Somerset Partnership NHS Foundation Trust

RH5

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)
RH5AA	Mallard Court		TA6 4RN

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

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Good
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

Overall rating for this core service Requires Improvement O

- Somerset Partnership NHS Foundation Trust was registered to provide sexual health services under the following regulated activities: Treatment of disease, disorder or injury, diagnostic and screening and family planning. The registered location was at 7 The Crescent, Taunton where clinics were provided each day, Monday through to Saturday. We will refer to this clinic as The Crescent throughout the report. Other clinics were provided throughout the county which enabled people to access services in their local areas.
- During the inspection we spoke with 17 patients who were attending clinics to seek their views of the care and treatment provided to them. We also received 58 comment cards which had been completed by patients prior to our visits. Comments made were positive about the staff and the treatment patients had received at the visit and for some patients who referred to previous visits. We spoke with 14 members of staff including managers, doctors, nursing, reception and administrative staff. We also spent time reviewing records and associated documentation.
- There were procedures in place which staff followed to safeguard children, young people and vulnerable adults. The trust encouraged staff to report incidents. Staff we spoke with were confident in this system and said they received feedback following reported incidents of the action taken and lessons learnt were shared amongst the staff team.
- There was evidence which showed the staffing skill mix and staffing levels impacted upon the service delivered to the patients. The service was involved in submitting a tender to provide an integrated sexual health service and there had been no staff recruitment since April 2015. This had resulted in some clinics being cancelled and not all services being available at all clinics.
- The risks associated with emergency situations were not fully assessed and managed.
- The care and treatment provided to patients was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Staff liaised with other professionals, both within the organisation and with professionals outside of the organisation to provide a service to patients.
- We observed, and patients confirmed, that the service provided within the clinics was respectful and patient's dignity and confidentiality was promoted. Patients were supported by staff to understand and make choices about their care and treatment options.
- Patients were encouraged to be involved in the development of the service. Young people were consulted on the literature provided to help them understand treatment options.
- Services were not accessible to all patients. For example, some clinics could not provide a full range of care and treatment due to the skill mix of available staff. The registered location had limited access for patients with mobility needs.
- Patients could not always receive services in a timely manner that was in line with national guidance.
- Patients were provided with information in the clinics on how to raise concerns and complaints. The service had received no formal complaints. Action was taken when a patient raised a concern and resulted in improvements to the service
- Risks identified within the service, for example as identified in the fire risk assessment, were not dealt with appropriately or in a timely way. The risks identified at a service level did not correspond with those at a trust level.
- The approach to service delivery was focussed on short term goals whilst waiting for the outcome of the tender application to provide an integrated service.
- Not all staff had the opportunity to meet and liaise with their colleagues or managers due to the disparate nature of the service.

Summary of findings

Background to the service

Information about the service

- Staff in the sexual health service provided advice and methods of contraception, chlamydia screening, pregnancy testing, psychosexual medicines, cervical smears, testing and treatment for some sexually transmitted infections, and provided distribution for C-cards. The C-card scheme enables registered patients to collect free condoms from a number of sites throughout the county.
- The registered location for services is at 7 The Crescent, Taunton. Clinics are also provided at Bridgwater, Chard, Glastonbury, Minehead, Wells and Yeovil. Patients can self-refer and make an appointment through the central booking service or attend a walk-in clinic. Additional clinics located in Strode, Yeovil and Somerset Colleges were available for students to attend.
- The most recent attendance figures provided by the trust show that 9,625 patients attended the contraceptive and sexual health services during the year 2013 to 2014. A further 6,042 chlamydia screenings took place and 176 patients attended psychosexual clinic consultations.

Our inspection team

Our inspection team was led by:

Chair: Kevan Taylor, Chief Executive Sheffield Health and Social Care NHS Foundation Trust

Team Leader: Karen Bennett-Wilson, Head of Inspection, Care Quality Commission

The team included a CQC inspector and two specialist advisors who worked within contraception and sexual health as a consultant and a nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive programme of mental health and community health services inspections.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 9, 10 and 11 September 2015. During the visit we talked with a range of staff who worked within the service, such as nurses, doctors and administrative staff. We talked with people who used the service regarding their experience. We observed how people were being cared for and reviewed care or treatment records of people who used the service.

Summary of findings

What people who use the provider say

During the inspection we spoke with 17 patients who were attending clinics. We also provided the clinics with comment cards for patients to complete prior to the inspection.

We received 58 completed comment cards of which 56 contained positive comments such as

- Staff are caring
- Friendly staff
- Very helpful staff
- Good service
- Staff very knowledgeable
- Clean and calm environment
- Relaxing atmosphere
- Staff polite and efficient
- Felt safe
- Always able to get appointment
- Staff respected my dignity
- Great advice
- All questions answered
- Always runs on time
- Staff are friendly and never judgemental
- Hygienic service

The two negative comment cards identified the patient felt they had experienced a lack of communication, had not been treated with dignity and respect, staff did not always listen and the patient had been forced to take a medication they did not want to take.

The trust sought the views of patients who used the service by asking them to complete the Friends and Family test. A high percentage of patients would recommend this service to their family and friends.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

Equipment used in the delivery of care and treatment should be maintained and checked in accordance with the manufactures guidelines and trust policy.

Patient records should be consistently completed in full.

The trust database which identified mandatory training completed by staff was not kept up to date and did not provide an accurate record.

Emergency medication and equipment should be clearly labelled for use in an emergency.

The staffing levels and skill mix of the service should be reviewed to ensure a consistent and timely service can be provided to patients. The main booking line should be accessible to patients when they telephone.

The provider should ensure that patients with mobility requirements are provided with the means to access the service.

Somerset Partnership 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

- There were procedures in place which staff followed to safeguard children, young people and vulnerable adults. The trust encouraged staff to report incidents. Staff we spoke with were confident in this system and said they received feedback following reported incidents of the action taken and lessons learnt were shared amongst the staff team.
- There was evidence of an inappropriate staffing skill mix at some clinics which impacted upon the service delivered to the patients.
- The risks associated with emergency situations were not fully assessed and managed.

Detailed findings

Incident reporting, learning and improvement

- We were informed by the trust prior to the inspection there had been no serious incidents that required investigation relating to the sexual health service. This was confirmed by staff during our inspection.
- Prior to the inspection the trust provided us with information regarding the incidents which had been reported between 1 April 2014 and 31 July 2015 through the trust's electronic reporting system.
- Incidents reported included clinical procedures, booking errors, concerns raised by patients regarding their care and treatment, systems relating to test results to patients and equipment failings that resulted in a reduction in service. The trust maintained a clear governance record which identified the action taken to address reported incidents. For example, we saw a report which showed a phone number had been duplicated and two sets of results had been sent out to one patient. Whilst the information sent out to the patient had not breached the confidentiality of another patient, measures were put into place to reduce the risk of this reoccurring.
- Learning from incidents was shared at staff meetings. There was an annual study day conference to ensure all staff were made aware and to reduce risk of reoccurrence of incidents.

Good

Are services safe?

- Staff told us they were encouraged and felt confident to report incidents and received feedback regarding any incident they reported. The feedback included information on any action that had been taken in relation to the incident.

Duty of Candour

- Staff we spoke with were aware of the Duty of Candour legislation. Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. The trust had provided staff with written information on the Duty of Candour and their individual responsibilities.
- We saw evidence which showed patients had been provided with written information in accordance with the Duty of Candour legislation.
- Staff were provided with information relating to incidents which had been reported and actioned under the Duty of Candour legislation at the annual study day and during regular case conference discussions. This was to ensure that learning from such incidents was shared.

Safeguarding

- Staff we spoke with demonstrated an awareness and knowledge of the trust safeguarding policies and procedures in relation to vulnerable adults, children and young people.
- All staff had completed the mandatory safeguarding vulnerable adults and children training, with the exception of one new member of staff. Clinicians were required to complete level 3 safeguarding training, whilst receptionists and administrators completed level 2.
- Staff provided examples of when they had made a safeguarding alert or referral, or raised concerns to the safeguarding lead nurse and/or consultant regarding a young person. Documentation was available as evidence of these referrals. Further action taken by the safeguarding lead nurse or consultant in the sexual health team was identified within the electronic patient record. This included liaison and working with other professionals. For example, the appropriate school nurse or the local authority child safeguarding department.
- A safeguarding assessment was carried out for children under the age of 16 and young people under the age of 18, who attended contraception and sexual health clinics. The assessment prompted the member of staff to identify issues relating to family relationships, sexual relationships, signs of exploitation, consent, risk of conception, risk of sexually transmitted infection and drugs or alcohol issues. Any information which highlighted a risk for the child was escalated promptly to the lead children's safeguarding nurse or consultant within the service.
- During our discussions with staff, a good understanding was demonstrated of the safeguarding of women and young people regarding female genital mutilation (FGM) and child sex exploitation (CSE).
- The service had completed a self-assessment against the national action plan against child sex exploitation as suggested by the Local Safeguarding Children's Board (LSCB) in 2014. The service had expressed a request be part of the multi-agency safeguarding hub (MASH) specifically for their knowledge around child sex exploitation. LSCBs enable organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.
- All staff were aware that they must inform the trust safeguarding team if they suspected any patient had been subject to or were at risk of female genital mutilation and complete an electronic incident form. We were told that the electronic safeguarding screening template was due to be revised and would include a prompt for staff regarding female genital mutilation.

Medicines

- Staff had access to policies and procedures which provided information regarding the use of medication. Staff we spoke with knew where to access the policies and procedures. Medication training was part of the mandatory training which staff completed.
- Medication was obtained from either the community pharmacy or a local NHS acute trust Pharmacy**.** Staff did not report any concerns with obtaining medication or the promptness of this service.
- Medication was ordered by electronic means and a record maintained of who had ordered the medication and which medication was received in the department.

Good

Are services safe?

- We observed there was no record to identify the medication which was taken from the stock at The Crescent to the college clinics held around the county. This was addressed during our inspection and we saw at a later visit to a college clinic there was a record of the stock levels of each medication held in the college.
- Medication was stored securely in locked medication cupboards in each consulting room in The Crescent. Staff holding clinics in other locations around the county had systems in place in order to be able to access securely stored medication.
- Staff working in college clinics had access to medication which was stored in locked filing cabinets/cupboards at the college. Staff who worked in the clinics held the keys and made arrangements for them to be stored at their base away from the college. This meant no unauthorised staff had access to these keys at the college.
- We observed staff in clinics which were held in community hospitals, made arrangements to ensure that the contraception and sexual health medication was secured both during and after the clinic.
- Information relating to any changes in systems for ordering or disposing of medication was provided to staff via email and at staff team meetings. We saw evidence to support this within minutes of the staff meetings.
- Staff informed us there were no controlled drugs used within the service and during our inspection of the medication held on site we did not identify any controlled drugs. Controlled drugs are those which are classified in law based on their benefit when used in medical treatment and their harm if misused. Additional checks and recording are required when administering or prescribing controlled drugs.
- Medication for use in an emergency was stored in consulting rooms in locked cupboards to which staff using the room held the key. For example, adrenaline which is a medication to treat anaphylaxis shock and which is required to be available following some procedures.
- Four nurses had additional qualifications which enabled them to be non-medical prescribers. This meant they were able to prescribe and administer certain medication without a doctor present. Other nurses were able to supply and/or administer specific medicines to patients without the need for a prescription as directed within written Patient Group Directions (PGDs).
- The consultant for the sexual health service was a member of the trust drugs and therapeutic group where the PGDs were presented following the PGD approval group meetings.
- One patient completed a comment card which we had placed in the service prior to the inspection which stated they had been forced to take a drug they did not want to take making them feel unsafe. We did not find any evidence to support this during our inspection and during conversations with patients and staff.

Environment and equipment

- The risk register for the sexual health service identified a number of risks relating to equipment and/ or environment. We saw action had been taken to follow these up by the manager and during our inspection staff from the estates department were in the building making repairs. These issues had been highlighted on the risk register for a long period of time and staff were pleased they had been addressed to make the area safer for themselves and patients. For example, the damaged carpet and fire doors had been attended to.
- The trust employed an external organisation to assess and record the fire risk assessment for The Crescent. The fire risk assessment had been reassessed every two years. A number of recommendations made were repeated as full action had not been taken by the provider.
- The medical devices department of the trust maintained a register of all medical equipment in the department and arranged for most equipment to be serviced and calibrated as necessary. However, we observed a number of sets of scales were overdue to be calibrated. Manually operated couches had been identified on the risk register as being a danger to staff. Staff confirmed no action had been taken to replace these, but they had been made aware of the risks and how to reduce the risk to themselves.
- Feedback from patients had been obtained through the use of comment cards. We saw some patients had commented on the waiting room at The Crescent being too dark and with too much information on display. Other patients thought the information available was a good thing. Specific comments had been made regarding the waiting room at the psychosexual clinic in that it was welcoming and good information had been made available.

Good

Are services safe?

Quality of records

- We reviewed 15 sets of electronic patient records completed by a variety of clinicians for a number of different treatments. Recorded information identified the care and treatment provided, consent, medication prescribed and/or administered and that patient information leaflets had been given when appropriate.
- Patient's records were mainly electronic. However, a number of paper records were made. For example, a registration form which patients were required to complete on attendance at all clinics; and when staff did not have access to electronic records when holding community based clinics. We observed staff maintained paper records at three of the college clinics we attended due to IT issues. Staff were aware of who they needed to contact to address these issues and planned to meet with the college IT department to address this. Paper records were stored securely in locked cupboards in each of the clinic bases.
- We observed that at the main reception area at The Crescent, registration forms were placed face up on the desk during one clinic. This meant that patients attending the desk would be able to read the name and address of the previous patient. This did not protect confidentiality of the patient. Other receptionists consistently turned them face down so that written information could not be seen.
- The sexual health service had carried out an audit of the standard of completion of electronic patient records in 2014. This had identified a number of areas where improvement was required. For example, the completion of a patient history. The audit had been repeated in January 2015 and improvements had been made. However, we identified a number of electronic assessment templates which formed part of the record for each patient were incomplete. This was noted by manager who took appropriate action to highlight these shortfalls to staff.

Cleanliness, infection control and hygiene

- All clinics we attended were in locations which were observed to be clean and hygienic in appearance.
- Handwashing facilities and sanitising hand gel was available in the clinics for staff and patients to use. Supplies of protective personal equipment such as gloves and aprons were available to staff. Patients confirmed these were used and that staff washed their hands during their consultation where necessary.
- A concern had been raised by staff who worked within the clinic at Bridgwater Community Hospital regarding the fabric covering examination couches. Not all of the couches were of a material that was suitable for cleaning as some were covered in fabric. Staff we spoke with at the Bridgwater clinic identified this had been a problem and had raised this with the manager of the hospital. Staff told us that recently, and we observed during our inspection the couches in the consulting room were of a cleanable fabric.
- A record was in place in each clinic to show that equipment was cleaned and checked each week with a signature to identify which member of staff had been responsible for this.
- Staff were all aware of the system for disposing of clinical waste and we observed that bins were labelled so that waste was disposed of appropriately.
- The trust provided the staff with a policy and procedure regarding infection control. This was accessible on the trust website and staff we spoke with were aware of the policy and where to find it.

Mandatory training

- The trust provided a programme of mandatory training to staff. For staff working within the contraception and sexual health service this included: basic life support, anaphylaxis, infection control, consent, dementia awareness, prevention and management of violence and aggression, equality and diversity, information governance, safeguarding of vulnerable adults and children, manual handling, medicines management, fire and information governance.
- The trust maintained an electronic data base which was accessible by staff. We were told this data base was not kept up to date and reflected staff who had left the department. We saw evidence which showed the manager had informed the training department of these errors. The manager evidenced to us the mandatory training for all staff, with the exception of one person who had recently been appointed, was up to date. The new member of staff was in the process of completing the mandatory training. Once this was achieved the service would have 100% compliance with the mandatory training.

Good

Are services safe?

- Staff we spoke with made positive comments about the standard and style of the training provided to them. They confirmed they were encouraged to update their training when necessary and were provided with the time in which to do this.
- The NHS staff survey 2014 identified that the trust performed worse than the national average for percentage of staff who had received health and safety training in the last 12 months. Health and safety training did not appear on the mandatory training matrix provided to us. Two members of staff we spoke with had no recollection of this training being made available to them. We were provided with information following the inspection that health and safety training took place during the mandatory corporate induction training day. This was a requirement for all newly appointed staff to attend.

Assessing and responding to patient risk

- The trust had a violence and aggression policy and procedure in place which was accessible to staff on the trust website. Staff we spoke with were aware of this policy and procedure and how to access it. Reception staff told us they had received conflict management training especially geared for reception staff. The training matrix showed that all staff were up to date with their prevention and management of violence and aggression training.
- Emergency equipment in the form of drugs and a defibrillator was available in The Crescent. This emergency equipment did not include oxygen and should a patient require emergency treatment we were told an ambulance would be called. In the Bridgwater clinic emergency medication was available to staff and emergency resuscitation equipment was located nearby in the minor injuries unit.
- We observed two emergency boxes in the main consulting room in The Crescent. These looked the same in appearance but contained different equipment and medication. We were told this was because one had been returned for restocking from a community clinic. This did not ensure staff would access the correct emergency box in the event of a patient collapsing and could result in a delay in accessing the correct equipment and medication.

Staffing levels and caseload

- The sexual health service maintained a duty rota which reflected which staff were on duty in which clinic. The staffing levels were reviewed monthly and we were told they were raised and discussed with the divisional manager at the management meetings. However, there were no minutes of these meetings to identify the content and any identified actions resulting from the meeting.
- The local risk register identified there had been no staff recruitment since April 2015 as the service had been involved in submitting a tender to provide an integrated sexual health service. This had impacted on the continuity of the service and as a result some clinics had been reduced and not all services were available at each clinic. We were told if the tender application was successful, additional staff from other services would be available and the staffing levels reviewed at that point. However, since April 2015 only one clinic had been totally cancelled and patients asked to make other appointments.
- The manager and trained nurses were knowledgeable about the skill mix required for specific clinics. When members of staff were not available for their clinic the skill mix was considered and amended. For example, if no doctor was available the preferred option would be to cover the clinic with a non-medical prescriber to enable patients to receive the treatment they required. This was not always possible and staff told us patients were required, at times, to make alternative appointments or attend other clinics in the area. This was not always convenient for patients and at times caused a delay in their treatment.
- The service did not use bank or agency staff due to the specific skills and knowledge required by staff. However, a number of the staff worked on a part time basis and were flexible about working additional hours to cover staff shortages. Staff commented this worked well for short notice absences but that it had been harder to cover longer periods of leave, for example extended sick leave or maternity leave.

Managing anticipated risks

- Staff were provided with information, guidance and training for the management of violence and aggression.

Good

Are services safe?

- At The Crescent there were panic alarms in all consulting rooms and in the reception areas. Staff knew where the panic alarms were but told us they had not had a drill or exercise to ensure all would respond appropriately in an emergency.
- The clinic held at Bridgwater Community Hospital had panic alarms in the consulting rooms but not at reception. The receptionist was often alone in the reception area when clinicians were with patients in the consulting rooms. Staff told us they would shout to their colleagues if there was a problem. This was not a robust plan to protect staff in the case of an emergency.
- The patient toilet at The Crescent did not have a call bell for patients to summon assistance if they required it. The toilet was isolated on the lower ground floor to the rear of the building meaning that staff would not hear a patient calling for assistance. There was a CCTV camera located in the reception area which showed the lower ground floor. This may have alerted staff to a patient who did not exit the toilet after a reasonable period of time.
- Lone working for staff was identified on the risk register due to the risks staff might potentially face when leaving and securing the building alone. Staff stated this rarely happened and that they were generally with a colleague at the end of the shift and when leaving.
- Sharps bins were available throughout the service for staff to dispose of used needles safely. Within the college clinics these were stored securely when the clinic was closed.
- Clinicians came to the waiting room and asked for their next patient by their first name only. Reception staff alerted clinicians on the electronic booking form of the risk when two patients with a similar name or the same first name were in the waiting room.

Major incident awareness and training

- The trust had a major incident policy and procedure which was accessible to staff on the trust website.
- The sexual health service had a business continuity plan. The trust had classed sexual health as an important service. This meant that the business continuity plan identified how in the case of a major incident in one of the locations, the service could be reintroduced elsewhere within three days.

Good

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

- The care and treatment provided to patients was planned and delivered in line with current evidence based guidance, standards, best practice and legislation. Staff liaised with other professionals, both within the organisation and with professionals outside of the organisation to provide a service to patients.
- Patients received a service from staff who were trained and competent to provide the required care and treatment. Staff received a structured appraisal each year but regular one to one supervision meetings werenot formalised within the service.
- Patients had access to a full range of information about their care and treatment including the provision of leaflets and electronic advice and support.

Evidence based care and treatment

- The trust provided us with information which demonstrated they referred to and operated within nationally recognised guidelines and standards.
- Clinical guidelines produced by the National Institute of Health and Care Excellence (NICE) were followed. For example, regarding long acting reversible contraception and one to one interventions to reduce the transmission of sexually transmitted infections including HIV and to reduce the rate of under 18 conceptions especially among vulnerable and at risk groups of patients.
- Guidelines and standards produced by the Department of Health were followed. For example, the best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health 2004.
- The Faculty for Sexual and Reproductive Health Service standards for sexual and reproductive healthcare were available to staff and incorporated into the working practices of the service. The Faculty for Sexual and Reproductive Health Service guidelines were also followed regarding reporting sexual and reproductive health activity data to the Health and Social Care Information Centre. The Health and Social Care Information Centre is the national provider of information and data for health and social care. Examples of the data provided to Health and Social Care Information Centre included measures of confidentiality, risk management access and activity.
- The trust was part of the national chlamydia screening programme and staff was aware of and operated within the standards provided by the national programme.
- The trust provided us with information which demonstrated they took part in local and national audits. For example, the service had carried out an audit of the quality of the sexual history taking from patients in January 2013 and again in 2015. The audit in 2015 showed improvements had been made in the history taken from patients and subsequent completion of the records. However, the outcome from the January 2015 audit was not planned to be shared with the staff until the annual study day in November 2015. This meant a delay in sharing information which could have helped improve the detail obtained from patients.
- The service was in the process of carrying out an audit regarding discontinuity rates in contraceptive implants fitted in the last three years. It had been identified that patients requested early removal of implants and the audit would identify the reasons for this. The outcome of the audit was planned to be presented in November 2015 and it was hoped the information gathered would assist in increasing the compliance of patients with their chosen method of contraception.
- An audit had been carried out in the service to monitor the number of telephone calls received in which patients had requested clinical advice. The audit had identified a need for this service and had been included in the tender application for an integrated sexual health service.
- There were no nationally recognised parameters in psychosexual health but the service was piloting a local version known as Measure Your Medical Outcomes Performance (MYMOP). This included the patient in determining which areas were most important to them to improve or change. A recent audit of the use of MYMOP showed 78% of patients showed significant improvement.

Good

Are services effective?

Pain relief

- Clinicians had access to pain relief for patients who required this during or after clinical procedures.
- Staff were knowledgeable about certain procedures which were likely to cause patients to require pain relief and the medication available to them.
- Nurses who worked within the clinic were either non-medical prescribers or used Patient Group Directions to provide pain relief to patients.

Technology and telemedicine

- The trust had developed software to enable a mobile app to run on smartphones and tablets which provided patients with information on sex, contraception, pregnancy and relationships. This also provided patients with information on clinic locations and times. Two patients we spoke with commented this had been useful to them and also to their friends.
- Staff who provided clinics within college settings had experienced difficulties in accessing the electronic system through the college wifi. One nurse was seeking help from the college IT department to address this, whilst another used paper records which were filed on return to the main site.
- The service used text messages to remind patients of their booked appointments. Data showed that this service had reduced the number of patients who did not attend (DNA) for their appointment. The month prior to our inspection 49 patients had not attended their appointment. Feedback from patients indicated that it would be helpful if the service enabled them to reply to the text.
- The chlamydia screening service provided results to patients who had attended clinics by text or email. The preferred option was by text to ensure confidentiality for the patient. If a patient had received a positive result they were not advised of the outcome by text but asked to telephone the department about their result. A nurse would be available to discuss their options with them.

Patient outcomes

- Leaflets were made available within clinics and waiting rooms for patients to take regarding a range of conditions and treatment options.
- Patient's views were sought through comment boxes being placed in waiting rooms at each clinic. The service reported the comments were mainly positive. When patients made a suggestion as to how the service could be improved this information was provided on a notice board in the waiting room entitled 'You said we did'. For example, regarding waiting times and staff attitudes.
- Patients who required appointments for urgent services such as emergency contraception were seen on the same day. All staff we spoke with were very clear that patients were either seen promptly or were offered an appointment for later that day which may have required them to travel to another clinic.

Competent staff

- A system of annual appraisal was in place for nursing staff and included a personal development plan. The NHS Staff Survey 2014 identified that as a whole, the trust performed worse than the national average for the percentage of staff having well-structured appraisals in the preceeding 12 months prior to our inspection. However, records showed that 100% of nursing and administrative staff who worked within the sexual health department had received an appraisal.
- We looked at seven personnel files for members of staff working in the contraceptive and sexual health service. The records showed the appraisal system was a two way process and staff were able to raise concerns and future development wishes as part of this process. The manager had not received a formal appraisal since being in post. They had been in post for one year.
- Regular supervision meetings or one to one coaching sessions did not take place for all staff. There were informal records made by managers of some conversations and management supervision for some staff. However, it was not clear from reviewing records and talking to staff and managers, of the process for ongoing formal one to one meetings with managers. Where concerns had been raised about a clinician's performance and competence, formal records had been made of meetings with their manager and the action planned to ensure the development of the staff member and safety of patients.
- Records showed the revalidation of the doctors who worked within the sexual health service were up to date, together with their annual appraisals.
- The two doctors who provided a psychosexual medicine service to patients provided each other with peer support and also sought peer and clinical support from colleagues who worked for other NHS trusts.

Good

Are services effective?

- Three members of staff we spoke with commented that they did not see their manager unless the manager was covering a clinic. They added there would be limited time for a supervision meeting or conversation on these occasions. All staff confirmed that if they required support or assistance they could telephone or email their manager and they were confident they would receive a prompt and helpful response. All staff felt they were supported by their colleagues who worked within the same clinics.
- Registered nurses working within the service could access two sexual health modules provided by the University of the West of England which aimed to develop knowledge and clinical competency when providing sexual health services. Two nurses who worked for the sexual health service were completing this training at the time of our inspection. A member of staff had been seconded to the University of the West of England as a Practice Educator and supported practice based learning within the work place for staff undertaking the modules.
- The Faculty of Sexual and Reproductive Healthcare provided the facility for registered nurses to become full members of the organisation on completion of a nurse diploma. Five out of the eight trained nurses who worked within the service had been awarded the diploma.
- The contraceptive and sexual health service was a recognised training site for the Faculty of Sexual and Reproductive Healthcare and had four approved trainers. These trainers provided training to doctors and nurses, including qualified and trainee GPs, to enable them to achieve qualifications in contraception and sexual health,including the clinical treatments such as fitting of implants and intrauterine devices.
- The service had two doctors who provided a service for patients in psychosexual medicine. Both doctors were up to date with the Institute of Psychosexual Medicine scheme of reaccreditation which was required to be completed every five years.The service provided an annual study day for doctors and nurses who worked within the sexual health service. This was well attended and previous agendas had included clinical and topical issues as well as updates on changes in national guidelines and audit outcomes.

Multi-disciplinary working and coordinated care pathways

- The service had developed working relationships with a number of other organisations and services to promote a positive care experience for patients. For example; genito-urinary medicine (GUM) clinics provided at neighbouring acute NHS trusts, abortion services provided by independent heath organisations and neighbouring acute NHS trusts, education staff working in schools and colleges as well as school nurses employed by the trust.
- Somerset Partnership NHS Foundation Trust did not provide HIV screening/testing or treatment services. The service maintained close links with their local acute trust who did provide this service and referred patients who they saw at clinic accordingly. We observed staff give very clear guidance and instructions to two patients who attended a walk-in clinic requesting an HIV test.
- The NHS Staff Survey 2014 showed that the trust scored better than average relating to effective team working.
- The trust participated in the national chlamydia screening programme. Liaison took place between the programme lead, the children and young person's nurse lead and a midwife employed by the acute trust who had responsibility for pregnant young women and young mothers. The service was represented at the chlamydia screening steering group which held quarterly meetings. These were attended by a number of organisations. For example, acute trusts, public health and GPs.
- The service had been part of the formation of the south west sexual health network peer support group which was in its infancy. The aim of the group was to establish and maintain links across services and improve the patient journey.
- Staff had worked with midwives at a local NHS acute trust and provided training to them regarding contraception, sexually transmitted infections and the promotion of chlamydia testing. Regular meetings had been set up with a dedicated teenage pregnancy midwife to promote the service with young people and children.

Referral, transfer, discharge and transition

- Patients who received care and treatment for contraception were not discharged from the service as they reattended**.**

Good

Are services effective?

- The service had developed working relationships with the gynaecology department at the local acute trust and a standard letter regarding referrals to this department had been developed.
- A letter was also sent to GPs to inform them if one of their patients had been referred to the gynaecology department. This was subject to the patient consenting to the sharing of this information.

Access to information

- Staff had access to patient information on electronic records which identified previous visits and care and treatment to the service.
- Where the electronic system was not accessible, for example in college clinics, staff maintained paper records. The paper records were stored securely and available for staff to access each time the patient attended a clinic. The information contained on paper records was transferred to the electronic patient record when the clinician returned to the office. This ensured that should a patient attend another clinic provided by the service their medical information would be available to the clinician.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust provided staff with a policy and procedure regarding consent. Staff were aware of this but stated they followed the Faculty of Sexual and Reproductive Health service standards in obtaining valid consent in sexual health services July 2014 in conjunction with the trust policy.
- We observed that verbal consent was sought from patients prior to any care and treatment being provided. The consent was recorded within the patient electronic records. This was in line with Faculty of Sexual and Reproductive Healthcare guidelines.
- Prior to an invasive procedure, for example the insertion of an intrauterine device (IUD) the patient was required to attend a pre-treatment meeting. At this meeting the treatment was explained and an electronic record completed to show the discussion held. When the patient attended for the treatment a reminder for the clinician was flagged on the electronic system to ensure the pre-treatment meeting had been held and that the patient had understood the process, and gave their verbal consent. This was in line with the Faculty of Sexual and Reproductive Healthcare guidelines.
- Verbal consent was obtained prior to the provision of emergency contraception in line with the FSRH guidelines.
- We saw 15 sets of records which showed that consent had been obtained in line with the Faculty of Sexual and Reproductive Healthcare guidelines.
- A service was provided to young people who were under the age of 16. Staff were aware of and knowledgeable about Fraser guidelines and Gillick competence. The Gillick competence identifies children and young people under the age of 16 with the capacity to consent to their own treatment. Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents' consent Young people who attended clinic with their parents and/or carers were seen on their own by the clinician in private and then if the young person agreed we observed their parent/carer being called to the consulting room. One patient confirmed they had been asked their permission for their parent to be invited to the consultation.

Good

Are services caring?

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

Summary

- Patients were active partners in their care and staff were committed to ensure the patient's choices and wishes were identified. Patients' emotional needs were valued by staff and information was widely available for patients to make informed choices regarding their care and treatment.
- Feedback from patients who attended the clinic was positive with a high percentage of patients stating they would recommend the service to others.

Compassionate care

- Friends and Family tests were used within the sexual health service to seek the views of people using the service. We observed that receptionists asked each person attending the clinics at Taunton to complete a short questionnaire at the end of their visit. The outcomes of the Friends and Family tests from January through to June 2015 showed that the number of surveys completed each month varied. The minimum number of surveys completed was 45 rising to 103 in April. The average number per month was 75. Of the patients who completed the survey 82% said they would recommend the service to their family or friends.
- We observed patients were treated with respect and that staff were polite and helpful during conversations. Staff were clear regarding the confidentiality of the patient both within the department and in the wider trust.
- We spoke with 17 patients after they had received care and treatment at the clinics. They were all positive about the treatment they had received on that visit. Specific comments made included "The staff are excellent from reception to doctor could not have been nicer" and "I am always treated compassionately and politely and not rushed"
- The service had a single point of contact for booking appointments. This was manned by the receptionist at The Crescent. At times the reception area was busy with people attending the clinic and the telephone ringing. We observed the receptionists were discreet in their conversations with patients on the telephone to ensure people attending the clinic did not hear confidential information. However, one receptionist, during a busy period, sounded abrupt on the telephone.
- The service had placed a sign at the entrance to the reception area in The Crescent regarding privacy and requested that patients stood an appropriate distance from the person in front of them. We did not see this in place at the Bridgwater clinic but the receptionist stated this had never been a problem and patients waited a reasonable distance from the desk.

Understanding and involvement of patients and those close to them

- Patients told us they had been able to have a full discussion with the doctor regarding options of treatment open to them. This had included a full explanation of what it would entail. One patient stated that they had previously felt nervous, but following the consultation was confident regarding the procedure.
- One patient told us they were "able to ask questions". They added that at an earlier visit they felt the doctor had laughed at them when asking questions. However, subsequent visits to the same doctor had not been the same and they were reassured.
- Patients we spoke with who had seen a nurse for their care and treatment told us they were friendly, helpful and provided useful information to them.
- Two patients told us the nurse had provided them with an information leaflet to take away with them to read, but had also gone through it with them in the clinic to ensure there were no questions they had regarding their proposed treatment.
- Staff asked patients how they would like to receive their test results and the patients we spoke with were confident this process would be followed.

Emotional support

- The trust had developed a policy and procedure on chaperoning which was available to staff and patients on the trust website. Information regarding the

Good

Are services caring?

availability of a chaperone was displayed in waiting rooms. Patients we spoke with were aware that a chaperoning service was available but none had required this service.

- The chlamydia screening programme ensured that when a positive result was identified, the text which requested the patient to telephone the office was sent at an appropriate time so that a clinician would be available to speak with the patient. To ensure that patients received appropriate information a clinician would follow up patients with positive results who had not contacted the service.
- We observed patients often attended clinics with friends or relatives. Staff respected patient wishes to have their friends with them in consulting rooms for support.

Requires improvement

Are services responsive to people's needs?

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

Summary

- Services were not accessible to all patients. For example, some clinics could not provide a full range of care and treatment due to the skill mix of available staff. The registered location had limited access for patients with mobility needs.
- Patients could not always receive services in a timely manner that was in line with national guidance.
- Patients were provided with information in the clinics on how to raise concerns and complaints. The service had received no formal complaints. Action was taken when a patient raised a concern and resulted in improvements to the service.

Planning and delivering services which meet people's needs

- A single booking line enabled patients to be provided with information about walk-in clinics or appointments for clinics, based on their requirements and locations. Clinics were held across the county in order to provide patients with services close to the area in which they lived.
- The trust had developed an App for use with smart phones and tablets which provided patients with information on sex, contraception, pregnancy and relationships. This enabled patients to access information in a location convenient to them.
- The trust website provided information regarding the service and how to access it including time scales of when patients should expect to receive appointments and treatments.
- We saw evidence which demonstrated the service had a flexible approach to meeting the needs of students as they changed the clinic day to fit in with the students' academic timetable. The opening of one clinic, which was based in a youth centre on the college campus, had been compromised by the centre not opening due to lack of college staff on more than one occasion.
- The contraceptive and sexual health clinics were being assessed against the 'You're Welcome' criteria set out by the Department of Health England. This set out clear quality criteria for youth friendly and suitable health services. It provided a framework for change in how resources were allocated, and helped to ensure better health outcomes for young people. Five out of the seven main clinics had achieved this award with the remaining two working towards meeting the criteria.

Equality and diversity

- Staff were provided with information regarding equality, diversity and interpretation and translation services within policies and procedures.
- The sexual health services carried out a review of the sexual health services in Somerset from a lesbian, gay, bisexual and transgender (LGBT) young people's view in January 2015. A number of recommendations were made as part of the report which have been actioned to improve and encourage LGBT to access the service. For example, working with schools and colleges and advertising of services.
- The interpretation and translation guidance stated that anyone who required a professional interpreter or needed written information translated for them had access to this service. Whilst staff were aware that this service was available we were told that on occasions family members had been used to translate information during consultations. This compromised the potentially confidential and personal nature of the information and service provided. The policy stated this should happen only in emergency situations.
- The trust had access to posters which advised patients, in a number of different languages, that translation and interpretation services were available. We did not see these in all clinics.
- Posters were also displayed regarding specific support groups in other languages for patients attending clinics.

Meeting the needs of people in vulnerable circumstances

- A chaperone policy and procedure was in place of which staff were aware. Information was provided for patients in waiting rooms. We did not see any patients who requested this service during our inspection.
- An emergency call bell system was in operation in the clinic locations for patients and staff to summons assistance if required. However, there was no means of

patients calling for assistance in the lower ground floor toilet in The Crescent. This was the only patient toilet available in the building and patients were frequently required to use this to provide specimens for testing. This was identified on the risk register and dated November 2013, but no action had been taken in response to the identified risk.

- Children and young people under the age of 18 years received a service in all of the clinics when required. Currently, apart from the college clinics, there were no specific clinics which provided a service to children and young people. However, staff informed us that the walk in clinics on a Monday and Friday afternoon were popular with young people and children.
- To support younger people and children who attended clinics, in some cases a follow up telephone call was made to offer further support or guidance based on information provided at the clinic.
- The topic of female genital mutilation (FGM) was on the agenda for the staff study day in November 2015 to ensure staff were fully aware of the implications of women presenting with or at risk from FGM and the action staff were to take.
- Staff informed us they were not aware of any specific resources available to them when providing a service to patients who lived with a learning disability or mental health illness. We were advised that when booking an appointment for a patient with a learning disability advice was given about attending with a carer or family member if possible.
- Not all patients were asked if they had additional mobility requirements when making an appointment for a clinic at The Crescent. People who required level access were required to enter the clinic by the back entrance. They would need to be seen in the consulting room on the lower ground floor as there were stairs to all other areas and no lift. The rear door had a doorbell which was located near the top of the door and may not be accessible to all wheelchair users. We pressed the doorbell to gain access at the rear but no one responded. Therefore, if a person with mobility needs attended for a walk in clinic potentially they would not be able to access the clinic.
- Information was available for patients on notice boards in waiting rooms regarding support groups and help lines involved with; domestic abuse/healthy relationships, rape/sexual abuse help line, female genital mutilation help and advice line and 2bu support group (A youth group for gay lesbian bisexual and transgender young people in the county).

Access to the right care at the right time

- Prior to the inspection we were provided with the local risk register for the service. This identified that not all staff were skilled and competent to deliver care and treatment which met the patient's needs at all times and that there had been a reduction in clinics due to staffing levels.
- The risk register identified that since the integration tender application was in progress recruitment had been halted. We were told this was because if the application was successful the staffing levels would be redefined to meet the needs of the planned service. However, this had caused gaps in the provision of service. Evidence was provided to us which identified one weekly nurse led clinic had been cancelled for a period of six months due to extended periods of staff leave and was replaced with a monthly consultant led clinic. Whilst an additional once a month contraceptive implant clinic had been introduced, some patients had experienced a delay in treatment and care. Other clinics had been covered by staff who could not provide a full range of care and treatment to patients which had resulted in them having to return.
- We observed one patient who attended a walk-in clinic being advised to return when a clinician was available who could provide them with the treatment they required. Not all nurses were trained to provide all care and treatment. For example, not all nurses had completed the training to be a non-medical prescriber and therefore were not able to prescribe certain contraception to patients.
- The number of patients who could be seen during a walk in clinic was variable and was dependent on the number and skill mix of staff working in the clinic. We observed that clinicians advised the reception staff when they felt the clinic was full and when patients should be asked to attend a future clinic.
- Staff told us that the contraception and sexual health services followed guidelines provided by the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists regarding patient's access to care and treatment times. The guidelines recommend that patients should be able to

access non-urgent information, advice or services within two working days and that treatment methods for long acting reversible contraception (LARC) are provided within two weeks of the patient's request if medically appropriate. Nursing staff who worked within the department had not completed additional training to enable them to provide some long acting reversible contraception. For example, where patients required the insertion of intrauterine systems, they had to attend a clinic led by a doctor or consultant. It is not mandatory that nurses complete this training but did mean that when patients attended a nurse led clinic they were advised to return at a later date for their treatment.

- We saw that some patients were waiting for up to, and in some cases over a month, for some appointments for certain procedures. The trust did not monitor how many patients refused appointments due to the clinic location and preferred to wait for an appointment closer to home. The Faculty of Sexual and Reproductive Healthcare guidelines identified that patients should be able to access telephone advice on the same working day or within 24 hours depending on local policy. We observed receptionists arranged for clinicians to telephone patients on occasions when this had been requested by the patient. As part of the tender application to become an integrated service a telephone service providing clinical advice had been factored and would be readily available should the service be successful in their application.
- A member of staff had audited the next available appointments and we saw evidence which demonstrated that at times the earliest appointment in the county was five days ahead, which meant that in order to meet the standards some patients were advised to attend a walk-in clinic. Other receptionists made an appointment for the patient which was not within the target time set.
- The Faculty for Sexual and Reproductive Health standards for the maximum wait time for patients who attended walk in clinics was 2 hours and that appointments could be provided within two working days for non-specialist non-urgent consultations.
- Evidence and our observations found that patients did not wait longer than two hours and most were seen within 30 minutes at walk in clinics. Staff were able to audit the length of time patients waited for their appointments by using the electronic booking system. On arrival at the clinic patients were requested to provide brief information to identify themselves and to book onto the system. The record then identified the time they were called to their consultation and when the care episode concluded. However, we observed that the at times the receptionist was delayed whilst answering the telephone and greeting new patients which resulted in some patients not being entered onto the system for approximately 30 minutes. This meant that the system showed the patient waited for 30 minutes to be seen by a clinician but the patient informed us they had been waiting for one hour.Clinics at outlying venues had access to the electronic system and we observed some receptionists making future appointments for patients. Other receptionists advised the patient to ring the main booking line. They told us this was because they were not always aware of which member of staff could provide certain treatments and procedure.
- We were told by staff that when they or their colleagues took annual leave or were on long term leave, there were not always arrangements made to cover their clinics. This meant that patients experienced a delay in treatment or had to travel to alternative clinics if able, to receive their care and treatment.
- The telephone booking line was manned by one person who also provided reception duties to patients attending the clinic. We spent time during the day and evening observing the operation of this system. We saw that during the day, there were times when an administrator worked in the reception area and sometimes assisted patients who came to the desk if the receptionist was on the telephone. However, they told us this was not part of their role but they 'helped out'. We also observed patients often had to wait for the receptionist to finish the telephone call despite there being another member of staff in reception. It was not clear to patients that this member of staff's role was not reception.
- On other occasions the telephone was unanswered if the receptionist was dealing with a patient who was at the desk. During one clinic we observed this happened on five occasions and the caller rang off before the telephone was answered.
- Staff and patients commented that at times they could wait for long periods of time for the telephone to be

answered or that it was continually engaged. We rang the booking line to test this on four occasions, at varying times of one day, during the inspection period. We found it engaged or unanswered on all occasions.

- We spent time with the receptionist who answered the telephone booking line. We observed that on some occasions patients were provided with an appointment up to three or four weeks ahead for certain procedures. We did not observe that an option was provided of travelling to alternative clinics where there may have been an earlier appointment.
- The service took part in the national chlamydia screen programme but was not meeting the national targets set for obtaining positive results. The chlamydia detection rate for Somerset in 2013 was 1,450 per 100,00 15-24 year olds. This was lower than the national rate of 2,016 per 100,000 and the National Chlaymidia Screening Programme target of 2300 per 100,00. An action plan was in place which focused on reaching at risk groups rather than testing large quantities of people. For example; concentrating on partner tracing and testing, working with school nurses to identify areas or pockets of infection, with midwives to promote testing during pregnancy and reviewing the database for the C card to ensure chlamydia testing had been offered. The C card is a national scheme that enables children and young people aged 13-26 to obtain free condoms. Somerset commissioning for the c card provided a service for young people aged 13-24.

Learning from complaints and concerns

- Leaflets which outlined the trustcomplaint procedure were available in the clinic waiting rooms for patients to take and/or refer to. The exception to this was within the colleges where clinics were provided. This meant young people attending these clinics may not have been aware of the process to raise a complaint or concern.
- Prior to the inspection the trust provided us with information which stated there had been no complaints made regarding the service within the previous 12 months. This was confirmed by the manager during the inspection.
- Patients were provided with an opportunity to raise concerns or comments regarding their experience of the service by completing a form and posting in a box in the waiting room.
- Action had been taken regarding concerns raised by patients. For example, we saw information relating to concerns raised about long waiting times and unfriendly reception staff. Apologies were given regarding waiting times on the notice board and discussions and been held with reception staff regarding customer service. The service had provided information to patients regarding these issues and the action they had taken to address these by providing a 'You said, we did' noticeboard in the waiting area at The Crescent.
- The trust quality improvement plan for 2015-16 identified that any negative feedback received from the friends and family test would be escalated within the trust to ensure action was taken to address the issues.

Requires improvement

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

- Risks identified within the service, for example as identified in the fire risk assessment, were not dealt with appropriately or in a timely way. The risks identified at a service level did not correspond with those at a trust level.
- The approach to service delivery was focussed on short term goals whilst waiting for the outcome of the tender application to provide an integrated service.
- Not all staff had the opportunity to meet and liaise with their colleagues or managers due to the disparate nature of the service.
- The manager of the service had been in post for one year. Staff were positive about the manager and the support she provided to them.

Service vision and strategy

- Prior to our inspection the trust provided us with their quality improvement plan 2015-16. This identified how the vision for the sexual health service was to move to an integrated sexual health service providing a seamless service when accessing sexual health care and treatment. Currently the trust provided contraception services.
- The trust had submitted a tender application which, if successful, would result in the service becoming a fully integrated service taking on additional work streams that were currently provided by other providers. The outcome from the tender application was expected the week following our inspection.

Governance, risk management and quality measurement

- The service maintained a local risk register which was subject to a monthly review by the local management team. The divisional and trust risk manager had access to the risk register and had responsibility for raising issues to the corporate risk register and ultimately to the board of the trust.
- We observed the service provided from The Crescent was within an older building which we were told was a listed building. This had implications for the trust regarding alterations they could make and the maintenance they could carry out to the building. We saw that on the second floor there were floor to ceiling sash windows which opened fully with no restrictors. Whilst this was not an area regularly accessed by patients, there was no facility to prevent patients accessing the second floor and being at risk from the open windows. This issue was not recorded on the risk register.
- The trust employed an external organisation to conduct a fire risk assessment of The Crescent and provide a written report every two years. We reviewed the risk assessments from April 2013 and April 2015. We saw that some recommendations from the 2013 report had been repeated again in the 2015 risk assessment. For example, the fire doors from consulting rooms which opened onto the staircase were not to the appropriate national standard. This meant staff did not have a satisfactory means of escape from the upper floors due to the distance to the exits which were located on the ground and lower ground floors. There was also a concern raised regarding the security at the front entrance in that people could enter the building and access all parts of the building undetected.
- There were recommendations from the risk assessment completed in April 2015 that had not been addressed at the time of our inspection in September 2015. For example, the fire doors on the second floor corridor and the door to the waiting room caught on the carpet which meant they did not automatically close but had to be manually pushed shut.
- None of the above fire risks were identified on the local or corporate risk register. The manager of the service had been in discussion with the risk and compliance manager and the estates manager regarding this. Advice had been provided that the fire risk assessment provided by the external organisation was the risk assessment to be used and only when a risk scored 12 or more was it to be transferred to the local risk register. This did not ensure that all staff and senior managers were aware of identified fire risks within the department.

Requires improvement

Are services well-led?

Leadership of this service

- The trust management team communicated with staff by a monthly newsletter which was sent out by email. We saw copies of this printed out in reception but staff also informed us they were aware of the email version. A recent newsletter included information about national guidance regarding the NHS and legislation, policy updates, changes to clinical procedures and practices and local information regarding staffing and partner working.
- Photographs of the board members of the trust were posted on the noticeboard in waiting areas. Staff told us they had not seen any of the board members visiting their service. They were aware of who the divisional manager was and that they attended the service regularly.
- The manager of the service had been in post for one year. Staff were positive regarding the manager and the support they provided. Not all staff met with their manager if they worked within an outlying clinic. All staff stated they would be able to speak to their manager regarding any concerns or problems and would telephone, email or see them in person if needed.The divisional manager attended the department each month for a meeting with the senior management team of the service. We attended the monthly meeting held during our inspection and observed that relevant issues were discussed and members of the meeting were allocated responsibility for following up issues raised.

Culture within this service

- Staff we spoke with told us they were pleased to work within the service and felt that the service provided a positive service and experience for patients.
- Staff spoke with pride about their team and colleagues and told us they worked together well to the benefit of the patients.
- Staff were enabled to raise and report concerns and felt listened to by their managers and senior staff.

Public engagement

- Young people and children who used the service had expressed discontent at the information provided to them. As a result of their feedback, the service responded positively and had arranged for the involvement of young people to assist with the redesign of the leaflets and literature.
- Young people had been involved in developing an HIV awareness quiz to promote healthy lifestyles.
- There had been a council led consultation with all stake holders, including members of the public, regarding the proposed integrated services and what they would like from the service

Staff engagement

- The results from the NHS staff survey for 2014 showed that the trust performed worse than the national average for the percentage of staff who stated they felt able to contribute towards improvements at work.
- Staff had been consulted as part of the plans to submit a tender for the provision of an integrated service. Staff we spoke with were aware of the tender and were awaiting the outcome.
- Nursing and reception staff attended team meetings in the location in which they worked. We were told these were held at quarterly intervals although the frequency was not always regular. There had been one whole team meeting of the service which we were told had occurred 'several' years ago. This did not give staff the opportunities to meet together regularly and be updated of team issues and information.
- Doctors' meetings had been held every three months although two members of staff stated these had lapsed and they had not met for approximately two years. We were assured that professional conversations took place at other meetings attended by medical staff and during the course of their working days.
- The service had kept staff up to date by the provision of an internal newsletter. We were told that due to the additional work generated by the tendering application there had not been a newsletter distributed since January 2015.

Innovation, improvement and sustainability

- The future and development of the service depended upon the outcome of the tender for an integrated service. Detailed service standards had been submitted as part of the tender.
- The trust had developed an App for use with smart phones and tablets which provided patients with information on sex, contraception, pregnancy and relationships. It included sections on local services,

Requires improvement

Are services well-led?

regular and emergency contraception and also had the ability to find a clinic or issue point for free condoms using GPS technology and links into Google maps to give directions from a current location.

- The local authority awarded the trust with the young people friendly service certificate in 2010 and this had been renewed in 2014
- The trust website had been updated to simplify the process for ordering a chlamydia test. The chlamydia test ordering point was now on the front screen.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Good Governance. Regulation 17(2)(b) Systems or processes were not operated effectively to ensure the provider assessed, monitored and mitigated the risks relating the health, safety and welfare of services users and others who may be at risk which arise from the carrying on of the regulated activity at the registered location. Where risks are identified providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.