

Staffordshire & Stoke-on-Trent Partnership NHS Trust

R1E

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)
R1EG3	Staffordshire and Stoke-on-Trent Partnership NHS Trust - HQ	South Staffordshire North Staffordshire & Stoke on Trent Shropshire, Telford & Wrekin Leicester City, County & Rutland	ST5 1QG







This report describes our judgement of the quality of care provided within this core service by Staffordshire and Stoke on Trent Partnership NHS 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 Staffordshire and Stoke on Trent Partnership NHS Trust and these are brought together to inform our overall judgement of Staffordshire and Stoke on Trent Partnership NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

The trust had not undertaken a full analysis of staff requiring safeguarding training for children and young people above level 1. Staff working in sexual health services were not trained to the required level to ensure they were able to protect vulnerable children and young people. The service had failed to meet its own targets for staff mandatory training.

Patients who attended the service in Leicester and provided positive test results for sexually transmitted infections were not always contacted within the advised two-week response time. As patients were advised, that “no news was good news”, this put patients and others at risk as it could result in infected patients having unprotected sex and passing on an infection.

Services operated on a walk-in basis and appointments were available on request. At busy times, the service employed a triage system but this was not done systematically, there was no standard operating procedure. The number of patients turned away and rescheduled appointments were not monitored to ensure patients were able to access services in a timely manner and the service was able to respond to patient need.

Governance systems and processes did not operate effectively, some systems to monitor performance and safety issues were not in place. Staff based outside Staffordshire did not feel part of the trust. Staff satisfaction was mixed, not all staff felt engaged and teams did not always work cohesively.

However, we also saw that staff demonstrated a caring, inclusive, compassionate attitude. Patients and carers felt engaged and involved in their care and treatment. Patients were satisfied with the care they received. There was access to emotional and psychological support for patients. Treatments followed recognised pathways and best practice in line with national guidance. Staff followed best practice guidance when obtaining consent and dealing with young people. Infection prevention and control measures were in place. Systems were in place to ensure medicines were managed, stored and administered or prescribed safely.

Summary of findings

Background to the service

Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) provides sexual health services across North and South Staffordshire and Stoke on Trent. Additionally the trust provide sexual health services in the Shropshire, Telford & Wrekin areas, and in the Leicester City, Leicestershire County and Rutland areas.

The sexual health services were managed on a geographical basis with local management teams supporting each of the four areas. Oversight of the service was maintained by the strategic manager for sexual health services. At the time of our inspection the strategic manager was also acting chief operating officer for specialist services in the trust.

Services were provided on an integrated service model, patients were able to access services for contraception and for screening or treatment of sexually transmitted infections at all the main hubs and most of the spoke locations through walk-in clinics. Some clinics catered for specific client groups or specialised in certain conditions, these clinics operated on an appointment basis.

Each geographical area had one or two main hubs from which services were provided and managed, in addition

there were smaller spoke clinics based in health centres, doctors surgery's and other locations within the community to provide easier access for a greater number of people. All geographic areas provide level 1, 2 and 3 care and treatment. Level 3 treatments were all consultant led.

Sexual health services encompassed all aspects of sexual development, psychological wellbeing and physical wellbeing throughout a person's life. This included contraceptive services and the prevention, detection and treatment of sexually transmitted infection. However, the majority of services provided by the trust were targeted at young people aged between 15 and 25 years.

The service provided in the Leicester City, Leicestershire and Rutland area was the latest addition to the trust's portfolio and was in year two of a three-year contract. The current contract to provide services in Shrewsbury and Telford & Wrekin was due to expire on 31 March 2016. The trust had advised commissioners that they would not be tendering for the services after this date.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh OBE FRCP, consultant in medicine for the elderly, East Lancashire Hospitals NHS Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

Head of quality; deputy director of nursing; consultant nurse; clinical quality manager, community matrons;

nurse team managers; senior community nurses; occupational therapists; physiotherapists; community children's nurses; school nurses; health visitors; palliative care consultant; palliative care nurse; sexual health nurses.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Summary of findings

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

We inspected this service in November 2015 as part of the comprehensive inspection programme.

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 hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 3 to 6 November 2015.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we

did contact Staffordshire Health watch and Stoke Health watch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held seven focus groups with a range of staff across Staffordshire who worked within the service. 120 staff attended those meetings and shared their views.

In order to make our judgement we visited seven locations across the four geographic regions. We completed two home visits in company with nursing staff. We observed how staff of all levels interacted with patients during various types of clinic. We spoke with 42 staff including consultants, specialist nurses, health care assistants, managers and administration and support staff. We spoke with seven patients about their experiences. We reviewed records in relation to the planning and running of services and we examined eight sets of electronic patient notes.

What people who use the provider say

Patient survey results for the six month April 2015 to September 2015 showed that patient satisfaction was over 90% in all but one area, during the latter three months. The area in question had only received 18 responses and of those 15 agreed with sentiment which equated to 87%. The highest rating was 97% which was achieved in three areas.

Patients we spoke with described nurses and doctors they had seen as "Fabulous", "I can't fault them, it was a first class service", "Lovely, really nice and understanding. They made you feel like your questions were important".

Summary of findings

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **MUST** take to improve

- Undertake a full analysis of staff requiring safeguarding training for children above level 1 reflecting the requirements of the Royal College of Paediatrics and Child Health “Safeguarding Children and Young people: roles and competences for health care staff”, Intercollegiate Document.
- Ensure that all staff have are up to date with their mandatory training requirements and that compliance is monitored on a regular basis to ensure compliance is maintained.
- Ensure that trends and learning from patient incidents and complaints is shared and that all identified actions are followed up to minimise the likelihood of reoccurrence and improve care.
- The trust must ensure that patients and the public are not put at risk by ensuring that all post-test contact systems are properly serviced and monitored to prevent late or missing results not being communicated in a timely manner.

- Review staffing levels to ensure that the numbers and skill mix of staff are able to meet the demands of the service and patients are able to access care in a safe and timely manner.
- The trust must ensure that governance systems are in place which enable managers to monitor and compare performance both within the trust and nationally.
- Develop and implement a consistent and robust service-wide approach to triage, which meets national guidelines and ensures patients can access services in a safe and timely manner.
- Establish systems to monitor the number of patients who are not seen on first visit, including the types of service they tried to engage with so that they can improve services in those areas.

Action the provider **SHOULD** take to improve

- Ensure that all staff have regular access to appraisals in order for them to develop their skills and competency.
- Ensure that staff working outside of Staffordshire have consistent access to IT systems to ensure effective service delivery and communication.

Staffordshire & Stoke-on-Trent Partnership NHS Trust

Community health (sexual health services)

Detailed findings from this inspection

Requires improvement



Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this provider as requiring improvement for safe. This is because:

- The trust had not undertaken a full analysis of staff requiring safeguarding training for children and young people above level 1.
- The service had failed to meet its own targets for staff mandatory training.
- There was limited evidence that learning from incidents was shared across the service areas so that learning could be applied elsewhere.
- Inconsistent recording meant that trends in reported incidents could not be identified.
- Patients who had provided positive test results for sexually transmitted infections were not always contacted within the advised two-week response time.

As patients were advised, that “no news was good news”, this put patients and others at risk as it could result in infected patients having unprotected sex and passing on the infection.

- Staffing levels were below establishment, this put pressure on services meeting patient demand.

However, we also saw that:

- Premises were clean and tidy, infection prevention and control measures were in place.
- Systems were in place to ensure medicines were managed, stored and administered or prescribed safely.

Incident reporting, learning and improvement

- The trust had an electronic incident reporting system, which was available to staff in all the main hubs of the sexual health services and many of the spoke locations. Staff understood how to use the system and many staff we spoke with described having input incidents. Staff

Are services safe?

said that they did receive feedback from incidents, which they had been involved in but were less confident that information from other incidents was shared with them.

- Managers stated that information from incidents was discussed at senior level and cascaded to individual teams for learning where appropriate. We were shown copies of team meeting minutes, which showed that incidents were a standing agenda item at the meetings. Learning from incidents was also highlighted to staff in emails.
- The trust had reported one serious incident relating to sexual health services during the period 1 September 2014 to 31 August 2015. The incident had occurred in the Stoke and North Staffordshire and Stoke on Trent area during February 2015. We did not see that a root cause analysis investigation had been undertaken following the incident. When we asked staff and managers at the different locations about serious incidents most staff were unable to recall the incident or any learning, which had been shared from it. Only those working in the local area were able to recall the details.
- Between 1 September 2014 and 31 August 2015, 186 incidents were reported within sexual health services. Analysis of the data was very difficult due to inconsistent naming conventions within reports. For example there were 35 incidents listed under 'North Team' but review of the data identified that only 28 incidents actually related to the Stoke and North Staffordshire team. Similarly, 34 incidents were listed under Leicester but our analysis showed that only 20 of those listed related to Leicester the remaining 14 referred to incidents elsewhere. The difficulty analysing incidents by location did not give us confidence that trends could be identified and addressed by senior managers.
- Trust wide alerts were communicated to staff through intranet news items and emails. Staff referred to these as "Pink Alerts" and gave an example of medication errors, which had occurred in one area of the trust, which were circulated to ensure the errors were not repeated.
- The trust provided data, which showed that as of September 2015, 83% of staff in sexual health services across the trust were up to date with level 1 safeguarding adults training, and 79% were up to date with their level 1 children's safeguarding training. This meant the trust had failed to meet their own target of 90%.
- Staff we spoke with were able to describe the various types of abuse and how to identify people who may at risk. One member of staff described how they had made a referral after a young person had attended a clinic. The staff member recognised that the person was vulnerable and ensured support was put in place.
- 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 under those requiring level 3 child safeguarding. We found that in staff in the Shropshire, Telford & Wrekin teams and the Leicester city and Leicester & Rutland teams had only completed level 1 child safeguarding. In the Stoke on Trent and North Staffordshire team, we saw that the majority of nursing staff were level 3 trained.
- When we asked managers at the various locations about the level 3 safeguarding training we had mixed responses. One manager within the South Staffordshire area had only been in post for a short time but was aware of the guidance and told us that training was being planned. A manager in the Leicester service suggested that additional training provided to staff on specific subjects such as child sexual exploitation mitigated the need for level 3 safeguarding training.
- We asked the trust for the percentage of staff trained to level three within the different disciplines as per the Intercollegiate Document. The trust had not undertaken a training needs analysis of which staff within the trust required the appropriate training.
- Nursing staff had received awareness training in child sexual exploitation and female genital mutilation (FGM).
- The trust had a named safeguarding lead. We were told how the safeguarding lead visited the main hub locations and provided support and guidance to staff.

Safeguarding

Are services safe?

They discussed concerns with young people and where appropriate, their parents or carers and referred suspected cases to the local authority safeguarding teams.

- We saw information for staff displayed in treatment rooms with guidance on safeguarding and details of how to contact the safeguarding lead. Staff at all locations we visited understood their responsibilities in relation to safeguarding both adults and children from abuse. A number of staff described having received guidance on identifying child sexual exploitation and how to escalate concerns and support patients.

Medicines

- The majority of medication provided by nursing staff at the clinics were subject to Patient Group Directives (PGD's). PGD's outline the drugs which were commonly prescribed to patients who have identified conditions. PGD's allow nursing staff to provide medication which would normally require a doctor or nurse prescriber to write a prescription for the patient. We saw that PGD's were followed correctly and appropriate records were maintained.
- In some locations, nurses who had received additional training were able to prescribe drugs for patients.
- We saw that systems were in place for the safe storage, administration and dispensing of drugs. Temperature sensitive drugs were stored appropriately and records were maintained to monitor that refrigeration equipment operated correctly. We were able to review records and check medication at several locations throughout all the geographical areas.

Environment and equipment

- Sexual health services throughout the trust operated from a variety of locations. The facilities ranged from new purpose built health centres, to rooms in old community buildings. We saw that all sites were maintained to ensure patients, visitors and staff were kept safe.
- We saw that equipment was well maintained, resuscitation boxes and trolleys were available at all locations and we saw that these were checked regularly

and records of the checks were maintained which meant staff could be confident that emergency equipment was available and suitable for use if required.

Quality of records

- We looked at eight patient records. We saw that records were accurate, clear and reflected individual needs. Patients were given unique reference numbers which enabled services to be provided confidentially.
- Electronic records were accessible through password-protected systems. Paper records relating to patients or their treatment were kept in locked cabinets or locked offices.

Cleanliness, infection control and hygiene

- All the locations we visited appeared clean and tidy. Hand washing facilities were available in all examination and treatment rooms. Alcohol gel dispensers were visible although we did not see patients making use of the gel. We saw staff using gel in the locations we visited.
- 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.
- Patients told us they had seen staff wash their hands before and after examinations, and they had seen staff use and dispose of aprons and gloves. The interactions we observed between staff and patients were such that we did not expect to see staff washing their hands. We did observe staff wearing gloves and aprons.
- Most sexual health clinic locations were housed within larger buildings with other health services; cleaning services were managed by the host organisations. Staff all described excellent relationships with facilities management services and understood how to raise issues if they had needed to. Day to day management of spills and general tidiness were the responsibility of the trust staff.
- Hand hygiene audits were completed regularly throughout the service; we saw the completed audit forms at two of the locations we visited. These showed that staff were 100% compliant with hand hygiene

Are services safe?

protocols. This was supported by our observations of hand gel being used and confirmation from patients that staff had washed their hands prior to and after examinations.

Mandatory training

- The trust identified ten areas which made up their mandatory training schedule. The trust target for compliance was 90%. From information provided by the trust, we calculated that the service had failed to meet this target in all ten of the mandatory training. For example, 63% of all staff had completed basic life support training, 78%, had completed Infection control training and 80% had completed equality & diversity training.
- The Leicestershire teams had the poorest levels of compliance, for example, 43% of staff had completed basic life support training, 45% had completed fire safety training and 51% had completed information governance.
- Staff in Shropshire and Leicester areas told us that computer problems such as inability to access the training system affected their ability to undertake on-line training.

Assessing and responding to patient risk

- Patients were able to access services without providing personal identification, this is recognised national practice to encourage patients who might otherwise not engage with services to come forward and seek treatment.
- We spoke with a health advisor at one location who had responsibility for contacting patients when test results had been received. They described how the department had been short staffed for a number of months, during this time a backlog of two months had built up in their contact lists. The trust confirmed to us that since 12 August 2015, a backlog of 79 patients had built up. Data from the trust showed that during the period May to October 2015, 91.8% of patients were notified of their test results within 10 working days against a standard of 95%. Patients who had screening tests were told that they would be contacted within two weeks if their results were positive. This meant that large numbers of

patients who were potentially infected; were not contacted within two weeks and may have resumed unprotected sexual activity in the belief they were clear of infection.

- Staff told us that they had repeatedly submitted incidents regarding the backlog of patient follow-ups, they had received no updates or support with the issue and managers had told them to stop submitting incidents.
- Integrated sexual health services meant that both male and female patients could access clinics for advice, guidance and treatment for all sexual health issues from contraceptive services to treatment for sexually transmitted infections.
- “At risk” and hard to reach groups were targeted through liaison with charities and other bodies with outreach Prevent and Promote staff providing testing and information in community settings and encouraging engagement with clinic services.

Staffing levels and caseload

- At the time of our inspection, the trust had 8.33 whole time equivalent (WTE) qualified nursing vacancies against an establishment of 62.71 WTE (13% vacancy). There were also 8.65 WTE nursing assistant vacancies against an establishment of 36.54 WTE (24% vacancy). We were told that seven nursing assistants were due to take up posts within the following two weeks.
- Vacancies were covered in most areas by staff working additional hours, or by bank staff employed by the trust. Agency staff were used for some non-clinical vacancies. Figures for July 2015 showed that out of the 16.98 WTE vacancies only 3.73 were filled by bank or agency staff. We saw that between May and July 2015, bank and agency staff filled 11 shifts. Forty-four shifts were not filled. Staff told us that staffing numbers was the main reason for not seeing patients in a timely manner and triaging systems being introduced.
- We saw that during procedures appropriate numbers of staff were available to ensure that patients were safe. Consultants had access to nurses and chaperones. Procedures that are more complex were only carried out at the trusts main hub sites where additional staff and equipment was available if assistance were needed.

Managing anticipated risks

Are services safe?

- We saw how comprehensive risk assessments were completed in respect of young and vulnerable patients who engaged with services.
- Protocols existed at each location in respect of staff and patient safety. These included lone worker policies and chaperone systems. Notices were displayed in treatment rooms and in some public areas advising patients that chaperones were available.
- Clinics in some locations had visiting security staff that were responsible for securing premises following clinics, this also provided assurance for staff leaving work.

Major incident awareness and training

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.
- The trust had a business interruption plan which included arrangements for staff to support patients in extreme cold and snow.

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 followed recognised pathways and best practice in line with national guidance.
- The service engaged in local and national audits to monitor performance and patient outcomes.
- Staff followed best practice guidance when obtaining consent and dealing with young people.

However, we also saw that:

- The service had not met its target for staff appraisals, 55% of all non-medical staff had completed as appraisal.
- Reliability of information technology and access to information was an issue in some areas of the service.

Evidence based care and treatment

- The Department of Health published the Integrated Sexual Health Services, National Service Specification in June 2013. This brought together contraceptive and family planning services with services for screening and treatment of sexually transmitted infections. The trust model of integration follows the guidance set out in that document. This was demonstrated by the Hub and Spoke model of clinics and the open access walk-in and appointment clinics.
- We saw that guidance from the British Association for Sexual Health & HIV (BASHH) and British HIV Association (BHIVA) was used to ensure pathways of care met people's needs.
- We found that patients received a full medication assessment of need at their first visit; or on the first appropriate opportunity, in line with electronic Medicines Compendium (eMC) 2010 guidance.
- Complete and thorough communications pathway guidance was followed. This ensured that all relevant parties were informed including GP's, specialist nurses and health advisors.

- Appropriate support was provided for patients who required termination of pregnancy. Counselling, treatments and post procedure contraception were provided in line with the Royal College of Obstetricians and Gynaecologists (RCOG) and the Abortion Act 1967.

Patient outcomes

- The trust engaged with national and regional British Association for Sexual Health & HIV (BASHH) and British HIV Association (BHIVA) audits.
- Local audits were completed which enabled staff to assess services and tailor them to meet local need. These included local and national (BASHH) gonorrhoea audits, quality of care in emergency contraception, HIV in pregnancy audit, long acting reversible contraception audit and audit of new HIV patients.
- The trust had a dedicated audit department, all information was collated by the audit team and reports were shared with teams at departmental meetings which took place every two months.

Competent staff

- We saw evidence of how new staff were inducted into the trust. Staff described having had a two week local induction programme during which they shadowed experienced staff and received instruction on the trust computer systems. Staff told us the trust-wide and local induction processes had been a really useful introduction to the work.
- Nursing staff described having managerial support in the form of one to one and team meetings; however there was no regular clinical supervision provided to ensure that standards were maintained and practice was in line with guidance.
- Data provided by the trust showed that across the service 55% of non-medical staff had had an appraisal in the last 12 months, against a trust target of 90%.



Are services effective?

- We saw minutes of band 7 and 8 staff meetings, which showed how information was shared between teams and areas. This included learning from incidents, complaints and performance information, which assisted staff to develop.
- Consultants described their clinical supervisions, which were undertaken by the clinical leads and included case discussions. They told they were supported to revalidate. Revalidation is required to ensure that doctors retain their knowledge and skills in order to provide safe and effective care and treatment. We saw that revalidation was 100%. However, some consultants complained of having little or no opportunity to expand their own knowledge, or to train or assist junior staff. They described how prior to the integrated service doctors operated in one location, met regularly and discussed cases. Due to the hub and spoke system, consultants often worked alone, had to travel to remote locations and had no easy access to peers for guidance, advice or support. They believed patients received an effective and responsive service but the system stifled innovation. The trust told us after the inspection that all consultants have a quarter of their time protected for educational activities within their individual job plans.
- Historically, staff had specialised either in contraceptive services or genitourinary medicine (GUM). The integrated service meant that staff had needed to retrain in order to be able to deliver advice guidance and treatment across all areas of sexual health.
- Retraining or providing additional training for staff has been more effective in some areas than others. In Staffordshire and Stoke on Trent they found that the local universities did not deliver integrated courses, and they are working with Stafford University to develop this. The trust was unable to obtain the training records of the Shropshire staff when they were transferred. Leicestershire and Shropshire experienced a large turnover of nursing staff when they moved to integrated services. Many staff did not want to work in both disciplines which we were told had led to resignations and transfers to other services. All areas had sufficient numbers of staff trained in integrated services to ensure services were provided. Small numbers of nursing staff had still to undergo integrated training; local managers used these personnel to cover specialist spoke clinics appropriate to their skills and training.
- Managers in Leicester stated that training staff for the integrated services did not start until early 2015. The training programme was on-going and it was anticipated that all staff will have been trained to provide an integrated service by the middle of 2016.
- Training compliance featured on the corporate risk register, in August 2015 the Chief Executive asked all directorates heads to provide a rectification plan in respect of appraisal and training compliance.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary team (MDT) meetings took place weekly, during which individual cases were discussed. This enabled best practice to be identified for individual patients. In addition, consultants described participating in West Midlands Network regional teleconferences where unusual or difficult cases were discussed and options for treatment considered. This was one area where doctors told us that knowledge and skills were shared and developed.
- Staff at a number of locations were able to describe instances where complex care plans had been developed for vulnerable patients as a result of multidisciplinary meetings. One case had involved a very young patient; we saw how plans had been developed which included treatment for infection, counselling and guidance for the patient and referral to external agencies to provide additional and on-going support.

Referral, transfer, discharge and transition

- Referral processes were in place for patients who required follow-up services such as x-rays or other diagnostic services. These processes worked better in some areas than in others. Staff in Stoke and North Staffordshire reported excellent relationships with the Royal Stoke acute hospital where they could admit patients directly to wards without them having to go through A&E. Other areas had to refer patients to A&E services.
- Staff in Telford were unable to electronically access diagnostic radiological results from the local acute trust

Are services effective?

due to the incompatibility of computer systems. Locally, staff said this impacted on the level of service they were able to provide but the trust assured us that this is not an issue as a written report is sent to the service.

- Referral processes were in place for support for young or vulnerable pregnant women. We accompanied staff on a home visit to one such patient. The patient described the support they had received and commented, 'I don't know where I would be now, if it wasn't for these'. In addition to providing health care and advice, staff supported patients to access benefits and signposted them to community services and charities for on-going support.
- Following each HIV appointment the patient's GP was updated by letter regarding the patient's condition, which helps to ensure the patient's health is considered holistically.
- The trust did not have a policy for following up patients with sexual infections who disengaged with the service. Staff at the different locations used their own initiative by liaising with GP services, social care services and in some cases where knowledge of the client made this appropriate; making home visits, to encourage patients to re-engage with the process.

Access to information

- Staff had access to patient notes and information through the electronic patient record system. They could also access trust policies and procedures through the trust intranet system.
- Staff based outside Staffordshire described difficulties accessing information due to the reliability of links between local and trust systems. We noted 35 of the 186 incidents reported between 1 September 2014 and 31 August 2015 related to information technology (IT)

issues. We were told that support services responded quickly to faults when they were on duty but issues during the evening would not be resolved until the following day.

- Reliability of the computer system within the Leicester service was on local risk registers. The issue had been on the corporate risk register up until July 2015, when actions such as weekly support visits were deemed to have reduced the risk to a point where it could be managed locally. Staff confirmed that reliability had improved but they were still experiencing regular interruptions to IT services.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Consent was sought from patients prior to treatments being given. We saw evidence of written consent in action plans and patient notes. We reviewed a total of eight sets of patient notes. Patients on the Young Persons Support programme in Stoke on Trent signed consent and agreement to their action plan.
- Gillick competence principles 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 sufficient maturity and understanding to enable them to provide full consent. Fraser guidelines were used when people under 16 years of age required access to contraception.
- Nursing staff and doctors 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.

Are services caring?

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

Summary

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

- Staff demonstrated a caring, inclusive, compassionate attitude.
- Patients and carers felt engaged and involved in their care and treatment.
- Patient survey feedback showed patients' were satisfied with the care they received.
- Services had access to emotional and psychological support for patients when it was needed.

Compassionate care

- We observed staff as they interacted with patients and visitors. Reception staff were polite and discreet. We heard how they explained processes to new patients and advised them of current waiting times.
- Many patients declined to speak with us during the inspection; however those who did were all complimentary about the staff who had dealt with them. All the patients we spoke with said they believed the anonymity of the service made it easier for them to engage with the service.
- Patients were encouraged to comment on the service they had received and comment cards were available for completion. Stoke and North Staffordshire team received 32 comment cards in August 2015. Eighty-seven percent were positive. The positive comments related to the attitude of staff and the overall service provided. Negative comments related to waiting times.
- NHS Friends and Family Test data which include responses for sexual health services are collected under the group title of Specialist Services. For six months January to June 2015, the group received a total of 3,500 responses of which 96% said they were extremely likely or likely to recommend the services to their friends or family.
- The service used a variety of methods to obtain feedback from sexual health patients and their carers.

We were provided with patient survey results for the six months between April and September 2015. We saw that positive feedback scores met or exceeded the 90% target.

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 or for screening services or advice regarding infection. They all told us how nursing staff, and where appropriate doctors, had explained clearly 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 which confirmed that staff had provided appropriate guidance.

Emotional support

- Specialist nurses, doctors or consultants took on the task of breaking bad news to patients who had been diagnosed as having contracted a sexually transmitted infection; this included infections with life changing consequences such as human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Staff we spoke with understood how such news could affect patients and their families and friends and understood how to support patients and where to refer them for further support.
- Staff at Telford's Aqueduct clinic told us that whilst they did not have dedicated counselling services they were able to refer to GP services for psychological services where required. Other locations had direct access to trust services for counselling.
- Different locations around the trust had close relationships with charities and support services in their areas to which they referred patients for further support and information. These included pregnancy support services, fertility support groups, national charities such as The Terrence Higgins Trust, Stonewall, and Rainbow Trust.

Are services responsive to people's needs?

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

Summary

We have rated this service as requiring improvement for responsive. This is because:

- The majority of services operated on a walk-in basis rather than appointments. At busy times the service employed a triage system but this was not done systematically, there was no standard operating procedure.
- The number of patients turned away and rescheduled appointment were not monitored in all areas to ensure patients were able to access services in a timely manner and the service was able to respond to patient need.

However, we also saw that:

- Local services were planned in line with national commissioning guidance and were designed to be inclusive.
- Equality and diversity issues were considered and the services was able to meet the needs of a range of vulnerable people.
- Complaints were dealt with proactively and positively

Planning and delivering services which meet people's needs

- The service model follows the guidance set out in the Department of Health's national service specification on integrated sexual health services (June 2013). Contraceptive and family planning services and services for screening and treatment of sexually transmitted infections are provided side by side.
- The service works with commissioners to plan and develop services in the future. The trust will not be providing services to the Shropshire and Telford & Wrekin when the contract expires in March 2016.
- Analysis of demand for services had identified an increase of between 10% and 20% between 2013 and 2015; this had resulted in extended clinic times and review of which days clinics were required.

Equality and diversity

- Staff received training in equality and diversity and the trust had an equality and diversity policy which staff could refer to if they needed to.
- Staff had a working knowledge of, or followed the principles of, the Equality Act 2010. The act offers individuals protection against discrimination in relation to nine characteristics; Age, Race, Sex, Gender reassignment status, Disability, Religion or belief, Sexual orientation, Marriage or civil partnership status and Pregnancy and maternity.
- Language line was available as an initial interpreter system. Face to face interpreters could be arranged if required. Information leaflets were predominantly written in English; however the information was available in other languages on request. The trust website could be viewed in multiple languages through use of on line translation services.

Meeting the needs of people in vulnerable circumstances

- In Stoke on Trent and North Staffordshire the trust provided a sexual assault referral clinic (SARC) in partnership with other agencies. The SARC clinic provided high-level forensic services. The unit was self-contained from other services in the building and had its own dedicated entrance and lifts which could not be accessed from other floors of the building. Facilities for victims prior to, during and following examination including video interview facilities suitable for interviewing child victims, were exemplary. Forensic cleaning following use was built into the operating procedure which ensured cross contamination could not take place. Reporting incidents to the police was not a requirement of using the service. The SARC clinic was available 24-hours per day, 365 days per year.
- Systems were in place to identify and risk assess young people who attended clinics. Health advisors were involved when young people engaged with the service and staff linked in with social services.
- The service had clear arrangements for dealing with vulnerable patients under the age of 13 years. Any patient under that age would automatically be referred

Are services responsive to people's needs?

to safeguarding. Treatments and counselling may still be provided if parental consent or ward of court consent is given. Staff at one location described their actions in relation to a vulnerable 12-year-old patient they dealt with. Staff described their actions in relation to a patient under the age of 13 years they dealt with. We saw that procedures were followed which provided immediate protection for the child and on-going support.

- Stoke and North Staffordshire team had a meet and greet reception system for all patients but this was particularly helpful to patients who had complex needs as staff were able to escort or direct patients to the relevant location for their clinic.
- We saw how clinics for some patient groups were planned to ensure that they did not coincide with busy open clinics. This enabled people to attend with a greater degree of anonymity.
- The service included home visits and clinic services. We accompanied a specialist nurse during a home visit to a vulnerable patient. We saw how safeguarding issues were considered including consideration of child sexual exploitation.

Access to the right care at the right time

- The Department of Health Integrated Sexual Health Services, National Service Specification states that 98% of patients should be offered an appointment within 48-hours of contacting the provider. The trust monitored access times in the Leicester, South Staffordshire and Shropshire and Telford & Wrekin services. Data provided by the trust for these three areas showed that for the period of May to October 2015, 100% of patients were offered an appointment within 48-hours of contacting the service. The trust does not routinely monitor access times in North Staffordshire.
- Data provide by the trust showed that approximately two-thirds of patients accessed services on a walk-in basis. The trust referred to its walk-in clinics as 'Queue and Wait' clinics on its website and in leaflets and notices. Staff told us that this was a more honest description and meant that patient's expectations were more easily met. One member of staff said, "We try to see people as quickly as we can, but you never know what's going to come through the door. Some things can take five minutes but another could take over an hour".

- During busy periods, staff at walk-in clinics operated triage systems to deal with capacity problems. Patients who were identified as having routine enquiries were asked to re-attend at a later time. Some locations told patients to return at specific times later the same day or advised patients to attend future walk-in sessions. Patients who had more serious conditions or those who were most vulnerable would be seen in a timely way.
- Staff told us that staffing numbers was the main reason for not seeing patients in a timely manner and triaging systems being introduced.
- Triage systems across the trust operated in different ways which meant there was no consistent approach. There were no standard operating procedures for triage of patients.
- Leicestershire clinics prioritised patients according to complexity and provided a time slot. Patients were advised that they could leave the clinic and return at a specific time. They were told they would be seen within half an hour of re-attending. Staff told us that the system was not effective and patients regularly had long waits on their return. One patient told us they had accepted the option of returning at a set time and when they returned they still waited over two hours to be seen for what turned out to be a six-minute consultation.
- The service monitored the number of people unable to be seen in Leicester. Data for the period May to October 2015, showed that on average 177 patients each month were unable to be seen, this equates to 4.7% of all attendances by clinic. The number of people unable to be seen in other areas was not monitored. The service did not routinely monitor if any patients had been repeatedly turned away. This meant that managers could not properly assess if services were responsive to patients.
- We saw that waiting times were displayed on notice boards in the waiting rooms but they were not always up to date. One clinic board showed a waiting time of 40 minutes when the service had just opened for the day. The board had not been updated from the previous day. We did hear reception staff advising patients on how long they might need to wait when they first arrived.
- Managers told us that 80% of patients were seen within two hours; the maximum waiting time described in the Royal College of obstetricians and gynaecologists,

Are services responsive to people's needs?

faculty of sexual and reproductive healthcare published guidance in 2013. The trust monitored clinic waiting times in the Leicester, South Staffordshire and Shropshire and Telford services. Data provided by the trust for these three areas showed that for the period May to October 2015, this target was consistently achieved. The trust does not routinely monitor clinic waiting times in North Staffordshire.

- Staff described how providing an integrated service was a positive step for patients as it had increased the length of time they needed to spend with each patient. Every patient had to be asked about all aspects of the general and sexual health, and their lifestyle. This impacted on the number of patients who could be seen
- North Staffs teams discussed all patients who had failed to attend appointments at their multi-disciplinary meetings. There was a local system of three attempts at before contact stopped unless the patient was classed as vulnerable. If the patient was vulnerable, attempts were repeated until the patient was contacted or until all options such as home visits, and liaison with other health professionals had been exhausted.
- Where patients had difficulty accessing clinics, arrangements had been put in place such as having blood samples taken at their GP's surgery and having the results faxed to the clinic.

- Leicestershire services included on-line screening services; patients could access HIV test kits through on-line ordering, although staff preferred patients to attend clinics so that they remained engaged with the service.

Learning from complaints and concerns

- Between 1 August 2014 and 31 July 2015, sexual health services received a total of 11 complaints. Two complaints were upheld and one complaint regarding clinical treatment at Leicester was referred to the Health and Parliamentary Ombudsman's service.
- Staff understood how to support people who wished to make complaints. Staff attitude towards complaints was one of learning and improvement. All staff described the desire to provide patients with the best experience they could. Staff told us, "We try to head off complaints by apologising first. This can prevent a formal complaint".
- Informal resolutions were recorded in addition to formal complaints. We saw evidence of an informal resolution where a complaint had been received in relation to how a patient had been contacted despite having advised previously of the method in question not being appropriate. The patient and carer had received an apology and the matter had been discussed at the team meeting.

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 have rated this service as requiring improvement for well led. This is because:

- Governance systems and processes did not operate effectively, some systems to monitor performance and safety issues were not in place.
- There were relationship issues and inconsistencies in quality of leadership and style
- Staff based outside Staffordshire did not feel part of the trust.
- Staff satisfaction was mixed, not all staff felt engaged and teams did not always work cohesively.

However, we also saw that:

- Staff were aware of and understood the trust-wide vision.
- We saw effective public engagement in all geographical areas of the service.

Service vision and strategy

- The trust-wide vision was understood by staff across the sexual health services. Staff had an honest belief that they fulfilled the vision in the work they did.
- The vision for the service was to provide a fully integrated sexual health services in accordance with Department of Health's national service specification on integrated sexual health services (June 2013). Clear strategies were in place to ensure all facilitate the vision, including communication and training plans.
- The trust had decided not to continue with the services in Shropshire and Telford & Wrekin beyond March 2016. Staff said they had been informed about the changes and whilst they did not know who would take the service over, they had felt supported through the process.

Governance, risk management and quality measurement

- Whilst there were systems in place which assisted managers to monitor the quality of service provided, we saw that there were areas where governance was lacking. There were a number of concerns identified during our inspection that service managers were not aware of or not taking action to mitigate risks. For example, there was no clear plan in place to ensure the appropriate staff had completed adult and child safeguarding training beyond level 1.
- The 'Queue and Wait' system meant that at busy times, patients were turned away for treatment and asked to return at an alternative time. There were no governance systems around this approach. The service did not monitor the number or frequency of patients turned away. Each location where services were provided operated a triage system. There was no standard approach and the use of the triage system was not monitored.
- There were no plans in place regarding known, frequent increased demand on services such as the annual influx of new and returning student populations to colleges and universities.
- We saw there were poor governance arrangements in the services in Leicester, in relation to test samples returning from external laboratories. There was no formal monitoring of 'missing' test results. Screening tests were forward for analysis, but there was no direct correlation between the numbers of test sent out and the number received back from the laboratory. Patients who had not experienced any symptoms of infection when attending screening were told that 'No news was good news'; that if they had not been contacted within two weeks and still had no symptoms they could assume the tests were negative and they were free from infection. This meant that if patients results were missing, they could in fact be infected and may go on to have unprotected sex and pass on the infection.
- Sexual health services had a combined risk register across all service locations and each geographic area management team managed the risk relating to their locality. Higher risk issues were escalated through the

Are services well-led?

strategic lead and discussed at corporate risk meetings. Where appropriate risks were added to the corporate risk register. We saw that staff training and access to I.T. service were on the corporate risk register.

Leadership of this service

- Staff within the North and South Staffordshire teams reported that they were well supported; they believed their line managers and senior managers provided an effective environment for them to provide services. Staff in other teams told us that line managers understood them and were supportive but that unrealistic expectations were made of staff in terms of caseloads and clinic locations and numbers.
- Some consultants in Leicestershire told us that they felt frustrated because they did not feel listened too. They felt supported by their own line managers and the operations manager but did not feel the trust gave them a voice.
- Management teams in services outside Staffordshire told us they did not feel they had received the support and guidance of senior trust management that they felt they needed. Relationships between some senior managers were not always conducive to good service provision. This had led to working relationships becoming problematic in some areas and inconsistency of approach by local and senior managers.
- Executive level managers were not as visible as some staff would like. Despite this staff believed senior managers understood the department and supported them when they could.

Culture within this service

- Staff took pride in their work and were proud of their colleagues and teams.
- Many staff working in the Shropshire, Telford & Wrekin, and Leicestershire and Rutland areas told us that they did not feel part of the trust. They saw themselves as local staff providing a service for local people who happened to be employed by Staffordshire and Stoke on Trent Partnership NHS Trust.
- We found varying degrees of job satisfaction from staff at different locations throughout the trust. Nurses and health care assistants in both the Shropshire and Telford and the Leicestershire services reported a negative

blame culture. For example, we were told that in preparation for our visit, the service had been visited as part of the trust's quality assurance visit programme. Staff were told when questioned that their responses were confidential. However, managers later challenged staff about specific comments they had made.

- In Leicester, it was reported that some nursing staff left the service as they were unhappy to move to an integrated model of service, managers however did tell us that some of the staff who left had now returned to the service.
- Staff in Shropshire, Telford & Wrekin, and Leicester City Leicestershire and Rutland described their experiences in being transferred into the trust. They told us that they had felt supported and welcomed into the trust, but many still felt that they did not form part of the core service.

Public engagement

- We saw effective public engagement in all geographical areas of the service. Outreach services operated in nightclubs, public houses, universities and colleges. In addition to offering advice and providing literature, the services offered on-site screening services.
- We saw that literature was available in all the locations we visited in relation to all aspects of sexual health including contraception and sexually transmitted infections. We saw how staff explained services and options to patients when they attended clinics, promoting good health and encouraging engagement.
- The service used a variety of methods to obtain feedback from sexual health patients and their carers. We were provided with patient survey results for the six months between April and September 2015. We saw that positive feedback scores met or exceeded the 90% target.

Staff engagement

- The trust circulated news and information to all staff in the form of an electronic newsletter 'The Word'; a large number of staff told us they did not have time to read the whole document. Those outside of Staffordshire said that there was very little information of interest to them when they did read it.

Are services well-led?

- There were regular team meetings between different staff groups and monthly management meetings where information was shared.
- Staff within the Shropshire Telford & Wrekin area told us that managers had kept them informed in relation to the trusts decision not to re-tender for the service.