on site and COSHH risk assessments were reviewed annually or following an incident. As part of induction processes, all new staff were made aware of COSHH and the use of control measures. This made sure that risks to patients and staff were minimised.

Risks to patients

There were effective systems in place to assess and monitor patients and manage any risks to their safety. Urgent health needs were prioritised and, if necessary, patients would be supported to attend hospital for emergency treatment before attending the SARC. Staff had access to an emergency grab bag and defibrillator, these were checked regularly to ensure they remained safe to use. Intermediate life support training was provided to all staff.

FNEs completed a holistic assessment of patients which identified risks such as alcohol dependency, suicide and self-harm. Risk levels were reassessed during the patient's time at the SARC. FNEs also assessed the need to provide patients with post exposure prophylaxis after sexual exposure (PEPSE), emergency contraception, Hepatitis B prophylaxis and onward referral to sexual health services.

Are services safe?

FNEs used alcohol and substance clinical assessment scales to assess patients with potential withdrawal symptoms. However, the process for staff to follow in making decisions about when to use these assessment tools and any follow on action, was not clear. A reviewed and updated version of the relevant policy was provided during the inspection which provided staff with clearer guidance.

The provider's health and safety policy identified relevant legislation and best practice guidance. It was clearly set out in the policy who in the organisation was responsible for delivering and measuring the SARC's health and safety performance. Business continuity arrangements were in place and patients could attend other SARCs in neighbouring areas if necessary.

Where incidents had happened in other locations operated by the provider, we saw that the learning had been shared across all sites and relevant improvements made. For example, the forensic bathroom door locks and handles had been changed in response to an incident at another location.

Information to deliver safe care and treatment

The patient records we reviewed were completed to a high standard with relevant detail to inform the safe delivery of care and treatment. The assessment paperwork was in line with FFLM standards. Records were fully completed and legible, containing detailed body maps where patients had any injuries. Records were stored securely inside lockable metal filing cabinets and in a room that only MHL staff could access.

Photos taken on a colposcope were stored securely and had an identification number so that no confidential patient information was displayed.

Staff from SV2 were responsible for making referrals to other agencies. Patient records showed that FNEs identified what referrals were required and documented when these had been completed.

Safe and appropriate use of medicines

All medicines were stored securely in a locked cupboard or fridge, stock levels and storage temperatures were checked daily. The keys for medicines storage were kept in a key safe which could only be accessed by FNEs. The code for the key safe was changed regularly. We checked the expiry dates of medicines and saw that all were within their expiry date.

FNEs ordered supplies of medicines as required and a supply of some medicines had been delivered shortly before the inspection. Vaccinations were kept in a locked fridge and the recorded temperatures were within the required range.

Patients were given appropriate advice about any medicines they were given, and staff told us they were confident in administering medicines. A range of patient group directions (PGDs) was available to enable FNEs to supply prescription-only medicines to patients (PGDs are written instructions for the supply or administration of medicines to a pre-defined group of patients who may not be individually identified before presentation for treatment). The provider kept PGDs under review and staff had signed to confirm they had read and understood them. PGDs were also signed by the medical director and lead pharmacist.

Track record on safety

The provider completed an analysis of incidents across all their SARC locations to identify themes which informed staff learning and service improvement. Staff used an electronic system to report any incidents and told us they felt confident in making reports. Incidents were sent to a central team to review and allocated to a manager to investigate. Where appropriate, SV2 staff were involved in embedding any learning.

The provider used NICE infection prevention and control quality standards to support the implementation of best practice. Measures to mitigate infection prevention and control risks were monitored at the Integrated Governance Board. These standards formed part of the provider's Forensic Standards Annual Report which set targets for the following year. This demonstrated an intention to improve infection prevention and control practice.

Are services safe?

Lessons learned and improvements

Any changes to practice and improvements were shared by the provider with the staff at Millfield House. Staff had the opportunity to discuss changes at team meetings and during supervision sessions. There was an open culture and staff were encouraged to report any incidents and share ideas for improvement.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Care and treatment were provided in line with best practice and national guidance. The senior FNE regularly checked a sample of patient records to ensure that staff were following the relevant guidance.

Patients' needs were assessed in line with best practice guidance and legislation, including that provided by the FFLM and NICE. The assessment of need then informed the provision of care and treatment and any onward referrals that may be required. The patient records we reviewed contained detailed assessments of patients' past and present health needs, including any injuries. Most patients who accessed the SARC started the treatment they had been assessed for during their visit, such as HIV PEP medication and emergency contraception.

The provider had a range of policies and procedures available to inform the delivery of care and treatment by staff. Most policies were detailed, up to date and provided detailed and relevant information for staff. The policy and process for staff to follow relating to patients experiencing alcohol withdrawal required further review to ensure that it offered appropriate guidance to staff. This was addressed by the provider following the inspection.

Prior to patients attending the SARC, staff from SV2 took some initial details over the phone from the patient. If it was apparent that an assault had occurred within the last 10 days, then SV2 staff transferred the call to an FNE employed by MHL. Even if the patient chose not to attend the SARC they still had access to advice from the FNE. Any police referrals went directly to MHL and the on call FNE who took relevant details. The FNEs would then gather relevant information prior to the patient's attendance at the SARC. The FNE and a crisis worker would meet the patient at the SARC entrance to welcome them and then commence the full assessment. Should a patient not wish to immediately attend the SARC they could arrange an appointment time convenient to them.

There were clear pathways and procedures in place which staff followed for assessment, treatment and making onward referrals. The staff we spoke with were clear about their role and responsibilities and emphasised they explained all options available to patients.

Monitoring care and treatment

The provider carried out a programme of audits to check that care and treatment was of an appropriate standard and that improvements were made. Audits included record keeping, safeguarding and medicines management. Where audits had identified areas for improvement, we saw these were made, such as ensuring that FNEs completed all fields in the patient records.

There was a system in place for the peer review of patient records by FNEs to ensure that care, treatment and record keeping was of an appropriate standard. Feedback was provided to individual staff and, where appropriate, to the whole team regarding the outcome and any improvements needed. FNEs could also access regular calls with colleagues in other locations to discuss any recent cases for learning. There was access to an on-call consultant should FNEs need advice while a patient was still at the SARC.

Follow up contact was attempted with all patients six weeks after their attendance at the SARC. This was used as an opportunity to check how the patient was and if they were engaging with services they had been referred to. The opportunity was also used to gain more in depth feedback from patients about their experience at the SARC and if any improvements could be made.

FNEs recorded the outcomes of patients' attendance at the SARC in their records, such as any procedures carried out, medicines administered and any onward referrals that were made. Detailed notes were made about any safeguarding referrals made to the local authority.

Are services effective?

(for example, treatment is effective)

Effective staffing

Patients' needs were met by staff who had the right skills and were supported. Newly recruited FNEs were provided with a comprehensive induction which covered the expectations of the role and local procedures and familiarisation.

All new FNEs undertook a period of shadowing examinations carried out by a colleague as well as attending various training courses to ensure they had the required skills, such as training in using a colposcope. All new FNEs were observed completing an examination before being signed off as competent to work without supervision.

Arrangements to support staff to be up to date and promote their wellbeing, were clear and effective. Staff received regular supervision, case management and attended team meetings. There was a continuous professional development framework in place which outlined what support and training was available to staff. Whilst staff were expected to take responsibility to ensure they remained up to date with mandatory training, the provider and registered manager also regularly monitored this. Records confirmed staff were up to date with their mandatory training.

Additional training and support was available to staff, for example, safeguarding supervision was offered to develop staff skills in communicating well with patients to explore and understand potential safeguarding risks. All staff spoken with felt supported and the training provided them with the skills required for the role. Staff could also identify any additional training that would be beneficial and MHL had engaged with a university to provide further education for FNEs.

Despite a challenging staffing situation, the provider had still been able to offer a clinical examination to all patients as required. A suitably skilled bank member of staff had covered some examinations where a member of the core team was not available. The registered manager also provided occasional support on the clinical rota.

Co-ordinating care and treatment

Patients could self-refer into the SARC and referrals could also be made by the police and other professionals. The provider had engaged with local hospital and ambulance trusts to raise the profile of the SARC to increase the number of referrals received. There was also regular and ongoing engagement with police officers to promote the SARC service and remind officers that the service was available 24 hours a day.

There were good working relationships between FNEs and their colleagues from SV2 who were co-located in the SARC. There were monthly joint team meetings where progress and any issues were discussed. We received positive feedback from the SV2 SARC Delivery Manager about how relationships had improved over time. FNEs held a daily video call to discuss the plans for the day.

Whilst the FNEs were not responsible for making referrals to other services, they followed these up with SV2 staff to ensure that referrals were made. Positive working relationships had been developed with the local authority which had seen FNEs being more involved in safeguarding and MARAC discussions.

Health improvement and promotion

Patients were offered health promotion advice and literature during their time at the SARC, including discussion about how referrals to other agencies may benefit them. FNEs provided information about sexual health, as well as offering barrier protection which the patient could take away with them.

Improved links had been made with substance misuse services and, where appropriate, the potential benefits of a referral to a substance misuse provider were discussed with patients.

Consent to care and treatment

Patients were supported to give informed consent to any treatment and examinations carried out. FNEs told us they explained everything to patients to ensure they understood and could make decisions about what they wanted to happen. FNEs received training in the Mental Capacity Act 2005 and understood how to apply this, in cases where a patient may lack the capacity to make a decision.

Are services effective?

(for example, treatment is effective)

Patients were asked to sign to confirm their consent to the examination and any treatment provided, or declined. This was reviewed on an ongoing basis during the patients' time at the SARC to ensure that the treatment options remained appropriate. Should FNEs be concerned that a patient's capacity to provide informed consent had changed, this would be reviewed again before proceeding any further.

Are services caring?

Our findings

Kindness, respect and compassion

Patients were treated with kindness, respect and compassion by FNEs. The feedback we received from the completed patient comment cards was very positive and patients complimented staff on their caring approach. Our sample of patient records and interviews with FNEs demonstrated that patients were treated with kindness and respect at all times.

Patients' feedback was collected before they left the SARC and during the six week follow up contact. A 'you said we did' board was displayed in the room used by patients post-examination which explained how the provider had acted upon feedback provided by patients.

FNEs told us that patients were in control of what happened at the SARC, and any examinations and treatment would only be carried out when patients felt comfortable to proceed. The provider was conducting some research to understand the diversity of the patients that attended the SARC, with a view to engaging more with any 'harder to reach' population groups.

FNEs understood the traumatic nature of sexual assault and how it would impact on patients' mental wellbeing. This was considered in the way that patients were cared for during their time at the SARC. Patients were offered a 'care pack' containing various toiletries and other items to take away with them.

Involving people in decisions about care and treatment

Our review of patient records showed that patients were fully involved in all decisions relating to any examinations and treatment carried out. Patients were asked to sign various forms to confirm that they understood and consented. The patient voice was clearly demonstrated throughout each of the records we saw.

FNEs could access interpreters to support patients if required, and this would generally be face to face, as it was felt this would better promote the patient's engagement and understanding. Where appropriate, patients could bring a relative or advocate to the SARC to support them.

The SARC website provided information about what patients could expect before, during and after their visit to the SARC. FNEs and SV2 staff explained to patients what to expect from their visit to the SARC over the phone, before they attended. When patients arrived they were met at the door by an FNE and crisis worker and there was a further explanation of what would happen.

Patients were provided with an information pack before leaving the SARC about the various support services available to them as well as information about the feedback and complaints processes. The provider was engaging with other SARC service providers to develop a suite of patient leaflets in other languages.

Privacy and dignity

The building was discreetly signed with parking for patients immediately outside. Patients were greeted by staff upon arrival to ensure they could quickly gain entry to the building. Only one patient was seen in the SARC at a time which meant that there was no risk of confidential information being overheard by another patient. The provider was exploring the possibility of patients entering the building via another door, which would offer a more private route into the building.

Paper based patient records were stored in a secure filing cabinet which was in an office that only FNEs could access. Some additional notes were kept on the computer system which was only accessible to authorised staff and password protected.

Patients were able to change and use bathroom facilities in private, although FNEs and crisis workers remained nearby to ensure the safety of patients. The forensic rooms were in an area of the building that was accessed by swipe card.

Are services responsive to people's needs?

Our findings

Responding to and meeting people's needs

The FNEs we spoke with told us about the importance of providing emotional support to patients during their time at the SARC. FNEs worked together with crisis workers to ensure that patients were listened to, and given the time they needed, to talk about their experience. Where necessary, the crisis workers made onwards referrals to ISVAs for further support.

Patients were able to self-refer by contacting the SARC directly and could choose not to involve the police. Forensic samples could be stored at the SARC so that patients could decide at a later stage to involve the police.

During the initial phone call before a patient attended the SARC, the FNEs collated information about the particular needs of vulnerable patients. For example, if a patient was dependant on drugs or alcohol this was recorded on the patient record and a clinical withdrawal assessment would be completed when the patient was at the SARC. This responsive approach ensured that patients understood the examination process and staff would regularly review the patient during their time at the SARC. Referrals were made to the local authority safeguarding team or other services as required to enable vulnerable patients to access further support.

The building was accessible for patients with physical disabilities. The forensic facilities were all located on the ground floor and there was step free access to these areas. One of the three forensic suites had an accessible bathroom with handrails and a call bell. The non-forensic rooms used by patients were tastefully decorated and provided a soft, calm environment for patients to talk with staff.

The provider had carried out engagement work with Derbyshire Police to raise awareness of the SARC services and reported that this had increased the number of referrals coming via that route. FNEs had also done similar work with staff at local accident and emergency departments and the ambulance service, so that their staff could direct patients to the SARC where necessary. Further work was planned to target particular population groups who may be more difficult to reach.

Taking account of particular needs and choices

The SARC saw adult patients and the environment was suitable. Whilst at the SARC patients were provided with food, drinks and replacement clothing and we saw there were plentiful supplies of each. Additional food options had been provided in response to patient feedback.

There were procedures in place to alert staff when a patient had attended the SARC on multiple occasions. FNEs would automatically make a safeguarding referral in this situation and would discuss with the patient what further support they may need.

Patients could request to see a male clinician if they wished to, although the male FNE would have to travel to the SARC from another area which would increase the response time. This was explained to any patients who made this request. Patients were generally seen at the SARC within 60 minutes of the referral being made in acute cases. This timescale could be extended if the patient decided that they wanted to attend at a different time.

Timely access to services

The provider monitored response times from the point of receiving a referral to the patient being met at the SARC. This was also reported to the service commissioners and the majority of patients were seen within the target response time. Any exceptions to this were reported to understand the reasons for any delays. We saw that improvements had been as a result of reporting any missed targets. For example, FNEs had engaged with police partners to ensure they better understood the importance of clear communication with all parties. The commissioners reported that they were satisfied with the provider's performance in meeting the target response time.

Are services responsive to people's needs?

The SARC website displayed information about the operating hours of the service and contact details that could be used by anybody wishing to self-refer.

Listening and learning from concerns and complaints

The provider had a complaints procedure which was made available to patients using the SARC. There had been no complaints received in the 12 months prior to the inspection. Complaints and patient feedback were a regular agenda item for staff meetings, and we saw that feedback was used to inform and improve the service provision. Patient engagement and complaints also featured in the quarterly reports that the provider prepared for commissioners. Feedback from patients who had accessed the SARC was positive. Patients appreciated the kind and calm way that staff communicated with them.

The learning and changes made from any complaints or incidents in the provider's other locations was shared with staff to ensure that learning was embedded across the organisation.

Are services well-led?

Our findings

Leadership capacity and capability

We saw that the FNEs provided a high quality and sustainable service. The registered manager was responsible for the management of two SARC services. They were contactable when not working on site and ensured that the service operated effectively, and that staff were supported. Senior leaders within MHL were contactable for support and advice during regular planned calls, or as and when required.

The registered manager and senior FNE had the skills and experience required to deliver the service strategy. Risks to the service delivery were identified and acted upon, such as the recruitment of an additional FNE to increase staffing capacity. There was appropriate delegation of tasks, such as carrying out audits, which also supported the development of staff.

The registered manager was also a registered nurse and had completed Level 1 of the FFLM qualification. The senior FNE had completed Levels 1 and 2 of the FFLM qualification.

The staff we spoke with felt that the service was well-led and had confidence in the local leadership as well as that of senior leaders within the organisation.

Vision and strategy

The provider's vision and strategy were embedded in the day to day practice of staff at Millfield House. Staff told us that the patients were at the heart of everything they did and there was a culture of continuous improvement. Our sample of patient records demonstrated that patients were fully involved in their care and treatment and contacted for their views and feedback afterwards. Any feedback provided by patients and partner agencies was taken seriously and used to further improve the service.

The provider's strategy supported the service to achieve their core priority which was to provide a timely forensic examination to all patients. It was evident that there was a strong focus on supporting staff to develop their competence and expertise through a range of training and professional development opportunities. This further enhanced the quality of the service being provided.

It had been acknowledged that more work could be done to reach out to population groups that don't currently engage with the SARC service or may not be aware of it. This was a focus for the team going forwards to further increase the number of referrals received.

Culture

The FNEs we spoke with told us there was an open culture within the service and they felt able to make suggestions or raise concerns freely, regardless of their level of experience. All FNEs were provided with equal opportunities for career development and felt able to access the support and training they needed.

There was a collaborative approach to the management of the service, the registered manager was approachable, inclusive and involved staff in the development of the service. There were regular meetings with the SV2 SARC staff and issues were openly discussed and worked through jointly.

The peer review of patient records was carried out in a constructive manner and aimed to provide staff with praise, as well as noting any areas for development.

FNEs told us that there was a clear system for reporting incidents, and they felt that this was encouraged because MHL wanted to learn and improve the service. Incidents were sent to a central team for initial review and then passed to the relevant person for investigation and learning was shared across all the provider's SARC services.

Are services well-led?

Governance and management

The day to day work of the FNEs was underpinned by a set of policies which guided staff in the various aspects of their role. Policies were regularly reviewed and updated when anything had changed. Governance structures meant there was oversight of standards such as in safeguarding, where staff practice was monitored to ensure that standards were maintained, and staff were acting appropriately to safeguard patients.

Information governance processes were supported by an up to date policy. Staff received training and relevant updates on information governance and the provider had identified leads that staff could contact with any queries. Records kept in the SARC were securely stored in line with the provider's policy.

The SARC used a matrix to identify which provider had responsibilities for particular activities, for example responding to the advice line, or making onward pathway referrals. This meant that MHL staff were clear about what activity they were responsible for and provided a system to ensure that the correct provider was held to account.

There were processes and well established meetings at various levels within the provider to identify issues that affect patients. For example, the quality assurance board reviewed reports relating to clinical effectiveness and improvement measures and reported to the executive team and commissioners. This meant that senior leaders within the organisation were aware of issues at location level and had oversight of any improvements being made.

Processes for managing risks, issues and performance.

There were clear governance arrangements and lines of accountability in place. The provider had a suite of audits which were carried out locally at the specified frequencies. Where any areas for improvement were identified an action plan was put into place and monitored to ensure improvements were carried out. The provider also carried out regular 'clinical excellence' checks to ensure that staff were working to current best practice and regulatory requirements.

The registered manager met with the service commissioners regularly and provided a quarterly performance report. Commissioners told us that they were satisfied with the performance of the provider and the quality of reporting. There were open lines of communication between the registered manager and commissioners. Any issues were reported and resolved quickly without waiting for the next scheduled review meeting.

There was a local risk register which contained a description of any risks and mitigating actions being taken, including those jointly owned with SV2 and the police. During our site visit we saw that not all ligature risks in the accessible bathroom had been identified or appropriately rated. The provider took immediate action following our feedback to update the relevant risk assessment and remove a shower rail from the bathroom.

There was a business continuity plan which included working throughout the COVID pandemic. Safety measures had been put into place to enable face to face assessments and examinations to continue during the pandemic restrictions.

Appropriate and accurate information

The registered manager collated performance and activity data and compiled the monthly Sexual Assault Referral Centres Indicators of Performance (SARCIPs) which were reported to the service commissioners. This information also informed the quarterly performance report which captured patient experiences as well as data.

Information governance arrangements complied with the requirements of the Data Protection Act and the General Data Protection Regulation. Staff gathered information that was required as part of the assessment and examination process, with patients' consent, and ensured that all records were stored securely. There were established processes in place to support the sharing of information with partner agencies such as local authority safeguarding teams.

Engagement with patients, the public, staff and external partners

Patients were encouraged to leave feedback before they left the SARC and could do so anonymously. We saw that there were post-boxes available in various places for feedback forms to be placed in. The FNE team had recognised that

patients may not be comfortable leaving feedback whilst still at the SARC and patients could provide this at a later date. The registered manager told us that they felt patients would be more likely to give more meaningful feedback once they had been able to process their time at the SARC. The patient feedback we saw was very positive and praised FNEs for their caring and empathetic approach. Patients also had access to the provider's complaints procedure.

The service also welcomed feedback from key stakeholders, and we saw that positive feedback had been received. Staff were also able to provide feedback about the quality of service provision and suggest improvements during staff meetings and supervision sessions.

Continuous improvement and innovation

There were effective systems and processes in place to drive continuous improvement and learning. Staff were supported to engage in continuous professional development and new starters received a comprehensive induction and package of support before being able to see patients alone. Learning from any training and events attended would be shared by staff with their colleagues during team meetings.

The service action plan was regularly reviewed to ensure that progress was being made. There was effective joint working with SV2 and police colleagues where any actions required their input.

Staff received regular management and clinical supervision, as well as appraisals. Staff told us that these were helpful and designed to provide them with the support they needed to further develop their knowledge and skills. The quality assurance processes were designed to encourage improvement and constructive feedback was provided to staff.