Brook Oldham

Quality Report

Positive Steps
Medtia Place
Oldham
OL1 1DJ
Tel: 0800 988 2209
Website: https://www.brook.org.uk/find-a-service/regions/oldham

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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

Brook Oldham is operated by Brook Young People and provides confidential sexual health services, support and advice to young people under the age of 20. Brook Oldham 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.

CQC received no notifications or safeguarding enquiries in relation to Brook Oldham in the 12 months prior to the inspection.

During the inspection, we reviewed documentation such as care and treatment records. We spoke with young people attending the clinics, staff working in organisations that interacted with Brook Oldham and staff working within the service.

We found the following areas of good practice:

- The service ensured up to date care and treatment was delivered to young people and based on national guidelines.
- Staff worked well together as part of a multidisciplinary team to coordinate and deliver patients' care and treatment effectively.
- Staff maintained contemporaneous and accurate records of the care they provided and these were stored securely.
- The service and staff were working collaboratively with external organisations in order to deliver effective, evidence based and collaborative care for young people.
- Consent practices and records were actively monitored and reviewed to ensure young people were involved in making decisions about their care and treatment in line with relevant legislation.
- Staff worked hard to ensure that the privacy, dignity and confidentiality of young people attending the service was protected and that they were treated respectfully at all times.
- There were good systems in place to manage and learn from complaints and service users were aware of how to raise concerns.
- Service users experienced minimal waits when attending for their appointments or drop in sessions.
- Young people were protected from avoidable harm. Safeguarding of young people was managed effectively by staff who were able to recognise early signs of abuse and act upon these appropriately.

Summary of findings

- Staff worked collaboratively to safeguard young people with a charitable organisation, who were co-located with Brook Oldham. This allowed joined up working and facilitated early recognition of possible abuse and exploitation.
- The service employed a practitioner who worked across different health settings to ensure that service users received consistent care and treatment, which took account of all relevant factors. This service included in-reach into acute hospitals and liaison with alcohol and drug teams.
- The premises were fit for purpose and co located with other advisory and support services, which provided a single point of access for young people.
- The feedback from young people who used the service and stakeholders was consistently positive.
- There was effective leadership throughout the service and we observed good working relationships and support systems for leaders within the service.
- Staff felt valued, respected and felt proud to work in the service.
- Staff told us that their leaders were visible, approachable and supportive.
- We found that staff felt engaged with the national organisation and were able to talk to us about the overall vision and values for the organisation.
- There was an open culture within the service and staff were actively encouraged to report issues of concern.
- There were good systems for managing risks and we found that risks that had been identified were appropriately monitored and acted upon.

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

- There was a very low rate of incident reporting, however, staff were able to tell us what type of incidents they would need to report and were able to show us how they would report an incident.
- Not all staff providing care and treatment to young people received level 3 safeguarding children training.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected sexual health services. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health (sexual health services)		We found the following areas of good practice: • The service ensured up to date care and treatment was delivered to young people and based on national guidelines. • Staff worked well together as part of a multidisciplinary team to coordinate and deliver patients' care and treatment effectively. • Staff maintained contemporaneous and accurate records of the care they provided and these were stored securely. • The service and staff were working collaboratively with external organisations in order to deliver effective, evidence based and collaborative care for young people. • Consent practices and records were actively monitored and reviewed to ensure young people were involved in making decisions about their care and treatment in line with relevant legislation. • Staff worked hard to ensure that the privacy, dignity and confidentiality of young people attending the service was protected and that they were treated respectfully at all times. • There were good systems in place to manage and learn from complaints and service users were aware of how to raise concerns. • Service users experienced minimal waits when attending for their appointments or drop in sessions. • Young people were protected from avoidable harm. Safeguarding of young people was managed effectively by staff who were able to recognise early signs of abuse and act upon these appropriately. • Staff worked collaboratively to safeguard young people with a charitable organisation, who were co-located with Brook Oldham. This allowed joined up working and facilitated early recognition of possible abuse and exploitation. • The service employed a practitioner who worked across different health settings to ensure that

Summary of findings

service users received consistent care and treatment, which took account of all relevant factors. This service included in-reach into acute hospitals and liaison with alcohol and drug teams.
- The premises were fit for purpose and co located with other advisory and support services, which provided a single point of access for young people.
- The feedback from young people who used the service and stakeholders was consistently positive.
- There was effective leadership throughout the service and we observed good working relationships and support systems for leaders within the service.
- Staff felt valued, respected and felt proud to work in the service.
- Staff told us that their leaders were visible, approachable and supportive.
- We found that staff felt engaged with the national organisation and were able to talk to us about the overall vision and values for the organisation.
- There was an open culture within the service and staff were actively encouraged to report issues of concern.
- There were good systems for managing risks and we found that risks that had been identified were appropriately monitored and acted upon.

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

- There was a very low rate of incident reporting, however, staff were able to tell us what type of incidents they would need to report and were able to show us how they would report an incident.
- Not all staff providing care and treatment to young people received level 3 safeguarding children training.

Summary of findings

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Brook Oldham

Services we looked at
Community health (sexual health services)

Summary of this inspection

Background to Brook Oldham

Brook Oldham 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.

Brook Oldham is recognised as a level 2 contraception and sexual health service (CASH), which provides confidential sexual health services, support and advice to young people under the age of 20 across the Oldham and North Manchester area.

The Department of Health's National Strategy for Sexual Health and HIV for England 2001 set out what services should provide at each recognised level. As a level 2 service, Brook Oldham provides contraception, emergency contraception, condom distribution, screening for infections, pregnancy testing, termination of pregnancy referrals, chlamydia treatment (Level 2) and partner notification chlamydia treatment.

Young people presenting with sexually transmitted infections were referred to an alternative level 3 CASH service close by in Oldham.

Support, guidance and advice were provided to young people who were transitioning to adult services for their ongoing care and treatment.

The service operated from a centre in Oldham town centre and was co-located with a number of other services for young people including drug and alcohol support, career services and educational courses. The service was nurse led and registered nurses, support workers and counsellors all worked to provide services for young people.

The service did not provide termination of pregnancy services but did facilitate referrals to appropriate care providers for termination of pregnancy services when required.

The service provided clinics six days a week on Mondays to Saturdays.

Between April 2016 and March 2017, there were a total of 8,005 contacts with young people in the Brook Oldham clinic. Of these 83 service users were referred to other services such as level 3 CASH services or counselling to best meet their needs. A new nurse manager had recently been appointed.

Our inspection team

The team that inspected the service was led by Katherine Williams, Inspector and comprised of three CQC inspectors and a variety of specialists including a specialist nurse in sexual health services and a specialist advisor for governance.

Why we carried out this inspection

This inspection was carried out as part of our comprehensive inspection programme for independent health services.

Summary of this inspection

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 Brook Oldham, asked a range of other organisations for information and sought feedback from patients through comment cards.

During the inspection visit, the inspection team:

- Visited the Brook Oldham clinic, looked at the quality of the environment and observed how staff were caring for patients;
- Spoke with three patients who were using the service;
- Spoke with the managers of the service, including the regional lead;
- Spoke with four other staff members; including nurses, receptionist and support staff;
- Looked at nine care and treatment records of patients;
- Carried out a specific check of the medication management and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

People who used this service spoke positively about the service they received. Young people were particularly positive about the staff who worked at Brook Oldham and told us that they felt comfortable accessing services there.

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?

- Staff knew how to report incidents and could give us examples of incidents, such as IT failure and medication errors.
- Staff we spoke to knew the principles of duty of candour and could tell us how they would exercise this duty.
- Substantive staff had completed safeguarding adults and level 2 safeguarding children training.
- Staff had infection control training and were aware of the organisations polices. Audits were completed and we observed appropriate hand washing and use of personal protective equipment (PPE).
- The environment was clean and tidy. Equipment was available and routinely serviced. Medicine storage was secure and logs maintained.
- There was sufficient staffing levels and staff felt confident to raise issues with management. Mandatory training was provided annually, face to face and via e-learning.
- The service utilised electronic records. We reviewed nine sets of records and found they were of a good standard and all risk assessments were fully completed.

However:

- The intercollegiate document 'Safeguarding children and young people: roles and competencies' (2014) sets out the levels of competencies and training required for staff working with children and young people. This document states that all staff who assess, plan, intervene and evaluate care with children and their parents, i.e. sexual heath staff, should undertake training at level 3. No front line staff had completed level 3 safeguarding children training.

Are services effective?

- Staff followed national and local guidelines and policies. The service participated in national audits, such as the sexually transmitted infection (STI) audit. Action plans were formulated and shared.
- Staff had access to training and development and support was provided for revalidation.
- The service worked well with other organisations and collaboratively planned and provided care.

Summary of this inspection

- Staff obtained consent to treatment and discussed care planning. Organisation policies for mental capacity were in place.

However;

- Only 33% of staff had an appraisal completed within the last 12 months.

Are services caring?

- Patients felt positive about the care and treatment they received and they felt supported to make informed choices.
- Staff engaged with patients and offered kind and considerate care.
- We saw that privacy and dignity was maintained and their needs were met.
- Young people spoke very positively about the service and in particular the approach of staff members.

Are services responsive?

- Sexual health services were subcontracted to Brook Oldham by another provider. Service planning and delivery was undertaken to meet the needs of the local population.
- Individuals had their needs assessed and adjustments made accordingly. The building was accessible to wheelchair users.
- Staff knew the complaints procedure and received feedback from complaints raised.

Are services well-led?

- Staff were enthusiastic about their jobs and felt well supported. They were aware of the trust values and were proud of the services they provided. Governance and quality meetings were held and incidents and risks discussed.
- The organisation engaged with both staff and patients. Compliments and complaints received were shared with staff. Lessons learnt were shared and discussed in team meetings.

Detailed findings from this inspection

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health (sexual health services) safe?

ncident reporting, learning and improvement

- The organisation had a national 'pillar' policy and procedure for the reporting of any incidents or concerns.Staff told us they could access it on the organisations intranet system and that hard copies were available in the office.
- Staff were knowledgeable about how to report an incident and demonstrated that they could use the system and explained the process.
- We discussed incidents with staff and asked them to give examples of the types of incidents they would report. Examples given included staffing issues, IT failures and clinical notes errors.
- However, we found that not all incidents were reported. For example, an incident discussed involved recording of information in the wrong patient's notes. The error was identified, immediate actions taken and staff member learning supported, however this was not incident reported.
- There were no clinical incidents or serious incidents reported between 20 December 2015 and 19 December 2016.
- There had been no never events reported between 20 December 2015 and 19 December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event**.**
- Staff told us that they discussed incidents and lessons learnt from them in team meetings. We reviewed copies of the team meeting informal minutes, which showed that incidents and lessons learned were discussed.
- Incidents were also reviewed corporately and learning cascaded.

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.
- Managers working within the service had a good understanding of their responsibilities in relation to Duty of Candour and were able to give examples of when they would need to exercise this.
- Staff we spoke to knew the principles of duty of candour and could tell us how they would exercise this duty.

Safeguarding

- The organisation had safeguarding 'pillar' policies in place and staff had access to them via the intranet and on site. There was a six step process, which staff told us about and we observed staff leaflets of the process.
- Staff understood and were able to explain the process for reporting safeguarding concerns and have access to the multi-agency safeguarding hub (MASH) system.
- There was a safeguarding proforma and register to record all safeguarding concerns. Staff could access this and completed a proforma. This was reviewed by the service managers and completed cases were 'greyed out'. This allowed staff to identify at a glance which cases still required attention.
- The safeguarding lead also supported managers and staff.

Community health (sexual health services)

- Frontline staff completed in-house level two safeguarding children training. Managers working in the service were trained to level 3 in safeguarding children and were available during all clinic hours. Staff also had access to a staff member with level 4 safeguarding training at all times.
- Records reviewed showed that 100% of substantive staff had completed level 2 safeguarding children training and no frontline staff had completed level 3 safeguarding children training.
- The intercollegiate document 'Safeguarding children and young people: roles and competencies' (2014) sets out the levels of competencies and training required for staff working with children and young people. This document states that all staff who assess, plan, intervene and evaluate care with children and their parents, i.e. sexual heath staff, should undertake training at level 3. Therefore the service was not meeting this national guidance. Following our inspection, the manager of the service has informed us that all staff are now required to undertake level 3 training and there was a programme in place to ensure all staff underwent this training as quickly as possible.
- Staff were able to recognise signs of female genital mutilation (FGM). They were also aware of the process to follow if they suspected female genital mutilation (FGM) and this process was displayed on staff noticeboards.
- Staff also routinely assessed service users for signs of child sexual exploitation (CSE) and signs of domestic abuse. They worked closely with other services and a charitable organisation to further improve their ability to recognise and act on possible child sexual exploitation.
- Staff were aware of the guidance and serious cases from external organisations specialising in handling disclosures, and the protocol for appropriate referral for young people who may disclose historical abuse.
- Brook Oldham had changed the way in which they alerted and managed concerns about service users they suspected were at risk of abuse and harm. They had used recent case reviews and studies to improve their practice and strengthen their relationships with multiple organisations. This allowed the easy but secure sharing of information and intelligence to ensure service users were safeguarded.
- Staff told us they received good support from the local authority safeguarding team and would ring the team if they needed advice.
- There was a safeguarding support rota for staff to utilise if help and support was required with any safeguarding issue. This rota included weekend cover arrangements. We observed that the rota was displayed for all staff to access on the noticeboard in the main office area.
- Care records used within Brook Oldham included prompts for staff to gather detailed information, which provided alerts to any potential safeguarding issues.
- Staff were made aware of the guidance from external organisations specialising in handling disclosures, and the protocol for appropriate referral for young people seen within clinics who disclosed historical abuse.

Medicines

- Staff followed corporate patient group directives (PGD). We reviewed these and found that they were in date and had been signed appropriately by staff. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. The staff we spoke to during the inspection kept their own copies of the signed PGD for reference during clinics.
- We reviewed the PGDs and they were appropriately signed off by a doctor, pharmacist, head of nursing and an executive director of Brook, which met best practice guidelines.
- Medicines used in the clinic were stored in locked cabinets and the keys were stored securely in the office which could only be accessed by authorised staff.
- Emergency drugs, anaphylaxis kits and oxygen were stored securely and staff had keys to access them. Daily checks were logged and fully completed.

Environment and equipment

- Brook Oldham was based in a building which was shared with other services. The facilities were fit for purpose and visibly in good repair.
- Any required repairs and maintenance of the building were carried out routinely and staff told us that there was good response if an urgent repair or maintenance was required.
- Water checks for legionella were carried out to ensure young people, staff and visitors to the service were not at risk.
- Portable appliance testing was carried out annually to ensure the electrical equipment was safe to use.

Community health (sexual health services)

- The fire alarm was checked weekly for the entire to ensure all alarms. The clinic was based on the ground floor and emergency exits were clearly signposted.
- Staff reported that they had access to the equipment they required to fulfil their roles.
- There was plenty of storage and waiting areas were spacious. Waiting areas also had noticeboards displaying useful information for service users.
- The waiting room was a generic area for several services, which meant it was not clear to other patients which service another patient was accessing. This helped maintain service users' privacy.
- We checked equipment within the rooms and all were serviced and in date, except for one examination light; staff stated this belonged to the building and was not utilised by them.

Quality of records

- Records were completed and stored electronically. Staff were trained to use the system and could access it with ease.
- During the inspection we reviewed nine sets of records and they were all clear, concise and included treatment plans and assessments at each visit.
- It was clear when the patient had attended, what time they were seen and what they had attended for.
- Record keeping audits were routinely undertaken as part of staff members' monthly reviews. For each meeting, the service manager would gather a sample of records which the staff member had used and audit these with the staff member. This helped ensure that staff were actively engaged with the process of records review and encouraged them to improve their practice when needed.
- Other audits on specific records were completed top ensure that staff were completing them correctly and contemporaneously. This included a review of records for patients being referred for termination of pregnancy.

Cleanliness, infection control and hygiene

- Staff were provided with training regarding the control and prevention of infection. Records showed that eight out of the nine staff were up to date with this annual training.
- Staff were knowledgeable about infection control procedures, including spillage and clinical waste.
- There were hand washing facilities available in each clinic room and personal protective equipment, including aprons and gloves, were readily available for staff to use. There were also posters displayed on walls in clinic areas with guidance on how to undertake hand washing correctly. We observed staff washing their hands between patient contacts.
- Clinical waste was stored away from the clinical area ready for disposal, and was disposed of by a private company employed by the building.
- Sharps bins were in use within clinics to ensure the safe disposal of sharp instruments, such as needles. These bins were signed dated and partially closed when not in use.
- Brook Oldham had completed the Brook national infection control audit (2016/17) and the outcome had exceeded the organisation's target of 85% at 92%, across eight standards assessed. The areas audited were hand hygiene, environment, kitchen, waste disposal, spillage/contamination, protective equipment, prevention of injury and specimen handling.
- Peer hand washing reviews were undertaken and staff participated in these audits.
- Examination couches in clinical rooms were cleaned between patients and we observed a daily cleaning rota was in place and this was fully completed.
- Equipment was visibly clean and had 'I am clean' stickers attached.
- Cleaners were provided by the building and emptied bins and cleaned the rooms.

Mandatory training

- The trust required each member of staff to attend mandatory training, which included manual handling, safeguarding, basic life support and infection control.
- Training was completed using a blended learning approach with some online learning and also some face to face training.
- The service manager and clinical lead manager utilised a training spreadsheet, which identified the training staff had attended and the date it was completed. This was monitored on a weekly basis and levels of compliance were reported to the board.
- Records showed a high rate of compliance with mandatory training with eight out of nine staff were up to date with their manual handling and basic life

support training. The one member of staff who was not up to date had stated that they undertook the training in another organisation where they worked and the management team were awaiting confirmation of this.
- Staff said they could access training easily and were asked about their training needs.
- New staff completed an induction and role specific competencies which they had signed off by their manager.

Assessing and responding to patient risk

- We reviewed patient assessments and documentation as part of the inspection process and noted that risks were assessed on service users initial visit and revisited on subsequent visits.
- Risk assessments completed included safeguarding, home and social situation, female genital mutilation (FGM) and child sexual exploitation (CSE).
- Staff told us they would observe patients in the waiting room to monitor for signs of distress and if they had any concerns, they would then raise them with the clinician prior to the patients' assessment.
- Staff had access to emergency equipment within the main clinic which contained oxygen and a face mask should a young person become acutely unwell at the clinic. There was written evidence to show this equipment was checked each week to ensure it was ready to use in an emergency.
- Staff were aware of the risks of anaphylaxis and nurses received training regarding the action to take if a young person had an anaphylactic reaction. This was a role specific addition to the basic life support training and was updated annually. Anaphylaxis is a serious, life-threatening allergic reaction which can be a result of administration of some medicines.
- All staff were required to complete basic life support training each year as part of the mandatory training programme. This ensured that staff were able to recognise young people who may become very unwell and respond to this appropriately.

Staffing levels and caseload

- There were 10 members of substantive staff employed at Brook Oldham and bank staff who worked in the clinic regularly.
- Three members of staff had left the service in the last 12 months prior to the inspection, which equated to a 30% staff turnover rate. The sickness rate for the service for the same period was low at 4.1%.
- Staff worked part time and covered the clinics planned over six days.
- There were no staff vacancies at the time of the inspection.
- Bank staff were utilised during annual leave or sick leave. The service had regular staff that they would utilise who had training in the IT systems used at the clinic and Brook policies and procedures.
- Reception staff were employed by another provider but were included in team meetings and adhered to Brook policies**.**

Managing anticipated risks

- There were panic buttons on each telephone for staff to utilise if there were unanticipated incidents / events. This alerted the managers within the building. Staff said the buttons had been used for such incidents in the past and staff did come to support.
- Paper copies of all note templates were kept at reception in case of an IT failure. Forms would then be scanned onto system and clinical staff would type consultation notes retrospectively onto the electronic system

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

Evidence based care and treatment

- Staff working at the service were knowledgeable about guidelines and recommendations provided by the British Association of Sexual Health and HIV (BASHH), National Institute for Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Staff were able to access these guidelines using the clinics computer system. We observed that staff utilised these guidelines when undertaking and planning care for young people accessing the service.

Community health (sexual health services)

- When we reviewed board level and local meeting minutes we found evidence that guidelines, policies and processes were regularly discussed, updated and amended to reflect the latest guidelines and best practice.
- The Brook corporate organisation designed and based their clinical policies and procedures on national guidelines and standards from organisations such as NICE guidelines and BASHH.

Patient outcomes

- Brook Oldham participated in local and national audits. These were based around a local and national audit cycle. The national audit cycle allocated different audits on a two to three monthly basis and covered a range of subjects, including termination of pregnancy sexually transmitted diseases testing and infection control. In addition, to these national audits, monthly audits were also undertaken, which were centred on operational subjects, such as safeguarding referral compliance and record keeping.
- The Brook Abortion Audit was undertaken in 2016 to understand the extent and management of unwanted pregnancy across Brook services. The audit standards used were taken from Chapter nine of the 2011 Royal College of Obstetrics & Gynaecology (RCOG) 'The care of women requesting induced abortion'.
- The Brook abortion audit was completed to understand the numbers and management of unwanted pregnancy across Brook services. The audit was undertaken by reviewing the records of 609 service users across Brook services and locations.
- The results of this annual audit showed that some staff across the service had not followed the guidelines measured when providing care and treatment to young pregnant women. The results showed that 60% of the records audited showed that appropriate STI testing was undertaken. This had not improved from the 2015 audit, which showed the same level of compliance with this standard, but had shown an improvement on the 2014 audit result, which showed that 44% of women received this testing. This was against a target of 100%
- This audit also showed that not all women received an estimation of gestation of their pregnancy. The audit result showed that 88% of records audited had estimated gestation recorded. This was also highlighted in the 2015 audit and the overall compliance with this standard had improved from 86% in 2015 to 88% in 2016. This was measured against a target of 100%
- We found that the recommendations from this audit had been discussed at a local level within Brook Oldham and actions were in place to address these issues.
- The Brook STI testing audit was undertaken in 2016 and was undertaken to measure whether young people were receiving the optimal level management of STIs in line with BASHH guidelines. The audit standards were taken from the British Association of Sexual Health and HIV (BASHH) guidelines for Sexual Health history taking (2013). The audit looked at the management of two STIs; Gonorrhoea and Chlamydia and also at notification of partners, as set out in the BASHH guidelines.
- A total of 557 service user records were audited across Brook services and locations. The results of this audit showed that Brook were performing better than the national average of 12% for service users being retested for chlamydia between seven and 14 weeks after diagnosis. Audit results showed that 25% of service users audited who had accessed Brook services were retested in this period.
- The audit also showed that 60% of service users audited received care and treatment for gonorrhoea which met the national BASHH standards.
- BASHH guidelines state that partner notification is a key tool to stop the transmission of STIs through a reduction of infection spread across the sexual network. The BASHH guidelines contain a standard which is either measured by the index patient or a health care worker for chlamydia. The minimum standard is that at least 0.6 contacts per index chlamydia case are seen and treated within four weeks when verified by the client and 0.4 if it is by the health care worker. The results of this audit showed that for both casual and regular partners, Brook services did not meet this key performance indicator (KPI). For casual partners, the index was significantly lower that the KPI at 0.1 and although for regular partners this figure was slightly higher at 0.36 but still remained below the KPI of 0.6. This meant that Brook were performing worse than expected in relation to the notification of partners when patients were diagnosed

with chlamydia. We saw evidence that the results of this audit had been discussed at a local level and recommendations from this audit were being implemented and measured at a local level.

Competent staff

- Brook Oldham supported registered nurses to comply with the three yearly revalidation process. Brook had provided training to all nurses regarding the requirements for revalidation and information was available on the Brook intranet pages. Managers within the service monitored when staff were due to revalidate and supported them with this process.
- Staff had access to training above their mandatory training requirements and told us they had training provided by a lecturer from the local university on a regular basis.
- Support workers had been provided with clinical training, such as carrying out pregnancy tests, chlamydia screening tests and provision of condoms to young people. The training also included competency being assessed prior to staff being able to conduct these interventions.
- The organisation required the nursing staff to complete Sexually Transmitted Infections Foundation (STIF) training. The STIF Competency Programme is a nationally recognised training and assessment qualification in sexual health developed and administered by the British Association of Sexual Health and HIV (BASHH) through its educational arm, the Sexually Transmitted Infections Foundation. It is a modular competency-based training and assessment package for non-specialist and specialist healthcare professionals requiring skills development to manage people with sexually transmitted infections. Records showed that all nurses had undertaken this training.
- Staff had completed sexual health training and were also having further training to offer support for drug and alcohol misuse.
- Only 33% of staff had an appraisal completed within the last 12 months at time of inspection. Staff told us they had dates set for completion.
- The nurse manager had informal 1-1 meetings with staff, but there was no formal system or clinical supervision.

Multi-disciplinary working and coordinated care pathways

- Brook Oldham shared their facilities with another service who they worked closely with.
- Staff told us they had good links with the local authority and would attend child sexual exploitation (CSE)and safeguarding meetings
- Managers also worked across localities and had buddy support from other managers.
- Staff have access to the multi-agency safeguarding hub (MASH) system so easier to contact colleagues and get feedback.
- Several other disciplines, including social care and youth justice, shared the building staff stated this was beneficial in meeting patient needs.

Referral, transfer, discharge and transition

- Patients self-referred to the service and could choose their appointment times.
- If the service was unable to treat the patient on site, or they required secondary treatment, a referral would be made to a local level three provider of the local trust.
- We saw that the service communicated effectively with patients general practitioners, school nurses and local authorities where appropriate.
- There were robust processes in place to ensure that appropriate referrals were carried out in a timely way. This included referrals to local authorities and support services.

Access to information

- Brook policies were available to all staff via the intranet and hard copies were kept in the office.
- Staff showed us how they accessed the intranet and where they could find relevant documents, for example policies and procedures.
- Staff were alerted to new and updated policies verbal and via email. Policies were also discussed at team meetings to ensure staff knowledge and understanding.
- Notice boards displayed information for staff on FGM and safeguarding, and included contact numbers if support was required.

Consent

- Verbal consent was sought by clinicians and discussions and consent documented on the electronic patient record.
- We observed one consultation where the clinician asked for verbal consent before commencing assessment.

Community health (sexual health services)

- Staff were aware of Fraser guidelines and followed them when seeing patients younger than 16 years of age. This is a national protocol for assessing the maturity of a young person to make decisions and understand the implications of their contraceptive choices.
- We saw the Fraser guidelines had been followed and documentation for this was included in the assessment record and revisited each time the patient attended the clinic.
- Questions were asked to assess the competence of the young person to understand information and give informed consent for any procedure and these were completed fully in the patient record.

Are community health (sexual health services) caring?

Compassionate care

- Staff were very caring with patients and treated them with respect.
- Clinical rooms were private and doors were closed during consultations to maintain confidentiality, privacy and dignity
- Patients we spoke to said they had confidence in the advice they got from the service and would recommend the service to friends.
- The waiting room however, was shared with other services and had the potential to not maintain service users privacy. Staff felt that the shared waiting room may have been an advantage as other people attending the building would be unaware of what service others were accessing. The service users we spoke with told us that they liked the shared waiting room as it allowed them to be anonymous.
- Brook undertook a quarterly national counter survey to engage with patients and review their services. Brook Oldham's survey conducted in September 2016 had an 82.4% response rate and 99% of patients said they would recommend the service.

Understanding and involvement of patients and those close to them

- We spoke with three patients and they found staff 'open' and 'professional'.
- Staff involved patients in their care planning and supported them to make an informed choice about their care.
- Patients could access the intranet site for the service and utilise the online advice service. Patients we spoke to told us they had accessed it.
- There nine records we reviewed confirmed that the patients had participated in the decision making process.

Emotional support

- Staff would refer to councillors for support and to other agencies, including MIND (a mental health charity who offer support and advice), if mental health issues were identified.
- One patient told us they just had a 'chat' with staff that were open and honest with them regarding treatments and investigations, as they were initially confused.
- Patients told us they were happy with the services they received and had good relationships with staff. Patients said they felt well supported

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

Planning and delivering services which meet people's needs

- Brook Oldham provided sexual health services within a shared building. Thirteen sessions per week were provided and patients could drop in or make appointments.
- Staff told us that waiting times could be an issue at times due to having two systems, appointments and drop in. The reception staff would give an approximate wait time on booking in. Staff reviewed the appointment system if the numbers of drop in attendances increased. Appointments could then be closed to reduce waiting times.

Equality and diversity

- Staff had access to the corporate Equality and Diversity Policy via the intranet and a hard copy was available on site.
- The service was provided in a building with wheelchair access and a hearing loop was available.

Community health (sexual health services)

- There was access to interpreters when required, either face to face or via telephone.

Meeting the needs of people in vulnerable circumstances

- The service works collaboratively with another service to offer a range of support services for young people.
- Brook Oldham offered a pregnancy testing service and advice service for options available. There was also a midwife on site several days per week.
- A variety of patient leaflets were available. These included complaints information and condition specific information.
- There was a multi skilled nurse practitioner who worked within the Brook service, but also worked with the acute hospitals and drug and alcohol services. This ensured that young people were quickly identified and provided help and support when they needed it. This also ensured that young people consistently saw the same staff member throughout their journey through interlinking services.

Access to the right care at the right time

- The service was located in the town centre, with easy access via public transport and car, and was accessible for wheelchair users.
- The service operated over six days a week; Monday to Friday 10am to 5.30pm, and Saturday 12pm to 3.30pm.
- Patients could arrange appointments that were convenient to them, either as a drop in or booked appointment time.

Learning from complaints and concerns

- The staff told us they had access to the corporate complaints policy and were able to discuss the process they would follow if a patient raised a complaint.
- Managers told us about the complaints policy and the process they would follow if a complaint was raised. They told us they discussed complaints in the team meeting.
- Staff said they had feedback from complaints raised, except for one incident where the staff member received no feedback.
- Receptionists gave patients a slip to complete, asking about their experience.
- Complaints were logged nationally and actions taken were reviewed. This gave the organisation an overview and highlight any trends or areas of concern. We saw evidence in meeting minutes that complaints were discussed and lessons learned were shared with all staff.

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

Leadership of this service

- The service had a service manager and a new nurse manager in post since September 2016. Managers tried to work flexibly to support staff.
- Staff felt confident to raise concerns and could contact the managers for support whenever required. This included senior managers on the safeguarding rota.
- Leaders of the organisation had the skills, knowledge and experience to lead effectively. They were respected by staff who felt valued in their roles.
- Staff told us that they felt supported and that leaders were also visible and approachable.
- Fit and proper person checks were carried out by the organisation for trustees and directors prior to their appointment. These included Disclosure and Barring Service (DBS) checks, obtaining a previous history (to ensure they had not experienced bankruptcy or been previously removed from the trusteeship of a charity) and that the applicant had no conflicts of interests. The DBS check provides information on previous criminal convictions and assists employers in ensuring suitable people work within the organisation.
- The national organisation had a Clinical Advisory Group. This group provided clinical direction and oversight to ensure consistency and continuous improvement across Brook services.

Service vision and strategy

- The national Brook organisation had a national vision which was valuing children, young people and their developing sexuality. Their aim was for all children and young people to be supported to develop the self-confidence, skills and understanding they needed to enjoy and take responsibility for their sexual lives, sexual health and emotional well-being.
- Staff in Brook Oldham were aware of this vision and aim and were able to articulate to us what it meant to them and their work.

Community health (sexual health services)

- There was a clear strategy for the delivery of services at Brook Oldham. Progress against key strategy measures was monitored through audit and data collection and staff were actively involved and engaged with this process.

Governance, risk management and quality measurement

- Risks were appropriately identified, managed and mitigated, where relevant, throughout the service. There was a collegiate approach to risk management, with staff fully engaged in managing and identifying risks.
- Local risk assessments were completed by the registered manager and service lead. We reviewed some of these and found that they were completed comprehensively with appropriate mitigating actions documented and re-assessed within their due date.
- There were clear channels to escalate risks up to board level and we observed examples of when this had happened. An example of this was the identification of risks associated with potential funding cuts, which had been logged appropriately on the services risk register and escalated through to board level within the national organisation.
- There were quarterly clinical governance meetings where pertinent issues and risks were discussed and updated.
- Strategic risks were discussed at the organisation's monthly board meetings and any actions or issues raised at this meeting were shared across the organisation. Staff working in Brook Oldham told us that they had seen issues from these meetings and that these were discussed at staff meetings. We saw evidence that information from these meetings was communicated in minutes of staff meetings.
- There were monthly team meetings for all staff. We reviewed notes of these meetings and noted that key issues relating to governance and risk were discussed and shared with staff during the meetings.

Culture within this service

- Staff felt very proud to work in Brook Oldham and of the services they provided. Staff had an overwhelmingly positive attitude.
- Staff told us that they were happy in their roles and raised no issues of concern during the inspection.
- We found that there was an open, learning culture where the highlighting of issues and incidents was encouraged and supported. Staff readily identified areas where improvements could be made and managers supported these improvements into practice where practicable.
- We observed good team spirit and senior staff felt teams were good and staff worked hard to ensure patients' needs were met.

Public engagement

- The Brook national organisation were active on social media and ran a number of social media campaigns to engage with the public. These included awareness of STIs and improving self-esteem
- Brook undertook a quarterly national counter survey to engage with patients and review their services. Brook Oldham's survey conducted in September 2016 had an 82.4% response rate and 99% of patients said they would recommend the service.
- Staff told us a form was also available at reception for patients to feedback, however he forms did not record any patient details, so staff were unable to respond to any negative comments or complaints received via the survey.

Staff engagement

- Brook undertook an annual staff survey, which covered a variety of including equality and diversity of their workforce. The results of the survey were not location specific.
- There were monthly team meetings for all staff, and during these meetings line managers shared compliments with the wider team. Compliments were also shared with staff on an individual basis.

Innovation, improvement and sustainability

- The service worked very closely with another service and was upskilling their workforce to be able to assess and support patients in sexual health and with issues with drugs and alcohol.

Outstanding practice and areas for improvement

Outstanding practice

- The service worked closely with a co-located charity to ensure continuity of care and information sharing. This partnership allowed the early recognition of possible signs of child sexual exploitation and was developed as a result of serious case reviews in nearby geographical areas.
- There was a multi skilled nurse practitioner who worked within the Brook service, but also worked with the acute hospitals and drug and alcohol services. This ensured that young people were quickly identified and provided help and support when they needed it. This also ensured that young people consistently saw the same staff member throughout their journey through interlinking services.

Areas for improvement

Action the provider MUST take to improve

- All frontline staff should receive the appropriate level of safeguarding children training.

Action the provider SHOULD take to improve

- All incidents should be recorded via the electronic system and have mitigating actions recorded.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes were not established and operated effectively to prevent abuse of service users. This is because: Not all clinical staff contributed to assessing, planning, and evaluating the needs of a child or young person were trained to safeguarding level three.