

Brook Young People

Brook Cornwall

Inspection report

Ground Floor, Penhaligon House
Green Street
Truro
TR1 2LH
Tel: 03003030714
www.brook.org.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

We rated this service as good because:

Staff assessed risks to patients, acted on them and kept good care records. Staff safely prescribed, administered and recorded medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided good care and treatment to patients and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available six days a week.

Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Leaders ran services well using reliable information systems and supported staff to develop their skills, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

The service did not always have enough skilled staff to care for patients and keep them safe. Not all staff were up to date with training in key skills nor understood how to protect patients from abuse. The service did not control infection risk well at all sites. They did not store medicines safely.

Not all staff understood the service's vision and values.

Summary of findings

Our judgements about each of the main services

Service

Community health (sexual health services)

Rating

Good



Summary of each main service

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Summary of findings

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Summary of findings

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Summary of this inspection

Background to Brook Cornwall

Brook Cornwall is part of the larger organisation Brook Young People and provides confidential sexual health services, support, and advice to people living in Cornwall and the Isles of Scilly. Brook Cornwall used to only provide services to young people under the age of 25 but took over all age services in Cornwall in December 2019.

Brook Cornwall is registered to provide care and treatment under the following regulated activities: diagnostic and screening services, family planning and treatment of disease, disorder or injury. There is a registered manager in place.

Brook Cornwall was last inspected in May 2017 and at the time, we did not have a legal duty to rate them. We highlighted good practice and issues that the provider needed to improve.

In the 2017 inspection, the provider breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 under:

Regulation 17: Good governance:

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part

17(2)(b) Assess monitor and mitigate the risk relating the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Staff often worked in separate parts of the building during clinics. This meant that should an issue arise a member of staff may be isolated and not be able to communicate with their colleague. Panic alarms were not in place in reception at all clinics.

This has now been partially met.

Regulation 16: Receiving and acting on complaints

16(2) the registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other person in relation to the carrying on of the regulated activity.

The provider had not ensured full information and guidance about how to complain was available or accessible to everyone who used the service.

This has now been met.

What people who use the service say

Patients said they were able to get an appointment on the same day and some within an hour. The service was good at fitting appointments around patients' other commitments and were very flexible.

Summary of this inspection

Patients said that staff explained various options for treatment and they found treatments that suited them.

Patients spoke very positively about staff attitude and said they could speak to them without feeling judged.

Patients said that staff they came across were helpful and understanding and provided reassurance. Patients thought the service was well managed, staff were friendly and made them feel settled. Patients were generally very happy with their experience.

Patients said that staff introduced themselves to patients as did the chaperons and were excellent in explaining that everything would be confidential, asking if the patient was happy to have a chaperon in the consultation.

Patients said the service was very discreet, easy to get to and parking was close by.

However, one patient said staff did not protect their modesty when they went out of the room, leaving them feeling very uncomfortable.

Some patients did not receive the follow up they were expecting from the service.

Some patients felt underprepared for their appointments and would have like more information about what to expect.

How we carried out this inspection

The inspection was led by a CQC Inspector, supported by a sexual health doctor who works as a specialist advisor for the CQC and an expert by experience.

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

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

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

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew. During the inspection visit, the inspection team:

Visited Brook Cornwall premises in Truro, Newquay and St Austell and looked at the quality of the environment.

Summary of this inspection

Spoke with 12 staff including the service consultant, the clinical lead, service managers, senior nurses, nurses, health care assistants and receptionists.

Spoke with eight patients who were using the service.

Reviewed eight patient care and treatment records.

Observed how people were being cared for.

Looked at a range of policies, procedures and other documents relating to the running of the service

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Outstanding practice

We found the following outstanding practice:

The provider had embarked on a long-acting reversible contraception (LARC) recovery project where they saw 300 additional patients during six months of the pandemic when GPs were not able to provide this service.

Areas for improvement

Action the service **SHOULD** take to improve:

The service should ensure that all staff are up to date with their mandatory training.

The service should ensure that staff record how new safeguarding concerns have been raised to the local authority on the safeguarding spreadsheet.

The service should ensure that facilities at Newquay Hospital are clean.

The service should ensure all sharp bins are labelled and emptied regularly.

The provider should consider practising alarm drills with staff.

The provider should review arrangements around accessing defibrillator machines at all locations.

The provider should ensure that the medication cupboard at Newquay Hospital is moved so all staff can access it safely.

The provider should ensure all medication cupboards are locked when not in use.

The provider should consider requesting access to patient information from their online provider so they are aware of treatments given to patients on their case load.

Summary of this inspection

The provider should ensure there are enough suitably skilled staff to cover unplanned staff sickness.

The provider should review medical cover arrangements.

The provider should ensure all staff have regular supervision.

The provider should check that all patients are aware of what might happen during their appointments.

The provider should ensure patient information cannot be overheard.

The provider should consider identifying unisex toilets on their premises.

The provider should make information readily available at their clinics to provide information on complaints and accessibility






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health (sexual health services)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Community health (sexual health services)

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are Community health (sexual health services) safe?

Good 

We rated safe as good.

Mandatory training

The service provided mandatory training in key skills although not all staff had completed it. Although 89% of staff were up to date with their basic life support practical training, only 68% of staff were up to date with basic life support theory and 68% of staff were up to date with anaphylaxis training. This was due to some staff having just recently returned from furlough and delays in restarting the service's training programme.

The mandatory training was comprehensive and met the needs of patients and staff. Administrative staff kept the training records up to date and emailed out to staff when they were due to refresh their training. Staff who were out of date with their training, had dates booked to complete this.

Safeguarding

Staff understood how to protect patients from abuse. Not all staff knew how to make a safeguarding referral to the local authority but knew where to get support from when necessary. Staff had training on how to recognise and report abuse. The service worked well with other agencies to safeguard patients.

Not all staff knew how to make a safeguarding referral to the local authority. Staff said they would inform their manager if they had concerns.

Staff accessed a safeguarding spreadsheet so they could easily identify patients who had safeguarding concerns. Staff used a safeguarding pro forma on the spreadsheet to identify any concerns relating to their patient before an appointment. However, it was not clear on this form if staff had identified a new safeguarding concern during an appointment that they had raised a safeguarding referral to the local authority. We reviewed three forms on the safeguarding spreadsheet and although staff had ticked that a safeguarding concern had been disclosed during the appointment, it was not clear from the form if the safeguarding concern was a new incident and therefore what action they had taken to immediately protect the patient. However, when we raised this with the manager during the inspection, we learned that staff had taken action to safeguard these patients.

Community health (sexual health services)

The service had a national head of safeguarding who shared lessons learned with staff and updated policies. The safeguarding lead reviewed policies and procedures every year.

Staff received training specific for their role on how to recognise and report abuse. Thirty out of 31 staff had received safeguarding levels one and two training, with one new member of staff yet to complete all modules. Seventeen out of 19 required staff had completed safeguarding children level three training, with two new staff left to complete the training and 16 out of 19 required staff had completed safeguarding adults level three training, with two new members of staff and one doctor yet to complete this training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. There were arrangements in place to safeguard women with, or at risk of, female genital mutilation (FGM), in line with Department of Health guidelines. FGM was included in the provider's safeguarding procedures document, including information around the mandatory duty to report it, how to report and what information to give to the police.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff held safeguarding meetings, received safeguarding supervision and managers circulated a safeguarding newsletter. They worked with other agencies regularly such as the 'multi agency referral unit' (MARU). Staff were aware of any clients who had a safeguarding flag via an alert on their shared electronic database. Staff conducted additional checks on clients with safeguarding concerns during national lockdown. Staff raised any safeguarding concerns with the MARU team. They received a list of young people at risk and potential perpetrators from multi-agency child exploitation (MACE) every two weeks. This information was recorded in patient records. They responded to MACE with any information they had about any of the young people on their list. Staff were aware of the safeguarding rota and who to contact out of hours.

The patient electronic records prompted staff to ask questions which identified risk factors related to safeguarding, such as if the patient felt safe with their partner or if they had ever had sex without consent.

The service provided sexual health services for children and young people and had policies and procedures in place to keep them safe.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Ward areas were not always clean. The clinical space at Newquay Hospital, which was owned by a different provider, was stained and not clean in places and there was no cleaning rota on display for staff to check if the area had been cleaned before they used it. The cleaning rota was held centrally with the hospital. At Newquay Hospital, sharps bins were not all labelled and those that were had been were due to be changed. In one of the clinic rooms, the sharps bin was filled over the fill line which meant there was risk of a sharps injury to staff.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Hand gel, hand soap and paper towels were in each room. Antibacterial wipes were available for the cleaning of equipment such as trolleys and couches. Staff prepped each clinic which included cleaning.

Community health (sexual health services)

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff managed clinical waste well.

All clinical rooms had alarms that staff could activate in an emergency. Staff were familiar with the provider's lone working policy but had not attended drills or practiced response to alarms. At Newquay, staff believed that one alarm in reception was connected directly to police but were not sure. The disabled toilet at Penhaligon House had a call bell which could not be seen or heard from the main reception area.

The medication stock cupboard at Newquay hospital was positioned above a fridge and staff had to climb up onto a chair to access it. This posed a health and safety risk that the manager said they would rectify that day.

The provider did not have their own defibrillation machines at Penhaligon House in Truro, or at their clinic at Newquay Hospital. Staff followed a 'first aid needs assessment' (FANA) which detailed the nearest defibrillation machine for each site. Although having their own defibrillator was not a requirement, this meant staff could not guarantee one was available if needed or had been checked and serviced. The provider had ordered a defibrillator for Penhaligon House.

Staff carried out daily safety checks of specialist equipment. Equipment was calibrated and portable appliance tested (PAT) tested. All clinics had anaphylaxis and an emergency boxed kit. There was adrenaline in the provider's anaphylaxis packs which were checked and changed regularly. There were a minimum of two anaphylaxis packs at each site.

The service had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely. Domestic and clinical waste pedal bins were in use. A cleaner emptied the bins daily and clinical waste was stored and disposed of safely. Clinical waste was stored in a restricted area and was collected weekly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff identified if there were any risks associated with a patient during their initial assessment. If a risk was identified, staff raised a caution register and an alert appeared on their file when opened, describing what the risk was. Staff took patients' histories, such as their pregnancy history to identify any risk with treatment.

Staff knew about and dealt with any specific risk issues. If a patient with an identified risk was due to come in, the team lead emailed the member of staff to make them aware to check the patient's notes prior to the appointment. For example, staff ensured there was a family support worker present during an appointment for a young person with attention deficit hyperactivity disorder.

Staff checked a patient's sexual history and risk assessed their current status, including the use of condoms, lifestyle factors such as alcohol and drug use and any safeguarding concerns.

Community health (sexual health services)

Emergency drugs and oxygen were available in clinics where intrauterine devices were fitted. Staff rang for an ambulance if there was an emergency.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff knew how to make a referral into the local mental health team.

Staff did not always have access to shared key information to keep patients safe when handing over their care to others. Brook worked with an online provider who took over responsibility for a patient once they started using their services. If a patient used the online provider for advice or treatment, they did not feedback the outcome of the patient's treatment back to Brook. This meant that Brook did not have an overarching knowledge of advice or treatment given to patients on their caseload.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers did not always accurately calculate the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The area manager completed a staffing needs assessment and presented to the operational manager and human resources for approval. The staffing needs assessment took into account the requirements for an all age, level three sexual health service. However, the service did not have enough qualified and skilled staff to cover a satellite clinic if someone called in sick.

The manager could not always adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants did not always match the planned numbers.

The provider was not able to employ agency or bank staff with the required skills and knowledge to cover when substantive staff called in sick. Receptionist staff cancelled clinics if a member of staff was off sick in a particular location. This meant that they risked not seeing vulnerable patients.

The service had low vacancy rates. There was one nurse manger vacancy, one health care assistant vacancy for 25 hours and one administrative lead vacancy.

The service had low turnover rates.

The service had low sickness rates.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep patients safe. The medical staff did not match the planned number. The service had vacancies for medical staff. Managers could not access locums when they needed additional medical staff. The service did not have a good skill mix of medical staff on each shift.

Community health (sexual health services)

The service had one consultant contracted to work two days per week. However, they only provided one face to face clinic per fortnight. Another doctor had just started at the service and was shadowing clinics during our inspection. They were contracted to work 15 hours per week. This meant the service did not have medical cover for one day a week. Although staff said they would contact the medical director for the organisation if they needed advice, they did not have anyone allocated to the service to provide this support. The service did not have cover for their current medical staff leave or sickness. The provider was actively recruiting for more medical staff at the time of our inspection.

However, during our inspection, we saw that when patients required urgent medical attention, staff followed appropriate systems and processes that kept patients safe.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely but not always easily available to all staff providing care.

All patient records were kept on a shared electronic database that all staff could access easily. Each member of staff held their own provider 4G enabled laptop so they could work remotely. Staff said this worked with varying degrees of success, depending on the network cover in a particular area. For example, at Newquay hospital, the signal was quite poor which meant staff experienced a delay accessing records. Staff were unable to access NHS systems or NHS staff Wi-Fi whilst working at their sites. Service managers were in negotiation with system providers about accessing their systems.

Medicines

The service used systems and processes to safely prescribe, administer, and record medicines. However, staff did not always store medicines safely.

Staff followed systems and processes when safely prescribing, administering and recording medicines.

Staff checked medicines weekly. Staff ordered all stock delivered to satellite clinics and transported it using the service's stock management procedure.

The use of medication was documented on individual patient notes with the batch number and expiry date clearly documented.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The patient electronic records had inbuilt questioning for allergy information and captured the date and the name of the prescriber. Medication given out under a patient group directive (PGD) were identified on the system.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures for the use of PGDs were well explained and staff had a good understanding of the correct procedure. PGDs provide a legal framework that allows some registered health professionals to administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). PGDs were regularly reviewed. PGDs were available on shared drive all nurses had their own paper copies.

Community health (sexual health services)

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Follow up procedures were in place for patients in receipt of specific medication. However, the provider did not receive any feedback from their online provider about medication that had been prescribed to patients when they used online services. This meant that the provider did not know if patients who had been prescribed the combined pill for example, had a healthy blood pressure.

Staff did not always store medicines and prescribing documents in line with the provider's policy. During clinics, keys for medicines were stored at reception so all clinicians could access the keys. However, at all sites we visited, the medicines storeroom or cabinet was left unlocked. Staff immediately rectified this during the inspection. Staff had ordered keypads for restricted areas at the Truro site but these had not arrived yet.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff reported incidents on an incident spreadsheet which was saved in a shared folder. Staff identified the incident, the actions taken, the organisations involved and the incident type.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff logged all communication with patients on an open incident form. Staff informed patients when incidents had occurred that affected them.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Staff had made improvements to the service following an incident review. For example, staff had made changes to the environment at the Pool clinic so there was a private area for patients to recover if they felt unwell after their appointment.

Managers investigated incidents thoroughly. Managers used the information collated following an incident review to make informed decisions about which providers to use to support the effective running of their services. For example, staff recorded a delay with the provider's external courier collecting patient samples. They weighed up the continued risk of this incident occurring again against the quick external laboratory turnaround time and decided to continue to use the courier despite the incident.

Managers completed a monthly quality report for their service which was shared across the organisation. This enabled all managers to review all logged incidents across the organisation and identify any themes or trends. The national governance committee reviewed these reports and requested more information if required.

Managers debriefed and supported staff after any serious incident.

Community health (sexual health services)

Are Community health (sexual health services) effective?

Good 

We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The national medical director was responsible for updating all policies and procedures in line with any updates to national guidance. The provider worked to the 2019 British Association for Sexual Health and HIV (BASHH) Standards for the Management of Sexually Transmitted Infection, the BASHH-FRSJ Joint Standards for On-line and Remote Providers and current versions of BASHH and FSRH clinical guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it. Patients told us that staff checked in with them during treatment and offered them medication to relieve any pain or discomfort.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Community health (sexual health services)

The service participated in relevant national clinical audits. Managers took part in national audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers regularly audited databases weekly. Managers shared and made sure staff understood information from the audits.

The service was involved in the southwest British Association for Sexual Health and HIV (BASHH) group and completed BASHH audits as and when required. Staff audited the partner notification platform regularly.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Treatment was delivered well overall by staff and most patients were happy with the outcome of their appointments, confident that if they had a preference staff would have listened and involved them.

The service reported to national data set about the health outcomes for patients. For example, how many people were seen, their STI diagnosis, which services they were using and where psychosexual service numbers were seen and where referred from.

Managers and staff used the results to improve patients' outcomes.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held full team meetings every two to three months. Managers held fortnightly managers' meetings via teleconference. Managers held clinical meetings with the nurses and the safeguarding lead attended regular safeguarding meetings. Part time staff did not attend regular staff meetings but said they were able to read the minutes which were sent to everyone via email.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Managers attended the Cornwall sexual health partnership group every quarter, led by their commissioners.

Staff provided outreach work to other organisations and had developed strong working relationships with the sexual assault referral centre (SARC), MARU and some departments in the local acute hospital. For example, staff worked in line with the BASHH birth plan when working with the antenatal team and provided free training for midwives at the local acute hospital. The provider created clear pathways for GPs to refer into the service. The provider had embarked on a LARC recovery project where they saw 300 additional patients during six months of the pandemic when GPs were not able to provide this service.

However, staff said that MDT working with other external agencies needed to improve. Staff sent referrals to external departments, such as gynaecology but some departments did not accept direct referrals from them, meaning the patient had to go back to their GP and request a referral themselves. This delayed treatment for the patient and meant the provider did not have control over the timeframe in which their patient was seen.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

Community health (sexual health services)

Key services were available six days a week to support timely patient care. The service held clinics six days a week.

The service was nurse led which meant that patients were not reviewed by consultants, depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. Staff could identify which senior member of staff was on call from the rota. Senior staff could seek support from doctors from their own organisation within normal working hours.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff took patients' temperature, saturation levels, pulse and vaccination history. There were some delays in documenting the results of patients' blood tests. Staff had however, treated the symptoms by prescribing antibiotics before the test results had come back.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. During appointments, staff asked about any alcohol and drug use and provided brief alcohol intervention support and signposted to mental health, substance misuse, and smoking cessation services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All patients were offered a chaperone for their appointments and we saw that this offer was taken up in all of the appointments we observed or saw recorded.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff recorded that they asked patient consent to treatment during their appointment. When a chaperone was present, their name and any interaction was recorded on the patient electronic record.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Staff followed a consent to treatment procedure.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The procedure for assessment for mental capacity included the Fraser guidelines around consent and staff had a good working knowledge of these guidelines. Staff understood the five principles of assessing capacity and documented if a patient lacked capacity in any area.

Community health (sexual health services)

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers kept a training matrix which showed the specific sexual health training each member of staff held. Staff said that they had not yet achieved the appropriate skill mix within their team.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers supported nursing staff to develop through constructive clinical supervision of their work. Staff received clinical and non-clinical supervision with a focus on wellbeing and actions identified. Supervision was interspersed with a workplan meeting which focussed on the staff member's priorities for the year. Personal objectives were reviewed every three months and these pulled through to staff's annual appraisal. However, there were gaps in nursing staff's supervision and non-nursing staff did not receive regular supervision.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. The consultant contracted to work with the service provided some specialist training, such as nurse prescribing, for staff but felt that more training sessions would be beneficial.

Managers identified poor staff performance promptly and supported staff to improve. Managers followed a policy for managing poor performance. There was a separate disciplinary and grievance policy.

Community health (sexual health services)

Are Community health (sexual health services) caring?

Good 

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Patients said that all staff were helpful and understanding and provided reassurance. However, one patient said that staff did not protect their privacy and dignity during a clinic where a member of staff left them in the consultation room without their modesty being covered.

Staff took time to interact with patients and those close to them in a respectful and considerate way. During appointments, patients described staff as attentive and reassuring. Staff were committed to ensure confidentiality throughout patient appointments. Staff understood the importance of reassuring patients that their treatment and information would be confidential to put them at ease, making their experience as positive as possible.

Patients said staff treated them well and with kindness. Patients told us that all the staff were kind and described staff as warm and welcoming, from the receptionist to chaperons, staff and clinicians. Patients said they felt comfortable once they had arrived after initially feeling nervous about attending the service.

Staff followed policy to keep patient care and treatment confidential. Staff documented on electronic patient records that they had discussed confidentiality and explained it to the patient.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff documented patients' family and social information; for example, if there were any looked after children. Staff also discussed patients' employment status and any problems. Staff discussed patients' physical, mental and emotional health.

All staff were professional, introducing themselves to patients, their role and what they would be doing during the appointment. Then during the appointment, they continued to communicate at each stage what they were doing.

Overall staff understood patients' personal needs and supported them in their decisions on treatment and medication. Patients said that staff listened to their preferences and discussed their options with them to select the best one for them. Patients said they could speak to staff without feeling judged.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Community health (sexual health services)

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff did not always make sure patients and those close to them understood their care and treatment. Staff gave each patient clear advice about any medication or treatment, explained any possible side effects and information on the potential risk. Those patients who received contraceptive treatment from the provider said that staff also explained aftercare, if they had any issues to contact themselves for advice or if they become unwell and needed medical help urgently to contact other primary care providers. Some mentioned they had received information with contact details for them and their online services at the end of their appointment. However, a number of patients were not aware of the online service and hadn't been signposted to them during their appointment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff did not always support patients to make informed decisions about their care. Staff gave patients information about different types of contraception available to them and offered them a choice, documenting discussions of what the patients' preferred method was. Staff discussed the advantages and side effects of different options and explained about the process. Staff documented discussions about future use of contraception and long-term effects of certain options.

However, some patients did not receive information prior to their appointment so felt unprepared for their consultation. Patients said they were not provided with information about how they might feel after an appointment, with one patient unable to drive home after their first appointment as they felt so unwell.

Patients gave positive feedback about the service. Staff were inconsistent in sharing information about consultations and the complaints process with service users which had an impact on their experience of the service.

Are Community health (sexual health services) responsive?

Community health (sexual health services)

Good 

We rated responsive as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. There were daily appointments at each clinic which were kept for urgent patients and were bookable on the day. We heard patients being told to ring back on the day to access these appointments if an appropriate appointment could not be made in advance.

People we spoke with all expressed how easy the service was to access, with no issues once referred and the process of making an appointment was prompt and how appointments were available that best suited them.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff directed patients with no symptoms to their online screening site whereby patients could register for a home screening kit for HIV, chlamydia and gonorrhoea and receive their results in five days. Patients with symptoms were advised to attend the clinic.

Managers monitored and took action to minimise missed appointments. Administrative staff booked patients into the next available appointment with a clinician competent for the task. Administrative staff had access to information on the shared electronic database which advised the tasks each clinician had competencies for.

Managers ensured that patients who did not attend appointments were contacted. Patients said they were able to fit appointments in around other commitments and had no issues getting an appointment that suited them at any of the clinics. Patients said the service was very flexible.

The service relieved pressure on other departments when they could treat patients in a day.

However, facilities and premises were not always appropriate for the services being delivered. Rooms were not sound proofed. Radios played loudly at the Truro and Newquay site in order to prevent patient conversations being overheard by others. At Newquay, staff working in the reception area were easily overheard and did not protect the data confidentiality of patients when they were booking appointments over the phone.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients told us the service was easily accessible and also discreet. Most clinics had adequate parking facilities and the main site was in the centre of town opposite a bus station.

Community health (sexual health services)

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff had access to communication aids to help patients become partners in their care and treatment.

The service did not have information leaflets available in languages spoken by the patients and local community. There were no leaflets displayed in any of the clinics.

There were no male staff employed by the provider. This meant that patients did not have a choice about seeing a male or female nurse. There were no unisex toilets identified for patients who identified as transgender.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service had no wait times to access appointments. Staff blocked out times in their diary every day to accommodate emergency appointments from a three to a same day slot. Waiting time for fitting coils was approximately two weeks. The waiting time for implant removal was four weeks at St Austell but sooner if the patient could travel to other clinics.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff prioritised urgent and booked routine appointments with longer wait times for patients with non-urgent conditions. Patients requesting smear tests were advised to call their GP as the service did not provide this service.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers worked to keep the number of cancelled appointments to a minimum. Staff had to cancel appointments if a member of staff was sick as they did not have enough staff to free up anyone to cover a different location. Staff offered patients one of the protected slots at a different location, but if they were not able to travel then they had to cancel the appointment.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff supported patients when they were referred or transferred between services. The service had a referral form for GPs to complete which was also an open access form on their website. There was an agreed referral pathways document that staff followed. Managers asked other services how they preferred to receive the referral. For example, the emergency department required the service to complete a referral form but also ring ahead to inform them a patient was coming in.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

Community health (sexual health services)

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Not all patients, relatives and carers knew how to complain or raise concerns. The service did not display information about how to raise a concern in patient areas.

There was no signage of how to complain in any of the sites. However, this was rectified at the Truro site on the day of our inspection. Patients were handed a card after each appointment which informed them how to complain or rate their care.

Not all patients were aware of the complaints process although they said they felt confident that the provider was open to feedback and change if required.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The service held a complaints register. There had been two complaints since May 2021. Staff recorded the dates of the complaints and the actions taken. Learning was identified and positive outcomes for the patients were identified.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff said that lessons to share was usually shared with staff by the clinical manager.

Staff could give examples of how they used patient feedback to improve daily practice.

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

We rated well-led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service leaders held the relevant qualifications for their role or were working towards them. The service leaders had a good understanding of the service and managed their team well.

Community health (sexual health services)

The service received support and advice from their medical director who was accessible via email and telephone. The service also employed a consultant who was contracted to work two days a week. The consultant provided advice and support during these contracted hours but held no leadership responsibilities.

The service funded nurse prescribing courses which the clinical lead was undertaking. The service manager and area manager had completed leadership courses which the service had also funded.

Staff said they felt the senior leaders were approachable and visited the sites regularly.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The service had an up to date statement of purpose. However, staff were unaware of the provider's vision and values. Staff did talk about the values around promotion of sexual health. Managers knew there was still work to do to instil the Brook values over NHS values for those staff who had recently transferred over.

The provider had a clear strategy about how to achieve a fully functional open access, all age level three reproductive and sexual health service and they updated their commissioners on their action plan regularly.

Staff said they worked for a respectful and inclusive employer.

New staff covered the service's vision and values as part of their induction.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt happy in their jobs and said that their management team was very supportive. Managers shared the results of patient feedback with the team and the team received praise for this by senior managers.

Staff completed annual staff surveys which showed positive results. Managers took action to make improvements to the service based on these results.

Staff accessed a wellbeing hub on the service's intranet. The service provided wellness action plans for the home and the workplace, resources for managers, an anxiety and resilience webinar and an employee assistance programme.

Staff took part in mental health first aid training. A wellbeing team sent out regular emails to all staff with suggestions and advice. Managers offered part homeworking, part office working to all staff following the pandemic. Staff completed a display screen assessment and support for working at home.

Community health (sexual health services)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Brook Cornwall is part of the national organisation Brook Young People. The organisation's board took overall governance responsibility for the organisation and delegated authority within a clear written scheme of delegation.

The service communicated regularly with the mobilisation board for Cornwall council. Their quarterly contract meetings had moved into contract management. There were still some areas of the contract specification outstanding, such as issues running clinics to 19:30 when the GP clinic they run out of closed at 17:00.

The service remained in regular contact with their commissioners about any issues providing the full contract specification of a level three sexual health service.

The provider was still encountering difficulties accessing some pathways that other providers had blocked. The leadership team were in regular communication with these providers about how to improve communication and patient pathways.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a business continuity plan which was due to be reviewed in August 2021. Their risk register was up to date and regularly reviewed and included the new risks identified to the running of the service during the pandemic.

Managers completed health and safety audits and ran annual site audits annually for satellite clinics and monthly audits for sites they owned. There was a health and safety checklist for all sites.

IT connectivity was on the provider's risk register. All staff had 4G enabled laptops as they were unable to connect to NHS systems and Wi-Fi. This meant that the quality of connectivity was dependent on where the staff member was based. Service managers were in negotiation with NHS managers to access their systems.

Staff considered additional risks for vulnerable HIV patients; for example, flu vaccinations in the winter.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Community health (sexual health services)

It was not always clear if data or notifications were consistently submitted to external organisations as required. For example, on the service's safeguarding spreadsheet, when a new safeguarding concern had been identified during an appointment, it was not clear if a safeguarding alert had been raised with the local authority.

Managers submitted data to Genitourinary Medicine Clinic Activity Dataset (GUMCad) national data set and Sexual and Reproductive Health Activity Data Set (SRHAD) dataset. All information from the provider's shared electronic database could be pulled off and analysed for national data sets. Managers sent information around their human papillomavirus (HPV) vaccination and cervical smear testing programme to NHS England.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers used the identified learning outcomes from the complaints process to make improvements to their service. Managers took feedback from patients to do the same. A clinical newsletter was emailed to all clinical nurse managers each month following the national clinical governance committee. This provided information to staff to share learning from incidents and updates from national external organisations to ensure all staff were up to date with best practice recommendations.

Operational meetings took place every three months which provided an opportunity for sharing national information and feedback from the organisation which management staff of each service attended. The content of these meetings was minuted and staff were provided with information through the email system

A monthly staff newsletter was sent to all staff. This served as an information sharing system and enabled staff the opportunity to contribute to this. Included in the newsletters we observed were clinical updates, news and updates from within Brook and outcomes from the audit programme. Staff took part in annual staff surveys.

There were patient representatives on the Board of Trustees. There was a national participation group and participation lead. There was a communications team that brought in young people to engage if there was any rebranding or redesigning taking place.

Managers completed an annual quality report for their commissioners. Managers shared quality accounts and published online NHS reports with commissioners, and Healthwatch and the local authority scrutinee committee.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Managers shared service successes and the improvements they had made to services with staff, stakeholders and patients. The clinical lead had recently gave a presentation at a national commissioners meeting about LARC recovery programme where the service had provided additional LARC services to catch up from GPs' shortfall over the pandemic.

The clinical lead had recently submitted a paper to a sexual and reproductive health strategy.