SH24 C.I.C.

35a Westminster Bridge Rd

Inspection report

35a
Westminster Bridge Road
London
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Tel:

Date of inspection visit: 7 March 2022
Date of publication: 13/05/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

This service has not previously been rated. We rated it as outstanding because:

- People were protected by a strong comprehensive safety system, and a genuine focus on openness, transparency and learning when things go wrong.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- The service managed medicines well. Good practice guidelines were not only met in relation to national guidance, but staff also contributed to research and the development of national guidance.
- The service managed incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. The service had sustained a track record of safety supported by accurate performance information.
- Managers monitored the effectiveness of the service and made sure that staff were competent. Staff worked well together for the benefit of patients, advised them how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- There was a truly holistic approach to assessing, planning and delivering care and treatment to all people who used the services. The safe use of innovative and pioneering approaches to care and how it was delivered was actively encouraged, including the use of new evidence-based techniques and technologies.
- Staff treated patients with compassion and kindness, respecting their privacy and dignity and valuing them as individuals. There was a strong visible person-centred culture and patients were empowered as partners in their care, practically and emotionally. Feedback from patients was consistently positive. Patients benefited from being cared for by staff who showed discretion and sensitivity.
- The service provided patients with valuable online resources to make informed and positive choices about their lives.
- The service was tailored to meet the needs of individual people and was delivered in a way that ensured flexibility, choice and continuity of care. Services were available 24 hours a day, seven days a week. Staff were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who used the service.
- Technology was used innovatively to ensure that patients had access to treatment, support and care at a time that suited them. This had increased access to safe sexual and reproductive healthcare to vulnerable patient groups in rural areas.
- The leadership, governance and culture of the provider was used to drive and improve the delivery of high-quality person-centred care. Staff understood the service's vision and values and knew how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patient receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- The provider used research, audits and publications to contribute to the evidence base in the field of sexual and reproductive health and were driving innovation and improvement in health care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health (sexual health services)	**Outstanding** ☆	See summary above for details.

Summary of findings

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Summary of this inspection

Background to 35a Westminster Bridge Rd

35a Westminster Bridge Rd is provided by SH:24 CIC a community interest company. The service has been operating since 2014. It offers online sexual and reproductive health services, developed with grant funding from Guys and St Thomas's NHS Foundation Trust charity and delivered in partnership with the NHS. The service has contracts with a range of organisations, including NHS trusts and local authorities to provide people with free sexually transmitted infection test kits, diagnosis and treatment, oral contraception, emergency contraception, information and advice, 24 hours a day.

Using digital technology, the service offers screening for sexually transmitted infections, provision of sexual and reproductive health medicines and advice, diagnosis and treatment of genital infections where feasible. The service provides remote clinical support by text or phone.

The service currently operates in 59 areas across the UK and Ireland.

At the time of inspection, there was a registered manager in place

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

To understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location. We gave the provider short notice of the inspection in line with our methodology.

As part of the inspection, the inspection team:

- Visited the service premises
- Spoke with four people who were using or had used the service
- Spoke with 16 members of staff including the chief executive officer, registered manager, clinical director, finance director and operational director as well as a mix of clinical and non-clinical staff.

Summary of this inspection

- Looked at 13 care and treatment records
- Looked at medicines' management in the service
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Reviewed feedback collected by the service from January and February 2022.

What people who use the service say

- We spoke with four people who used the service. All the feedback we received was overwhelmingly positive. All four patients we spoke to confirmed that the service was easy to access, efficient and that staff were caring, professional, respectful and knowledgeable about sexual and reproductive health. They said staff were non-judgmental and made them feel good about accessing services for the sexual health.

Outstanding practice

We found the following outstanding practice:

- The service significantly scaled-up its online contraceptive services at the start of the COVID-19 pandemic in response to in-person clinics closing or providing a reduced service. They did this quickly, safely and effectively.
- The service provided new and innovative ways of working, which meant they reached vulnerable patient groups in rural areas and increased overall access to sexual and reproductive healthcare. This included establishing treatment a pathway for photo diagnosis and treatment of genital herpes and genital warts.
- The service was providing around about 13,700 STI test kits a week to patients across the UK and Ireland including reaching rural and vulnerable populations who have not accessed sexual health services before by providing services online.
- The service regularly published research and audits in peer-reviewed health and medical journals as well as regularly presenting research to colleagues at local, national and international conferences in sexual and reproductive health. The service used published research to improve practice and patient experience.
- The service used cross-functional working to improve service quality, safety and efficiency. This included clinicians working together with the product design team when issues were identified to find solutions quickly. This resulted in changes to language and images used, to be more inclusive in response to patient feedback.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health (sexual health services)	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Community health (sexual health services)

Safe	Outstanding ☆
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are Community health (sexual health services) safe?

Outstanding ☆

This domain was not previously rated. We rated it as outstanding.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff confirmed they had undertaken mandatory training and that they were up to date with this. Mandatory training consisted of face to face training in basic life support and online training accessed through the NHS e-learning system in other subjects. Subjects included data security awareness, health, safety and welfare, fire safety, equality and diversity and human rights, safeguarding (children and adults), children vulnerable to abuse and exploitation, domestic abuse, female genital mutilation (FGM), mental capacity (including children and young people) and best interests.

Staff training records confirmed staff were up to date with all mandatory training. This was recorded on a spreadsheet which was divided into mandatory non-clinical, mandatory clinical and additional continual professional development (CPD) best practice. This made it easy for managers to see when staff needed to update their training.

Managers checked compliance with mandatory training during staff supervision and annual appraisal. The registered manager maintained a training record that identified the training staff had attended and the date it was completed. Locum and bank staff were expected to provide evidence of mandatory training compliance. Training records were kept for all staff and included mandatory online, clinical team and additional continual professional development training as well as confirmation they had completed their induction and read the provider's statement of purpose and policies.

Safeguarding

Staff understood how to protect adults, children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Outstanding ☆

Community health (sexual health services)

Staff received training in safeguarding adults and children. At the time of inspection, clinical staff demonstrated 100% compliance with safeguarding children and young people level 3, children vulnerable to abuse and exploitation, looked after children, safeguarding adults' level two and three, domestic abuse and female genital mutilation (FGM) training. All staff we spoke to demonstrated effective understanding of their responsibilities in relation to safeguarding and were confident in making safeguarding referrals.

The service had separate safeguarding policies that covered young people and adults. They did not offer testing or treatment to anyone under the age of 16 after taking legal advice and concluding they could not demonstrate capacity to consent under the Data Protection Act for this patient group. The safeguarding policies included relevant legislative background and guidance for all areas the service covered including Ireland and Northern Ireland.

Once patients had registered their personal details with the service, they were asked whether they had been sexually assaulted. Young people were asked a further five safeguarding questions which were based on the British Association for Sexual Health and HIV (BASHH, 2014) guidance, 'Spotting the Signs' and developed in consultation with national experts, local health professionals, safeguarding leads and young person advisors to the Southwark Safeguarding Children Board.

The service used an alert system during the registration process to flag up patients at risk of abuse or exploitation. The patient was then contacted by a member of the clinical team at a prearranged time. A minimum of three attempts were made to contact the patient using at least two different methods of communication. The final contact attempt signposted the patient to support for their safeguarding issue and local sexual health clinic. For example, patient who said they had thoughts of harming themselves was followed up by a clinician and referred to their local community mental health team.

Where the safeguarding issue related to domestic abuse, sexual assault or female genital mutilation (FGM) discussion was held with the safeguarding lead before a decision was made to close the referral.

All patients flagged as safeguarding were added to a safeguarding spreadsheet and risk ranked. This was then reviewed at monthly safeguarding and quality and risk meetings. We reviewed minutes of the safeguarding meeting which, in addition to the safeguarding report, covered training, policy, new guidelines, administrative and operational issues, patient feedback, incidents and complaints, staffing and audits.

Clinical staff had access to monthly safeguarding supervision which was delivered by the safeguarding lead for a local NHS trust. Staff told us this was a safe, open forum to be able to discuss clinical issues, areas for development and seek support and guidance.

There was a monthly safeguarding governance meeting which was well attended by clinicians. We reviewed minutes of the February 2022 meeting and agenda items included training, policy updates, reviewing new national guidelines, operational issues and patient feedback. There were also thoughtful and nuanced discussions for example, how to balance safeguarding risk with patient need for a testing kit.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

The service operated online and did not see patients on the premises.

Clinical staff had completed online training in infection and prevention and control.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

Patients were not seen onsite and staff used a hybrid model of working, working from home and the office. Staff had access to privacy pods and two meetings rooms which were soundproofed for privacy. The building was wheelchair accessible.

There was a fire extinguisher in place which was checked and within date. Portable appliance testing (PAT) testing was also observed on electrical items and in date. All staff received fire safety training as part of their induction.

Staff had access to two kitchens with fridges which were only used only for drinks and that were observed to be clean. An external cleaning company was contracted to clean the office twice per week and we observed it to be visibly clean throughout.

The provider worked with laboratory and pharmacy partners to deliver the online services which were accredited through United Kingdom Accreditation Service (UKAS)

Repairs and maintenance of the building were carried out routinely and when required by the landlord and an external building contractor.

Assessing and responding to patient risk

A proactive approach to anticipating and managing risks to people who use services was embedded and recognised as the responsibility of all staff. Staff were able to discuss risk effectively with patients.

The service had comprehensive and effective risk management arrangements in place. They had developed their clinical risk management policy in line with the Faculty of Sexual and Reproductive Healthcare (FSRH) standards for risk management and response to risk, risk assessment and evaluation and risk identification.

We looked at 13 patient care and treatment records which all had a risk assessment in place and detailed the various risks that staff assessed as part of their comprehensive assessment. All patients were prompted to complete risk assessment information as part of registering with the service online. Questions were developed in line with local and national guidelines. For example, the British Association for Sexual Health and HIV (BASHH) and FSRH (2019) Standards for online and remote providers of sexual and reproductive healthcare service.

The questions patients were prompted to answer included what area they lived in as well as questions about their health history which would determine availability of treatment options. The service did not provide treatment to anyone under the age of 16. Each area was commissioned to offer different services and / or treatments. If the service was unable to provide care and treatment, patients would be signposted to other services as appropriate.

The online assessment questionnaire was different for those under 18 years of age and over 18 years of age. Both had been designed to draw out potential safeguarding issues and included prompts to enable clinicians to investigate the physical, mental and emotional health of people using the service. For example, patients under 18 were asked for additional information to confirm their identification. Records we looked at showed examples of patients being asked for photo identification where there were concerns about their age.

All patients were asked if they had been sexually assaulted and young people aged 16 to 18 years were asked a further five safeguarding questions. For example, if they had ever been scared or uncomfortable with the person/s they were having sexual contact with or if they were ever given gifts, money, drugs, alcohol or protection for sex. Answering yes to any of these questions would prompt a clinician to call the patient to offer additional support.

The online platform design enabled staff to understand healthy sexual behaviour and distinguish this from harmful behaviour. Decisions made, actions taken, and staff involved were clearly recorded on all the records that we looked at. Triage would enable clinicians to immediately refer patients to in-person clinics. For example, if a patient required a treatment within a time frame the service was unable to meet.

The online platform had inbuilt software which enabled the provider to pick up additional risks. For example, if someone used the same mobile number on more than one occasion to order tests or treatment or if someone requested a prescription multiple times. This would then place a flag on the record and the patient would be contacted by a clinician to discuss their care and treatment.

The service had several additional policies that covered female genital mutilation (FGM), domestic abuse and assessing suicide risk in more detail. These policies also addressed policy and legislative differences in the geographical areas the provider covered enabling staff to access area specific information where required.

The provider had a notification system in place for partners of patients who tested positive for sexually transmitted infections. This was done anonymously via text message which notified the person and advising them to go for testing, providing links to support services whilst maintaining patient confidentiality. This system helped prevent further transmission of sexual health disease and enabled partners to access treatment.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

At the time of our inspection, the service had 79 substantive staff working across four different teams: clinical, growth and support, operations and product and engineering. This figure included four staff who had not yet started. There were ten vacancies, although none of these were in the clinical team. Clinical staff included six senior sexual health nurse prescribers, four senior sexual health nurses and three sexual health nurses.

Between 1 January 2021 and 1 January 2022 12 out of 79 staff members left the organisation indicating a turnover of 15%. Of the 12 staff who left only two were from the clinical department and none were clinicians. The service used a staffing model to estimate staffing needs and level which looked at activity in terms of testing kits and prescriptions to support decisions.

Outstanding ☆

Community health (sexual health services)

In August 2021 the service had carried out a capacity review for all areas of the business including the key teams, logistics and marketing department. This looked at the current and future states (next 12 months) in terms of demand and staffing and gave resource proposals for each.

Staffing resource was a standing item of the director group meeting attended by the finance director and this supported agile decision-making. For example, during HIV testing week they predicted a steep increase in demand and recruited a temporary pool of bank staff who had induction and training to ensure this demand could be met safely and effectively.

Managers and staff told us the provider did not have difficulty recruiting to vacant positions as it was an attractive place to work. This was because staff felt valued, the service promoted a different and innovative way of delivering care, there was reduced bureaucracy and a flat hierarchy.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The systems to manage and share information that was needed to deliver effective care treatment and support, were coordinated, provided real-time information across services and supported integrated care for people who used the service. Innovative practice supported accurate and personalised information sharing.

All records were electronic. We reviewed 13 sets of patient records across a range of different treatment pathways. Records included initial triage, risk assessment, consent management, issues raised, and actions plans, effective safeguarding recording. There was evidence of multidisciplinary working, for example, with support services, other sexual health clinics, mental health teams and local authorities.

The service had clear governance structures around data management including an information governance lead, Caldicott Guardian (a senior person responsible for protecting the confidentiality of patient health and care information and making sure it is used properly), Senior Information Risk Owner (SIRO) and data protection officer. The senior management team held overall responsibility for developing team-wide oversight of data protection and ensuring procedures and guidelines were implemented effectively.

The provider used a 'Privacy by Design' approach to systems engineering, in line with General Data Protection Regulation (GDPR). Using a four-step design and development structure, data protection was embedded into each step. The service also used Data Protection Impact Assessments (DPIA) and a comprehensive vetting process to ensure they only used third party suppliers that also adopted a data protection by design and default approach.

Medicines

The service used systems and processes to safely prescribe medicines.

Staff not only met good practice standards in relation to national guidance, they also contributed to research and the development of national guidance. Compliance with medicines policy and procedure was routinely monitored and action plans were always implemented promptly.

Outstanding ☆

Community health (sexual health services)

The service operated online only and therefore did not store any medicines onsite. There was a service level agreement in place with a partner pharmacy which ensured that it was compliant with the relevant legislation and guidance in relation to the procurement, storing, dispensing and issuing of medicines.

There was a clear governance framework that underpinned the remote prescribing and medicines management procedures. The remote prescribing policy was written in line with national legislation and guidance to ensure effective communication occurred during patients' clinical review, risk assessment and prescribing process.

Prescribing practices were in line with a range of different legislation and policy documents. For example, Human Medicines Regulations 2012 (the Regulations), clinical guidance set out in the British National Formulary (BNF), the UK Medical Eligibility Criteria (UKMEC), the Nurse and Midwifery Council's (NMC) guidance, 'Remote Assessment and Guidance 16/2008' and the General Medical Council's (GMC) guidance.

The service provided staff with guidance and information on the safe management of medicines in the policies and procedures which were available on the organisation's intranet. The service had robust policies and guidance on each medicine prescribed by the service. Staff were also aware of additional information which was available to them on the FSRH website. For example, 'Key principles for intimate clinical assessments undertaken remotely'.

Patients' identities were verified through a process of cross checking against the NHS spine through an integrated online portal held within the patient's administration record for the purpose of confirming the person's details with their address and date of birth.

Before any medicine was prescribed, patients completed a remote risk assessment through the service's secure online portal with follow up through text message or phone call, as necessary. The risk assessment had an automatic flagging system to identify any potential contraindications that a patient might have to the relevant medicine. All flags were reviewed by an appropriately qualified clinician.

All prescriptions followed an 8-step process which included reviewing risk information, adding an electronic note to the patient's order as well as an electronic signature.

The service had separate policies for prescribing for each condition they treated or contraceptive prescribed including, but not limited to, policies for injectable contraceptive, emergency contraceptive, chlamydia treatment and photo-diagnosis of genital herpes and genital warts. Each policy detailed the relevant clinical guidelines and standards of practice, diagnoses and management, treatment and exclusion criteria.

The service undertook medicines audits regularly. For example, an audit was planned on voided prescriptions which would look at rates of prescriptions voided, for what reason and length of prescribing by drug type. The service had published audits in several journals including the Journal of Medical Internet Research, International Journal of STI and AIDS and the British Medical Journal Sexual and Reproductive Health (BMJ SRH). Publications in the BMJ SRH included, 'How do users of a 'digital only' contraceptive service provide biometric measurements and what does this teach us about safe and effective care?'.

Incident reporting, learning and improvement.

Outstanding ☆

Community health (sexual health services)

There was a genuinely open culture in which all safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement. All staff were open and transparent, and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the level of harm and near misses, which ensured a robust picture of quality.

The incident management policy detailed clear incident reporting and management governance processes. The service had designated staff identified as the Caldicott Guardian and Senior Information Risk Owners (SIRO).

The service had an online incident reporting system which all staff had access to and had received training on. The system was designed to make the process quick and simple and staff told us it was easy to use, that they were encouraged to report when things went wrong and that there was a low threshold for reporting incidents.

When an incident occurred a senior member of the clinical and / or other relevant team was notified. If the issue was time sensitive (for example, a prescription not delivered) then immediate actions were taken to reduce the consequences of the incident and mitigate any ongoing clinical risk.

The provider understood the duty of candour which was clear in records. Patients were contacted by telephone when things went wrong, offered an apology and kept them updated until the incident or complaint was resolved.

Clinical incidents were reviewed at a fortnightly meeting attended by clinicians. Themes were identified with action plans to support solutions. For example, it was noted emergency contraception had been delayed for several patients in December 2021. After initially resolving the issue for patients affected, the incident reporting system supported a deeper analysis which identified the root cause related to difficulties with the patients' addresses. As a result, an 'address picker' was introduced to increase accuracy of patient addresses. They also met with the independent pharmacy to improve dialogue with delivery partners such as the postal service.

Learning was based on a thorough analysis and investigation of things that went wrong. All staff were encouraged to participate in learning to improve safety as much as possible and where relevant, participating in local, national and international safety programmes. Opportunities to learn from external safety events were identified. For example, in response to poor user experience and increased manual error and likelihood of unmatched results in offline test kits, the service took actions to mitigate these risks. These included working with their pharmacy partners, making design and code changes to the online platform, liaising with other providers and undertaking an impact analysis of offline kits to share with relevant commissioners.

Staff we spoke to felt informed about incidents and any learning from these was disseminated through daily clinical meetings, emails or the staff electronic messaging boards.

Safety performance

The service used monitoring results well to improve safety.

Data was collected and submitted through national reporting systems. The service completed the required data submissions to the Genitourinary Medicine Clinic Activity Dataset (GUMCAD). GUMCAD is the mandatory surveillance system for sexually transmitted infections in England, an electronic, pseudonymised patient-level dataset reported by about 400 services. The service also reported data for the Sexual and Reproductive Health Activity Data set (SRHAD) and the Chlamydia Surveillance System (CTAD).

Outstanding ☆

Community health (sexual health services)

The service submitted notifications in line with an approach agreed with the UK Health Security Agency (UKHSA). This provided a source of contraceptive and sexual health data nationally and showed the service provided patients with appropriate sexual health screening, care and treatment.

Are Community health (sexual health services) effective?

Outstanding ☆

This domain was not previously rated. We rated it as outstanding.

Evidence-based care and treatment

There was a truly holistic approach to assessing, planning and delivering care and treatment to all people who used the service. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. New evidence-based techniques and technologies were used to support the delivery of high-quality care.

The service provided a wide range of testing and treatment for sexually transmitted infections (STI) and contraception or if not available remotely, clear, integrated care pathways for seamless referral to other services or clinicians.

Prior to 2020, the service had been contracted primarily for care and treatments of STIs only. However, as a result of in-person clinics closing or services being reduced during the pandemic, they were increasingly contracted to begin delivering remote contraception services, including emergency contraception (EC). As a result of a strong governance framework and innovative online portal, the service was able to mobilise quickly to meet this increased demand and has seen their capacity double over the last two years as a result.

The service had a confidential partner notification system to ensure others who might be at risk were informed without delay. This tool worked in accordance with British Association for Sexual Health and HIV (BASHH) guidance on partner notification and the General Medical Council (GMC) supplementary guidance in relation to confidentiality in situations when disclosure of information about communicable diseases is required.

The service had clearly defined pathways for each treatment option offered which included a risk assessment and clinical review. For example, self-injectable contraceptives had questions tailored to the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) and the Chlamydia prescribing policy was in written line with BASHH guidance.

Staff were clear about what they could and could not do to help patients with sexual health issues and there were clear eligibility criteria. For example, the photo diagnosis for genital herpes and genital warts was only available to patients who had a previous episode confirmed by laboratory testing and all patients under the age of 18 would be referred to a clinic for diagnosis and treatment. Additionally, emergency contraception was not prescribed to patients under 16 and those aged between 16 and 18 were prompted to answer an additional five safeguarding questions based on BASHH (2014) guidance, 'spotting the signs.'

All clinical staff had training, clinical supervision and appraisal to ensure that they were confident and had the right skill set to treat patients with sexual health issues. Although an online service, all patients had the opportunity to speak directly with a clinician who could provide information on a range of contraceptive options, promote positive sexual health, provide information about the prevention of pregnancy and minimising the risk of STI.

Community health (sexual health services)

The service was able to recognise and respond to different sexual health needs such as those related to gender (including female genital mutilation), sexual orientation, ethnicity and age.

We reviewed the treatment pathways and they were based on clinical guidelines and policies and procedures on national good practice and recommendations such as those provided by the National Institute for Health and Care Excellence (NICE) guidelines, BASHH and the FSRH.

The provider's medicines management was in line with a range of legislation and policy guidance including the Human Medicines Regulations 2012 (the regulations), BNF, UKMEC, NMC guidance 'Remote Assessment and Guidance 16/2008' and the GMC guidance, 'GMC Good practice in Prescribing and Managing Medicines and Devices 2013'.

Pain relief

Staff assessed and monitored people during and after treatment.

Patients on all treatment pathways were followed up by text to ensure they did not have any adverse reaction to the treatment given and although this did not include a specific question related to pain it did include an invitation to make contact if they experienced any difficulties.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The provider participated in local and national audits, worked toward key performance indicators and contributed to national and international research in the area of sexual health and online sexual health care and treatment delivery. Clinical staff published articles in journals and delivered talks at sexual health conferences on a regular basis. For example, an article in the BMJ journal, Sexually Transmitted Infections, published in February 2022, 'Evaluating the use of reactivity levels to inform risk communication and improve service user experience in an HIV self-sampling service'.

Audits completed in the 12 months prior to our inspection included an audit and literature review of populations who use emergency contraception frequently in comparison with those who use it once. The results of this will be used to develop additional health promotion information to support the transition from emergency to oral contraception. An audit of prescription returns from July to October 2021 led to the implementation of an address picker to improve accuracy of patient addresses which was the commonest reason for failed delivery.

The service had an audit schedule for 2022. For example, an updated audit of photo diagnosis of genital herpes and warts which would build on an initial audit completed when the service first started to document diagnosis rates, repeat use and service user experience. An audit to look at hepatitis C positivity rates within populations who test online against populations who test in face to face services to support an understanding of whether digital is a good way to reach people with undiagnosed hepatitis C infection. Further audit activity was planned on adult safeguarding, voided prescriptions, the HIV notification pathway and partner notification systems.

We found that results from audits and research were shared with staff at team meetings. For example, a recent team meeting included a presentation on a literature review of black and minority ethnic groups' interaction with digital services followed by group discussion which explored how exploring marketing and promoting digital health services might contribute to a more inclusive and representative user base.

Community health (sexual health services)

The provider collected data for service performance, collated this into report and used it to improve service delivery. The performance report for January 2022 showed data for different metrics including STI activity, kits delivered for the previous 12 months, contraception prescriptions delivered, chlamydia treatments delivered as well as metrics for sexual assault safeguarding, partner notification and other demographics such as age, ethnicity, gender and sexual preference.

Competent staff

The continuing development of staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

Managers appraised staff's work performance and held supervision meetings to provide support and development.

All staff had annual appraisals which was a two-way process to plan future training and development needs. Nurse revalidation was in place which ensured each nurse was up to date, fit to practice and able to provide a safe level of care.

Clinical staff told us they had regular supervision sessions and felt well supported by their line managers and senior leaders in the service. Staff described an open and friendly culture where there was always someone available to talk to either on the phone, in person or by using the internal online messaging system.

Managers gave all new staff a full induction tailored to their role before they started work. The induction included mandatory and role-specific training, and competencies in key areas. Safeguarding supervision was provided to clinical staff on a monthly basis by an external supervisor who was a safeguarding lead at an NHS trust.

Staff told us there were opportunities, support and time to undertake training and professional development to cover the scope of their work. For example, a clinical administrator told us they were given dedicated time every week for continual professional development and had identified several areas of interest they would be supported to develop.

Training records we reviewed showed staff received a range of relevant training for their role including contraception and sexual health HIV / STI updates. Clinical staff undertook training in domestic violence and abuse, female genital mutilation, sexually transmitted infections foundation course and menopause training.

The service predicted when service demand would be high and prepared for this. For example, prior to HIV testing week they recruited additional bank staff to support with the increased demand for testing kits. All bank staff were required to complete the mandatory training and induction prior to starting work.

Multidisciplinary working and coordinated care pathways

Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who used the service.

During our inspection we spoke with staff from different teams within the organisation including clinical and product and engineering. All staff we spoke to described good working relationships across teams. They were proud of the multidisciplinary and cross-team working approach. They told us they could access clinical support and advice from their colleagues when needed.

Outstanding ☆

Community health (sexual health services)

The provider implemented 'agile' working (an iterative approach to project management that supports delivery quicker with fewer problems) and had 'cross-functional' teams that developed the clinical pathways. Pathways were developed by designers, coders and clinicians working together to create a product. For example, the design team could put together a prototype of a pathway suggested by the clinicians and get user experience feedback before refining it to go 'live'. The same cross functional teams met to work through 'bugs' that arise and find solutions quicker.

The clinical team met daily to discuss the priorities, hold case discussions, raise issues, review guidelines and share learning. This meeting supported clinical safety and quality and was prioritised. It was chaired by the medical director or senior clinician and all clinical staff were expected to attend. The service had an online messaging forum which included separate channels for different teams. Staff told us this was used widely by all colleagues and supported the feeling of being a team and working together. We reviewed the February 2022 schedule of discussion items for the daily clinical meetings which included joint meetings with the designers and developers to discuss service improvements.

Staff told us that the service and their colleagues were patient focused, accessible, approachable and willing to work together to ensure patients received the right care and treatment. They told us the service had an open, learning culture where they felt confident to raise concerns and suggestions if needed.

The provider worked closely with the police, local authority and NHS services particularly around safeguarding. Many patients moved between the online and in-person NHS or private clinics and the service was developing an application programming interface between both electronic patient record systems so that clinicians from either could access patient records more easily.

Health promotion

Staff promoted the health of patients who used the service.

We found a wide range of health promotion information on the service website in relation to mental health, alcohol abuse, unwanted pregnancy, contraception. sexually transmitted infections, abuse, and domestic violence. The website signposted users to other, useful health information, services and websites. There was a blog which covered various subjects including consent in relationships, period poverty and body positivity.

The service had clear strategies for their UK and Ireland operations, as well as globally. This included modernising their digital platform for the benefit of patients. This would include 'game changing features' such as personal health records (PHR) in addition to new and innovative ways of communicating with patients such as chat bots (online programmes designed to simulate conversation with human users). This would potentially revolutionise communication with patients, improve clinical consultations, information provision and overall patient experience.

Consent and the Mental Capacity Act.

Staff supported patients to make informed decisions about their care and treatment.

Staff obtained consent from patients before carrying out any treatment. Staff were clear about consent and their responsibilities in relation to capacity and consent. All staff were expected to read the service policy on capacity and consent and were up to date in their mandatory training which included the following e-learning, 'Mental Capacity Act as Part of Human Rights', 'Assessing Mental Capacity' and 'Mental Capacity Act and Young People aged 16 or 17'.

Outstanding ☆

Community health (sexual health services)

The provider decided not to treat patients under the age of 16 due to the difficulty in being able to accurately assess compliance with Fraser Guidelines (Fraser Competency is used to assess if a child under 16 is of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge or consent) online or over the phone.

The provider sought consent from all patients through the online request to agree to the terms and conditions of the service.

Are Community health (sexual health services) caring?

Outstanding ☆

This domain was not previously rated. We rated it as outstanding.

Compassionate care

Patients were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally by an exceptional and distinctive service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how these related to care needs and took these into account in the innovative way they delivered services. The service had received positive patient feedback from the transgender community who had stated they found the service very inclusive. Language changes had been made to the online portal as a result of patient feedback. For example, to questions about who people had sex with and weight management information and advice.

Staff took time to interact with people who used the service in a respectful and considerate way. Patients told us that they were treated with dignity and respect during their care and treatment. Treatment plans showed consistent, compassionate follow up provided to patients. For example, we saw supportive discussions recorded with patients around how to tell their partner about their test results and clinicians contacting other clinics to arrange follow up needed for individual patients.

Staff told us the service had an open culture and that they would feel able to raise concerns about disrespectful, discriminatory or abusive behaviour and attitudes. They told us senior leaders were approachable and accepted that mistakes could happen. People were encouraged to speak up, without being blamed so that a solution could be identified. The staff meetings were described as a ‘safe space’ where issues could be raised without fear.

Emotional support

Staff provided emotional support to patients to minimise their distress. Staff clearly recognised the stigma attached with accessing their services and supported patients emotionally. They recognised emotional and social needs as being as important as physical needs.

Staff understood the impact that a person’s care, treatment or condition might have on their wellbeing and those close to them, both emotionally and socially. Patients we spoke to told us the service felt ‘safe’ and they could always contact someone if they needed to. They told us clinicians made them feel that taking care of their sexual and reproductive health was a positive thing to do.

Outstanding ☆

Community health (sexual health services)

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. They were also advised how to find other support services. For example, one patient who needed an intrauterine device was supported by the clinician who contacted a local clinic on their behalf to assist them to make an appointment to have one fitted.

The service managed HIV reactive results well. For example, before a clinician would give results to a patient over the phone they could be supported to do so by listening in on a more experienced clinician deliver results and take part in roleplay to support their practice and increase their confidence in this area. Recent research the service had published on risk communication and improving service user experience in an HIV sampling service had supported the development of a more nuanced approach to counselling which could potentially reduce a patient's anxiety prior to confirmatory testing.

Understanding and involvement of patients and those close to them

Patients who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person.

Patients described the service positively, saying it was easy to get the information they needed to make decisions about their care and treatment. One patient with disabilities told us the service had increased their access to the right care and treatment as they found it difficult to attend a clinic in person due to physical challenges and shielding during the pandemic.

Patients described regular communication with clinicians throughout their care and treatment, knew what was happening and could be involved in the decision-making. For example, one patient told us they had raised concerns about a previous adverse reaction to one medicine and were sent an alternative as a result of this conversation.

Staff always empowered people who used the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles in delivering care and individual patient needs and preference was always reflected in how care was delivered. For example, the medical director and registered manager frequently contacted individual patients to discuss the feedback they provided on their care and to work with them to develop solutions.

The service sought feedback from patients using the service by inviting them to provide online feedback following care and treatment. We reviewed patient feedback dashboards from January and February 2022 and found it to be overwhelmingly positive overall. 1721 patients gave feedback with 93% giving the service 5/5 stars and a further 6% giving it 4/5 stars in February 2022.

Are Community health (sexual health services) responsive?

Outstanding ☆

This domain was not previously rated. We rated it as outstanding.

Planning and delivering services which meet people's needs.

Outstanding ☆

Community health (sexual health services)

Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility, choice and continuity of care.

The service used innovative approaches to providing integrated person-centred pathways of care. The service was flexible, provided informed choice and ensured continuity of care.

The aim of the service was to improve access to sexual and reproductive health care through the provision of online sexual and reproductive health services. The service provided testing for STIs including HIV, syphilis, chlamydia and gonorrhoea. It also provided treatment for STIs where feasible (for example, simple genital chlamydia and secondary episodes of genital herpes and genital warts).

The service prescribed oral contraceptives including progesterone only (POP) and combined oral contraceptive (COC) and injectable contraceptive, the contraceptive patch and contraceptive ring. They also prescribed treatment for chlamydia, genital herpes and genital warts. These services included a remote risk assessment and postal delivery of prescription medications. The provider also had various 'how to' video guides to using test kits and injectable contraceptives.

The digital application allowed patients to request STI testing kits or contraceptives 24 hours a day. Clinicians reviewed the requests and processed patient orders where appropriate.

The provider had increased its service provision over the last seven years and, at the time of the inspection, the service was providing around 13,700 STI test kits to patients across the UK. The service contracted with a range of organisations including local authorities and NHS trusts to provide people with free STI test kits, information and advice, 24 hours a day. Patients who lived in these local authorities could access the service and the provider made the criteria clear on their website as patients were required to enter their post code for eligibility.

The service had seen demand double as a result of the COVID-19 pandemic as local clinics closed. As a result, the provider was contracted to provide contraception online which had not been done before. The provider had a clear governance framework that supported the service to meet the challenge of this service expansion effectively.

The service had plans to introduce a personal health record where health data and information could be maintained by the patient, to support incoming and outgoing communication with patients, clinical consultations and information provision.

Meeting the needs of people in vulnerable circumstances

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met those needs. This included people with protected characteristics under the Equality Act and people who were in vulnerable circumstances or who had complex needs.

The service provided free and confidential STI testing accessible 24 hours a day to anyone over the age of 16, although this was restricted to those living within certain areas due to the funding arrangements for the service. However, the provider had increased this to 59 local authority areas with clear plans to expand further, capitalising on increased demand for digitalised sexual health services as a result of the pandemic. If a patient did not live in an eligible area the service's website provided advice and signposted them to other appropriate services.

Outstanding ☆

Community health (sexual health services)

The service had recently undertaken an audit of emergency contraception (EC) with a view to looking at health inequalities potentially exacerbated by the increase of digital health technology and whether there were any actions the provider could take to mitigate any risk. The results concluded patients living in deprived areas and from black and minority ethnic backgrounds could effectively access online EC services.

An audit from January to October 2021 had evaluated the pilot service in the Republic of Ireland and the results showed that online testing was not only acceptable and feasible in rural areas it also increased the access for high risk populations who had never used a sexual health service before.

Access to the right care at the right time

People could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure people had timely access to treatment support and care.

The provider was an online service operating 24 hours a day, seven days a week. This meant patients could access what they needed easily and quickly. For example, a patient who requested the combined oral contraceptive could expect to wait an average of 59 hours between ordering their medication and it being dispatched to them by post. A patient requesting EC could expect a quicker turnaround waiting on average 24 hours between ordering and medication being dispatched to them by post.

Learning from complaints and concerns.

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

Information on how to make a complaint was available on the provider's website. There was a clear complaints policy and procedure which contained appropriate timescales for dealing with complaints. The service had received 36 complaints in the 12 months prior to the inspection. We reviewed the way these had been managed and found they had been approached in a transparent, open and timely manner. The service had a spreadsheet which categorised complaints including severity / impact, reporting category, immediate actions taken, corrective / preventative actions taken and conclusion.

Minutes of staff meetings we looked at showed complaints were discussed. For example, one patient complained about weight management advice being offered via text message stating not everyone would want to receive this. The need for this message and the wording was discussed at the safeguarding meeting.

The service could demonstrate where improvements had been made as a result of learning from reviews and we saw evidence of the provider engaging with patients who made complaints and practice changing as a result. For example, changes were made to terminology on the website to reflect a broader range of gender options when asking patients 'who do you have sex with' following a patient complaint. When another patient complained about language used in health information communications about weight, this was discussed with the wider team to review and change how information on this issue was communicated to patients.

The service made changes as a result of feedback. For instance, one patient complained that only white skin tones were depicted in the instruction leaflet for the test kits. In response, the colour of the hands in the leaflets were changed to blue, to avoid alluding to any skin tone. The patient was contacted, thanked for their input and notified of the changes made a result.

Outstanding ☆

Community health (sexual health services)

Are Community health (sexual health services) well-led?

Outstanding ☆

This domain was not previously rated. We rated it as outstanding.

Leadership of services

There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.

Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of the issues, challenges and priorities in their service and beyond.

The registered manager of the service was a public health expert medical doctor with advanced training for epidemiological methods, monitoring and evaluation and the medical director was a consultant in sexual health at an NHS foundation trust. Both had published and spoken extensively in relevant medical journals and sexual health conferences. All staff we spoke to said leaders were visible, friendly and approachable. They described an open culture where staff were actively encouraged to raise issues. Staff also told us they could make contact quickly and easily with managers to seek guidance, advice and support.

The provider's board had overall governance responsibility for the organisation and delegated authority through the chief executive to the executive and management teams, within a clear written scheme of delegation.

Staff described good cascading of information across the organisation through daily multi-disciplinary meetings and dedicated team chat channels through the online instant messaging portal. Staff told us they felt empowered to make decisions and leaders asked for their opinions on the service direction. We saw examples of good communication in the minutes of the monthly staff meetings we reviewed which included updates on the global strategy and business development ideas.

The organisation encouraged cross functional working by building it into their strategy which supported the use of joint working to address tactical and strategic projects. When high demand impacted on the time staff could dedicate to this, resources were made available to allow staff to continue cross functional teamwork. This not only enabled staff to develop skills and experience but also supported increased efficiency and effectiveness. For example, the clinical and customer care super group had clinical and operational staff working to better manage pressures generated by the high volume of incoming patient queries.

Service vision and strategy

The service strategy and supporting objectives and plans were stretching, challenging and innovative whilst remaining achievable. The service strategy was fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system wide collaboration and leadership.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were consistently implemented and had a positive impact on quality and sustainability of

services. The provider's vision and a strategy for putting this into action was communicated to all staff in a briefing document dated February 2022 entitled 'how we get things done'. The provider's mission was to be the world's leading digital sexual and reproductive health provider by designing services that were free or affordable and enabled people to access and use self-care. Staff understood the organisation's culture and values.

The service described itself as 'agile' which meant it was flexible and responsive in the way it worked. We saw this put into action through cross-functional teamwork with clinicians and product designers working together to create a product that could deliver safe and effective care and treatment to patients. For example, the implementation on an address picker to increase the accuracy patient addresses. This meant fewer prescriptions went missing.

The strategy focused on 'business as usual' including maintaining clinical safety and key relationships and developed a scaling plan including modernising delivery through the online platform, for example, the use of chat bots in communication, improved operations and the use of big data (large data sets that can be used to reveal pattens and trends) to inform the improvement of their own activities and increase the value of their work to patients and commissioners. The strategy recognised opportunities for health technology because of changes in the landscape following the pandemic and had plans to capitalise on these (for example, the development of personal health records).

The UK and Ireland strategy reflected the opportunities for tendering for services as commissioning practices continued to evolve post-pandemic. Key results identified in the action plan included using service data and research to support making hybrid sexual and reproductive health services more mainstream by working in partnership with relevant bodies for instance, the faculty of sexual and reproductive healthcare.

The service had a clear global strategy which included their current international initiatives funded by the Child Investment Fund Foundation (CIFF) and the Global Fund, an international financing organisation to invest resources to end epidemics such as HIV and AIDS. Future initiatives included working with funders to offer services in low income populations. This included launching services in Ghana and Nigeria that included a handover and sustainability plan with local partners.

The strategy and vision identified new ways of working including adopting leader-leader principles an approach to leadership based on supporting staff to take control, develop their competencies and working toward shared goals in addition to cross-functional working through the development of specific cross-functional teams.

Culture within the service

Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. Staff felt respected, supported and valued. They were focused on the needs of the people receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they were supported to develop their careers. For example, one person requested management training because their role involved staff management. The service supported this by identifying a suitable course and giving them time to undertake this training. Another person identified data protection as a career development opportunity and was supported to do a five-day course in general data protection regulation.

The organisation had recently introduced wellness vouchers which staff could use toward a wellbeing activity such as exercise classes and planned to build a benefit platform which could allow staff to select what benefit they would prefer and a monthly points allowance to spend.

The service carried out biannual staff surveys. The most recent survey results revealed that 89% of staff said their work was very or extremely meaningful, 85% of staff said they were very or extremely well supported in their role, 80% said they were very or extremely encouraged to communicate within the service and 96% said their values aligned with those of the provider.

Governance

Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

Staff told us there was a strong governance structure and were aware of the different members' responsibilities. They felt the provider's governance structure was robust and well managed. Staff was able to access all the organisation's policies easily on the staff intranet.

We reviewed a wide range of policies and procedures including data protection and management, incident management, risk management, safeguarding and reporting responsibilities. All policies were regularly reviewed and up to date. They were disseminated to staff through staff meetings, supervision, training and by email. Staff were also involved in the review of policies through the daily clinical meetings.

The service had a clear governance framework with clear lines of accountability and oversight. For example, the audit and renumeration committee met annually and was responsible for financial oversight, salary review and the service's annual accounts. The board met on a quarterly basis to review and approve strategic business plans, monitor performance, have oversight and scrutiny of finances and decision making as well as independent oversight of a range of other governance issues such as major incidents and safeguarding.

Staff had a monthly meeting where they were informed of the latest developments and key learning, any performance updates and strategic projects as well as inviting staff to present areas of interest or key learning to the wider team. At the meeting in January 2022, staff were given an update on the organisation's scaling plan, including increasing awareness of why strategic decisions were being made. There was a discussion on the latest staff survey results, and a performance update which included thanking staff for their hard work over 2021.

The directors group met weekly to discuss strategic oversight, staffing, demand and performance, regulatory compliance, incidents and complaints as well as review notable risks. During the pandemic the chief executive officer had arranged regular catch up meetings to improve communication and promote an open culture. Staff could book a slot with them on a weekly basis to discuss an issue or ask a question.

The service had clear lines of accountability and responsibility which were outlined for staff on the organisation chart. There was a director for each area, and each had their own accountabilities for example, the operations director was responsible for privacy, security and other incident management. The registered manager was responsible for regulatory compliance and global growth and the clinical director was the safeguarding lead and accountable for clinical governance, quality review, audit and research.

The service invited and welcomed feedback from patients either through text communication during the care and treatment process or through the website. Feedback was compiled onto a dashboard that was reviewed at the quality and risk management (QRM) group, directors' group and board meeting.

Management of risk, issues and performance

Outstanding ☆

Community health (sexual health services)

There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how it functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

The service managed risk well. There was clinical meetings four days per week which allowed staff to discuss complex cases. Discussion items were scheduled in advance. Topics included reviewing the faculty of sexual and reproductive healthcare (FSRH) consent standards that were out for consultation, safeguarding case review and a presentation of a review of chlamydia results.

The QRM group met on a monthly basis and discussed a wide range of risk issues including incidents, complaints, safeguarding, audits and service user experience and feedback as well as reviewing the risk register. QRM meeting minutes for the three months prior to our inspection recorded a discussion of risk incidents with action plans, risks associated with complaints, key performance indicators and key risks.

The service operated a risk register which was reviewed at the board meeting and QRM group. Risks were subdivided by various categories (including financial, clinical, operation). Each risk was given a description and rated with a weighted score. We reviewed the February risk register and noted that each risk was owned by a member of the QRM group. Each risk had clear mitigating actions and contingency measures in place.

Information management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service invested in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant.

The provider operated dashboards to collect and analyse data and performance. We reviewed key performance indicator dashboards for a range of metrics which included kit dispatch turnaround, prescription, reactive & blood results, STI testing metrics and the monthly all service performance (for January 2022). Metrics were subdivided into service areas and these were reviewed weekly at the directors' group and measured against the business and scaling plans. Performance data was presented to the board in monthly all service performance documents.

The service had a range of policies and procedures related to data management which were accessible to all staff on the shared drive. The organisation had a dedicated information governance lead, a Caldicott Guardian and a SIRO.

The senior management team met weekly and held responsibility for creating a culture of 'privacy awareness' within the organisation and a 'data protection by design and default' approach had been adopted. Privacy by design is a systems engineering approach which follows seven foundational principles and is approved by the international organisation for standardisation and included in general data protection regulation.

The service had a dedicated security team that constantly monitored data security. Numerous steps were taken to ensure information security. For example, key characteristics, such as a patient's name, were stored separately from the patient's results and only together in an encrypted place and quick response codes were used for patient test kits. The service also had regular external penetration tests by external testers to ensure security standards were met.

Community health (sexual health services)

There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision-making as well as system-wide working and improvement. The service had a reporting responsibilities policy which included the genitourinary medicine clinic activity data set, the sexual and reproductive health activity data set and the chlamydia surveillance system. Data was reported quarterly to service provider and local authority sexual health commissioners and done in line with UK health security agency specifications

Engagement

There were consistently high levels of constructive engagement with staff and people who used the service. Rigorous and constructive challenge from patients and stakeholders was welcomed and seen as a vital way of holding services to account.

The provider made it easy for patients to provide feedback on the service and this was overwhelmingly positive.

We saw changes to clinical practice arising from incident reviews. For example, when a patient requested sexual assault help and was given a late response a change was made to offer patients the opportunity to book directly into a telephone call slot with staff instead of a text. When a GP raised concerns a patient who experienced migraines with auras was prescribed combined oral contraceptives, the service investigated and identified the patient had not reported this to them. The GP was satisfied with the investigation and outcome.

Leaders responded to staff survey results. The most recent survey highlighted that only 62% of staff said they had regular, useful 1:1s with their manager. This figure included the entire staff group and clinicians told us they received regular clinical supervision. However, in response, the organisation produced an action plan to address issues raised including a minimum expected regularity and promoting the continuous documentation of 1:1s for all staff.

The provider had developed their policies and procedures in partnership with other organisations. For example, their safeguarding and risk assessment questions for 16 – 18 years olds were developed following consultation with national expects, local health professionals, local safeguarding leads and young person advisors to a local safeguarding children board. The policy on FGM listed several specialist organisations patients could be referred on to for additional support which included the national society for the prevention of cruelty to children, FGM help line and local organisations like black women's health and family support.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement, which was seen as the way for the organisation to learn. Improvement methods and skills were available and used across the organisation.

The organisation and individual staff regularly presented at sexual health conferences and published articles in relevant medical journals. This included presentations to the annual BASHH conferences and a publication as recent as February 2022 in 'Sexually Transmitted Infections' a BMJ journal.

Staff used an interactive partner notification tool and in the event of a positive test result patients received a text message with a secure weblink. By opening the weblink, patients were offered the option to inform one or more of their sexual partners by text message or email. They monitored the effectiveness of this through regular audits.

Safe innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. The service had a strong record of sharing work locally, nationally and

internationally. For example, the service had presented their work and its results to the BASHH annual scientific meeting and the International Union Against Sexually Transmitted Infections Conference. Key outcomes and results from audits were also shared widely. For example, an audit to establish factors that would encourage patients to disclose a safeguarding concern online and facilitate an appropriate response was submitted for publication to the International Journal of STD and AIDS.

The provider encouraged leadership using the 'leader-leader' model which encompasses four principles of control, competence, clarity and courage. This approach supported working toward shared goals and trusting team members to deliver. In their strategy document the organisation committed to making sure all staff would be given the opportunity to demonstrate leadership.