G4S Health Services (UK) Limited

The Glade Sexual Assault Referral Centre-Telford

Inspection Report

30 West Road
WellingtonTelfordShropshireTF1 2BB
Tel: 01886 833555
Website: www.theglade.org.uk

Date of inspection visit: 14 May 2019
Date of publication: 03/01/2020

Overall summary

Summary findings

We carried out this announced inspection on 14 May 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.

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

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

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

Background

The Glade Sexual Assault Referral Centre (SARC)Telford provides a service of care to women and men who have allegedly been raped or sexually assaulted in West Mercia; Worcestershire, Herefordshire and Shropshire, Telford and Wrekin. The services are commissioned by NHS England and West Mercia Police.

The Glade SARC Telford provides services to adults (over 18 years of age). West Midlands Paediatric Service, led by Birmingham Community Healthcare in partnership with several other trusts and organisations, provide the service to anyone under 18. Young people aged 16 and 17 years old can choose to access The Glade instead of the regional paediatric services if appropriate.

The SARC is located within a quiet area in a housing estate within its own secure gated grounds. There are two separate buildings with level access for people who use wheelchairs. The SARC has its own car parking and the signage is discrete. The entrance is welcoming, with CCTV for added security. The entrance to the SARC is accessed by key and security code which prevents the general public from accessing the centre unauthorised. A clear record is maintained of all visitors.

The staff team consists of full-time and flexible staff that provide cover both day and night. Permanent staff include a centre manager, a coordinator (who is a crisis

Summary of findings

worker) along with two nurses and a midwife who are sexual offence examiners. Flexible staff are staff who work an on-call rota, to cover daytime, nights and weekends and include examiners and crisis workers.

The service is provided by G4S Health Services (UK) Limited (G4S) and as a condition of registration 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 **The Glade SARC – Telford** is also the SARC manager.

The centre is not always manned with staff attending only when required. All the administration is carried out at the Worcester SARC. All requests and referrals to the Glade SARC are managed through a call centre run by G4S, who liaise with examiners and crisis workers to ensure appointments meet the needs of patients and are within forensic examination timescales.

On the day of inspection, we spoke with four staff including the registered manager, the coordinator, a sexual offence examiner and a crisis worker. We looked at the records of nine patients. We left comment cards at the location in the two weeks prior to our visit but received no responses from people who had used the service in that period. We looked at policies and procedures and other documentation about how the service is managed.

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 in place to manage risk but some were not effective.
- Safeguarding procedures were inconsistent.
- Staff did not always adequately document the mental capacity of patients.
- Records were not always completed in a consistent manner and the voice of the patient was not always apparent.
- The service had thorough staff recruitment procedures.
- Staff knew how to deal with emergencies. Appropriate medicines and life-saving equipment were available.
- The clinical staff provided patients' care and treatment in line with current guidelines.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- The appointment/referral system met patients' needs.
- The service had effective leadership and culture of continuous improvement.
- Staff felt involved and supported and worked well as a team.
- The service asked staff and patients for feedback about the services they provided.
- The service staff dealt with complaints positively and efficiently.
- The staff had suitable information governance arrangements.
- The service appeared clean and well maintained.
- The staff had infection control procedures which reflected published guidance.

We identified regulations the provider was not meeting. They must:

- Carry out safeguarding audits to improve the assessment of risks.
- Carry out audits to improve the quality of mental health and mental capacity assessments.

Full details of the regulation/s the provider was/is not meeting are at the end of this report.

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

- Record safeguarding issues arising from substance misuse.

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 not providing well-led care in accordance with the relevant regulations. We have told the provider to take action.

Are services safe?

Our findings

Safety systems and processes

There were safeguarding policies and procedures at G4S that provided staff with information about identifying, reporting and dealing with suspected abuse. We noted they did not include formalised procedures for repeat attenders to the SARC.

The SARC manager had oversight of the local safeguarding referrals made and the outcomes but there was no regular formal safeguarding audit. This meant that there was no opportunity to understand the effectiveness of changes in documentation. Safeguarding was a standing agenda item at each team meeting and this was used to share any recent changes, for example paperwork. The service had a national lead for safeguarding who oversaw the processes across all the SARCs in the providers portfolio.

Evidence showed staff received safeguarding training following the intercollegiate guidance on safeguarding roles and competencies for healthcare staff. We saw evidence that the co-ordinator attended training and shared learning at team events. This was the main way of staff learning about local updates and pathways because there are only staff on site when there is an examination.There are processes to support staff to attend local training sessions, for example, courses are initially offered to those on call that day. Staff can attend if there are no referrals that shift. This means that the service cannot be assured that most of the staff are aware of local services and pathways and have had opportunity to build local relationships.

Staff kept comprehensive logs of safeguarding training and activity to demonstrate their ongoing competence. Data provided showed that almost all staff had received safeguarding level 3 training and the remaining one staff member had been booked on the next training session. Staff we spoke with knew about the signs and indicators of abuse and neglect and how to report concerns, including notification to the CQC.

Safeguarding practice was generally well evidenced in patient records and there was a system to highlight vulnerable patients on records. For example, adults with known safeguarding concerns, people with a learning disability or a mental health condition, or who required other support such as with mobility or communication.

New safeguarding and assessment templates were completed inconsistently and we found discrepancies in how the questions were answered. Some staff answered each question with an answer clearly recorded whereas other staff crossed through questions making it unclear whether this meant that there were concerns or the answer was not applicable. We did not see evidence of an audit or planned audit activity to assure the provider of the impact of the new safeguarding assessment.

We did not see evidence of an agreed and effective recording process that reflects how staff have assessed and monitored a patients mental health. Examiners complete mandatory paperwork and when indicated best interests assessments. However, records did not reflect the ongoing assessment of mental health during the patients time at the SARC.For example, some staff completed a mental health assessment before the physical examination and some staff afterwards. The actual time of the assessment was not recorded in the patient record which made it difficult to track deteriorating mental health during a patient's time in the SARC.

Staff explained that substance misuse was not explicitly explored or recorded in examination records because it may be used against victims in criminal proceedings. Staff use a data collection form which asks whether the patient was intoxicated or whether they are dependant on a substance. If indicated on review of the records the co-ordinator will reassess the patients substance misuse during the follow up phone call. Referrals for support are made at this point.

When children and young people were involved or may have witnessed a significant event, the staff reported they checked whether children were known to children's social care. When we reviewed records, we saw evidence that responses to the hidden child were inconsistent. Some practitioners called the Multi-Agency Safeguarding Hub (MASH), the single point of contact for all safeguarding concerns regarding children and young people, to see if the patient was open to them. In these cases conversations with children's social care are documented. There is no safeguarding audit to provide assurance that the processes within the SARC are effectively safeguarding the hidden child.

Staffing

Are services safe?

Staff were employed in line with the provider's recruitment policy. Pre-employment safety checks included enhanced Disclosure and Barring Service (DBS) checks, an extensive interview process and validation of references and qualifications by the provider's central HR team. Staff were also subject of additional national vetting through the police before being employed.

Team members reported staffing to demand ratio felt safe and manageable and they received their rotas in a timely manner. Staff explained that if it was in the patient's best interests for them to stay, that staff members could claim overtime. This allowed them to work in the best interests of the patient. Staff members told us they were never alone in the building. The call centre co-ordinated the crisis workers and the sexual offence examiners arriving at the same time. Staff reported that they always phoned to close a case and phoned the call centre when they got home. During the visit we saw working panic alarms in the rooms.

Staff maintained their competence through regular refresher training in key subjects essential to the effective running of the service and through peer review of their work. Sexual offence examiners (SOE) received specialist training in their role that met national requirements set by the FFLM with the provider undertaking peer review of their work to provide assurance of their experience and level of competence. This approach to peer review and supervision for clinical staff supported practice improvement. Patient notes and video recordings made by SOEs were peer reviewed by an allocated senior SOE quarterly according to the policy for staff at each of the provider's SARCs. This ensured SOEs worked consistently according to FFLM standards and enabled them to check the accuracy of their work. SOEs peer reviewed each other's records and participated in peer review activity with clinicians from other providers.

The service had a whistleblowing policy. Staff told us they could raise concerns and they had confidence that these would be addressed.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety throughout their episode of care, from the first call to the pathway support services, during the examination and whilst receiving follow-up care. Patients were assessed for a range of risks, including sexual exploitation, deliberate self-harm, potential suicide and sexually transmitted infections (STI) using templated assessment tools. In police referrals, to maintain the integrity of the initial evidence, SARC staff started the risk assessment using the police information. We found that the voice of the patient was not as strong in these records as those that had self referred.

Staff acted to assure the safety of patients identified as being at risk of harm or with urgent health concerns. For example, the examination included a full assessment for the need for post-exposure prophylaxis after sexual exposure (PEPSE) or the need for emergency contraception. In such cases appropriate medicines were supplied. They encouraged patients to attend with someone who could support them to make the process less daunting. Guidance on assessment was embedded within the records.

The co-ordinator, who covered the sites in Wellington (Telford) and Bransford (Worcestershire), was responsible for oversight of any onward referrals that may be required such as the counselling service or sexual health or genitourinary medicine (GUM) clinics. All patients were subject of a follow-up to check on their health and wellbeing. Referrals to other services were made or repeated at this follow-up to ensure patients were receiving appropriate support. Records we reviewed showed evidence of effective follow up for referrals related to the patient. Patients were re-assessed for risks such as exposure to domestic abuse or the risks to their physical and mental health when they were seen by the ISVA workers.

There was a corporate business continuity policy covering the provider's work. The service's health and safety policies, procedures and risk assessments were up to date. Emergency equipment and medicines were available to reflect the Resuscitation Council Quality standards for cardiopulmonary resuscitation practice and training. Staff kept records of their checks to make sure these were available, within their expiry date, and in working order. Staff knew who to contact in an emergency, including for incidents of self-harm, violent behaviour and first aid.

Staff knew how to respond to medical emergencies and completed training in emergency resuscitation and basic life support (BLS) with airway management. Immediate Life Support (ILS) training for sedation was also completed. Emergency equipment and medicines were available, and

Are services safe?

staff kept records of their checks to make sure these were available, within their expiry date, and in working order. There was a well-stocked emergency bag that contained emergency items such as those for airway management.

The provider had a system in place to ensure clinical staff had received appropriate vaccinations and the service had clear protocols in place to support patients with urgent health concerns.

Premises and equipment

There were processes in place to ensure equipment was used safely. This includes safe arrangements for specialist equipment used for recording intimate images during examinations including photographs and video. These records are used by forensic examiners to facilitate a review of findings and for second opinion. At The Glade there were appropriate arrangements for obtaining consent for making a photographic record and for ensuring the safety and security of these records in accordance with national guidance issued by the Faculty of Forensic and Legal Medicine (FFLM).

Equipment was regularly checked, and disposable parts of the equipment were within their expiry dates. This included specialist equipment used for recording intimate photographic and video images. Medical devices were replaced annually with up to date equipment according to a contractual arrangement with a supplier.

Infection prevention and control measures were appropriate. The service carried out infection prevention and control audits and regular "floor walks" to review the premises. The service was clean when we inspected.

Arrangements to remove waste from the centre were appropriate. There were decontamination protocols in place to ensure high quality forensic integrity in line with the operational procedures and equipment for medical facilities in victim examination suites or Sexual Assault Referral Centres (SARCs) FFLM 2016. We saw cleaning schedules for the premises. Policies and procedures were in place to ensure clinical waste was segregated and stored appropriately.

Information to deliver safe care and treatment

We noted the information in the patient records was accurate, complete, and legible and the records were kept securely and complied with data protection requirements. A review of the records showed that information was taken to ascertain as comprehensive background as possible using risk assessment templates based on templates recommended by the FFLM with specific forms for adults and for young patients aged 16 and 17. Although, as noted above, not all potential risks were always identified.

Where a patient was identified as at risk of harm or urgent health concerns were identified, immediate and continuing action was taken to safeguard them. This included an assessment for post-exposure prophylaxis after sexual exposure (PEPSE), antibiotic and/or hepatitis B prophylaxis and the need for emergency contraception as well as physical injuries that needed urgent treatment. Risks to people who use the services were assessed, monitored and managed.

Internal information sharing between all the staff groups was effective and this ensured staff in different parts of the service understood a patient's case. Patient referrals to other service providers contained specific information which allowed appropriate and timely referrals in line with service protocols and current guidance.

Safe and appropriate use of medicines

The service had systems for appropriate and safe handling of medicines. The staff we spoke with were aware of current guidance with regards to prescribing medicines. All medicines were ordered from an approved supplier with a suitable stock control system of medicines which were held on site. All the medication we looked at was within the expiry date, stored safely and securely, and the stock and administration records were accurate.

The service held a limited number of medicines including emergency contraception, post-exposure prophylaxis after sexual exposure (PEPSE) (used for emergency HIV treatment) and paracetamol. The service stored and kept records of NHS prescriptions as described in current guidance.

Staff administered certain medication under a Patient Group Direction (PGD). That is, a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation. The PGDs were in date clear, appropriately signed off, compliant and in line with current best practice.

Are services safe?

The provider carried out monthly medication audits including the application of PGDs for use of prophylactic medicines. The latest audit showed that assessments of patients for these medicines were accurate and that medicines were provided safely.

Track record on safety

There had been two incidents raised in the last 12 months which were both clerical. We examined these and found the SARC manager had taken appropriate action to investigate and share the learning to prevent reoccurrence. All staff had access to the incident reporting system with management oversight. We saw evidence of a comprehensive review of processes and documentation in response to a serious incident.

Lessons learned and improvements

The service learned and made improvements when things went wrong but also learned from things that went well. All learning was shared with the team electronically to prevent such occurrences happening again. In addition to discussing shared learning from local incidents at team meetings, the team also reviewed information from other G4S provided SARC services, and these were used to improve services which was good practice.

Staff told us they were aware of the process and that they were made aware of those incidents that affected their roles.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

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

Policies, procedures and pathways enabled staff to deliver care and treatment that was based on the Faculty of Forensic and Legal Medicine (FFLM) quality standards and National Institute for Clinical Excellence (NICE) Infection Prevention and Control quality standards. Staff had access to the policies, pathways and documents through the intranet. Staff found this extremely useful and informative. Any changes to national guidelines were discussed and disseminated to staff through newsletters, emails and team meetings.

Staff had the relevant experience and skills to assess health needs and deliver care and treatment in line with FFLM and British Association for Sexual Health and HIV (BASHH) standards and guidance supported by clear clinical pathways and protocols to include plans for immediate healthcare including emergency contraception, antibiotic or HIV/Hepatitis B prophylaxis. Records showed that assessments were comprehensive and ensured the patient needs were identified. However, safeguarding and mental health needs were not always consistently considered in the records we reviewed.

Consent to care and treatment

Policies outlined how consent and confidentiality should be managed in different circumstances, including in a forensic environment. Signed consent was obtained from all patients in accordance with the Faculty of Forensic and Legal Medicine (FFLM) guidelines with verbal consent being sought at differing stages of examination. If there was doubt that a patient had not understood what was happening, the examination did not proceed. Staff understood the importance of obtaining and recording patients' consent to treatment.

Consent to care and treatment was evidenced in the records we reviewed. Staff records showed that they had received training in the Mental Capacity Act (MCA) 2005. During our interviews with staff we were assured that they knew how to assess a person's capacity using the relevant code of practice, and whom to involve in the process to ensure decisions could be made in a patient's best interests. However, our review of records showed that the assessment documentation did not sufficiently support staff in decision making about this and this had not been picked up by the service in their audits.

The team understood their responsibilities under the act when treating patients who may not be able to make informed decisions. Clinical staff told us they gave patients information about treatment options and the risks and benefits of these, so they could make informed decisions. Staff described how they involved patients' relatives or carers when appropriate and made sure they had enough time to explain treatment options clearly.

Monitoring care and treatment

We saw evidence of a core audit programme which included infection control, medicines management and health and safety. Management audited patients medical care records to check for content and consistency. The service was supported by the provider, G4S, in conducting some medical and governance audits. Additional patient record audits were in place for newly employed staff to help them improve their examination and record keeping. Staff were involved in both self audit and peer review to help them improve their examination and record keeping. A recent example was given of a record keeping audit where staff were given feedback and the audits were discussed during appraisal processes.

Effective staffing

New starters followed a role specific induction process that covered information such as organisational structure, the vision and goals, common processes, standard operating procedures (SOP), information governance guidance and professional service standards. A shadowing period was available and determined on an individual needs-led basis. In addition, crisis workers and forensic clinicians received competency-based training.

Staff told us training opportunities were available and they were supported to develop. All staff completed training such as medical emergencies and basic life support training annually with specific training available for each group of staff, these used national occupational standards

Are services effective?

(for example, treatment is effective)

set out by the 'Skills for Justice'. The sexual offence examiner had completed an examiners course and subsequently had competencies signed off through mentoring and buddying.

Clinical staff completed continuing professional development and told us the service provided support and encouragement for them to do so. All clinical staff were involved in quality improvement initiatives including peer review as part of their approach in providing high quality care. Peer reviews provided updates and support and were undertaken as often as a staff member requested with a minimum of four reviews a year. They were held with a peer reviewer from the West Midlands and could be one to one or in a group. Clinical advice was available whenever needed with feedback given through the supervision and audit processes.

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

Staff told us they discussed training needs at annual appraisals and during clinical supervision. Managers monitored staff training, supervision and appraisal and mandatory training was up to date. Whilst formal supervision records were of a good standard, some ad-hoc supervision was not recorded. We reviewed training arrangements, records and spoke with staff and management to confirm that staff were competent in both forensic medical examinations and in assessing and providing for the holistic needs of patients, including the assessment and management of physical and emotional conditions that may or may not be related to the alleged sexual abuse.

Co-ordinating care and treatment

Staff worked with multi-agency professionals to ensure the examination and follow-on care met patients' needs. The team were working with the police, health and social care professionals effectively to ensure patients received support and continuity of care. Staff members felt they had good relationships with the main providers they refer on to such as the ISVA service. The co-ordinator had a key performance indicator (KPI) to make a follow up call to the patient within 72hours of assessment which they met for all patients that access the SARC. This was to allow referrals to be processed more quickly. Records we looked at confirmed this call was being made and the data showed the target was being met.

There were clear and effective pathways into and out from the SARC that included psychosocial, advocacy, counselling and ongoing support services. When patients received care from a range of different staff, teams or services, this was coordinated by a member of staff from the SARC to ensure a smooth transition. We saw evidence of pathways from the SARC to other agencies such as the emergency department and to the sexual health or genitourinary medicine (GUM) clinics as well as pathways into the SARC such as those patients who wanted to self-refer. Staff reported good relationships with local GUM clinics and if a patient did not attend any follow up appointments then staff at the SARC followed this up with the patient. This was applied consistently in the records we saw.

All patients had access to short- or long-term counselling via an external provider. There was sometimes a wait for this service but in the interim crisis counselling can be provided at The Glade. Patients have a choice about what type of counselling they would like to access from the independent sexual violence advisor (ISVA). The ISVA workers also made referrals to local services for all patients, such as the community mental health team. We noted consistent and effective multi-agency work in the records we reviewed.

Are services caring?

Our findings

Kindness, respect and compassion

During the inspection, we found that staff were kind, respectful and compassionate to patients who had experienced unwanted trauma. Staff emphasised the importance of being kind and helpful when patients were in pain, distress or discomfort. Staff explained that when patients arrived at the service they were greeted with empathy, respect and understanding. Staff explained the importance of being non-judgemental and supporting patients to feel welcomed and relaxed. Staff ensured patients knew they could go at their own pace and they could stop the examination at any time.

We did not receive any completed comments cards from patients in the two weeks leading up to our inspection. However, the provider collected feedback which commented positively that staff were welcoming, friendly and helpful.

Patients could access washroom facilities after their treatment and a change of clothes were made available for patients if this was required. Hot and cold drinks and snacks were offered to people on their arrival

Privacy and dignity

Staff were aware of the importance of privacy and confidentiality. The service respected and promoted privacy and dignity for patients by ensuring the layout of the rooms and waiting areas provided privacy. There were separate entrances, so patients could access the service discreetly if they wanted to protect their anonymity. Patients were examined with sensitivity with privacy screens in the examination rooms that enabled patients to undress in privacy.

All members of the staff team understood the importance of not disclosing information about the patients they supported with unauthorised individuals and organisations. The office areas were private, and information was not visible to unauthorised personnel or patients. Confidential records were stored and held securely to protect people's personal data and right to privacy. Patient paper records were securely stored, and staff password protected electronic records.

Involving people in decisions about care and treatment

The service's website and information leaflets provided details about the range of services available and outlined the confidential nature of the SARC. Patients could choose how much of the service they used and were explained what they could expect when they attended to help them understand the treatment options. Patients who self-referred had a choice about whether to involve the police or not, including whether to provide forensic samples so they could make that choice later if they wished.

Patients were empowered to make informed decisions about their treatment and care. Clinical records confirmed this and clearly outlined the steps the practitioners had taken as well as all the information discussed with the patient. Records confirmed consent was obtained as patients progressed through the journey including the taking of intimate photographs and videos. Staff described the conversations they had with patients to satisfy themselves they understood their treatment options and helped them to think about their treatment and aftercare. When services had been declined, patients were given the appropriate information and the choice to return and use the service if they wished.

Staff helped patients to find further information and access community and advocacy services. Interpretation services were available for patients who did not have English as a first language. Interpreters were often arranged by the police and remained on the opposite side of the curtain if they are needed for an examination. Language Line, telephone interpretation is available for follow up care. We saw notices in the communal areas, informing patients this service was available. Information is available for patients in different languages if needed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The SARC organised and delivered services to meet patients' needs and preferences considering the needs of the local population. All staff were clear on the importance of emotional support needed by patients when delivering care. The crisis workers were the initial point of contact and had the skills and knowledge to offer emotional support and advice to patients who attended. Staff recognised the vulnerability of all patients accessing the service and described examples of how they adapted their care to meet individual needs.

Staff from the centre responded to people with particular needs, such as patients with a history of domestic abuse, substance misuse, mental ill-health, self-harm, female genital mutilation (FGM) and those who are sex workers to ensure they had equal access. Staff told us they made referrals to appropriate services, with consent, for vulnerable patients.

People who did not want the involvement of police or criminal justice processes could self-refer and access any of the services offered. This included a forensic examination, a holistic health assessment, STI screening, emergency contraception and the ISVA service. The centre kept all forensic samples of people who self-referred for seven years to ensure they could have the opportunity to involve the police later if this was what they decided.

The service was accessible to people who use wheelchairs with full, level access throughout the location. Interpreters were arranged for every patient whose first language was not English.

Feedback collected by the provider showed that patients were made to feel welcome, comfortable and safe. Patients stated they were enabled to make decisions about what they needed, and they were provided with information about the processes. Feedback from patients stated they were made to feel welcome and were looked after with one patient feeling the staff went the extra mile to make them me feel comfortable.

Timely access to services

Patients had access to a 24-hour, seven-day service through a responsive pathway. Patients accessed the service within acceptable timescales whether they were referred by the police, through safeguarding processes or had self-referred. Other providers, such as GPs or sexual health clinics could make referrals to the SARC. The provider's data showed the centre consistently met the one-hour call-out timescale.

People were given enough information about the services at the SARC and about what to expect during their episode of care. The location's website was clear, easy to navigate and stressed the confidential nature of the SARC and that patients could choose how much of the service they used and that they were in control throughout their experience.

Information showed most patients were female and the centre received a low number of male referrals. The centre collected evidence to show how often clients made a request in regards to the gender of the examiner. They also recorded how often it was achieved and whether clients chose to access the service at another location if the need could not be met. This data is shared with commissioners.

Listening and learning from concerns and complaints

The provider had a clear procedure for acknowledging and investigating complaints, with scope for complaints to be escalated by external organisations that patients could contact if they were not satisfied with the way the service dealt with their concerns. Information and guidance about how to make a complaint, concern or raise a query was clearly displayed. Systems were in place for the recording and managing of complaints, however, the provider had not received any complaints over the last 12 months.

The registered manager explained complaints and concerns are shared between all G4S SARC managers and the outcomes are discussed with staff to share learning and improve the quality of the service. Feedback forms had recently been redesigned to make them more patient friendly.

Are services well-led?

Our findings

Leadership capacity and capability

Staff told us leaders had the experience, capacity and skills to deliver high-quality, sustainable care. They were visible, approachable and worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

The service had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. Succession planning was embedded in the service and strategies had been put in place to plan for future growth.

Several quality plans supported the strategy and risk registers addressed any identified harm. The service team was knowledgeable about issues and priorities relating to the quality and future of services. The leaders understood the challenges and were addressing them.

Vision and strategy

There was a clear vision and set of values. The mission statement outlined the vision and values and included The Glade's commitment to delivering an excellence service to all patients; providing sustained improvement in the care of sexually abused and assaulted adults and young people.

The service had a strategy and supporting business plans to achieve priorities which were acknowledged by all staff. The continued strategy was to increase professional and public knowledge of the services offered at The Glade, and the choices open to patients. The quality strategy focussed on implementing and operating quality systems that supported a culture of empowerment, quality management, shared learning and continuous improvement. Within the strategy and assurance framework were clear accountabilities, structures and systems for reporting and monitoring. Clinical leaders worked alongside and in partnership with service managers.

Messages were shared by the head of the SARC service and the operations manager about the vision and strategy. Staff told us they had been consulted on how they felt services could be improved and felt involved in the progress of the SARC.

Culture

The service had a culture of providing high-quality sustainable and compassionate care as shown by the positive feedback from patients collected by the provider. The leaders and managers acted on behaviour and performance inconsistent with the vision and values. Staff reported they felt respected, supported and there was a good morale. They were clear about G4S's vision and values and a recent refresh has been promoted through online training.

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

Governance and management

There were clear responsibilities, roles and systems of accountability to support good governance and management. The nominated individual had overall responsibility for the management and clinical leadership of the service. The registered manager was responsible for the day to day running of the service. Staff knew the management arrangements and their roles and responsibilities.

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

The provider had a system of clinical governance in place which included policies, protocols and procedures that were accessible to all members of staff and were reviewed on a regular basis. However, we did not see evidence of an effective process to assess and, where necessary, monitor the mental health of a patient. In addition, we saw mental capacity assessments were not always completed and records with mental capacity assessments confirmed there was no agreed timeline for staff to complete assessments.

There were systems in place for providing assurance to the Board about the safety and quality of the services provided. Data collated as part of the assurance and governance framework was used to drive service improvements. Local systems for ensuring the follow up of identified safeguarding risks were in place and overseen by the

manager. However, there were no formal safeguarding audits to explore the effectiveness of safeguarding risk assessments carried out by staff. This included the monitoring of the completion of a safeguarding risk assessment template and the professional curiosity of staff. The manager acknowledged the absence of safeguarding audits and undertook to rectify this shortfall.

Appropriate and accurate information

Information was accurate and enabled the provider to have a holistic overview of its performance. The service acted on data and operational information to ensure quality was maintained. The service had information governance arrangements and staff were aware of the importance of these in protecting patient's personal information.

Engagement with patients, the public, staff and external partners

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

The service gathered feedback from staff through meetings, surveys, and informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation, and quality assurance. The service had projects in place to help improve the outcomes and to improve the running of the service with commitment from the management team.

Projects included raising awareness by SARC promotion to Hair and Beauty salons, GP Surgeries, the Shropshire LSB Safeguarding Conference and delivering training to NHS professionals such as student midwives. The aim was to carry on this work and to continue to raise awareness of current SARC service such as increasing the awareness of the self-referral service to professionals and members of the public.

Motivational schemes such as the "employee of the month" encouraged staff to progress via professional development and promote organisational values.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 There were systems and processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk namely: • safeguarding audits to improve the assessment of risks. • audits to improve the quality of mental health and mental capacity assessments. **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**