Care Quality Commission

Sheffield Children's NHS Foundation Trust

# The Children's SARC

## Inspection Report

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## Overall summary

We carried out this announced inspection on 9 and 10 July 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 carried out by two children’s inspectors and a specialist professional advisor.

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

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

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

**Background**

The children's sexual abuse referral centre (SARC) is part of the child assessment unit located in Sheffield Children’s NHS Foundation Trust (SCNFT) in South Yorkshire and Bassetlaw. As the service is provided by SCNFT, the trust is responsible for meeting the requirements on the Health and Social Care Act 2008, and the associated regulations about how the service is run.

The service is co-commissioned with NHS England and the four Yorkshire and Humber Police and Crime Commissioners. The provider is contracted to provide a child sexual assessment service for delivery of child sexual assessment services for children and young people aged 0-16 years old or 16-18 years old (up to their 19th birthday) if the young person has additional needs or where deemed to be clinically appropriate for both acute (up to 14 days of the alleged incident) and non-recent (after 14 days since the alleged incident) cases.

At the time of the inspection the service was not commissioned to offer a 24-hour service. The service is delivered on an appointment-based system and the provider accepted referrals from Monday to Friday from 9am to 6pm and there was an advisory on-call service available from 6pm to 9pm. The service is commissioned to operate a weekend service from 10am - 6pm on Saturdays and 11am - 4pm Sunday and Bank Holidays, to accept referrals for children from the neighbouring West and North Yorkshire SARCs.

# Summary of findings

The staff team include a named nurse for safeguarding children, the SARC manager, four health care support workers and six consultant forensic paediatricians who worked as forensic paediatricians. During our inspection we spoke with the named nurse for safeguarding children, the SARC manager, two health support workers and three forensic paediatricians one of whom is a licentiate member of the Faculty of Forensic and Legal Medicine. Children and Young People's Independent Sexual Violence Advisors (ChISVAs) are based off site and are separately commissioned. Children and young people have access to two part time psychologists who are separately employed by Child and adolescent mental health services (CAMHS).

We reviewed the care and health records of 14 children and young people who had used the service and the records for the management of medicines. We checked four staff recruitment files, minutes of meetings, audits, and information relating to the management of the service. During our visit we toured the premises and observed a peer review meeting.

Comment cards were sent to the service prior to our visit and we received four responses from children and their relatives. Throughout this report we have used the term 'patients' to describe children and young people who use the service to reflect our inspection of the clinical aspects of the SARC.

**Our key findings were:**

- The service had systems to help them manage risk, however some policies required updating.
- The staff had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The provider followed the trusts recruitment policy, however this did not indicate how often DBS checks were renewed.
- 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, however there was a lack of follow up arrangements for patients ongoing care.
- 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, however audits needed to be improved to evaluate the effectiveness of the service.
- 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.

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

- Review the risks associated with DBS checks.
- Follow up two week referrals to the Children and Young People's Independent Sexual Violence Advisors. (ChISVAs).
- Improve governance arrangements to evaluate the effectiveness of the service.
- Improve policies and procedures to reflect the day to day operations of the SARC.

# Summary of findings

## The five questions we ask about services and what we found

We asked the following question(s).

**Are services safe?**

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

**Are services effective?**

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

**Are services caring?**

We found that this service was providing caring 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**

Systems were in place for staff to follow to ensure patients' safety. There was a safeguarding team based on site and the named nurse for safeguarding children provided managerial oversight of the SARC site manager and four named clinical safeguarding nurses. This meant that staff had direct access to the safeguarding team if they had any concerns about patients at risk of abuse. Safeguarding advice was also available to staff via the telephone and from the SARC manager.

Patient safeguarding alerts were used on all patient records in the service. There was a safeguarding alerts project group in the trust to monitor and audit the use of alerts within electronic records to identify risks to patients safety. The review was carried in April 2019 and found that alerts were regularly flagged on patient records and the provider was looking at the further use of The Child Protection - Information Sharing project (CP-IS).

Within patient records we found that there was liaison between safeguarding teams and we heard that safeguarding referrals were made to children's social care by staff based in the SARC.

All the staff team had received training for safeguarding adults and children that met intercollegiate guidance for safeguarding roles and competencies for healthcare staff. One staff member's safeguarding children level 3 training had expired and they were scheduled to attend the next training course. Safeguarding huddle meetings took place daily. This included representation from the SARC staff and the paediatric liaison practitioner which gave staff the opportunity to discuss patient referrals and safeguarding concerns to improve communication and decision making about each case. Forensic paediatricians understood the reporting procedures for female genital mutilation (FGM) and explained they routinely screened for FGM during every female patient examination.

**Staff**

There was an up to date whistleblowing policy in place and this included guidance for staff on how to raise workplace concerns. This included information on how to seek further support from the Freedom to Speak Up Guardians who offer guidance and support if staff do not feel able to raise concerns through line management arrangements.

There was not always sufficient substantive trained health support workers available to support the forensic paediatrician in the examination room. Health support workers covered the on-call rota and we heard that at times they were working "over and above" to ensure appropriate safe staffing levels. To cover any staff shortages additional support staff had been identified within the trust. These staff were undergoing training so that they could support the forensic paediatrician in the SARC. Staffing levels were monitored on a regular basis; rotas demonstrated that there was sufficient forensic paediatrician cover throughout the week and for the on call rota.

The provider carried out checks to ensure people were suitable for their roles. Pre-employment checks were carried out in accordance with the trust's policy. Recruitment checklists were signed by human resources to evidence that all the relevant checks had been undertaken before new employees commenced work and any gaps in employment gaps were explored. Photographic identification was held on staff records, for example, passport identification and/or driving licences.

Disclosure and barring service (DBS) checks carried out by the trust were not renewed once staff were recruited into post. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. However in one staff personnel file we found that their DBS check had not been updated since 2013. There was no additional vetting of staff checks carried out by the Police. We pointed this out to the SARC centre manager who told us they were unsure of how often DBS checks were undertaken in the trust. We checked the trust's policy that did not indicate how often DBS checks were carried out within the trust.

Staff had direct contact with the security service in the hospital in the event of an emergencies, for example, for any incidents of violent behaviour or if patients and families became challenging. Patients were not left unaccompanied when accessing the SARC and there was always more than one member of staff on site during opening hours to ensure that staff teams did not lone work. Due to the SARC being based within the hospital, staff had

access to other health service departments to support patients with their healthcare needs. For example, during forensic examinations the forensic paediatrician assessed if patient's injuries required urgent treatment and would accompany them to accident and emergency departments if this was necessary.

**Risks to patients**

Staff assessed, reviewed and managed risks to patient's health and well-being and managed signs of deteriorating health. We observed a peer review meeting between all the staff which took place each month. This process gave practitioners an opportunity to challenge and agree the outcome of each case. Peer reviews were documented and scanned onto an electronic system via an encrypted shared drive. Cases were presented of patients who had allegedly been subject to different types of abuse, such as neglect, physical and sexual abuse. External health and social care professionals were involved in assessing risks to patients and providing advice and updates on the patients care and treatment. In one SARC case we heard a patient had been subject to human trafficking resulting in modern day slavery. The patient was placed with a foster family who had supported them through their trauma and to access appropriate healthcare services to meet their unmet needs. Discussions took place in relation to the patient's history, family dynamics, evaluations from medical photographic examinations and the actions were agreed to ensure that patients were kept safe from the risk harm.

Comprehensive assessments were carried out by the forensic paediatrician during their medical examinations. This included risk assessments, body maps, completing consent forms and there was a comprehensive holistic approach to assess patients' physical and emotional wellbeing. Reports were produced by the forensic paediatrician following assessments and these were shared with the relevant professionals, such as social workers, the GP and the psychologist. In the records reviewed there was a clear analysis of risk and the child's voice was captured within the documentation.

**Premises and equipment**

Policies and procedures used to assess environmental risks were not always up to date or in place. Trust wide procedures were used and were not specific to the SARC. The business continuity plan was out of date and did not demonstrate risks associated with the disruption of the service. In addition, there was no evidence that ligature points in the premises had been risk assessed to monitor patient safety. The SARC manager explained changes to update the procedures were ongoing as part of the newly appointed health and safety officers roles within the trust. We were assured that this would be put into place.

Fire safety procedures were up to date and we saw evidence of a comprehensive fire risk assessment in place for the service. Environmental tools were in place to assess the risk to the patients who accessed the premises from slips, trips and falls. Risk assessments associated with Control of Substances Hazardous to Health (COSHH) were undertaken to ensure the safe storage of items considered to be hazardous to patients' health.

All areas of the SARC premises were observed to be clean. There was one clinical room where forensic medical examinations took place. Health care support workers were responsible for cleaning and decontaminating this room and all people entering the room wore Personal Protective Equipment (PPE) to prevent infection risks associated with their work, such as cross contamination. Staff recorded in a log book when the forensic examination room had been forensically cleaned in accordance with (FFLM) guidance.

Clinical waste management procedures were followed by staff on site in line with the trust's infection control policy. Documentation showed there were checklists in place for cleaning the waiting room and children's toys in the waiting area to prevent cross contamination. Clinical waste bins were available to dispose of used items safely in accordance with the provider's processes and staff had completed up to date infection control training to demonstrate their understanding of this.

The interview and waiting rooms in the SARC were small and did not provide a child friendly environment for children accessing the service. There was a separate playroom on site where children and their relatives could wait and children had access to jigsaw puzzles, cuddly toys, arts and crafts. Although toys and books were provided for children, there was a lack of suitable resources for adolescents to keep them occupied whilst they were waiting. We saw evidence of planned refurbishments to the SARC to move to a larger area of the building in October 2019 to improve facilities for children and young people accessing the service.

# Are services safe?

Emergency equipment was available and had been tested to ensure this was safe to use. Specialist equipment, known as a colposcope, was available for making records of intimate images during examinations, including high-quality photographs and video. The purpose of these images is to enable forensic examiners to review, validate or challenge findings and for second opinion during legal proceedings. There were effective arrangements for ensuring the safe storage and security of these records. Master copies of images and a working copy were used for peer review with parental consent. These were sealed and recorded in a log book and held in a secure cabinet in line with FFLM guidelines. Staff were trained to the appropriate level to use the equipment and there was a colposcope user guide for staff to refer to in the examination room.

**Information to deliver safe care and treatment**

Patient records were kept securely in locked filings cabinets and encrypted drives containing patient data was password protected in compliance with the General Data Protection Regulation (GDPR) requirements to ensure patient confidentiality.

Forensic items such as samples were not held on site. After forensic examinations were carried out, forensic paediatricians bagged and tagged all items and accurately recorded this on a forensic sample list before handing this to the police. Copies of the documents were retained in patient files for legal purposes.

**Safe and appropriate use of medicines**

Systems were appropriate for the safe handling of medicines. The SARC nursing staff were non-prescribers of medicines. The doctors were the prescriber of medicines. Medicines were safely managed and securely stored in appropriate conditions in the forensic examination room. Patient Group Direction such as emergency contraception was available for patients if required. (PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).

Records evidenced that FMEs shared information with sexual health services and Genito-Urinary Medicine (GUM) clinics and there was evidence of prescribing in accordance with the British Association for Sexual Health and HIV(BASSH) guidelines.

Medicines stock levels were checked by the pharmacist and these were all correct and up to date. Hepatitis B vaccinations were kept in the fridges and temperatures of the refrigerators were monitored and recorded accurately.

During the inspection the doctor initially explained there was no emergency adrenaline on site and would call the crash team in an emergency, however this meant a potential delay may result in an adverse outcome for patients. We spoke with the SARC manager about this and they showed us that resuscitation equipment was available in the SARC and immediately informed the doctor of this. Resuscitation training had been undertaken by staff to ensure that they were equipped to manage patient medical emergencies.

Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) medicines were available and held in the hospital pharmacy and the emergency drug cupboard in the emergency department, however the information leaflets for PEPSE were out of date and it was explained these were in the process of being reviewed.

**Track record on safety**

During child protection medicals and as part of health promotion, patients were screened to ensure their Hepatitis B immunisations were up to date. The vaccinations were held in a non-forensic examination room and the keys were held in a secure place. The doctor administered vaccinations and recorded this in the patients' records and needles were disposed of safely in accordance with the trust's policy.

**Lessons learned and improvements**

Systems were in place to drive continuous improvements. There was a comprehensive audit undertaken on the sexually transmitted infection (STI) pathway to improve patient safety. This was to ensure that staff were routinely documenting in patients' records that they had accessed sexual health services and to identify the most vulnerable patients who would benefit from being supported with access to sexual health clinics. Recommendations identified the need to improve links between GUM services and SARC in all areas (outside of Sheffield), and sharing information with commissioners to highlight any risks to patients who had missed follow up appointments and how this could be improved.

# Are services effective?

## (for example, treatment is effective)

## Our findings

**Effective needs assessment, care and treatment**

Psychological support was available to patients experiencing psychological trauma related to abuse, neglect and trauma. Psychologists used a different electronic system and there was a clear referral process in place from the SARC to psychologists via CAMHS. The psychologists offered a range of interventions to support patients who experienced significant trauma to enable their needs to meet effectively. They offered a flexible service to patients and their relatives that was needs led. This included pre and post court proceedings counselling and options to self refer into the service up until the patient reached 18 years old. Safeguarding issues were flagged within electronic records to ensure professionals accessing the record could easily identify risks to patients within their caseloads.

The child assessment unit was based on site and this supported the co-ordination of care with other professionals and agencies when concerns were raised about the physical, emotional and potential neglect of a patient. The forensic paediatrician carried out medical examinations and a patient's history was discussed with the child, parent, the social workers and other professionals who raised the initial concerns.

Outcomes of assessments were shared with the GP, social workers and other professionals and these reports were provided for child protection and care proceedings. Referrals to wider health services were sent to sexual health services and CAMHS to ensure that patients received effective care and treatment to meet their needs.

**Consent to care and treatment**

Staff understood, and records evidenced, that consent to care and treatment was obtained in line with legislation and guidance and that patients were offered treatment options and the risks explained.

Staff we spoke with obtained consent using assessments based on Gillick competence and in accordance with Fraser guidelines to determine if patients were able to consent to care and treatment without parental consent, for example, when obtaining consent for child protection medicals and discussions about contraceptive advice. The SARC manager explained they obtained consent from patients in relation to taking photographic images of injuries and the importance of communicating in a child friendly way about what they were agreeing to and the decisions that may impact them.

Where a patient refused consent for care and treatment staff listened and were guided by the patient. Discussions took place on what may happen if they did not what to proceed with the examination or if the patient was distressed and this was recorded in the patient records. Where it was indicated that patients had complex needs, their communication needs were documented to ensure patients were understood how they would be supported by the service.

**Effective staffing**

Staff were supported with effective supervision when this was required. For example, the SARC staff team had been involved in providing effective care to patients involved in a high profile case. Following on from the case staff were offered team briefing sessions and individual referrals were made to the health and wellbeing service and occupational health providing access to guidance and support.

Regular one to one supervision and group meetings had been attended by staff to discuss their performance, skills and practice and identify the areas they could improve. There was no evidence of supervision records held within the SARC service and we were told these were held centrally by the trust. However we were assured by the staff team they accessed regular supervision, including group supervision facilitated by the psychologist and they told us that they felt well supported.

Essential training was completed by staff to equip them with the skills and knowledge necessary to provide effective treatment and care. New employees underwent an induction to develop the skills and experience that they required to support patients. Staff performance was monitored and assessed during probationary period before they were confirmed in post. A monthly matrix was monitored by the SARC manager to ensure oversight of compliance of training was being adhered to. The training matrix demonstrated that health care support workers had access to learning and development that was provided throughout the year on a rolling basis and showed that staff had attended regular training.

The training programme comprised of topics including child protection, resuscitation, health record keeping,

# Are services effective?

## (for example, treatment is effective)

PREVENT awareness and a Workshop to Raise Awareness of PREVENT (WRAP), risk management, bullying harassment and equality, moving and handling, information governance including Datix and fire safety. Training needs were discussed at team meetings and information was disseminated following attendance to share learning, for example, staff attended lunchtime seminars offered by the local authority which covered a broad range of topics, including safeguarding themes.

Clinical staff had access to continuing professional development (CPD). All staff in the SARC participated in a well embedded peer review programme. Training needs identified during one to one discussions were added into personnel files and attendance at future training events monitored. The electronic training system (ESR) was used within the trust, which recorded face to face and online training. Information we reviewed showed that staff were offered additional training to update their knowledge and skills.

There was a programme of training in place for forensic paediatricians to undertake forensic examinations. This entailed shadowing another examiner and interactive training, such as the use of audio visuals and hands-on demonstrations. Five out of the six forensic paediatricians had completed the FMERSA course. FFLM best practice days were attended and staff received emails in relation to FFLM guidance updates. Forensic paediatricians had completed training to ensure they had the right skills for preparing and giving evidence to the courts in safeguarding cases.

**Co-ordinating care and treatment**

SARC practitioners within Sheffield children's hospital worked with other professionals to ensure there was a joined up approach to ensure patients received effective care. Advice and guidance were given by forensic paediatricians to external health professionals over the phone. There was a folder detailing telephone advice that had been given, such as, who had contacted the service and what had been advised about the next steps to take in relation to accessing the service and the ongoing support available.

Staff attended a SARC user group meetings and these took place four times a year. Health professionals came together from SARC staff teams across South Yorkshire, including police and social care. There was good attendance from the forensic paediatricians and named doctors. Staff described the user group as being an important part of SARCs working closely with the police across South Yorkshire to share information and look at different ways of working across the teams.

The service had recognised that health support workers were not routinely updating their interactions with patients in the health records. For example, there were no written records about food and drinks being offered to patients, interaction, behaviours during play and observations. This was recognised by the SARC manager as an area for improvement as she was aware that, on occasion, further disclosures and important detail from observations had been shared by the support workers with the forensic paediatrician. New paperwork had been introduced called 'support worker observation forms' to ensure interactions with patients were routinely documented as an important part of the SARC process, however, it was too soon to say if this had improved.

# Are services caring?

## Our findings

**Kindness respect and compassion**

Patients were treated with kindness, respect and compassion. Staff explained that the teams worked together to support patients who accessed the SARC. Health care support workers were the first point of contact when patients arrived at the SARC and staff were able to plan for their reception, taking into account any psychological or emotional support they may need.

Patient feedback obtained by the service was overall positive and complimentary about staff support. Feedback questionnaires had been written in a child friendly format to ensure patients understood what they should expect to happen when they accessed the SARC. Patient comment cards showed that children, young people and their families thought that staff made them feel welcome on arrival, explained what would happen, that staff had listened to what they had to say and examinations were carried out sensitively.

Two patients and two relatives had completed the Care Quality Commission (CQC) comments cards about their experiences using the service and the feedback evidenced that patients were satisfied with the service. One patient had written the service was good because they had a playroom but also bad because they had to wait in pain. A second patient recorded the service was amazing and the staff were helpful, polite and that it was the best hospital they had been to. They further added the staff let them talk about how they wanted to be a nurse.

Families commented on the availability of the service and how staff provided a holistic approach to support them through the process. One family member had commented that the SARC availability and the facilities were excellent. A second parent had written that staff were friendly and how they had put their child at ease. They said the staff focused on the needs of the patient and that the staff were supporting them emotionally throughout the process.

Children, young people and their families were advised about the gender of the examiner prior to accessing the service. The forensic paediatrician explained patients rarely made requests for preferred gender staff during their care and treatment. However, one patient had requested a male doctor and the trust made efforts to accommodate this, but at the time a male forensic paediatrician was not available. To address this the provider was in the process of liaising with a male forensic paediatrician in an external organisation to provide additional cover when this was requested by patients.

**Privacy and dignity**

The service was patient led during the whole process. Detailed examination records evidenced person centred care and the child's voice showed patients were listened to and given the option of not continuing with the examination if this was required. Patients had access to shower facilities located in the forensic examination room and toiletries and a change of clothing were provided. Food and drink were available for patients after the forensic paediatrician indicated if a mouth swab was required. Snack boxes were arranged for patients and refreshments were available for families who attended with patients.

The service had not updated their information leaflet on their website to reflect that the police were no longer present in the forensic examination room to receive the samples and put them into evidence bags. This historic practice had been stopped as a result of patient feedback. The provider agreed to update the information leaflet on their website to reflect the change to the service.

**Involving people in decisions about care and treatment**

Interpreters were available and scheduled by the administrator through the use of a telephone based interpreting service or face to face to ensure that patients understood the treatment and options available. The service website information was produced in child friendly format for children and young people about what would happened when patients accessed the SARC.

# Are services responsive to people's needs?

## (for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The individual needs of vulnerable patients were clearly recorded in their records. During child protection medicals we saw that records contained questions about substance misuse and these were documented in the patient record and shared with other professionals, such as the social worker and the GP. In one case we found that the patient was referred to a substance misuse service by the social worker and other support services were discussed, such as access to counselling via the patient's school. Following this, the forensic paediatrician had spoken with the lead safeguarding officer at the patient's school to ensure the risks to the patient's safety were continually monitored and there was ongoing support to meet their needs.

Arrangements and adjustments were being reviewed for patients with disabilities. At the time of the inspection we observed there were accessible toilets and bathrooms on site. The SARC was moving to new and larger premises with better planned facilities to further improve access for children and young people with disabilities.

**Timely access to services**

Patient care was planned in a way that took account of their individual needs and preferences. Feedback questionnaires and the records we checked demonstrated that patients received timely access to the SARC and were satisfied with the responsiveness of the service. Referrals into the SARC are made by the police and social workers usually following child protection procedures. The records we checked showed that assessments were undertaken on patients in a timely way for acute and non-recent cases. The SARC service was available Monday to Friday 9am to 6pm and an advisory on-call service was available after 6pm up until the hours of 9pm. During the weekend the service operated from 10am- 6pm on Saturdays and 11am to 4pm on Sunday and Bank Holidays. Information about opening times and contact numbers were displayed on the providers website.

We found that referrals for patients to receive ongoing support were not always followed up in a timely way. Patients living in Sheffield were invited back to the SARC for their two weeks follow up appointment, however, in two of the records we found there was a delay; they were seen three to four weeks after. It was not clear from some records if patients had been referred or followed up by local services because of poor recording. There was a lack of oversight and clear pathways once patients were referred out of the SARC service.

Patients were provided with written information about how the service operated, which included contact numbers and complaints guidance. Patient information leaflets were displayed in the waiting areas to inform them how to make a complaint, however, these were not in a "child friendly" format. The provider had an up to date complaints policy in place which described how concerns should be investigated and acted on. There had been no complaints raised by patients about the service over the last 12 months. The SARC manager explained they would review complaints and lessons learnt during team meetings if any complaints were raised.

# Are services well-led?

## Our findings

**Leadership capacity and capability**

The SARC manager had been employed in the service for a year and explained there had been a gap in the management and oversight of the SARC two years prior to them being employed at the service. They told us they had received no formalised induction, but had attended all relevant training courses, such as mandatory child protection training and crisis trauma. The manager was knowledgeable about the SARC and had proceeded to make some changes to the service, for example, introducing documentation to ensure health support workers observation formed part of the overall assessment of patient needs.

Due to unplanned leave the SARC manager's training in some key areas had expired though dates had been booked to bring her up to date. In the manager's absence the named safeguarding nurse had provided managerial support to the SARC and health support workers we spoke to told us they were well supported during this time.

**Vision and strategy**

The SARC service operated a medical forensic led model and we found there was a lack of follow up in making sure that patients had accessed ongoing care once they were referred out of the SARC. The SARC manager and the health support workers were deployed between the SARC and the Child Assessment Unit and had enough time to fulfil their duties and responsibilities in their role. The health support workers felt their skills could be utilised further in the SARC and there were discussions in relation to a business management case being produced to employ a crisis support worker role in the service. There were plans to align the whole service to ensure a more integrated model of care. The SARC manager told us the service was working towards the Barnahus model which was established as a child-centred response to abuse where all services are delivered under one roof. The trust's plans to move the facilities to a larger sized building to accommodate patient needs was an integral part of this integration. Commissioners and police were involved in consultation and discussion about changes to the service. However we did not see information to show how patients were involved in this discussion.

**Culture**

The SARC manager told us that they always encouraged a culture of openness and transparency within the team. Staff we spoke with confirmed this; they told us they were proud to work in the SARC and that they enjoyed their roles because of the help and support they provided to families. They said working in the SARC can be very emotional and that the team worked well together, with good management and support. We observed that the team communicated with each other effectively, for example, during the peer review meeting.

**Governance and management**

Quality assurance systems were mostly effective. Audits of patients' medical records had been carried out by the FME to check gaps in health records for patients' care and treatment. This highlighted that patients' full details were not always fully completed by the staff team; the finding was shared with the staff to remind them that patient records must be accurately completed by the staff team. The records that we reviewed showed improvements in the recording of patient details. An evaluation of the service took place which should have been reviewed in 2017 but this had not been done. This was a missed opportunity to improve systems in relation to DBS checks and the monitoring of referrals to ChISVAs. This contributed to the overall gaps in assurance around the processes used to monitor the quality and safety of the service.

Standard operating procedures were in place for staff supporting the forensic paediatrician during a forensic medical. This detailed the management arrangements of patients upon arrival, how to set up the forensic treatment room, collection of samples, medicines management, the storage of photographic images and the cleaning of the examination room in line with FFLM guidance. This was to ensure there was a clear handover and process in place for staff whilst supporting forensic paediatricians within the SARC and helped new employees to have the relevant information available to them, when this was required.

The provider attended quarterly contract management review meetings to discuss compliance with the contract, including performance against the service specifications and key performance indicators. We heard from the commissioner that the provider was complaint and that they were meeting patients' needs. The provider had systems in place to monitor the quality of service provision and there was a process in place for managing risks to patient safety. Datix was used to report any risks to the

# Are services well-led?

service and to make sure that any remedial action was followed up. There were only two incidents recorded on Datix, one in relation to a patient who had fallen and the second in relation to the failure of the panic alarms system which happened at the time of the inspection. We were able to see that the provider was working closely with the security team to ensure patient and staff safety whilst this was being repaired. Incidents were recorded by staff, and there was evidence of action and follow up on both incidents.

**Appropriate and accurate information**

The provider submitted data to the commissioners within the planned timescales. The information submitted was sufficient and accurate and showed that the provider had good oversight about how the SARC was run. Plans to improve the quality of the premises were well advanced, as were plans to recruit more staff to ensure there was an effective approach to a flexible workforce.

**Engagement with clients, the public, staff and external partners**

Patient satisfaction surveys were sent to patients to obtain their feedback and to ask for ideas on how the provider could improve. We saw evidence of how this patient feedback had influenced change. For example, patients had reported that the forensic examination and waiting rooms were too warm, so the provider had installed air conditioning units to ensure that patients were comfortable. Child friendly feedback forms were displayed in the waiting rooms and were available for patients in an “easy read” format to obtain their views about using the service

Specialist Child Abuse Investigator Development Programme was delivered at the children's hospital to the police and social workers. SCAIDP is part of the wider 'Investigating Child Abuse and Safeguarding Children Programme'. The training was rolled out to promote the importance of child protection medicals with external services to strengthen partnership working.

**Continuous improvement and innovation**

There was a commitment by managers to ensure staff appraisals were undertaken at which their well-being and future training and development needs were discussed. Safeguarding training had been delivered to supervisor champions to deliver safeguarding messages to the SARC staff team members.