Leeds Community Healthcare NHS Trust

RY6

Community health (sexual health services)

Quality Report

Stockdale House
Headingley Office Park
8 Victoria Road
Leeds
LS6 1PF
Tel: 0113 220 8500
Website: www.leedscommunityhealthcare.nhs.uk

Date of inspection visit: 31 January 2017 – 2 February 2017
Date of publication: 29/08/2017

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)
RY6X6	Merrion Centre		
B86031	Reginald Centre		
B86003	Armley		
B86667	Beeston		

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

Overall we rated the service as requires improvement because:

- The trust provided information highlighting that at the time of the inspection 16 out of 20 staff (80%) were trained to level 3 safeguarding or level 2 Leeds Safeguarding Children's Board (LSCB) safeguarding training which the trust stated was equivalent to level 3 training against a trust target of 90%. The trust provided further information stating staff had received safeguarding training which was the equivalent to level 3 safeguarding. Not all staff had received child sexual exploitation awareness training with 66% of staff having received training in 2015/ 2016.
- Medicines refrigerators temperature checks were not consistently carried out. However this had improved at the time of inspection.
- Some mandatory training targets did not meet the target set by the trust.
- Clinical supervision was not well embedded across the service, however there were plans to address this.
- The service had capacity and demand issues, managers were aware of this and a project was planned to address these issues however most patient complaints related to long clinic waiting times.
- The service operated a phone line, however due to the high volume of calls and reception staff vacancies, calls were not always answered and messages not returned within the target of one hour.
- The risk register did not contain all risks that were known to the service however managers and the senior leadership team were aware of the issues such as long waiting times.

However

- There were systems in place to record incidents and staff we spoke with were aware of reporting incidents and how to report them. Managers investigated incidents and provided feedback to staff through team briefs. Managers had an understanding of the duty of candour and being open and honest with patients.
- The environment was visibly clean and tidy in the areas visited. Records we looked at were found to be appropriately completed and securely stored on the electronic patient record system.
- Staff were able to describe the relevant national guidance and local procedures. Staff could describe the British Association of Sexual Health and HIV (BASHH) guidelines and the Faculty of Sexual and Reproductive Healthcare guidance (FSRH). Audit programmes were in place and the service carried out local audits alongside the required key performance indicator monitoring.
- The service was in the process of dual training staff to ensure they could provide contraceptive and genito-urinary medicine (GUM) services across all clinics. Staff we spoke with told us they would work within their competencies and seek advice where required. This training was ongoing and there were three dual trained staff during our inspection.
- There was multi-disciplinary team working within the service. The integrated Leeds Sexual Health Service included sexual health registered nurses, medical staff, health advisors, healthcare assistants, outreach nurses, administration team and a research team.
- Staff we spoke with were able to describe when they asked for consent and when they used written consent. Staff were able to describe their understanding of the Fraser guidelines and Gillick competence.
- Patients we spoke with were mostly positive about the service. Staff provided patients with compassionate care and support and understood the needs of patients. Friends and family test data across the service was positive. Chaperones were available at the clinics for patients.

Summary of findings

- The service was an integrated sexual health service, formed in April 2015, and provided a main hub and spoke model of clinics to patients. Services were planned with local commissioners. The integrated service model meant that patients could attend any clinic and be seen for contraceptive and GUM services. The service offered appointment and walk in clinics.
- Outreach services were provided outside of the clinics and in partnership with a number of different third sector organisations. Health advisors were available at the main hub to provide further support and advice to patients where required.
- There had been a low number of complaints to the service.
- The integrated service had a strategy in place and managers were able to describe their vision for the service. Risks were escalated through the partnership meetings between all the partner agencies where required.
- Staff were passionate about their roles and work and the care they provided to patients. The service engaged with the public in a number of ways such as patient questionnaires and had a dedicated sexual health website, which provided advice and access to a live chat with the service.

Summary of findings

Background to the service

Information about the service

Leeds Community Healthcare NHS Trust provided sexual health services as part of an integrated model throughout Leeds. The service provided a range of level 1, level 2 and level 3 integrated care across the main clinic hub at the Merrion Centre and four spoke sites.

The integrated sexual health service formed in 2015.

Leeds Sexual Health services provided care and treatment for a range of sexual health issues across Leeds. The service provided a full range of contraception and level 1, 2 and 3 genitourinary medicine services such as sexually transmitted infection, HIV testing diagnosis and treatment to patients. The service had outreach services, health advisors and also worked in partnership and accommodated a research team from a local NHS Trust at the Merrion Centre site.

The integrated service included Leeds Community Healthcare NHS Trust staff, staff from a local NHS trust and staff from a third sector organisation. Leeds Community Healthcare NHS Trust had overall responsibility for the governance and management of the service. Leeds Community Healthcare NHS Trust provided us with data and information and we visited four out of five registered locations

The service had an in-house laboratory at the main hub which was used to diagnose some conditions, for example gonorrhoea.

The service offered a mixture of appointment based clinics and walk in clinics at all sites. Clinics were a mixture of consultant led clinics and doctor led clinics.

The Beeston Sexual Health clinic was moving to another location in the months following the inspection.

Leeds Community Healthcare NHS Trust sexual health services offered outreach to different communities in the local area. The service worked with a number of third sector organisations through the outreach service.

We visited the Merrion Centre, Beeston Hill Health Centre, Armley Health Centre and the Reginald Health Centre. The services had seen an increase in demand for appointments and walk in clinics.

We spoke with 31 staff, nine patients and carers and we looked at nine patient records.

Our inspection team

Our inspection team was led by:

Chair: Carole Pantelli

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a specialist advisor.

Why we carried out this inspection

We inspected this core service as part of our follow up community health services inspection programme. This service had not been previously inspected and was inspected as part of the follow up inspection.

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, 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 31 January, 1 February and 2 February 2017. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 15 February 2017.

What people who use the provider say

People who used the service were positive about the care and treatment they received. They said staff were caring, friendly and approachable.

All the patients we spoke with were complimentary about the staff and in the way they were treated. They told us staff spoke to them in confidence and treated them with dignity and respect.

All the patients told us they were fully informed about their treatment and were provided with choices about their care and ongoing health needs where appropriate.

Good practice

- The service had introduced a number of outreach services to assist the service in reaching difficult to reach groups and provide a service closer to people. The outreach services worked closely with third sector organisations.
- The service had a dedicated website which received around 50,000 views a month and provided information on the services offered with contact details and a feedback form to gather the views of patients. This also offered live chat so people could directly ask the service a question.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Must:

- Ensure the service meets the training target for staff having the required level of safeguarding training.

Should:

- Ensure key performance indicators for the service are met.
- Continue to improve the rate of clinical supervision and support for staff groups across the service
- Ensure mandatory training compliance and that all staff have received CSE awareness training.
- Consider communicating waiting times in clinics.
- Ensure processes are in place to consistently monitor refrigeration temperatures.
- Ensure risks are recorded on the risk register.

Summary of findings

- Review and establish clear systems and processes for documenting checks for the emergency oxygen checklist.

Leeds Community Healthcare NHS Trust

Community health (sexual health services)

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Refrigerator temperatures had not been checked and documented fully in the last six months. This had improved in January 2017 where the refrigerator temperature log had been completed daily.
- Mandatory training compliance was 81% against the trust target of 90% for some training areas. Only 66% of staff had completed CSE awareness training in 2015/2016. At the time of the inspection 16 out of 20 staff (80%) were trained to level 3 safeguarding or Leeds Safeguarding Children's Board (LSCB) level 2 safeguarding training against a trust target of 90%.
- Triage when the service reached capacity was inconsistent, however managers were looking at ways to improve this.

However,

- There was an incident reporting system in place and staff knew how to use it. Feedback had recently been embedded into the team brief.
- All areas visited were visibly clean and tidy.
- Staffing levels were generally as planned across the services, however there had been some areas where staffing had been an issue. Vacancies were being recruited to and some teams were awaiting recruitment processes to complete.

Detailed findings

Safety performance

- Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). Sexual Health services reported no serious incidents between 1 December 2015 and 30 November 2016.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There had been no never events reported in the last 12 months at the sexual health service.

Requires improvement

Are services safe?

Incident reporting, learning and improvement

- Within the integrated Leeds Sexual Health Service, ten incident sub categories made up 74% of the incidents reported within the core service from 1 July 2016 to 31 December 2016. The service reported 29 incidents between 1 July 2016 to 31 December 2016. The trust provided information stating 24,494 patients attended between 1 July 2016 and 31 December 2016.
- Diagnosis was the most common incident sub type accounting for nine of the 29 (31%) incidents reported within the period for the core service. Diagnosis is a category of incident in the electronic incident reporting system.
- Assessment and laboratory investigation were the next most common with three incidents each.
- We looked at five incidents on the reporting system and found these had been completed fully with a description and action taken. A lessons learnt section was completed where appropriate.
- Staff we spoke with were aware of how to report an incident on the electronic reporting system. Staff and managers told us learning from incidents was shared with the team at the two weekly team briefs.
- Managers told us a root cause analysis (RCA) would only be completed if a serious incident had occurred, however there had been no serious incidents in the service.

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) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person.
- Staff had an understanding of the duty of candour. Managers we spoke with were aware of the duty of candour regulations and being open and honest with patients.
- There had been no incidents requiring duty of candour reported in the last 12 months.

Safeguarding

- Staff were not always aware of the level of safeguarding they had achieved or were required to complete. Some staff told us they had completed level 2 safeguarding and the safeguarding supervisors had achieved level 3 safeguarding. The trust provided further information regarding safeguarding training, which showed 16 out of 20 (80%) clinical staff in the service had completed Leeds Safeguarding Children's Board (LSCB) level 2 training, which the trust stated was the equivalent to level 3 of the intercollegiate document. Information provided by the trust showed that three of these staff had received level 3 training.
- Safeguarding children mandatory training compliance was 85% and safeguarding adult's mandatory training compliance was 85%. The trust target was 90%. The service did not provide the level of safeguarding training in the training compliance figures.
- The intercollegiate document for safeguarding children and young people: roles and competences for health care staff (2014) states that "All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns" should have level 3 safeguarding training.
- Staff we spoke with told us they were aware of how to report safeguarding concerns and what signs they look for when considering safeguarding concerns. Staff told us they would seek advice from the safeguarding leads in the service or health advisors if required.
- The service had a doctor who had taken the lead on safeguarding and three safeguarding lead nurses who lead the group discussions at the quarterly safeguarding supervision.
- The service held a multidisciplinary team (MDT) meeting each Monday to review safeguarding concerns for under 16 year old's attending the service. Staff told us each Friday the service gathered data on the attendances for the week and would discuss cases at the MDT meeting. This meeting was attended by the safeguarding lead doctor, safeguarding supervisor nurses and other members of staff where relevant.
- The trust reported 16 safeguarding referrals to the Local Authority in the last 12 months between 1 December 2015 and 30 November 2016 (3% of provider total). Three referrals were made in relation to adults, which accounted for 3% of the provider total. Thirteen referrals were made in relation to children, which again accounted for 3% of total referrals made by Leeds Community Healthcare NHS Trust.

Requires improvement

Are services safe?

- A female genital mutilation (FGM) clinic referral form was used at the service. This was used to refer patients to a local third sector organisation. Staff told us they had recently attended an education session on FGM.
- A Leeds Sexual Health safeguarding review pathway had been developed and described who to contact if staff had a safeguarding concern, the designated safeguarding supervisors and the safeguarding telephone contact numbers for Leeds Community Healthcare NHS Trust.
- The service had contact guidance sheets on display in clinics rooms which highlighted who to contact if people were at immediate risk and included safeguarding contact numbers for the trust safeguarding team and the local authority.
- Staff told us they had quarterly safeguarding supervision which was delivered in groups and led by the safeguarding leads in the service. Information provided by the service highlighted that there was 67% compliance of staff working for Leeds Community Healthcare NHS Trust for safeguarding supervision. Figures for both Leeds Community Healthcare NHS Trust and the other local trust showed 56% compliance for safeguarding supervision. The information showed that 39 out of 69 staff employed by both organisations attended the last safeguarding supervision session.
- The electronic patient record used by the service had two risk assessment templates available to staff, one for the first appointment and one for follow up appointments. The risk assessment asked a number of questions which staff used to risk assess people attending clinic, for example the trust provided information highlighting that CSE was included in the risk assessment. Staff told us this risk assessment was used to identify any risk to under 16 year olds and where there was concern, for 17 and 18 year old patients.
- The trust provided a team brief document for January 2017 to December 2017 highlighting team brief dates for the year and this highlighted the service had a planned team brief for child sexual exploitation (CSE) awareness training in April 2017. Information provided by the trust stated that staff had attended a CSE awareness training session in January 2016. The trust provided a KPI report for 2015/2016 and this showed that only 66% of staff had received CSE awareness training.
- The service had a safeguarding children policy which had been written by Leeds Community Healthcare NHS trust and approved in November 2016. Staff had access to the policy on the computers.

Medicines

- Medicines were mostly managed safely and securely, however during our inspection we found that in the previous six months the medicines refrigerator daily check log had not always been completed daily. This had improved in January 2017 where the refrigerator temperature log had been completed daily.
- We found two medicines to be out of date by one day and when notified staff of this, these were removed immediately. Other medicines we checked were found to be in date.
- The service had a small amount of FP10 prescriptions (written prescriptions) which were stored securely in a locked cupboard.
- We checked an emergency bag that included an oxygen cylinder. This had a daily check sheet and this had not been completed fully each day as the checklist highlighted during the last three months. The oxygen cylinder did not have an expiry date attached, however when staff were notified of this, they took action immediately. The trust provided further information stating the checklist was incorrect during the inspection and should have been a weekly check, not a daily check. Further checklist records provided by the trust for oxygen checks showed weekly and daily checks had been documented between November 2016 and February 2017.
- A patient group direction (PGD) allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.
- PGD's we checked were found to be signed by staff using them. A master file was kept at the Merrion Centre and copies were kept at spoke sites.
- There had been concerns raised regarding the temperature of medicines in a locked storage cupboard at the Beeston clinic. This had been reported through the incident reporting system and the medicines management team had been notified. The medicines management team had placed a temperature monitor in the cupboard and were looking at this data monthly.

This temperature monitor was in place during the inspection. As part of the estates review, the service at the Beeston clinic is scheduled to move to a new location.

- All medicines cupboards were found to be locked and keys were locked in a locked cupboard when not in use.
- We requested information from the trust regarding the signing in and out of medicines. The trust provided the sexual health service handling and use of medicines procedure. This was approved in January 2016 and had a review date of three years. Managers told us this was the procedure used for signing in and out of medicines.

Environment and equipment

- The environment was generally suitable in all clinics visited. Seating was available and at the Merrion Centre clinic, the service had changed the layout of the waiting area and increased seating capacity. The entrance areas at the clinic had electronic check in for appointments only and a condom card machine; however, during our inspection this was not in use and working. Staff had reported it.
- Signs asking patients to wait behind a sign to ensure the privacy of patients speaking at the reception were in use at the clinics.
- The main hub clinic had a television in the waiting area which was used to display sexual health educational information to people waiting, for example information on syphilis and FGM.
- The main hub clinic waiting room had covering over the windows to ensure privacy and dignity of patients was maintained during their wait.
- Clinic rooms were suitable in size. There were 12 clinic rooms and 2 additional (non-clinical) consulting rooms at the main hub site.
- Equipment such as IT equipment was managed by another local NHS trust. There were no concerns regarding IT raised during our inspection, however due to the different NHS trust's being involved in the partnership, if an IT issue was to be reported, staff would sometimes have to do this to two different providers.
- There were partitions at the reception desk at the Merrion Centre, and at the Reginald Centre the reception was in a clinic room. These changes were in response to patient feedback about the lack of confidentiality at reception. However, at Armley the reception desk was open, and during our visit we could overhear the conversations with the receptionist whilst in the waiting room, which compromised confidentiality.

Quality of records

- All records were electronic and held on a system which was password protected.
- The trust stated that there were no instances in the last six months (1 June – 30 November 2016) whereby patients were seen without their notes being available to the clinician across all five sites.
- We looked at six records during our inspection and found the electronic patient record templates to be completed. Risk assessment templates we looked at on the system were completed. We looked at a further three records during our unannounced inspection and found the templates to be completed. The record template included fields which were mandatory and staff were required to complete these sections before proceeding.

Cleanliness, infection control and hygiene

- All areas visited were visibly clean and tidy. We saw staff adhere to 'arms bare below the elbow' policy in clinical areas. Hand gel was available in clinics and gloves were available in clinic rooms.
- The service had undertaken a safe clean care audit and produced an action plan. This audit related to the service at the Merrion Centre and showed that 80% compliance was achieved and classified as partially compliant as the service had to achieve over 85% to be compliant. In the audit, each action required area was completed along with the lead person to complete and the timescale.
- A hand hygiene essential steps record showed that most staff had completed the training.
- The main hub clinic had adapted storage cupboards so that items could not be stored on top of the cupboards in order to ensure infection control.

Mandatory training

- As the service had integrated in 2015, staff training records continued to be held on separate systems between the providers. Managers told us they had access to the required data for their staff. The provider

had mandatory training requirements for all staff. We reviewed staff training records and found that the following mandatory training compliance was 81% as at 30 November 2016, against the trust target of 90%.

- There were four courses below 75%, including Fire Safety (70%), Infection Control (67%), Moving and Handling (63%) and also CPR (65%). The number of staff eligible for training courses ranged from 20 to 27 individuals.
- When comparing compliance for Sexual Health services with overall provider level, compliance of this core service was lower in six out of the 11 areas, with the exception of Equality and Diversity, Information Governance, Conflict Resolution and Mental Capacity Act. Staff had had difficulty accessing some elements of training at the time of the inspection.

Assessing and responding to patient risk

- Managers told us they could access a defibrillator from local offices if required, however they told us they were considering getting a defibrillator for the sexual health clinic at the Merrion Centre main hub.
- The main hub had two emergency packs available, for cervical shock for example. These were sealed and in date when checked.
- The service was busy and could reach capacity at certain times. Where this occurred staff would triage patients to ensure risk was taken into account when people attended the walk in service, however this was inconsistent and did not always happen. Managers told us they were looking at ways to address this and had recently introduced a checklist to the back of the registration form which was going to be used to assist in triaging patients. The trust provided further information stating they now have the nurse in charge to do a verbal triage which is recorded on the rear of the triage form.
- The service had an in-house laboratory for testing some conditions such as gonorrhoea. This meant that patients could be tested and provided with an outcome and treatment, if required, during the same appointment.
- Human immunodeficiency virus (HIV) point of care testing was also available at the service. This meant that patients could be tested, given a result, offered advice and referred on where required.
- The health advisor team within the service undertook public health work including partner notification and the monitoring and management of outbreaks, for example syphilis. There was a document detailing the three options offered regarding partner notification.

Staffing levels and caseload

- Information provided by the trust included the average over establishment for the LCHT element of the service, over a 6 six month period was 1.879 whole time equivalent. At October 2016 there was an under establishment of 0.3wte.There were 4.6 whole time equivalent vacancies, which was 34% of the nursing assistants.
- The data provided shows funded and contracted hour and did not include any additional hours worked by substantive staff or through the bank.
- The provider also had a staff turnover rate of 1.3% in October 2016
- Information from the provider showed that the average sickness rate for this core service in October was 5.9% which is 0.1% lower than the trust average for October 2016 of 6.0%. The trust was unable to provide data on its use of bank and agency staff to cover required shifts given that the trust does not have any standardised shifts across services.
- Managers and staff told us the service sometimes felt there was not sufficient staffing numbers due to the demand on the service; however the data showed the service were mostly at the planned levels for staffing. Reception staffing was not always sufficient due to vacancies and sickness. Teams such as reception and health advisor teams were under pressure due to vacancies and awaiting recruitment processes to complete. Information provided by the service highlighted that maintaining staffing levels had been a challenge.
- The service was recruiting to vacancies and had recently recruited healthcare assistants, band 6 nursing posts, a health advisor post and three reception staff.Locum doctors were in use and agency reception staff were used to alleviate the pressure of low staffing levels. There were two locum doctors across the service.

Requires improvement

Are services safe?

- Managers told us all clinics held always had a registered nurse on duty and in most circumstances a doctor was part of the clinic. There was no fixed amount of staff per shift across the clinics, managers organised rotas based on staff availability and the clinics being offered.
- When clinics were on, the service assigned a lead nurse to be on duty during these clinics.

Managing anticipated risks

- A control of substances hazardous to health (COSHH) folder was kept in the laboratory and stored safety data sheets and COSHH assessments the service had carried out.
- There was a business continuity plan which covered staffing shortages and escalation plans, IT failure, adverse weather. In case of IT failure there was a 'clinic in a box' process.

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 rate effective as good because:

- Staff were aware of the local and national guidance available for use in the care and treatment of patients. Staff could describe guidelines relevant to sexual health services.
- Staff we spoke with could describe their competencies and the service moving to a dual trained model of care. Not all staff were dual trained, however dual training was being rolled out.
- There was clear multidisciplinary team working across the service, registered nurses, medical staff and health advisors worked together across the service, for example at the weekly safeguarding multi-disciplinary team meeting.
- The service could refer to different services where required such as psychosexual therapy and a number of third sector organisations.
- Staff we spoke with were able to describe when they get consent from patients. Staff were aware of Gillick competence and Fraser guidelines.

However,

- Clinical supervision was not well implemented in the service and had not happened on a regular basis for all staff groups. The service had plans to address this in the future.

Detailed findings

Evidence based care and treatment

- Staff we spoke with could describe the national and local guidance they worked with to provide care and treatment. Staff could describe the BASHH guidelines and had access to them. Staff could also describe other guidance and guidelines such as the Faculty of Sexual and Reproductive Healthcare guidance (FSRH).
- The sexual health service had an audit programme in place for 2016/2017 which set out the proposed audits the service will undertake and set out the audit lead and the start and end date of the audits.
- The service had carried out an audit to show how many individuals accessing the sexual health clinics had a consultation with adequate risk assessments and assessment of contraception needs. The service randomly selected 42 electronic patient records. The audit showed that 100% of patients had either an STI or contraception assessment or management completed. This audit was carried out in April 2016.
- A standard operating procedure for positive results was in place at the service.

Technology and Tele-medicine

- The sexual health service had a website which was used to promote their services, provide advice and contact details and provided live chat at certain times of the day. The website also provided a service finder section.
- Patients received results via text message. Text message appointment reminders were in place to assist in reducing 'did not attend' rates in the services.

Patient outcomes

- The service submitted data to GUMCADv2 and SRHAD as required. GUMCADv2 is the genito-urinary medicine clinic activity dataset. SRHAD is the Sexual and Reproductive Health Activity Dataset.
- During quarter one and quarter two in 2016/2017, the service had a requirement and performance target for the percentage of routine results from the laboratory received within seven working days. The target for this performance indicator was 100%. The service did not achieve this and were slightly below this indicator at 98.9% in quarter one of 2016/2017.
- The integrated sexual health service had a key performance indicator for the percentage diagnosed with chlamydia for all ages. The target for this indicator was 9% to 11%. The trust were at 9.8% in quarter one and were at 8.1% in quarter two 2016/2017.
- The integrated sexual health service had a key performance indicator to promote the benefits of long-acting reversible contraception (LARC). The target was 16% and the service achieved this target in quarter one with 41% and quarter two with 41%.

Good

Are services effective?

Competent staff

- Not all staff received regular clinical supervision. Information provided by the trust showed that compliance was 64% against a trust target of 65%. No date range was provided for this data and it must be noted that staff numbers were small, with those areas at 0% clinical supervision containing only one member of staff. Supervision rates for Nursing and Midwifery Registered within clinical supervision were highest at 78%, however Medical and Dental was lower at 50%.
- The service was in the process of dual training staff to ensure the care and treatment offered integrated contraceptive services and sexual health services. At the time of our inspection there were three dual trained staff members. Dual training was being rolled out so that registered nurses who were dual trained could see patients for contraceptive and GUM services. Staff told us that when they were not dual trained, they would see patients within their competence levels and if required would seek advice and guidance from another member of the team if it was out of their competence.
- Staff working in the laboratory were required to complete a microscopy training pack. Staff told us they had completed these and had to be witnessed by a qualified member of staff before being signed off.
- Healthcare assistants in the service were required to complete a phlebotomy training course and care certificate training pack before being able to be signed off as competent During our inspection, managers told us they were in the process of developing competency assessments and the competency framework was described as informal and managers were working to make this more formal. A clinical induction pack for registered nurses was under development.
- Some members of the reception team had received customer service training to assist in dealing with visitors and patients to the clinics. There were other staff waiting to attend this training, however it had been difficult to attend due to lack of resources within the team. Staff had received in house training at team brief, for example on positive language.
- The service had a local induction checklist for new starters which included general information about the department, policies and procedures and health and safety. Newly qualified staff were assigned a mentor. Staff told us a clinical induction pack for nurses was under development.
- Training passports were in the process of being developed along with a clinic competency assessment; these were not in place during our inspection. The competency framework used by the service was informal and managers told us they were working on making this a formal competency framework.
- Appraisals were in place for staff at the service. Nurse leads and managers at the service carried these out annually.
- Not all permanent non-medical staff received regular appraisal, although it should be noted that staff numbers are very small. Information provided by the provider showed that the overall appraisal rate for Sexual Health services (non-medical) was 71% of which two of seven staff had not had an appraisal in the 12 months. This is lower than the provider target of 92%. The trust provided information highlighting 100% of nursing and medical staff had received regular appraisals within the past 12 months. Overall appraisal rates were 89%.
- The trust reported that 100% of their 18 medical staff had been revalidated.

Multi-disciplinary working and coordinated care pathways

- The service was integrated so patients could access contraception and genito-urinary medicine care and treatment at any of the clinics. The service had doctors, registered nurses, health advisors and outreach workers based in the main hub.
- The service was integrated with another local acute NHS trust and worked closely with third sector organisations to provide additional care and treatment where required. Staff from both the community NHS trust and the local acute NHS trust worked together at the main hub and the spoke sites.
- The service held a weekly safeguarding MDT meeting to discuss all patients under 16 who attended the clinic. This was attended by different staff at the service including the safeguarding lead doctor and safeguarding lead nurses.
- Managers had recently started to work closely with the trust improvement team to look at addressing issues around capacity and demand in the service.

Referral, transfer, discharge and transition

- Any person could refer themselves to the sexual health clinics or attend the walk in clinics available. The service

was able to offer appointments to patients who preferred not to use the walk in service. There were specific clinics for different groups of people available, for example, a young person's clinic was available daily between 15:30 and 17:30. Patients could contact the clinic and book an appointment through the website, or by telephoning

- An 'express clinic' had been introduced at the main hub to provide a more efficient and quicker service to patients who wanted to be tested for gonorrhoea and chlamydia. This service had specific opening times between Monday and Thursday each week. This meant that patients did not need to wait for a walk in appointment or a pre booked appointment to be tested. The clinics website provided further information on the express clinics for patients to access.
- The service could refer to a number of different services, for example, they could refer patients for psychosexual counselling, termination of pregnancy clinics (TOP) and third sector organisations, which provided advice and guidance to people.

Access to information

- Staff had access to the systems required in the services, for example the incident reporting system and the trust intranet. The IT systems were managed by separate trusts at the different clinics, however staff could access systems if required.
- The service had a patient record system which could be accessed in all clinics and was used to access patients records and included a risk assessment tool which could be used in clinic when needed.
- Staff we spoke with could access guidance and procedures through the systems available.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff could describe when and how they get consent and how they document consent. Staff could also describe what mental capacity was. The service sent out text messages to patients with the results of their tests, staff told us consent to send this text message was sought before sending it to the patient.
- Staff told us they asked for written consent for all invasive procedures.
- Staff we spoke with could describe Gillick competence and Fraser guidance and demonstrated knowledge and understanding of this guidance. The risk assessment used on under 16 year old patients included questions around Gillick competence and Fraser Guidelines. 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 to decide whether they can receive contraceptive advice or treatment without parental knowledge or consent.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff provided people who used the service with compassionate care and support. We observed staff speaking with patients in a respectful way. Staff understood the needs of patients and were flexible in meeting patient needs.
- Chaperones were available in clinics to provide support to people using the services.
- People using the service were complimentary about staff and the way they were treated. Patients told us staff were friendly and approachable.
- Friends and family test data was positive for the service.
- A dedicated youth worker was available for counselling and support services. The clinic at the main hub had a separate room for counselling services.

Detailed findings

Compassionate care

- Patients checked in to the reception desk and were provided with a paper form to complete. This meant patients could provide information in a confidential manner. We observed receptionists talking with patients in a respectful way.
- Health care assistants provided chaperone duties to support patients.
- Staff we spoke with were passionate about their work and spoke sensitively about the needs of patients. They would be flexible to meet patient needs. We observed a patient become angry about the long waiting time in the clinic; staff responded compassionately and arranged for the patient to return later in the day for an appointed time.
- The integrated service had a key performance indicator for the percentage of service user feedback on surveys that rates satisfaction as good or excellent. The target was 90% and the service achieved this target in quarter one and 89.7% in quarter two.
- Friends and family test data showed that 90.7% of respondents would recommend the service between April 2016 and December 2016.
- The service had a young people service report from March 2016. This showed that 89% of respondents were very satisfied and 11% were satisfied.

Understanding and involvement of patients and those close to them

- We spoke with nine patients about their care and treatment. We did not observe care due to the sensitive nature of the service being provided.
- All the patients we spoke with were complimentary about the staff and in the way they were treated. They told us staff spoke to them in confidence and treated them with dignity and respect.
- All the patients told us they were fully informed about their treatment and were provided with choices about their care and ongoing health needs where appropriate.
- The service carried out local surveys at the clinics to measure patient satisfaction, and there was evidence that responses were acted on, for example a change to clinic times.
- People who used the service told us staff were friendly and approachable.

Emotional support

- There were no set appointment times for patients meaning staff could spend the required time with patients whilst in clinic.
- The service had a dedicated youth worker available to provide support and counselling. There was a separate room available in clinic for counselling services.

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

We rated responsive as requires improvement because:

- Current waiting times were not displayed in the clinics however, reception staff advised patients at the time of booking and patients said that staff did apologise if there were long waits. Complaints received by the service generally related to access and waiting times in the service. However KPI data showed that the service was meeting their own targets for waiting times for booked appointments and walk in appointments.
- The service operated a phone line, however due to the high volume of calls and reception staff vacancies, calls were not always answered promptly and messages not returned within the target of one hour.
- Managers told us 'did not attend' rates had been high in the service, however they had introduced text reminders for appointments to try and reduce the 'did not attend' rate.
- The service did not monitor the number of patients who left before being seen by a clinician.
- Some performance indicators and targets set by the service were met in some quarters of the year, however not all performance indicators were met in different quarters of the year. For example, the percentage of results received by service users within 10 working days during quarter three 2015/2016, was at 74% and during quarter four 2015/2016, the service was at 87.5% against a target of 90%.

However,

- Services were delivered and planned to meet the contracted outcomes from the local authority commissioners. The service was an integrated service which meant that clinics could deliver contraceptive care and genito-urinary care in all clinics.
- The service was a hub and spoke model which delivered a mixture of appointment and walk in clinics across the main hub and four spoke sites. The main hub clinics were open six days a week.
- The service provided us with a sexual health services capacity and demand project document. The document highlighted that the project aim was to address the current capacity and demand issues across the service.This detailed a proposed timeframe for the project of December 2017. A service review meeting from September 2016 between commissioners and the integrated service showed that performance and key performance indicators were part of the agenda.
- The service had a website which provided advice and access to a live chat facility managed by a healthcare assistant. The live chat was available at certain times of the day.
- The service had access to interpreter services.
- Outreach services were provided by a dedicated outreach team within the sexual health service.

Detailed findings

Planning and delivering services which meet people's needs

- Services were delivered and planned to meet the contracted outcomes from the local authority commissioners. The service was required to deliver 60,000 episodes of care to patients and deliver the care within indicated targets. A key performance indicator report supplied by the trust for 2015/2016 showed there were 59,321 episodes of care between July 2015 and June 2016.
- A service review meeting from September 2016 between commissioners and the integrated service showed that performance and key performance indicators were part of the agenda. A quarterly performance meeting from November 2016 also showed key performance indicators were part of the agenda for the meeting.
- The service was integrated. This meant that staff could deliver contraceptive care and genito-urinary care in one place and in one appointment, to greater meet the needs of patients.
- The service was run on a hub and spoke model. The hub was the base for all the staff and the spokes were smaller clinics run from multi-agency, multi-use buildings, from which medical and nursing staff delivered drop in and appointment clinics.
- The hub clinics ran services six days per week, some stretching into the evening, to enable workers to access care. The four spoke clinics were in different areas of Leeds to facilitate access to vulnerable people.

Requires improvement

Are services responsive to people's needs?

- During the inspection we saw very full waiting rooms, and people waiting in excess of three hours for care, which suggested that the need for the service was greater than what was being provided.
- The service had a website. The website allowed people to access the online testing service, advice and education. The website also supported a live chat facility which was manned by a health care assistant. However, this service was not being monitored as to the type of advice provided or if the needs of vulnerable people were being met. There was no documentation to reflect the delivery of the live chat.
- There were a limited number of patient information leaflets available as the services had no leaflet stands to display leaflets for patients. The trust provided further information that stated in response to patient feedback, patient education leaflets could be sent out by SMS (text) messaging after individual patient appointments and appropriate to patient needs.

Equality and diversity

- The service had access to an interpreting service. There were details on interpreter services and contact details in clinic rooms.
- Training for equality and diversity was mandatory. As of 30th November, 2016, 100% of staff had completed the training.

Meeting the needs of people in vulnerable circumstances

- The service had an outreach team who supported the needs of different groups of service users, for example the LGBT communities and young persons.
- The service held daily clinics for people under the age of 19 years. The youth workers also attended schools and colleges to provide health education and advice and to signpost young people into the service.
- All young people under the age of 16 years, who accessed the service were flagged and were discussed in a multi- disciplinary meeting. There was a policy to follow-up young people who did not attend an appointment, or left a clinic without receiving care.
- The service operated a 'red umbrella' card system. Red umbrella cards were given to sex workers by the outreach team. If a patient attended a clinic and gave the receptionist the red umbrella card the receptionist would not take any personal details, but would fast track the patient straight to a clinician.
- Staff referred patients requiring termination of pregnancy (TOP) to local TOP services.
- The service had bariatric equipment available in some clinics and would signpost patients to those clinics.
- The main hub had a separate room in the clinic which was used for counselling or vulnerable people attending the service. Staff we spoke with told us they would fast track vulnerable people attending the service.

Access to the right care at the right time

- Data provided demonstrated the service had a local target to see 80% of patients within 48 hours and were meeting this at 81%. The service saw 82% of patients within 48 hours in quarter one of 2016/2017 and saw 80% of patients in quarter 2 of 2016/2017 within two working days of contacting the service.
- The target for receiving routine results within seven days was 100%. At the time of inspection the data showed this was 98.9%. There had been issues with a backlog of results due to the IT system failure at the organisation providing test results to the service. We were told this backlog had been resolved. This performance indicator relates to the service receiving routine results from the laboratory.
- There was a key performance indicator for the percentage of results received by service user within 10 working days. During quarter three 2015/2016, the service was at 74% and during quarter four 2015/2016, the service was at 87.5% against a target of 90%.
- The key performance indicator for the percentage of results received within 10 working days for Chlamydia was 96% in January 2017 against a target of 95%. This was 74% in January 2016 against a target of 95%.
- Audit data was provided for the period June 2016 to November 2016. The data showed that 100% of patient records were available and accessible at all the clinic locations.
- The service offered a mixture of walk in and booked appointments. Patients self-referred, were referred by their doctor, other health professional, or outreach worker. The organisations 2016 KPI summary report showed that the target for patients attending the walk in clinic was to be seen within 60 minutes and 79% had been seen within this time against a target of 75%. The 2016 summary report showed that patients attending a booked appointment were to be seen within 30 minutes of their appointment time. The target was 85% and the

trust achieved this at 89%. The 2016/2017 KPI report showed the service achieved 88% in quarter one and 89% in quarter two of 2016/2017 to be seen within 30 minutes for a booked appointment.

- There was a triage system by which the paper forms were assessed to streamline the flow of asymptomatic and symptomatic patients. Asymptomatic patients would be advised to use the express self-care system. This was a self-service to provide urine samples, without the input of a clinician, and therefore did not require patients to wait.
- Current waiting times were not displayed in the clinics however, reception staff advised patients at the time of booking. Patients we spoke with told us they would have liked frequent updates from staff about the waiting times.
- All the clinics we visited were experiencing long waiting times. One patient we spoke with had waited in excess of two and a half hours to see a clinician. The service did not monitor the number of patients who left before being seen by a clinician.
- The service operated a phone line, however due to the high volume of calls and reception staff vacancies, calls were not always answered promptly and messages not returned within the target of one hour.
- Managers told us did not attend (DNA) rates were high across the service. Managers we spoke with acknowledged there had been high DNA rates and told us they had introduced a text message reminder to attempt to reduce high DNA rates. The sexual health service had a 'did not attend' (DNA) policy in place.
- The service provided us with a sexual health services capacity and demand project document. The document highlighted that the project aim was to address the current capacity and demand issues across the service.This detailed a proposed timeframe for the project of December 2017.
- Where the service was short staffed, managers would take the decision to cancel clinics. However where this happened staff would text patients and ask them to contact the service and staff would offer the appointment at one of the other spoke sites or the hub clinic. This had happened twice in January 2017.
- There was a key performance indicator target of 95% for appointments for Interuterine/ implantable contraception available within five working days, however did not meet this target in quarter one and quarter two of 2016/2017. In quarter one, the service were at 89% and this had reduced to 79% in quarter two.
- The service had a target of providing four pop-up clinics each year. The KPI's showed that in quarter one there had been two pop-up clinics and in quarter two there had been two pop-up clinics.
- The service had a key performance indicator for the percentage of women accessing urgent contraceptive advice and services within 24 hours. The target for this was 90% and the trust achieved 100% for quarter one and quarter two in 2016/2017.
- The clinics were all in areas with good transport links, patients told us the service was accessible.

Learning from complaints and concerns

- In the 12 month period from December 2015 to November 2016 compliments received for Sexual Health Services outweighed complaints (14 and nine respectively). Sexual Health Services at the Merrion Centre received all nine complaints during this period of which the most common theme (five complaints) was in relation to appointments, whether this be waiting times for appointments, booking errors or accessing services.
- Complaints made to the service were investigated by the service managers. Managers could describe learning from complaints and lessons learnt were documented in the electronic incident report. Feedback regarding lessons learnt from complaints was provided to staff at team brief.
- Patients raising concerns about the waiting times were the most frequent concern. We observed a patient voicing their concern about the waiting time to staff during the inspection. The patient was not provided with details of how to make a formal complaint. However, we saw posters about how to make a complaint in two of the clinics we visited.
- The service achieved their target of 100% for patients receiving an acknowledgment of their complaint within three working days in quarter two.

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 well led as good because:

- The service had a strategy in place and managers we spoke with could describe their vision for the service and plans going forward to improve services.
- Managers attended meetings where performance and challenges to the service were discussed, for example at service management meetings and partnership meetings.
- The service had around 40 key performance indicators to monitor performance. Performance and KPI's were discussed at meetings where partner representatives from the integrated services were in attendance and managers meetings.
- Managers could describe the risks to the service and the action being taken to mitigate those risks.
- The service had carried out a number of patient questionnaires to seek patient views.
- Staff were passionate about the work they did and the care they provided to patients.
- The service had engaged in a number of innovative and improvement pieces of work such as outreach services to the local communities. An active research team involved in sexual health research had led to changes in practice.

However,

- Risks identified during the inspection were not recorded on the risk register. However managers were aware of the risks to the service such as capacity and demand and the service was undertaking a project to improve waiting times.
- Although managers said that no staff carried out lone working, for example the outreach team worked closely with third sector organisations, there were no risk assessments in place for this group of staff.

Detailed findings

Leadership of this service

- The service was managed by a service lead who had responsibility for all staff across the integrated service in terms of staff rota's and day to day management of the service. The service had two clinical nurse leads and two medical leads across all services.
- Most staff were positive about the leadership of the service at local level.
- Staff told us they received regular communication from the trust through emails and newsletters.

Service vision and strategy

- The service had developed their own vision for the service and this was on display in the clinics. Staff could not always describe the vision for the service. Managers told us their vision of providing a fully integrated service to the population of Leeds and having a fully dual trained nursing workforce.
- The service had a strategy plan for 2014 to 2017.
- Managers could describe where they wanted to take the service and develop the service for the needs of the local population.

Governance, risk management and quality measurement

- The service collected information and data to measure performance and had key performance indicators. This allowed the service to manage their performance and review data for each quarter of the year.
- The service had regular meetings with commissioners and the partners of the integrated service to discuss performance and challenges of the services and plans going forward.
- Managers could describe the risks to the service and the action being taken to mitigate those risks.
- A risk register was in place, however this did not record all the risks we found during our inspection such as capacity and access issues however managers told us of the risks to the service which included waiting times and dual training of staff.
- Managers told us that risks were generally highlighted to them through the incident reporting system and this would then be taken to the clinical advisory group meetings and partnership meetings and if required

Good

Are services well-led?

senior staff would then report this to a senior trust level meeting. Managers told us they raised concerns and risks at the monthly clinical forum meetings. Managers also had regular meetings with commissioners.
- A memorandum of understanding was in place between all three providers of the integrated services. This was due for review in June 2017.

Culture within this service

- Staff we spoke with were passionate about providing good care and treatment to patients and providing support where required. There was clear understanding of the service and the service staff were providing to patients. Staff were proud of the care they provided to patients.
- Staff told us morale was generally good, however the integration and changes in the services had led to varied morale over the previous year. Managers told us they were aware of increasing morale amongst staff and were improving communication to staff, supporting staff with training needs and told us they had an open door policy.
- Managers told us that no staff at the service carried out lone working. Staff such as outreach teams worked outside of the clinic's bases and outside clinic opening times, however managers told us they were always with a member of the third sector organisations they worked closely with. Staff such as outreach teams did not have work telephones and there were no risk assessments in place for outreach working, for example on who to contact out of hours if required.

Public engagement

- The service had carried out a number of public engagement events through the outreach team who worked with community groups and third sector organisations to engage with hard to reach groups in the local area. The outreach team delivered sexual health talks to hard to reach groups.
- The service had developed a dedicated website for Leeds Sexual Health services. This provided information to patients on the services available and where they could access services, live chat with the service and provided an area for feedback from patients.
- The service had carried out a number of questionnaires with patients to gather feedback on the services and increase public engagement. For example, the service had carried out a questionnaire on the Saturday clinics which was to find out what preferred opening times for patients were at these clinics.

Staff engagement

- The service had introduced two weekly team briefs, which had improved engagement. The service had also carried out a staff survey in 2015. Further information provided by the trust highlighted managers had regular meetings with staff.
- Managers had plans to involve staff in the work around improvements in demand and capacity across the clinics.

Innovation, improvement and sustainability

- The main hub clinic provided patients with access to Wi-Fi in the waiting area whilst they were waiting to be seen.
- The main clinic at the Merrion Centre had set up a television in the reception and waiting area and had provided educational information, for example this provided information on syphilis.
- The service had introduced a number of outreach services to assist the service in reaching difficult to reach groups and provide a service closer to people. The outreach services worked closely with third sector organisations.
- The service had a dedicated website which received around 50,000 views a month and provided information on the services offered with contact details and a feedback form to gather the views of patients. This also offered live chat so people could directly ask the service a question.
- The service regularly looked to improve the service offered across the clinics. Some staff had attended national conferences relevant to their roles.