Brook Young People

1-1056342029

Brook Burnley

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1062780284	Brook Burnley	Brook Burnley	BB11 1TS

This report describes our judgement of the quality of care provided within this core service by Brook Burnley. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Brook Burnley and these are brought together to inform our overall judgement of Brook Burnley

Summary of findings

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Overall summary

We found the following areas of good practice:

- Safeguarding procedures were robust and staff had received the appropriate level of safe-guarding training and were compliant with national guidance. There was regular safeguarding supervision for staff. Mandatory training levels were good with all members of staff compliant with training on the day of the inspection.
- There was an organisational approach to the reporting and grading of incidents. Staff at Brook Burnley were confident to report incidents and there was feedback of learning to staff.
- Staffing levels were adequate though there had been a vacancy. Staff from other clinics and agency staff, who had previously worked for the service, addressed most of the staffing shortages. There was a business continuity plan that had been updated following an information technology failure in 2016.
- There were policies and procedures for patient treatment that followed national guidance and these were reviewed annually. Staff were assessed as competent and were being trained to deliver level two sexual health services.
- There were examples of multi-disciplinary team working including with children's and adolescent mental health services and other organisations in the statutory and voluntary sectors.
- There was a focus on the health and well-being of children and young people and staff worked with a number of agencies and organisations to improve their outcomes.
- The consent procedures of the clinic were robust and staff had received training in the mental capacity act.
- Children and young people who used the service were treated with privacy and dignity. There was a holistic approach to the health and well-being of children and young people.
- Feedback from children and young people was positive and they were full of praise for the service.
- There was a counselling service which was run by staff and volunteers; this service had made a great impact on some of the children and young people who had accessed it.
- The clinic opened on a number of days including Saturdays, access to the service was good for all potential patients and referral processes included self-referral. Information was also available via a website, which was user friendly and appropriate for the age group accessing the service.
- Information for patients was available in various formats and met the needs of people with a learning disability or poor literacy skills and those whose first language was not English.
- The clinic was responsive to patient feedback and had started to provide appointments at different times following feedback from children and young people.
- Information about how to complain was available in a number of formats and complaints were well managed and learning shared.
- The service had a vision and strategy, which staff were aware of and the culture of the service was open with a strong focus on the rights of children and safeguarding.
- There were clear governance structures in place across the organisation and a data analytics tool which provided audit and activity data to the service managers to monitor and improve services, where appropriate.
- Public engagement with children and young people was very strong with the organisation being the "voice of the young person."

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

- Reported risks were not always current and relevant and risk assessments that had been completed were not always acted upon.
- We had concerns about the checking and recording of medicines as we found evidence that medicines were not checked and recorded according to the organisational policy.

Following this inspection, we told the provider that it should take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Background to the service

The service, which is a charity, provides a level one sexual health service to children and young people aged under 25 years of age, a level one service provides management of sexually transmitted infections and other services including information about sexual health, contraception, pregnancy testing and referrals for termination of pregnancy. The regulated activities for the service are family planning, treatment of disease, disorder or injury and diagnostic and screening procedures. The service registered with the Care Quality Commission in 2013 and there is a registered manager. This was the first inspection of the service.

The service is part of a Lancashire county wide sexual health service which is commissioned through a local NHS foundation trust. It is based on a hub and spoke model and Burnley is the East Lancashire hub. The service receives some funding from a local clinical commissioning group.

Burnley is the 41st most deprived local authority in England and has high rates of abortion for those aged 25 years and under. In the period 1 April 2015 to 31 March 2016, there were 4151 patient visits to the clinic.

The Burnley clinic was due to be renovated in April 2017 and the clinic was to be relocated to an NHS facility nearby. The renovation would improve the layout of the reception areas and the clinical rooms and address a number of health and safety issues. Staff said that as soon as they had a firm date for moving out of the clinic, they would advertise this to their patients.

Our inspection team

The inspection team included three inspectors from the Care Quality Commission.

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

Before visiting the service, we reviewed a range of information about the service and asked other organisations to share their views. We carried out an announced inspection on 10 January 2017 and an unannounced inspection on 17 January 2017. During the inspection, we looked at the quality of the environment and observed how staff were dealing with patients and we spoke with three patients who were using the service. We spoke with the registered manager, the operational manager and five other staff including nurses, counsellors and a receptionist. We collected feedback from eight patients using comment cards and looked at seven care and treatment records of patients. We observed a daily huddle and looked at a range of policies, procedures and other documents relating to the running of the service.

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?

Summary of findings

• Is it well-led?

What people who use the provider say

- Patients were very positive about the service and the clinic responded to feedback and made changes to the service. This included feedback that some patients wanted an appointment system as well as a drop-in service. Shortly before the start of the inspection an appointment system had been initiated.
- Feedback was collected in different ways; there were feedback cards in reception and patients could leave feedback on the website. Patients were asked "did you get what you came for" and there were counter measures which was a system where patients could leave a response to a particular question. This was done every three months. The clinic also did an exit survey for patients.
- Patients said that the service was non-judgemental and that they trusted the service. Feedback about staff was positive and patients felt safe and not judged by the staff.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The risk register should be current and relevant.
- Risk assessments should be completed with actions and review dates.
- The organisation should ensure that medicines are checked and this is recorded according to the organisation's policy.

Brook Young People

Brook Burnley

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- Safeguarding procedures were robust and staff had received the appropriate level of safe-guarding training and were compliant with national guidance. There was regular safeguarding supervision for staff. There had been no safeguarding alerts at the time of the inspection.
- Mandatory training levels were good with all members of staff compliant with training on the day of the inspection.
- There was an organisational approach to the reporting and grading of incidents. The staff at Brook Burnley were confident to report incidents and there was feedback of learning to staff.
- Staffing levels were adequate though there had been a vacancy. Staff from other clinics and agency staff who had previously worked for the service, addressed most of the staffing shortages. There was a business continuity plan that had been updated following an information technology failure in 2016.

However:

- We had concerns about the checking and recording of medicines as we found evidence that medicines were not checked and recorded according to the organisational policy.

Safety performance

- There had been no serious incidents reported by the organisation between October 2015 and the time of the inspection.
- No safeguarding alerts or concerns had been raised in the reporting period (22 October 2015 to 21 October 2016).

Incident reporting, learning and improvement

- There was an incident reporting procedure across the Brook organisation for consistent reporting and grading of incidents. Incidents and near misses were monitored and reviewed across the organisation and at a local level. There had been six incidents in the period January 2015 to December 2016.
- The incident recording system was paper based. These records were completed by the relevant health professional involved. These were then discussed with the registered manager and escalated within the Brook organisation, if appropriate.

Are services safe?

- Incident records we reviewed contained all the relevant information and the actions to be taken to prevent recurrence. Where required this included obtaining expert advice and assistance from external organisations.
- Following a reported incident, an action plan and a risk assessment had been completed but the actions arising from the incident had not been completed within the appropriate timescales. This was discussed with the manager during the inspection.
- This incident and the measures to be taken were documented on the quality and risk assurance report for the period July to September 2016. This report was sent to the senior managers of the organisation.
- Incidents were discussed at the monthly management team meetings and any follow up that took place from these meetings, was documented on the incident record.
- We saw the overview of the incidents that was reported every three months as part of the Brook quality and risk assurance report.
- Learning from incidents was shared with staff both informally during the daily debrief sessions and formally at team meetings. At an organisational level, learning was shared through the Clinical Leadership Team (CLT), the Clinical Advisory Group and the Risk and Finance Committee. This organisational wide learning was shared by the CLT with Nurse and Service Managers for sharing with their teams via team meetings or earlier, if deemed necessary.

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.
- There was an organisational policy for duty of candour policy.
- Staff we spoke with were aware of the duty of candour policy and gave examples of when they had used it.
- We saw that the duty of candour was applied within the appropriate timescales when the service responded to appropriate incidents.

Safeguarding

- There was an organisational "pillar" policy for protecting young people. Within this overarching policy, there was a specific safeguarding policy which had been reviewed and updated in March 2016. This policy included how staff should assess risk of harm and exploitation, procedures to follow to escalate concerns and support offered to young people.
- A six step safeguarding procedure was in place. This gave clear guidance to staff in the identification, assessment, referral and support of young people at risk of harm, abuse or exploitation. This procedure included a documented pro-forma which followed the six steps for each young person identified. These pro-formas were discussed at the monthly review meetings. There was information for staff regarding the management of safeguarding concerns and this included reporting procedures, relevant contact names and telephone numbers, specific helplines such as emergency accommodation, rape crisis and details of support available for patients.
- All staff we spoke with were aware of the safeguarding procedures and knew how to access contact details for reporting and offering support. At least two staff members reviewed every safeguarding concern to ensure the correct procedures were being followed.
- If there was a safeguarding concern about any patient, there was an alert system on the electronic patient record. This meant those patients were easily identifiable to all staff.
- The organisation had links to other agencies and were part of any joint safeguarding work. This included the local child sexual exploitation forum, the local authority safeguarding groups and the police.
- Staff had completed training provided by Lancashire Safeguarding Children Board. This included training on child sexual exploitation, self-harm, young people and mental health and female genital mutilation.
- A discussion with the children's social services team took place about any child under the age of 12 years who was sexually active. Where necessary, a referral would be made to the children's safeguarding team.
- Every month all safeguarding concerns and referrals to social services were reviewed. The care of any young person under the age of 12 who had attended the clinic was also discussed at these meetings. Any outstanding actions were followed up until all actions were completed.

Are services safe?

- Young people who attended the clinic who were under the age of 16 were prioritised for treatment.
- Each Brook service had a safeguarding lead. Other staff could discuss any issues or concerns with this designated person and receive guidance and support, if required. There was support to discuss safeguarding concerns out of normal working hours with a national lead for safeguarding.
- There was a worker who was co-located in the multiagency child sexual exploitation team (CSE) who provided a link for safeguarding monitoring and information sharing regarding patients identified as vulnerable to CSE.
- The assessment process on the electronic patient record did not include specific information to assess the risk of Female Genital Mutilation (FGM). There was no direct question about FGM, but this was to be asked as part of the question about the risk of domestic violence. This does not meet the Department of Health Guidelines: "Female genital mutilation risk and safeguarding guidance for professionals March 2015". Following the inspection we were made aware that the electronic template had been amended to assess for the risk of FGM. We saw visual evidence of this.
- Five staff had attended training provided by the local authority to raise awareness of forced marriage, FGM and honour based abuse. They were aware of their responsibility to report FGM and the procedure to follow.
- There was a chaperone policy accessible for staff. This explained the procedures for which a chaperone should be present, who was suitable to act as a chaperone and actions to take if the patient declined.
- Posters were on display in all communal areas and consulting rooms regarding the use and availability of chaperones.
- Both of the nurses employed at the clinic had completed safeguarding training to a level above that required. One had completed level five and the other level four.
- Safeguarding supervision was provided every three months by nurses employed by the organisation. Specific concerns were discussed as part of the monthly team meetings as learning points for all staff.
- If a patient left the consultation without it being completed, the staff member reported this as a safeguarding alert if they had any cause for concern about that patient or any other young person.
- We saw that where a patient had disclosed any concerning information, this had been acted upon appropriately by staff. This included offering advice about keeping safe on social media.

Medicines

- Staff had access to information via the organisation's intranet regarding the management of medicines. Policies and procedures followed national guidance and were reviewed annually to ensure the information was current. Individual procedures included prescribing, stock control and over labelling of medicines.
- The service used Patient Group Directives (PGDs) to prescribe and supply medicines. PGDs are written directions allowing non-doctors, including trained nurses to assess patients and supply medicines without prescriptions, subject to exclusions. The Brook intranet had a range of medicine specific PGD's, including contraceptive pills, implants and antibiotics, which were produced and reviewed annually at national level. There was a policy for working to Brook wide PGD's
- Clinical staff at Burnley were trained to provide medicines following these Brook-wide PGD's. Paper copies were kept in the staff office and all appropriate staff had signed and dated a competency sheet for each PGD. These were appropriate for the level one service provided.
- Medicines were purchased and delivered by a local wholesaler and two staff were responsible for orders, storage and stock control. There was a central storage area on the second floor of the building, which consisted of two locked metal cabinets. Clinical rooms were replenished from this stock.
- A stock control procedure was in place that stated all medicines were expiry date checked monthly. We were told that expired medicines were disposed of by returning to the supplier and this was confirmed in the medicines stock control procedure. We found that all stock in the two clinic rooms were stored appropriately in locked cupboards and were in date. However we found two boxes of Erythromycin 250mg tablets (antibiotics) that had expired six months earlier in one of the central storage cupboards. These medicines would have been prescribed by the doctor who had recently left the service

Are services safe?

- The clinical manager was unaware that the medicine was still stocked and assured us that they would be disposed of; this had been done by the unannounced inspection.
- There was a procedure in place for labelling medicines that were given to patients using pre-printed labels. Patient specific details were hand written on the label that contained drug specific directions and then added to the medicine container.
- Medicine administration records were kept electronically. The nurse who prescribed and administered the medicines was chosen from a drop down menu within the system. Although this record could be changed there was a failsafe system within the audit trail which showed a change had been made. This meant the medicine recording system was secure.
- The portable emergency anaphylaxis kit had not been checked weekly in accordance with the Brook procedure "risk management of clinical emergencies". These checks were to ensure emergency equipment and medicines were stored in the identified place, the necessary medicines and equipment were present and they had not expired. There had been no recorded check from 22 September 2016 to 11 October 2016 and none from 29 November 2016 to 19 December 2016. This meant there was no assurance during these periods that this equipment was available in an emergency. This was brought to the attention of the manager during the inspection.
- A portable oxygen cylinder was present in one of the consulting rooms for emergency use. Brook policy was that this was checked to ensure it was in full working order on a daily basis. Records showed this had not been checked between 21 December 2016 and 9 January 2017 which meant there was no assurance it was in full working order during that time. This was brought to the attention of the manager during the inspection and had been checked daily at the unannounced inspection.
- A risk assessment for the interaction of medicines was completed as part of the electronic patient record. This included interactions with emergency contraception with any other medicines the patient was taking.
- Medicine safety precautions were followed. These included observing patients take their medicines on site when applicable, such as emergency contraception and recording the batch numbers of administered medicines.

Environment and equipment

- The service was located in a three storey building with a reception area, a waiting room and treatment rooms on the ground floor. There were treatment rooms and counselling rooms on the other floors. Staff in the reception area were unable to see the patients in the waiting room. The scheduled building works will provide an open waiting room with reception area.
- There was equipment available for resuscitation; we saw that this was checked according to the organisational policy and that this was appropriately recorded. Emergency safety equipment such as fire extinguishers were available. These had been maintained within the required timescale.
- Portable electric appliances had been tested and the most recent test date was displayed.
- The appropriate receptacles for the safe storage of clinical disposable sharps were present in the consulting rooms. These were not overfilled.
- The disposable equipment in the consulting rooms was within the recorded expiry dates.

Quality of records

- The patient records were electronic and a recognised system for sexual health was used. This included a medical, family, sexual and social history. We looked at seven sets of patient records during the inspection and saw that they had been completed appropriately.
- The electronic patient record system used by Brook was different from that used by the trust that commissioned the service. This meant that if a patient was seen in a clinic delivered by trust providing sexual health services, they could also be seen in a Brook clinic on the same day without staff being aware. This had been identified as a potential safeguarding concern; however there was no risk assessment in place. This had been addressed at the time of the unannounced inspection. The computerised record system was due to change by the end of March 2017 and the same system would be in use for both organisations. This would remove this potential risk. Electronic records were password protected to ensure they were kept secure. All paper records we saw met with data protection guidelines in terms of patient identification and were securely stored.
- A Caldecott Guardian had been appointed for the organisation. They were available to staff to offer support and guidance if required.

Are services safe?

Cleanliness, infection control and hygiene

- The communal areas, consulting rooms and toilet facilities were visibly clean and tidy.
- Posters for guidance to effective hand-washing were displayed in the toilets and hand-washing facilities were available in the consulting rooms. We saw that staff washed their hands before and after treating patients.
- Hand gel was present on the reception desk for patients to use on arrival.
- Personal protective equipment, such as disposable aprons and gloves, was available in the consulting rooms and we saw that staff used them.
- There was carpet flooring in part of one of the consulting rooms. There were plans to remove this which would improve the infection prevention and control of that room.
- The sharps injury procedure was displayed on the wall of the consulting rooms next to the sharps bins.
- Legionella bacteria had been found in the water supply in several areas of the building when tested by an external company on 13 December 2016. Action had been taken to manage this risk including pasteurisation of the water tanks and flushing the system and testing the water temperatures daily. The water was re-tested in January 2017 following this inspection. Some readings remained higher than normal limits and a review of the control measures and risk assessment was required. Recommended actions including the regular flushing of the taps was undertaken.

Mandatory training

- All staff were up to date with mandatory training.
- This training included equality & diversity, mental capacity, fire awareness and manual handling and information governance.
- Most of the mandatory training was provided on a face to face basis by an external trainer on an annual basis. Staff reported this training was thorough and specifically tailored to their role.
- Some training such as information governance was provided by e-learning.
- Volunteer counsellors could access mandatory training.

Assessing and responding to patient risk

- Staff would contact 999 in case of an emergency.
- Staff had access to emergency equipment including oxygen. Medicines were available if a patient suffered from an allergic reaction during treatment.
- Staff were trained in basic life support skills and in the management of anaphylaxis. We saw records that showed that all staff were compliant with this training.
- The patient record included information about patient allergies and we saw that these had been completed.
- We reviewed a record where a patient had fainted during a consultation. The nurse had checked the patient's observations and responses appropriately and recorded them on their record. This had been followed up with advice to seek medical help if they continued to feel unwell and they had been supported in the clinic until they felt well enough to leave.

Staffing levels and caseload

- Two clinics ran simultaneously on most days, which were led by registered nurses. There had been one clinic weekly led by a doctor; however this had ceased to be available in December 2016.
- A weekly rota was displayed in the reception area. This showed there had been two nurses daily working with the receptionist Monday to Friday for the two weeks previous to the inspection apart from one day. With the opening of the appointment only clinic on a Saturday morning, there was one nurse and the receptionist on duty.
- A 15 minute debrief took place twice daily at the beginning and end of each clinic session. We observed that staff discussed the work booked for the day, any potential issues with specific patients, staffing issues such as sickness and any plans for the following day. These sessions were documented and the record was shared via email with the service manager.
- There was one vacancy for a part time nurse. This post had been vacant since November 2015. The manager was working some shifts as a nurse to provide support during this vacancy. The vacancy had not being recruited to as it was thought that a nurse from another clinic would be redeployed to Burnley.
- Between July and September 2016, four shifts had been filled by bank staff employed by the organisation that had many years relevant experience. Staff from a nearby Brook clinic also provided support, when available.

Are services safe?

- In the same period, there had been eight shifts where one qualified nurse had worked alone with the receptionist. This meant only one clinic could run on that day and some patients had to be given an appointment for the following day's clinic.
- A business case had been produced to increase the staffing numbers by employing a health care assistant to work in the sexually transmitted infection clinics. This post was not yet advertised.
- The total number of staff who had left employment at the organisation in the past 12 months was six which represented 46.15% of the permanent workforce. Three of these staff had left to progress their career and one had retired.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- Brook Burnley had a business continuity plan; following an information technology failure in 2016 the plan had been updated with learning from the incident.
- The organisation had regular fire drills and fire safety procedures. There were staff fire marshals to help evacuate the building in case of a fire.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

- There were policies and procedures for patient treatment followed national guidance and these were reviewed annually. Staff were assessed as competent and were being trained to deliver level two sexual health services.
- There were examples of multi-disciplinary team working including with children's and adolescent mental health services and other organisations in the statutory and voluntary sectors.
- There was a focus on the health and well-being of children and young people and staff worked with a number of agencies and organisations to improve their outcomes.
- The consent procedures of the clinic were robust and staff had received training in the mental capacity act.

Evidence based care and treatment

- Staff followed best practice guidance and national standards, such as recommendations from the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH).
- Policies and procedures for patient treatment followed national guidance such as those provided by The National Institute for Clinical Health and Care Excellence (NICE) guidelines, BASHH and the FSRH and were reviewed annually to ensure the information was current.
- The organisation worked to national guidelines including guidance from the National Institute of Health and Social Care Excellence (NICE) and local guidelines, this was monitored by the commissioners of the service every three months.
- The service used guidelines from the National Service Framework document "Every Child Matters."
- As part of the delivery of the level one sexual health service a sexual history was taken from patients and then a risk assessment was made and patients were treated by the service or signposted to appropriate services. This was part of the BASHH guidelines and was monitored through national and local audits.

Pain relief

- Brook did not routinely provide pain relief to patients attending the clinic.
- Records showed staff discussed with patients the need to obtain 'over the counter' pain relief following some procedures such as emergency contraception.

Nutrition and hydration

- Staff had access to hot and cold drinks and snacks, should a patient require these.
- Staff had acted on concerns when patients appeared to be malnourished by providing food and drink to them and making referrals to other agencies.

Patient outcomes

- The service collected and monitored patient outcomes and shared this information with partner organisations and Public Health England in order to support service development. Brook had an information sharing policy.
- Brook Burnley participated in clinical audits planned locally and nationally. These included implant fitting and removal, sexually transmitted infections (STI) testing and treatment, infection control, emergency contraception and abortion referral.
- The implant audit was undertaken in June 2016. Brook Burnley submitted information from 40 patients who presented for implant related services and 564 patients were monitored nationally. The results measured responses to five criteria each year since 2013, in order to monitor changes over time. Three criteria had improved since 2015 and two had reduced by 6%. Three actions had been set as a result of the 2016 audit, which included, offering implants to 'quick start' emergency contraception patients, standardised counselling guidance and STI testing for patients with irregular bleeding issues. Progress updates were provided to teams via the clinical leadership team and advisory group meetings.
- Audit updates formed a part of the monthly clinical meetings and results, outcomes and implementation of decisions were discussed at these meetings.
- The counselling service used the Warwick- Edinburgh mental well-being scale to monitor and measure improvement in mental well-being. Mental well-being

was monitored at the beginning, during and at the end of treatment. Patients often did not attend their full schedule of counselling appointments as they stopped attending as their mental well-being improved.

Competent staff

- All staff had participated in an annual appraisal in the last 12 months. At appraisal, learning needs were identified and training was planned.
- Nursing staff including the registered manager of the service had the skills and knowledge relevant to their role. This included adolescent and sexual health qualifications and experience. They had all completed a one year course in family planning.
- Registered nurses are required to comply with a three yearly revalidation process from April 2016. Brook had provided training to all nurses regarding the requirements for this.
- All Brook Burnley nurses held the Letters of Competence in Subdermal Contraceptive Implant Techniques (LoC SDI) qualification. This meant that all nurses were able to offer implants to appropriate patients.
- All of the nurses were due to undertake the Faculty of Sexual and Reproductive Healthcare (FSRH) diploma, supported by Brook. The diploma is accredited by the Royal College of Nursing and provides the learner with the evidence based knowledge, and attitude and skills required to deliver safe and effective sexual and reproductive health care in community, primary and secondary care settings.
- The service was currently a level one sexual health service, but the commissioners of the service required a level two service by March 2017. The level two service incorporates the level one service plus some additional services. Additional training had been put in place and staff would be appropriately trained to meet the needs of the level two service. Managers and staff said that they were looking forward to providing the additional services. There was a journal club for staff; this involved staff getting together to evaluate articles from appropriate medical literature.
- Brook held a national conference in March 2016 for nurse managers and senior doctors with presentations from external and internal speakers to provide sharing of information and current guidance and training.
- There was a counselling service with paid and volunteer counsellors.
- The volunteer counsellors received regular monthly external supervision and feedback to support them in the delivery of the service. They were all members of the British Association for Counselling and Psychotherapy which meant that they had received appropriate training. One of the counsellors had received training in self-harm.

Multi-disciplinary working and coordinated care pathways

- The staff at Burnley told us they worked well together as a team to support each other and their patients. We were told that staff were confident to raise issues with their colleagues. A daily meeting took place, which included all staff, to ensure they were up to date with any changes or issues and had an opportunity to raise any concerns.
- Brook Burnley had been subcontracted by a neighbouring NHS foundation trust to provide sexual health services in the East Lancashire region. Staff had liaised with trust staff to ensure that a cohesive service was provided.
- The local foundation trust had chosen to adopt the Brook safeguarding policies across their services. This ensured a seamless service and information collected and actions followed were the same across the Lancashire safeguarding teams.
- The counselling service was working with the local child and adolescent mental health services (CAMHS). Some of the patients who had received counselling from the service were on the CAMHS pathway, but did not meet the threshold to access the service.
- Brook Burnley were actively involved in development of a Blackburn with Darwen multiagency sexual health strategy. Staff said they had good relationships with the local authority and child sexual exploitation teams. A member of the team attended local meetings addressing issues such as patient confidentiality and safeguarding.
- The organisation worked with a range of organisations including health, social care and the voluntary sector to provided services and sign-posting for children and young people.

Referral, transfer, discharge and transition

- The clinic reported good working relationships with General Practitioners, the local hospital and the local authority when patients were referred from Brook for

their services. Brook provided a list of advocacy services in the area that young people could access including Engage and Brook Targeted Youth Support East Lancashire.
- Patients could self-refer into the service and there were systems in place to refer patients to other services.
- The service referred patients to other agencies either through designated referral pathways e.g. psycho sexual service or the termination of pregnancy service or by telephone. Appointments were usually booked while the patient was still at the clinic.
- Patients were referred into the counselling service from a number of organisations including the youth offending service and children's centres.
- Staff worked closely with other organisations in the town and if they had to close the service, they would telephone other services and refer patients across, as appropriate.

Access to information

- Staff had access to computers and used an electronic patient record specifically designed for sexual health services. The system allowed quick access to audit results, which helped to reduce clinical risk and improve the quality of the sexual health service.
- There was a dashboard which allowed staff and managers to access information including uptake of services, referrals to other agencies and equality monitoring and ethnicity of patient. This information was produced for the commissioners of the service.
- All policies and relevant clinical information were available on the organisational intranet.
- The service did not routinely contact the patients G.P. and if they did this was usually by phone.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The "consent to treatment" policy had been reviewed in May 2016. Information had been added regarding mental capacity and obtaining consent from people who lacked capacity.
- The electronic patient record included a section for the consent of procedures such as contraceptive implants.This consisted of a "yes" or "no" answer selected from a drop down menu to record consent had been received.There was no record of what had been explained to the patient including potential side effects.
- To ensure patients understood the procedure, implications and management of implantable contraception, all patients had counselling prior to the procedure taking place. This included advantages and disadvantages of the implant, potential side effects and the process of insertion. A leaflet had been developed by staff at the clinic for patients to refer to following the procedure.
- The confidentiality of patient information was discussed at the beginning of a consultation.This included the potential need to share any information without the consent of the patient should the staff member be concerned someone was at risk of harm.
- All staff had completed training on how to implement the Fraser guidelines as part of the safeguarding training and this included a patient's requesting a referral for a termination of pregnancy or emergency contraception. There are national guidelines to assess the maturity of a young person to make decisions and understand the implications of their contraceptive choices. The young person was encouraged to discuss their situation with an adult as part of this process.
- We saw the Fraser guidelines had been followed and documentation was included in the assessment record. This was completed at each visit if the patient attended the clinic more than once.
- Questions to assess the competence of the young person to understand information and give informed consent for any procedure were included as part of the computer records. We saw these had been completed fully.
- Visual aids were available for any patient who had difficulty understanding information verbally. This meant staff could explain procedures and treatments to patients to ensure they understood what they were giving consent for.
- There was training for the Mental Capacity Act though staff told us they had not provided treatment for any patient who lacked the mental capacity to consent themselves. They were able to discuss the process which would be taken to ensure any treatment was in the best interest of the patient.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

- Children and young people who used the service were treated with privacy and dignity. There was a holistic approach to the health and well-being of children and young people.
- Feedback from children and young people was positive and they were full of praise for the service. There was emotional support for those who had requested a termination of pregnancy.
- There was a counselling service which was run by staff and volunteers; this service had made a great impact on some of the children and young people who had accessed it.

Compassionate care

- We saw that staff at the clinic understood and respected people's personal, cultural and social needs. We spoke with two patients at the clinic. A patient we spoke with had complex issues due to their ethnic background they said that they loved the service, that the nurses made them feel comfortable and were non-judgemental. Another patient we spoke with said everything at the clinic was great; the staff were friendly and much more helpful than the local doctor's surgery. They said that waiting times could be a problem and that it would be better if the clinic did testing for sexually transmitted diseases.
- Young people who attended Brook Burnley clinic were treated with respect and their privacy and dignity was maintained at all times. There were signs placed on the consulting room doors when a consultation was in progress to protect the privacy of the patient.
- Confidentiality was respected at all times by staff. In the reception area patients ticked a sheet explaining their concerns so that staff and patients did not overhear.
- We looked at seven comment cards, which were all very positive and described helpful and professional staff, very good treatment, good support, an amazing service and staff who, listened and responded to needs and concerns and that did a great job.
- In the waiting room, the staff told us they had arranged the seating to maximise the privacy of patients. Different combinations had been tried in order to make young people feel most comfortable. Popular music was played in the waiting area during opening times to reduce the possibility of conversations being overheard and create a relaxed atmosphere.
- Counsellors acknowledged when a patient required additional time and were able to meet their needs. Extra sessions were arranged so that the counsellor could continue to help the young person in need.

Understanding and involvement of patients and those close to them

- We saw a case study of a patient following a series of counselling sessions at Brook Burnley. They were emotionally supported throughout their journey and were able to re-establish family ties as a result.
- The service had a number of methods of seeking the views of young people, these included counter measures where patients were given a counter and asked to put them in collecting boxes marked "yes" or "no" in response to two closed questions; "would you recommend Brook to a friend" and "did Brook help you today". This survey was run twice a year for two weeks. For the Burnley site for the period 2015-2016, the response to the first question 100% of the counters were placed in the box labelled "yes "(response rate 84%), in response to the second question 100% of the counters were placed in the yes box (response rate 47%).

Emotional support

- The emotional wellbeing of the young person was a priority to all staff working in the clinic. The Brook vision and mission statements ensured that support of patients was integral to the success of the organisation.
- There were a number of registered counsellors, some of whom were volunteers, who delivered services at Brook Burnley that supported the needs of young people. Referrals could be made by clinicians or patients were able to self-refer to the service.
- We saw many positive comments from patients providing feedback. These included "everyone is really welcoming and relaxed - should open longer on a weekend", "I got what I came for and the people who work here are all friendly and not judgemental" and "lovely staff, felt calm and reassured".

Are services caring?

- When a patient was referred to another service for termination of pregnancy treatment, the staff would contact the patient three weeks following the appointment to offer support, guidance and emotional support.
- We saw a reflective piece of work produced by a counsellor who had a patient with complex needs. The staff had recognised that additional support was required, and, with the consent of the young person, had involved the services that could improve the individual's wellbeing.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

- The clinic opened on a number of days including Saturdays, access to the service was good for all potential patients and referral processes included self-referral. Information was also available via a website which was user friendly and appropriate for the age group accessing the service.
- Information for patients was available in various formats and met the needs of people with a learning disability or poor literacy skills and those whose first language was not English.
- The clinic was responsive to patient feedback and had started to provide appointments at different times following feedback from children and young people.
- Information about how to complain was available in a number of formats and complaints were well managed and learning shared.

Planning and delivering services which meet people's needs

- Brook had three main core areas of business. These were to provide clinical and support services, provide education and promote wellbeing and to campaign as a voice for young people. From April 2016, Burnley clinic had reviewed their service provision to meet the needs of the population and the commissioners. Outreach services had ceased and plans were in place to improve the facilities and staff training in order to provide level two sexual health services. This would help to meet the needs of the population as young people had fedback to the service that an enhanced service was required.
- The main source of funding for the service was from a local NHS Foundation Trust. Brook Burnley was subcontracted to provide services to this trust as part of a county wide sexual health service. There was a service level agreement (SLA) in place.
- The Brook Burnley building was situated in an area of the town that had good transport accessibility and was close to the local further education college. The entrance was signposted but discreet. Patients could use the rear entrance for privacy if required.
- There was a level access to the rear and a toilet accessible to patients with mobility issues. There was no ground floor consulting room; however a small waiting area could be used if necessary. There were plans to change the use of this room into a consulting room.
- The reception was accessed via the main entrance; the door was secured with electronic door release operated by the receptionist. The reception was tidy and had a number of informative posters and leaflets informing visitors of the services provided.
- There was a large number of informative posters in the waiting area; leaflets were provided with directions to access the information in other languages via a website. A large display relating to child sex exploitation was exhibited in the waiting area that had been made locally.
- Brook had a website that was appropriate for the target audience of young people. It was informative and educational. There were links to each Brook clinic and the site provided directions and opening times and the services available at each site
- An online service, known as 'Ask Brook 24/7' was available for young people who did not want to visit the clinic in person, but needed support. The website contains 500 answers to frequently asked questions with subjects including contraception, gender, relationships and abuse. Signposting to additional support was provided with telephone helplines and addresses for local support. There was also information informing young people on how to delete their browsing history on their computers.
- Exit surveys were carried out every three months. As a result, opening times had changed and the Saturday appointment system was being piloted.
- A condom distribution scheme was available in the area known as the Burnley "Wrapped Up" scheme. Young people aged 13-25 years could join the scheme. After an initial registration, young people could then obtain free condoms from approximately 70 sources across Burnley, Rossendale, Pendle and Hyndburn. These included youth centres, colleges, pharmacies, and Brook Burnley.
- The service level agreement with the local trust specified certain postcodes where young people lived in order that they received services from Brook. The staff

would provide appropriate advice and signposting to young people who tried to access services from outside these postcode areas; Brook were not reimbursed for this.
- Brook Burnley were funded by a local clinical commissioning group to provide counselling sessions at two locations in the area. Thirteen sessions per week were provided and patients were referred from a number of sources to the service. Brook Burnley provided counselling using contracted and volunteer counsellors.
- In the eight months prior to the inspection, the counselling team had seen 25 patients providing 228 counselling sessions. In 2015-2016, staff saw 51 patients and provided 281 sessions. This meant the average number of visits per patient had increased from five to nine. The average waiting time to begin counselling was 4.5 weeks. Counsellors could provide up to 13 sessions per week and two locations were available for young people to attend.
- A targeted youth counsellor was employed by Brook to work throughout the Lancashire region. They had patients in the Burnley, Hyndburn and Ribble Valley areas. Their role was to work with young people between 12 and 19 years of age who had a risk element to their behaviour. They worked closely with other agencies.

Equality and diversity

- Diversity is one of the six values for Brook and the vision for Burnley included diversity and participation.
- The patients that visited the clinic reflected the ethnicity of the local population. Between October 2016 and December 2016, 14% of the visitors to the clinic were non-white British and the ethnicity of the population of Burnley and Hyndburn was 12%.
- Following the popularity of the lesbian, gay, bisexual transgender group in the neighbouring Brook Blackburn, the team had identified a need in the Burnley area and had begun plans to facilitate a group once the building works had been completed, later in the year.
- The clinic collected information on the ethnicity of the patients for the commissioners.

Meeting the needs of people in vulnerable circumstances

- The service saw patients in vulnerable circumstances. This included looked after children, those subject to child sexual exploitation, young people referred from the youth offending service and patients with a learning disability.
- The clinic had access for patients with mobility issues via the rear of the building. A dedicated parking space was available directly at the back of the building, with a ramp to the door. Staff told us that the clinical rooms on the first floor were not accessible; however, when a patient was unable to use the stairs, the staff used the small waiting room to see the patients privately. Staff acknowledged that this was not ideal and plans were in place to convert the room to a clinical room as part of the building works that were scheduled.
- If patients needed to access the service without wanting to come into contact with other patients this would be facilitated through the rear private entrance and booking an appointment prior to arrival. This included patients from identified vulnerable groups such as those subject to child sexual exploitation (CSE).
- There was a folder for patients with a learning disability or with poor literacy skills, this included information in a picture format on a range of topics including puberty, personal space and menstruation.There was a pathway for these patients that was included in the folder. Staff told us that they had patients with a learning disability who attended the clinic.
- Information including helpline numbers was displayed for various vulnerable groups.This included a display about child sexual exploitation in the waiting room and leaflets and posters for those "being told to marry a stranger."
- There were toilet facilities available on both the ground floor, that were wheelchair friendly and on the first floor,where the clinical rooms were situated.
- Brook Burnley provided pregnancy advice and/or pregnancy options information for young women who attended clinic for a pregnancy test or were knowingly pregnant. Between April 2015 and March 2016, 152 young women were provided with pregnancy advice and 83 referrals were made to external providers for termination of pregnancy. Burnley was ranked as fifth highest for teenage conception rates in England.

Access to the right care at the right time

- The clinic provided a walk in service four days per week from 1pm to 7pm Monday and 1pm to 5.30pm Tuesday

Are services responsive to people's needs?

through to Thursday. As a result of patient feedback an appointment only service was being piloted on Saturdays from 11am to 3pm. Staff said this was working well.

- Most appointments were drop in which meant that people who required emergency appointments were seem quickly.
- A clinic where patients booked in advance had been started the week before the inspection. This was being done on a trial basis, but would be continued if it was well attended.
- Opening times had been amended following an audit that recorded the number of patients that visited over the course of a day. A later start and finish time had facilitated patient's wishes.
- Most feedback received from patients indicated that an appointments system would be preferred. Staff felt this would create problems for people accessing the clinic for emergency contraception and could create difficulties when patients did not attend booked appointments. Appointments were offered for specific visits such as repeat implant appointments.
- Sometimes, if an issue arose, when the clinics needed to be closed, patients who were already in the system were offered an appointment and others were signposted to alternative providers. Staff at the service telephoned the alternative providers to make sure that they were open and medicines would be available as necessary. This had resulted from patients being signposted to alternative providers and necessary medicines being unavailable.
- In the period July 2016 to September 2016, there had been eight shifts where one qualified nurse had worked alone with the receptionist. This meant only one clinic could run on that day and some patients had to be given an appointment for the following day's clinic.
- Counselling services were available and young people could self-refer to this service or the clinicians could discuss the benefits with the young person and make a referral. Services were offered to patients at times to suit them, including evenings.
- A patient told us that they had been referred urgently to the counselling service and had an appointment for the week following the inspection.

Learning from complaints and concerns

- The complaints procedure was displayed in the consulting rooms and there were leaflets and posters in the waiting room and in the reception area. Complaints could be verbal, face to face or by telephone or could be received electronically or in writing.
- There was a complaints and compliments policy. Complaints were handled by the service and innovation manager and patients were invited in to meet the manager following a complaint. The complaint form on which the complaint was documented had information about the timescales for responding to complaints and was signed by the patient. There was also a complaints action sheet that was completed by the service and innovation manager with actions arising from the complaint and the documentation of the dates of acknowledgment of the complaint and the response. There was a brief description of the response. The action sheet was a tracking system for the complaint.
- If a complaint was not made directly by a patient, Brook would ensure that the patient was aware of the complaint and was in agreement with its content. No information about the patient, or acknowledgement that the patient was a patient of Brook was given to the complainant, without the patient's express permission.
- The service had received four complaints in the reporting period November 2015 to October 2016. Two of these complaints were upheld and appropriate actions were taken by Brook to address these complaints. One of these complaints had been addressed within the required timescales, the other complaint had been delayed due to annual leave, however the delay in responding to the complainant had been agreed with the complainant. The other two complaints had been closed as the complainants had failed to attend planned meetings to address their complaints. The service had tried to contact the complainants to re-arrange meetings on a number of occasions but the complainants had failed to respond. We saw that the learning from the complaints was communicated to staff at the staff meetings for both complaints and neither of the complaints were referred to the ombudsman.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

- The service had a vision and strategy which staff were aware of and the culture of the service was open with a strong focus on the rights of children and safeguarding.
- There were clear governance structures in place and a data analytics tool which provided audit and activity data to the service managers to monitor and improve services where appropriate.
- Public engagement with children and young people was very strong with the organisation being the " voice of the young person"

However;

- Reported risks were not always current and relevant and risk assessments that had been completed were not always acted upon.

Service vision and strategy

- The values and mission statement for the organisation was available on the Brook website.
- Brook's mission was to ensure that all children and young people have access to high quality, free and confidential sexual health services, as well as education and support that enables them to make informed, active choices about their personal and sexual relationships so they can enjoy their sexuality without harm. All the work undertaken at Brook reflect this and staff supported young people to make informed choices.
- Staff we spoke with supported the mission, the values and the vision of the organisation and were passionate about their work with young people.
- Brook had developed eight strategic goals which supported the mission, the values and the vision of the organisation. The strategy was a national strategy however there was no local strategy.

Governance, risk management and quality measurement

- Brook is a charity with trustees who have the responsibility for governing the organisation and directing how it is managed and run. There were governance sub-committees each was chaired by a trustee lead. The subcommittees were risk, finance and assurance and there was also a clinical advisory group and the safeguarding committee.
- At a national level Brook's clinical advisory group met every three months to assure the board of trustees that the clinical governance structures and processes were operating effectively. This group was responsible for governance of quality, safety, patient experience and complaints.
- There was a clinical leadership team, which consisted of the Medical Director, the Head of Nursing, two Nursing Leads and the Quality Improvement Manager who met with the Deputy Director of Service Delivery every two months and provided operational oversight of governance of quality, safety, patient experience and complaints. The service and innovation manager provided quality and risk reports to the service delivery directorate of Brook, these summarised incidents, complaints and other significant events and the actions taken in response to them. The clinical leadership team reviewed the reports for issues that needed to be followed up and learning that could be shared across the organisation.
- There was a corporate risk register and a local risk register. The local risk register was not always current and the risks were not always relevant, many of them were health and safety issues. At the unannounced inspection the local risk register had been updated, risks were rated by likelihood and impact, but there were no review dates on the register.
- We saw that risk assessments had been completed but in one of the assessments, the actions identified had not been completed within the timescale and there was no review of the risk. The risk assessment had been updated at the unannounced inspection but actions were not implemented fully because of the building work due to take place in the building in April 2017.
- A risk assessment for the safety of the receptionist when there was only one nurse in the building had been completed. Actions to reduce the risks had been identified with a completion date of the end of November 2016. We saw these actions had not been

done. There was no record of progress to date. This risk assessment had been updated at the unannounced inspection and action had been taken towards mitigation of the risks.

- In January 2016 there was a failure of the information technology (IT) system resulting in staff being unable to access patient records and information for commissioners. This lasted for two months. The service manager produced a risk register which identified the risks to staff, service users, and commissioners and to the organisation. Each risk was identified and rated and a supporting action plan was put into place to mitigate the risk. The IT service has since been upgraded to reduce the risk of this happening again.
- There was a red flag system on the electronic patient record system to alert staff to any patient who had displayed abusive behaviour.
- Brook received funding from a local clinical commissioning group (CCG) for the emotional health and well-being service which was the counselling service. There was a dashboard for this service and Brook provided quality reports every three months to the CCG as part of the performance management framework. We spoke with the commissioner of the service who had recently taken over this service; they said that there were no current concerns about the service.
- 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. The organisational aim was for all Brook services to achieve level two of the PQASSO and Brook standards and managers confirmed Brook Burnley had attained all but two of the quality areas for the level two accreditation.
- There was the data analytics reporting tool which was a cloud based application that provided Brook managers locally and nationally with timely access to activity data from all of Brook's clinical systems. Brook-wide clinical data was collated in one place which enabled staff to create reports, analyse patient's interactions with the services and to use data to improve patient care. An example of this was tracking the proportion of young women offered a sexually transmitted infection test prior to an implant removal for unscheduled bleeding. In light of the implant audit's finding of a fall in compliance with this particular standard, actions were put in place to address this.

Leadership of this service

- The Registered Manager and the Service and Innovation Manager told us that the senior team in the organisation was very visible; they visited the different sites and were available by phone and email and encouraged contact. The regional nurse lead for the north of the country was based at the Burnley clinic.
- During a recent information technology (IT) failure the senior team were supportive of the team at Brook Burnley. Additional resources were provided to meet any additional costs including staff time.
- The service and innovation manager had completed bespoke leadership and management development training; modules included managing people, managing resources, managing risk and managing quality. The manager said that they had learned a lot from the course and it had been useful.
- Leadership of the service was strong. The senior managers of the service sometimes undertook clinical sessions to ensure that patients were seen in a timely manner. This meant that they often had to work late or on their days off to meet their management responsibilities.
- The lead nurse for the North West region was based at this Brook clinic. This meant staff could easily and informally discuss any issues relevant to their role.
- There was no volunteer co-ordinator in post at the time of the inspection which meant that the registered manager was covering this as part of their role; they said that this was an additional challenge.

Culture within this service

- Brook works within the United Nations Convention on the Rights of the Child. They value young people's rights to involvement, education, confidentiality, choice, sexuality and diversity. These values were reflected throughout the service and underpinned all the work that took place. Managers and staff were proud to work there and were proud of the work they did.
- The culture of the service was open with a strong focus on safeguarding. Confidentiality was respected and staff said this was why young people liked the service. Young people we spoke with and feedback to the service supported this.

Are services well-led?

- The service and the organisation considered that they were "a voice for young people" and that they were advocates for children and young people. We saw evidence of this.

Public engagement

- There were young people involved in the clinical governance structures at a national level.
- Other methods of engagement were an exit survey "did you get what you came for"; feedback from this resulted in the setting up of an appointment service. There were also compliments and comments and 'you said we did'. We looked at six of these comment cards during the inspection and all were extremely positive about the staff and the service they provided.
- In answer to the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by the organisation" 97% of staff recommended Brook as a provider of care for family or friends.
- A patient forum was planned following the refurbishment of the premises. A group was in place at the Blackburn clinic and staff told us that patients were encouraged to speak out and share experiences. This forum was for the lesbian, gay, bisexual and transgender community and would be organised by the volunteer from Blackburn.
- Patients had access to "Ask Brook" a national information service which offered a confidential online webchat and interactive text message service and a toolkit of frequently asked questions which young people could access 24 hours a day, seven days a week. "Ask Brook" was available to young people by text or by live online chat. Young people could also access on line social media to communicate with the organisation.
- Brook staff were involved in educating young people and providing information to them. We saw they did this in innovative and young people friendly ways. There was a display of work in the waiting area that had been created as a project within a local school

Staff engagement

- A monthly national newsletter was shared electronically with all staff. This included national news updates as well as policy and clinical updates.
- There was a national staff survey in December 2015 with 53% of staff responding to the survey. This was an improvement on the two previous years; 94% of staff reported feeling proud to work for Brook.
- There were monthly staff meetings with a set agenda. We saw minutes of meetings which included sharing good news, health and safety, information governance and outcomes from national audits.

Innovation, improvement and sustainability

- The development and delivery of the level two sexual health service from April 2017 will make meet the needs of the clients and the commissioners and make the service more sustainable for the future.