Gateway Plaza

Quality Report

Unit 1
Gateway Plaza
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We found the following areas of good practice:

- Staff understood their responsibilities to raise concerns and report incidents. There were clear processes in place for reporting and investigating incidents and staff received feedback at team meetings.
- Safeguarding young people and vulnerable adults took sufficient priority. Staff were knowledgeable and had completed the required level of safeguarding training.
- People's care and treatment was planned and delivered in line with current evidence based guidance and national standards.
- Staff were supported to deliver effective care and treatment, including through regular supervision.
- There was a programme of learning and training in place for staff to become dual trained in genitourinary medicine and sexual health.
- The service used technology very well, with patients able to book appointments in a variety of ways and be kept informed of clinic updates via Facebook and Twitter.
- Staff were aware of the need to assess Gillick competence and apply Fraser guidelines when obtaining consent with young people.
- Feedback from patients was positive. People were treated with dignity, respect and kindness. Patients felt supported and said staff were non-judgemental.
- Patients were communicated with in a way they could understand and were involved in decisions about their treatment. They were supported emotionally with their treatment.
- Services were planned and delivered in a way that met the needs of the local population, with appointment-only clinics or walk-in and wait clinics that were offered at the main hub and various spoke clinics.
- Services were provided for people in more vulnerable circumstances.
- There were effective governance systems in place to ensure quality and performance was managed.
- Managers were visible and showed good leadership; staff had noticed improvements since a new head of service had been appointed. There was good engagement with all staff and staff felt listened to.

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

- The service did not have access to atropine for resuscitation as recommended in national standards.

Summary of findings

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Gateway Plaza

Services we looked at:
Community health (sexual health services)

Summary of this inspection

Background to Gateway Plaza

Gateway Plaza is the location for Barnsley Integrated Sexual Health Service (BISH). This service was formed in 2015 and is provided by Spectrum Community Health CIC, which is a not for profit social enterprise.

Services are offered at Gateway Plaza, which is the main hub, and other spoke clinics, which provide access across different settings, such as colleges. Outreach services are also offered.

Patients can access walk-in and wait clinics or appointment only clinics. The service provides a young person's drop-in clinic.

Services are provided to both adults and young people offering a full range of sexual health services and advice, including contraception, Hepatitis B vaccinations and screening and treatment for sexually transmitted infections (STI's), including Chlamydia and Human Immunodeficiency Virus (HIV).

Between February 2016 and January 2017, the service saw 20,693 patients.

The service has 32 members of staff including medical staff, nursing staff, health advisors and administration staff. The service had a registered manager in place.

A Relationship and Sex Education (RSE) team deliver relationship and sex education lessons in schools in the local area.

Our inspection team

Team leader: Debbie Bedford

The team that inspected the service comprised two CQC inspectors and two sexual health specialist advisors.

Why we carried out this inspection

We inspected this service as part of our ongoing independent health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed information that we held about the location, asked the commissioner for information, held a focus group with staff and provided comment cards for patients to complete.

During the inspection visit, the inspection team:

- visited Gateway Plaza and one of the spoke clinics, looking at the quality of the environment and observed how staff cared for patients;
- spoke with nine patients;
- collected feedback from 63 patients using comment cards;
- spoke with the executive nurse for Spectrum and the service leads for Gateway Plaza;
- spoke with 11 other members of staff; and
- looked at five patient records

Summary of this inspection

What people who use the service say

Patients spoke very positively about the service. Staff were described as caring, friendly and non-judgmental, providing information to patients in a way they could understand and involving them in decisions about their treatment. Patients felt staff were respectful and there was a welcoming environment.

Most liked the walk-in and wait clinics and felt they were seen in a reasonable time, whilst a few felt the waiting times were too long.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- There were processes in place for reporting incidents and staff knew how to report them. Staff received feedback about incidents at team meetings.
- Staff were knowledgeable about their safeguarding responsibilities to young people and vulnerable adults. They had completed the relevant safeguarding training and had safeguarding supervision. We saw insufficient follow up of one young person who had failed to attend an appointment in 2016, however staff told us new processes were now in place, which ensured that records would be reviewed for those patients that failed to attend.
- Premises were clean and tidy, with effective infection prevention and control measures in place.
- Medicines management was good, with effective procedures in place. However, there was no atropine available for resuscitation as recommended in national standards.
- Service leads acknowledged that there had been problems with staffing due to long term sickness, but this was being managed within the service and there were sufficient appropriately trained staff working each day.
- Records we reviewed were of a high standard and regular documentation audits were undertaken.

Are services effective?

- The service provided evidence based care and treatment, following national guidelines. Staff had access to policies, procedures and guidelines on the intranet.
- There was good use of technology to provide information to patients and allow them to book appointments, including a dedicated sexual health website, a Facebook page and a Twitter account, and use of text messaging.
- The service collected and submitted data to Public Health England, in line with requirements.
- Key performance indicators were being met.
- The move to an integrated service had brought together staff from genitourinary medicine (GUM) and sexual health services. Service leads acknowledged that only one member of staff was dual trained, however, there was a programme of learning and training being undertaken to address this.

Summary of this inspection

Are services caring?

- Feedback from patients was positive; staff were described as being kind and caring.
- Staff maintained privacy and dignity at all times and displayed a non-judgemental attitude.
- Patients were involved in their treatment choices and provided with information in a way they could understand.
- We observed staff talking to patients in a sensitive manner and providing reassurance.
- Health advisors were able to support patients after a diagnosis.

Are services responsive?

- Clinics were offered on an appointment only basis or walk-in and wait. The service was offered on a hub and spoke model, however if short staffed then the spoke clinics may be cancelled.
- Staff had access to telephone interpreters, however this could prove difficult at times if particular interpreters were not available or more complex discussions needed to take place.
- Outreach services were provided for people who were more vulnerable as a result of their circumstances, such as sex workers, asylum seekers and homeless people.
- The Relationship and Sex Education (RSE) team had developed a booklet for use with young people with learning disabilities.
- The service was meeting national standards for length of time patients were seen within after contacting the service.
- Walk-in and wait clinic waiting times were displayed, however some patients felt the waiting times were too long.

Are services well-led?

- There were effective governance systems in place to ensure quality and performance were managed and information could be cascaded between senior management and clinical staff.
- There was effective leadership, with staff speaking positively about leaders both at local level and at organisational level.
- The organisation engaged well with staff, staff felt able to voice their opinion and felt listened to.
- However, the risk register did not identify some of the risks that the leaders identified at the time of the inspection, such as staffing and dual training.

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health (sexual health services) safe?

Incident reporting, learning and improvement

- Incidents were reported using an organisation wide electronic reporting system. Staff we spoke with were aware how to report incidents. We saw on display a pathway for reporting an incident.
- There had been no never events or serious incidents reported between February 2016 and January 2017. 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 were 39 incidents reported between February 2016 and January 2017. Of these, 14 had been recorded as information governance breaches; however, there was no recurrent theme.
- Staff we spoke with told us they received feedback about incidents at team meetings. We reviewed team meeting minutes and saw that incidents were discussed. Minutes were emailed out to staff to ensure all staff had the relevant information.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff had access to a 'being open and duty of candour' policy. This outlined the process for staff to follow when an incident had occurred that may trigger duty of candour. Service leads could explain this process to us.
- There had been no incidents triggering duty of candour within the last 12 months.
- Staff told us they were encouraged to be open and honest with patients.

Safeguarding

- There were safeguarding policies available. We reviewed policies including safeguarding adults, safeguarding children and female genital mutilation (FGM). All policies were in date and contained relevant information to support staff.
- Staff were able to tell us the process for reporting their concerns, including when they would report concerns and how they would report them.
- The chief nurse for Spectrum was the safeguarding lead for the organisation overall and there was a Band 7 health advisor who was the safeguarding lead for the Gateway Plaza site.
- A Spectrum safeguarding forum ensured policies and procedures were kept up to date and assessment tools were discussed.
- The Gateway Plaza safeguarding lead attended a multi-vulnerability and complex abuse case panel (which fed in to the local safeguarding board), a strategic child sexual exploitation (CSE) group and the Spectrum safeguarding forum. They also had contact with the named nurse from the multi-agency safeguarding hub (MASH).
- An under 18's and vulnerable adult template was in use which was based on Barnardo's 'spot the signs' that helped staff recognise signs of sexual exploitation.
- All patients were seen alone initially to give them the opportunity to disclose information in a safe environment.
- All clinical staff were trained to safeguarding children Level 3. The intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for

Health Care Staff' (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to Level 3 in safeguarding.

- Data provided by the organisation for February 2017 showed that 100% of relevant staff had attended Level 1 safeguarding training, 95% had attended safeguarding adults Level 2, 97% had attended safeguarding children Level 2 and 100% had attended safeguarding children Level 3.
- The safeguarding lead nurse held group safeguarding supervision sessions. Staff were expected to attend four sessions a year. However, data provided showed that in 2016 staff had only attended one or two sessions each.
- We reviewed two sets of records for children under 16 years. We saw appropriate safeguarding referrals made. However, we identified for one patient that there had been inadequate follow up when they had failed to attend a follow up appointment in 2016. We raised this with the service leads at the time of the inspection who told us that they were aware of this and there were now new systems in place to try to avoid this happening again, such as recall lists. If patients did not attend for follow up appointments, records were routinely assessed and reviewed and a judgment made as to the next course of action.
- Patients were able to access a chaperone if required. Signs at reception informed them of this. An up to date chaperone policy was available for staff.

Medicines

- Staff had access to a Spectrum medicines management policy, which covered ordering, storage, supply and administration.
- We saw medicines stored in locked cupboards. Contraceptive and sexually transmitted infection (STI) treatment medication was stored separately. Cupboards were well ordered and tidy. We saw that all medication was in date.
- Emergency medication was kept centrally in a locked cupboard; no medication was kept in consulting rooms. However, the service did not keep atropine as recommended by the Faculty of Sexual and Reproductive Healthcare (FSRH) service standards for resuscitation (2016). We raised this at the time of our inspection and the service leads agreed to follow this up.
- We saw three fridges that contained medications; each had fully completed up to date temperature checklists, which showed the temperature had been maintained within required levels.
- Some staff administered medication under patient group directions (PGD's). PGD's are written instructions that allow healthcare professionals to supply or administer medications without the need to see a doctor. We checked PGD's and found they were out of date. We raised this with the service leads who explained that an extension had been granted for the PGD's as new ones now had to be signed off by the clinical commissioning group (CCG).
- Four staff members were nurse prescribers, allowing them to prescribe certain medication. Teaching sessions were held regularly which included information about medication and ensured practitioners kept up to date with current practice.
- No medication was kept at the spoke clinic we visited. Patient's needing medication had to attend the main Gateway Plaza site to collect it.

Environment and equipment

- The reception area at Gateway Plaza was clean, light and spacious. Frosted window panels ensured privacy of patients attending the clinic was maintained.
- We saw that the consulting rooms had all the relevant equipment required. There were a range of sharps containers appropriate to clinical activity and all were secure.
- The spoke clinic we visited used a room within a college health and wellbeing service. The room contained a couch for examination.
- All electrical equipment had been electrical safety tested and was up to date with testing. We saw one fridge that contained plates for microscopy; it did not have regular temperature checks undertaken. Staff told us they were awaiting verification of the correct temperature range the plates should be stored between.
- Appropriate resuscitation equipment was available and we saw checklists to confirm that regular daily checks had been completed.
- Staff told us that the heating in the Gateway Plaza building was an issue, with the building being very hot at times. This had been reported and action had been taken, however staff still felt there was a problem.

Quality of records

Community health (sexual health services)

- The service held electronic patient records, which were accessible through password protected systems.
- Records for patients with HIV were paper based as they were from a local NHS trust. Paper records were kept securely in locked cabinets whilst on site.
- We reviewed seven sets of records. We saw good standards of record keeping with comprehensive assessments undertaken and individual plans of care documented.
- Documentation audits were regularly undertaken. We saw an audit conducted in March 2017. Overall results were shared at the weekly team meetings. If any individual member of staff was identified as requiring more specific feedback this would be undertaken in supervision sessions with their manager and monitored accordingly.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and well maintained. Examination couches were clean and we observed staff cleaning couches between patients.
- Disposable curtains were in use and we saw that they had the date they were last changed marked.
- 'I am clean' stickers were used to indicate that cleaning had taken place.
- We observed all staff complying with arms bare below the elbows and washing hands as appropriate. Personal protective equipment, such as aprons and gloves, were available. We saw staff using them appropriately.
- The service had an infection control lead nurse who linked with the infection control training provider. They were planning to introduce an onsite training development package.
- An infection control audit carried out in January 2017 showed that they had scored 100% for the patient's immediate area, patient equipment, sharps safety and hand hygiene facilities. The general environment scored 88%, storage areas and clean utility scored 86% and dirty utility and waste disposal scored 67%. There were actions in place to address the issues found, such as moving items stored on the floor in the dirty utility. During our inspection, we did not see items stored on the floor.
- Data provided showed 100% compliance with infection control training and 95% compliance with infection control training level 2. Spectrum's board had set a compliance target of 95%.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training. The average mandatory training compliance as of March 2017 was 96%.
- Training records were held centrally by Spectrum and were sent weekly to the head of sexual health services to ensure that staff were kept up to date. Staff were sent email reminders when their training was due.
- Staff could access training online and were given non-clinical time to ensure they could complete their required training. Staff we spoke with said they were given time to complete training.
- Staff told us that training had been continued from their previous employment when the two services merged. Spectrum had allowed them to complete the training they were attending.

Assessing and responding to patient risk

- Staff undertook risk assessments at initial and follow up appointments. Specific templates for assessment of under 18 year olds and vulnerable adults were used.
- Every patient seen at the clinic was offered sexual health screening.
- If the walk-in and wait clinics became busy, patients were triaged to ensure those needing to be seen immediately were seen whilst other arrangements, such as return the next day, could be made for other patients.
- A comprehensive results management system ensured that positive results were dealt with in a timely manner, including referral to other services if required. This complied with the British Association for Sexual Health and HIV (BASHH) standards for the management of sexually transmitted infections (2014).
- There were procedures in place if a patient deteriorated and staff had access to emergency equipment, such as oxygen, facemasks and adrenaline.

Staffing levels and caseload

- The service employed 12.81 whole time equivalent (WTE) qualified nurses and 2.36 WTE nursing assistants. There were 2.36 WTE vacancies for qualified nurses.
- Service leads told us they had taken the decision not to recruit to the vacancies until more of the existing staff had gained a dual qualification. An experienced agency nurse was used to cover some of the sessions, along with cover from existing staff.

Community health (sexual health services)

- There was always suitably qualified nursing and medical staff in clinic.
- The service employed three sexual health/ genito-urinary doctors and two HIV consultants.
- Service leads acknowledged that there were high sickness levels that had affected the ability to deliver spoke clinics at times. The main hub clinic was prioritised so that a full clinic could be run from there. Data provided showed a sickness rate of 6.3%. The head of service was ensuring that the sickness management policy was fully implemented.

Managing anticipated risks

- The service had a business continuity plan that would be activated in response to any situation that caused significant disruption to services.
- We saw this implemented during our inspection, the electronic patient record system developed a fault nationally and practitioners could not access patient records. Staff told us that they had explained the situation to patients and were recording consultations on paper records until they could access the electronic record to update it.

Are community health (sexual health services) effective?
(for example, treatment is effective)

Evidence based care and treatment

- Staff had access to policies and guidelines on the intranet. Guidelines we reviewed were in date and were evidence based.
- Staff were aware of and followed national guidance from the National Institute of Health and Care Excellence (NICE), the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH).
- Templates and risk assessments were developed in line with guidance from the FSRH.
- BASHH guidelines had been adapted for use in clinic. Regular education meetings were held in which any updates to guidance would be disseminated to staff.
- The service followed the Department of Health 'Integrated Sexual Health Services National Service Specification' (2013) which recommends a hub and spoke model of care with walk-in and appointment clinics.

Technology and telemedicine

- Patients who were already registered with the service and who had no symptoms, but wanted full sexual health screening, could make online appointment bookings. Patients could make appointments for clinics, view future appointments, order repeat prescriptions and cancel appointments. The online booking system was also available as an app for mobiles or tablets.
- Appointments could also be made via email or phone.
- Patients could access information leaflets and advice videos via a dedicated Spectrum sexual health services webpage. Chlamydia screening kits could also be ordered online.
- Facebook and Twitter accounts were used to provide information to patients, including changes to clinics and advising when the walk-in and wait clinics were full.
- Patients received results and appointment reminders via text message.
- Links to appropriate websites were sent to patients via text message.

Patient outcomes

- The service regularly collected and submitted data to Public Health England in line with mandatory requirements, including genitourinary medicine clinical activity dataset (GUMCADv2), which provides information on sexually transmitted infection diagnoses.
- Key performance indicator targets had been met for quarter two 2016/2017. For example, clinicians received 100% of routine laboratory results for sexually transmitted infections (STI) within seven working days of a specimen being taken and 100% of patients testing positive for chlamydia received treatment within six weeks of test dates.
- Data also showed that 100% of women had access to urgent contraceptive advice within 48 hours of contacting the service and 100% of women had access to a long acting reversible contraception method of choice within five working days of contacting the service.

Community health (sexual health services)

- The relationship and sex education (RSE) team used questionnaires given at the beginning of the course and again at the end to see whether student's knowledge had increased. Questions included: How would you rate your knowledge on sexual health? Can you name the specialist clinics you would go to if you were worried about an STI or pregnancy? Results showed that all students showed an improvement in the questions after the course.
- An annual audit programme was in place for 2016/2017. However, when we looked at audits that had been undertaken, such as a records audit and infection control audit, there appeared to be a lack of action plans.

Competent staff

- Prior to integration of the service in 2015, staff worked in either contraceptive services or genito-urinary medicine (GUM). Staff were therefore working towards being dual trained in order to deliver advice, guidance and treatment in all aspects of sexual health.
- At the time of our inspection, one member of staff was dual trained. Service leads told us that there were three or four staff who had received training and were ready for competencies to be signed off for them to be dual trained.
- Staff had attended Sexually Transmitted Infection Foundation (STIF) courses as recommended by the British Association for Sexual Health and HIV (BASHH).
- Staff ensured they worked within their competencies. If they were seeing patients that they felt required different expertise, then they could ask colleagues in the clinic to provide support and guidance.
- Staff had regular appraisals, 100% of staff had received an appraisal within the last 12 months.
- Managers told us that staff were beginning to have clinical supervision sessions.
- There was training and support available for nursing staff concerning revalidation.
- Medical staff had regular appraisals and 100% had been revalidated.
- Healthcare assistants had undertaken competencies in microscopy, meaning that this service could be provided on site and patients could be started on treatment immediately.

Multi-disciplinary working and coordinated care pathways

- Staff had close links with other agencies and services, such as schools and youth workers.
- A service level agreement was in place with a large voluntary sector organisation to provide services to people not in education, employment or training, sex workers, the homeless and asylum seekers.
- There was a service level agreement in place with a local NHS trust to provide services for patients with HIV.
- The relationship and sex education (RSE) team worked proactively with secondary schools, pupil referral units and youth offending teams to provide relationship and sex education training to young people.
- The service worked closely with drug and alcohol workers.

Referral, transfer, discharge and transition

- The service was open access, meaning that anyone could use their services, either via the walk-in and wait clinic or by appointment.
- Staff worked closely with other professionals, such as midwives, who would refer mothers to the service for contraception advice.
- Referrals could be made to and taken from the local Sexual Assault Referral Centre (SARC).

Access to information

- Staff could access the electronic patient record at the hub and spoke clinics. This meant they always had access to an up to date patient record.
- Staff told us they could not access the organisations intranet at the spoke sites, however if they needed any information, they would contact staff at the hub.
- Staff could access the intranet at the hub site and this contained all polices and guidelines.
- Staff had access to the NHS paper records for those patients with HIV.
- Patients were asked at registration if the service could contact their GP to provide relevant information.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff demonstrated knowledge of Gillick competence and Fraser guidelines. Gillick competence refers to determining a child's capacity to consent and Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Community health (sexual health services)

- We saw consent documented in the records we reviewed. Consent was embedded within the templates on the electronic patient record.
- Staff had access to a 'Consent to Examination or Treatment' policy. We observed this to be in date.
- We saw on display a pathway for obtaining informed consent.

Are community health (sexual health services) caring?

Compassionate care

- We observed staff treating patients with kindness and compassion, taking time to interact with them.
- We observed staff talking to patients in a sensitive manner. Reassurance was provided when discussing intimate details.
- Staff respected the patients' privacy and dignity throughout the appointment.
- We observed reception staff to be caring and they showed empathy towards the patients.
- Friends and Family Test (FFT) data from January 2017 showed that 96% of people were extremely likely or likely to recommend the service to others.
- We spoke to nine patients during our inspection and all spoke positively about the staff. They were described as being kind and caring. Patients felt their privacy and dignity was maintained and staff were non-judgemental.
- We received 63 comment cards and 62 of them had positive comments, which included staff making them feel comfortable and being professional.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt listened to. They felt involved in the discussion about their treatment.
- We observed staff asking the patient's opinion and discussing different options.
- The service undertook partner notification and would follow up the partner if they had been treated elsewhere.

Emotional support

- The RSE team discussed all aspects of a relationship with the young people.
- Health advisors provided support to patients after a diagnosis.
- The service was not commissioned to provide psychosexual counselling as it had been previously. Staff would refer patients back to their GP to access this.
- We observed a staff member discussing the patient's mental health and listening to their concerns.
- Feedback we received from patients was positive and they said the staff made them feel less anxious.

Are community health (sexual health services) responsive to people's needs? (for example, to feedback?)

Planning and delivering services which meet people's needs

- The service was commissioned by the local authority to provide an integrated sexual health service, offering sexual health and contraception services.
- Services were designed around a hub and spoke service model, with the central hub being the base for staff. Patients could access services at the central hub or at outreach or spoke clinics, which were based in buildings run by other organisations.
- Clinics were offered at a variety of times. At the central hub, walk-in and wait sessions were held in a morning and appointment only clinics in an afternoon and a Saturday morning.
- A youth drop in clinic was offered to under 19 year olds between 3pm and 5.30pm. The service ensured that this clinic had more staff available as they recognised that some young people might want to be seen quickly on the way home from school.
- Spoke clinics offered services in different locations, such as local colleges.
- The waiting area had a television and contained patient information leaflets. A water cooler was available for patients. A sign at reception asked patients to wait until they were called forward, to maintain patient confidentiality.
- Young people under the age of 25 could access free condoms through the condom card scheme (C card).
- The relationship and sex education team offered training to all the local schools using resources designed by and with the young people.

Equality and diversity

Community health (sexual health services)

- The service was wheelchair accessible and had disabled toilet facilities.
- Staff had access to telephone interpreters. Staff told us that this could be difficult at times. On some occasions, patients had been asked to return to clinic, as there were no appropriate interpreters available. They also highlighted that patients with HIV had to complete a 12 questions questionnaire, which could be difficult and quite impersonal if done via the interpreter phone line.
- We observed one patient that attended clinic that spoke limited English. The staff member used the phone interpreter service and drew pictures to be able to understand the problem further.
- The service had problems accessing sign language interpreters, however the service had not needed to access a sign language interpreter on many occasions.
- A flag on the patient record indicated if the patient had any individual needs. Staff would make provision to address these needs.

Meeting the needs of people in vulnerable circumstances

- Outreach services for sex workers, asylum seekers and homeless people were provided in partnership with a charity organisation.
- Pathways were in place for staff to follow to safeguard and refer victims of sexual assault.
- The RSE team had developed a booklet for young people with learning disabilities, which allowed them to give a visual response to questions.
- Service leads acknowledged that they did not have any information leaflets available for those patients with a learning disability. Staff would involve carers with the patient's permission.

Access to the right care at the right time

- The walk-in and wait clinic meant that all patients could be seen within 48 hours. The National Integrated Sexual Health Services Standard Specification (DH 2013) and Standards for the Management of Sexually Transmitted Infections (BASHH 2014) suggested that 98% of people contacting a service should be offered to be seen or assessed with an appointment or 'walk-in' within two working days of contacting the service.
- Patients were given approximate waiting times when they attended the walk-in and wait clinics. We saw waiting times displayed on a board in the waiting area.
- Data showed that most patients were seen within two hours. In quarter one of 2016/2017, one patient out of 854 waited longer than two hours at the walk-in clinic and in quarter two of 2016/2017, one patient out of 2201 waited longer than two hours to be seen.
- The walk-in and wait clinics were managed depending on how many staff were on duty. If the clinic became full, then patients were triaged and offered an alternative appointment.
- In order to gain feedback from patients, comment cards were placed at the clinic before our inspection. Out of 63 comment cards we received, five mentioned that they felt the waiting time was too long. However, others said they had been seen promptly.
- Information collected by the clinic for did not attend (DNA) appointments showed that the number of DNA's had decreased since the introduction of the walk-in and wait clinics.
- A process was in place so that records were reviewed for any patient that did not attend an appointment. This allowed staff to decide on the next course of action to take.
- Data provided showed that between February 2016 and January 2017, 0.56% of patients left before they were seen.

Learning from complaints and concerns

- Gateway Plaza received ten complaints between February 2016 and January 2017. Four were formal complaints and six were locally resolved. One complaint had been referred to the parliamentary ombudsman, but was not upheld.
- Six of the complaints referred to access to the service and waiting times. As a result of complaints about waiting times in the walk-in and wait clinic, staff introduced a whiteboard with approximate wait times displayed and an explanatory leaflet was produced for patients to explain how the walk-in and wait clinics worked.
- We saw posters displayed in the clinic areas informing people how to make a complaint.

Are community health (sexual health services) well-led?

Leadership of this service

Community health (sexual health services)

- A head of sexual health services worked between Barnsley Integrated Sexual Health (BISH) and Wakefield Integrated Sexual Health (WISH) services. BISH had a head of service and a clinical lead in post.
- The executive nurse for the organisation provided support to the sexual health service.
- Staff we spoke with talked positively about the leaders of the service; they said there had been a big improvement since the head of service had been in post and they had a positive impact on the service.
- Staff also spoke positively about the organisation as a whole; they felt listened to and able to voice their opinions. They felt management were approachable and visible, with visits from the executive team and non-executives. They described good leadership at all levels.

Service vision and strategy

- The organisation had a vision 'to achieve the best health and wellbeing outcomes for our clients and place individuals, families, carers and communities on the road to rehabilitation, recovery and integration'.
- Staff were aware of the organisation's vision and values and they were displayed in the areas we visited.
- There was no documented strategy for the sexual health service but service leads had a vision for the sexual health service for all staff to be dual trained, staff to be supported and to meet access needs.

Governance, risk management and quality measurement

- There was a clear governance structure within the organisation. Three committees fed in to the organisation board; a quality and patient safety committee, finance and performance committee and a human resources and development committee.
- Each committee received reports from groups, including, a quality group, information governance group, medicines management group and safeguarding forum. The committees provided board assurance reports after every meeting.
- Operational groups, including for sexual health services, fed in to the governance groups, ensuring information passed up to the board and down to staff.
- The board reviewed high level risks within the organisation. There were no identified high risks for the sexual health service.
- Service leads identified staffing and dual training as their top risks; however, these had not been identified on their risk register.
- There were local procedures in place for reviewing risks and adding new risks to the risk register.
- Risks were reviewed regularly and included in the Director of Operations report to the board. We looked at two Director of Operations reports and saw that the risks to the sexual health service, such as staffing, were identified.
- BISH held weekly team meetings, which included operational meetings, risk meetings and education sessions. We saw team meeting minutes, which showed relevant information, had been cascaded down to staff.

Culture within this service

- Staff felt valued, respected and part of a team.
- Staff were committed to providing the best integrated service they could. They told us that when the two services had come together it had been a difficult time, but they felt things had now improved.
- All staff were supportive of each other and worked well together to offer an integrated service to patients.

Public engagement

- People's views were gathered with the use of a patient satisfaction questionnaire.
- We saw on display in the waiting area a board with examples of 'You said, we did'. For example, patients' had said they wanted more flexible ways to book appointments, the service had responded by enabling patients to book appointments online, via email or via the phone.
- Young people in schools were involved in the recruitment process for staff of the RSE team.

Staff engagement

- Staff told us that when the two services joined together meetings were held with staff, they felt listened to and involved with the changes.
- Some staff members sat on the staff council where they would discuss staff welfare, changes in policy, workforce issues and human resources issues. Council members would sit on the different committees.
- The organisation sent the staff a monthly newsletter and the chief executive produced a regular letter to staff.

Community health (sexual health services)

- Staff felt very involved, they described having attended roadshows and focus groups, and taking part in the staff survey and wellness checks.
- Awards were given for employee of the month.

Innovation, improvement and sustainability

- The integrated sexual health service had been commissioned in 2015; staff had worked hard to become an integrated team having previously been two different teams with two different providers. Staff had taken on new roles and the dual training had been difficult but staff were working through competencies and felt very well supported.
- Staff sent web links to patients via text through the electronic patient record. Recorded within the patient record is the information that was sent.

Outstanding practice and areas for improvement

Outstanding practice

- Staff used the electronic patient record to send web links to a patient via text message.

Areas for improvement

Action the provider SHOULD take to improve

- They should ensure that they have the recommended medication for use in an emergency.
- They should ensure that all staff are having the required amount of clinical and safeguarding supervision.
- They should ensure that they can provide access to sign language interpreters.
- They should ensure all identified risks are identified on the risk register.
- They should consider developing a sexual health service strategy.