The Terrence Higgins Trust

Terrence Higgins Trust Outreach Sexual Health Service - Buckinghamshire

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 1 November 2016 and unannounced inspection on 4 November 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Buckinghamshire has a population of approximately 521,922. The rate of teenage pregnancy and sexually transmitted disease is better than the England average. The level of deprivation in Buckinghamshire is better than the England average.

The Terrence Higgins outreach service delivers a level 2 sexual health service across Buckinghamshire. The

Summary of findings

service offers clinics for guidance and treatment of sexual health issues including contraceptive services and screening and treatment of sexually transmitted diseases. The range of services included:

- A range of contraception services including oral contraception, emergency contraception and long acting reversible contraception (LARC)
- Screening for a range of sexually transmitted infections (STI's)
- Human immunodeficiency virus (HIV) prevention and support
- Wellbeing in sexual health (WISH) training for individuals and organisations
- Health promotion
- National C-card condom scheme.

The service was commissioned alongside a local NHS trust to provide an integrated level 2 and 3 sexual health service for Buckinghamshire in April 2016. The service currently provides 10 clinics at a range of locations including colleges, GP surgeries and community centres. From April 2016 to September 2016, the service saw 547 patients, the majority (approximately 77%) were female. The majority (40-45%) of patients are aged 18 to 24 years old.

The service currently employs 13 members of staff. This includes one service manager, three nurses, four youth engagement officers, an HIV and sexual health practitioner, two administration staff, wellbeing in sexual health trainer and results officer. The service had three vacancies at the time of our inspection.

We do not currently have a legal duty to rate single speciality services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

The service manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We spoke with three patients who all provided positive feedback about the service. Patients commented the service was helpful, provided an easy consultation and they would recommend to others.

Our key findings were:

- We observed staff provided kind, compassionate care and maintained the privacy and dignity of patients. This was supported by patient feedback survey results. Staff provided emotional support to all patients and in particular patients living in vulnerable circumstances.
- The service used nationally recognised guidelines to develop services and contributed to two national clinical activity datasets. The patient electronic record generated clinical protocols based on the patient's condition.
- The service had a system in place to manage medicines including the ordering, storage, dispensing, administration and disposal. However, there were some aspects of this system that did not meet national guidelines. This included the documentation of receipt and checks of medicines, security of key safe and arrangements for the disposal of unwanted or expired medicines.
- There were systems in place to safeguard young people and adults from abuse. Staff were aware of how to make a safeguarding referral and had completed training on child sexual exploitation and female genital mutilation. However, we found not all staff were clear about the policy for reporting sexual assault in adults over the age of 18.
- Governance arrangements were managed jointly between the local service and corporate team. For example, governance meeting were held at board level but day to day management of incidents and performance were managed locally. Although the service did monitor the quality of service provision in some areas, it did not meet the requirements of the corporate audit programme.
- The service referred to advice in national guidance for example the British Association of Sexual Health and HIV (BASHH) and Faculty for Sexual and Reproductive Health (FSRH) to develop services. However, there was no formal process for reviewing new clinical guidelines and applying changes to practice.

Summary of findings

- All the clinics we inspected were visibly clean and tidy. We observed staff adhering to basic hand hygiene and personal infection control practices. However, in two clinic locations there was no clinical waste bin and staff had to tie an open waste bag to the sink.
- The service placed outreach services strategically and held events in a variety of locations in order to meet the needs of local people. Staff had developed services for hard to reach groups such ethnic minority female groups. Patients could access the service using a single access telephone number. However, the provision of some clinics had to be altered due to staffing issues. There was no clear protocol for the management of patients who did not attend their appointment.

There were areas where the provider could make improvements and should:

- Review processes in place for medicines management to ensure they meet national guidelines.
- Ensure all staff follow the organisations policy on reporting sexual assault in adults over the age of 18.
- Review the arrangements for managing patients who fail to attend their appointment.
- Review clinical audit arrangements to ensure all areas of the service are monitored for quality assurance.
- Review the process to consider changes to clinical guidelines and how these are applied within clinical practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

We found the following areas of good practice:

- All staff knew how to report incidents and could give examples of how practice had changed as a result of incident reporting.
- Staff had a good understanding of how to make a safeguarding referral and had undertaken additional training in child sexual exploitation and female genital mutilation. The service had a system to flag vulnerable people on the electronic patient record.
- Patients records were secured securely, either on an electronic system or in tamper proof envelopes. All the records we reviewed were completed in line with the Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines.
- Patient group directions (PGD's) were in date and authorised by appropriate staff. Staff recorded the administration of medicines in the electronic patient record in line with FSRH medicines management guidelines. The service had an agreement with an NHS trust to label and dispense medicines.
- The service manager kept up to date records of all disclosure and Baring service (DBS) checks and evidence of professional registration.
- All staff were aware of the chaperone policy and information for patients regarding chaperones was available in all clinics.
- All clinics we visited were visibly clean and tidy and staff adhered to infection control guidelines such as bare below the elbows and use of personal protective equipment.

However, we found the following issues that the service needs to improve:

- Not all staff were clear about the policy of reporting sexual assault for adults over the age of 18. Two members of staff told us they would have a duty to report all cases of sexual assault. This could lead to a breach of confidentiality and place the patient in danger.
- We had some concerns regarding the management of medicines. The keys to the medicine storage at the base office were stored within a general key safe and therefore unregistered staff could access medicines. Documentation regarding checks and receipt of medicine did not always include the name or signature of the person performing the task, which made it difficult to track. The service did not have a service level agreement in place with a pharmacy for disposal of medicines as recommended by FSRH guidelines.
- The service did not monitor or record the hepatitis B immunisation status of their staff.
- The service was not following their own lone working policy in regard to providing all staff with a panic alarm.
- At two clinics we visited there was no clinical waste bin and staff used an open bag tied to the sink. This could pose an infection control risk.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

We found the following areas of good practice:

- The service used nationally recognised guidelines such as the Faculty for Sexual and Reproductive Health (FSRH) and British Association for Sexual Health and HIV (BASHH) to develop services.

Summary of findings

- The service submitted data to the genitourinary medicine clinic activity dataset (GUMCADv2) and sexual and reproductive health activity dataset (SRHAD).
- The service performed slightly better than the BASHH benchmark to inform patients of their test results within 10 days. From July 2016 to September 2016 the service achieved 97% against a benchmark of 95%.
- The service performed slightly better than the BASHH benchmark for treatment times. From July 2016 to September 2016 97.5% of patients were treated within six calendar weeks of a positive result against a benchmark of 95%.
- The service carried out a universal assessment for all patients at every appointment. This generated a protocol recommending assessment and treatment based on the patient's symptoms.
- The service achieved an appraisal rate of 100% for all staff.
- There was a competency assessment process in place for all clinical staff.
- The service worked with the local NHS trust level 3 sexual health service to deliver an integrated service to patients. The service also worked with a number of other services including the child and adolescent mental health service (CAMHS), sexual assault referral centre and school nurses.
- Staff had a good understanding of Fraser guidance in relation to providing sexual health services to young people under the age of 16. We reviewed three records for young people under the age of 16 who had all had a Fraser competency assessment completed.

However, we found the following issues the provider needs to improve:

- The service did not meet the requirements of the corporate clinical audit programme. During our inspection, we saw evidence that only two out of the 12 clinical audit areas had been completed.
- There was no clear process in place for reviewing new clinical guidelines and applying changes to practice.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

We found the following areas of good practice:

- All the patients we spoke with told us the staff were helpful and approachable.
- The service employed a practitioner who specialised in HIV and provided support to patients and families living with HIV.
- Staff were aware patients may receive bad news during consultations and had plans in place to manage this for example some clinics had access to a counselling room and staff could extend appointment times.
- Patients were treated with dignity and respect and involved in decisions about their care.
- The patient satisfaction survey for November 2016 showed 100% of patients felt they had been treated with dignity and respect and felt the service was confidential.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

We found the following areas of good practice:

- The service worked with the local NHS level 3 sexual health service to provide an integrated level 2 and 3 sexual health service. Services were strategically placed to meet the needs of the local population and there was a single point of access telephone line in place.
- The youth engagement team held events in a variety of locations and worked with different community groups to access hard to reach groups. For example, the service had recently started an Asian women's group.

Summary of findings

- The service promoted equality and diversity and provided clinical and emotional support to people living in vulnerable circumstances. For example, people living with HIV in prison. The service also ran an early intervention programme to provide one to one support and education for vulnerable groups.
- There was a fast track appointment system in place for vulnerable and high-risk patients who needed to be seen urgently. This included looked after children.
- The service used pictorial information sheets to give information to patients with a learning disability.
- Information on how to make a complaint was displayed in all clinics and there was evidence the service had made changes based on patient comments.

However, we found the following issues that the service provider needed to improve:

- From April 2016 to October 2016 the service cancelled 9.6% of clinics. The service had to make adaptions to service provision due to staffing issues. For example, one clinic only had nursing provision on alternate weeks instead of weekly.
- From April 2016 to October 2016, the 16.7% of patients did not attend their appointment. There was no standard protocol in place for managing patients who did not attend their appointment.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We found the following areas of good practice:

- The organisation had a system in place for governance arrangements.
- Staff were passionate about their work and took pride in working for the Terrence Higgins Trust.
- The organisation had clear vision and values and staff could describe these.
- The service collected patient feedback and had made changes in practice because of this. The service also contributed to the corporate staff survey.

However, we found the following issues that the service provider needed to improve:

- Although the service had completed some clinical audits, this did not meet all the requirements of the corporate audit schedule.

Terrence Higgins Trust Outreach Sexual Health Service - Buckinghamshire

Detailed findings

Background to this inspection

We carried out an announced inspection on 1 November 2016 and an unannounced inspection on 4 November 2016.

The team that inspected the service included a CQC inspection manager, two CQC inspectors, a CQC assistant inspector and a specialist advisor with expertise in sexual and reproductive health.

As part of our inspection, we spoke to three patients, reviewed six medical records and with consent, observed clinic appointments. We spoke with 10 members of staff including the corporate medical director, clinical director, nurses and youth engagement workers. We reviewed data collected both before and after the inspection.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

- The service reported all incidents using an electronic reporting system which was available remotely across all clinic sites. Staff knew how to use the system and told us they received feedback on incidents. Staff could give examples of where learning from incidents had changed practice. For example, staff reported incidents where the laboratory did not leave a message when phoning to give test results. This resulted in delays in giving patients results. Staff told us, senior managers met with the laboratory and now an email is sent to alert staff if a telephone call has been missed.
- The member of staff reporting the incident was responsible for allocating it to a senior member of staff to investigate. The service manager held overall responsibility for most incident reports. However, all clinical and safeguarding incidents were automatically shared with the regional clinical practice and governance nurses, clinical director and medical director as they were reported. All incidents graded at level three (moderate harm) or above are reviewed by the wider executive team and corporate quality and clinical governance committee.
- Staff told us learning from incidents was shared at team meetings. However, we reviewed meeting minutes from six monthly team meetings which did not show any evidence of this. Staff told us the medical director published a 'lesson learnt' bulletin to share learning from incidents across the organisations every three months.
- The service reported 23 incidents from January 2016 to November 2016. There were 10 incidents relating to clinical practice, five safeguarding incidents, two information governance incidents and two security incidents. The remaining four incidents related to IT, reputational, HR or health and safety. We reviewed details of all 23 incidents and found inconsistency with the category selection of the incident. For example, two incidents relating to missing samples were reported. However, one was categorised under clinical practice and one under information governance. This could a pose a risk that trends of incidents would not be correctly identified.
- 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 had been used, so any 'never event' reported could indicate unsafe care. The service had systems in place for informing about notifiable safety incidents
- The local service manager was aware of the requirements of duty of candour (DoC). 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.
- Although the staff we spoke with did not know about DoC, they were aware of the concepts of openness and honesty. All the staff we spoke with told us they would be open and honest with patients if a mistake was made. The service had not had any incidents which triggered DoC, but managers could discuss the process they would follow. Staff received training on DoC as part of their induction when they joined the service.

Reliable safety systems and processes (including safeguarding)

- The corporate clinical director and medical director had responsibility for implementing safety systems and processes across all the services within the organisations.
- The clinical director for the Terrence Higgins Trust was the corporate lead for safeguarding children and vulnerable adults. Staff could discuss safeguarding concerns with the local service manager who would seek advice from the clinical director if needed. There was also an on call service to discuss safeguarding concerns until 10pm every day.
- Records provided by the service showed that in October 2016, 86% (six out of seven) of clinical staff had completed safeguarding children level 3 training. The intercollegiate document safeguarding children and young People: roles and competencies for health care staff (2014) states all professionals working with children, young people and / or their parents or carers who could potentially contribute to assessing, planning and intervening in safeguarding concerns require training to level 3. The document states this includes

professionals working in sexual health. All clinical staff and youth engagement workers had completed safeguarding adults level 2 training and all senior nurses had completed safeguarding adults level 3 training. The service did not provide a target for training.

- The service did not provide separate safeguarding supervision to enable staff to discuss and reflect on safeguarding concerns or incidents. However, this was included in clinical supervision for staff. The local service manager told us they were in the process of agreeing specific safeguarding supervision with the local NHS trust.
- The staff we spoke with had a good understanding of how to make a safeguarding referral. The service made four safeguarding referrals from January 2016 to November 2016. We also reviewed a safeguarding referral made during our inspection. This was completed and sent to the local authority immediately after seeing the patient in clinic.
- Managers and staff had a good knowledge of procedures and guidance about child sexual exploitation (CSE) and were aware that this was a potential risk in the local area. Staff talked knowledgably about risk factors and had completed yearly training updates for CSE. The service used a standard assessment of risk factors for CSE and this was a mandatory part of the clinical assessment for young people under the age of 18.
- The service manager contributed to a review of services and processes concerning CSE led by the local authority as part of the lessons learnt from a serious case review. Following this review, the service changed their electronic record to improve the assessment of young people aged 16 to 18 years old. The service also adopted a policy of not allowing mobiles phones in the clinic due to the risk of patients being forced by perpetrators to keep the phone on to ensure they do not disclose abuse.
- Staff had a good knowledge of female genital mutilation (FGM) and the mandatory reporting process. Staff completed a standard risk assessment for women at risk of FGM in every initial consultation. All clinical staff had completed training in FGM.
- The local service manager did not directly engage with the local safeguarding board. However, they did work closely with the matron of a level 3 sexual health service at a local NHS trust who shared learning from these meetings and highlighted any patients within the service who may be at risk.
- The service had a policy in place to manage disclosures about sexual assault during consultations. If an adult disclosed sexual abuse, they would be offered a referral to the local sexual assault referral centre (SARC). The policy outlined that although the patient should be encouraged to report the assault, this could not be reported by staff without the patient's consent. However, not all staff were clear about this policy and some staff told us they would have a duty to report a disclosure of sexual assault even without the patient's consent. This could lead to a breach in confidentiality and place the patient at more risk. We raised this with the service manager during our inspection who planned to carry out training with all staff to ensure they were aware of the correct policy.
- The service offered all patients a chaperone in line with British Association for Sexual Health and HIV (BASHH) guidelines to protect both patients and staff. Staff documented in patient notes that a chaperone had been offered and if this was accepted or declined, and the name of the chaperone.

Quality of records

- All patient records apart from the patient registration form were electronic and completed in line with FSRH Service Standards for Sexual and Reproductive Health (2013). We reviewed six patient medical records that were all complete and up to date.
- Staff accessed electronic patient records using their individual work laptops. All laptops had a three-tier security log in system to access patient records. Staff transported patient registration forms from the clinic to the base office in tamper proof envelopes.
- The service had not carried out a formal documentation audit to assess the quality of patient notes. The service manager told us they reviewed notes written by individual nurses as part of their supervision and if concerns had been raised. However, results of this were not recorded.

Staffing

Are services safe?

- Staffing levels were determined by Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines. This guidance described the time required for a clinic slot to provide effective care was 10-20 minutes depending on the type of appointment. All appointments provided were at least 30 minutes and provision could be made for additional time if needed.
- Nurses, youth engagement workers and healthcare assistants staffed the service. There was no medical provision within the service and if patients required a consultation with a doctor they were referred to the local NHS trust.
- The service had found it difficult to recruit appropriately trained nurses with a sexual health qualification. This was a national issue and was included on the risk register as the main risk to the service. The service manager told us they were advertising for staff and were discussing the option of sharing staff with the local NHS trust.
- The service provided planned and actual staffing for all clinics. This showed the service was short staffed by three healthcare assistants and one nurse. In order to address the staffing shortages, two clinics were held alternate weeks instead of weekly and a youth engagement officer was provided in another clinic instead of a healthcare assistant.This meant that although young people could still access chlamydia screening, the c-card scheme and pregnancy testing they could not access contraceptive medicine.
- Although the service was registered with an agency to provide temporary staffing if required, the agency could not always provide sufficiently qualified staff and permanent staff were asked to cover annual leave or sickness.
- The service required all clinical staff to hold a Disclosure and Barring Services (DBS) check. DBS checks were performed by the service prior to staff commencing work. This was recorded on their individual electronic file and the local service manager kept a record of this. We reviewed these and all staff DBS checks were in date.
- The local service manager kept a record of staff professional registrations, for example with the Nursing and Midwifery Council (NMC). The record detailed the date of registration renewal. We reviewed all staff records and all staff professional registrations were in date.
- Chaperones were available in all clinics in line with Faculty of Sexual and Reproductive Health (FSRH) guidelines. If clinics were held in GP surgeries, reception staff were asked to be chaperones. In clinics held in colleges, the young person was asked who they would like to accompany them.

Monitoring health & safety and responding to risks

- The service had a business continuity plan which documented action to be taken in case of failure of systems, buildings or severe staff shortages. If clinics needed to be cancelled for any reason then the patient would be offered an alternative appointment with the local NHS trust.
- The service had a designated representative who had completed health and safety training to enable him to take up this role.
- The service kept a Control of Substances Hazardous to Health (COSHH) data sheet for all substances used within the service. These were kept in the base office and signed by all staff.
- Staff told us there was a lone working system in place to ensure staff safety. Staff described they sent texts to colleagues when meeting individual patients to inform them when they arrived for the appointment and when leaving. If staff failed to text after an appropriate amount of time, a colleague would phone them to check on their safety. However, staff did not have personal or room alarms when seeing a patient alone in a consulting room as outlined in the organisation's lone working policy.
- The service did not record or monitor nurses' hepatitis B status and therefore did not know all staff were adequately protected.
- Staff sent specimens to the laboratory in tamper proof envelopes. These were signed and sealed in front of the client to ensure they could not be mixed with other specimens or tampered with after the appointment.
- The nursing staff we spoke with were aware of action to take if patients became unwell in clinic, such as after an

injection. The service had a policy to call an ambulance in an emergency. However, all clinic locations where invasive procedures were carried out had a full resuscitation trolley and oxygen available. This was managed by the host organisation for example GP surgery and then re-checked by the nurse in charge of the clinic.

- All clinical staff held up to date basic life support training. This was renewed on a yearly basis.
- Staff could place an alert on patients' records to warn of risks to staff, for example if there was a risk a patient could become violent or aggressive. Staff could also highlight individual risks to patients in the same way for example, patient allergy or vulnerable person.

Infection control

- All the clinics we visited were visibly clean and tidy. Most remote clinics were located within larger buildings and cleaning was managed by staff at the host organisation. Nurses in each clinic were responsible for ensuring the environment was clean and safe to provide care and treatment for patients. The nurse in charge of the clinic completed a visual assessment of the area before the start of a clinic. However, this was not formally documented and therefore there was no record to show if this had been carried out.
- Hand washing facilities were available in every clinic treatment room. Hand sanitiser and personal protective equipment (PPE) such as gloves was available and we observed staff using these appropriately.
- We observed all staff complying with the 'bare below the elbows' policy which ensured staff could wash their hands thoroughly and help minimise the risk of cross infection.
- The service did not carry out any hand hygiene audits, or monitor staff compliance with the use of personal protective equipment (PPE). The clinical director told us the service did not have any infection control incidents and therefore were reassured staff were following guidelines. The clinical director planned to introduce hand hygiene observations in clinics but this had not started yet.
- The service had completed an infection control audit in October 2016 to assess their compliance in areas such as environment, access to handwashing facilities, disposal of waste, spillage and contamination and specimen handling. This audit showed the service was compliant with most standards. However, at two clinics there was no clinical waste bin and staff used an open bag tied to the sink. This could pose an infection control hazard as clinical waste was not stored in a closed bin.
- All clinical staff had completed infection control training in the last year.

Premises and equipment

- The service operated from a variety of locations, which ranged from GP surgeries and health centres to rooms in colleges. All the sites we visited were well maintained to protect the safety of patients, visitors and staff. The service manager told us staff would raise any concerns via an incident form and they would liaise directly with the host organisation to resolve this.
- All equipment was provided by the host organisation and therefore the service did not own any equipment. Any issues identified with equipment would be raised directly to the host organisation.

Safe and effective use of medicines

- Medicines at the base office were stored inside a locked cabinet. The keys were stored within a general staff key safe which meant any member of staff could access these. There was a risk that unregistered practitioners could access medicines.
- In clinic locations, staff stored medicines in locked cabinets. The nurse leading the clinic was responsible for completing a full check of all medicines against the stock list. This was recorded on the electronic spreadsheet but did not record who completed the check. All keys to the cabinet were held securely on the clinic site.
- Staff transported medicines from the base office to clinic locations in a locked transport box when needed. Staff recorded the stock they took from the office and what items were used during the clinic. Although this was recorded on an electronic spreadsheet, the member of staff taking or receiving medicines was not documented. Therefore, there was no clear record of who was responsible for ensuring the medicines taken were accurate. We reviewed the medication spreadsheet, which clearly showed where medicines had been taken from the base office and signed into a clinic location.

Are services safe?

- Staff checked medicines stock and expiry date each week and documented this using the electronic spreadsheet. All medications in clinic were checked during the clinic by the nurse responsible for running the clinic.
- The service had a service level agreement (SLA) in place with an NHS trust to provide and label all medicines. We reviewed records of three orders of medicine which were delivered to the base office. Only two of these records were signed by the member of staff receiving the order and only one included the date the medicine was delivered. This meant there was not an accurate record of who was receiving medicine orders.
- Clinical staff supplied all medicines to patients under patient group directions (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 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.
- We reviewed the PGD's in use across the service and all were up to date and had been authorised by the corporate medical director and a senior pharmacist. Staff could access PDG's electronically and had access to a PGD folder in each clinic. All clinical staff using PGD's were required to complete the corporate PGD workbook yearly in addition to signing the relevant PGD's.
- Staff recorded medicines administered or supplied to patients on their electronic patient record in line with FSRH medicines management guidelines (2014). The electronic record system recorded which nurse administered or supplied the medication and allowed the service manager to run a treatment record for the service if required or track any specific drug given. This ensured the service manager was able to track the administration and supply of medicines effectively.
- The service disposed of expired medicines at a local pharmacy. However, there was no formal service level agreement in place with the local pharmacy to dispose of expired medicines. This was not in line with the London Faculty of Sexual and Reproductive Health (FSRH) medicines management guidelines (2014).
- The corporate head office managed alerts and recalls for medicines. The electronic medicines spreadsheet held details of the batch number of medicines held at each clinic. When a medicines alert was received, the service manager checked this against the spreadsheet and asked all staff to check stock in clinic. There was no formal system to monitor responses to these alerts.
- Staff told us medicine administration errors were reported using the electronic incident reporting system. There had been one medicine administration error in the last year where the incorrect medicine had been given to a patient. The nurse contacted the patient to inform of this mistake and administer the correct medicine.

Mandatory training

- The service identified six areas for mandatory training which included health and safety, infection control, information governance and basic life support.
- All staff had completed their mandatory training required by the organisation apart from safeguarding children level 3 training. .

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

- The service 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 Gynaecologists standards was followed, for example in relation to patient group directions.
- The service also developed services to meet the British Association for Sexual Health and HIV (BASHH) guidelines. For example, the service introduced human immunodeficiency virus (HIV) point of care testing and used BASHH guidelines to set service parameters.
- The corporate medical director was responsible for the implementation and review of clinical guidelines. However, there was no clear process in place for reviewing new clinical guidelines and applying changes to practice.
- The service collected and submitted data to Public Health England in line with the mandatory obligation required by the government. This included genitourinary medicine clinic activity dataset (GUMCADv2) and Sexual and Reproductive Health Activity dataset (SRHAD). A purpose of the data was to monitor the effectiveness of services. Data included demographic details, new diagnosis of sexually transmitted infections (STI) and uptake of long acting reversible contraception (LARC).
- The Service collected and monitored the time taken for the notification of new patients STI's. From July to September 2016, the service notified 97% of patients of their results within 10 days against a BASHH benchmark of 95%.
- The service also performed better than the benchmark for turnaround time for treatment.From July 2016 to September 2016, 97.5% patients with positive results were treated within six calendar weeks against a benchmark of 95%.
- From April 2016 to June 2016 the service achieved 100% compliance for partner notification discussions. . However, from July 2016 to September 2016 the service offered partner notification discussions to 92.5% of patients against a benchmark of 97%. The service submitted data to show this had improved to 100% compliance in October and November 2016. Partner notification is the practice of notifying the sexual partners of a person newly diagnosed with a sexually transmitted infection. .
- From April 2016 to November 2016, the service consistently met the BASHH standard for treating positive cases within four weeks of the first partner notification discussion or contact.
- From April 2016 to September 2016 the service achieved 100% compliance in offering all patients a chlamydia screen. The service did not complete the corporate clinical audit programme. The corporate audit programme outlines 12 areas for the service to audit from April 2016 to March 2017. During our inspection we saw only two of these audits had been completed. The FSRH service standards states all providers should have a programme to regularly audit service provision and act upon results to ensure improvements in the service. This posed a risk that the service would not be aware of potential poor performance and therefore would not be able to make improvements.
- Staff offered patients a choice to receive their results by text message or telephone call. No results were available by email due to information governance restrictions. However, young people could access sexual health advice by email.
- The service carried out a universal assessment for all patients at each appointment using an electronic records system. This generated a specific protocol based on the patient's needs.

Staff training and experience

- All clinical nursing staff held a dual qualification in nursing and sexual health.
- There was a mandatory training programme in place for all nurses working within the service this included specific HIV and wellbeing in sexual health training (WISH).
- We reviewed the role based training records for staff which showed staff training was up to date in all modules apart from immunisation update where two out of three members of staff were out of date. These staff were not currently providing immunisations.

Are services effective?

(for example, treatment is effective)

- There was a competency assessment process in place for all clinical staff. This included areas such as knowledge of STI, specimen collection, consent, contract tracing and sexual history taking and assessment. We observed a member of staff returning to work following a period of maternity leave. The service manager had arranged for the member of staff to be supernumerary for two weeks while they worked through their competency assessment.
- Staff told us they had access to clinical supervision every six weeks to discuss clinical issues with colleagues.
- The service had achieved a staff appraisal rate of 100% at the time of our inspection. Staff told us they valued the appraisal process to aid their development. For example, one member of staff had with a specific job role told us they discussed the limitations of having clinical supervision with staff who did not work in the same area. As a result their manager was trying to arrange clinical supervision with other staff in the organisation in the same job role.
- Staff told us they had opportunities for further professional development for example one nurse told us they had recently attended a training course on partner notification and another had attended a course on sexting.

Working with other services

- The service worked in partnership with a local NHS trust since April 2016, although these were financially independent of each other. The Terrence Higgins Outreach service provided a level 2 sexual health service and the NHS trust provided a level 3 sexual health service.
- The service lead had meetings with the local NHS trust on a four to six weekly basis to discuss the delivery of the service. This included discussions on safeguarding, governance, clinical issues and key areas of work.
- The service had a sharing of information agreement in place with the local NHS trust. We reviewed this agreement and observed it was in date and authorised by appropriate staff.
- There was a single point of access telephone number and booking system which was managed by the local NHS trust. The introduction and maintenance of this system was discussed at joint meetings with the NHS trust and commissioners.
- The service had undertaken joint work with a local safeguarding children charity to help prevention of child sexual exploitation (CSE) this included joint work at local schools for children with learning disabilities on topics such as internet safety, consent and healthy relationships.
- Staff told us they had a good relationship with school nurses who could refer young people directly to the service. Staff also liaised with school nurses if they had concerns about young people.
- The service had a direct link with the child and adolescent mental health service (CAMHS) and could make a referral using secure email. Staff told us they could phone to access advice from the service if needed.
- The service undertook work with a variety of different agencies including the local sexual assault and referral centre, women's aid charities and other charities promoting sexual health.

Consent to care and treatment

- Patients' told us and we observed staff asked patients for verbal consent before any care or treatment was provided.
- Staff demonstrated a good knowledge of Fraser guidance to ensure young people under the age of 16 years old, who declined to involve 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 old to decide whether they can receive contraceptive advice or treatment without parental knowledge or consent. The electronic records system automatically prompted staff to carry out a competency assessment on all children aged 16 and under. We reviewed three records of children aged under 16 years old and all had a competency assessment completed.

Are services effective?

(for example, treatment is effective)

- Staff told us if a young person was deemed not to be Fraser competent, they would work with the young person to aid understanding and encourage the young person to confide in a responsible adult. Staff told us young people would always be involved in any referral process.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

- Staff delivered care and treatment in a kind and compassionate manner. They placed a strong emphasis of promoting the dignity of the patient and recognised the sensitive nature of the work they carried out. We spoke with three patients during our inspection who were all complimentary about the service. One patient told us the service was, 'very helpful, a good service' another patient told us, 'I would definitely recommend this service, it was an easy consultation'.
- Three patients consented to us observing their assessment by a nurse. In all the consultations we observed, the nurses undertook the assessments in a caring way, for example asking questions sensitivity and maintaining a non-judgemental approach.
- We observed a clinic appointment where the nurse offered STI testing to a patient. The nurse explained and carried out the procedure in a calm and compassionate manner, frequently making sure the patient was comfortable.
- The service carried sent an electronic patient satisfaction survey to patients after their appointment. The results for November 2016 showed 100% of patients felt their privacy and dignity and been respected during their appointment. The survey also showed 100% of patients felt the service was confidential.
- The service employed an HIV worker who provided direct support to patients and families who had received a diagnosis of HIV. The support was based on the needs of the individual.
- Staff were aware patients may receive bad news during clinic appointments and could arrange to spend additional time with patients if they were upset. A standard clinic appointment was 30 minutes, however, staff could extend this if needed by contacting the service manager who would take responsibility for re-arranging other appointments. At one college site we visited, there was a separate counselling room for patients who received bad news.
- All the staff we spoke with knew about the chaperone policy and we observed posters in all clinics informing patients about chaperones.

Involvement in decisions about care and treatment

- Staff ensured patients were the centre of their work and placed a strong emphasis of ensuring they were involved in decisions about their care and treatment.
- Patients told us staff gave them information outlining different options and supported them in choosing the right option for them as an individual. We reviewed the notes of a patient who had disclosed sexual assault. The nurse had offered a range of different options such as referral to the local sexual assault referral centre, sexually transmitted infection (STI) testing and long acting reversible contraception (LARC).
- Staff saw young people who attended clinic with a parent or carer alone first and then gave the patient the choice to have the parent in the clinic appointment. This enabled the young person to make their own decisions without the influence of parents or family members.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- The service worked with commissioners to plan clinics that met the needs of the local population in each specific area. Services were located based on geographical need and patient demographic. For example, one clinic we visited was based in that area due to a high percentage of people not owning cars, high teenage pregnancy rate and drug and alcohol abuse.
- The service worked in partnership with the local NHS trust to ensure patients could access a level 2 and 3 sexual health service. From April 2016 to August 2016, the service made 59 referrals to the level 3 service.
- The youth engagement team held events at different locations to ensure they were able to reach all groups in the community. For example, the youth engagement team held events at a local university during fresher's week.
- The Terrence Higgins Trust had a website giving information about a wide range of sexual health topics such as living with the human immunodeficiency virus (HIV), sexually transmitted diseases and contraception. Patients could locate services in their area by using the service finder on the website.

Tackling inequity and promoting equality

- Staff understood the diverse patient group who accessed the service. Staff told us they were passionate about providing a sexual health service for everyone, particularly those in vulnerable circumstances.
- The HIV service provided support to patients in vulnerable circumstances. For example, at the time of our inspection the service was providing emotional support to two patients living with HIV in prison.
- The HIV service adapted method of giving information based on the individual's needs for example their literacy level. The team had a variety of different methods including quizzes, games, presentations, pictures and reading materials.
- The service ran targeted work with adults and young people through the early intervention programme. This covered a variety of issues such as online safety, healthy relationships and consent. Each programme was based on the individual's needs.
- Staff told us they encouraged vulnerable patients to re-engage with the service. For example, staff told us about a young woman who was vulnerable and in a high-risk relationship. Staff referred her to the early intervention programme to assist with self-esteem, online safety, and to recognise healthy relationships.
- Staff and stakeholders told us about targeted work the service had undertaken with specific groups to address discrimination in the local area. This included a group of young, male college students with negative views on women, colleagues of a patient with HIV and promoting equality for lesbian, gay, bisexual and transgender patients.
- Professionals could refer vulnerable patients into a fast track system where they would be seen in the next available clinic, usually within one day. The service kept one appointment open in every clinic which could only be booked by the senior or lead nurse. Staff also told us they could open the clinic early or offer a later appointment in order to meet the needs of a vulnerable patient.
- The service had recently started an Asian women's group to give information on healthy relationships, contraception and child sexual exploitation. A youth engagement worker who was fluent in Punjabi and Urdu ran the group. Staff told us they had also been asked to give information on sexual health by a local mosque.
- A member of the youth engagement team who was proficient in British Sign Language told us they were trying to establish an information session for patients with hearing loss.
- The service had access to interpreters for patients who did not speak English using language line. Staff told us they could access information sheets in different languages from head office.
- The service used a pictorial factsheet to ensure patients with learning disabilities understood the information being given.For example, a nurse used the factsheet

Are services responsive to people's needs?

(for example, to feedback?)

with a patient who had learning disabilities and disclosed sexual assault to confirm they understood the meaning of sexual intercourse. This was important in order to provide the correct care and treatment.

Access to the service

- There was a single point of access for all patients, managed by the NHS trust. Staff would direct the patient to the most appropriate service based on a triage assessment. The local NHS trust had access to the Terrence Higgins Trust outreach booking system and could book patients to the most convenient appointment.
- The service had a text reminder service. Administrators asked patients if they would like to use this service when booking an appointment and recorded their preference on the electronic patient record. The patient received a text reminder of their appointment at the time of booking and two days prior to their appointment.
- The service prioritised appointments for patients at risk. In every clinic there was an appointment held which could only be booked by the service manager or a senior nurse. Patients who were deemed at high risk could be offered an appointment the next day. The service also prioritised looked after children and could offer next day appointments if required. A looked after child is a child or young person who is in the care of the local authority for more than 24 hours.
- Patients were given a choice to receive results of STI testing by telephone or text message. Results by email was not available due to the risk of security breach.
- We spoke with three patients who all told us they had problems accessing the single point of access booking telephone line. One patient told us they had tried eight times to make an appointment using the booking line and eventually had to leave a voicemail. The service had identified there was a problem with the single access booking line and were working with the local NHS trust to resolve this.
- The service had planned 249 outreach clinics from April 2016 to October 2016. The service provided information showing 24 (9.6%) of these clinics were cancelled. No information of the reasons for these cancellations was provided.
- Due to staffing issues the service had to alter the provision of some clinics. Two clinics were held alternate weeks instead of weekly and.
- From April 2016 to November 2016 there had been a 16.7% did not attend (DNA) rate. The service did not have a specific protocol in place to manage patients who failed to attend their appointment and therefore this was left to the individual nurse to manage. However, all the staff we spoke with told us they would attempt to contact the patient if they were vulnerable.
- Patients could self-refer to the HIV support service. After an initial assessment had taken place, patients were offered contact based on the assessment of their needs at the time. This ranged from weekly contact to contact every six months.
- Patients were offered point of care HIV testing and were able to get the results within the same appointment. Patients who received a HIV positive diagnosis were referred to the level 3 sexual health service. Staff told us they would make an urgent referral and ensure the patient was seen within 48 hours.

Concerns & complaints

- The service received one complaint from September 2015 to October 2016. This related to a college clinic being closed on the day a young person visited. The complaint was investigated but not upheld.
- Information for patients on how to make a complaint was displayed in all clinics. The patients we spoke with told us they would make a complaint using the service's website or electronic feedback form.
- The service used electronic system to collect patient feedback on their clinical service and comment cards for the youth engagement and HIV service. Feedback was collected on a monthly basis and sent out to all staff every three months.
- Staff told us they had received feedback regarding some administration staff in clinic locations (not employed by the THT service) who did not respect privacy when patients attended for their appointment. The service had conducted a survey asking patients how they would like to ask for the service at these locations. As a result,

Are services responsive to people's needs?

(for example, to feedback?)

the service changed the booking in system to be more discreet. During our inspection we observed patient's asking for the 'THT' service instead of sexual health clinic.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Leadership of service

- There was a local service manager in post who took responsibility for managing the service on a daily basis. Support was provided by a regional manager and national clinical director.
- The service manager was visible to all staff working in the service and staff had confidence in the leadership of the service. Staff told us the service manager was approachable and possessed the clinical skills to work in clinic. Therefore, the service manager could provide assistance and supervision to staff if needed and this was recognised and valued by staff.
- The service manager had not attended any leadership training, however, this had been identified in a recent one to one meeting with the regional manager and was included on their appraisal.
- Staff told us that the corporate leadership had recently improved and staff felt there was more communication from head office. For example, staff told us, and we saw from meeting minutes the CEO attended a team meeting at the base office to meet staff and learn about the work of the service.

Culture of Service

- Staff took pride in their work and were proud to work for the service. Staff told us the best things about working for the service were, 'working with young people and building relationships', 'seeing a change in people' and breaking down barriers to sexual health'.
- Staff were committed to providing a high quality care for patients. We saw examples of staff staying late in clinic to telephone a vulnerable young person who had not attended for their clinic appointment. Staff also told us they would extend clinic hours if a vulnerable patient needed a fast track appointment.
- The service had a whistleblowing policy in place which staff knew about. Staff told us there was an open culture within the service and they felt comfortable raising concerns to senior staff if needed.
- Staff had a good understanding of openness and transparency. All the staff we spoke to told us they would inform a patient immediately if a mistake had been made.
- The service had a turnover rate of 26% that equated to four substantive staff leavers from June 2015 to July 2016. The sickness rate for the service was 0.42% in the same time period.

Governance arrangements

- Governance arrangements were managed jointly between the service manager and corporate governance committee. Three corporate governance and practice nurses had recently been employed to support service managers and provide assurance for quality and governance within regional areas.
- The corporate clinical governance team held quarterly meetings that were by attended trustees and the board team. The clinical governance team discussed subjects such as learning from incidents, learning from complaints and concerns and policy review. However, it was not clear how these messages fed into local services and to staff.
- The service held monthly team meetings and we reviewed six sets of meeting minutes. The minutes showed there had not been any discussion about the learning from complaints or incidents.
- The service reported their performance using a quality scorecard that measured internal performance. The scorecard recorded performance against contract, clinical incidents graded at moderate harm or above and issues of concern with strategy or staff. The scorecard was spilt into three areas at a regional level; long-term condition management, health improvement and clinical services.
- There was a corporate clinical audit schedule in place. We reviewed this schedule that included audits on pregnancy testing, documentation, PGD audit and contraception. However, we did not find any evidence these had been completed. The service had completed audits on turnaround times for specimen results and partner notification contacts.

Vision and Strategy

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- The Terrence Higgins Trust had a vision for 'a world where people with HIV live healthy lives free from prejudice and discrimination, and good sexual health is a right and reality for all'. This was supported by four values for the organisation to be ambitious, honest, different and independent.
- Staff knew about the vision and values of the organisation and were passionate about promoting these. Staff told us they felt the organisations values aligned with their own personal values.
- The strategic priorities of the organisation included increasing and normalising HIV testing and ensuring sexual health information and contraception was available to everyone. Staff knew about the organisations strategy and could describe how the local service was contributing towards it.

Provider seeks and acts on feedback from its patients, the public and staff

- The service collected patient feedback for all the services it provided. Some services sent an electronic survey while others collected patient feedback using comment cards. There was evidence the service had responded to feedback from patients, for example making the booking in system at clinics more discreet.
- The corporate staff survey in 2015 showed an overall staff satisfaction rate of 69% which was lower than the previous survey undertaken in 2016. The organisation had implemented an action plan in response to the survey to improve communications and visibility of the executive team.