Terrence Higgins Trust - South West

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection of Terrence Higgins Trust South West as part of our programme of comprehensive inspections of independent health services between 28 and 29 November 2016. The service was registered with the Care Quality Commission to provide the following regulated activities: diagnostic and screening services, family planning and the treatment of disease, disorder or illness. There are no ratings for this inspection as we do not currently rate community based independent sexual health services.

Terrence Higgins Trust South West is part of a national organisation for people over the age of 18. The trust campaigns on various issues related to human immunodeficiency virus (HIV). In particular the charity aims to reduce the spread of HIV and promote good sexual health (including safe sex). They provide services on a national and local level to people with, affected by, or at risk of contracting HIV and campaign for greater public understanding of the impact of HIV and acquired immune deficiency syndrome(AIDS). The Bristol branch provides services to people living in Bristol and the wider areas. The service was provided in line with the terms of the contract agreed with the local commissioners. The service was innovative in ways in which they reached high risk client groups and vulnerable service users.

The service was contracted to provide a weekly 'fastest' clinic for up to 10 people. A 'fastest' is where people are screened for HIV and receive the result of the test during the clinic visit. The test used by the service provided a result within 20 minutes. People were also provided with the opportunity to be tested for other sexually transmitted infections at this clinic.

Routine outreach and pop up clinics offering the 'fastest' were also provided to reach high risk groups within the local community. Support was also provided by a registered nurse to prisoners, prison staff and GPs at three local prisons. We did not visit any of these as part of our inspection.

The service also provided an education service to both statutory and non-statutory organisations regarding HIV and related issues. A counselling service was provided from Terence Higgins South West together with support groups for people living with HIV. These aspects of care and treatment are not part of the Care Quality Commission (CQC) registration.

We found people were provided with a safe, effective, caring, responsive, and well led service. Our key findings were as follows:

Staff were encouraged to report incidents and action was taken as a result. The organisation and staff were aware of the importance of Duty of Candour legislation and when to apply this.

Staff were provided with guidance and training regarding the safeguarding of vulnerable adults. Clinical staff were also made aware of their responsibilities for any children attending the clinic with an adult. Staff had access to additional role specific training to ensure they were competent to deliver the service.

The areas of the building that service users accessed were clean, hygienic in appearance and free from clutter. Staff had access to and consistently used protective personal equipment to promote the control of infection.

The service used technology appropriately in order to deliver an effective service. The service liaised and worked with other organisations in the local and wider areas to assist services users to access appropriate care and treatment. For people who required additional emotional help and support, pathways were in place to refer service users to appropriate professionals.

People who used the service consistently made positive comments about the service, the staff and the manner in which they were treated. Staff showed empathy, kindness and understanding to service users.

Risk assessments were carried out to identify and reduce any identified risks to service users and staff.

Summary of findings

The culture of the service was one of openness and transparency. The local leadership shaped the culture through effective engagement with staff and service users. Staff felt respected and valued by their colleagues and their managers.

However, there were also areas of practice where the service needs to make improvements.

Importantly, the organisation should:

- review the arrangements for storing clinical waste prior to its collection.
- ensure combustible materials stored on landings and corridors that increase the fire risk within the building are removed.
- ensure peoples' medical records are completed fully and that the records are clear and understandable to the reader, particularly where acronyms are used.
- make sure staff are fully aware of the action to take should there be a need for a staff member to use their panic alarm. The organisation should ensure staff using the counselling rooms have a means to call for help in an emergency.
- systems for identifying, monitoring and mitigating against risks should be strengthened.
- review the facilities in place for hand washing in clinical rooms.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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Terence Higgins Trust South West

Services we looked at:
Community health (sexual health services).

Summary of this inspection

Background to Terrence Higgins Trust - South West

Terence Higgins – South West is part of the national Terrence Higgins Trust charity. The trust campaigns on various issues related to human immunodeficiency virus (HIV). In particular the charity aims to reduce the spread of HIV and promote good sexual health (including safe sex). They provide services on a national and local level to people with, affected by, or at risk of contracting HIV and campaign for greater public understanding of the impact of HIV and acquired immune deficiency syndrome (AIDS). The Bristol branch provides services to people living in Bristol and the wider areas.

The service was registered with the Care Quality Commission to provide the following regulated activities: diagnostic and screening services, family planning and the treatment of disease, disorder or illness.

Our inspection team

Our inspection team was led by;

Melanie Hutton, Inspector, Care Quality Commission.

The team included a sexual health/HIV advanced nurse practitioner.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We carried out an announced visit on 28 and 29 November 2016. We did not carry out an unannounced visit.

During the inspection we spoke with three service users, two registered nurses, the registered manager, the clinical director, the business manager and two volunteers. We also obtained feedback from nine completed comment cards which people had access to when waiting at the clinics prior to our inspection.

We reviewed policies, procedures, documentation and ten sets of service user medical records.

Summary of this inspection

Information about Terrence Higgins Trust - South West

Terence Higgins South West provided services across Bristol, North Somerset and South Gloucestershire. The main offices and clinical rooms were located in the St Phillips area of Bristol. Outreach services were also provided within Bristol, North Somerset and South Gloucester.

Between November 2015 and November 2016 data showed that 374 people attended the clinic. We did not see evidence identifying how many repeated contacts were made.

What people who use the service say

We provided the organisation with comment cards for people to complete and share their views of the service with us. Nine cards were returned. The completed cards all contained positive feedback with specific comments including “I’ve never experienced anything other than excellent care in the times I have used the THT Trust. I am always treated with dignity and respect”, “they [the staff] are thoughtful and caring at all times, I know I would not have made it through this year without them” and “I was treated with respect at all times, made to feel welcome and offered a drink while I waited”.

We spoke with three service users who attended the weekly clinic during our inspection. All made positive comments about their experiences of the care and support provided.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Terence Higgins South West had systems and practices in place to ensure people who used the service and staff were safe including:

- Staff were encouraged to report incidents and action was taken as a result.
- The organisation and staff were aware of the importance of Duty of Candour legislation and when to apply this.
- Staff were provided with guidance and training regarding the safeguarding of vulnerable adults.
- There were arrangements in place for ensuring the environment was safe and suitable for its purpose.
- The areas of the building that service users accessed were clean, hygienic in appearance and free from clutter. Staff had access to and consistently used protective personal equipment to promote the control of infection. There were hand washing facilities in the clinical areas.

However:

- Clinical waste including used sharps, such as needles, were stored in an unsecure area in the courtyard. People had access to this area and at times would be unaccompanied.
- There were inconsistencies in the completion of clinical records with gaps noted regarding important medical information.
- Staff had not been drilled on the action to take in the event of a colleague pressing their panic alarm. This did not ensure that the correct processes would be followed in the event of an emergency.
- There were no panic alarms in the counselling rooms which potentially put staff at risk when working alone with service users in this area.
- Staff did not receive training on conflict resolution / dealing with violence and aggression.
- Staff only areas of the building were cluttered and combustible materials were stored in offices, on landings and near to the staircases. This posed a fire risk and in some areas a tripping hazard.

Are services effective?

Terence Higgins South West had systems and practices in place to ensure they provided an effective service. for example:

- Consideration was given to national guidance and recommendations when providing care to services users.

Summary of this inspection

- The service used technology appropriately in order to deliver an effective service.
- Staff had access to additional role specific training to ensure they were competent to deliver the service.
- The service liaised and worked with other organisations in the local and wider areas to assist services users to access appropriate care and treatment.
- Verbal consent was consistently obtained from service users prior to providing any aspect of the service.

Are services caring?

Terence Higgins South West provided a caring service to service users. During the inspection we found:

- People who used the service consistently made positive comments about the service, the staff and the manner in which they were treated.
- We saw staff showed empathy, kindness and understanding to service users.
- Staff provided information to people regarding their care and advised them of future care needs.
- For people who required additional emotional help and support, pathways were in place to refer service users to appropriate professionals.

Are services responsive?

We found that the organisation provided a responsive service.

- The service was provided in line with the terms of the contract agreed with the local commissioners.
- The service provided access to service users with disabilities.
- People who used the service were advised how to make a complaint should they need to do so.

However:

- The clinics were oversubscribed with approximately ten people each month not being able to be seen at the clinic. However, the clinic provided information regarding alternative services for the service user.

Are services well-led?

We found there was limited evidence around governance arrangements and feedback to the national organisation.

- There was a lack of evidence to demonstrate that the organisation was assured that people received a quality service.

Summary of this inspection

- Not all risks had been identified and mitigated against. There was no local risk register which identified all known risks in one document which could be shared with the organisation. The national risk register was not available to staff outside of the trust board. This did not promote openness and transparency.
- There was not a robust system in place to obtain feedback from people.
- Staff meetings were infrequent and did not give staff the opportunity to meet together as a team to discuss any issues or concerns.

However:

- Risk assessments were carried out to identify and reduce any identified risks to service users and staff.
- Staff made positive comments about the local leadership of the service and the support they received.
- The culture of the service was one of openness and transparency. The local leadership shaped the culture through effective engagement with staff and service users.
- Staff felt respected and valued by their colleagues and their managers.
- The organisation provided all staff with updates and information through email and newsletters.
- The service was innovative in ways in which they reached high risk client groups and vulnerable service users.

Detailed findings from this inspection

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health (sexual health services) safe?

Incident reporting, learning and improvement

- Providers are required to notify CQC of any significant events and incidents. We had not received any reports of serious incidents within the last 12 months. We reviewed a log of the 10 incidents staff had reported to the service between December 2015 and November 2016 and saw these did not meet the criteria for reporting to the CQC under Regulation 18. The incidents reported included security of the premises, potential risk from violence and aggression from service users and technology difficulties such as disruption in the connection to the internet. Though no such reportable incidents had occurred, it was unclear if there was a process to report in the event of one occurring.
- The organisation reviewed the control measures in place to see if they needed to take action to reduce the risk of the incident reoccurring. We saw action had been taken to reduce the risks to staff from violence and aggression by the provision of individual panic alarms.
- All staff had access to the electronic incident reporting system used by the organisation and were encouraged to report any incidents. The provider informed us the purpose of the electronic system was to ensure that all incidents were reported, monitored, reviewed and acted upon.
- Staff were provided with incident management training within their induction period via e-Learning.
- We reviewed the process the organisation followed regarding incidents. The member of staff who reported the incident assigned the online form to their line manager and also to the relevant department in the organisation. For example, health and safety or finance. The electronic system also included the information governance manager within the distribution which ensured they were made aware of each reported incident.
- Each reported incident was required to be dealt with by the assigned responsible person within one month. The electronic system automatically flagged a reminder by sending an email to the responsible person and the information governance manager if not completed within the timeframe. This ensured that incidents were followed up appropriately. We were informed by the clinical director that low level incidents were managed at a local level with higher risks dealt with by senior management within the organisation. However, this was not evidenced on the incident log provided to us so we were unable to ascertain how incidents were assigned and addressed.
- Information obtained from the investigation of reported incidents was collated by the medical director and shared every three months within an email which was sent to all staff. This shared actions to be taken by staff to reduce the risk of similar incidents reoccurring.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify service users (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Information had been provided to staff through email and on the intranet regarding the duty of candour. This also included guidance on the action they were required to take in order to meet the appropriate regulation.
- There had been no formal training for staff regarding the duty of candour. The registered manager had become aware of a lack of understanding of the regulation and had reissued guidelines to all staff. The registered manager discussed these with the staff. During these discussions the registered manager assessed the staff members understanding of the duty of candour principles. Staff were then all required to provide a signature to evidence they had read and understood the regulation.
- The registered manager planned to create a log to record and evidence the action taken following any Duty of Candour incident. This had not yet happened as there had been no reported complaints or incidents which came into this legislation.

Safeguarding

- All staff had been provided with safeguarding adults training to level 2. Staff we spoke with were clear of their responsibilities following identification of any safeguarding issues. Staff we spoke with were knowledgeable about when they would refer people to external organisations. For example, following disclosure of sexual assault.
- The contact details of the safeguarding teams at the local council were provided to all staff together with an internal safeguarding lead professional. Local safeguarding multi disciplinary policies and procedures required the organisation to report any identified safeguarding concerns through the council.
- The organisation did not provide a service to children. Clinical staff had completed safeguarding children level 3 raining which enabled them to recognise any potential safeguarding issues should children attend the clinic with adults. All staff were provided with the contact details for the children's safeguarding teams should they observe any concerns. The organisation was reviewing the training for volunteer reception staff and was considering including safeguarding adults and children within this programme.

Medicines

- No medicines were used within the clinic.
- People who were identified as requiring treatment with medication for any infectious disease were referred to the local genitourinary medicine (GUM) centre.

Environment and equipment

- The clinic was provided from a Grade 2 listed building in the St Philips area of the city. This meant there were limitations on the adaptations and modernisation that could be carried out due to planning regulations. The building was over three floors which were accessed by stairs and a lift. The lift was broken at the time of our inspection. However, any person who attended the clinic with mobility issues could be seen in a meeting room in a part of the building which had disabled access from the street.
- People had access to a small waiting room which seated four people. Any additional service users were asked to wait in the meeting room. This helped with maintaining confidentiality of people attending the clinic.
- There were two clinic rooms which were furnished appropriately to enable staff to run the clinic. Staff had access to an estates management team should equipment such as examination couches need repair.
- The estates management team also carried out portable appliance testing. This is a process by which electrical appliances are routinely checked for safety.
- All equipment used for clinical purposes, for example, tourniquets for blood taking, were for single use only and disposed of following each use..
- The organisation had an IT department they could call upon to address any problems with the computer system in operation. Staff reported that the department responded promptly to any identified problems.
- When waiting for collection, the sharps bins and clinical waste rubbish bags were stored in an unlocked cupboard in an enclosed courtyard at the rear of the building. The clinical waste collection took place every

three months. We saw service users accessed this area alone during clinics and when accessing the meeting room. This did not ensure the safekeeping of sharp and hazardous materials.

Quality of records

- People's records were maintained in an electronic format. This was a nationally recognised electronic record system which had been designed for sexual health services. Access to the person's electronic record system was password protected. The electronic records used a system of coding which followed nationally recognised codes. These identified the needs of the service user and any tests carried out.
- People completed a brief written information sheet on arrival at the clinic. This provided detail regarding contact information, sexual orientation, disability, ethnic group and how the person heard about the service. Following the persons appointment this paper record was stored securely in a locked filing cabinet in a locked office.
- This information was put onto the electronic records system by the reception staff, noting the time the person attended the clinic. This enabled the nurses to see people in order by the time they arrived.
- The electronic records consisted of assessment, risk and care and treatment proformas which served as a prompt to staff during the consultation with the service user and following treatment. For example, staff followed set proformas for episodes of care such as HIV testing and sexually transmitted infection testing. Mandatory parts of each proforma had to be completed before the proforma could be saved and exited. This ensured that essential information was not missed.
- The organisation had identified an increase in reports of chemsex and were in the process of developing a section on the proforma to gather information on this. Chemsex refers to gay or bisexual men using drugs to facilitate sex with other men in a planned way.
- The service provided point of contact testing for HIV. This meant that service users received their results within 20 minutes of the test. The result was recorded within the electronic record together with the batch number of the test used. This ensured that the service maintained a quality control of the procedure.
- The registered manager had instigated a monitoring system of the test results received from the laboratory. Part of this process included a check of all the results received each week and ensuring they had been entered onto the service user's electronic records. This process was to ensure that any positive results returned were not missed.
- At the time of entering results into the records the registered manager also reviewed the content of the service user record for accuracy and detail completed at the clinic visit.
- During our inspection we reviewed the electronic records for 10 people who had used the service. We observed that there were areas not completed for six sets of records. These included the result from the point of care test not being recorded and a lack of consistent recording of the batch number or the expiry date of the point of care test.
- During the clinic, staff wrote the electronic records number and date of birth onto stickers to attach to samples. The labels were not printed directly from the computer system. This increased the risk of misidentifying samples although the registered manager stated this had not happened.
- We also observed that staff used acronyms that did not have clear meanings. There was no formal key code to decipher the acronyms which could potentially lead to misunderstanding between different staff.

Cleanliness, infection control and hygiene

- The clinic was visibly clean and hygienic during our inspection visit. We saw all areas of the clinic used by service users were tidy and clutter free.
- A cleaner was employed to clean the clinical areas, waiting room, reception and the toilets within the main clinic. Staff were responsible for cleaning the offices and areas that people who used the service did not access. There was no cleaning schedule in place. We were told this was because the cleaning staff knew what they were required to clean each week.

Community health (sexual health services)

- An infection control audit was completed each week of the clinical areas. This audit monitored the cleanliness of clinic rooms, trolleys, toilets and that the gel and soap dispensers were filled. Comments from the audits were recorded and feedback given to the clinical team if issues identified. We reviewed a number of the audits and saw that no problems had been identified.
- We observed there were plentiful supplies of personal protective equipment (PPE) available to staff such as gloves and aprons. Staff told us they used PPE when necessary. We observed one episode of care and saw that the nurse washed their hands before and after taking a blood sample and used hand gel and PPE.
- The examination couch was covered with disposable paper towel and was replaced between each service user.
- After use, sharps were disposed in appropriate bins and were sealed and labelled correctly when full.
- Samples of blood and urine were sent to a laboratory for testing through the royal mail postal service. The samples were placed in outer protective covers prior to being placed in a plastic envelope and sent to lab through royal mail. This was to protect the sample and reduce any risk of infection to anyone in contact with the mail.
- The staff offices were cluttered and in some areas the carpets needed vacuming. No service users accessed these areas.
- There were handwashing facilities and alcohol gel for sanitizing hands in each consulting / treatment room. However, one of the consulting rooms only had access to a portable hand washing unit which staff said did not work well so they did not use. Instead they accessed hand washing facilities outside of the clinic room in the public toilet or other consulting room. This did not fully promote the control of infection as staff had to leave the area prior to washing their hands.

Mandatory training

- There were two registered nurses who worked in the clinic and were employed on a sessional basis. This meant that they were employed to provide clinical care and treatment during the opening hours of the clinic only. Their main employment was within sexual health with other providers. They told us that their main training was undertaken with their substantive employer and their training certificates accepted by Terrence Higgins Trust. Evidence from their training records was recorded on an electronic training system. This showed the nurses were up to date with their annual training.
- There were assistant practitioners employed by the service who worked within the outreach service and provided support to people attending groups and drop in sessions at the service.
- The mandatory training for the assistant practitioners consisted of an initial induction training consisting of basic life support, anaphylaxis treatment, safeguarding level 2 and organisational policies and procedures, For example, lone working and health and infection control. An electronic data base showed the assistant practitioners were up to date with their annual training updates.

Assessing and responding to patient risk

- The service had developed risk assessments to support staff when assessing the safety of testing people. This assisted the staff to make a decision as to whether it was safe and appropriate to carry out a point of contact HIV test for individuals. Staff were required to be satisfied that the potential reactive outcome from an HIV test would not cause the person to behave in a harmful manner either to themselves or the member of staff. We were provided with information which demonstrated that following the completion of the risk assessment, a decision had been made not to carry out a point of contact HIV test for one person. This was due to their inability to consent to the test and unpredictable response if the test was reactive, following over consumption of alcohol.
- If the service assessed they could not test due to the perceived risk to the person, a referral was made to a local organisation to follow up. Staff contacted the external organisation to ensure the referral had been received and that the person had attended. The staff also had contact details for the emergency mental health team support for the service user if necessary.

Staffing levels and caseload

- Two registered nurses, an assistant practitioner and the registered manager provided clinical care and treatment at the weekly clinic. Cover for the clinics was arranged by the sessional staff advising when they were able to work and the registered manager filled in any gaps.
- All clinical staff were sessional workers, employed to cover the weekly clinic and therefore not substantive staff. For this reason the organisation did not report sickness levels and there was no information relating to vacancies or turnover of staff.
- The service did not use agency or bank staff. However, at times over the past year, there had been occasions when reduced numbers of available staff to run the clinic had impacted on the service provided.
- We were told there had been two occasions in the past 12 months in which the clinic had to close due to not being able to staff the clinic. There had been other occasions when the access numbers to the clinic had been reduced to fewer than 10 due to only one clinician and the receptionist being on duty.

Managing anticipated risks

- There were systems and processes in place to minimise the risk to staff working within the service. However, these systems did not fully protect staff at all times.
- Staff working within the clinic had access to panic alarms in the treatment and consultation rooms. Staff were able to show us where the alarms were and told us they were aware of the sound that they made when pressed.
- However, there had not been a practice drill to ensure staff were aware of the action to take in an emergency. We were told that the system was discussed and staff knew that one person would call the police and provide help to their colleague. The lack of testing meant the organisation was unable to be assured that the correct processes would be followed in the event of an emergency.
- There were no panic alarms in the counselling rooms which were on the first floor of the building and were isolated from the reception area and the offices upstairs. Staff informed the receptionist if they were meeting with a person in the counselling room but this did not fully protect them from the risk of violence and aggression and being able to summon help in an emergency.
- No training had been provided for staff on conflict resolution / dealing with violence and aggression. A recent incident had been reported by a member of staff where they had been at risk from violence and aggression from a service user.
- Systems and processes were in place to protect staff, people who used the service and visitors to the premises from the risk of fire. The fire alarm was tested by staff each week and had been assessed and serviced by an engineer in January 2016. The alarm was triggered by smoke detectors. There were fire extinguishers located throughout the building, with one on each floor and a fire blanket in the kitchen. The service had two nominated fire wardens and information was available to show where the assembly point outside the building was. However, the fire checks had not identified that the combustible materials stored on landings and corridors increased the fire risk within the building.
- Staff were provided with clear guidelines and information on the action to reduce risk and harm when working in outreach venues. For example there were specific guidelines regarding the areas staff could work within saunas. Staff could use the café, restaurant and bars to carry out their work, but avoided the changing rooms, sauna or spa areas. Staff were required to work with another colleague at all times when providing outreach work and to ensure other colleagues and the police were aware of their location.
- The organisation provided an on call support system for clinical staff which was provided by senior staff within the organisation. For example, the medical director, clinical director or registered managers. This ensured that staff had access to support if needed when providing clinical care to people or following an untoward incident.
- The recruitment process for staff and volunteers was thorough and managed by the organisations human resources team. The registered manager, business and area managers were clear that no member of staff or

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volunteer commenced working at Terrence Higgins Trust without a satisfactory Disclosure and Barring Service (DBS) check and references. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Are community health (sexual health services) effective?
(for example, treatment is effective)

Evidence based care and treatment

- The organisation was aware of and included national guidelines for best practice within the policies and procedures provided to staff.
- We saw evidence that the organisation followed the operating level 1 stepped care model recommended by the British HIV Association (BHIV) regarding the psychological standards for HIV.
- The clinical director had responsibility for ensuring that new or updated national guidance was identified and cascaded to all staff by email or within the organisation's monthly newsletter.

Technology and telemedicine

- People were asked how they wished to be contacted by the organisation and how they wished to receive their test results. Their response was recorded within their electronic records.
- The testing laboratory sent the person a text if their result was negative. However, a positive result was referred back to the service whereby a telephone call was made to the service user or a text was sent asking them to telephone the clinic for their results
- The organisation had developed an information sharing website to assist people living with HIV.
- The organisation provided a telephone helpline which was operated on weekdays from 10am to 8pm.

Patient outcomes

- Terence Higgins Trust was contracted to provide a weekly 'fastest' clinic with a maximum capacity of ten clients. A 'fastest' is a HIV test which provides a reactive or negative result within a short period of time. The test used by the service provided a result within 20 minutes. People waited at the clinic for their result. People who required care and treatment following their tests were referred to external organisations as this was not a service provided by the Terence Higgins Trust South West.

Competent staff

- Assistant practitioners were employed to carry out 'fast tests' within the community as part of the outreach service. They received in house training and competency checks to ensure they were competent to carry out these tests. Records were maintained of this training.
- Three of the four permanent non-medical staff had an appraisal within the last 12 months. A date had been arranged for the remaining member of staff to have their appraisal. Sessional clinical staff did not receive an annual appraisal although they did receive formal supervision.
- The sessional registered nurses were provided with formal supervision twice a year but informal supervision more frequently. Staff told us the registered manager was very approachable and they could speak with him or meet him for support and discussion when required. Feedback from the registered manager was that formal supervision was difficult to achieve due to the nature of the sessional contract. However between the formal supervision, informal discussions regularly took place between the registered manager and nurses.
- The assistant practitioners were provided with supervision three times a year. Records were maintained of these supervision sessions which showed the content and format followed.
- One registered nurse provided support to people who were in prison. They attended the prisons each week with a GP and saw people who required 'fastest' or ongoing HIV support. The registered manager met with this member of staff to provide formal supervision. We saw electronic records of the content of this supervision together with actions that had been identified. The next supervision was to be an observed practice / supervision within the prison.

- A comprehensive workbook for training and inducting had been implemented.
- Clinical staff we spoke with told us that prior to providing care and treatment to people they were required to attend the Terence Higgins trust Foundation training course which was held in the head office in London.Staff told us this enabled them to gain a good understanding and knowledge regarding HIV.
- Volunteers worked within the clinic, providing reception cover. All volunteers were required to complete training which took place over one weekend and a number of evenings. Topics included confidentiality, the epidemiology of HIV, first aid and health and safety
- New volunteers were required to shadow an experienced member of staff prior to working alone. This took place for a minimum of three shifts.
- Registered nurses were required to maintain a professional registration with the Nursing and Midwifery Council (NMC). We saw records were maintained which identified the registration for three members of staff was up to date.
- Nurses were required to revalidate their registration every three years. Revalidation is a process that demonstrates the nurse practiced safely and effectively. The sessional nurses were revalidated through the NHS trusts they worked for. The registered manager had revalidated their nursing registration in September 2016.
- Staff were encouraged to attend courses held by a partner organisation in the local area. For example, staff had attended a transsexual awareness course and a chemsex training session.
- The organisation had access to a small amount of funding for training which staff were able to apply for. One member of staff we spoke with had accessed this money to attend a specific training they had identified which was pertinent to their role.

Multi-disciplinary working and coordinated care pathways

- The organisation worked closely with the local genitourinary medicine (GUM) and HIV treatment services within the acute NHS trust. For example, effective communication took place when referring people to these services for ongoing care and treatment.
- There was evidence of good working relationships between the service, prison staff and GPs. Effective communication and shared care had taken place between the three services regarding the care and treatment of a person who was detained at the prison. This ensured they accessed appropriate medical services in a timely way following a positive HIV test.

Referral, transfer, discharge and transition

- There was an agreed referral process in place for any people who had a reactive HIV screen carried out at the service. An email was sent to the local organisation which provided care and treatment for people who required further testing and/or care and treatment for HIV. This provided the details of the person and the laboratory test results were attached. A telephone call was also made.
- For people who lived outside of Bristol a referral was made to a service which provided appropriate support, care and/or treatment for HIV in their local are. The information regarding such local services was sourced by the clinic staff using the internet.
- The staff advised the appropriate service of the referral and checked that the person had attended. If they did not attend, staff contacted them using the details provided to them at the clinic. However. There was not a protocol in place regarding the number of attempts or processes to follow when trying to contact people with reactive results. This did not ensure staff would consistently follow the same agreed process. However, the registered manager informed us that due to the low numbers of reactive tests in the clinic this had not been an issue as they had capacity to follow up the action taken by staff. People were asked to provide two different methods of contacting them, such as email and mobile number. This was to mitigate the risk of not being able to make contact with them.

Access to information

- Staff working within the clinic had access to electronic service user records. On one occasion the internet access had been compromised and the clinic had

started late whilst trying to resolve the issue. On this occasion some people's records had not been accessible and the staff had recorded the clinic information on a paper record which was later transferred to the electronic system.

- Outreach workers did not have access to people's information but documented appropriate details of any support or 'fastest' testing carried out. This was transferred to an electronic record on return to the office.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Written consent was obtained on the initial information sheet completed by the people on arrival at the clinic. This gave information and permission on how to contact them. For example, with their test results.
- Consent was obtained prior to commencing any test or procedure. However, one set of medical records we reviewed did not evidence that consent had been sought from the person concerned.
- As part of the records and test result audit the manager completed each week, gaps in recording were identified and discussed with the staff member concerned. We informed the registered manager of this record which had not been completed and were told they were aware of this and had spoken with the staff about it.
- Staff carried out an assessment of people's capacity to provide informed consent. The staff had on occasions, not carried out procedures where they had concerns that the person had a reduced capacity due to the use of either drugs or alcohol. This had been recorded in the person's medical records.

Are community health (sexual health services) caring?

Compassionate care

- People were asked to identify their name and reason for visit on a brief questionnaire. This meant that personal information was not discussed in the reception area which could have been overheard by others.
- The volunteer on reception told us that should they require further information they would ask the person to step outside of the reception room into the corridor or back yard for a discreet and quiet conversation.
- People we spoke with made positive comments about the kindness shown to them by the receptionist and the way in which the clinicians treated them. All of the people we spoke with had had a positive experience at the clinic.
- We left comment cards at the clinic to enable service users to give us feedback on their views of the care and treatment provided to them. The completed cards all contained positive feedback with specific comments including "I've never experienced anything other than excellent care in the times I have used the THT Trust. I am always treated with dignity and respect", "they [the staff] are thoughtful and caring at all times, I know I would not have made it through this year without them" and "I was treated with respect at all times, made to feel welcome and offered a drink while I waited".
- The reception staff offered people a cup of coffee or tea while they were waiting in the clinic.
- Electronic records we reviewed showed that a chaperone was offered prior to people's consultation and care. People we spoke with confirmed they were aware of the availability of a chaperone during their consultation. We saw there were posters advertising this within the waiting area.

Understanding and involvement of patients and those close to them

- People we spoke with all confirmed that staff provided them with information regarding their care and treatment and made sure they understood the information and had opportunities to ask any questions.
- We observed one consultation and treatment session and saw the person provided with full and detailed explanations about their care and treatment. They

Community health (sexual health services)

were encouraged to ask questions and the nurse also ensured they had the opportunity to talk about concerns and that health promotion for ongoing life was discussed.

Emotional support

- People made positive comments about the support provided to them including; "I think the support you receive at THT is amazing – I would not be where I am today without it", "the nurse pre empted my fears/ worries and talked about these initiating the dialogue which was a relief" and "they spend time with you when needed, supporting and understanding".
- Staff demonstrated awareness of the potential impact testing could have on people and at times would seek further support for them prior to carrying out an HIV test. For example, the local community mental health team.
- There were pathways in place for people to be referred to support with their mental health.
- The service provided a counselling service and employed a number of professional counsellors who delivered this. People were referred to the counselling service from external professionals such as GPs or following attendance at the clinic.

Are community health (sexual health services) responsive to people's needs? (for example, to feedback?)

Planning and delivering services which meet people's needs

- The service was run within the terms of the contract which was with the local commissioners.
- The weekly clinic was commissioned to provide a service for a maximum of ten people each week. This was often oversubscribed and people were sign posted to other local services. People we spoke with stated they believed there needed to be another clinic on a different day to support the demand.
- The contract required the service to provide four 'pop up' clinics each year which would target specific at risk groups. We were told how the service had held two pop up clinics recently in a mobile clinical bus in Weston-Super-Mare where there had been a new bar opened for gay men and a pop up clinic had been carried out within a drug and alcohol unit in South Gloucestershire.
- The pop up clinics were advertised on the website, social media and by word of mouth to encourage attendance.
- The organisation provided testing for sex workers and could provide a letter or certificate to detail the outcome of their results.

Equality and diversity

- Staff had access to a policy and procedure which set out key principles for promoting equal opportunities and valuing diversity across the service.
- There was a lift in place to provide disabled access to clinic rooms but this was broken. It had been reported to the organisation. However, people who required care and support could be seen in another part of the building which did have level access from the pavement.
- Staff had access to a telephone translation service if required for people whose first language was not English.

Meeting the needs of people in vulnerable circumstances

- Support and care was provided to specific groups of people, for example for women living with HIV. A group of women met monthly at the Terence Higgins clinic in Bristol branch to share information, receive care and support and massage therapy. We were told this was a positive and empathetic group. Guest speakers were invited to share latest news and information regarding the care and treatment of HIV.
- In the weekly clinic, appointments were planned 30 minutes apart to give people adequate time to discuss any issues or aspects of their care. However staff were clear that this timeframe was flexible. Often appointments did not take as long and on occasions additional time was provided to people when needed.
- The service did not provide care to people under the age of 18. Any young person attending was referred to the appropriate local service.

Community health (sexual health services)

Access to the right care at the right time

- People we spoke with all confirmed that if they were not able to be seen at the Monday 'fastest' clinic, information was provided of other services in the area together with the times of appropriate clinics.
- During our inspection we saw that an additional person was added to the clinic list as they had travelled a long distance to attend the clinic. The registered manager stated this decision to add additional appointments would be made on an individual basis and the capacity of the clinicians to be able to see the person.
- Receptionist staff stated that once the first ten people had arrived, they would discuss with the clinician before referring other people to other appropriate services. They added that should someone appear to be distressed they would not turn them away without discussing with the clinician first.
- People told us that if they did not arrive early or at the clinics opening time they would not be able to be seen as this was a very popular clinic.
- Records were maintained of how many people were turned away at the weekly clinic. Between July 2016 to November 2016, 51 people were turned away which equated to approximately ten each month.This information had been shared with the commissioners of the service.
- People we spoke with said they could wait for their appointment from 20 mins to 1.5 hours. They all said this was acceptable to them as they were aware of potential delays and it was such a good service. This was not identified as an issue within the comment cards we received from people. People were always told by the reception staff what the waiting time was when they arrived.

Learning from complaints and concerns

- There was information provided in the reception area regarding how to make a complaint. However, three people we spoke with were not aware of this information but stated if they were not satisfied with the service provided they would be able to speak with the receptionist or a clinician. All three people confirmed they had never had cause to complain about the service.
- Staff spoken with were not aware of any complaints and were knowledgeable about their duty of candour responsibilities.
- The service maintained a compliments and complaints log. There had been no formal complaints made to the service.

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

Service vision and strategy

- The service was commissioned to provide a weekly clinic and a number of outreach services each year. There was a Bristol wide strategy plan in place for 2016 to 2017 which was reviewing the delivery of sexual health services within the area.
- The outcome of this review would determine the strategy and vision of the service provided in Bristol
- Terrence Higgins Trust had an organisational five year strategy in place which was to end HIV transmission and late diagnosis, reduce the transmission of sexually transmitted infections and improve sexual health and support people to live well with HIV. The service operated in accordance with the organisational strategy by the provision of the weekly 'fastest' clinic and the support groups available to people.
- The organisational vision was for people with HIV to live a healthy life free from prejudice and discrimination. Staff we spoke with were positive about the vision of the organisation and that people received a person centred service.

Governance, risk management and quality measurement

- The organisation maintained a national risk register. The registered manager, clinical director and business manager confirmed that there was no local risk register in place for the Bristol service. The national risk register was not publically available and we were told by the clinical director and business manager that this information was only available to the board executive team. This did not ensure that risks were

identified fully and action taken to reduce the risk to staff and service users. A lack of a local risk register and governance structure meant the organisation would not be aware of risks at a service level.

- Risk assessments had been completed regarding potential risks and their management. These included staff safety in the weekly clinic and at outreach venues. They also included giving distressing news to a service user and subsequent safety of both staff and service user. Staff had been made aware of the risk assessments and associated actions they were required to take to reduce the risk.
- However, not all risks we identified had been risk assessed. We discussed the risk of unsecured storage of used sharps, such as needles, in areas where people who used the services accessed. The service did not consider that the unsecure storage of such items was a risk as it was compliant with the organisations clinical waste policy and procedure.
- We were shown around the building and observed that there were combustible materials stored under the stairs and stacked in offices. This had not been considered as a fire risk or recorded on a risk assessment.
- During discussions with staff we identified that at times they worked alone in the building without informing colleagues they were there. For example, during an evening or weekend completing paperwork. There was no system in place to protect staff from lone working in this situation; however staff were clear they would not be alone in the building with a person who used the service.
- The management team reviewed all incidents and were confident that multiple incidents about the same issue would raise awareness and the identified risk would be escalated within the organisation. However, it was not clear how this would happen given that there was no local risk register and there was no access to the national risk register. We were told that the clinical director attended quality and safety meetings within the organisation where issues were discussed. Feedback to the staff from these meetings was provided by email.
- The clinical director visited the Bristol service regularly and reviewed systems and processes that were in place in the service to monitor the quality of the service provided. For example, the records maintained of the checks carried out to ensure test results had been recorded correctly within people's records and personnel records such as staff training compliance.

Leadership of this service

- The registered manager had registered with the Care Quality Commission two months prior to our inspection as the previous registered manager was on maternity leave and was due to come back to work in 2017.
- Staff we spoke with felt supported by the registered manager who they found to be approachable and always contactable by telephone or email or in person when at the clinic.
- If the registered manager was not available there were always two named people on call within the organisation for support and help if required.
- The 2015 staff survey which had been carried out nationally had identified concerns about the leadership of the organisation at a national level. This was seen to have improved in the mid-year review which was carried out in November 2015.
- It was not clear from the staff survey how many staff from the service had provided feedback to the survey.

Culture within this service

- Staff spoke of the positive approach of the Terence Higgins Trust when caring for people and were positive about how the philosophy of the trust was not focused on the illness but the person.
- All of the staff and volunteers we spoke with were positive about the organisation and how they felt valued working within it.
- Staff we spoke with told us they would feel able to raise any concerns but had not had the need to do so.

Public engagement

- Feedback on the service was obtained from comment cards. We were told there had been small numbers received but these had been all positive. The comment cards were left on the table in the waiting room. The service did not ask people to complete these but left it to the person to see the card and

initiate its completion. This did not promote the completion of the cards and could explain why there were low numbers completed. At the time of our inspection there had been no information collated or audited which we were told was because of the low numbers of completed cards. One person we spoke with had been telephoned to ask for their views and feedback on the service provided.

- Prior to our inspection we had left comment cards for people to complete in the waiting room. There were nine cards completed by people, eight of whom said the service was excellent and one thought it was good.

Staff engagement

- The Terence Higgins Trust communicated important information with staff by email via a monthly newsletter. An additional email was sent in between times if an urgent matter needed to be shared.
- Staff meetings were held for the staff that operated the 'fastest' clinic on a Monday evening. However, the last meeting was in May 2016. We reviewed the minutes from this meeting and saw that a number of staffing and operational issues were discussed together with detail on any actions to follow up and who the responsible person was to do this.
- The registered manager and clinical staff stated it was difficult to arrange staff team meetings due to the other work commitments of the sessional staff. Any relevant information was shared with staff though individual face to face meetings during the weekly clinic when time allowed, or through email. This did not give the staff team the opportunity to meet together and discuss any issues as a team.
- The organisation had carried out a national staff survey in May 2015 which had raised concerns around leadership culture and behaviours at the Terence Higgins Trust. This had resulted in a national action plan which introduced measures to improve transparency, listening, involving the right people in decision making and improving internal communications and sharing of information. A midyear survey completed in November 2015 showed staff felt there were significant improvements across these areas. Where there remained areas which could be improved an action plan was in place. Staff we spoke with were all positive about working for the organisation and had no concerns or complaints.

Innovation, improvement and sustainability

- The service was innovative in ways to reach service users through their outreach work. For example there had been a recent health promotion evening around Bristol at night. A staff team spent the evening approaching the public and asking them if they had a condom. If the answer was yes they were given a lollipop but if they did not they were given a condom. The aim of this event was to promote safer sex. People were also given information on where to go for testing if they required this.
- An assistant health professional accessed social media sites such as dating websites for gay men and heterosexuals which identify people's location. They based themselves in an accessible location for a period to time and advertised this on the social media site. This was to meet with people and supply condoms and information on sexual health services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The organisation should review the arrangements for storing clinical waste prior to its collection.
- The organisation should ensure combustible materials stored on landings and corridors that increase the fire risk within the building are removed.
- The organisation should ensure peoples medical records are completed fully.
- The organisation should ensure that records are clear and understandable to the reader, particularly where acronyms are used.
- The organisation should make sure staff are fully aware of the action to take should there be a need for a staff member to use their panic alarm.
- The organisation should ensure staff using the counselling rooms have a means to call for help in an emergency.
- The organisation should strengthen their systems for identifying, monitoring and mitigating against risks.
- The service should review the facilities in place for handwashing in clinical rooms.