

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

RRE

Community health (sexual health services)

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RRE11	St George's Hospital	Stafford GUM & Sexual Health Clinic (Based in County Hospital, Weston Road, Stafford)	ST16 3SA
RRE11	St George's Hospital	Cannock GUM & Sexual Health Clinic (Based in Cannock Hospital, Brunswick Road, Cannock)	WS11 5XY







This report describes our judgement of the quality of care provided within this core service by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Requires improvement	
Are services well-led?	Good	

Summary of findings

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Summary of findings

Overall summary

We judged that the service overall was good.

The safety, effectiveness, caring and well led elements of the services were good.

Staff had a very inclusive approach to services. They displayed a caring and supportive attitude when dealing with patients and their carers. Patients could not speak highly enough of the staff that they had encountered.

There were areas for improvement with regards to the responsiveness of the teams in that patients experienced long waits when they attended appointments & Walk-in clinics were cancelled if staff reported sick. There were no

separate clinics for groups who might find it difficult to attend general clinics within normal working hours and no outreach clinics or services to engage difficult to reach groups.

In order to make our judgement we visited both locations. We observed how staff of all levels interacted with patients. We spoke with eleven staff, including consultants, nurses, healthcare assistants, and administrative staff. We spoke with five patients or their relatives about their experiences and reviewed records in relation to the planning and running of services.

Summary of findings

Background to the service

South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT) provided sexual health services in the South Staffordshire area.

The trust took over the service on 1 May 2015. Prior to SSSFT operating the service, it had passed from the now dissolved Mid-Staffordshire Trust, initially to Royal Wolverhampton Hospitals and then to SSSFT. Despite the number of changes to the service provider, most of the staff had worked in the service for many years and had transferred with the service.

The services provided included; Chlamydia testing, Gonorrhoea testing, Hepatitis B testing and vaccination, Hepatitis C testing for at risk patients, HIV Testing and treatment, contraception including emergency contraception, post-exposure prophylaxis for HIV (PEPSE), Pregnancy test and advice, opportunistic smear tests.

The service operated from two clinic locations; one based within County Hospital, Stafford and the second from within Cannock Hospital. Cleaning and facilities management was provided by the host hospitals; however all nursing, medical, administration and reception staff were provided by SSSFT. Clinics at the two locations were operated by the same team of staff. The service alternated such that there was a morning clinic at one location followed by an afternoon clinic at the second location.

Walk-in clinics operated during the same time as appointment clinics and patients without appointments were accommodated in between appointments.

For the period May to October 2015, the service saw 2536 new patients and carried out 3906 sexually transmitted infection tests.

Our inspection team

The inspection team consisted of the following:

- One CQC Inspector

- One specialist advisor

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully 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 these services, asked a range of other organisations for information, and sought feedback from patients and staff members at focus groups.

Summary of findings

What people who use the provider say

Patients told us that staff were very friendly and supportive, comments included;

“Really nice” and “They really put you at ease”.

When we asked people what the service could do to improve one person replied, “They could tell people about it”.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should improve access to services for hard to reach groups in society.

The trust should improve service provision outside normal working hours.

The trust should develop monitoring systems to ensure that cancelled or early closure of clinics is monitored and assessed.

The trust should ensure that learning is shared in respect of incidents and complaints.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Community health (sexual health services)

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated this service as good for safe. This was because:

- Staff were aware of their safeguarding responsibilities. All staff had been trained to level 3 in children's safeguarding in accordance with national guidance.
- Medicines were appropriately stored with temperature sensitive medication kept in refrigerators with regular temperature checks.
- Clinics were clean and tidy; issues with access at one location were in to process of being addressed.
- Patient records were well maintained and stored securely.
- Risks to patients were assessed, monitored and managed in a way that kept people safe.
- Staff told us that they understood how to use the system although none of the staff that we spoke with had any experience of reporting an incident via the system. Staff told us that trust wide feedback from incidents was poor with little learning provided.
- There had been no serious incidents reported since the trust took over the service in May 2015 and up to and including the time of our inspection. Senior staff told us they believed the team were under-reporting incidents; they were looking at ways of supporting staff and encouraging them to report incidents.
- A number of staff described instances of low staffing which had resulted in walk-in patients being turned away, however they had not reported these as incidents.

Incident reporting, learning and improvement

- The trust had an electronic incident reporting system which was available to staff.

Are services safe?

Safeguarding

- The trust had a named safeguarding lead. Contact details were available to staff and schematic diagrams of the safeguarding process were also available. The trust lead attended the clinics on a periodic basis to provide safeguarding supervisions.
- In March 2014 the Royal College of Paediatrics and Child Health published the Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate Document. The document defines the level of child safeguarding training which is required for various staff groups. The staff group 'Sexual Health Staff' were listed by the trust under those requiring level 3 child safeguarding. 100% of clinical staff in the sexual health service of the trust had completed adult safeguarding to level 1 and 2; and children's safeguarding to level 1, 2 and 3. Staff we spoke with were able to describe the various types of abuse and how to identify people who may at risk.
- There had been one safeguarding referral made to the local authority between May 2015 and March 2016; this had involved a patient under the age of 18. The subsequent investigation led to a review of the documentation used for patients under 18 years. A new template was designed which included additional questions for staff to ask of patients and to ensure that staff recognised potential cases of domestic violence and child sexual exploitation.

Medicines

- We saw that there were systems in place to ensure the safe receipt, storage and administration of medicines.
- A member of the trust pharmacy team attended each location on a weekly basis to check and replenish stock. Pharmacy staff could be contacted by phone for advice or guidance if required. Staff we spoke with were unaware of any formal audit of medicines in the department.
- Temperature sensitive medicines were kept refrigerated and regular checks were completed and recorded to ensure that fridge temperatures remained within the required range.
- The service did not have any nurse prescribers or patient group directives covering medication. This meant that patients needed to be seen by a doctor if

any prescriptions for medicines were required. When doctors prescribed medication the prescriptions were checked by a nurse. This meant that patients sometimes had to wait until a nurse became free before they could be given their medication.

- The drugs cabinet at Cannock was based in one of the treatment rooms. Staff told us that this often delayed dealing with patients as they had to wait to gain access to drugs until the room was free. This caused unnecessary delays for some patients.

Environment and equipment

- Sexual health services operated from two clinics; the Stafford clinic was based in the County Hospital and the other at Cannock Hospital. Maintenance of the buildings was provided by the acute hospital trust; staff informed us that this arrangement worked well.
- Access to the Stafford clinic was via long thin corridors which led from the main hospital through to the GUM Clinic waiting room. This provided poor access for patients in wheelchairs or with mobility problems as they could only access the route if no one was trying to exit as they entered. This issue had been identified by the SSSFT and there were plans for the service to re-locate out of the hospital into a town centre location. Unfortunately planning permissions and other administrative delays had caused the transfer to be put back until later in 2016.
- Examination, treatment and waiting rooms were all adequate in terms of cleanliness, comfort and privacy.
- Facilities at the Cannock Hospital clinic had easy access combined with large, well equipped treatment and examination rooms.
- We found that equipment was well maintained at both sites. Electrical safety testing had been completed on portable appliances. Fire exits and firefighting equipment were evident, un-obstructed and in service date.
- Resuscitation trolleys were provided by and maintained by the host locations. Trolleys were situated in the main hospitals outside of the sexual health clinics. When we accompanied staff to check the availability of the trolley at Cannock, the trolley was not where staff had expected it to be. It was located moments later; however, there was no check in place by clinic staff to

Are services safe?

ensure the availability of the equipment prior to opening clinic. This meant that in an emergency situation staff may not be able to locate the equipment. The staff assured us and we saw that there had been no previous adverse incidents in relation to the emergency equipment.

Quality of records

- The trust used both paper and electronic patient records. Paper records were in the process of being scanned into the electronic system in order to create a consistent IT approach to record keeping. All new patients to the service were entered onto the electronic system.
- We also looked at a total of ten patient records and saw that records reflected individuals' needs. Patients were given unique reference numbers; this enabled services to be provided confidentially and maintained the dignity of those using the service.
- The overall quality of notes was good. Pathways of care were clear and easy to follow and risk assessments reflected the needs of individual patients. However, we did see that the service was had used a 2011 template for patients under the age of 18 years. The information on the sheets was unclear and required updating. The head of operations for the service told us that the teams were in the process of developing a revised form.
- Electronic records were accessible through password protected systems which meant that information governance & security was robust. Paper records relating to patients or their treatment were kept in locked cabinets or locked offices and were securely stored.
- Other records relating to running of services, maintenance of equipment and premises, were completed correctly and stored securely.

Mandatory training

- We reviewed the training matrix for the sexual health team and saw varied compliance across the different staff groups. The average rate of compliance for Consultants and doctors was 50.9%; nurses and health care workers averaged 68.9% and administrative and support staff 82% in comparison to the trust target of 85%.

- The trust had a complex system monitoring compliance with mandatory training. Rather than assessing compliance with individual subjects, staff were required to complete all mandatory subjects to be credited with the training. This meant that the addition of one additional subject such as conflict resolution had a dramatic effect on the overall compliance rate.
- Conflict resolution training had been added to the mandatory training schedule in the weeks before our inspection. Some staff on the Sexual Health services team had managed to complete the additional training and had achieved 100% compliance whereas others had dropped from 100% compliance to 75% as a result.

Cleanliness, infection control and hygiene

- We found both clinic locations to be clean and tidy. Cleaning services were provided by the acute hospital trusts. We did not view the host hospital cleaning schedules; however staff assured us that they had always received good service from the cleaning teams.
- Responsibility for tidiness and general spills was that of the clinic staff during the time that the clinics were open.
- Staff understood the importance of cleanliness in preventing the spread of infection. Personal protective equipment such as disposable gloves and aprons were available in all the locations.
- We saw that staff observed guidance on being bare below the elbow in clinical areas.
- The team had an infection prevention and control link nurse, who completed regular hand hygiene audits.

Assessing and responding to patient risk

- Patients were able to access services without providing personal identification; this is recognised good practice introduced in order to encourage patients who may otherwise not engage with services to come forward and seek treatment.
- When patients attended clinics by appointment or through walk-in clinics, staff reviewed the patient's general health. If the patient was known to the service any changes in physical health or sexual activity were recorded. Where additional risks were identified (such

Are services safe?

as patients who were symptomatic of infection at the time of attendance); these were discussed with patients and where appropriate, referrals to consultants were made.

- We saw the Triage/Assessment forms which staff used to enable them to identify individual symptoms and risk. We saw that these assisted staff to recognise those patients who required further investigation of their symptoms or whose lifestyle exposed them to risk of more serious infection or disease.
- Where sexually transmitted diseases were diagnosed, advice and guidance was provided to the patient and included consideration of any recent sexual partners who may also be at risk.
- Facilities for examination and support of victims of sexual assault were available through referral to specialist services external to the trust.
- Emergency contraception services were available. This included provision of what is commonly referred to as the morning after contraceptive. Female patients were able to undertake the treatment if they were at risk of unwanted pregnancy.

Staffing levels and caseload

- The trust calculated the staffing levels using a Safer Staffing tool in line with the system used on the trusts inpatient wards.
- At the time of our inspection, the team included seven nurses and one nursing assistant. However, one nurse was on long term leave at the time of our inspection and had not been replaced.
- Planned vacancies were covered in most areas by staff working additional hours. Unplanned vacancies were often not filled which led to closure of walk-in clinics.
- Staff told us that numbers were adequate for the demand on the service unless unplanned absences

occurred such as sick leave. Each clinic provided services for between 10 and 20 patients, with average attendance of 12 patients. These included both appointments and walk-in patients.

- The service did not have a waiting list for sexual health services. As soon as patients attended walk-in clinics or appointments they commenced any treatments or diagnostic procedures their condition required immediately.
- Clinics were planned to operate with a minimum of three staff, at least two being nurses and the third being either a nurse or healthcare assistant. We saw records which showed that on Thursday 17 March 2016, nurse staffing was one qualified nurse and one health care assistant. Staff told us that this resulted in the closure of the clinic to walk-in patients. There was no record of how many patients had attended but not been seen.

Managing anticipated risks

- Protocols existed at each location in respect of staff and patient safety for emergency situations such as fire evacuation. Both the Stafford and Cannock clinics were based in hospital premises; this provided a degree of security for staff and patients.
- We saw plans of the proposed new premises for the Stafford clinic. The premises will have no direct access to the clinic from the street which will protect patient anonymity.
- The trust had robust lone worker policies in order to provide guidance in respect of personal safety, these included buddy systems and general security of rooms and treatment areas. One doctor we spoke with explained that the trust had a very pro-active security stance due to the secure accommodation provided in other areas of the service.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated this service as good for effective. This was because:

- Treatments were used that followed recognised pathways and best practice in line with national guidance.
- Audits were completed locally which allowed managers and clinicians to monitor performance and patient outcomes.
- The trust engaged in National Audits and provided monthly performance information to all commissioning organisations.
- Verbal consent was obtained before care or treatment were provided. Written consent was obtained prior to any intrusive or sensitive procedures were undertaken.
- Staff followed best practice guidance when dealing with young people; applying Gillick and Fraser principles in assessing capacity to provide consent for patients under the age of 16 years old.
- National guidance in relation to waiting times and appointments were being met. Patients who were able to access walk-in clinics were seen within two hours and patients requiring appointments were all offered appointments within the 48 hour time frame.
- All nursing staff had received an appraisal during the year.

Evidence based care and treatment

- The Department of Health published the Integrated Sexual Health Services, National Service Specification in June 2013. The scope of the guidance was to create a joined up pathway for contraceptive and family planning services with services for screening and treatment of sexually transmitted diseases. The guidance states that services should be fully integrated and be provided in the community using a hub and spoke system of clinics.
- Hub and spoke clinics are based on services having main hub premises where more complex needs can be

met and complimenting these with smaller spoke clinics based in the community. The guidance also suggests that specialist clinics operate for different sections of the community such as specialist young person's clinics, clinics for men who have sex with men (MSM) and commercial sex workers. The system enables and encourages people to engage with services.

- Whilst the trust was not commissioned to provide this integrated service; the trust model did not meet any of the guidance with exception that they did run separate **human immunodeficiency virus**(HIV) clinics. There were no Hub and Spoke clinics and the open access walk-in and appointment clinics. The walk-in clinics ran at the same time as the appointments.
- Guidance from the British Association for Sexual Health & HIV (**BASHH**) and British HIV Association (**BHIVA**) was used to ensure pathways of care met peoples' needs.
- Patients received a full medication assessment of need at their first visit, or on the first appropriate opportunity. This was in line with electronic Medicines Compendium (eMC) 2010 guidance.
- Complete and thorough communications pathway guidance was followed as described in the department of health Framework for Sexual Health in England 2013. This ensured that a multidisciplinary approach was taken and relevant professionals such GPs, specialist nurses and health advisors were involved in decisions relating to individual care.

Patient outcomes

- The trust participated in British **BASHH** and **BHIVA**
- Local audits were completed in relation to patients who attended clinics these enabled staff to assess services and tailor them to meet local need; however the assessment of local need was based solely on the number of patients who engaged with the service. As there was limited external engagement, the trust could not be assured that needs of the wider population were being fully met. The audit results were shared with commissioners.

Are services effective?

- Data for the period May 2015 - through October 2015 for the two clinics was as follows:

Stafford

New patients – 1,233

Follow up patients – 543

Male patients – 848. Female patients – 1,037

Number of Chlamydia screens offered and accepted (under 25years of age) - 232

Positive Chlamydia diagnosis (under 25years of age) – 47

Cannock

New patients – 1,303

Follow up patients – 627

Male patients – 765. Female patients – 1,165

Number of Chlamydia screens offered and accepted (under 25years of age) - 425

Positive Chlamydia diagnosis (under 25years of age) – 45

- Did not attend rates was collected for patients who failed to attend clinic appointments; between May 2015 - February 2016, a total of 327 patients failed to keep their appointments; during the same period 316 patients were re-booked. At Cannock, the 400 patients failed to attend and 294 re-booked. However, we did not see any analysis of the data to establish reasons for patients failing to attend which may have enabled the service to be altered to meet peoples' needs.
- The service offered liquid nitrogen based CryoThermic or topical treatments to treat conditions. The service uses the BAASH guidance in order to decide which treatments to use in individual cases.
- Pathology services were outsourced by the trust. Stafford samples were processed at the University Hospital North Midlands and Cannock samples were processed by Royal Wolverhampton Hospitals NHS Trust; both the Stafford and Cannock clinics experienced delays of up to three weeks in receiving results of tests. The Cannock clinics' results system was due to improve from April 2016 when the new electronic

patient system was due to go live. This system was compatible with that of the pathology service and would ensure that the team received quicker electronic updates and results.

Competent staff

- All staff received an induction upon commencing employment with the trust
- Nursing staff described having managerial support in the form of 1:1 supervision and team meetings.
- Medical and nursing staff are required to revalidate their professional registration. Revalidation involves gathering evidence of experience and remaining up to date with current techniques and information. Both nurses and doctors told us they had been supported to undertake revalidation.
- We found that clinical and nursing staff were knowledgeable and understood their role within the organisation.
- All nursing staff in the department had been appraised during the twelve months prior to our inspection.
- All nurses working in the sexual health service had completed a Health Advisor Course, which meant they were all able to provide appropriate advice to patients in relation to lifestyle and sexual health issues.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary team (MDT) meetings took place weekly. Discussions included individual cases, unusual or difficult cases and options for treatment considered on an as required basis.
- Care pathways were in place and included; Emergency contraception, Termination of pregnancy, sexually transmitted disease rec-calls and HIV treatment pathway.
- The trust did not provide a forensic sexual assault service. Patients who presented following sexual assaults were given initial support and advice but were referred onto neighbouring providers for forensic examination and support.

Are services effective?

- We saw information was available for external organisations and charities; however there was no direct partnership working with external departments or organisations.
- GP's were updated in relation to HIV patients to ensure that they received appropriate support in the community. Consultants discussed medication doses and types with GP's and were available for advice.
- Local safeguarding teams were updated in relation to any vulnerable patients.

Referral, transfer, discharge and transition

- The framework for sexual health services in England 2013 requires that all sexual health patients who book into a clinic should be seen within two hours of arrival. Patients who require appointments should receive an appointment with 48 hours. The trust met both of these targets in relation to patients who managed to get through on the phone or those who were able to reach the reception area.
- Reception staff did not triage patients which meant that all patients making a first appointment or attending clinic for the first time waited their turn to be seen. The one exception to this being young people under 18 years who were fast tracked through the clinics.
- The trust did not have a set procedure to follow if patients with sexual infections disengaged from the service.
- Referral processes were in place for patients who required follow-up services such as x-rays or other diagnostic services.
- Following each HIV appointment the patients' GP is updated by letter regarding the patients' condition; this communication assists in ensuring that joined up pathways of care and follow up are practiced. General attendance at sexual health clinics is not shared with GP's unless the patient elects to have their GP informed; this is in line with national guidance and protects anonymity of patients who might otherwise not engage with the service.
- Referral processes were in place to support patients who sought a termination of pregnancy. Patients who

required this service were referred to neighbouring NHS hospitals or private clinics for treatment. Advice about lifestyle, future contraception and sexual health were provided by the nursing staff.

Access to information

- Staff had access to information via the electronic patient record system. They could also access trust policies and procedures through the trust intranet system.
- The majority of patient medical notes were paper based, the trust were moving to an electronic based system and notes were in the process of being scanned into the new system. We saw how the paper notes were filed and stored in secure filing rooms at each site.
- Electronic systems were password protected and we observed staff logging out of computer systems when they left terminals which ensured that records were protected.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Gillick competency and Fraser guidelines were used throughout sexual health services to ensure that young people under 16 years of age who declined to involve their parents or guardians in their treatment had the capacity to enable them to provide full consent.
- We saw evidence of written consent in action plans and patient notes. Patients also told us that they had been asked for verbal consent before any treatment or care had been provided.
- All nursing staff and doctors had received training on the mental capacity act. They understood how to support patients with a learning disability or impaired mental capacity. Staff described instances where they had needed to consider patients' ability to make informed decisions and how best interest decisions were reached and recorded.
- The trust had a policy on the Mental Capacity Act which provided advice and guidance to staff. Staff we spoke with understood that the trust had a central team for the administration of the mental capacity act with contact details available on the trust intranet.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated this service as good for caring. This was because:

- Staff were observed to have a caring, inclusive and compassionate attitude towards patients.
- Patients appeared comfortable in the presence of staff.
- Patients and carers felt engaged and involved in their care and treatment.

Compassionate care

- We observed staff as they interacted with patients and visitors. Reception staff were polite and discrete; we heard how they explained processes to new patients and advised them of current waiting times.
- Patients we spoke with were all complimentary about the staff they had met; this included nurse's doctors and receptionists.
- We saw how staff approached patients in a non-judgemental manner and put them at ease when they called them to treatment rooms for appointments.

Understanding and involvement of patients and those close to them

- The majority of patients we spoke with had attended clinics on their own; either for contraceptive advice,

screening services or advice regarding infection. They advised that staff had clearly explained what options were available to them. Patients who had attended for screening tests were able to describe to us the process for being updated on their results and confirmed that staff had provided appropriate guidance.

- We saw evidence that signed consent was obtained from patients prior to procedures being undertaken.

Emotional support

- Doctors or consultants took on the task of breaking bad news to patients who had been diagnosed as having contracted a sexually transmitted disease including diseases with life changing consequences such as **human immunodeficiency virus (HIV)**
- Referrals were made to appropriate charities which provided on-going support and information.
- We observed how a patient who attended the reception area in a distressed state was supported by a nurse who escorted them from the reception area directly to a private room to preserve the patient's privacy and dignity.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated this service as requires improvement for responsive. This was because:

- Walk-in clinics were cancelled if staff numbers were reduced due to sickness or absence. Nursing staff described this as occurring on a weekly basis however no formal record was kept to show how often this occurred.
- Walk-in clinics operated at the same time as appointment clinics; this meant that patients with appointments were often kept waiting. However all patients were seen within the two hour waiting time, or received appointments within 48 hours in line with national guidance.
- There was no engagement with the local community other than via the trust web site so The service could not be assured it was meeting the needs of the local population
- There were no weekend clinics and limited evening clinics closed at 6pm; this meant that people who could not attend during normal working hours would have restricted access to services. Senior managers told us that there were no plans to change the service provision at this time.

Planning and delivering services which meet people's needs

- Services were available to all patients over the age of 13 years. Joint working arrangements were in place with paediatric services within local acute trusts for patients under the age of 13.
- There was no engagement with the local community other than via the trust web site to advertise the services, promote good sexual health and inform the public of symptoms which might encourage them to use the service.
- The trust were not commissioned to provide outreach services such as taking testing services and information out to community events and locations such as

universities, colleges, military camps, nightclubs or public houses. Nursing staff and some doctors told us they wanted to provide these services but were unable to do so.

- Staffing numbers meant that the trust could not afford to increase demand by going out into the community and advertising the services. When we asked a consultant what the team did to promote services and encourage additional patients to engage, they said, "its word of mouth".
- Staff told us that because patients with a diverse range of issues accessed services; it was difficult to provide a consistent timely service for all patients. Whilst most appointments lasted less than fifteen minutes, if a vulnerable or distressed patient attended the processes could take an hour or more to deal with.
- The trust was not commissioned to provide outreach services and no plans to cover known, frequent increased demand on services such as the annual influx of new and returning student populations to colleges and universities or national events such as PRIDE festivals.

Equality and diversity

- The trust had an equality and diversity policy which staff could refer to if they needed to.
- Staff understood the diverse clientele who used services. Everyone who used services was treated with the same respect and had an equal opportunity to engage with the service as any other. Staff had received training in equality and diversity.
- Interpreter services were provided through a telephone language line service and face to face interpreters could be arranged if required.
- Information leaflets were predominantly written in English; however the information was available in other languages upon request. Sexual health services on the trust website could only be viewed in English.

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- Systems were in place to identify and risk assess young people who attended clinics. Staff liaised with partners in social services to ensure young people were adequately protected. All patients under the age of 18 years were assessed using in line with the British Association for Sexual Health and HIV (BASHH).
- Patients under the age of 13 years were referred to paediatric services at other providers.

Access to the right care at the right time

- Whilst both appointment and walk-in clinics operated at the same time, all patients who attended the clinics were seen with the required 2 hours required by national guidance. Appointments were all made within 48 hours of a patient contacting the service.
- Waiting times were not displayed to inform walk-in or appointment patients of any delays.
- Walk-in clinics closed early or did not open approximately once per week. This was due mainly to the availability of staff to deal with demand if staffing levels were reduced due to sickness or absence. Signs would be placed on the entrance advising that the walk-in clinic had closed. Clinic times and contact numbers for appointments were displayed with the closure signs. No formal record was made of these closures which meant they were not monitored by senior staff. When we spoke with the head of specialist operations and family services, they told us the only time clinics had been closed had been due to industrial action.
- Clinics opened for half a day each weekday at the two locations. One clinic ran in the morning, staff then had to close down and relocate to the other location and set up for the afternoon clinic.

Mornings 9am to 11am (Last appointment time and closure of walk-in)

Afternoons 2pm to 4pm (Last appointment time and closure of walk-in) With each location having one late closing clinic which operated until 6pm (Last appointment time and closure of walk-in)

- Some staff we spoke with said that alternating all day clinics between the 2 sites would benefit patients and staff by increasing the number of appointments and opportunity for walk-in patients. They said they had mentioned this at team meetings in the past but that the idea had not progressed.
- There were no weekend clinics and limited evening clinics closed at 6pm; this meant that people who could not attend during normal working hours would have restricted access to services. Senior managers told us that there were no plans to change the service provision at this time.

Learning from complaints and concerns

- The trust had a complaints policy and a Patient Advice and Liaison Service (PALS).
- Staff understood how to support people who wished to make complaints. They told us that wherever possible they tried to resolve issues for people at the time which prevented formal complaints being made.
- There had been three formal complaints Between May 2015 and March 2016. Two of these related to waiting times at HIV clinics for which patient had received written apologies and the other was a complaint about a doctor which was on going.
- Staff told us that that they did not receive any learning from complaints either locally or from issues around the trust.
- Since the trust took over the service there had been no complaints which had been referred to the parliamentary ombudsman service.
- Doctors and nursing staff understood their responsibilities in relation to duty of candour. While staff explained how they were open and honest with patients, no one was able to provide an example of where formal duty of candour processes had been used.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We found that sexual health services were well led.

- The trust had a clear vision and set of values. The trust values were printed on lanyards which staff used to display their identity cards.
- Staff had a good understanding of the service and their role within it; they felt supported by their managers.
- Leaders were visible and approachable and staff told us they felt respected and valued.
- Staff had undergone two transfers in a short period of time and to a large degree had been left without clear direction. In January 2016, the trust appointed a band 6 nurse to support to the service manager and provide a lead for the nursing and healthcare staff which had resulted in improved appraisal rates, training and overall support.

Service vision and strategy

- The staff were aware of the trust vision and values. The trust values were printed on lanyards which staff used to display their identity cards, this acted as a constant reminder for staff.
- The trust had bid for and won the contract to provide further sexual health services in Shropshire and Telford and Wrekin areas; This contract was due to start on 1 April 2016.

Governance, risk management and quality measurement

- Trust policies, procedures and guidance were available to staff through printed copies and via the trust intranet.
- Although incidents were reported, there was limited evidence of learning taking place as a result.
- Systems were in place to enable managers to monitor, audit and assess the quality of service provided.
- Regular meetings took place between staff groups with clear escalation and feedback routes available where required.

- Staff believed that senior managers understood the department and supported them when they could. The team had also been visited by the chief executive.
- Senior staff and consultants told us that the service had not reached out into the community; patients attended either through referral from their GP or through “Word of mouth”. They told us there had been no analysis of demand for the service other than analysis of numbers of patients attending clinics.

Leadership of this service

- We met with the lead nurse for the service and the head of operations for specialist and family services who had corporate responsibility for the service. We found that they had a good understanding of the service and the issues which staff had faced having gone through two major transfers in a relatively short period of time. Staff told us that the service had improved since the nurse lead had taken up post. They felt they were now listened to and issues were being addressed. She was described by some staff as ‘brilliant’. Training rates and appraisal rates had all improved following appointment of the lead nurse.
- Some staff highlighted that although the nurse lead was very competent in managing and had experience of contraceptive services, she did not have experience of Genito Urinary (GU) medicine.
- As a result of changes to the service since the trust took over in 2015, conflicts had arisen between managers and senior clinicians which had impacted on staff morale. We saw how the trust had implemented a number of interventions to manage the issues and support staff at all levels. Staff told us that relationships had improved and were continuing to do so.
- Staff described how the Chief Executive had visited the service when it had first been taken over by the trust. He had welcomed the staff and they described having been made to feel a part of the new trust. Staff also described further visits by the chief executive and senior managers who they said they had found to be friendly approachable and interested in the work they did.

Are services well-led?

Culture within this service

- There was an open friendly culture within the department with Nurses, receptionists, doctors and administrative staff all worked closely together. There was no sense of hierarchy, each person and their role and was respected by the other.

Public engagement

- There was very little public engagement from the sexual health service in South Staffordshire. The trust website had information about the service which people could access. These pages of the website included a 'Hide the page' button which meant people could quickly navigate away if they were disturbed whilst viewing the page and didn't want others to know what they were viewing.
- Lack of engagement enabled the service to cope with the current level of demand. The services was not commissioned to provide outreach services and had no capacity to cope with increased demand if the service had promoted itself. Senior staff told us that there were no plans to change the current level of service in South Staffordshire until the commissioning and tendering of the service had been completed.

Staff engagement

- All staff working within the trusts sexual health services had access to the trust intranet. This provided information regarding events and incidents in the trust, as well as access to all the trust policies and procedures.

- Executive level visibility was good. Staff described how the chief executive had visited the clinic and spoke with staff about how excited he was to be taking on the service and that he had returned since to view the service in operation.
- The trust circulated news and information to all staff in the form of an electronic newsletter
- The 2015 staff survey showed that staff satisfaction across the trust was high. The trust had a higher than average score in 19 out of 32 key areas. Staff in the specialist and family services division which included the sexual health services, showed slightly higher levels of satisfaction in 21 of the 32 key areas. These included areas such as team working, recommending the trust as a place to work or receive treatment and satisfaction with the quality of care provided.

Innovation, improvement and sustainability

- The trust's contract to provide sexual health services in Shropshire, Telford and Wrekin areas commenced on 1st April 2016.
- The Stafford clinic was due to move to new premises at the end of March 2016.