Mountain Healthcare Limited

Oakwood Place SARC

Inspection Report

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Overall summary

We carried out this announced inspection on 22 & 23 October 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations. The inspection was led by a CQC inspector who was supported by a second CQC inspector and a specialist professional advisor.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Background

Oakwood Place SARC is located in the town of Brentwood in Essex and provides services to children aged 13-17 and adults aged 18 and over. Children aged 12 and under are also seen at Oakwood Place SARC by different providers on a rota basis which covers seven days a week. Mountain Healthcare Limited provides the paediatric service only on a Friday each week.

The service is accessible 24 hours a day, seven days a week and 365 days a year. Staff are based on site during daytime hours Monday to Friday and are on call out of hours and at weekends. The location is secure and only SARC staff, Essex police staff and patients can access it.

The service is delivered from within a separate building in the grounds of Brentwood Community Hospital. The building is accessible for patients with disabilities. The accommodation includes two forensic suites each with an adjoining shower room and waiting room. In addition, there are also more comfortable interview rooms as well as a children's play room.

The team includes a service manager, five forensic nurse examiners (FNEs) who made up four whole time equivalent FNE positions and ten crisis workers, three of whom cover administrative duties in the office. The service manager is also an FNE and provides cover when required. The provider also employs forensic medical examiners (FMEs) who will carry out the forensic examinations for children.

The service is provided by Mountain Healthcare Limited and as a condition of registration they must have a

Summary of findings

person registered with the Care Quality Commission as the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations regarding how the service is run. The service is jointly commissioned by NHS England in the East of England and the Essex Police, Fire and Crime Commissioner.

During the inspection we spoke with five staff members, the service manager, the Director of Nursing, Associate Head of Healthcare and Medical Director. We looked at policies, procedures and other records about how the service was managed. We sampled care records for 11 patients who had accessed the SARC within the last 12 months. Between January – June 2019 a total of 149 adults and 90 children had accessed the service. Throughout this report we have used the term 'patients' to describe people who use the service to reflect our inspection of the clinical aspects of the SARC.

Our key findings were:

- There were well-developed safeguarding processes in place and staff understood their responsibilities for safeguarding their patients.
- The service had appropriate systems to help them manage risk.
- The provider had thorough staff recruitment procedures.
- Systems were in place to assist staff when dealing with emergencies. Appropriate medicines and life-saving equipment were available.
- The service appeared visually clean and was well maintained.
- Care and treatment was provided in line with current guidelines.
- Staff asked for patients' consent and supported children to provide consent where possible.
- Staff had access to a wide range of relevant training and felt well supported.
- Staff were caring and compassionate and patients were treated with dignity and respect.
- Patients' privacy was respected and their personal information was protected.
- Patients were seen quickly following their referral or an appointment was made for an appropriate time.
- There was a process in place for patients to complain about the service.
- There was effective local leadership and support at a senior manager level.
- A positive and open culture thrived which encouraged continuous improvement.
- There was a strong ethic of teamwork, openness and learning.
- Patients and staff were asked for their feedback about the service.
- There were effective clinical governance arrangements in place which supported staff to provide patients with a high-quality service.

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

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

Are services caring?
We found that this service was providing caring services in accordance with the relevant regulations.

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

Are services well-led?
We found that this service was providing well-led care in accordance with the relevant regulations.

Are services safe?

Our findings

Safety systems and processes

Patients were safeguarded from the risk of abuse because there were appropriate systems in place to identify and report safeguarding issues. Staff had received the appropriate level of safeguarding training which was in line with intercollegiate guidance and had achieved or were working towards the provider's 'Safeguarding Passport'. The Safeguarding Passport allows staff to evidence their knowledge and experience of safeguarding processes in their day to day work with vulnerable patients. The staff we spoke with demonstrated a clear understanding of the signs of potential abuse and described the different forms abuse can take. Staff also clearly described the appropriate process to follow to report suspected abuse.

The assessment of patients that staff carried out highlighted vulnerabilities such as existing safeguarding concerns, age, learning disability or mental health condition or patients who had been physically injured. Staff were also trained to recognise the signs of modern slavery and female genital mutilation (FGM). Safeguarding referrals were made for all children aged 13-17 and on a case by case basis for adults. Any child aged 12 or under would have been referred to the SARC by the relevant social services team and therefore would already be known to the local authority. However, staff were clear that they would still report any safeguarding concerns anyway. The staff we spoke with told us that, if a partner agency such as the police or a GP practice said they had already made a referral, they would check this. If there was any doubt, then staff told us they would make a referral as well. In every case, all safeguarding referrals were followed up within 72 hours to ensure that they had been allocated and action taken by the local authority.

The provider had safeguarding policies and procedures in place which gave staff guidance in identifying, reporting and dealing with suspected abuse. There were twice weekly safeguarding calls for all of the provider's SARC staff across the country to discuss any issues or ask for advice from colleagues. The safeguarding pathways were available in the office for each local authority area covered by the SARC. The service manager had engaged with each local authority to increase the understanding of what a SARC service is and the vulnerability of patients. This had led to staff being invited to attend safeguarding strategy meetings to provide their input.

The provider had systems in place which were used effectively to monitor staff practice. For example, there were regular safeguarding supervision and peer review sessions where staff discussed cases they had handled recently with their manager and colleagues. The safeguarding supervision sessions were led by a member of staff that had undertaken a recognised child protection supervision training course. In addition, a safeguarding audit was carried out on a monthly basis for all staff. This involved taking a sample of records and checking that staff had taken the appropriate action to protect the patient.

Staff

The provider had a whistle blowing policy in place which was available to all staff. This provided staff with information about how to raise a concern confidentially should they not wish to do so at a local level. The staff we spoke with confirmed they would feel comfortable raising a concern with the service manager and also that the directors were approachable and willing to listen and resolve any issues.

There was a recruitment process in place which was managed centrally by the provider's human resources department. Disclosure and Barring Service (DBS) and police checks were carried out on new staff before they could commence working. The provider also obtained references from previous employers and a character reference where this was not possible. The DBS and police checks were renewed every three years.

Clinical staff were expected to maintain their professional registration through continuous professional development and we saw that this was regularly monitored through staff supervision. The service manager carried out regular checks to ensure that clinical staff registrations remained valid.

Risks to patients

There were effective systems in place to assess, monitor and manage risks to patient safety and staff understood how to use these to assess risks to patients. FNEs carried out an assessment of risk with the patient when they arrived at the SARC. This included a check of their physical

and mental health and the risk of suicide or self-harm. For any paediatric patients there were questions relating to potential child sexual exploitation. The records we reviewed confirmed that staff completed all relevant sections of the assessment or gave a reason if something was not relevant. Staff told us that, if they remained concerned about a patient after they had left the SARC, they would not close their case even after making the planned follow up phone call. Staff would continue to maintain contact with the patient and partner agencies in an attempt to reduce any remaining risks to their well-being.

If there was a medical emergency or other concerns about a patient's wellbeing staff were clear that the patient would go to hospital for treatment. The service manager had worked with colleagues in the accident and emergency department at the hospital to ensure that staff there understood that the patient's health took priority over attendance at the SARC. Staff at the SARC carried out an assessment for post-exposure prophylaxis, antibiotic and/or hepatitis B prophylaxis as well as the need for emergency contraception.

The provider had an up to date health and safety policy which was reviewed frequently, and this supported local management to manage potential risk. A quarterly health and safety risk assessment of the building and external areas was carried out which ensured that avoidable risks to staff and patients were well managed. Any areas of the building requiring attention were reported to the maintenance contractor for action. In addition, the service manager had carried out a suicide and self-harm risk assessment which identified potential risks to patients and steps that should be taken to manage each type of risk. Staff did not see patients alone and they would ensure that two members of staff were present before greeting the patient. Patients were only left alone when using the bathroom facilities and staff ensured that they stayed outside the room.

Crisis workers and clinical staff had completed the appropriate level of life support training for their role and knew how to respond to a medical emergency. Emergency equipment and medicines were available and checked on a regular basis to ensure they were within their expiry date and in working order.

Premises and equipment

The equipment used for patient examinations was regularly checked by staff to ensure it remained safe to use. While there was no annual service agreement with the provider of the colposcope (specialist equipment used for making records of intimate images during examinations, including high-quality photographs and video), we saw evidence that they had attended to carry out software updates. There was a business continuity plan in place which was relevant to Oakwood Place SARC and described how services could continue to be provided during an adverse event.

The provider had appropriate policies and guidance in place relating to infection control and staff were provided with infection control training. Forensic samples were managed in line with guidance from the Faculty of Forensic and Legal Medicine (FFLM). There were appropriate infection control procedures in place which were followed by staff. A specialist company was called in to carry out forensic cleaning after each patient had left the premises. The facilities were appropriately cleaned in order to comply with the guidance provided by Faculty of Forensic and Legal Medicine (FFLM). There was an adequate supply of personal protective equipment and clinical waste was managed appropriately. A monthly deep clean of the forensic areas was carried out by an external contractor.

The provider carried out regular infection control audits of the premises and staff practice, and action was taken to rectify any issues found. There were also regular DNA sampling checks carried out in each of the forensic areas to ensure that the forensic cleaning was effective.

The relevant staff were trained to use a colposcope and images were recorded onto DVDs and we saw that these were stored securely. The images were deleted from the colposcope after the content of the DVD had been checked and verified.

Designated staff carried out essential building safety checks such as fire alarm tests. The maintenance contractor also carried out a series of regular and annual tests. These included portable electrical appliance testing and the flushing and disinfecting of water outlets.

Information to deliver safe care and treatment

Staff told us that they had access to the information required to provide safe care and treatment to patients and we saw this was the case. The patient records we saw showed that staff obtained the necessary information from

the attending police officer (where appropriate) and patient upon arrival at the SARC. For paediatric patients, staff also obtained information from the adult that accompanied them. All patients' records sampled were legible, clear and easy to read as well as being fully completed. Care records were held securely and complied with data protection requirements. Paper records were transferred to a computer system which allowed for easier reporting and auditing of records.

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

Any referrals staff made to other service providers, such as independent sexual violence advisors (ISVA) were fully documented in the patient record. These demonstrated that referrals were made promptly, and the benefits of such referrals were explained to patients. Staff made follow up phone calls to adult patients six weeks after their attendance at the SARC to check on their welfare and to remind them and encourage them to attend any follow up appointments. For paediatric patients, a follow up phone call was made three weeks after attendance.

Safe and appropriate use of medicines

There were effective systems in place for the safe management of medicines. Only a small amount of the required medicines were kept on site.There were systems in place to ensure that staff regularly checked to ensure that medicines did not pass their expiry date and also that there was always a sufficient supply available. Medicines were kept in a lockable cabinet which was securely attached to a wall in a room which only staff could access. The temperature of the area that medicines were stored in was checked on a regular basis and the records we saw confirmed that temperatures remained within the recommended range.

The patient group directions (PGD) (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) in place were appropriate for the medicines to be supplied. Clinical staff had signed to confirm they had read the PGDs and told us that they felt comfortable administering the medicines covered by the PGDs.

Track record on safety and lessons learned and improvements

There was a clear and easily accessible system in place for staff to report adverse incidents that happened in the service, as well as positive events. An incident report was submitted by the relevant staff member to the provider for action and investigation where required. An appropriate person, usually the service manager, carried out investigations and actions were assigned to ensure that improvements were made. Learning from incidents was shared with staff by email communication and also at staff meetings. Staff also reported incidents that involved other parts of the pathway after a patient had left the SARC. This demonstrated the staff team's commitment to drive improvement in other services that their patients may access.

There was a provider-wide system for the dissemination of patient and medicines safety alerts. Such alerts were distributed by senior staff to the service manager who in turn alerted staff. We also saw examples of the provider ensuring that staff learned from any incidents that happened at other locations.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

Patients' needs were effectively assessed when they arrived at the SARC, firstly by a crisis worker and then by a FNE. Care and treatment was provided which reflected the guidelines from the Faculty of Forensic and Legal Medicine (FFLM). Staff used a standardised patient record template which provided a clinical pathway and ensured that patients' immediate healthcare needs were met. This prompted staff to assess whether the provision of emergency contraception and treatment of physical injuries was required. Referrals were made to the local genito-urinary medicine services should patients require HIV/Hepatitis B prophylaxis and staff followed up to ensure patients attended appointments.

Staff were involved in quality improvement initiatives such as regular peer review sessions which were used to provide professional challenge and sharing of best practice. This formed part of the team approach to providing high quality care. Staff told us that they found these sessions helpful in encouraging their professional development and effective team working. The provider had a system to provide staff with relevant updates from agencies such as NICE and the FFLM to ensure they were working to the current guidelines.

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

Patients were provided with appropriate advice about where to seek more help and support, such as local sexual health and counselling services. Adults who attended with children were also provided with this advice. Leaflets were available which signposted the various services and these could be provided in alternative formats such as easy-read.

Consent to care and treatment

Staff were provided with training in the Mental Capacity Act (2005) (MCA) and consent for adults. In addition, staff were provided with training in Gillick competence and the Fraser guidelines in relation to assessing a child's capacity to provide consent. New staff worked through the subject of consent and the relevant legislation as part of their induction package. Staff understood the importance of obtaining and recording patients' consent to treatment. Staff told us, and records confirmed, that patients were provided with information about their choices and what would happen during their examination. This allowed patients to give informed consent which they could choose to withdraw at any time. The patient records that we saw clearly demonstrated that this process was always followed by staff.

The provider had policies regarding consent and the MCA as well as Gillick and Fraser guidelines. There were clear processes in place should staff have any doubts about a patient's capacity to make an informed decision about their care and treatment. The patient records for adults prompted staff to carry out a two-stage test of the patient's capacity to make a particular decision. One of the records we saw demonstrated that staff had supported a patient to make an informed choice about their treatment by presenting information to them in a way they could understand.

Some patients (both adult and paediatric) attended the SARC with a relative or carer and, where appropriate, staff involved them in the decision-making process. Staff were able to describe situations where they would need to speak with the patient alone and how they would manage this.

Monitoring care and treatment

Staff used a standardised patient record to record relevant information about each patient's medical history and current physical and mental health needs. This included establishing whether a patient had any needs relating to substance misuse. The service manager had led work to develop care plans for patients who had received services at the SARC before. This ensured that all staff were aware of, and sensitive to their needs.

The service manager carried out monthly auditing of patients' records to check that clinical staff recorded the necessary information. Where it was felt that improvements could be made this was discussed with staff during their supervision meetings. The staff we spoke with told us they felt that the service manager provided constructive and helpful feedback about their performance also gave praise when it was felt staff were performing well.

Staff used the patient record to record the outcome of the patient's appointment at the SARC, such as whether any onward referrals had been made or partner agencies

Are services effective?

(for example, treatment is effective)

contacted. Staff made a follow up phone call to every patient that attended the SARC to check on their welfare. This call also allowed staff to remind patients of the importance of attending any appointments that had been booked for them. The provider monitored the outcomes of each patient's appointment at the SARC and reported these to their commissioner on a regular basis.

Effective staffing

New members of staff undertook an induction programme which covered the essentials of working in a SARC service. Following this, new starters undertook a six-month competency assessment process which combined structured learning with self-directed reading and e-learning modules. New staff were also required to shadow more experienced colleagues who supported them during their probationary period. Clinical staff carried out their own continuing professional development and revalidation. There was an annual appraisal system in place and the service manager maintained a schedule to ensure these took place.

The provider had recently implemented a new system to monitor training compliance and the service manager also chose to maintain their own local spreadsheet. This showed that the majority of staff had received the training considered mandatory for their role. Further training was booked for the weeks following the inspection to address remaining gaps. Staff received mandatory training which was tailored to their role, this covered areas such as safeguarding of adults and children, infection control and basic/intermediate life support. Staff were able to access further training to develop their knowledge base, such as in child sexual exploitation and alcohol and substance misuse awareness. Clinical staff received training in working with the victims of sexual offences, including carrying out a forensic examination. This training met the requirements of the FFLM to ensure that staff were competent to carry out forensic examinations.

The provider had up to date policies relating to clinical and managerial supervision which were followed in practice. There were regular group peer review sessions which staff told us they found to be helpful and supportive. These covered both adult and paediatric cases to ensure that all staff were working effectively with all age groups. Staff received one to one clinical and managerial supervision once per quarter as a minimum, but this could be increased according to need. Staff told us that they could speak with the service manager if they needed to and that the team worked together and offered support to colleagues as and when required.

Co-ordinating care and treatment

There were effective partnership working arrangements between staff at the SARC and the police. Adult patients could either self-refer or the police made referrals to the service. Arrangements were made for a crisis worker and FNE to meet the patient at the location along with a police officer (should it be a police referral). The police force had a lead officer who was responsible for liaison between the force and SARC staff. We saw that SARC staff raised any issues through this route and they were effectively resolved.

There was good coordination between staff to ensure that the patient's journey through the service was as smooth as possible and this allowed the patient to be in control of the process. The service had well established links with partner agencies such as mental health teams, sexual health services and GP practices to ensure that patients received follow up care and treatment. It was evident from patient records that staff explained what services were available to patients and obtained their consent to make a referral. Staff also offered to make referrals to the local independent sexual violence adviser (ISVA) service and we saw that many patients accepted this service.

Whilst at the SARC patients and carers were provided with leaflets which gave information on, and contact details for, the various services available to them. These were available in other languages on request and in easy read format. This meant that, even if patients did not accept a referral at the time of their attendance at the SARC, they could choose to contact those services at a later date. Staff had access to interpretation and translation services to support their communication with patients who did not speak English or who had other communication requirements.

Are services caring?

Our findings

Kindness, respect and compassion

The clinical staff we spoke with told us that the role of the crisis worker was vital in developing a rapport with and gaining the trust of each patient. The crisis worker spent time with each patient when they first arrived at the SARC to ensure they understood what would happen and to reassure them that they would be able to make decisions about their care and treatment. Children had access to a selection of toys and books and the crisis worker could spend time engaging with and reassuring children before any interviews or examinations took place.

The provider had recognised that the nature of the work undertaken by staff could have a long-term impact on their emotional well-being and that this, in turn, could impact on the service staff provided to patients if not managed appropriately. Staff had access to support to manage the effects of 'vicarious trauma' and 'compassion fatigue'. This ensured that staff had a safe space to talk about the challenges of their work and how this might impact on their well-being. It was felt that this support enabled staff to continue providing a caring and compassionate service to all patients.

We reviewed patient feedback forms that had been returned to the provider recently and these contained very positive messages. Patients of all ages were encouraged to provide feedback if they wished to, as well as carers and other professionals that attended the SARC with a patient. One patient indicated that staff had treated them in a kind and considerate way and made them feel safe during their time at the SARC.

Staff were aware of the nature of the population in the area that the SARC served. The service manager and other staff had undertaken work to engage with the different communities in their local area and to better understand different cultures. All of the clinicians employed by the service were female and patients or the police were informed of this at the point of the referral being made. However, if a patient wished to see a male clinician, this could be facilitated by assigning one of the male doctors employed by the provider at other locations. Paediatric patients would be able to request a clinician of a specific gender and every effort would be made to accommodate this. The provider was actively trying to recruit male clinicians to increase their availabilty to better meet patient's needs. Quality standards for male patients were in the process of being rolled out across all of the provider's SARC locations.

Privacy and dignity

If there were two patients in the SARC at the same time, staff would try to ensure that their privacy was maintained and that they did not come into contact with each other. The layout of the building meant that it was possible to keep patients separated. The building was a standalone facility within hospital grounds. Whilst it was signposted, the nature of the service was not immediately apparent.

When staff had finished seeing a patient their records were securely stored in the office and not left where other patients might see them. Patients did not have access to the office so could not view any confidential records kept in this area or on the computer. Staff received training in information governance and there were clear systems in place to protect confidential patient information. Staff only disclosed information to other organisations that was necessary to allow the continuation of patients' care and treatment. Reports produced by the SARC did not contain patient identifiable data.

Patients had access to bathroom facilities after their examination and any treatment they required and staff would wait outside. Staff offered each patient a care bag which contained various toiletries which could be used at the SARC and also taken away.

Involving people in decisions about care and treatment

Staff told us that patients were fully involved in decisions about their care and treatment and this was confirmed by staff entries into the patient records we looked at. Patients, relatives and carers were also involved in making decisions about referrals to other services and staff provided information to inform patients' choices. The patient records that we viewed demonstrated that appropriate and timely referrals were made in all cases.

Staff used various methods to communicate with patients in the most effective way. Interpretation services were available for patients who did not speak English as a first language or if there was any doubt about their understanding. A range of picture cards had been

Are services caring?

developed and were used for children and people who found it more difficult to communicate verbally. Staff told us that they involved child patient's parent or carer in discussions as appropriate.

Patients received written information about what to expect at the SARC upon arrival and also about what would happen next. These were provided in various formats for adults and children to ensure that they were as accessible as possible to all patients. The service's website also provided relevant information which supported the decision-making process for patients about whether or not to contact the SARC service.

Staff told us that they regularly checked that the patient was happy to continue throughout the process. If the patient expressed that they no longer wished to continue, this decision was respected. Should there be any doubt about a patient's understanding of what was happening at any stage of the process then staff would stop and take appropriate measures to support the patient to make a decision.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Our discussions with staff demonstrated that they were passionate about providing patients with emotional support and practical advice throughout their appointment at the SARC. Crisis workers were pivotal to the patient experience as they were the main point of contact for patients. Clinical staff also emphasised the importance of being aware of and responding to individual patient's needs. Staff varied the approach they used when seeing a child and communicated in a way that was appropriate to their age and level of understanding.

The patient records we looked at confirmed the support that had been offered to patients at the SARC as well as the contact that had been made with other professionals such as ISVAs and local authority social workers, to ensure that ongoing support was provided. We spoke to an ISVA during our inspection who confirmed that the SARC team were very proactive in making referrals to their service.

The SARC was accessible to patients with physical disabilities as it was located in a single storey building. The doorways were wide enough to accommodate a wheelchair or pushchair. The bathrooms were also wheelchair accessible and there were suitable adaptations to meet the needs of patients.

Arrangements were made for patients who were not able to attend the SARC for any reason to be seen at an alternative location such as a hospital or care home. Although, staff did not have access to a portable colposcope to use outside the service they could use a camera system which also provided a source of light to aid examination. The service manager had identified the more difficult to reach groups within their community and had carried out targeted work to promote the SARC service. Staff were provided with training in equality and diversity and there was a commitment to providing an equitable service to all members of their community.

Feedback was invited from patients and other professionals who had contact with the service. We reviewed feedback that the provider had gathered from patients, parents and carers who had attended the SARC in the three months prior to the inspection. This indicated a high level of satisfaction with the responsiveness of the service. Feedback received from professionals was also very positive and individual members of staff had received praise for their responsive and caring approach.

Timely access to services

Patients could access the service 24 hours a day, seven days a week and the service was available 365 days a year. When a referral was received, staff checked whether the patient was still within the timescale for a forensic examination as this could determine the urgency of the appointment. Staff also gathered other information about the nature of their needs, such as whether any treatment may be required. The target response time was 60 minutes from receipt of a referral which had been agreed with local commissioners. The majority of patients were seen within this timescale.

Some patients requested to be seen at a specific time and an appointment was offered for them to attend at a later time or date to facilitate this. Some patients did not need or want to visit the SARC, for example because the reported abuse was historic in nature. They were offered telephone advice and the opportunity to be referred on to counselling services. The provider displayed information about accessing the service on their website and in their service leaflet. Children aged 12 and under were supported to access the service by their local authority and a designated worker would arrange an appointment at the SARC on behalf of the child.

Listening and learning from concerns and complaints

There was a complaints policy in place, which was within its review date. This gave information to staff about dealing with any complaints that patients may make. Staff would attempt to resolve any issues patients may have while they were still at the service. All patients, relatives and carers were provided with a leaflet which detailed how to make a complaint should the issue not be resolved locally.

There was a system in place for recording and managing complaints, but no complaints had been received in the 12 months prior to the inspection so we were unable to fully assess how complaints were investigated and responded to. The complaints process provided patients with information about how to escalate their complaint should

Are services responsive to people's needs?

(for example, to feedback?)

they not be satisfied with the response. Although no complaints had been received, the service manager told us that patient feedback whether it was positive or negative was important to the ongoing improvement of the service.

Are services well-led?

Our findings

Leadership capacity and capability

The service manager was in the process of becoming the registered manager for this location. Staff told us that the service manager led by example and provided strong leadership and direction, as well as empowering staff to be autonomous. The service manager was also a forensic nurse examiner and covered shifts on the rota when required and had relevant qualifications and training for their role.

The provider's medical director was the registered manager at the time of the inspection and provided strategic oversight of all SARC provision across the country. In addition, the director of nursing provided day to day operational support to the SARC staff. They were available for telephone support informally as well as taking part in the rota of senior FNEs who provided telephone advice across all of the provider's SARC services. There was effective dissemination of messages from board level to local staff through the service manager.

The staff we spoke with felt that the service was well-led and that the service manager provided strong leadership as well as being supportive. The staffing structure that was in place meant that the service could continue functioning normally when the service manager was not available. Should the staff on site feel that they could not make a decision locally, they could convene an 'emergency decision making group'. These were made up of senior managers from across the provider who could decide on more complex cases.

Vision and strategy

The provider had a clear vision and strategy of continuous learning and improvement within their SARC services and this was embedded in the practice of staff at Oakwood Place SARC. The service manager was committed to the development and upskilling of staff, such as by encouraging them to take further university qualifications. A nursing preceptorship programme had been established with an experienced member of the clinical team. The vision was that the service would look to recruit newly or recently qualified nurses as preceptees on a two-year programme. It was hoped that this would help to secure longer term stability and growth of the staff team.

The service manager was committed to bringing about improvements to the paediatric care pathways in the community for patients who had used the SARC. This involved trying to encourage partner agencies to establish a formal treatment pathway for children to be tested and treated for sexually transmitted diseases. They were also part of national group which was focussed on this work.

There was a committed and stable team of staff and we saw that staff turnover was low. The service manager shared messages from the senior management team with staff at team meetings and through other communications, such as the staff noticeboard and by email.

Culture

The service manager told us that staff morale was good and that staff worked well as a team. This was borne out during our interviews with staff, who told us that they felt motivated to come to work and that they made a positive difference for patients. There was an inclusive culture among the staff team and this was encouraged by the service manager.

The staff we spoke with felt their views were considered in the development of the service and that their views were respected and listened to. During our inspection we saw that staff were comfortable and confident talking to each other and the service manager. There were different avenues of support available for staff to talk through any challenging cases they had been involved with.

The provider had a policy relating to the Duty of Candour which guided staff about what action would need to be taken whenever any incidents occurred, including considering whether the patient needed to be informed. Staff were aware of their responsibility to report any adverse events and told us they knew how to do so. Staff told us that there was a culture of learning and improvement, rather than trying to apportion blame. This meant that staff were comfortable in reporting any adverse events. For example, there had been an incident whereby there were out of date items in an emergency grab bag. As a result, the frequency of checks had been increased to reduce the likelihood of this happening again.

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

Are services well-led?

Governance and management

During our inspection we reviewed the provider's policies and procedures relating to the SARC service and saw that these were up to date and kept under review. Clinical governance meetings took place regularly which involved service managers from the other SARCs in the region. This supported the local clinical governance arrangements because lessons learned and ideas for improvement were shared as well as findings from inspections. Managers also shared feedback from conferences they had attended and any initiatives that they were working on.

The service manager had the overall responsibility for the management and clinical leadership of the service as well as the day to day operation. Key tasks were delegated to appropriately trained and qualified staff and the team were fully supported by the senior management team. Staff understood what the management arrangements were as well as their own roles and responsibilities. When the service manager was not available or on site, staff had access to colleagues in other SARC services as well as senior managers for advice and support.

A risk register was maintained which covered the four SARC services in the region and included any risks pertinent to the Oakwood Place SARC. This demonstrated that the service manager was proactive in reporting any matters of concern so that the provider or commissioner could take the required action. The risk register was also used to document any issues that were not directly under the control of the SARC, but which impacted upon their patients. For example, the lack of an established pathway for children to receive treatment for sexually transmitted infections had been logged as a risk and the provider had raised this issue with relevant partner agencies.

Appropriate and accurate information

Staff maintained detailed, legible and appropriate records about the patients that used the service, and these were stored securely both in paper form and electronically. This meant that, should computer systems not be available, staff could still refer to a paper record. Data about the performance of the service was shared with commissioners on a monthly basis as part of the contract monitoring arrangements. The commissioners reported that the data quality from the Oakwood Place SARC was good and demonstrated that they were meeting their contractual obligations.

The findings of audits were shared with individual staff and at team meetings to ensure that there was a culture of continuous improvement. The views of patients were important to the development of the service. Each patient, relative and carer was asked to provide feedback before they left the SARC. The comments that we reviewed were very positive and complimentary. This feedback was shared with staff to ensure that they also received the positive feedback about their work.

Engagement with clients, the public, staff and external partners

The service manager and staff had been involved in engagement work with their police partners to give them a greater understanding of SARC services and the rights of patients. Staff had also recently taken part in a police initiative aiming to inform members of the public about the law regarding female genital mutilation and the harm it can cause. During our inspection the SARC team hosted an open day where professionals from many different agencies were invited to visit the SARC and learn about the service provided. This was part of an annual calendar of similar events which aimed to boost the profile of the service.

The provider was also keen to improve the experience of children whilst at the SARC service. To help achieve this, some young people were asked to visit the SARC and produce a report and suggestions for improvement. We saw that, where possible, changes had been implemented such as the provision of Bluetooth speakers which patients could link to their phones to play their own music.

Staff were encouraged to provide their feedback through their group and individual supervision sessions as well as during team meetings. The minutes of meetings that we reviewed evidenced that staff were able to fully contribute to the discussions. Staff were also encouraged to put forward ideas for the improvement and development of the service.

Continuous improvement and innovation

There were effective systems and processes in place for learning, innovation and continuous improvement. Staff had access to a wide range of relevant training and a peer review system which encouraged constructive feedback and continual learning and improvement. The provider had implemented a programme of regular audits of various aspects of the service. If any issues were noted, these were

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fed back to staff with the focus being on learning and improving the service provided. For example, the service manager carried out record keeping audits to check that staff were completing records appropriately and the findings shared with the individual staff member.

The service manager had worked with the police and other partner agencies to develop a new initiative called 'Project Goldcrest'. This was being piloted for its effectiveness during our inspection and was aimed at giving child victims of sexual exploitation (aged 13-17) greater choice and control. A 'Self-Administered Forensic Evidence' (SAFE) kit had been developed which would allow the child to collect their own forensic evidence if they did not want to undergo an examination. This evidence could be stored for much longer than is usually required so that the child had longer to disclose sexual abuse and exploitation to the police. It was hoped that this more child focussed approach would lead to an increase in the level of reporting of abuse and would be reviewed after 12 months.

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