Solent NHS Trust

RIC

# Community health (sexual health services)

## Quality Report

Highpoint Venue
Bursledon Road
Southampton
SO19 8BR
Tel: 0300 3002016
Website: www.letstalkaboitit.nhs.uk

Date of inspection visit: 27 - 30 June 2016
Date of publication: 15/11/2016

# 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) |
|---|---|---|---|
| RIC34 | Royal South Hants Hospital | Sexual Health | SO14 OYG |
| RIC17 | Saint Mary's Hospital | Sexual Health | PO3 6AD |
| RICH3 | Crown Heights | Sexual Health | RG21 7AN |

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

# Summary of findings

## Ratings

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

# Summary of findings

## Contents

# Summary of findings

## Overall summary

**Overall rating for this core service Good**

We rated sexual health services as good because:

Staffing levels and skill mix were planned, implemented and reviewed by the matrons to meet the level of need for the service/ needs of patients. All staff including bank staff were provided with induction, including competencies, to ensure they could safely and effectively undertake their role.

Where patients received care from a range of different staff, teams or services this was co-ordinated. All relevant staff, teams and services were involved in assessing, planning and delivering patients care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patients' needs.

Feedback from patients who used the service and other stakeholders was positive about the way staff cared for them. Staff treated patients with dignity and respect, and patients told us they felt supported and said staff cared about them.

Evidence based practice was being followed for care and treatment. Patients had appropriate and timely notifications but there were delays in the diagnosis time for Chlamydia patients and for testing times for children with HIV parents.

Services were planned in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. The needs of all patients were taken into account when planning and delivering services. For example, the trust provided clinics for young people at locations and times when they could access them. Patients were offered appointments within 48 hours.

Information and data were used proactively to identify opportunities to drive improvements in care, for example, same day access clinics. Service changes were developed with input from doctors, nurses and patients who used the service, to understand their impact on the quality of patient care.

There was a culture of continuous learning, and sharing knowledge nationally, to achieve good patient outcomes.

Since the last inspection of the service in March 2014, there have been improvements in timely access to the clinics. This has included same day access clinics. Patients were now not being turned away from clinics without being assessed and prioritised, and given a plan that took account of their sexual health needs. Although delays meant some patients did not wait for treatment.

# Summary of findings

## Background to the service

**Information about the service**

Solent NHS Trust delivers a level 3 integrated sexual health services across most of Hampshire (north), Southampton (west) and Portsmouth (east). The service offers clinics for advice, guidance and treatment for all sexual health issues from contraceptive services to treatment of sexually transmitted diseases for female and male patients. The service provided included management of complex contraceptive problems and recurrent urinary tract infections.

The range of services included:

- Human immunodeficiency virus (HIV) specialist services, including support to inpatient care
- Termination of pregnancy (TOP) services in partnership with the British Pregnancy Advisory Service (BPAS). The role of the trust was to provide a site and a consultant.
- Vasectomy services, through internal service provision and contracting arrangements with primary care providers
- Psychosexual counselling
- Chlamydia screening programme and targeted outreach services
- Targeting sexual health promotion
- Young people's drop in clinics at further education colleges and some schools
- Sexual Assault Referral Centre (SARC) for victims of sexual assault and rape, delivered in partnership with Hampshire constabulary.

Southampton has a population of 207,000, Portsmouth 242,000 and Hampshire 1,338, 000. The rates of new sexually transmitted infections in the under 25s are worse than the England average in Southampton and Portsmouth. The teenage pregnancy rate in Southampton is higher than the England average. Hampshire teenage pregnancy rates are better than the England average, where the level of deprivation is also better than the England average. Southampton and Portsmouth have higher rates of deprivation than the England average.

The service was organised into three teams north, east and west. The north covered the Basingstoke, Andover, Winchester and Bordon area, the east Portsmouth, Havant, Fareham and Gosport, and the west Southampton and Eastleigh. The services were delivered through three central clinical 'hubs'. The hubs were in the north Crown Heights in Basingstoke, in the east St Marys Hospital Campus in Portsmouth, and in the west the Royal South Hants Hospital in Southampton. There were 22 community 'spoke' clinics sited in towns or conurbations, and clinics at 23 college locations.

From January 2015 to December 2015, the total number of patients seen was 57,052. The figure had risen from January to December 2014 when it had been 55,334.

## Our inspection team

The team that inspected sexual health services included two CQC inspectors, and two specialist advisors with specialist knowledge of sexual health services.

## Why we carried out this inspection

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

# Summary of findings

## 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 Solent Trust, we reviewed a range of information we held about the trust and asked other organisations to share what they knew. The week before the inspection, we held two focus groups with a range of staff who worked within the service, such as nurses, healthcare assistants, doctors and administration staff.

We carried out an announced inspection from 27 to 30 June 2016.

During the inspection, we visited the three hubs at Basingstoke in the north, Portsmouth in the east and Southampton in the west, three 'spoke' clinics and one specialist clinic. We spoke with 38 sexual health staff including doctors, nurses, healthcare assistants, health advisors, pharmacist, receptionist, operations managers, matrons, the head of service, the clinical governance lead, clinical director and the operational director. We reviewed 11 electronic patient records. We spoke with eight patients, and observed four patient consultations with the patients consent. We also received 20 comments cards from patients who had used the service.

## What people who use the provider say

The patients we spoke with were complimentary about the staff and told us staff were caring, friendly and sensitive to their needs. Staff from outside organisations also told us how kind and empathetic the staff were.

Friends and family test data for the trust had scored above the England average for recommending the trust as a place to receive care from October 2015 to March 2016. The trust average score was 94%, against the England average of 87%.

## Good practice

Tulip Clinic in particular for sex industry workers and exploited children was noted for its very good practice.

## Areas for improvement

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

**MUST**

- Staff leading specialist clinics had not received level 3 safeguarding children training.

### Action the provider COULD take to improve

**SHOULD ensure**

- The Five Steps to Safer Surgery checklist is regularly audited for vasectomy patients.
- Adult safeguarding training and Mental Capacity Act training reaches the target of 85% compliance.
- Waste bins lids are labelled with usage guidance in the 'spoke' clinics, to ensure safe disposal of waste.
- Staff working in all clinics use the temporary closures on sharps boxes and this is monitored.

# Summary of findings

- Staff attend training to be able to use personal alarms, and are using them in line with the lone working policy.
- Improved confidentiality for patients booking in at clinic receptions.
- Reduce the do not attend rate at clinics
- Review access to the service in the east, to reduce redirection of patient
- Reduce the number of patients who do not wait for treatment.

Solent NHS Trust

# Community health (sexual health services)

**Detailed findings from this inspection**

Good

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated this service as good for safe because:

- Staff reported incidents using the trust electronic reporting system, and lessons learned were shared across the service. Staff were open and honest with patients, and followed duty of candour legislation where appropriate.
- Staff had a good working knowledge of the safeguarding process, and particular safeguarding risks in relation to patients attending the sexual health service. Compliance with safeguarding children training was at 89%. The four designated safeguarding leads had completed level 3 safeguarding training.
- There was a suitable range of equipment available for patients using the service, which was maintained and safety tested.
- Premises we inspected were clean and tidy, and personal protective equipment was available at the clinics, to protect staff and patients.
- Medicines were managed safely ensuring patients' needs could be met effectively.
- Patient records were up to date and fully completed supporting effective care of patients. These included embedded patient risk assessments.
- Risk assessments were undertaken where there was potential for significant risk to staff, patients or visitors.
- Staffing of clinics was managed effectively, with recruitment as required and retention of staff a clear objective.
- Business continuity plans were in place, in case of an incident affecting the running of the service.

**However;**

- Safeguarding adults training was at 80% compliance, which was below the trust target of 85%, and staff leading specialist clinics had not received level 3 safeguarding children training.
- The service had not audited the use of Five Steps to Safer Surgery for vasectomy patients.
- Clinical waste was not always managed safely in the 'spoke' clinics we inspected. Staff had not labelled bin lids with usage guidance, to ensure safe disposal of

waste. In addition, the sharps boxes temporary closures, were not being used. This was despite instructions following a previous incident related to spillage of sharps.
- There were delays in patients in the north and east receiving results from tests for sexually transmitted infections.
- There were some staffing gaps in administration and healthcare assistants, which had affected the delivery of services.

### Safety performance

- From 1 January 2015 to 31 December 2015, staff in sexual health services had reported 255 incidents. The service had not reported any Never events. Never events are serious, largely preventable patient safety incidents that should not happen if the available preventative measures have been used, so any 'never event' reported could indicate unsafe care.
- Over the same period, the trust reported two serious incidents requiring investigation relating to sexual health services. There was evidence of root cause analysis, an investigation and lessons learnt with outcomes of recommendations that were shared with staff. For example, a member of staff had sent a text to a patient stating they had a negative result when it was a positive. Following this incident, the service developed a competency for staff in the management of results rather than a brief training session. Staff were also given dedicated time to manage results.

### Incident reporting, learning and improvement

- The trust had an electronic incident reporting system, which was available to staff in the main hubs of the sexual health services and the 'spokes' and specialist clinics. Staff understood how to use the incident reporting system, and staff we spoke with described incidents they had reported and learning from the incidents. The most common incidents reported by staff were IT connectivity issues. Staff did not raise concerns about the incident reporting process in the locations visited. However, in sexual health governance meetings this had been noted as a concern due to IT issues.
- The service had introduced an audit tracker in February 2016, to support the management of incidents. The three operational managers coordinated an incident action tracker. The operational managers reviewed operational incidents, and an appropriate clinician reviewed clinical incidents. The audit tracker clearly identified the theme, action required and lessons learned. For example, staff had left a triage form with patient identifiable data in a clinic. Managers discussed this with staff and sent a global e-mail to all staff to remind them to clear their desk and follow the trust policy on disposal of patient identifiable paperwork. Staff commented that they were now receiving feedback following incidents, which helped then share learning from incidents with their colleagues.
- Clinical and operational leads were all aware of how to implement actions. A group of staff were also trained in establishing the cause of incidents and developing lessons learned, through root cause analysis.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. This includes giving them details of the enquiries made, as well as offering an apology. All staff we spoke with could demonstrate an awareness of the duty of candour.
- We saw examples where a duty of candour letter was sent to a patient, demonstrating the trust were following the requirements of legislation. The chief executive sent a letter following a member of staff inappropriately accessing a patient's records. The letter contained an apology and reassurance that action taken to prevent recurrence of this type of incident.

### Safeguarding

- The trust had a safeguarding adults and children's team. There was a named safeguarding lead for the sexual health service. The service also had four sexual health nurses who had dedicated time allocated to safeguarding duties. The trust safeguarding process worked in conjunction with the Hampshire, Isle of Wight, Portsmouth and Southampton Local Safeguarding Children Boards (LSCB) 'Safeguarding Children Procedures.'

Good

# Are services safe?

- The trust data demonstrated that at May 2016, 80% of staff in sexual health services were up to date with safeguarding adults training. This was below trust target 85%. Staff compliance with safeguarding children training at level 2 was 89%.
- 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 stated that clinical and non- clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be complete level 3 safeguarding children training. The designated sexual health safeguarding leads had attended level 3 children safeguarding training. However, staff leading specialist clinics and they were not trained to level three in safeguarding. A safeguarding lead advised us that more level 3 safeguarding children training courses were to be provided by the trust. The safeguarding lead was not able to give us the dates of when further level 3 training to be provided. In the interim, staff explained they followed a safeguarding flow chart produced by the trust that we saw in the consultation rooms, and would contact a designated safeguarding lead if support was needed.
- The staff we spoke with were clear about when they would seek help with a safeguarding issue.
- Staff described, and we saw, the service had clear arrangements for dealing with vulnerable patients under the age of 13 years. This included making an automatic referral to the safeguarding team, which provided immediate protection for the child and on going support. The team had referred seven patients under 13 years, from 1 January 2015 to 31 December 2015.
- We saw flow charts for staff displayed in the clinic 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. The chart made it clear when to complete a referral to the multiagency safeguarding hub (MASH).
- Staff support with safeguarding from colleagues was also available. The safeguarding leads we spoke with, explained there was a quarterly safeguarding forum within the trust, which was valuable for updating practice and networking. Staff in clinics told us that 1:1 safeguarding supervision could be accessed from a safeguarding lead if required, to discuss cases. Staff had an understanding of the various types of abuse and how to identify people who may be at risk. Nursing staff had received awareness training in child sexual exploitation (CSE), female genital mutilation (FGM) during the last six months at six weekly educational update sessions. Sixty-five clinicians had attended the session on FGM, and 67 attended the session on CSE out of 262 staff. A number of staff described having guidance on identifying child sexual exploitation (CSE), and how to escalate concerns and support patients. The electronic patient record contained questions related to child sexual exploitation and guidelines were available for staff to follow.
- The safeguarding leads attended a monthly Hampshire 'missing, exploited and trafficked children' (MET) meeting, which included attendance from the police, social services and Barnardo's. The meeting provided an opportunity to gather intelligence, a reporting mechanism and trends of local sexual exploitation to be monitored. The safeguarding leads placed an alert on a patient health record, if known to the sexual health service.
- From 1 January 2015 to 31 December 2015 there were approximately 2980 patients aged 16 years and younger attending the sexual health service. Hot spots of patient attendance and trends of child sexual exploitation were recorded and circulated to staff at the MET meeting. This raised staff awareness of particular locations where they may see these children and young people, when they were running clinics.

## Medicines

- The trust had an updated medicines policy accessible on the staff intranet. The service had systems in place for the safe storage, administration and dispensing of drugs in line with the policy. The medications we checked were in date.
- Clinical staff administered or supplied most medications using a patient group direction (PGD). A (PGD) is a written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition. Their use allows specified

health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health professional working within the PGD is responsible for assessing that the patient fits the criteria set out in the PGD.

- The PGD used in sexual health had gone through an approval process, and had been signed off by senior staff. Staff accessed PGDs electronically via the trust's intranet site. For each PGD, the staff member and assessor signed off competency. This happened when a staff member started with the service, and at two yearly intervals. The matron advised us if an amendment issued in between these times PGD not signed at this time. The amendment would be discussed at a one to one or at a six weekly education session. Two staff records were reviewed, demonstrating this process to be in place. At one site we inspected we were shown PGDs that were printed off and out of date. This was fed back to the trust, and action immediately taken to remove the out of date PGDs that had been printed.
- Nurses who had received additional training were able to prescribe drugs for patients, in addition to those administered by PGD. There were eight trained non-medical prescribers. The sexual health service lead had links with the chief pharmacist in the trust, and a pharmacist was based in the east, west and north. This enabled effective day to day pharmacy support to all areas of the service. There were monthly steering group meetings for non-medical prescribers. The meeting provided an opportunity to review National Institute for Heath and Care Excellence (NICE) guidance for changes in practice, against non-medical prescribers' formulary in sexual health. Non-medical prescribers were also able to attend a twice yearly forum and an annual conference for non-medical prescribers to enhance their practice. The service leads had reviewed the policy in place for non-medical prescribing which was issued in October 2013, and due for ratification in July 2016.
- FP10 prescription pads (a hand written prescription form) were stored securely with a process for tracking their use. Faculty of Sexual and Reproductive Healthcare (FSRH) service standards for sexual and reproductive healthcare state there should be an audit trail for numbered prescriptions. We saw the service tracking system when a FP10 used was in place.
- Temperature sensitive drugs were stored appropriately and records maintained to monitor refrigeration equipment operated correctly. Staff we spoke with were aware of the process to follow with if a temperature went to high or low.
- Oxygen cylinders were available, in date and stored appropriately at all of the locations we visited.
- The trust medical gas policy dated February 2016 also included guidance on the management of liquid nitrogen. In a consultation room in the east hub, we noticed a vacuum insulated container had been prepared with liquid nitrogen. It was visible and within reach of children, this was a safety concern. The trust were made aware so they could investigate why the container was in the room, when there were no patients.

### Environment and equipment

- Sexual health services operated from a variety of locations, which ranged from purpose built health centres, to rooms in colleges. All of the sites we visited were well maintained to protect the safety of patients, visitors and staff.
- Emergency boxes/ bags or trolleys containing emergency drugs and airway equipment were available in the 'spoke' clinics and three hubs that we checked, in case of an emergency. All drugs were secure, in date and equipment packaged appropriately
- Equipment and electrical items were serviced and safety tested. Two microscopes in the west hub had been due a service in May 2016. We brought this to the attention of the matron, who immediately took action to check with the medical devices department regarding the service date being overdue.
- Clinical waste bin lids were inconsistently labelled in the 'spoke' clinics we visited, which potentially could cause inappropriate waste segregation. All bins were hands free pedal activated bins. In the 'spoke' clinics we inspected, the temporary sharps closures for the sharps bins were not being used. A healthcare assistant reported an incident where a sharps bin lid had not been secured properly. The bin was knocked over and the sharps fell out, although the individual sharps did

have safety mechanisms in place. An email went to all staff, asking them to ensure sharps boxes lids were firmly in place. These issues were not a concern at the hubs in the east, west and north that we visited.

- Health and safety training was at 79% against the trust target of 85%.

### Cleanliness, infection control and hygiene

- All locations we visited were visibly clean and tidy. We saw evidence of cleaning schedules and observed staff cleaning the equipment with cleaning wipes before, during and after clinics.
- Staff understood the importance of cleanliness in preventing the spread of infection. Personal protective equipment (PPE) such as disposable gloves and aprons were available in all locations. We observed the appropriate use of PPE however, the trust did not audit this, and they explained they expected staff to challenge each other to address poor practice.
- Hand washing facilities were available in the examination and treatment rooms we inspected, with elbow taps. Alcohol gel dispensers were visible and staff were observed using these in all locations.
- We observed all staff complying with the bare below the elbows policy.
- The trust carried out twice yearly hand hygiene observation audits. In December 2015, one of the eligible areas in sexual health did not submit an audit, reducing the overall score for the service to 78%, those that did take part had an average score of 97%. Staff working in infection control have trained additional link advisors for the service to improve compliance with hand hygiene audits. Staff in sexual health services from eligible areas all submitted audits in June 2016, with an overall score of 97%.
- Infection control link staff (links) were provided with quarterly workshops. The links, at the March 2016 meeting, discussed aseptic technique, with the question - Can you demonstrate competency? The links were given guidelines to hand out to staff. A staff member we observed followed a good aseptic technique.
- Compliance with infection control training was 80% against the trust target of 85%.
- Most remote clinics were located within larger buildings where cleaning services were managed by the host organisations. Day to day management of spillages and general tidiness was the responsibility of the trust staff. Spillage kits were available at the locations we inspected.

### Mandatory training

- The trust identified 11 areas of mandatory training, this included resuscitation, manual handling, infection control, safeguarding and fire safety. The service overall was 84% compliant with mandatory training against a target of 85%.
- The service provided six weekly half day education sessions for staff. This included topics such as infection prevention and control, decontamination and safeguarding adults and children updates.

### Assessing and responding to patient risk

- The service used triage and risk assessment to identify and assess risks to young people who attended clinics. For example, we saw separate triage forms for female and male patients to allocate the patient to the appropriate health professional for asymptomatic (without symptoms) and symptomatic treatment. We observed a member of staff using an electronic risk based patient assessment tool for a young person. At the HIV point of care testing clinic, we saw staff using a risk assessment form to manage a patient's risks.
- The service advised us that the five steps to safer surgery checklist (WHO) was used when undertaking vasectomy procedures. However, we did not see any evidence that the use of the checklist had been audited.
- Nursing staff we spoke with were aware of action to take if patients become unwell, such as after an injection. Medication and emergency equipment was available. A doctor was available and on call 24 hours a day if needed for genitourinary medicine (GUM) related issues.
- Staff could place a 'pop up' alert on a patients records, for example, if there was a risk a patient could become violent or aggressive. The senior team had made security aware of the increasing incidents of aggression in the service, and staff had been texted if a patient booked in was known to have had an aggressive episode. The service has provided 48 staff of 262 with

conflict resolution training to date. The service were in the process of arranging a bespoke training session for the administration staff at clinic receptions. This was then to be rolled out to the clinical teams.

- At the remote clinics, staffs attended the clinics in two's or more and were aware of the lone worker policy. On staff computers there was a 'wiggle amp' they could use to indicate to a colleague that assistance needed. Staff were not always using personal alarms as recommended by the policy. For example, we attended a speciality clinic where only one of the two members of staff had a work telephone. If working with a patient, the other member of staff would then sit in a reception area in case there were further patients. We discussed this with managers, who explained there was a training issue, and training was being organised to support staff. 'Buddy systems' were used, and we saw evidence of a 'buddy system' board in use at the north hub.

### Staffing levels and caseload

- The clinical director explained her focus on recruiting and retaining medical staff, and offering them developmental opportunities. At the time of our inspection, the percentage of medical staff vacancy was 6.5% due to retirement. The service employed locum doctors for a limited time, and medical staff agreed to work excess hours if there were staffing gaps. The service had no medical vacancy at October 2016.
- Staffing levels were determined according to Faculty of Sexual and Reproductive Healthcare (FSRH) and British Association for Sexual Health and HIV (BASHH) standards. This guidance described the time required for a clinic slot to provide effective care. The matrons maintained staffing rotas, in line with the guidance, which detailed which staff were available at which clinic. There was a rota covering the east, and a rota covering the west and the north.
- The service had found it difficult to recruit appropriately skilled qualified nurses, which is a national issue. A matron explained that the service recruited band 5 nurses, developed their knowledge and skill base, so as they were able to fulfil the responsibilities of band 6 qualified nurses. At time of our inspection, there were 1.28 wte (5%) qualified nurse vacancies in the west from an establishment of 21.53 wte. In the east there was a 0.97 wte (4%) vacancy from an establishment of 24.33 wte.
- The service used suitably qualified bank nurses to fill gaps when needed. In the period January to December 2015, this was 18 shifts in the west, 36 in the east and 23 shifts in the sexual health promotion team. The bank nurses undertook competencies, attended the six weekly education sessions, and received the fortnightly sexual health newsletters.
- Staff told us they considered staffing levels to be safe and bank staff were used to cover gaps, and staff were offered excess hours. The clinics we visited were staffed as planned. A gap in the staffing rota in the east hub had been a filled with a bank nurse.
- There was also 3.6 wte (27%) vacancy for nursing assistants in the west and 1.63 wte (14% ) in the east. Medical staff told us gaps in healthcare assistant cover slowed their clinics down because of medical staff then needing to take blood for testing or waiting for chaperones. The service was recruiting healthcare assistants, and supporting their development. We spoke with healthcare assistant in a specialist clinic, who had received funding to undertake her NVQ level 3.
- A matron advised that some healthcare assistants were leaving to do their nurse training, and wanted to return to the service. Before being considered, they were advised to obtain some general experience, to support their development and future effectiveness with the sexual health service.
- The senior team advised us that recruitment to the service was on going, and we saw posts advertised on NHS jobs. This had included 1.9 wte administration posts for positions in the west hub. The service had arranged interviews for these positions week commencing 4 July 2016.

### Managing anticipated risks

- Staff assessed and managed risks. The service offered sexual health clinics and point of care testing using a trust bus. This service enabled vulnerable patient groups to get advice and treatment, without the need to attend a hospital. A risk assessment had been undertaken. Risks such as confidentiality, needle stick

Good

# Are services safe?

injury and infection were identified. Actions to mitigate included a detailed process in place to ensure confidentiality and a spillage kit. A protocol was available if a member of staff sustained a needle stick injury.

- Young people, when colleges and universities closed, could access young people's clinics. There was information on the trust website to support them with finding a clinic.
- We saw a business continuity plan dated October 2015. This included risks such as loss of accommodation, supplies (equipment and pharmacy), staff and information technology. The plan prioritised services delivered within sexual health, and outlined immediate actions and responsibilities. Key staff we spoke with were aware of the plan.

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

We rated this service as good for effective because:

- Treatment pathways and guidelines took account of national guidance including National Institute for Health and Care Excellence (NICE) and The Faculty for Sexual and Reproductive Health standards.
- Patients pain was managed effectively.
- Service met notification times to inform patients of sexual transmitted infections
- Technology was used to support effective patient care and developed in response to feedback from patients
- A programme of audit was in place with changes and actions recommended, to improve patient outcomes.
- Appraisal compliance for the service was over 95%.Staff were well trained and completed competencies for their roles.
- Multidisciplinary working was effective, and coordinated care pathways in place.
- Clinicians obtained patients consent in line with national guidance.

However

- The service needed to improve its performance in the time taken to test children of HIV parents and the diagnostic rates of chlamydia.

## Evidence based care and treatment

- The Department of Health published the Integrated Sexual Health Services National Service Specification in June 2013. The trust model of integration followed the guidance set out in the document. This brought together contraceptive and family planning services to provide services for screening and treatment of sexually transmitted infections. This was demonstrated by the service with the 'hub and spoke' model of clinics, the open access walk-in and appointment clinics, and aim to be a 'one stop' service.
- The trust referred to, and operated within, nationally recognised guidelines and standards. The Faculty for Sexual and Reproductive Health (FSRH) of the Royal College of Obstetricians and Gynaecologist standards was followed, for example, in relation to patient group directives for non medical prescribers in sexual health. A further example was the national guidelines in the management of pelvic inflammatory disease.
- The service assessed and followed National Institute for Health and Care Excellence (NICE) guidance. For example, NICE guidelines and 'human immunodeficiency virus (HIV) testing and 'long acting reversible contraception' (LARC).
- To ensure evidence based treatment was delivered, the service collected appropriate data. The service collected data for the three local authorities about the update of LARC.
- The trust took part in national audits and was part of the national chlamydia screening programme. The service was working with the three local authorities to deliver the national chlamydia screening programme.
- Staff in the service had achieved positions with national organisations. Two consultants were elected officers with the British Association for Sexual Health and HIV (BASHH). The consultants' responsibilities included developing national standards and making specific advisory notifications to members. This work undertaken by the consultants supported the service to give care and treatment in in line with evidence based guidance.
- The service had presented a National report at the annual British Association for Sexual health and HIV (BASSH) national conference, which was the management of under 16's in sexual health clinics.
- The trust submitted their quality improvement plan for 2016 to 2017 following a request after the inspection. This proposed two quality improvement projects and 12 local clinical audits/ service evaluations. The quality improvement projects were 'examining access to the service', and 'what interventions worked'. For example a

project included, 'A review of interventions, what works and is it effective'. The local audits and service evaluations included 'Late diagnosis of HIV, 'contraceptive pills patient group directive compliance' and 'reasons and pathway to access sexual health clinic in Southampton'. The service advised the national audits and trust wide projects it would be participating in from April 2016 to March 2017 were to be confirmed.

### Pain relief

- If patients required analgesia during or after clinical procedures at the clinics, clinicians were able to access pain relief for them from medications held on site. For example, local anaesthetic prior to a vasectomy.
- Staff were knowledgeable about which procedures were likely to cause patients to require pain relief and the medication available to them. The service showed us a blank template they had designed which enabled them to record any pain relief administered to a patient during the procedure.

### Technology and telemedicine

- The service used technology to enhance the delivery of effective care and treatment. The trust sexual health website was used to signpost people to sexual health services, for example, finding a clinic and advice about contraception. The service also provided access to an on-line testing kit for sexually transmitted infections, to use at home. The website also had a section that professionals, such as GP's could access. This provided information such as how to make referrals to sexual health specialisms, and pathways of care if a patient had symptoms of a possible sexually transmitted infection.
- The service used text messaging to communicate test results to patients where possible. If a patient had a positive result, the text advised the patient of the need to contact the service. The service was in the process of assessing how patients in the west and north hubs would be prefer to be contacted about test results.
- With the new IT system, staff were able to use their computers to link with colleagues online in other locations within the trust. This enabled staff in the service to keep in touch, and support each other remotely with clinical and operational issues. An operational manager we spoke with was hoping to link with colleagues on a weekly basis using this technology.
- To facilitate attendance at meetings, some staff joined meetings by telephone or teleconference, for example the monthly sexual health clinical governance meeting.

### Patient outcomes

- The service had a clinical lead with responsibility for audit. The service completed regular local audits, took part in national audits and completed evaluations of the service. In December 2015, an audit reported that had been looking at the testing of children of recently diagnosed HIV patients. The audit found that although discussion of tested and documentation had improved from 67% to 100% following the publication of guidelines entitled 'Don't forget the children' published by BASHH in 2009. The median time for testing the children of HIV parents was 24 months, rather than six to 12 months as recommended. An action from the audit was a new HIV template designed on the electronic patient record to capture all relevant key information to increase the compliance with the timeliness of the testing of children born to HIV positive patients. A re audit was planned to check the impact on practice in 2017.
- The integrated sexual health service collected and submitted data to Public Health England in line with the mandatory obligation required by the government. This included the Sexual and Reproductive Health Activity (SRHAD) and Genitourinary Medicine (GUMCADv2) data sets. A purpose of the data was to monitor the effectiveness of services. Data included demographic details, new diagnosis of STI and uptake of LARC.
- The service routinely collected and monitored the time taken for the notification of new patients sexually transmitted infection (STI) results. The service had a seven day contractual target, from April to June 2016 the target was achieved for 88% patients. From April to June 2016 the 10 working day target, which is the target set by BASHH, had been 95% overall. The service had developed closer partnership working with the

laboratories, to support them in prompt notification of a STI to a patient. This supported the service in the effective management of STI, to reduce prevalence and transmission.

- For young people the target of uptake for LARC was 25%, and the service had exceeded the target by between 5% and 8% across Hampshire, Portsmouth and Southampton. The service key performance target for uptake of LARC for all ages was 35%. The service had achieved this target in Hampshire,and exceeded this target by 5% in Portsmouth and Southampton.
- The service had under performed with diagnostic rates of chlamydia in Hampshire and Southampton from April 2015 to March 2016, in Portsmouth the service had over performed by 14%. The service had put an action plan in place, and diagnostic times in Hampshire had improved in Hampshire by 5% with the underperformance now at 19%. The service underperformance in Southampton was 12%, which represented an improvement of 6%. Hampshire public health had noted the improved performance, with an action plan in place.

### Competent staff

- From 1 January 2015 to 31 December 2015, line managers had carried out 94% of appraisals for non medical staff, and 96% for medical staff against a target of 95%. We reviewed two staff appraisals. The appraisal included a review of the previous year's objectives, values discussion, what went well, manager and appraisee feedback and objectives for following year. For clinical staff, there was also a section regarding revalidation.
- The service provided group clinical supervision at the six weekly education session updates held in the east and west for staff to attend. Staff from the north could attend either the sessions in the east or the west.
- The service provided comprehensive induction packs for all new staff. The packs included competency logbooks for nursing and medical staff. The service provided role specific induction for administrative staff and health care assistants (HCAs).
- Non-medical prescribers (nurses prescribing medicines) received detailed training resources to demonstrate and update competencies. Easy to access, up to date guidelines were available for medicine management and prescribing.
- The FSRH had provided a diploma since 2014 accredited by the Royal College of Nursing (RCN) and Royal College of General Practitioners (RCGP). The diploma demonstrated that the nurse had the evidence based knowledge, and attitude and skills required for independent practice to deliver safe and effective reproductive healthcare. Within the service, six staff had completed, seven staff were currently undertaking and three staff were due to commence the diploma.
- Staff had awareness of their role and boundaries within the service. HCAs described their roles as having administrative and clinical responsibilities and felt prepared for the care they provided, however, some staff wanted further development and wished to expand their skill set.

### Multi-disciplinary working and coordinated care pathways

- There was effective multidisciplinary working, and coordinated care pathways in place .Staff reported good networking in place with the police, social services, and the Barnardo charity to support vulnerable people. They told us of examples where this had had positive benefits for patients.
- Specialist medical and HIV nursing staff met weekly, with the infection and respiratory team at Southampton General Hospital, to discuss inpatients with HIV. Staff from the HIV team also attended a monthly antenatal multidisciplinary (MDT) to ensure effective care of mothers, who were HIV positive, and their children. Internal MDT was also held for HIV patients, attendees included medical, nursing, pharmacy and health advisor staff.
- Health advisors from sexual health were working with a school in Southampton in relation to preventing teenage pregnancy.
- Health advisors were involved when young people engaged with the service and staff worked with social services to plan pathways of care for vulnerable young people.

Good

# Are services effective?

- A regional MDT teleconference was held monthly at which (HIV) cases were presented for application of non licensed drug use. This system allowed peer review to be a part of the decision making.

### Referral, transfer, discharge and transition

- Co-ordinated referral protocols were in place and included HIV (human immunodeficiency virus) pathway and Under 16 teenage pregnancy pathway. Referral facilities were available for Termination of Pregnancy (TOP), Child and Adolescent Mental Health Services (CAMHS) and sexual assault clients.
- Patients were able to self refer themselves to attend a sexual health clinic without having to see, or be referred by, another healthcare professional. Patients were able to contact the single point of access (SPA) through one telephone number. Staff we spoke with in the clinics, said the single point of access (SPA) countywide was working well. Lead nurses in sexual health had provided bespoke training, supported with guidance. Guidance was regularly updated, with version 11 released in November 2015.
- Staff followed the Hampshire, Isle of Wight, Portsmouth and Southampton Local Safeguarding Children Boards (LSCB) policy related to information sharing.
- Staff had referral processes in place to request scans or x-rays for patients and were aware of how to refer to other relevant organisations. A doctor had introduced a system to track patients scan results in response to a missing result.
- Staff did not inform patients GPs of their attendance unless the patient had an initial referral by letter or the patient gave their consent.

### Access to information

- Staff had access to patient information through the electronic patient record system. They also accessed trust policies and procedures through the trust intranet system. We observed staff accessing this for protocols, guidelines and PGDs.
- Within most of the remote clinics staff could access patient records via laptops. At a specialist clinic we visited staff completed a paper record. Staff would then transfer the information on the paper record to the electronic patient record when the staff member returned to the office. This ensured that that patients information would be available to all clinicians in the service.
- The trust had developed the electronic patient record, so staff had permissions to access different parts of a patient's electronic record according to the needs of their job role, to protect patient data. We saw this to be in place during our inspection.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Patients told us, and we observed, staff asked patients for verbal consent before any treatment or care was provided.
- Staff demonstrated knowledge of Gillick competence and Fraser guidance to ensure young people less than 16 years, who declined to involved their parents or guardians in treatment, had sufficient maturity and understanding to enable them to give full consent. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidance is used for children under 16 years to decide whether they can receive contraceptive advice or treatment without parental knowledge or consent. Both sets of guidance were embedded in the electronic records system to remind and prompt staff.
- The service had consent forms where needed, for example, deep contraceptive implant removal. A printed form with information about the procedure was given to the patient to read on the day of the procedure. Staff scanned signed consent forms into the patients' electronic record.
- Local guidance was available on assessing mental capacity and best interest decisions. Staff we spoke with said they would seek support from one of the four safeguarding leads, if unsure how to assess a patient's mental capacity. Staff training with Mental Capacity Act training was at 66%.
- If it was in the patient's interest for another health care professional to be informed then their consent to disclosure was sought.

Good

# Are services caring?

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

## Summary

We rated this service as good for caring because:

- All the patients we contacted were complimentary about the staff and told us staff were friendly and sensitive to their needs. Staff from outside organisations also told us how kind and empathetic the staff were.
- We observed receptionists talking to patients in a respectful way.
- Patients told us nursing staff and doctors explained clearly what options were available to them
- Friends and family test results demonstrated from October 2015 to March 2016, 94% would recommend the trust's services to their friends and families.

**However;**

- In the locations we inspected the reception desks were all open. Any signs asking people to stand back were at the desk. It was possible for patients to hear what staff said to the patient in front of them, if they did not stand back

## Compassionate care

- Many patients declined to speak with us during the inspection; however the eight patients we did speak were all complimentary and told us staff were friendly and sensitive to their needs. One patient we spoke with said 'staff really nice, they put me at ease'.
- The CQC distributed comments cards to the service, 20 comments cards were received back from patients. The themes from these were positive and included friendly and helpful staff and excellent service. Two references were made to the web site being hard to navigate, an updated version has now been launched. Also two references that waiting times could be improved, about which the service has, and continues to make improvements.
- Four patients consented to us sitting in whilst they were assessed by a clinician. Clinicians undertook the consultations in a caring way. A patient said 'the doctor had a very gentle and caring manner'.
- The Barnardo and Medaille Trust charities also commented how friendly and empathetic they found staff. Both charities had examples of the positive differences the service had made to the sexual health of patients.
- Patients commented how staff did not make them feel awkward or embarrassed. Patients also commented on the non-judgemental approach by staff when they were being assessed. A patient said, 'make you feel very comfortable, no one judges you here'.
- Patients fed back that even when they had arrived with no appointment to a booked appointment clinic, staff stayed after the clinic closed to advise and help.
- The trust had scored above the England average for recommending the trust as a place to receive care from October 2015 to March 2016. The trust average score was 94%, against the England average of 87%.
- Patients checked in to the reception desk, except at the northern hub where there were also kiosks. We observed receptionists were very welcoming, and talked with patients in a respectful way and tried to prevent other patients overhearing conversations. We observed that patients did not always stand an appropriate distance back when we inspected at Saint Mary's Hospital and the Royal South Hants Hospital. There were signs asking people to stand back, but these were next to the reception desk. This made them difficult for a patient to see until they reached the reception desk.

## Understanding and involvement of patients and those close to them

- Patients felt involved as partners in their care. A patient described 'perfect amount of information explained in the right way'. Patients also described how they felt listened to, and felt what they were saying was taken into consideration. For example, a patient said 'felt that staff listened and treated me as an individual.'
- Staff offered a satisfaction questionnaire to patients having a vasectomy from September 2015 to January 2016. This followed the introduction of telephone assessments for vasectomy. Health care assistants following training assessed patients over the telephone,

rather than face to face in the department. Patients completed 89 questionnaires. The results showed that 99% of patients were happy with the information given at the assessment appointment.

- Staff accommodated request by patients if they wanted a relative or friend to join them in their consultation. If a person needed extra time, for example if living with a learning difficulty, staff allowed extra time for the appointment.
- The clinicians at the consultations we observed, except one, ensured patients had enough understanding to make an informed decision. When we fed back concerns to a matron about the concern with one consultation, a plan was put in place to address this with the member of staff.

### Emotional support

- Patients told us staff were friendly, welcoming and approachable. A patient told us emotional support was genuine and compassionate. For example, a patient who had a point of care test said they felt the consultation to be 'safe and confidential'.
- Patients also appreciated the support if a test was positive. A patient explained 'they were asked how they would feel if a test was positive'. The patient said 'scared'. The patient then said 'staff talked though support that would be offered, and supported the conversation with an information leaflet'. The patient summed up the whole experience as feeling 'professional with enthusiastic support, and they would recommend using the service to colleagues and friends'.
- Psychosexual counselling services were available in six locations, which included clinics in the east, west and north. Psychosexual counselling aims to address sexual concerns. Patients could access the service following referral by their GP.
- Staff were aware of guidance regarding chaperones, and there were notices in the clinic for patients about chaperones.
- Staff also made patients aware of other sources of support such as their GP and pharmacies. The service also mentioned 'Brook', the young people's sexual health and well being charity.

Good

# Are services responsive to people's needs?

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

## Summary

We rated this service as good for responsive because:

- The service was being planned based on the identified needs of the local population and there was active engagement with stakeholders to provide co-ordinated pathways of care.
- The service supported people to access the right care at the right time. Appointment systems were easy to use and supported choice.
- The service promoted equality, removed access barriers, and met the needs of people in vulnerable circumstances.
- The service was meeting targets for patients to be offered an appointment within 48 hours for contraception and sexually transmitted infections services were offered an appointment within 48 hours.
- The psychosexual service met the 18 week referral to treatment target.
- The service continuously reviewed and acted on feedback and complaints about the quality of care and used the information to improve services, and were open and honest about the action they had taken.

However,

- Patients were sometimes redirected to an alternative clinic or had appointments booked at a different time when a clinic was full. The service had needed to redirect more patients in the east, than in the west and the north. Patients were not turned away without a plan but a number of patients did not wait to be seen.
- A number of clinics in the localities had been closed because of staffing issues and the need to allocate education and training time for staff. Patients were being offered subsequent appointments within 48 hours.
- The number of patients who did not attend booked appointments was 11%. The service was taking action to reduce non-attendance and to contact patients with untreated sexual transmitted infections.

## Planning and delivering services which meet people's needs

- Services to local communities were planned based on the local joint strategic needs assessments of Hampshire, Southampton and Portsmouth councils. Key aspects that impacted on the sexual health service was the high conception rate in Southampton, and large transient student population requiring services targeted at young people.
- The sexual health service was designed and delivered by the use of a hub and spoke service model. The hubs acted as a base for staff and the spokes were remote clinics based within buildings run by other organisations or health providers. The spoke clinics were nurse led and the hubs, which provided a more specialist service, were consultant led.
- The web site and a single booking line gave patients information about the services offered and clinics, based on their requirements and location. The website usage had an average of 30,000 users a month. The service reported that 72% of all users were viewing the website on a mobile device. This indicated that the site worked well on a mobile device.
- The service was working closely with commissioners in planning and delivering services. The commissioners included NHS England, local authorities and clinical commissioning groups. The clinical director and head of services had held six weekly meetings with the local authorities since January 2015. The sexual health service ran a successful on line self test for chlamydia as part of the National Chlamydia screening programme. The service was in discussion with the local authorities about the risks linked to stopping chlamydia testing in primary care. They had used data and information to support these discussions. The service with Hampshire County Council was working with an action plan to increase chlamydia screening across the service. The service was also planning to discuss with commissioners, national media campaigns.
- The trust recognised the challenges faced by the service, which in June 2016 had commenced a retendering process. The tendering was due to conclude in October

Good

# Are services responsive to people's needs?

2016. The overall aim was to deliver a service that remained fully integrated meeting complex sexual health needs of patients , and able to offer a service out of hospital as a 'one stop' option.

- Integrated sexual health services (ISHS) delivered services such as the C-Card (a community condom distribution service) for people younger than 19 years of age, to reduce spread of sexually transmitted diseases and reduce pregnancy rates. From 1 January 2015 to 31 December 2015, approximately 9,500 young people had accessed the service.
- Following a service evaluation, the auditors recommended a new type of testing for Trichomonas Vaginalis in asymptomatic high risk women. The managers/ service leads planned to discuss this with commissioners.

## Equality and diversity

- Staff understood the diverse clientele who used services. Patients from diverse nationalities and of many sexual preferences accessed the service. Staff received diversity training as part of their mandatory training, and the service was 93% compliant. The sexual health newsletter in June 2016, advised staff equality and diversity training had now been made available. An outline of the course was provided, and details of how to book onto the course.
- A matron had attended a lesbian, gay, bisexual and transgender (LGBT) conference in June 2016. One of the speakers was an MP with responsibility for five policy areas in relation to women and equalities. Two of the policy areas were LGBT, and stopping violence against women and girls. The matron was able to share knowledge with staff in the service, and network with colleagues.
- An interpreter system was available. Staff were able to give examples of when they had accessed this service, and how helpful it had been. Staff had also used a web based translation tool, and found it very helpful in consultations. A matron explained the service was planning to formally introduce the use of this web based translation tool within the service.

## Meeting the needs of people in vulnerable circumstances

- There were separate young people clinics, which offered services to patients under 20 years, and staff directed these patients to those clinics. Patients under 18 years were automatically flagged on the electronic record system to alert staff.
- Southampton was above the England average for teenage pregnancy. Southampton had a teenage pregnancy rate of 36 per 1000, the England average was 24 per 1000 in 2015. The service had developed a teenage pregnancy action plan dated 2016-2018. This listed three priorities and 13 actions to support the reduction of teenage conceptions. An example of a completed action was the development of a pregnancy care pathway for young women under 20 in Southampton.
- The sexual health team had 'easy to read' literature and diagrams to support people less able to understand standard literature and guidance. A friends and family test (FFT) feedback form was also available in easy to read, pictorial format.
- The service had set up a monthly clinic in November 2015 specifically to meet the needs of patients with a learning disability. The sexual health service linked closely with the learning disability service in the trust. The clinic was set up in response to a syphilis outbreak in the area. At the appointment patients were given extra time, to be able to discuss risky behaviours, contraception and sexually transmitted infections. The service provided ongoing care where the patient felt at ease, either at the clinic or where they lived. The lead said this might be a patient followed up in the community, or further appointments made at the clinic.
- Staff were thoughtful about waiting areas for clinics. In the hubs there were sub waiting rooms, which could be male or female or related to different clinic that was running. The nurse in charge at a 'spoke' clinic we inspected explained that there was often not so much space at the 'spoke' clinics. However, staff also managed this well with strategically placed chairs along a corridor, and signposted to a general waiting area if they preferred.
- Disabled toilets were available and accessible. A toilet in the locations we visited was next to the testing area promoting privacy for the patient.

Good

# Are services responsive to people's needs?

- Staff accessed interpreters to help support patients. For example, a receptionist had been concerned about a patient with a much older person who reported to a clinic. The nurse through the help of an interpreter and a double appointment identified the patient's vulnerable status. Staff made a referral to the multiagency safeguarding team, and social services were able to help the patient.
- Bariatric examination couches were available in the east and west hubs but not the north. A bariatric patient attending the hub in the north, with agreement, would need to be directed either to the hubs in the east or the west. The service has monitored this situation, and there have not been any incidents. Bariatric blood pressure cuffs were available at all clinics.

### Access to the right care at the right time

- At the inspection in March 2014, people were not always able to access sexual health services as waiting times were long for walk in clinics, and people were at risk of being turned away. The service had reviewed clinic timetables in response to patient feedback and used priority cards to be issued if people were turned away. However, this did not always happen. Actions taken by the trust since the inspection had meant that all patients who may be turned away would have a plan. Data submitted by the trust demonstrated they did not turn any patients away without a plan.
- A patient completed a male or female registration form on arrival at a wait to be seen clinic. Staff advised patients that the forms were confidential. The service used the form to assess the needs of the patient. Staff then ensured a patient was allocated to see the most appropriate member of the team. Transgender patients would attend a clinic they felt comfortable with.
- At the time of our inspection, the west hub had started a pilot with the introduction, of same day access clinics, on 21 January 2016. A patient was able to telephone on Mondays and Thursdays for an appointment the same day. This was to replace the wait to be seen service. The service scheduled appointment slots, to allow planned time to catch up, if appointments overran. The matron did not allow all the slots to be made available, until she knew there was no short term sickness affecting the number of staff available to run the clinic.
- Telephone assessment clinics were also in place to accommodate patients after all same day appointments are full. A nurse contacted these patients, and triaged their needs. The patient was assessed and relevant sign posting given on the same day, for example, appointment, on-line testing and GP. If the patient's needs fitted the urgent criteria, the patient was offered an appointment on the same day.
- The sexual health service had undertaken a digital pilot, offering self testing for sexually transmitted infections through their web site, which started in September 2015. This was a service for asymptomatic patients. The service has carried out an evaluation, which demonstrated the on line test to be highly acceptable to those requiring a test for a sexually transmitted infection. At April 2016, the return rate for tests was 46%. The service was planning to send out reminder text messages in the future, to those who had received kits. The pilot has finished but the online testing continued and extended to 16-18 year olds.
- The service collated data on the redirection of patients to other clinics when services were full or too busy. The number of patients being redirected was gradually decreasing in the west and the north. In the west, 8% of patients were redirected (October 2015). In April and May 2016, the percentage had dropped to under 3% of patients. In the north, the service in redirected 9% of patients (October 2015) In April and May 2016, percentage of patients redirected had decreased to less than 2.5%. However, in the east for these three months the redirection data for the service had varied, in October 2015 8%, in April 2016 6.75% and in May 2016 13.5 %. Patients were most frequently offered another appointment, or redirected to another clinic. The sexual health service was undertaking an evaluation of the same day access clinics in the west. The service leads then planned to take a decision regarding implementing same day access clinics in the east.
- The service redirection data included numbers of patients who did not wait to be seen. For October 2015, December 2015 and January to May 2016 the figures were 17 patients in the east, 35 patients in the west and 274 patients in the north. The service felt the data in the north was affected by the booking process, and some

patients choosing not to wait. The service is planning an audit to understand why patients in the north less inclined to wait, as the average waits are less than other clinic areas.

- A matron told us in the last 12 months no clinics at the three hubs had been closed. However, 38 clinic sessions in localities had been closed over the last 6 months. Sixteen of those were at Rowner in the east, which was due to be closed in the new tender due to the clinics proximity to Gosport War Memorial Hospital. Twelve closures had been to enable the six weekly education and training sessions to be delivered to all staff. Ten closures had been due to staffing. If any clinic closed the service put a note up on the web site about the closure. The single point of access staff then booked appointments for patients to ensure an appointment offered within 48 hours.
- In the service, 100% of patients for contraception and sexually transmitted infections services were offered an appointment within 48 hours from 1 January 2016 to 31 March 2016. The key performance indicator set by the local authority was 98%. In the east 96 %, north 93% and in the west 92% of patients for contraception and sexually transmitted infections services were seen within 48 hours from 1 January 2016 to 31 March 2016. The key performance indicator set by the respective local authorities was 85%
- From January to June 2016 there had been an 11% did not attend rate (DNA). Staff told us this tended to be asymptomatic patients, or patients who have had treatment and do not attend follow up appointments. The service had guidance in place advising of action to take if a patient did not attend. For example, if a patient had an untreated sexually transmitted infection, a health advisor contacted the patient. An example of action the service had taken was to reduce the time ahead of appointments booked, and send text reminders of appointments. The service was currently looking at how to implement 'choose and book', and was hoping that would lead to a reduction in the DNA rate.
- The psychosexual service met the 18 week referral to treatment target.

### Learning from complaints and concerns

- The service received 36 complaints from 1 March 2015 to 29 February 2016. 11 of the complaints were fully upheld and 11 partially upheld. The three main types were clinical treatment, diagnosis and delay (10), access (9) and attitude of staff (8).
- Staff knew how to manage and respond to complaints. For example, following a complaint regarding clinical care, a procedure for contacting a patient overseas put in place. Following a complaint about staff attitude, the member of staff completed a personal reflection on they communicate with patients. The service provided customer care training for the team involved.
- A matron who led a quarterly meeting for band 7 nurses discussed complaints as part of the meeting, so the band 7 nurses could then share lessons with their teams.
- The service had developed a range of leaflets to support patients, for example, 'your guide to HIV rapid testing in the community'. On the back of the leaflets developed by the service, was advice on how to contact the service if a patient had a complaint.

Good

# 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 rated this service as good for well-led because:

- Governance arrangements supported the delivery of the strategic objectives and the monitoring of the quality of services. The service identified risks to the delivery of care and these were effectively managed. Financial pressures were managed so as not to impact on patient care.
- Staff at different levels, in different teams and from different teams worked collaboratively.
- Staff were passionate about their work, and aware of their responsibilities, and the limits of their authority.
- A proactive approach was taken to seek feedback from people who use the service, from patients, and from staff.

**However;**

- The trust had systems in place to support lone workers, but not all staff choose to carry a personal alarm.
- Some staff working in the north of the service, Hampshire area, did not feel as supported or connected to the services in Southampton and Portsmouth.

## Service vision and strategy

- The service had entered into a re-tender process just prior to our inspection in June 2016. Their goal was to focus on the procurement of sexual health services for 2016/ 2017. The strategic aim was care integration, putting the patient at the heart of services. This was supported by the objective to deliver care pathways that were integrated with local authorities, primary care, and other providers, drawing on wider community resources.
- The service had a business plan, with objectives and key performance indicators in place, to support them in being successful with the retender.
- Staff we spoke with were aware of the vision of the service and the organisation. The trust vision was to provide great care, be a great place to work and deliver great value for money. The service had a vision to deliver great care, with work undertaken and new steps introduced, to improve access to tests and clinics for patients. Staff knew the vision of a 'one stop' was the best service and continued to embrace changes to achieve this vision, for example, the expansion of the vasectomy service.
- Staff were aware of the trust values, which the trust named 'heart'. These were honesty, everyone counts, accountable, respectful and teamwork. Patient feedback and feedback from other organisations, demonstrated for example, how the staff worked as a team to achieve the best outcome for patients.
- The service told us they did not have a non-executive director with responsibility for sexual health services.

## Governance, risk management and quality measurement

- The service held monthly clinical governance meetings. The clinical governance lead, who was a senior nurse, chaired the meeting.A matron chaired the meeting. Attendance included medical, nursing, management, pharmacy, information technology and operations manager. The agenda included an audit update, NICE guidance, service evaluations, research update, serious incidents update, patient experience, medicines management and a review of the local risk register and the corporate risk register. Actions were generated at meeting and followed up. At the meeting in October 2015, it was noted that the laptops for staff had not arrived. The head of sexual services escalated to the chief operating officer, and the list of laptops had not been received. At our planned inspection in June 2016, staff we spoke with had received laptops, and were using them in clinics.
- The senior team reviewed risks and actions taken. For example, in January 2016 there were five risks on the local risk register. These were risks with a score of less than 12. The service reduced the risk score to six at the east hub for appointments and access, following changes to the clinics. At the time of our inspection,

there were nine risks on the corporate risk register. A risk was the reduction in public funding. The countywide operational director, who represented sexual health services at board level, had taken this risk to the board. The board had agreed to support the service with £620 thousand. This enabled the service to continue to deliver the current service delivery model, as agreed with commissioners.

- The sexual health service submitted an exception and recommendation report to the trust assurance committee monthly, chaired by a non executive director. The clinical director and the clinical governance lead for sexual health represented the service at this meeting. A governor also attended the assurance committee. The report to the June 2016 meeting included the decision to increase on line testing to 16-18 year olds, and that three additional questions asked to check safeguarding.
- There was a quarterly Band 7 meeting chaired by a matron, to provide a forum for governance and information sharing. The consultants also met quarterly, to support communication and information sharing. The four safeguarding leads also met quarterly, to discuss referrals and learn about updates.

### Leadership of this service

- The clinical director described how the service was clinically led. The clinical director chaired a clinical leadership meeting every two weeks that included, the human immunodeficiency virus (HIV) the genitourinarymedicine (GUM) and the sexual and reproductive health (SRH) medical leads, the head of service, clinical governance lead and two matrons. The meeting held to discuss service issues and innovation.
- Members of the senior executive were visible to the staff working in sexual health services. For example, the chief executive and the chief operating officer had attended two of the six weekly education sessions provided for staff.
- The matrons we met were passionate about the care that was provided for patients, and supportive to the teams. A matron we met during our inspection was involved in the telephone triage of patients. Another was chair of the sexual health services clinical governance committee. A matron had been nominated for the 2016 nursing times of the year award.
- Staff felt service leaders were more visible in the east and west areas, than in the north

### Culture within this service

- Staff took pride in their work and were proud of their achievements over the last two years with improvements in staff knowledge and skills, and no patients turned away from the service without a management plan. A staff member commented on the importance of 'not keeping patients waiting too long'. Staff were also proud of the relationships they had built with colleagues. For example, with the laboratories, which helped ensure results of tests went to patients within national timescales.
- All staff were committed to providing a great service for patients despite the challenges for example with needing to triage patients, as clinic spaces full.
- The teamwork across all areas of the service was good. Staff were dedicated, worked together and helped each other. For example, a band 5 nurse told us about the support given to her by senior clinical staff to enable her to be able to apply for a band 6 position in the sexual health service.
- Staff in the north hub told us they did not feel as well supported as their colleagues in the east and west. There was an awareness of the trust value everyone counts, but staff felt this was not always seen in the north. For example, yoga classes for staff had been set up in the east and west, but not the north. This was a trust arrangement, and not a sexual health service led arrangement.

### Public engagement

- The service acted on feedback from the public. At the north hub, we saw friends and family forms and a post box for completed forms. The service had fitted a water dispenser in the north hub, following patient feedback. A matron told us there was a plan to place patient feedback boxes at the 'spoke' clinics.
- A patient survey was currently taking place in the hubs. Patients were given the opportunity of putting a token into one of three boxes, which indicated their preferences method for receiving results. The options were by text, email or telephone.

Good

# Are services well-led?

- The service was also seeking feedback from patients who attended psychosexual counselling. The service had produced a questionnaire to help them obtain feedback, for analysis, to develop the service.
- The service was in the process of updating their website at the time of our inspection. The service had sought the feedback of people at a conference attended in early June 2016 for lesbian, gay and transgender regarding the newly designed sexual health website. The feedback was that it was clearer, as less cluttered. Professionals, such as GP's, also had a section they could access on the site for up to date information. The service launched the updated web site in early July 2016.

## Staff engagement

- The service actively sought to engage staff. An example, a fortnightly newsletter that staff said was useful for providing updates. Items had included changes such as, in June 2016, a different link for incident reporting, and coding instructions for care delivered. Ensuring staff coded care correctly was essential, to ensure the service was paid for all activity undertaken.
- Patient feedback from friends and family was communicated via the staff newsletter. This highlighted positive feedback and areas for improvement. Positive themes in June 2016 included staff being friendly, caring and helpful. A negative theme included the need to make people more aware of the on line testing. The service new website being launched and now clearer was designed to address this concern.
- The governance lead had developed an action plan, following the staff survey in 2015, with 13 priority areas identified. The biggest concern for staff in 2015 was 65% of staff indicating not enough staff to do my job properly. The service noted they had been training nurses to be able to take on roles required in sexual health, which took six to 12 months.

## Innovation, improvement and sustainability

- The service worked to continuously improve the service, and value for money, to ensure sustainability. For example, the senior team advised us they were considering in the future working with two laboratories rather than four. The leads felt this would enable closer working relationships through working with less staff. In addition, if a fault developed in a laboratory, closer contacts should enable the laboratory to inform the service sooner. The service hoped this would ensure patients results did come back within contractual and national guideline timelines.
- The service was aiming to provide an expanded service for GP referrals. For example, support for female patients with heavy menstrual bleeding; increasing number of surgeons able to perform a vasectomy.
- The clinical director said the service was working with GP's, to provide them with confidence in managing patients sexual health needs and care pathways, where required.
- The service was planning to expand vasectomy service to the west, as well as maintaining services in the east. Currently medical staff in the east provided vasectomy training for medical staff in the west.
- The service was also planning to work with pharmacists regarding HIV testing and contraceptive injectable medication.
- The service was training nurses to fit either an intrauterine device (IUD) or an intrauterine system (IUS). A band 7 nurse currently being to undertake the insertion of these types of long acting reversible contraception. The service was writing a patient group direction (PGD), to support this practice.
- Staff from the service had also presented audits at national conferences and published in international journals. A consultant worked as an examiner with the Faculty of Sexual and Reproductive Healthcare (FSRH). A genitourinary medicine consultant undertook genitourinary medicine patient reviews for the General Medical Council (GMC). These activities showed their beliefs and values in sharing and developing practice in sexual health services.
- A matron told us that some staff from midwifery were only able to provide contraceptive advice, and not advice regarding sexual health. The service was planning to have all staff dual trained, to support the weekly clinic rota. The HIV lead told us how patient safety was not compromised by financial incentives. The sexual health service had not agreed to meet the HIV commissioning, quality and innovation (CQUIN)

Good

# Are services well-led?

identified in 2015/2016, which accepted by the board. The HIV lead felt it would not be effective for patients within this service, due to the reduced monitoring of patients.

- The sexual health service staff needs were changing with the use of the internet, and information on their web home page. The leads informed us the service was likely to lead less administration support in the future. There had been a staff consultation from January to March 2016, and posts frozen. The service wanted to avoid the need for redundancies.
- The service was also working on a demobilisation plan, if the re-tender was unsuccessful.