

Brook Liverpool

Quality Report

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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

Summary of findings

Our judgements about each of the main services

Service

**Community
health (sexual
health
services)**

Rating

Summary of each main service

We regulate independent community sexual health services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Brook Liverpool

Services we looked at:

Community health (sexual health services)

Summary of this inspection

Background to Brook Liverpool

Brook Liverpool is operated by Brook Young People. This is a charitable organisation that works with younger people under the age of 25 providing confidential sexual health services, support and advice. Brook Young People has had a presence in Liverpool since 1974.

Brook Liverpool is a level 2 contraception and sexual health service (CASH) and provides contraception, emergency contraception, condom distribution, screening for sexually transmitted infections (STI), pregnancy testing, referral for termination of pregnancy

and counselling. A genito-urinary medicine clinic delivered by a local acute provider held clinics twice weekly within Brook Liverpool where patients who required level 3 services could attend.

Education and outreach services are also provided by Brook Liverpool and delivered in schools, colleges, higher educational establishments and hostels across the city. The service includes delivery of education programmes on topics such as contraception, sexuality and relationships, often delivered with partner agencies, as well as targeted work and individual consultations for advice and STI screening.

Our inspection team

Inspection Team

The team included two inspectors with the Care Quality Commission and a sexual health specialist nurse.

The inspection team was overseen by an Inspection Manager.

Why we carried out this inspection

We inspected this service as part of our programme of planned comprehensive independent health inspections.

How we carried out this inspection

During our inspection we visited the main clinic at 81 London Road in central Liverpool.

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?

To get answers to these questions we seek information in a number of ways. Before the inspection visit we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 24 January 2017 and an unannounced visit on 30 January 2017. During the visits we spoke with a range of staff who worked within the service, such as nurses, education staff, receptionists and managers. We talked with young people who used the service, we observed how young people were cared for and we reviewed care and treatment records of young people who used the service.

Summary of this inspection

Information about Brook Liverpool

Brook Liverpool primarily serves young people who reside in the city of Liverpool, however young people from neighbouring areas such as Sefton, St Helens and Knowsley also attend. Brook Liverpool 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.

The service operates from a main clinic in the centre of Liverpool and regular outreach and education support is delivered within eight venues across the city. Staff members include registered nurses, clinical support workers, education and health wellbeing workers, a sexual health doctor and counsellor.

The service provides clinics six days per week Monday to Saturday at the main Brook Liverpool site and fortnightly clinics in schools and colleges.

Between 1 January and 31 December 2016, there were 15,945 contacts with Brook Liverpool across all sites.

During the inspection we spoke with seven young people, observed care and treatment and inspected 15 sets of records. We also spoke with 16 staff including administration staff, nurses, managers, education and outreach staff and medical staff. We received 42 'tell us about your care' comment cards, which patients had completed prior to our inspection and we reviewed performance information about the service.

Twenty eight members of staff including nurses, education workers, doctors, reception staff, counsellors and managers delivered the service.

What people who use the service say

Brook Liverpool carries out a number of surveys to seek the views of young people who used the service. The findings were generally positive and young people we spoke with were happy with the service.

Brook Liverpool carried out surveys of young people attending the clinic that were similar to the national Friends and Family Tests. In April 2016, a survey of young people who attended clinics showed 92% of respondents felt comfortable with how they were greeted at reception, 87% did not think Brook Liverpool could do anything better during their visit and 100% would recommend Brook Liverpool to a friend.

Feedback received by the education team between January and December 2016 was also positive and included the comments: "The people doing the sessions are very enthusiastic", "Very useful and good for us" and "I enjoyed talking about what it means to be in a good relationship".

In response to feedback, the service had introduced a speedy testing clinic and an online booking system from March 2016, as well as extending the end of service clinic time to relieve pressure on staff and waiting times for clients.

Young people we spoke with were positive about the service provided. Specific comments included staff are "friendly" and "lovely", and the service is "really good". In addition, from a total of 42 comment cards completed prior to our inspection, all, without exception, contained positive feedback and included statements, such as the "service is good, the women are lovely and really helpful", "Staff were fabulous. All caring and I felt that I was treated with respect" and "Helped me with everything I needed".

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; however clinic closures due to a high volume of service users or reduced staff numbers were not reported.
- Brook Liverpool complied with National Brook Policy which was to have a procedure in place for incident reporting, investigation, and learning. The policy stated that all incidents required some level of investigation and all serious incidents required a comprehensive root cause analysis.
- Not all patient facing staff who contributed to assessing, planning, and evaluating the needs of a child or young person had completed level three safeguarding training as required by Brook and recommended in the Intercollegiate Document (2014).
- We observed one client record which indicated a safeguarding referral was required. However, this had not been actioned. This was raised with staff and addressed immediately.
- Systems were in place to ensure children and young people who had been identified with safeguarding concerns were followed up either by appointment at the clinic or a telephone call. However, we were not assured that these systems were robust or monitored.
- We found confidentiality of young people who were referred for termination of pregnancy placed at risk due to patient identifiable data collated in a book.
- Data provided at the time of inspection showed that of 14 clinical based staff, none had received an annual infection control update in the last 12 months and none of the education staff had attended any infection control training.
- We found that policies and procedures in relation to infection control were not always followed. We observed on two occasions staff not washing their hands following consultations, and staff who handled specimens had not received infection control updates for over 12 months.
- Mandatory training data provided at the time of our inspection showed 12 of the 14 clinical staff were compliant with basic life support and anaphylaxis training (85.7%). However, no staff were recorded as completing an annual fire safety refresher course or record keeping refresher course within the last 12

Summary of this inspection

months. The training data provided also suggested staff in the education team had not received any mandatory training. We were not assured that systems were in place to support compliance with mandatory training.

However,

- Staff provided examples of recent incidents, described how lessons learnt were shared and discussed changes in practice as a result.
- Staff had completed specific training in relation to Female Genital Mutilation and were aware of current national guidance.
- Medicines were appropriately managed and stored.
- The environment was clean and tidy and equipment was maintained. There were systems in place to ensure the location was cleaned and we observed a number of completed cleaning schedules. We observed several pieces of equipment that had been maintenance checked within the 12 months prior to our inspection.
- Six sets of client records we reviewed included consent, evidence of patient participation and decision making, allergy status, who was present at the consultation, a diagnosis and management plan.
- The electronic record system alerted staff to service users who were under the age of 16 years old so they could fast track them as a priority.
- An infection control audit performed in November 2016 identified Brook Liverpool as achieving 99% against an organisational target of 85%.

Are services effective?

- The Brook organisation based their policies and procedures on national good practice recommendations and standards such as those provided by The National Institute for Health and Care Excellence (NICE) guidelines, The British Association for Sexual Health and HIV (BASHH) UK, and the Faculty of Sexual and Reproductive Healthcare (FSRH).
- We observed a number of pathways in place and staff received a monthly national newsletter which included updates on clinical and policy issues.
- Pain relief was provided and advice given pre and post implant administration.

Summary of this inspection

- Information was easily available on the organisation's website for young people to access and the website included a visual tour of the clinic which could be viewed prior to attending.
- Outcomes of tests and appointment reminders and follow-ups could be provided to young people by text, if they had consented to this, and we observed staff informing young people of this option during consultation.
- Brook had a national annual clinical audit cycle for 2015 to 2016. This identified planned audits which included: implant fitting and removal, sexually transmitted infection testing and treating, infection control, emergency contraception and abortion referrals.
- Systems were in place to assess staff competencies in a variety of clinical procedures which included: managing specimens, referral and signposting to local services, asymptomatic screening, chaperoning, condom education and distribution, and pregnancy testing.
- Nursing staff were required to complete Sexually Transmitted Infections Foundation (STIF) training, and nine out of the ten qualified nursing staff had completed this at the time of our inspection.
- Educational events were delivered with a range of partner agencies and provided information on topics such as sexuality, contraception, smoking cessation, drugs and alcohol.
- Assessment of young people under 16 years of age was completed in accordance with Fraser Guidelines. 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 observed core client records indicating this assessment had been completed.

However,

- Staff competencies were not reassessed following initial sign off. We asked managers how often competencies were reviewed we were told they were not reviewed unless an incident or a problem with practice had been identified. The lack of a timeframe to review competencies could result in changes to current best practice not being adhered to.

Are services caring?

- Young people were treated with respect and dignity at all times.
- Feedback from service users was overwhelmingly positive both in discussion and via comment cards completed prior to the inspection.

Summary of this inspection

- Young people told us they felt welcomed by the service, the friendly staff were “always very respectful” and made them feel at ease.
- Staff we spoke with and interactions we observed between staff and young people demonstrated that staff treated people with respect and dignity and were non-judgemental.
- A National Countermeasures Survey conducted in 2016 indicated that 97% of respondents at Brook Liverpool would recommend Brook to a friend.
- We observed two consultations where staff gave young people information about options of treatment available to enable them to make an informed choice. This demonstrated how young people were involved in decisions about their care.
- Counselling was available for young people and provided support on a range of issues such as depression, self-harm or family difficulties.
- Completion of the core client record aimed to identify concerns such as bullying, emotional abuse, bereavement or caring responsibilities. It also helped to recognise any resilient strengths and protective factors such as involvement of friends or family in whom the young person could confide.

Are services responsive?

- Due to the central location of Brook Liverpool, the service could be accessed easily using public transport.
- The service was available six days a week between Monday and Saturday and offered a drop in or appointment service. A selection of appointments was available to book via the website and a poster was displayed in the main waiting area to advise young people they would receive a text confirmation and reminder of their appointment.
- The Brook website had 24 hour access to ‘Ask Brook’ which provided information on a range of topics including termination of pregnancy, staying safe on line, and contraception. If young people required urgent or emergency information or care there were a range of services listed with details of how to contact the service.
- The service had a male worker in clinic and a male worker in the education team. If a young person raised a preference to have a consultation with a male rather than female this could be arranged by appointment.
- Staff had access to a language line which provided a telephone interpretation service for young people attending the service whose first language was not English.

Summary of this inspection

- Young people under the age of 16 were prioritised and seen promptly by the appropriate clinician and staff told us that young people who were 'looked after' would be seen by the same member of staff to ensure continuity of care, as working patterns allowed.
- For the period 1 January to 31 December 2016 there were 15,945 contacts to Brook Liverpool. Of these contacts 6,824 (21.4%) were seen within ten minutes, with 13,773 (43.3%) seen within an hour. There were also 169 contacts that waited three to four hours.
- A triage system was in use led by a Clinical Support Worker to ensure young people were signposted to the appropriate service and were not waiting unnecessarily.
- All verbal comments or complaints were passed on to the Complaints Manager even if the client did not request an investigation and was satisfied with the explanation or apology given, so that the information could be used to improve service quality.
- Complaints were reviewed by the senior management team. As a result of the upheld complaints an ongoing review of efficiency in delivering services was implemented. The service introduced a speedy testing clinic and an online booking system from March 2016. The end of service clinic time had extended to relieve pressure on staff and waiting times for clients. We observed posters in waiting areas advising clients they could book online appointments.

Are services well-led?

- Brook's core values were confidentiality, education, sexuality, choice, involvement and diversity. Following discussions with staff it was evident that these values were embedded in their day to day work.
- The Board had overall governance responsibility for the organisation and delegated authority through the Chief Executive to the executive and management teams, within a clear written scheme of delegation and statement of internal financial controls.
- Brook Liverpool was commissioned by the public health department of the local authority to provide clinical and education services within the city. Quarterly contract meetings were held to review performance and finance. Monthly operational reports were also provided to advise of any incidents and safeguarding activity.

Summary of this inspection

- Brook used the Practical Quality Assurance System for Small Organisations (PQASSO). The organisational aim was for all Brook services to achieve level 2 of the PQASSO and Brook standards and managers confirmed Brook Liverpool had attained level 2.
- The organisation used a data analytics reporting tool (DART) dashboard to provide managers with local and national activity data. This included information such as the number of young people attending a specific location and the uptake of interventions and services delivered, such as screening for sexually transmitted infections.
- Clinical staff meetings were held at Brook Liverpool. We saw minutes of meetings held in June 2016 and September 2016 and saw that organisational updates, staffing, training, and safeguarding were standard agenda items.
- All staff we asked at the time of our inspection told us they felt well supported and valued by their managers.
- Teamwork was evident throughout our inspection and staff said they were proud of “the way the teams work for each individual client”.
- Feedback from service users was actively sought by Brook Liverpool and exit survey results for December 2016 were displayed on a notice board in the main reception waiting area.
- A National Countermeasures Survey conducted in September 2016 indicated that 97% of respondents at Brook Liverpool would recommend Brook to a friend.
- A Brook wide survey conducted in December 2015 elicited 219 responses. The survey showed that 97% of staff would recommend Brook as a service provider, 82.6% of staff would recommend Brook as an employer and 90% of staff felt Brook treated its staff with dignity and respect.
- The education team had delivered a Future Focus programme to a group of young women in a local school during the end of term holidays. The course was delivered over four consecutive days and included social skills, confidence, self-esteem, relationships, sexual health and awareness of risk taking behaviour. Twelve young women were chosen and 11 completed the programme and achieved a level one award in Skills for Further Learning and Employment.

However,

- A corporate risk register was in place, yet prior to our inspection request there was not a documented local risk register. Managers told us that risks were identified and responded to

Summary of this inspection

and actions documented. During our inspection a local risk register was raised and included three risks scored with regard to likelihood and impact, however no planned review date was documented.

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Brook Liverpool is operated by Brook Young People. This is a charitable organisation that works with younger people under the age of 25 providing confidential sexual health services, support and advice. Brook Young People has had a presence in Liverpool since 1974.

Brook Liverpool is a level 2 contraception and sexual health service (CASH) and provides contraception, emergency contraception, condom distribution, screening for sexually transmitted infections (STI), pregnancy testing, referral for termination of pregnancy and counselling. A genito-urinary medicine clinic delivered by a local acute provider held clinics twice weekly within Brook Liverpool where patients who required level 3 services could attend.

Education and outreach services are also provided by Brook Liverpool and delivered in schools, colleges, higher educational establishments and hostels across the city. The service includes delivery of education programmes on topics such as contraception, sexuality and relationships, often delivered with partner agencies, as well as targeted work and individual consultations for advice and STI screening.

Summary of findings

We found the following areas of good practice:

- Staff provided examples of recent incidents, described how lessons learnt were shared, and discussed changes in practice as a result.
- Medicines were appropriately managed and stored.
- The environment was clean and tidy and equipment was maintained. There were systems in place to ensure the location was cleaned and we observed a number of completed cleaning schedules. We observed several pieces of equipment that had been maintenance checked within the 12 months prior to our inspection.
- Six sets of client records we reviewed included consent, evidence of patient participation and decision making, allergy status, who was present at the consultation, a diagnosis and management plan.
- The Brook organisation based their policies and procedures on national good practice recommendations and standards such as those provided by The National Institute for Health and Care Excellence (NICE) guidelines, The British Association for Sexual Health and HIV (BASHH) UK, and the Faculty of Sexual and Reproductive Healthcare (FSRH).
- We observed a number of pathways in place and staff received a monthly national newsletter which included updates on clinical and policy issues.
- Information was easily available on the organisation's website for young people to access and the website included a visual tour of the clinic which could be viewed prior to attending.

Community health (sexual health services)

- Outcomes of tests and appointment reminders and follow-ups could be provided to young people by text, if they had consented to this, and we observed staff informing young people of this option during consultation.
- Brook had a national annual clinical audit cycle for 2015 to 2016. This identified planned audits which included: implant fitting and removal, sexually transmitted infection testing and treating, infection control, emergency contraception and abortion referrals.
- Nursing staff were required to complete Sexually Transmitted Infections Foundation (STIF) training, and nine out of the ten qualified nursing staff had completed this at the time of our inspection.
- Educational events were delivered with a range of partner agencies and provided information on topics such as sexuality, contraception, smoking cessation, drugs and alcohol.
- Assessment of young people under 16 years of age was completed in accordance with Fraser Guidelines. 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 observed core client records indicating this assessment had been completed.
- Feedback from service users was overwhelmingly positive both in discussion and via comment cards completed prior to the inspection. Young people told us they felt welcomed by the service, the friendly staff were “always very respectful” and made them feel at ease.
- Staff we spoke with and interactions we observed between staff and young people demonstrated that staff treated people with respect and dignity and were non-judgemental.
- A National Countermeasures Survey conducted in 2016 indicated that 97% of respondents at Brook Liverpool would recommend Brook to a friend.
- Counselling was available for young people and provided support on a range of issues such as depression, self-harm or family difficulties.
- Due to the central location of Brook Liverpool, the service could be accessed easily using public transport.
- The service was available six days a week between Monday and Saturday and offered a drop in or appointment service. A selection of appointments was available to book via the website and a poster was displayed in the main waiting area to advise young people they would receive a text confirmation and reminder of their appointment.
- The Brook website had 24 hour access to ‘Ask Brook’ which provided information on a range of topics including termination of pregnancy, staying safe on line, and contraception. If young people required urgent or emergency information or care there were a range of services listed with details of how to contact the service.
- The service had a male worker in clinic and a male worker in the education team should young people raise a preference to have a consultation with a male rather than female.
- Staff had access to a language line which provided a telephone interpretation service for young people attending the service whose first language was not English.
- Brook’s core values were confidentiality, education, sexuality, choice, involvement and diversity. Following discussions with staff it was evident that these values were embedded in their day to day work.
- The Board had overall governance responsibility for the organisation and delegated authority through the Chief Executive to the executive and management teams, within a clear written scheme of delegation and statement of internal financial controls.
- Brook Liverpool was commissioned by the public health department of the local authority to provide clinical and education services within the city. Quarterly contract meetings were held to review performance and finance. Monthly operational reports were also provided to advise of any incidents and safeguarding activity.

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- The organisation used a data analytics reporting tool (DART) dashboard to provide managers with local and national activity data. This included information such as the number of young people attending a specific location and the uptake of a range of interventions and services delivered, such as screening for sexually transmitted infections.
- Clinical staff meetings were held at Brook Liverpool. We saw minutes of meetings held in June 2016 and September 2016 and saw that organisational updates, staffing, training, and safeguarding were standard agenda items.
- All staff we asked at the time of our inspection told us they felt well supported and valued by their managers.

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

- Not all patient facing staff who contributed to assessing, planning, and evaluating the needs of a child or young person had completed level three safeguarding training as required by Brook and recommended in the Intercollegiate Document (2014).
- We observed one client record which indicated a safeguarding referral was required however, this had not been actioned. This was raised with staff and addressed immediately.
- Systems were in place to ensure children and young people who had been identified with safeguarding concerns were followed up either by appointment at the clinic or a telephone call. However, we were not assured that these systems were robust or monitored.
- Data provided at the time of inspection showed that of 14 clinical based staff, none had received an annual infection control update in the last 12 months and none of the education staff had attended any infection control training.
- We found that policies and procedures in relation to infection control were not always followed. We observed on two occasions staff not washing their hands following consultations, and staff who handled specimens had not received infection control updates for over 12 months.

- Mandatory training data provided at the time of our inspection showed 12 of the 14 clinical staff were compliant with basic life support and anaphylaxis training (85.7%). However, no staff were recorded as completing an annual fire safety refresher course or record keeping refresher course within the last 12 months. The training data provided also suggested staff in the education team had not received any mandatory training. We were not assured that systems were in place to support compliance with mandatory training.
- During our inspection a local risk register was raised and included three risks scored with regard to likelihood and impact, however no planned review date was documented.
- There was no system in place for ongoing review of staff competencies. We asked managers how often competencies were reviewed we were told they were not reviewed unless an incident or a problem with practice had been identified. The lack of a timeframe to review competencies could result in changes to current best practice not being adhered to.
- We found confidentiality of young people who were referred for termination of pregnancy was placed at risk due to patient identifiable data collated in a book.

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, to help the service improve. We also issued the provider with two requirement notices that affected sexual health services. Details are at the end of the report.

Community health (sexual health services)

Are community health (sexual health services) safe?

Incident reporting, learning and improvement

- The organisation had a national policy and procedure which guided staff on the reporting of any incidents or concerns and was available on the organisation's intranet system.
- Staff we asked at the time of our inspection knew where to find the policy on the intranet and told us they would raise the incident with their manager and complete an incident form. However, they stated that there were very few incidents to report.
- We asked eight staff to give examples of the types of incidents they would report, these included: accidents, violence and aggressive behaviour, infection control, hazards, lack of confidential rooms and errors in relation to treatment. Staff told us that when clinics were busy and they closed temporarily to new arrivals, this was documented on a clinic monitoring form, which was submitted weekly to the nurse manager and service manager. Staff told us they did not complete incident forms in these circumstances. However, Brook procedure for incident reporting cites clinical risk due to low staffing levels as an example of a recordable clinical incident.
- There were no Never Events recorded by Brook Liverpool in the 12 months prior to our inspection. 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.
- Between 29 June and 24 November 2016, ten incidents were recorded by staff at Brook Liverpool. Six were categorised as no harm to the service user and three classified as near miss, potential risk of serious harm. The ten incidents included three drug administration errors, two record keeping omissions and one significant event.
- The significant event was in relation to a transfer of a poorly young person. The investigation of the incident led to a review of the pathway for prioritising young people that need more urgent review by a nurse. New guidance was introduced and shared.
- We reviewed documentation relating to one of the drug administration errors classified as near miss, potential risk of serious harm. This evidenced discussion with the practitioner and formulation of an action plan. Brook procedure for incident reporting, investigation and learning states that all incidents require some level of investigation and all serious incidents require a comprehensive root cause analysis (RCA) investigation and should be added to the risk register.
- We requested the investigation documentation for five other reported incidents and found appropriate investigation had been undertaken, and were provided with details of actions taken to mitigate future risks.
- Staff provided examples of recent incidents, described how lessons learnt were shared and discussed changes in practice as a result.
- We saw evidence of actions taken to support staff and mitigate risk when an incident had occurred. Actions agreed from one incident included: regular meetings and review, recording all medicines administered and staff checking medicines with another staff member prior to administration.
- Access to genito-urinary medicine services was available at the Brook Liverpool location, however, these services were not provided by Brook Liverpool and therefore they were not responsible for submitting data for these services to Public Health.
- Data was submitted to the Sexual and Reproductive Health Activity Data Set (SRHAD). The SRHAD consists of anonymised patient-level data which is submitted on a quarterly basis and collected on behalf of Public Health.
- Brook Liverpool did not provide screening services for human immunodeficiency Virus (HIV) and therefore did not submit data to the HIV and Aids reporting services (HARS).

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.
- Not all staff we spoke with were familiar with the term 'duty of candour', however, they could describe the principle and the circumstances in which it was used.
- We reviewed one incident monitoring form and three entries in the core client records associated with the

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drug administration errors. All core client records referenced completion of an incident form and two of the three cases had documented that service users had been offered the complaints process. Where appropriate we found that an apology and support had been offered to young people.

Safeguarding

- Safeguarding policies and procedures were incorporated in Brook's Protecting Young People Policy. This was the first of six Pillar Policies designed to support and guide staff.
- Policies were available on the intranet and staff knew how to access them.
- A single safeguarding pro forma was in use for all safeguarding concerns and included identification of the concern and level of risk of harm as well as the client's attitude to the concern raised, any special circumstances for example if the client was under 13 years old and if the concern resulted in an internal or external action plan.
- Between 1 July and 31 December 2016, 23 internal and 23 external safeguarding referrals were initiated by Brook Liverpool staff.
- Details of safeguarding concerns were shared with the commissioners of the service on a monthly basis and included an overview of the concern, the action taken and the outcome, where appropriate.
- Assessments of young people less than 16 years of age were completed in accordance with Fraser Guidelines. 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 observed core client records indicating this assessment had been completed.
- The service assessed staff competency in relation to child protection and vulnerable young people, which included: knowledge of Fraser Guidelines, consent, confidentiality and attendance at adult and child safeguarding, as per organisation policy.
- Safeguarding training was part of the mandatory training matrix and required all patient facing staff to be trained to level 3.
- Data we received from Brook Liverpool at the time of inspection indicated that from a total of 20 staff who provided clinical assessment and intervention, nine staff had completed level three safeguarding training (45%). Of these nine staff, three were recorded to have completed the training somewhere other than Brook with an alternative employer. All staff were recorded as having completed level one and level two safeguarding training.
- The safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document (2014) states that clinical staff who contribute to assessing, planning, and evaluating the needs of a child or young person should be trained to safeguarding at level three and makes reference to sexual health care staff.
- We raised this as a concern during the announced inspection and received assurance within the week that the Local Safeguarding Children's Board had been contacted to organise the delivery of level three safeguarding training for all Brook Liverpool front line staff and managers.
- Safeguarding alerts could be placed on the young person's electronic record which automatically flagged up when their record was opened and could be removed once the concern was resolved. At the time of our visit we observed clinical records where alerts had been put in place.
- Of the six core client records we reviewed, one belonged to a young person aged 13 years, who had a history of safeguarding concerns and was known to other services. On inspection there was no evidence on the clinical record that a safeguarding pro forma had been completed or any liaison with the other services had taken place. We raised this at the time of our inspection as we were concerned that children and young people were not being appropriately safeguarded.
- Action was taken immediately by clinical staff to ensure all appropriate referrals were initiated. Prior to the unannounced inspection an investigation using a root cause analysis approach had commenced to establish why standard safeguarding procedure was not followed in the individual case and a record keeping audit initiated to ensure any other previous safeguarding actions required had not been missed.
- The service also had a safeguarding/cause for concern diary, which was used to identify children and young people that had visited the service and had been identified for a planned follow up due to some concern. The staff would check the book to ensure that follow up

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had taken place and then tick the entry to identify the action was completed. The diary was also used to request a review by the doctor and these were listed each Monday.

- We reviewed the diary for the dates 2 January to 28 January 2017. We found all reviews by the doctor were checked as completed. There were 48 entries that required follow-up due to concern. Of the 48 entries, 10 had not been checked as completed. We cross checked five of these with the electronic records. Of the five electronic records we reviewed, we found three had no documentation of any follow up. One missed follow up was for a young person aged under 16 years, staff confirmed this had not taken place and arrangements were made at the time of our inspection to make contact with the young person. We received further assurance from managers following the unannounced inspection that follow up had been actioned in the 10 cases identified.
- Brook's Sexual Behaviours Traffic Light Tool was in use by practitioners in Brook Liverpool. This tool had been developed to support professionals working with children and young people by helping them to identify and respond appropriately to sexual behaviours. Commissioners informed us that all services working under the banner of the Local Safeguarding Children Board (LSCB) had adopted Brook's 'Traffic Light' tool to identify young people at risk of Child Sexual Exploitation (CSE). This ensured consistency and allowed benchmarking across the services.
- Child sexual exploitation (CSE) involves under-18s in exploitative situations, contexts and relationships. This can involve the young person (or another person) receiving something such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts or money in exchange for the young person performing sexual activities or having sexual activities performed on them.
- The service had an information sharing agreement approved for use by the CSE Lead and they engaged with the local multi-agency CSE forum to cross reference cases against their safeguarding concern lists.
- Female genital mutilation (FGM) (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in

the UK. The organisation had updated their policy and procedure following the amendment of the Female Genital Mutilation Act 2003, which was amended by the Serious Crime Act in 2015.

- Questions regarding FGM were incorporated as part of a service users' assessment and documented in the core client record. We observed a flowchart detailing the mandatory reporting duty for FGM in the main staff room. Staff we spoke with had completed specific training regarding FGM and were aware of current national guidance.
- A member of the Brook executive team was available on-call out of hours should a safeguarding concern be identified and need escalating.

Medicines

- Brook had guidance and information on the safe management of medicines within policies and procedures which were available on the organisation's intranet. The medicines management policy took account of best practice as outlined in the Faculty of Sexual and Reproductive Healthcare (FSRH).
- Medicines were stored in locked cabinets in rooms that were accessed via a swipe card or key code.
- Clinic rooms had medicine cupboards on the walls and we observed these to be locked and only unlocked when medicine was being dispensed. We observed medicines to be in date with long expiry dates. Medicine stock controls were in place and performed by a nominated member of staff.
- There was one cylinder of oxygen in date and stored on site with a bag, valve and mask and an adult face mask.
- Atropine and adrenaline that was within the anaphylaxis packs, was observed to be in date with daily checks recorded.
- Fridge temperatures were recorded daily and we observed checklists which identified fridge temperatures were within ranges. There was an incident five days prior to our inspection where there had been an electricity failure resulting in the fridge temperature being recorded as 11.6 degrees Celsius, which was outside the acceptable range and all the contents of the fridge had been disposed of as per policy.
- Medicines for disposal and out of date medicine was returned to a local pharmacy by staff in a locked box.
- The service used Patient Group Directives (PGDs) to enable nurses to dispense medicine. A patient group direction allows some registered health professionals

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(such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. We observed PGDs had been signed off by a doctor, pharmacist, head of nursing and an executive director of Brook, which met best practice.

- We reviewed eight PGDs for different medicines and all were in date and signed as per National Institute for Clinical Health and Care Excellence (NICE) guidelines. We reviewed eight staff records which identified that staff had signed relevant PGDs to enable them to administer medicine under the directive.
- The service did not perform audits to determine if medicine was prescribed in line with the PGDs.
- We observed two staff administering medicines under a PGD, a label was attached to the medicine, the patient's name and date of administration was written on the label and both staff checked the contents of the medicine box, explained to the young person how to take, side effects, and what to do if they missed a dose. Young people were advised to contact the service or their GP if they had any concerns and they were directed to the information leaflet about the medicine. We observed at the time of our inspection that batch numbers were recorded on the electronic record when medicine was dispensed. The education team did not administer any medicine and therefore all medicines were stored at Brook Liverpool location.
- We observed a section available on the electronic record where it was compulsory for staff to record allergy status.
- Staff were kept updated of any changes in relation to medicines management via emails, team meetings and supervision sessions provided by the doctor.

Environment and equipment

- Clinic rooms were well stocked with personal protective equipment such as gloves and aprons.
- Portable appliance testing was carried out annually and we observed blood pressure monitoring equipment, and computer equipment had stickers in place that identified that the equipment had been maintenance checked within the 12 months prior to our inspection. We observed weighing scales had been calibrated in January 2017.
- The environment appeared clean and tidy and free from clutter.

- All cleaning products were observed stored in a locked cupboard.
- There was a policy in place for handling specimens and staff we asked were aware of the procedure. We observed specimen bags in place for the transportation of specimens.
- We reviewed weekly checklists completed on floor one and two, which included: first aid kit, eye wash, oxygen cylinder and emergency box.
- There were systems and procedures in place for the disposal of clinical waste. We observed clinical waste guidance visible in each clinic room and the sluice rooms.
- Sharps bins were in use within the clinic to ensure the safe disposal of sharp instruments, such as needles. In clinic rooms we observed, sharps containers were labelled appropriately and stored closed with those at risk of hazard attached to the walls.
- As the service was provided across three floor levels, stairs and a lift were available to access all floors. There was wheelchair access via a lift to all floors.
- Fire escape routes were clearly visible on all floors.
- Brook Liverpool used a local general maintenance company for any environment or equipment repairs. Staff told us the service was responsive, if an urgent response was required a same day service was often received. Information technology technicians were based at Brook Liverpool and responded the same day if the need was urgent.

Quality of records

- Brook Liverpool had an electronic system in place for clinical records. Each record had an identifiable number, was dated and identified the staff member that had performed the consultation.
- An assessment record known as the Brook Client Core Record was completed during the young person's first visit to the clinic. The client core record was different for people who were under the age of 18 years to include more detail in relation to consent and safeguarding. The assessment was reviewed on each subsequent visit and updated as necessary. The template provided staff with prompts to gather detailed information regarding the client's history and lifestyle. The additional medical record included: past medical history including, venous thromboembolism (VTE), prescribed medicine and over the counter medicine.

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- Parts of the electronic record were highlighted with a red spot, which prompted the staff that it was a mandatory field and must be completed. The record we viewed on our unannounced part of the inspection had the mandatory fields completed.
- The education team did not have access to the electronic record when providing the service outside of the clinic. We asked two staff from the education team how paper records were transported and recorded on the electronic system. Records were placed in a sealed envelope with the patient's date of birth and initials, they were returned to the clinic and input on the electronic system the same day or the day after.
- We reviewed six sets of electronic records and found all included consent, evidence of patient participation and decision making, allergy status, who was present at the consultation, a diagnosis and management plan. In all six records the patient were given medicines under a PGD and we found the name, strength, dose and frequency of the drug were recorded and the patient had received information about the medicine.
- All safeguarding forms were scanned onto the electronic record and were then stored in a locked cabinet in a keypad protected room.
- We observed a book which recorded confidential information for all children and young people that had been referred for a termination of pregnancy from 8 July 2009 to the time of our inspection. We raised this at the time of our inspection as storing patient identifiable information in this way was not best practice, the storage of this book was not secure and did not protect people's confidentiality. When we returned on our unannounced part of the inspection we observed the book had been removed and was securely stored.
- Brook had a policy in place for peer review of clinical records. Each member of staff had five sets of records reviewed four times a year and any learning needs were discussed with the clinician and actions were put in place if required. If during review it was found that a safeguarding pro forma had not been completed, this was escalated to the safeguarding team to determine if any actions were required, reported as an incident and discussion took place with the clinician to identify any learning needs or support.
- At the time of our inspection there were no record keeping audits available. From November 2016 Brook nationally implemented peer reviews which involved auditing client notes for each member of staff. This data

had been uploaded electronically and once significant data is uploaded this will be used to review individual staff members record keeping to establish if there are any training needs. Any concerns were raised straight away with staff members and were investigated by the line manager.

Cleanliness, infection control and hygiene

- Staff had access to Brook policy and procedures for infection control via the intranet. Information and guidance included: the use of personal protective equipment, hand hygiene, disposal of waste and sharps, handling of specimens and cleaning spillages. The policy and procedures were reviewed in October 2016.
- The Brook Procedure for Specimen Collection and Transportation October 2016 stated that specimens of blood and body fluids must only be taken or handled by staff who have received the appropriate training. This included infection control updates. We asked two staff from the education team who performed chlamydia screening and one staff member who was clinic based, the process for handling, storing, and transporting specimens and all three staff were aware of the procedure to follow which was reflected in the policy.
- The Brook Training Matrix November 2014 identified that all staff providing direct clinical care required an annual infection control update however; data provided at the time of inspection showed that of 14 clinical based staff, none had received an annual update in the last 12 months and none of the education staff had attended any infection control training.
- We observed cleaning rotas completed for the clinic toilet areas. We observed the six monthly deep clean schedules last completed in January 2017 for clinic rooms on the first and second floors. We observed daily cleaning schedules for the sluice areas for January 2017 completed to date and the cleaning schedule for December 2016 completed for the clinic rooms on the first floor.
- We checked the curtains in two clinic rooms and found the curtains had been changed and the date for next change was visible. Staff were observed to be bare below the elbow.
- We observed handwashing facilities and patient protective equipment available in the clinic rooms on the first and second floors and hand washing technique signage above all sinks in clinic rooms, the sluice rooms and toilets.

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- There were no handwashing facilities available in the ground floor triage room however: there was hand gel available from a wall dispenser. We asked a member of staff that used the room about hand washing facilities and they told us they did not handle specimens in this room and washed their hands in the sluice.
- The Brook Hand Hygiene Policy October 2016 stated that hands should be washed before and after attending to a client. We observed two consultations with two different members of staff and we did not observe either member of staff cleaning their hands prior or following the consultation. During one of the consultations the staff member had contact with the young person to perform a blood pressure reading.
- An infection control audit performed in November 2016 identified Brook Liverpool as achieving 99% overall, against the eight standards, which included: the environment, hand washing, personal protective equipment, specimen handling, kitchen, disposal of waste, spillage and contamination, injury from sharps and splashes. The hand washing standard achieved 93.8% compliance and all the other standards achieved 100% compliance. The organisation had a target to reach 85% to be deemed compliant. There was no action or recommendation within the audit to improve hand hygiene compliance.
- All instruments, for example speculums, were for single use and disposable.
- Staff had access to emergency equipment at Brook Liverpool. There was oxygen available with a bag, valve and mask, and anaphylaxis kits. Records we reviewed showed that this equipment was checked daily.
- We observed the resus council guidelines stored with emergency equipment and the guidelines were visible in each clinic room.
- All clinical staff were required to complete basic life support training each year as part of the mandatory training programme. Data provided at the time of our inspection showed 12 of the 14 clinical staff were compliant with basic life support (85.7%).
- First aid equipment was available to staff and was checked regularly to ensure it was ready for use.
- Staff described the process of calling 999 in the event of a medical emergency.
- At the time of our inspection, we observed nurses that administered implants to patients did not have access to an anaphylaxis kit in each clinical room. Kits were available but the nurses were reliant on calling another member of staff who would need to enter two locked doors to access the equipment. We were concerned that a delay in the time to respond, should such an incident occur, placed the patient at significant risk. We discussed this with staff and when we returned on the unannounced part of the inspection we observed that action had been taken and there were kits in each medication cupboard in the clinic rooms. The cupboards were clearly labelled to identify that emergency medicines were stored there.
- The service had developed a traffic light tool which supported staff to assess a young person's level of risk in relation to sexual behaviour which provided staff with prompts and actions that should be taken if a need was identified.
- The electronic record had a flagging system in place to alert staff of any cause for concern that may have been identified for a child or young person. The system also alerted staff if the person was under the age of 16 years old, so that they could fast track them as a priority.

Mandatory training

- There was a Brook Essential Training Matrix that identified essential training requirements and timeframes for completion and updates dependent on staff roles. Subjects included fire safety training, infection control, manual handling and record keeping.
- Data provided at the time of our inspection showed 12 of the 14 clinical staff were compliant with basic life support and anaphylaxis training (85.7%), however, no staff were recorded as completing an annual fire safety refresher course or recordkeeping refresher course within the last 12 months.
- Training data provided suggested staff in the education team had not received any mandatory training.

Assessing and responding to patient risk

Staffing levels and caseload

- There were 28 members of substantive staff employed at Brook Liverpool on 1 November 2016. The team had a skill mix of administration staff, nurses, healthcare assistants, specialist practitioners, a counsellor, a doctor and managers.

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- The service was predominately nurse led, with a doctor on site one day a week for four hours.
- During the period August to October 2016, the service employed 4.7 whole time equivalent (WTE) nurses and 1.1WTE healthcare assistants. There were 0.16 WTE nurse vacancies and no healthcare assistant vacancies.
- During this period ten shifts had been covered by bank or agency staff. There were 32 additional shifts available to be filled due to sickness and leave however, agency and bank did not cover any of these shifts. The service did not always cover every shift. Instead, during quieter periods such as summer holidays or outside the university term times, staffing levels were adjusted accordingly, going to minimum safe staffing levels (usually three nurses instead of four or, two nurses instead of three) and they utilised their permanent staff that covered additional partial hours in addition to their contracted shifts, to relieve pressure on clinic flow.
- The service used clinic monitoring forms to collect data daily. Information included: staffing levels, the number of people who could not be seen if the service was busy and the time staff left the clinic. If clinics were busy and young people could not be seen they were referred to alternative clinics or services or offered an appointment for an alternative day.
- In order to improve the flow of clients through the clinic and make the best use of the clinical team's skills, the service had introduced the role of a healthcare assistant to provide the initial triage point where appropriate. On the 21 days we reviewed we found there were five days when there was no healthcare assistant providing this role.
- There were no caseloads assigned to staff however, arrangements could be made for children and young people to have a future appointment with the same clinician to enable continuity of care.

Managing anticipated risks

- The main clinic had a panic alarm system installed in all of the clinic rooms and in reception there was a further alarm which was directly linked to the Police.
- Blood spillage kits were stored in each sluice and we observed a completed weekly check record.
- Fire evacuation procedures were in place and these were practised twice yearly.
- There were always at least two staff on site to close up the clinic. The education team always worked in twos and were provided with a mobile phone.

Major incident awareness and training

- Brook Liverpool had a business continuity plan, which was revised in January 2017. This included key risks that could affect the delivery of services including adverse weather conditions, failure of utilities and information technology failure.
- A contact list for use in an emergency was held in the main reception area and staff room and staff were aware of its location.

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

Evidence based care and treatment

- Policies and procedures were developed and reviewed against best practice and legislation. Staff working at the service were knowledgeable about guidelines and recommendations provided by the British Association of Sexual Health and HIV (BASHH), the Faculty of Sexual and Reproductive Healthcare (FSRH) and the Royal College of Obstetricians and Gynaecologists (RCOG). Staff were able to access these on the intranet.
- Brook organisation based their policies and procedures on national good practice recommendations and standards, such as those provided by The National Institute for Clinical Health and Care Excellence (NICE) guidelines, BASHH and the FSRH.
- We observed a number of pathways, for example: onward referrals, sexual assault for under 16 year olds and over 16 year olds, pregnant young people and referral process, text messaging, flow chart for safe management of drug keys, chlamydia testing, consent and a pathway for healthcare assistants to raise young people's concerns. The pathways were in a paper folder for staff to access.
- Staff received a monthly national newsletter, which included updates on clinical and policy issues.

Pain relief

- When administering implants, the service used a local anaesthetic in the form of cream to numb the area to reduce any symptoms of pain and discomfort. Young people were given advice on pain relief pre and post implant administration.

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- Paracetamol was kept on site, however this could only be administered by the doctor. There was no PGD in place for nurses to administer paracetamol and it was generally given by the doctor during insertion of an intrauterine device (coil).

Nutrition and hydration

- There was no access to cold drinking water for people attending the clinic in any of the waiting areas, however, due to the central location of Brook Liverpool, facilities for food and drink were close by.
- Lifestyle choices, which included diet, were discussed as part of the core care record and height and weight was recorded to determine a young person's Body Mass Index (BMI).

Technology and telemedicine

- Information was easily available on the organisation's website for young people to access. This included information regarding the services provided, sexual health, contraception and other relevant organisations. There was also a link to the BASHH website, which gave an explanation of the services BASHH provided.
- The website included a visual tour of the clinic, which young people could view prior to attending.
- Young people were able to obtain a response to specific questions by using the organisation's 'Ask Brook' service.
- A 'contraception chooser' tool was available on the Brook website to enable young people to research the best method of contraception for them.
- There was an option via the website to book an appointment at the clinic, rather than using the clinic drop in service.
- There was no facility for young people to complete a history before they arrived at the service.
- Outcomes of tests and appointment reminders and follow-ups could be provided to young people by text, if they had consented to this, and we observed staff informing young people of this option during consultation.

Patient outcomes

- Brook had a national annual clinical audit cycle for 2015 to 2016. This identified planned audits, which included: implant fitting and removal, sexually transmitted infection testing and treating, infection control, emergency contraception and abortion referrals.

- The service performed an audit of sexually transmitted infection which used the standards from the British Association of sexual health and HIV (BASHH) Guidelines for sexual health history taking (2013).
- Brook Liverpool contributed to the Brook Abortion audit 2016. This was undertaken to understand the extent and management of unwanted pregnancy across Brook services. National results indicated that sexually transmitted infection (STI) screening was performed or documented. Brook Liverpool results indicated that STI screening was performed or documented as not required in 70.7% of cases, which was better than the average.
- National recommendations following the audit were that all women referred for an abortion should be screened for sexually transmitted infection or it should be documented if it is inappropriate.
- Brook Liverpool contributed to the national Implant Audit. The target was for one third of women having an implant removed to be STI screened prior to removal. For the period April to June 2016 a total of 14 Brook locations completed the audit. Brook Liverpool were in the top five performers, with a 15% compliance rate; however, this was below the target rate of 33.3%.
- Data was provided to the commissioners on a quarterly basis to show performance, which included the uptake of implants, Long Acting Reversible Contraception (LARC), referral for abortions and sexually transmitted infection screening.
- We observed staff in consultation advising young people of the risks of some medications if their Body Mass Index (BMI) was above the recommended safe levels.

Competent staff

- The service had an induction process in place for new staff, which included an information checklist and a competency induction session.
- Systems were in place to assess staff competencies in a variety of clinical procedures, which included: managing specimens, referral and signposting to local services, asymptomatic screening, chaperoning, condom education and distribution, and pregnancy testing.
- We reviewed a completed induction checklist for one staff member and a record of signed off competencies for another. The competencies were signed in 2012 and when we asked managers how often competencies were reviewed we were told they were not reviewed

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unless an incident or a problem with practice had been identified. The lack of a timeframe to review competencies could result in changes to current best practice not being adhered to.

- At November 2016, 24 out of 26 staff had received an appraisal within the previous 12 months. Those outstanding were due to one staff member on sick leave and one new member of staff not yet due an appraisal. Supervision took place four times per year, two sessions were delivered in a one to one meeting and two as clinical peer group supervision. Attendance at these sessions was considered mandatory, however, these increased in frequency if necessary to support staff that were being performance managed.
- Registered nurses are required to comply with a new three yearly revalidation process from April 2016. None of the nurses were due to revalidate until 2017.
- Nursing staff were required 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). 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. There were three levels of training: fundamental, intermediate and advanced.
- Nine out of the ten qualified nursing staff had completed the BASHH STIF Foundation Theory Course at the time of our inspection.
- Staff were able to attend training from the Faculty of Sexual Health to enable them to administer implants. This was provided by an electronic module, face to face training and nurses were signed off as competent by a doctor and competencies were reviewed at five year intervals.
- Six out of ten of the qualified nursing staff had completed implant training at the time of our inspection.
- Medical cover was provided for one session per week by a doctor employed by Brook. Clinical support was provided by Brook's national medical director and clinical meetings were held quarterly.

- Other clinical resources used by medical staff included updates from the Faculty of Sexual Health, webinars and the Continuing Professional Development (CPD) requirement of the Royal College of Obstetricians and Gynaecologists.

Multi-disciplinary working and coordinated care pathways

- Staff reported strong links with the Local Safeguarding Children's Board (LSCB) and described attendance at multi-agency safeguarding training. The education team had delivered training to partner agencies relating to Brook's Sexual Behaviours Traffic Light Tool.
- The education team worked with local services for young people, which included: schools, colleges, and hostels. The team were the regional lead for education and well-being across Merseyside, Cheshire, and North Wales.
- Educational events were delivered with a range of partner agencies and provided information on topics, such as sexuality, contraception, smoking cessation, drugs and alcohol.
- The education and well-being coordinator attended multi-agency strategy meetings to input into the development of services for children and young people.
- Pathways were in place for service users confirmed as pregnant who required ante-natal care and a telephone number was provided to promote easy access to arrange a hospital appointment.
- If information was required to be shared, for example with a young person's GP or an acute provider, letters were provided for the young person to take by hand.
- The genito-urinary medicine service provided by a local acute trust delivered two clinical sessions per week from the Brook Liverpool site. This allowed immediate referral between Brook Liverpool and the genito-urinary service if required and capacity allowed.

Referral, transfer, discharge and transition

- Children and young people did not require a referral to attend the service; however, referrals were received from other services, including schools and colleges.
- If following triage or consultation a need was identified and referral to other services was required, the staff at Brook Liverpool had processes in place to refer, for example termination of pregnancy and safeguarding.

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- Between 1 January and 31 December 2016, 815 referrals or signposts were initiated by Brook Liverpool staff. Services referred to included: police, midwifery services, Local Authority Children's Services and clinical services at a local acute trust.
- When young people reached the age of 25, they were no longer eligible to access the service. We asked three staff members what plans were in place to support this transition of care. Staff told us the service would inform the young person in advance of them reaching 25 and would provide them with information of options that were available to them.
- We observed information in clinical rooms advising of services for young people over the age of 25 and staff told us service users would often photograph the poster for reference after discharge from Brook Liverpool.
- We observed information provided to young people advising of how their information would be shared in the event of failed appointments and unsuccessful contact attempts where staff believed the service user or another person maybe at risk of serious harm.
- We reviewed six clinical records to determine if consent had been gained and correct procedures to gain consent had been followed and we found this was recorded in all six records.

Are community health (sexual health services) caring?

Compassionate care

Access to information

- Staff had access to the electronic patient records, which provided a record of the care, treatment and medical and social history of the child or young person. However, the education team did not have access to the electronic care records when they were working remotely.
- The electronic system alerted staff to known risks or concerns about individuals attending the clinic.
- Best practice guidelines and Brook policies and procedures were all available via the intranet.

Consent

- Assessment of young people under 16 years of age was completed in accordance with Fraser Guidelines. 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 observed core client records indicating this assessment had been completed.
- Staff told us consent was obtained by the practitioner at each consultation.
- We observed two consultations where verbal consent was obtained prior to the delivery of care and treatment. For example verbal consent was obtained prior to recording a young person's blood pressure.
- Consent was recorded on the electronic record prior to referring a young person to an external agency.
- Young people were treated with respect and dignity at all times. The Brook wide client satisfaction survey undertaken in April 2016 indicated 92% of respondents were comfortable with how they were greeted at reception, 100% of respondents felt comfortable in the reception and waiting areas and 100% were happy overall with their visit to Brook.
- A privacy line was present at the reception desk to ensure confidentiality when patients checked in and young people were asked to point to an option on a registration form to identify their reason for attendance which removed the possibility of other service users overhearing.
- Feedback from service users was overwhelmingly positive both in discussion and via comment cards completed prior to the inspection.
- Young people told us they felt welcomed by the service, the friendly staff were "always very respectful" and made them feel at ease and they appreciated the confidential nature of the booking in system.
- A Chaperone policy was in place and signs were displayed advising young people of this service.
- Young people told us they felt staff were caring and made them "feel at ease".
- Staff we spoke with and interactions we observed between staff and young people demonstrated that staff treated people with respect and dignity and were non-judgemental.
- As part of the registration process, young people were asked to indicate their preferred method of contact, for example phone, text or letter and staff were very conscious of observing this preference in any subsequent contact.

Community health (sexual health services)

- Brook Liverpool invited feedback from service users in a number of ways. We observed notices in each waiting area asking “Did you get what you came for?” A National Countermeasures Survey conducted in 2016 indicated that 97% of respondents at Brook Liverpool would recommend Brook to a friend.

Understanding and involvement of patients and those close to them

- We observed two consultations where staff gave young people information about options of treatment available, to enable them to make an informed choice. This demonstrated how young people were involved in decisions about their care.
- Young people consistently reported that staff communicated with them in a way that was helpful, staff were reported to be knowledgeable and understanding and provided all the information they needed. One young person commented “I was listened to and was given the right treatment and care”, while another said: “staff are always caring and helpful, provide plenty of options and help to find the best solution for you”.
- Young people told us staff “had a nice way” when asking questions and were “non-discriminatory” and “non-judgemental”. Others said “staff take care of me very well” and “got me in touch with the right people”.
- We observed young people attending the clinic with friends, this enabled young people to feel supported during their attendance.
- Feedback from young people following attendance at educational sessions included the comments “Today I learnt about safe sex and where I can go for advice”, “I enjoyed talking about what it means to be in a good relationship” and “The best bit was finding out new information and I now know that there is someone to talk to at Brook.”

Emotional support

- The Brook Liverpool education and training team delivered sessions in schools and colleges in a wide range of subjects, including body image, self-esteem and relationships. Targeted support was delivered to smaller groups of young people and one to one sessions were provided using solution focussed therapies, such as brief intervention and motivational interviewing.
- Counselling was available for young people and provided support on a range of issues, such as depression, self-harm or family difficulties.

- Sexual health practitioners and education staff described how they had effectively liaised with school staff to achieve positive outcomes for young people.
- Core client records were completed for each young person who attended the service. This included questions regarding both physical and emotional health as well as social circumstances.
- Completion of the core client record aimed to identify concerns such as bullying, emotional abuse, bereavement or caring responsibilities. It also helped to recognise any resilient strengths and protective factors, such as involvement of friends or family in whom the young person could confide.
- Referrals were initiated to external agencies as required. In the period 1 January to 31 December 2016, seven young people were recorded as referred to a voluntary advisory service for children and young people, six to a drug and alcohol treatment charity and four to a smoking cessation support service.

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 Liverpool was based in a five storey building in the centre of Liverpool close to several higher education establishments. The main clinical consulting rooms were situated on the first and second floors and had stair and lift access.
- Due to the central location, the service could be accessed easily using public transport and free Wi-Fi was available throughout the building.
- Televisions were in prominent positions in each waiting area for the benefit of young people who were waiting for their consultation, as well as toilets and baby changing facilities. However, there was no access to a drinking water fountain in any of the waiting areas.
- The windows of the ground floor waiting area were opaque to prevent service users being viewed by people passing by and screens were positioned so that occupants could not be seen as other service users entered and exited the building.

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- Chairs were arranged into separate areas in the waiting room to allow young people to sit in a smaller group within the larger waiting area, if they wished.
- White boards were observed in each clinical waiting area advising young people of the staff who were on duty that day and in which consultation room.
- The service was available six days a week between Monday and Saturday and offered a drop in or appointment service. A selection of appointments were available to book via the website and a poster was displayed in the main waiting area to advise young people they would receive a text confirmation and reminder of their appointment.
- Feedback from one service user was that “online booking of appointments has made visiting the clinic much easier”.
- Brook Liverpool were commissioned to provide educational services to schools, colleges, higher education establishments and hostels within the city. This was delivered in a range of innovative ways, often in partnership with other agencies and covered topics such as values, sexuality and aspirations. One such programme Future Focus aimed to increase confidence, self-esteem and resilience and was delivered to smaller groups of young people who had been identified as ‘at risk’ or vulnerable.
- The Brook website had 24 hour access to ‘Ask Brook’, which provided information on a range of topics, including termination of pregnancy, staying safe on line, and contraception. If young people required urgent or emergency information or care, there was a range of services listed with details how to contact the service.
- Young people were allocated a numbered ticket following check in. This prevented the need for a young persons’ name to be called when it was time for their consultation and ensured the young person’s confidentiality was protected.
- Shifts were staffed to have more staff on duty at busier times to reduce waiting times for young people.
- Staff had access to a language line, which provided a telephone interpretation service for young people attending the service whose first language was not English. Staff we spoke with were aware of the service, but had not needed to access it.
- There was access to all floors via stairs, a lift, and a wheelchair lift.
- Across the clinic we observed numerous information leaflets, most of which were in English. We asked two staff if all leaflets were available in alternative languages, they thought they were, but were unsure how to access them. One of the staff told us they would search on the internet for information.

Meeting the needs of people in vulnerable circumstances

- The education team outreached into the community via schools, colleges and hostels to support emotional development and learning of core skills, with specific programmes that address the needs of the most vulnerable young people.
- Staff received training on how to challenge discrimination connected to sexuality, race and disability.
- Brook Liverpool had a counselling service and young people could self-refer to this service, or staff could discuss the benefits of the service with the young person and could make a referral on their behalf.
- Young people under the age of 16 were prioritised and seen promptly by the appropriate clinician and staff told us that young people who were ‘looked after’ would be seen by the same member of staff to ensure continuity of care, as working patterns allowed.
- Staff we spoke with told us there were no specific arrangements in place for young people with learning disabilities. However, issues of capacity were assessed for each individual and if capacity was identified as a concern there were pathways in place to support people with their decision making.

Equality and diversity

- The service had a male worker in clinic and a male worker in the education team, should young people raise a preference to have a consultation with a male rather than female.

Access to the right care at the right time

- For the period 1 January to 31 December 2016, there were 15,945 contacts to Brook Liverpool. Of these contacts 6,824 (21.4%) were seen within ten minutes, with 13,773 (43.3%) seen within an hour. There were 169 contacts (1%) that waited three to four hours, however, managers could not give a definite reason for this.

Community health (sexual health services)

- One young person we spoke with at the time of our inspection told us they had been waiting an hour and fifty minutes on that occasion and had previously experienced a four hour wait. Five of the 42 comment cards we received referred negatively to the length of time young people had waited to be seen, however, one comment card stated after booking an appointment the young person “walked straight up and was out within 10 minutes”.
- A triage system was in use led by a Clinical Support Worker to ensure young people were signposted to the appropriate service and were not waiting unnecessarily.
- Young people who booked in to the service but did not wait for a consultation were followed up by clinical staff if they were assessed as vulnerable or if there were any safeguarding concerns.
- During extremely busy times staff told us the clinic would close to new arrivals and any service users who could not be seen following triage would be offered an appointment to return or referred to another appropriate provider. This action was documented by staff on a Clinic Monitoring Form, which was submitted weekly to the nurse manager and service manager. Information captured included the time when the volume of service users was noted to be high, the number of staff on duty, the number of young people waiting to be seen either as a drop in or by booked appointment and the number of clients who walked out. It also reflected any safeguarding issues or other incidents, such as IT issues.
- Information provided by Brook Liverpool showed that between 31 October and 31 December 2016, the clinic closed and went to triage on 20 occasions and a total of 32 service users left without being treated. The closures were mostly at the end of a clinic or during a clinic when there was high demand. On six of the occasions when the clinic was temporarily closed it was reopened when capacity was manageable. Any young people that attended the clinic when it was closed to bookings at that time were offered an appointment for an alternative date or referred to an alternative service. Staff told us that the closure of a sexual health service in a neighbouring area had significantly increased the number of out of area attendees in previous weeks. We found that when clinics had needed to close this was not always reported as an incident.
- Brook had a client complaints policy and procedure in place for managing complaints.
- We observed information available in each waiting area for young people who wished to make a comment or complaint. These included a contact telephone number and comments and complaint forms with envelopes, which could be completed and passed to staff.
- Information about making complaints and providing feedback was also available on the Brook website.
- All oral comments or complaints were passed on to the Complaints Manager, even if the client did not request an investigation and was satisfied with the explanation or apology given, so that the information could be used to improve service quality.
- Brook Liverpool reported seven complaints between April 2015 and November 2016. Four of these complaints in relation to waiting times were upheld. No complaints were referred to the Ombudsman.
- Complaints were reviewed by the senior management team. As a result of the upheld complaints an ongoing review of efficiency in delivering services was implemented. The service introduced a speedy testing clinic and an online booking system from March 2016. The end of service clinic time had extended to relieve pressure on staff and waiting times for clients. We observed posters in waiting areas advising clients they could book online appointments.

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

Service vision and strategy

- Brook Liverpool worked within the single strategic framework of the Brook Network. This unified approach aimed to increase the number of young people who access Brook services and set out the vision, mission and strategic commitments of the organisation.
- The Brook had developed 12 education and wellbeing values, to ensure that professionals working with children and young people received good quality training, enabling them to support the positive development of young people's sexual and emotional health, relationships and wellbeing. These values had been adapted by Brook staff and young people and we observed staff that were passionate about the care they provided and were living the values.

Learning from complaints and concerns

Community health (sexual health services)

- Brook's core values were confidentiality, education, sexuality, choice, involvement and diversity. Following discussions with staff, it was evident these values were embedded in their day to day work.
- The vision of the organisation was for "a society that values all children, young people and their developing sexuality. We want all children and young people to be supported to develop the self-confidence, skills and understanding they need to enjoy and take responsibility for their sexual lives, sexual health and emotional well-being".

Governance, risk management and quality measurement

- The Board had overall governance responsibility for the organisation and delegated authority through the Chief Executive and the executive and management teams, within a clear written scheme of delegation and statement of internal financial controls. The board of trustees met formally at least four times a year and had four governance sub-committees: Risk, Finance and Assurance, Subsidiaries, Clinical Advisory Group and the Safeguarding Advisory Committee.
- The role of the Risk, Finance and Assurance Committee was to ensure that Brook managed its finances and risks effectively and efficiently in support of its charitable objectives. It provided assurance that Brook met its statutory and other obligations under the Companies and Charities Acts, its Articles of Association and other relevant frameworks.
- The Clinical Advisory Group was led by a Medical Director and Head of Nursing and provided clinical direction and support with the aim of ensuring continuous improvement in the quality of clinical services delivered to clients by Brook. The group oversaw the development, monitoring and implementation of clinical governance and quality improvement plans and their link into the broader health agenda.
- Service managers held quarterly meetings to discuss any operational issues and a process for escalation to the operations manager was in place if required.
- Brook Liverpool was commissioned by the public health department of the local authority to provide clinical and education services within the city. Quarterly contract meetings were held to review performance and finance. Monthly operational reports were also provided to advise of any incidents and safeguarding activity.
- Brook used the Practical Quality Assurance System for Small Organisations (PQASSO). This is a performance evaluation system and quality mark for charitable organisations in the UK. Evaluations use a system of peer review between small charities based on 12 quality areas, which include governance, leadership and management, user-centred service and monitoring and evaluation. It supports organisations to systematically examine where they are performing well and where they need to improve. Brook had supplemented the 12 generic PQASSO quality areas with six Brook standards specific to a young people's sexual health service. The organisational aim was for all Brook services to achieve level 2 of the PQASSO and Brook standards and managers confirmed Brook Liverpool had attained level 2.
- The organisation used a data analytics reporting tool (DART) dashboard to provide managers with local and national activity data. This included information such as the number of young people attending a specific location and the uptake of a range of interventions and services delivered, such as screening for sexually transmitted infections.
- A corporate risk register was in place, however, prior to our inspection request there was not a documented local risk register. Managers told us that risks were identified and responded to and actions documented, these were placed on a risk register. However, there were no dates identified for completions of actions.
- During our inspection, a local risk register was raised and included three risks scored with regard to likelihood and impact, however, no planned review date was documented.
- Risk assessments of rooms were completed by the education team prior to undertaking outreach sessions and a twice yearly risk assessment was performed in the main Brook Liverpool reception area.

Leadership of this service

- Brook Liverpool was led by a service manager and a nurse manager. The nurse manager had been absent for a prolonged period of time in the 12 months prior to our inspection. During this period the service was led by a team of lead nurses from the existing staff. The nurse manager was on sick leave and therefore unavailable at the time of our inspection.

Community health (sexual health services)

- Clinical staff meetings were held at Brook Liverpool. We saw minutes of meetings held in June 2016 and September 2016 and saw that organisational updates, staffing, training, and safeguarding were standard agenda items. We saw evidence of sharing audit results.
- All staff we asked at the time of our inspection told us they felt well supported and valued by their managers.
- Staff we spoke with felt part of the wider Brook network and told us they had a voice and were listened to by managers.

Culture within this service

- Teamwork was evident throughout our inspection and staff said they were proud of “the way the teams work for each individual client”.
- One staff member told us that “Brook is an amazing service” and they had waited for two years to work in the organisation.
- Some of the members of the education team had commenced their career with Brook Liverpool following work placements or experience as service users.
- The education team worked in twos when providing outreach work to promote staff safety and had access to a work mobile phone.
- An on call named executive member of Brook was available for all staff who required support with complex issues.

Public engagement

- Exit survey results for December 2016 were displayed on a notice board in the main reception waiting area.
- A client survey was completed by Brook Liverpool in April 2016 and results showed of the 129 young people who took part, 100% were happy overall with their visit and 100% would recommend Brook Liverpool to a friend.
- A further National Countermeasures Survey conducted in September 2016 indicated that 97% of respondents at Brook Liverpool would recommend Brook to a friend.
- Feedback was obtained from students who took part in sessions delivered by the education team. Comments from students received between January and December

2016 included: “I learnt how to stay safe on the internet”, “the people doing the sessions are very enthusiastic” and “the best bits where learning about STIs and how to keep safe.”

- The education team worked with 25 young people per month and their contribution fed into the National Participation Group.

Staff engagement

- A monthly national newsletter was shared electronically with all staff. This included national news updates as well as policy and clinical updates.
- A Brook wide survey conducted in December 2015 elicited 219 responses. The survey showed that 97% of staff would recommend Brook as a service provider, 82.6% of staff would recommend Brook as an employer and 90% of staff felt Brook treated its staff with dignity and respect.
- Staff told us that occupational health services were available and work place health assessments and adjustments could be arranged if required.
- An annual national awards ceremony took place to recognise good work.

Innovation, improvement and sustainability

- The education team had delivered a Future Focus programme to a group of young women in a local school during the end of term holidays. The course was delivered over four consecutive days and included social skills, confidence, self-esteem, relationships, sexual health and awareness of risk taking behaviour. Twelve young women were chosen and 11 completed the programme and achieved a level one award in Skills for Further Learning and Employment.
- Plans were in place for all sexual health nurses to undertake the genito-urinary medicine course.
- Since the closure of a sexual health service in an adjoining borough, attendance figures for out of area service users to Brook Liverpool had increased significantly. In one week in November 2016, 33% of all young people attending had been from out of the area. Managers were working with commissioners to address the implications of the increased demand.

Outstanding practice and areas for improvement

Outstanding practice

- The education team ran an accredited programme called “Future Focus”, which was aimed at increasing confidence, self-esteem and resilience and was aimed at smaller groups of young people who had been identified as ‘at risk’ or vulnerable. Brook liaised with host agencies to select those whom the programme would most benefit.
- Brook worked with young people over a four day programme of personal development delivered within schools or other youth settings. Innovative activities had been designed that encouraged young people to learn through participation. Groups of up to 14 young people explored values, relationships, interpersonal skills, confidence, self-esteem, goals and aspirations within the context of sexual health and relationships.
- An accredited award was also offered to young people who participated in the programme, resulting in a level one qualification “Further Skills for Learning and Employment”, administered through an accredited awarding organisation. The service reported that receiving a qualification can be inspirational and can act as a catalyst for aspiration and positive change. The service gave us an example of how they had worked with a local school to open during school holidays to enable a session to be run which resulted in 11 of the 12 participants completing the programme and achieving a level one award in skills for Further Learning and Employment.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that all clinical staff who contribute to assessing, planning, and evaluating the needs of a child or young person are trained to safeguarding at level three as required by Brook and recommended in the Intercollegiate Document (2014).
- The provider must ensure infection control training is completed by all staff providing direct clinical care and involved in specimen collection and transportation.

Action the provider **SHOULD** take to improve

- Review the data collated in a book in relation to termination of pregnancy and unless there is a statutory obligation to record it in this way should consider anonymising data to protect young people’s confidentiality.
- The provider should ensure staff document any discussions and action taken in the client core record in all cases in relation to incidents.
- The provider should ensure the infection control policy is followed and staff wash their hands between consultations.
- The provider should ensure mandatory training is completed as required within the mandatory training policy.
- The provider should consider introduction of a timeframe for review of staff competencies to ensure adherence to best practice guidelines.
- The provider should ensure any local risks are clearly identified and have a documented timeframe for review.
- Consider auditing compliance in relation to Patient Group Directives.

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
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	<p>Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>How the regulation was not being met:</p> <p>Systems and processes were not established and operated effectively to prevent abuse of service users.</p> <p>This is because:</p> <p>Not all clinical staff who contributed to assessing, planning, and evaluating the needs of a child or young person were trained to safeguarding level three.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The provider was not assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.</p> <p>This is because:</p> <p>No clinical staff had received an annual infection control update in the last 12 months and none of the education staff had attended any infection control training despite undertaking Chlamydia screening as part of their role.</p>