Brook Bristol

Quality Report

3rd Floor
The Station
Silver Street
Bristol
BS1 2AG
Tel: 01179290090
Website: www.brook.org.uk

Date of inspection visit: 22 October 2019
Date of publication: 20/12/2019

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Brook Bristol is operated by Brook Young People. The service is open six days a week for the provision of sexual health services for children and young people up to the age of 19 years. The service is provided in the main location in the centre of Bristol and also from outreach clinics in a number of schools and colleges across Bristol.

The service was managed by a registered manager who divided their time between Brook Bristol and another Brook service. This was an interim arrangement due to an unsuccessful recruitment process for a full time manager for the Brook Bristol service earlier in the year. A transitional manager (non clinical role) was also in post and provided daily management support in the service.

We carried out an announced inspection of the main clinic using our comprehensive inspection methodology.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

This service had not been previously rated. We rated it as **Good** overall. Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Overall summary

Brook Bristol is operated by Brook Young People. The service is open six days a week for the provision of sexual health services for children and young people up to the age of 19 years. The service is provided in the main location in the centre of Bristol and also from outreach clinics in a number of schools and colleges across Bristol.

The service was managed by a registered manager who divided their time between Brook Bristol and another Brook service. This was an interim arrangement due to an unsuccessful recruitment process for a full time manager for the Brook Bristol service earlier in the year.
A transitional manager (non clinical role) was also in post and provided daily management support in the service.

We carried out an announced inspection of the main clinic using our comprehensive inspection methodology.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

This service had not been previously rated. We rated it as**Good**overall. Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Summary of findings

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health (sexual health services)	Good 	Good

Summary of findings

Contents

Good

Brook Bristol

Services we looked at

Community health (sexual health services);

Summary of this inspection

Background to Brook Bristol

Brook Bristol is operated by Brook Young People which has provided confidential sexual health services, support and advice to children and young people for the past 45 years. The service works in partnership with the local acute NHS trust and other providers to deliver an integrated sexual health service for children and young people living in Bristol, North Somerset and South Gloucestershire.

Brook Bristol is located within the city centre and provides 24 to 30 clinics a month, spread over six days a week. The service also provides weekly outreach clinics in 13 schools and colleges across Bristol and the surrounding areas.

Brook Bristol is recognised as a level two contraception and sexual health service (CASH). The Department of Health's National Strategy for Sexual Health and HIV for England 2001 set out what services should be provided at each recognised level. As a level two service, Brook Bristol provides contraception, emergency contraception, condom distribution, screening for infections and treatment of chlamydia and herpes, pregnancy testing, long acting reversible contraception (LARC) implant insertion and removal and intrauterine device (IUD) insertion and removal, termination of pregnancy referrals and counselling. Young people presenting with sexually transmitted infections other than chlamydia and herpes are referred to an alternative level three CASH service in Bristol for treatment.

The service primarily serves the communities of Bristol but also accepts young people who attend from outside this area.

At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in May 2019. This was an interim arrangement until a full time clinical manager could be recruited and appointed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two inspectors. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Information about Brook Bristol

The service is a level two sexual health service for young people under the age of 19 years and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Treatment of disease, disorder or injury

During the inspection, we visited the main clinic in Bristol city centre. We spoke with eight members of staff, including registered nurses, health care assistants, reception staff, and managers. We spoke with four patients and we reviewed seven sets of electronic patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in April 2016.

Activity (July 2018 to July 2019)

- In the reporting period July 2018 to July 2019 the service provided clinics six days of the week. Between April 2018 and March 2019 the total number of children and young people who attended the clinics were 9,995. The service was funded through the local NHS trust.

Summary of this inspection

The service employed 17 staff members, including registered nurses, health care assistants, administrators, managers and receptionists.

Track record on safety

No Never events

Three clinical incidents with low harm

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli

One complaint

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Maintenance of medical equipment

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?

Good

This service had not previously been rated. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff took action to promote the control of infection and prevent cross infection.
- The design, maintenance and use of facilities, premises and equipment kept people safe and staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- Staff always had access to up to date accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- The service used systems and processes to safely record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used monitoring results well to improve safety.

However:

- Whilst staff had access to guidance relating to female genital mutilation, they were not provided with training to reinforce the action they were to take should this be suspected.
- Staff did not consistently comply with the infection control procedures as they were not always bare below the elbow in the clinical area.

Summary of this inspection

- Used sharps materials, such as syringes and needles, were left unattended in clinic rooms in the presence of children and young people.
- Staff had not been provided with the opportunity to attend drills or practices of the procedures to be followed, should they be at risk and need to summon assistance.
- Staff did not have access to up to date patient group directions (PGD) for the administration of medicines.

Are services effective?

Good

This service had not previously been rated. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Children and young people attending the clinics had access to drinking water during their visit to the service.
- Staff assessed and monitored patients during and after insertion of an intrauterine device.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff promoted the health of children and young people attending the service.
- Staff supported patients to make informed decisions about their care and treatment.

Are services caring?

Outstanding

This service had not previously been rated. We rated it as **Outstanding** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. There was a strong visible person-centred culture. Staff went above and beyond their role to support patients. Feedback from patients was consistently positive.
- Staff provided emotional support to patients, families and carers to minimise their distress. Staff clearly recognised the stigma attached with accessing their services and supported patients emotionally.

Summary of this inspection

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

Are services responsive?

Good

This service had not previously been rated. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The service met the needs of children and young people in vulnerable circumstances.
- Children and young people could access services which provided the right care at the right time.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Are services well-led?

Good

This service had not previously been rated. We rated it as **Good** because:

- Leaders had the integrity, skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Summary of this inspection

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and had plans to cope with unexpected events.
- The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and development of staff.

However:

- However, the registered manager had responsibility for another service as well as Brook Bristol. This impacted on the time available to be in Bristol.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Community health (sexual health services)

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

Information about the service

Brook Bristol is operated by Brook Young People which has provided confidential sexual health services, support and advice to children and young people for the past 45 years. The service works in partnership with the local acute NHS trust and other providers to deliver an integrated sexual health service for children and young people living in Bristol, North Somerset and South Gloucestershire.

Brook Bristol is located within the city centre and provides 24 to 30 clinics a month, spread over six days a week. The service also provides weekly outreach clinics in 13 schools and colleges across Bristol and the surrounding areas.

Brook Bristol is recognised as a level two contraception and sexual health service (CASH). The Department of Health's National Strategy for Sexual Health and HIV for England 2001 set out what services should be provided at each recognised level. As a level two service, Brook Bristol provides contraception, emergency contraception, condom distribution, screening for infections, pregnancy testing, long acting reversible contraception (LARC) implant insertion and removal and intrauterine device (IUD) insertion and removal, termination of pregnancy referrals and counselling. Young people presenting with sexually transmitted infections are referred to an alternative level three CASH service in Bristol for treatment.

The service primarily serves the communities of Bristol but also accepts young people who attend from outside this area.

At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in May 2019. This was an interim arrangement until a full time clinical manager could be recruited and appointed.

Good

Community health (sexual health services)

Summary of findings

Sexual health services

Good

Brook Bristol carried out independent sexual health services for contraception and genito-urinary medicine in Bristol and the surrounding areas for children and young people up to the age of 19 years.

Overall we rated the service as good because:

Staff were supported and competent to carry out their roles. Staff were valued and felt listened to.

The service was patient-centred and focused on supporting children and young people and keeping them safe.

The premises and equipment were suitable for the services provided and easily accessible to children and young people.

Are community health (sexual health services) safe?

Good

Safe means the services protect you from abuse and avoidable harm.

This domain was not previously rated. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service required staff to complete a programme of mandatory training each year. Training was being reviewed by the head of nursing and head of human resources. They aimed to develop the training matrix so that it included additional information. For example, as well as recording completion of training by staff to include the format and content of training. The last review had taken place in 2014. Following completion of eLearning, an electronic report was sent to the facilities department, who managed human resources within the service and maintained a central log for all staff.

Compliance with training within Brook Bristol was good. All staff had completed the face-to- face training, with two new members of staff in the process of completing all eLearning. The registered manager monitored the training compliance and prompted staff when refresher training was due. The registered manager provided assurances to us the training programme was nearing completion.

The training was delivered through eLearning and face-to-face training. eLearning included moving and handling, infection prevention, conflict resolution and data protection. Face-to-face training sessions included safeguarding adults and children levels one and two, anaphylaxis and basic life support. The registered manager had a recognised teaching certificate which enabled them to deliver training within the service. For example, level one and two safeguarding adults and children. There was no practical moving and handling training and no designated first aider within the service as

the previously nominated person had left the organisation. However, a health care assistant was due to undertake the first aider training course in November. Staff had completed training to support them to manage challenging behaviour and de-escalate situations.

All staff were provided with fire training annually as part of the mandatory training. Reception staff held the role of fire marshal, for which they had attended additional training. There had not been a building fire drill in the last three years. The fire drill training had last been carried out by the management company of the whole building.

Additional role-specific training was provided to staff. The registered manager had completed safeguarding training at level four and clinicians had completed anaphylaxis training. This equipped staff to respond to emergencies in the event of an allergic reaction experienced by young people attending the clinic.

Staff we spoke with confirmed the standard of training felt good; they had not requested additional training and the content of the training was relevant and useful.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

There had been no safeguarding alerts made to CQC by or regarding Brook Bristol.

Staff had access to electronic policies and procedures on how to safeguard children and young people. The policy provided guidance on the action to take when suspected physical, mental or sexual abuse had taken place and children and young people were or could be at risk. Additional detailed information was included regarding female genital mutilation (FGM), child sex exploitation (CSE), gang culture, trafficking, slavery, breast ironing, forced marriage, honour based violence, domestic violence, racialization, IT abuse and sexual activity in children under the age of 13 years. There were additional policies to safeguard those in vulnerable circumstances. For example, those with learning difficulties or complex needs, and children under 16 years accessing services without the requirement of parental consent. Sexual exploitation of children and young people under 18 years involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. FGM is the ritual cutting or removal of some or all of the external female genitalia. The practice is found in Africa, Asia and the Middle East, and within communities from countries in which FGM is common. Breast ironing, also known as breast flattening, is the pounding and massaging of a pubescent girl's breasts, using hard or heated objects, to try to make them stop developing or disappear.

The organisation provided training to all staff in safeguarding adults and children at level one and two on induction. This was updated annually. All clinicians were required to complete eLearning level three safeguarding children training. At Brook Bristol there were two members of staff who had recently been appointed and were awaiting a date for this training. The level three safeguarding children training was renewed every three years. All staff with the exception of one member of staff had completed level four decision making training in relation to safeguarding.

The training included face-to-face training and the completion of a workbook to confirm the staff members' knowledge and understanding. Topics covered within the training included; consent – including Fraser guidelines and Gillick competencies, principles of the Mental Capacity Act, informed decision making, policies and procedures, safeguarding responsibilities, asking questions and completing the client care record including how to check and confirm a young person age, confidentiality, spotting signs of risk, use of a sexual behaviours traffic light tool categorising healthy sexual behaviour and distinguishing harmful behaviours and CSE. However, Staff commented the training did not include in depth information relating to the recognition and management of incidences of FGM as this was a brief part of the training. The training material we saw supported this comment. (Gillick competence assessment seeks to ensure children under the age of 16 years have the ability and understanding of their decisions. The Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parent or carers consent).

Good

Community health (sexual health services)

A flow chart proforma led staff to complete a summary of concerns and complete an assessment to record a level of risk or harm. Further documentation identified who the information had been shared with, both within and external to the organisation, an action plan and follow up actions.

During our inspection we observed staff asked questions during consultations with children and young people which identified if there were any safeguarding concerns.

Brook Young People had worked with the British Association for Sexual Health and HIV (BASHH) to develop an assessment tool called 'Spotting the Signs' to help professionals detect children and young people experiencing CSE.

Staff we spoke with knew how to raise a safeguarding concern. The contact details for the safeguarding leads within the organisation were readily available and a senior leader was on duty at all times the clinic was open. Staff were also able to provide the contact detail for the local authority and knew when they would directly report safeguarding concerns to the local authority or the police. Staff followed a care pathway to safely refer children and young people to the appropriate services, should they disclose they were a victim of sexual assault.

Staff provided examples of recent safeguarding referrals. Brook Bristol had raised concerns regarding one young person who attended the clinic with the acute trust providers of sexual health and had then taken the lead on ensuring a safeguarding referral was made and acted upon. Another young person had attended the clinic for care and treatment and through discussion, concerns were identified and a safeguarding referral made. Outreach nursing staff were able to provide examples of safeguarding concerns where Brook Bristol was involved with multiple agencies, including the school, police, children and adolescent mental health service (CAMHS) and the local authority. Outreach staff would discuss safeguarding concerns with their colleagues and escalate to senior staff, the local authority or the police as necessary. Staff considered their priority to be the safety of children and young people and, if necessary, would remain in the school to ensure the child was kept safe. Outreach staff all reported good working relationships with the safeguarding leads at the schools and colleges they visited.

Previous safeguarding concerns were recorded on the patient electronic record. There was an alert facility on the reception booking form, which highlighted to the nurse any risks or extra care needs. There was also a facility to note any learning disability or physical disability which required extra support. The IT system in use meant that staff could not move forward to the patient review without confirming they had seen the alert.

Staff always made an opportunity to speak with children and young people on their own when they attended the clinic with a relative or friend. This gave staff the confidence that they felt safe and had the opportunity to raise concerns they could not voice in front of others. Information was displayed in the clinic to advise children and young people regarding safeguarding. However, there were no information posters or leaflets displayed regarding domestic violence and the action the child or young person could take or where to seek help.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff generally used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.

The environment was visibly clean and hygienic. Arrangements were agreed with the management company of the building for cleaning staff to attend the clinic six days each week. Cleaning records were up to date and demonstrated that the environment was regularly cleaned, although the attendance of the cleaner varied between morning and evening. Staff were not clear regarding the arrangements for when the cleaner should attend, although all confirmed they generally met with them in the mornings. We observed that the clinic rooms, toilets, baby changing area and waiting room were clean.

Clinical staff cleaned equipment after use, such as examination couches or scales. Appropriate cleaning chemicals and wipes were available for this purpose and were stored securely when not in use. Staff damp dusted the clinic rooms each morning in preparation for the clinic ahead. A biological hazard spillage kit was available, and staff were provided with guidance on how to use this.

Good

Community health (sexual health services)

The organisation required Brook Bristol to carry out an annual infection control audit. This had been carried out between November and December 2018 using the Brook infection control toolkit, which is based on the standards of the Infection Control Nurses Association. Full compliance with the audit standards required a minimum score of 85% in all areas audited which Brook Bristol exceeded. This audit was carried out by a clinician working in the service. There were no other infection prevention and control (IPC) or hand hygiene audits carried out outside of the annual audit.

A clinical waste collection contract had been arranged with an external company. This had recently been renewed to increase the collections of clinical waste, due to an increase in demand. Disposal boxes for sharp items such as needles were collected from the service within this contract.

Staff carried out weekly water checks from all taps and outlets and ran the hot water for a certain length of time. This was to reduce the risk of Legionella infection. Annual checks and servicing were carried out within the waste contract on all water outlets to reduce this risk.

Staff complied with The National Institute for Health and Care Excellence (NICE) guidelines QS61, which recommends: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. During our inspection we observed staff regularly washed their hands and applied sanitising hand gel. The service did not robustly monitor this through regular audit. We saw staff did not consistently comply with the 'bare below the elbows' policy to control the risk of infection.

Protective personal equipment (PPE), such as gloves and aprons, were available for staff to use.

All staff had access to the IPC policy and procedures through the electronic records system.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, there was a risk to children and young people from harm from sharps or inappropriate access to equipment.

During our inspection we visited the main clinic for Brook Bristol. This consisted of a reception area, waiting room, four consultation rooms and a counselling room, toilets, offices and staff clinical rooms. All areas were visibly clean and tidy.

Appropriate arrangements were in place for the management and disposal of clinical waste. Each consultation room had bins for the disposal of sharps materials, such as syringes and needles. When in use and not sealed for disposal, the contents were accessible. During their clinic appointment children and young people were sometimes left on their own in the consultation room which meant the sharps were accessible to them. This was a potential risk of harm from a sharps injury or access to equipment.

A central sterile supply department check list was completed each Monday morning to ensure all IUD clinics would have the equipment they needed available. The supplies came from the local NHS acute trust.

There were no emergency call bells in the consultation rooms. Administration staff told us there used to be, as it had been their role to test them. They believed they were no longer used as the access to them was not easy for clinicians. Each member of staff had a personal alarm. These were not regularly tested, and no test had been completed to check where they could be heard within the clinic. There had also not been a drill to plan the action staff would take should a personal alarm sound. This did not ensure staff would be confident of the action to take should a child or young person display challenging behaviour. However, staff we spoke with confirmed they had not experienced any incidents of challenging behaviour or aggression.

There were systems and processes to ensure that all equipment was maintained and serviced to ensure it was fit for use. Records were maintained of the servicing, maintenance and calibration carried out for all medical equipment. Reminders were provided to outreach staff when equipment, which was in schools and colleges, was required to be serviced. There was replacement equipment staff could use if the equipment could not be tested during a time when outreach clinics were closed.

Portable electrical appliance testing took place every two years and was next due to be tested in January 2020.

The clinic was accessible during the hours the management company were on site. Arrangements were made to secure the keys to the clinic at the end of the day.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

On arrival all children and young people were asked their age and asked to complete a 'welcome to Brook' triage questionnaire / booking form. The form required the children and young people to tick the reason for attending, such as for condoms, pregnancy testing, termination of pregnancy, emergency contraception, contraception (repeat, new), infection testing and treatment. There was a health and wellbeing section of the form, which included lifestyle questions such as drug and alcohol use, whether the client felt safe in their life, whether they were at risk of harming themselves and whether they had a support network.

Reception staff reviewed and triaged the initial form and alerted clinicians immediately if any questions or concerns were identified from the form. This ensured that children and young people with identified risk factors were prioritised and seen by clinicians when necessary. We saw this took place when one person had been made aware of an infected ex-partner and when a young person was clearly agitated or distressed.

The reception staff then booked the child or young person into the clinic, advised of waiting times and the under 16 years priority service or referred to another service, providing opening times and contact details. The under 16 priority service meant that children under 16 years were fast tracked to ensure they were seen on the day they attended.

Staff added details from the triage form to the electronic records system, colour coding new or returning children and young people for ease of use of the clinicians. These questionnaires were locked in a cabinet at reception and collected by the clinician before the appointment.

The IT booking system was not linked to external organisations, such as the local NHS trust or level three sexual health service. Therefore, any cross reference of risks or making appointments were done by telephone call. We were told that a staff member could ring the level three service to check if a child or young person had been seen there to ensure a continuity of service or identification of any safeguarding risks. Both services would record the interaction to provide an audit trail of discussion and risk management. All referrals to other services, except for those clients over 19 years, went through the nurse on duty.

Information was available to clients about consent to sex. We listened to advice and information being given, which included what the scope of non-consenting sex was. Staff were very clear in information provided about consent and the child or young person's right to consent.

Adrenaline was kept on site as part of the anaphylaxis management kit. This was checked regularly to ensure the adrenaline was in date and the kit ready to use. There were no other emergency medicines or equipment held in the clinic. Should a child or young person collapse, the nearest defibrillator was in a nearby supermarket and staff would call the emergency ambulance for assistance. Oxygen was available as this was used for the IUD clinic.

Atropine was available in case of cervical shock during IUD clinic which would be administered by the doctor on duty.

The electronic records system alerted staff to risks from violence and aggression or safeguarding concerns for individual children and young people attending the service.

During outreach clinics in schools a community youth worker, employed by the council, triaged patients to send to either the nurse or youth worker who worked for Brook Bristol.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There were 17 members of staff employed in the service, including registered nurses, health care assistants, doctors, administrators and managers. Over the last year eight members of staff had left the service and there had been a period of recruitment which had resulted in a relatively new staff team. The service had been proactive

in recruiting staff who wished to pursue a career in sexual health and provided a comprehensive training package to ensure their competencies were completed in a nurturing environment.

There was a 1.5 whole time equivalent (WTE) vacancy for a registered nurse and a 1.5 WTE vacancy for a health care assistant. These posts were being advertised. The service had been unable to appoint a manager so as an interim arrangement a transitional manager had been appointed on a fixed term contract and the registered manager from another service was providing management support for Brook Bristol.

On the day of our inspection, the staff on duty were a band six nurse in charge, a band five nurse in training, two health care assistants, two reception staff, the registered manager, the transitional manager and one administrator. There was one member of staff who had taken sick leave on the day of our inspection. This member of staff had not been replaced and subsequently the clinic was very busy.

There were no members of staff on long term sick leave.

Staffing challenges had resulted in planned changes to be made to the outreach model. There was to be a reduction in the number of nurse-led outreach clinics in schools and colleges. These were to be led by youth workers, who, as well as providing counselling and support, would receive additional competency-based training to provide pregnancy tests, c cards (the provision of condoms scheme) and chlamydia testing. The current nurse-led clinics were prioritised in areas of deprivation and based on clinical need. However, staff we spoke with told us that there were still areas that were lacking this service that also had a need.

There had been a reduction in staff and a reorganisation when reception staff had to apply for the shifts they wanted. The current reception staff had been provided with the working patterns they chose. Bank staff for reception had been discontinued which meant the reception often operated with only one receptionist after 5pm. Staff found this difficult when the service was busy and they had to work closely with the nursing staff to keep flow going.

There was a doctor on duty on Monday and Wednesday afternoons, whose primary role was to fit intrauterine devices.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

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

Records were clear, up to date, stored securely and accessible by all staff, who were provided with an individual password for this purpose.

Records were all electronic, with paper back up records as a contingency, should systems fail. We reviewed five sets of electronic records and two assessments being transferred to the IT system. Records included initial triage, risk assessments, consideration of Gillick competence, consent management, issues raised and action plans in response. Records were maintained of multidisciplinary working, for example, with the police or support services.

Children and young people could access their own data. This required them to complete a consent form and pay a £10 fee. Staff gave an example of the records being accessed by one young person to share with a counsellor.

Letters to a child or young person's GP or other clinician were sent for a follow up once consent to the share information had been obtained.

There were no paper records routinely used within the service with the exception of the initial triage form and at times of IT failure Paper records were shredded once scanned and saved on the electronic system. The templates used for initial assessment and triage were added to the electronic system and then securely shredded. In the event of the IT system failing, paper records were used and the information uploaded once the system was fully functioning. The paper records were then shredded.

The organisation audited the records of children and young people attending the service. The most recent audit for Brook Bristol had been completed in June 2019, during which 40 sets of notes had been reviewed as part of wider audit of the care and treatment delivered. Brook

Bristol had received feedback on areas to improve in their record keeping. For example, consistently recording if a child or young person had irregular bleeding following the insertion of an implant. This information had been cascaded to staff to action.

Medicines

The service used systems and processes to safely record and store medicines. However, the staff did not have access to up to date patient group directives (PGD) for the administration of medicines.

Medicines were stored appropriately and securely.

Staff were provided with guidance and information on the safe management of medicines within policies and procedures. Guidance included the procedures to follow when transporting medicines to outreach clinics. However, staff did not consistently comply with this policy and procedure as whilst medicines were secured in a locked box, they were not returned to the clinic in accordance with the instructions in the policy. The policy advised that if not practical to return the medicines the same day, the locked box may be stored securely at the clinician's home until the next day. Staff we spoke with transported and kept the medicines securely for three days which covered their working week. They told us the medicines were stored in a locked box in a secure area of their home which was not frequented by visitors.

Patient Group Directions (PGDs) were used for all medicines and were available on the intranet and in paper format. A PGD is a written instruction which enables health care professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The PGDs were detailed and included exclusion criteria, dosage and caution of use. The PGDs were signed by staff members to evidence they had read and understand the PGD.

The PGDs were out of date and their review date had been extended. We saw an email to the registered manager, permitting the extended PGD usage, but there was no record of who had agreed the extension. The PGDs were written and signed by the local acute NHS trust and not Brook. Since the PGDs had been written, guidance for the use of one medicine had changed. The PGD for the use of azithromycin identified this medicine as the first antibiotic of choice but this was no longer the case. Staff were using doxycycline as first line antibiotic therapy and erythromycin as second line. Therefore, staff were following the up to date national guidance but not following the out of date PGD and there was no new doxycycline PGD in use. There were no nurse prescribers within the service and if there was no doctor available to write a prescription, national guidance could not be followed. Staff informed us of an instance where one young person had been referred to another service for their treatment as nursing staff could not dispense doxycycline to them due to contraindications. The staff were unable to give the correct dose of Azithromycin as there was no PGD or Prescriber on site.

Medicines were administered safely by staff who had received appropriate training and competency checks to carry out this task. We spoke with a registered nurse who was new to the service. They were completing competencies within sexual health care and treatment, which included dispensing and administering medicines. They had been signed off as being competent to dispense emergency contraception and antibiotic therapy but were required to have other medicines, such as the contraceptive pill, checked by a registered nurse.

Electronic patient records identified medicines provided to children and young people and a risk assessment of the suitability of medicines. For example, a record was made of any allergies which would affect the medicines use.

The laboratory room for storage of medicines and specimens was secured and we saw repairs to the door taking place to ensure security. Specimens were collected mid-afternoon by the acute trust and were stored appropriately in a fridge used specifically for this purpose. The fridge temperatures were monitored regularly. Chlamydia screening was funded and managed by the local acute trust, which included collecting and processing all specimens. Blood tests were obtained by all clinicians and were stored in a separate fridge awaiting collection. If the afternoon collection was missed, the specimens were kept until the next day. Specimens included tests for HIV, syphilis, chlamydia and gonorrhoea.

Two separate fridges were used for the storage of medicines, which were always secured. The temperatures of the fridges were regularly checked.

Good

Community health (sexual health services)

Information was provided on medicine storage shelves as a reminder and to reduce risk. For example, the information referenced a medicine which was not suitable for children and young people with peanut or soya allergies.

Incident reporting, learning and improvement

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

There had been no never events or serious incidents reported by Brook Bristol in the last year. A never event is a serious incident that is wholly preventable, as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death.

The incident reporting process within the organisation had recently been reviewed and updated. A programme of training had been provided and there had been discussions with staff at team meetings regarding incident reporting. As a result, the organisation had identified an increase in reported incidents due to staff awareness in how and when to report incidents. However, whilst staff understood how to report incidents and near misses, they were not all completely clear about the scope of things they should be reporting and confirmed they did not consistently received feedback. Any learning locally or from the wider service was shared through the team briefing and staff meetings.

Staff reported incidents through the electronic reporting system, which included the registered manager and transitional manager in the process. The incident was recorded on an incident log for the service and reviewed at service-specific governance meetings, which occurred four to six weekly. The incident log was shared within the organisation through the quality assurance committee.

When necessary, action was taken following reported incidents. We were provided with an example of a recently reported incident. This was regarding discrepancies in the latest medicine stock take. On investigation, it was established to be due to poor documentation, rather than missing medicines. Feedback was provided to staff individually and through the team meeting. Action was taken following discussion with and suggestions from staff to reduce the risk of the incident reoccurring. There had been an incident in another Brook service where medicines had been stolen from a car. As a result, the medicines policy and procedure had been changed to reduce the risk of reoccurrence and information shared throughout the organisation.

The organisation found the most reported incidents were due to the IT system which impacted at times on the running of the clinic. This had been identified as a risk on the risk register but the service was constrained through a shared computer system as part of a group of sexual health providers locally.

Safety performance

The service used monitoring results well to improve safety.

Data was collected and submitted through national reporting systems. The service completed the required data submissions to the Genitourinary Medicine Clinic Activity Dataset (GUMCAD). GUMCAD is the mandatory surveillance system for sexually transmitted infections in England. Data was also submitted through the Sexual and Reproductive Health Activity Data Set (SRHAD) collection. This provides a source of contraceptive and sexual health data nationally and showed the service provided children and young people with appropriate sexual health screening, care and treatment.

Brook Bristol shared information with the local acute trust as part of a partnership contracting agreement. The local trust extracted data regarding Brook Bristol from the electronic system for submission to GUMCAD and SRHAD.

The service benchmarked infection figures with the local NHS trust, which were submitted to Public Health England (PHE) to identify trends for potential outbreaks of infections.

Are community health (sexual health services) effective?

Good

Community health (sexual health services)

(for example, treatment is effective)

Good

Effective means that your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

This domain was not previously rated. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The service followed guidance from the British Association for Sexual Health and HIV (BASHH) and the National Institute for Health and Care Excellence (NICE). Brook Young People ensured information was shared throughout the organisation when guidance or best practice advice was updated nationally. Policies and procedures included good practice guidelines from external organisations, for example, the BASHH standards for management of sexually transmitted infections.

The registered manager had completed training to become a trainer for the Faculty of Sexual and Reproductive Healthcare (FRSH), which are accredited by NICE.

The organisation had reviewed six national clinical audit plans during 2018/19 and planned to act to improve the quality of the health care provided following recommendations made within the national audits. For example, any child or young person presenting for emergency contraception would be offered an intrauterine device as the most effective method of emergency contraction and documentation completed with their response.

Brook Bristol had completed audits of the assessments carried out to identify child sexual exploitation (CSE) and domestic violence with partner organisations. No actions for improvement had been identified Brook Bristol to take. However, an audit for partner notification had identified some areas for improvement initially – the full report was awaited to determine if further training for staff was required to meet standards or whether there had been coding/recording errors.

Nutrition and hydration

Staff did not monitor the nutrition and hydration of children and young people attending the clinics due to the nature of the service provided.

A cold-water dispenser was available in the waiting area of the main clinic for children and young people to help themselves to.

Staff told us that if a child or young person became light headed following a procedure such as insertion of implant or intrauterine device they were offered a drink and/or a biscuit to help their recovery.

Pain relief

Staff assessed and monitored patients during and after insertion of an intrauterine device.

Children and young people were provided with information prior to attending the clinic for insertion of an intrauterine device which included advice on pain relief to take prior to attending for their appointment. The information was also provided through Brook Young People's website. The doctor prescribed analgesia if required following the procedure.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service had a clear approach to monitoring, auditing and benchmarking the quality of these services and the outcomes for people receiving care and treatment. Quality and outcome information showed that the needs of people were being met.

Children and young people were provided with a service within agreed timeframes for appointments and which complied with the commissioning arrangements. The service submitted data to the lead provider of sexual health services in Bristol and the surrounding area who commissioned Brook Bristol's service which confirmed this.

The service completed the required data submissions to the Genitourinary Medicine Clinic Activity Dataset (GUMCAD). GUMCAD is the mandatory surveillance system for sexually transmitted infections in England.

Good

Community health (sexual health services)

Data was also submitted through the Sexual and Reproductive Health Activity Data Set (SRHAD) collection. This provided a source of contraceptive and sexual health data nationally and demonstrated the service ensured delivery of the national target on sexual health services.

The outreach service had been reviewed and the service found the model used did not fully meet the needs of children and young people. As a result additional clinics had been introduced, run by educational specialists who provided counselling, one to one support to children and young people and distribution of condoms.

Competent staff

The service made sure staff were competent for their roles.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Brook Young People provided training and development for staff to ensure children and young people received their care and treatment from staff with the right skills and knowledge. One young person told us "Staff are approachable, fun and relaxed but also professional and know what they are talking about."

Annual appraisals and six weekly clinical supervision provided staff with the opportunity to discuss and identify training and development needs. Key performance indicators were identified and discussed to give the staff team focus and direction. The registered manager met with staff regularly when they were working in the Bristol clinic, which provided opportunities for information sharing meetings and conversations.

Staff were supported to achieve competencies, as recommended by BASHH and FRSH. The registered manager was a clinical educator, having achieved recognition and training from FRSH. Staff felt supported by the registered manager and the band six registered nurse in developing their skills and competencies, although face-to-face time with the registered manager was limited due to their responsibility for two services. A newly recruited registered nurse was undertaking the FRSH sexual health diploma, supported by the band six nurse to achieve competency within the sexual health speciality.

Support was available from the head of nursing and the registered manager for registered nurses who were required to revalidate with their professional nursing body. This was an external check that the nurse was up to date and fit to practice.

Brook Bristol were partners in a wider provision of sexual health services in the Bristol area. The acute trust led this partner group and provided opportunities for Brook Bristol staff to attend training and workshop sessions. The registered manager held records to evidence the training attended for example, update information regarding contraceptive use and prescribing.

Brook Bristol received medical support from doctors on two days each week. The doctors mainly provided medical cover for the insertion of intrauterine devices (IUD) but also saw other children and young people with sexual health care and treatment needs.

The nursing staff, except for the registered manager, had not completed training to ensure they were competent to fit IUDs. This had been planned to take place, with one registered nurse identified to complete the training. All band six registered nurses were trained to fit and remove long acting contraceptive implants. A further member of staff had been identified to complete this training. Until registered nurses had completed the training and had their competency assessed they did not carry out these procedures.

Suitable arrangements were in place to ensure that local healthcare providers were informed in cases where a staff member was suspended from duty. As part of the partnership working information relating to staffing issues was shared with the lead health care provider regarding staff suspension to protect staff and children and young people attending the service. This was carried out under careful consideration to ensure confidential information was not breached and ensured Brook Bristol complied with IHAS/NHS Employers guidance. The guidance, developed in partnership between the NHS Employers organisation and the Independent Healthcare Advisory Services (IHAS), outlines the principles on how healthcare organisations share information. This is specifically where a healthcare worker's conduct or performance has been investigated and questioned where they may work in more than one organisation or go onto work in another.

Good

Community health (sexual health services)

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Any referrals to the service were handled effectively with clear criteria and a multi-agency approach to ensure people received the right care swiftly. Children and young people up to the age of 19 years could self-refer and attend a walk-in clinic or ring for an appointment. Clinicians recommended children and young people to attend the clinic and we observed one clinician telephoning staff prior to the young person attending.

The service used a range of care pathways to ensure children and young people received appropriate care and treatment. The staff were efficient and consistent in referring young people to services run by partner organisations. Clear referral protocols were followed for children and young people who needed more specialist services or who did not meet the criteria for Brook Bristol. We observed young people over the age of 19 years being given advice about where they could access services. Where services were required which were not provided by Brook Bristol, information was given to the young person on the care and treatment they required and where this could be provided. Referrals to other services were made immediately and the young person advised of the referral during their consultation.

Staff were able to access support for children and young people with mental health needs through their GP. If staff had concerns regarding the safety of a child or young person in association with their mental health presentation at clinic they would refer the young person to the local authority social services or telephone for the emergency ambulance service to support. Counsellors worked in the clinic twice a week and staff were able to make a referral for children and young people who required this service.

Appropriate systems were in place for peer review and supervision for staff to share and discuss complex cases to aid learning and provide good outcomes for children and young people. Additional support had been provided by staff from the local acute trust following the care and treatment required by one young person Brook Bristol had referred.

Brook Bristol liaised with local schools and colleges to provide information to young people during assemblies and outreach clinics. They also liaised with the local university and distributed information leaflets for young people on campus.

Health promotion

Staff promoted the health of children and young people attending the service

We saw health promotion material throughout the clinic but it was most prevalent in the waiting rooms. There was lots of advice displayed in toilets, including instructions on Chlamydia and gonorrhoea testing.

Information included breast and testicular self-examinations, safe sex, consenting sex and post exposure prophylaxis (PEP). PEP means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected.

There was clear support information for LGBT (lesbian, gay, bisexual or transgender) children and young people available in the waiting areas.

Social media was used to reach a wider client group and there was information about support groups available. For example, there was access to an app which children and young people could download to access someone to listen to them confidentially. (An app is a type of software that allows you to perform specific tasks which when open runs inside the operating system until you close it). There were services publicised for clients to contact should they have issues with self-injury.

Whilst staff clearly assessed children and young people's risk from domestic violence, we did not see any support information for children and young people affected by this or where they could seek help outside of the clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

Good

Community health (sexual health services)

Staff understood how and when to assess whether children and young people had the capacity to make decisions about their care. They were provided with policies, procedures and training on how to assess and gain consent.

Staff were familiar with and understood the Gillick competence assessment and Fraser guidelines. The Gillick competence assessment seeks to ensure children under the age of 16 years have the ability and understanding of their decisions. The Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents' or carers' consent. Information regarding Gillick consent and Fraser guidelines was included within the safeguarding training provided to staff. Staff were prompted to carry out the assessment within the electronic record system.

Prior to an invasive procedure, such as the fitting of an intrauterine device (IUD) the child or young person attended an initial assessment meeting with a clinician. The treatment and procedure was discussed at this meeting and then again prior to the procedure taking place. Consent was gained verbally and recorded within the electronic patient record.

Are community health (sexual health services) caring?

Outstanding ☆

Caring means that staff involve and treat you with compassion, kindness, dignity and respect.

This domain was not previously rated. We rated it as **outstanding.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. There was a strong visible person-centred culture. Feedback from patients was consistently positive.

Reception staff used a printed form with questions to enable young people to identify reasons for attending the clinic without having to verbalise the reason for their visit and risk others overhearing. Clinicians collected the forms and called young people by their first names to promote their privacy.

A radio played in the waiting room, which helped to mute conversations taking place at reception. The reception area was set aside from the waiting room with a partially dividing wall, allowing some privacy at the reception desk.

We observed young people's privacy and dignity being respected, while a staff member shared clear information about confidentiality and safeguarding. The assessment and discussion was well managed at the right pace and tempo, using language the young person understood and related to. There was clear preventative advice, interspersed with humour, to ensure continued engagement.

Staff closed clinic room doors during consultations and there were no conversations about children and young people in corridors. Each consulting room door was locked, and staff used screens appropriately during intimate examinations.

We observed reception staff being helpful, cooperative and supportive.

Young people were treated with dignity, kindness and respect at all times. Young people we spoke with provided positive feedback. For example, one young person told us "I have been coming here for two years and feel really comfortable to come here and ask questions. It takes such a long time to get a GP appointment, whereas here it's not as long and its close to school. The staff are really good. It's so popular here and is often very busy." Another said "I get really good helpful service; the service was recommended by a friend. Staff are always friendly, and I feel I can ask questions. I feel comfortable and one staff member in particular is really good, they always smile and make me laugh, which makes me excited to come here. It's often very busy and can be difficult to be seen."

The service completed 'I want great care' audits, using an electronic tablet at reception for young people to complete on their way out. Young people could also take a card with them to complete. The results were seen by

the registered manager and by Brook nationally. The completed surveys for September 2019 showed that the service scored 4.88 out of 5 for promoting the children and young people's dignity and showing respect.

Children and young people had access to chaperones during intimate examinations and procedures. This role was carried out by another clinician.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. Staff clearly recognised the stigma attached with accessing their services and supported patients emotionally.

The emotional and social needs of children and young people were highly valued by staff and were embedded in their care and treatment. Staff had sensitive discussions that made young people feel comfortable. We observed a clinician offer the HIV blood test. The young person enquired as to what that involved, and the clinician explained it would be a needle to take blood. The young person declined, and the member of staff took the time to find out if it was because of the thought of the needle. The young person said it was because they had already had that test and the clinician advised the young person to think about it. They did not put pressure on the young person or try to persuade them to have the test but were keen to alleviate any fears they might have about the needle.

Young people had their psychological needs assessed and addressed, such as anxiety. We saw staff fully interacting with the young people, asking questions in a way that was suitable for the situation, while actively listening and supporting them. We heard questions asked such as "are you feeling positive, happy and safe?" and "is your partner nice to you and do they treat you well?".

Children and young people could access counselling and advocacy services through Brook Bristol. There were counsellors at the clinic twice a week.

Staff spoke quietly and with confidence and recognised people who were distressed. We saw a young person who was very anxious and requested to see the nurse. Staff explained they had no appointments but recognised the young person's distress and asked them to wait while they endeavoured to find space for them to be seen.

Understanding and involvement of patients and those close to them

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

Young people were encouraged to have their say and were listened to. They were given opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. The completed I want great care surveys for September 2019 showed the service scored 4.89 out of 5 for involving children and young people in their care and treatment.

We heard staff asking young people if they had support at home, what their living arrangements were and whether they felt stressed. Staff offered the support of Brook Bristol anytime and the young people knew they could come to Brook if they felt they could not speak to anyone else. During one appointment, we heard a staff member ask if the young person's family liked their new partner and whether they had met their new partner's family. The young person disclosed that they had not met their partner's family as they were very religious and did not approve. The staff member offered Brooks services to the young person and their partner and said they were available if they wanted to talk about that and reassured the client that Brook were "not just for contraception".

We heard a young person make a request for a year-long supply of contraception to avoid being without. The member of staff had a supportive attitude, discussed the issue and ultimately was able to fulfil this request.

We observed clinicians discuss confidentiality and safeguarding with young people. Staff used appropriate language for young people to understand, there was some clear preventative advice which was interspersed with humour to ensure continued engagement. A young person said, "Staff are approachable, fun and relaxed but also professional and know what they are talking about."

Young people's preferences for sharing information with their partner, family members and/or carers were established, respected and reviewed throughout their care. We observed clinicians ask young people if they had good relationships with their partner and family or carer, whether they knew they were attending Brook and if they were able to discuss the reasons for attending with them.

Good

Community health (sexual health services)

Information and support was provided verbally and through referral to the Brook website and also an external website which was suitable for young people.

Young people were able to attend the clinic with friends or relatives if they wished.

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

Good

Responsive services are organised so that they meet your needs.

This domain was not previously rated. We rated it as **good.**

Planning and delivering services which meet people's needs

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

Brook Bristol was part of a local provider's group which provided an integrated sexual health service throughout Bath, Bristol and Gloucestershire, led by the local acute NHS trust. Brook Bristol was contracted to provide sexual health services for children and young people up to the age of 19 years within a two-year contract from the acute NHS trust.

A quarterly meeting was held with the commissioners of the service. Attendance at this meeting included members from the joint providers of sexual health services in the Bristol area the matron responsible for the contract, the service manager, a sexual health consultant and the transitional and operations manager from Brook Bristol. During this meeting the needs of children and young people were discussed, and action planned which enabled Brook Bristol to work together with external organisations to develop their service.

Brook Bristol had identified vulnerable groups within children and young people and were in discussion with the external provider group on how to reach these groups within their contract. For example, children who did not attend school and travelling young people. Brook Bristol planned to attend 'freshers' weeks at the local university and people referral units to discuss sexual health care and treatment with children and young people attending.

Brook Bristol was in the process of redesigning their outreach service into schools and colleges. This was in part due to a lower number of outreach nurses, which meant not as many schools and colleges could be provided with a regular clinic service. Currently the service was moving to an outreach advice model in which youth workers were being trained to deliver additional services such as provision of condoms under the national c Card scheme and chlamydia testing. They were able to signpost young people to appropriate services if needed. Outreach nurses attended three schools and clinics regularly and would visit other schools or colleges if requested by the youth workers. This increased resource and contacts with children and young people.

The service was located in the town centre on the top floor of a building dedicated to youth services. The service was accessible by public transport and car parks were located nearby.

Meeting the needs of people in vulnerable circumstances

Brook Bristol worked closely with providers of sexual health services within the Bristol area. There were clear pathways in place for referring patients to other services when necessary. For example, the level 3 sexual health service which provided care and treatment for the testing and treatment of sexually transmitted diseases and HIV and to termination of pregnancy services. This showed that the service complied with NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their co-existing conditions.

The service telephoned children and young people with additional vulnerabilities, for example children under 16 years, if they had attended a clinic but did not wait to be seen. This was to discuss their needs and ensure they had sought help either at another clinic or were planning to return to another walk-in clinic.

Arrangements were in place to meet the diverse needs of children and young people attending the service. The initial booking form asked specific questions such as

'gender at birth?', 'gender identity?', 'sexuality?', 'do you use cannabis?', 'do you use anything to get high?' and 'do you consider yourself to have a disability?' to enable children and young people to share their specific needs.

Staff treated the children and young people as individuals and respected their language, ethnicity and cultural backgrounds. There were arrangements for staff to access any necessary interpretation and/or services. Interpreters could be booked and attend appointments with clients. Video or telephone interpreters could be used for anyone attending the service whose first language was not English. Staff were familiar with this service and had used it on occasions. There were point boards available which enabled children and young people to identify which language they spoke.

Information was displayed in the toilets for children and young people who were transgender and were required to provide samples of urine or swabs for testing.

The electronic patient record system provided information to the staff regarding any vulnerabilities of the children and young people, for example, those living with a learning or physical disability, those with previously identified safeguarding issues or historic sexual or physical abuse or mental health illness. The records provided information on additional assistance the child or young person had previously received.

The service was accessible to all. There was a lift which brought children and young people to the Brook Bristol clinic. Accessible toilets were available within the clinic.

A hearing loop was available for people with hearing difficulties and staff described an occasion when a sign language translator had attended an appointment to support a client. There were counselling services for deaf women using British Sign Language.

Staff working in outreach areas liaised with the clinic when they referred a child or young person to the clinic so that the reception staff were aware and could provisionally assess the attendance levels at the clinics and offer the child or young person an available appointment to ensure they were seen.

All children and young people attending the clinic were encouraged to take part in sexual health screening tests. The service was able to offer point of care HIV testing although the registered manager was not able to provide detail of how many young people accessed this service.

Pregnancy testing was provided at the service and children and young people who had a positive result were able to access a counselling service at Brook or be referred to other services in the area for support with a termination of pregnancy.

Access to the right care at the right time

Children and young people could access services which provided the right care at the right time. Children and young people could access the service when they needed it and received the right care. However, at times children and young people experienced waits of up to two hours at the walk in clinics.

The Brook Bristol website provided clear information on the services available, times of the clinics and the service location.

The service operated walk in clinics six days a week, Monday through to Saturday. The clinics were open from 12 noon to 7pm on Mondays to Thursdays and until 5pm on Fridays and Saturdays. The website advised children and young people that some appointments were available, for which they would need to contact the clinic to book. These included the doctor's clinics, for which appointments could be made by ringing the service. When appointments were made, for a new issue or to receive results, reception staff confirmed that a reminder would be sent by either email or text, subject to consent and an agreement made with the child or young person. If the clinic was unable to offer an appointment in a reasonable time frame the child or young person was referred to other services within the area.

The staff considered there was a seasonal impact on attendance at clinics. For example, half term holidays were quieter, Saturday afternoons were always busy, as well as return to education time; for example in September and the New Year. Outreach nurses held clinics in three schools and attended other schools and colleges in the area, according to need. Education workers provided support in other schools and colleges

and signposted children and young people to appropriate services or requested the outreach nurse to attend the school if required. The outreach clinics were timed with the school or college to best meet the needs of the children or young people, for example, at lunch time and first period after lunch. A youth worker completed a triage process at each outreach clinic to assess if the young person needed to see nurse or youth worker or both.

We observed clients walking in who could not be seen because they exceed 19 years, as per the local contracting arrangements. For example, we saw a client arrived who needed the emergency contraceptive pill and who was over 19 years. Staff were helpful and provided three alternative signposts to help the client, they advised to ring back if not successful and they would try to help further. This interaction was not recorded and data regarding such people who attended and were not seen was not gathered.

Doctor led clinics were planned for the insertion of intrauterine devices. The doctor was supported during the clinic by an HCA. There were no follow up clinics and no routine checks. We observed staff offering children and young people tests and further support. For example, two young people were visiting Brook Bristol for repeat contraception (OCP) had their social needs and mental health assessed. They were offered sexually transmitted infection screening, wellbeing support and a different method of contraception (condoms).

The service was developing technology that enabled children and young people to complete a short assessment survey at home and bring this with them when they attended the clinic.

The clinics were busy and often oversubscribed. Reception staff provided children and young people with information on how the long the wait would be and if they were advised to return on another day or attend another service. A triage process was in operation, with children under the age of 16 years and those requiring urgent services prioritised. There were notices in the waiting room explaining the under 16 fast track system and we heard administration staff explaining the clinic was busy.

Reception staff provided clear information to children and young people of other services and clinics running in the area and how they could access these if they did not wish to wait. The service had a 'turn down' policy, which was used when the clinic was very busy and there was no walk-in capacity. We saw this policy being used.

During the day of our inspection, two patients we spoke with had been waiting between one hour 45 minutes and 2.5 hours for an appointment. Two other patients we spoke with had tried to get a walk-in appointment the previous week and were unable to, both were advised to book for the following week. One patient we spoke with had attended the walk-in clinic previously and had waited for three hours. Another patient said "if you arrive early, as soon as they open, then it's usually okay. If you can't get here by 2pm, then there's no point coming." However, patients also told us that some days the clinic was not so busy, and they did not wait long.

The transitional manager stated appointment times were usually 20-30 minutes in length to see a doctor or nurse. During our inspection, we observed two booked appointments which took approximately 50 minutes each to complete. These delays were for several reasons including; computer/network issues and a nurse in training being unable to prescribe medication without sign off from their nurse colleague. There was also a member of staff on sick leave which had impacted on the wait times for patients during our inspection. The staff member had rung in sick on the morning of inspection and the service had been unable to back fill their shift.

Children and young people who had attended the clinic for the sole purpose of a chlamydia test were kept to one side of the reception area and had access to a toilet and facilities to leave the specimens. The space was small and not ideal to ensure confidentiality, but staff managed conversations discreetly.

If a child or young person had booked an appointment and did not attend, contact was made by the staff to offer another appointment. This contact was added to the electronic patient record for information at a later date. If children and young people left before being seen a different code was used to record this episode of care on the electronic system and all data was saved.

Learning from complaints and concerns

Good

Community health (sexual health services)

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

The service had a complaint procedure which identified what constituted a formal complaint and how the service would respond. Staff also had an electronic template to complete which prompted them to gather the appropriate information necessary to investigate the complaint.

There had been one formal complaint made within the last year, which had been received in September 2018. The complaint had been made by a young person who had attended the service and was not happy with the care and treatment they had received. We saw evidence which demonstrated this had been investigated and feedback provided to the client. The client had not been satisfied with the outcome but had declined further attempts by the service to meet and discuss the issues. From the investigation information available there had been no obvious learning or developments from this complaint.

Information on how to make a complaint was provided on the service website and could be obtained from the clinic at reception.

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

Good

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

This domain was not previously rated. We rated it as **good.**

Leadership of services

Leaders had the integrity, skills and abilities to run the service. However, the registered manager had responsibility for another service as well as Brook Bristol. This impacted on the time available to be in Bristol.

The previous manager of Brook Bristol had left the service and a recruitment process to replace this member of staff had been unsuccessful. As a result, the registered manager role was shared between Brook Bristol and another Brook service. The registered manager planned to spend two days each week in the Bristol service. At other times they were available to staff by email and telephone. In addition, a transitional manager had been employed on a fixed term contract and was available in the service each day. This was a non-clinical management role.

The registered manager was an experienced nurse within the field of sexual health and had completed a post graduate medical education certificate. They discussed how this had developed their skills in supporting and developing the staff team.

The head of operations and head of nursing within the organisation provided support to the registered and transitional managers. The registered manager told us they always found the senior leaders open and approachable.

Staff made positive comments regarding the management of the service and found the registered manager to be approachable, supportive and a good leader. However, they commented it was challenging not having their manager in the clinic each day.

Service vision and strategy

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

Brook Young People had a vision and strategy which set out how the services were to be delivered to young people under the age of 25. Brook Bristol were part of a local commissioning contract which included other providers. The commissioning arrangements met the

needs of the local community and were part of local plans within the wider health economy. The service provided by Brook Bristol under this arrangement delivered care and treatment to children and young people up to the age of 19 years.

Brook Young People had a strategic plan for 2019 to 2020, which had a number of priorities to improve the service to young people. These included the delivery of effective partner notification methods, the management of irregular bleeding following insertion of a contraceptive implant, promoting sexually transmitted infection testing and a contraceptive implant when women presented for emergency contraception. Staff were aware of these priorities during our discussions.

The strategy and vision for 2020 to 2023 was in the process of development and the director of strategy had attended Brook Bristol to engage with staff and capture their views. Information regarding the business and work plans were shared with staff through email communication and during their appraisals.

Brook Young People held a national conference, at which staff were able to share their views with the organisation regarding the development of information technology to gain information in a timely way from young people using the service. For example, there was a vision to improve the technology to obtain feedback from young people and for the initial assessment record to be completed by the child or young person at home or in the waiting room.

Priorities for improvement Brook services will continue to work towards common clinical improvement priorities. This year we would like our

Culture within the service

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

Staff we spoke with were proud to work for Brook Bristol and said they felt lucky the whole team really enjoyed their jobs and were passionate about their clients. They felt there was a good team dynamic and staff had supported each other to settle into their roles. There had been a significant turnover of staff over the past year. The new staff team had brought different skills and experience to their roles, were respectful of each other and appeared to have gelled well. The organisation supported the staff in learning new skills and gaining experience within their roles.

Staff felt valued by the organisation. The staff had recently met with a director from the organisation who had shared the developing strategy with the team. Staff understood the organisational values. The registered manager shared information from within the organisation with the team on a one to one basis and at team meetings. This helped the staff to feel part of the organisation.

Processes and procedures were in place to ensure the provider met the Duty of Candour legislation. Staff had access to incident reporting policies and procedures and were aware of the duty of candour and how to report incidents. Staff were confident to raise incidents but commented they did not always receive feedback. Conversations had taken place within team meetings following reported incidents to share learning. For example, following one incident the potential risk of harm had been discussed and the relevant policy reviewed with the staff.

Appropriate measures were taken to protect staff from the risks associated with lone working. For example, the outreach staff working in schools and colleges always worked in twos or threes and staff were never in the clinic alone. However, during times of sickness or annual leave the reception staff at times worked in the reception area on their own as other staff were in different areas of the clinic.

Governance, risk management and quality measurement

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

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and had plans to cope with unexpected events.

The service had systems and processes to monitor risk and performance. Risks were identified and entered onto a local risk register. Incident reports were reviewed, and associated risks entered onto the local risk register by the registered manager, transitional manager or the education coordinator. The risks were rated using a red, amber or green system. The risks were reported to the quality committee and significant risks entered onto the organisational risk register and shared with the senior leadership team and the board.

Regular governance meetings took place, which provided information and oversight of services to the senior leadership team. At a local level the registered manager, education coordinator, transitional manager and the organisation's head of operations met each quarter. This meeting followed a set agenda and provided a forum for discussing any additional issues identified. The agenda included items such as staffing issues, contract compliance, incidents, patient feedback and inspection activity. The meetings were minuted with actions allocated to relevant staff to address. The minutes were provided to the senior leadership team meetings who collated information for the board.

Staff were aware of the governance arrangements within the organisation and their local service. Team meetings were held which provided a forum for information sharing and learning.

The governance procedures had identified the Patient Group Directions (PGD) were out of date and action was being taken by the registered manager to address the issue with the acute trust.

The organisation had a clear business continuity plan which was made available to all staff. This included systems to follow when the running of the business was affected, or the service had to close. For example, during times of adverse weather or IT failure. Staff were provided with clear guidance on the action to take when electronic records could not be accessed and the use of paper records and their safe storage.

The national safeguarding lead carried out an annual safeguarding audit. The service submitted a report every three months which identified the safeguarding referrals and action taken by staff to protect patients from abuse. The reports enabled the safeguarding lead to review and identify any themes or trends and provide oversight to the organisation's quality and assurance committee.

The head of nursing cascaded information through managers' meetings and email to ensure staff were kept up to date with national legislation and best practice standards. This included sharing information from national organisations such as British Association of Sexual health and HIV (BASHH), British HIV Association (BHIVA) and National Institute for Health and Care Executive (NICE).

Appropriate liability insurance had been arranged and was due to be renewed in March 2020.

Information management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were provided with guidance to follow to ensure patient information remained safe and secure when sharing information with others, for example, when sending information to patients' GPs or sharing information with another provider. Additional policies and procedures were available to staff regarding their code of conduct, confidentiality and data protection.

The information relating to patients was stored securely on an electronic system, uploaded to a secure data base and accessed by staff through password protected computers. This meant that staff were able to review previous episodes of care and treatment provided to each patient as well as access previous or current test results.

Should there be an IT failure staff reverted to using paper records, which were destroyed once the system enabled them to be scanned and saved. Staff told us the IT system was not always reliable and frequently 'froze'. This meant accessing and writing records took extended periods of time, which delayed the clinics at times. The organisation was aware of this issue and it had been highlighted on the risk register.

The organisation reviewed information collated by the service to understand performance. This information was used to make improvements within the service. For

example, safeguarding themes and trends had identified an increase in the mental health needs of young people attending the service. Policies and procedures to guide and inform staff had been produced regarding self-harm and suicidal idealisation and there was a programme of training planned to start the week after our inspection. Additional questions to assess a young person's mental health had been introduced together with action staff were to take if they had concern.

Public engagement

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

The service sought feedback from young people attending the service through the promotion of "I want great care" surveys. These were available in paper form or electronically through use of an electronic tablet while at the clinic. Young people could also complete the form on line at home. The data from the service for September 2019 showed 101 children and young people had completed the survey and 96.67% would recommend the service.

However, we did not observe staff encouraging young people to complete the surveys while at the clinic. The data from the service for September 2019 showed 101 children and young people had completed the survey and 96.67% would recommend the service.

A two-week patient satisfaction survey had been carried out at the beginning of 2019. This was regarding the partnership working Brook were included in with the local sexual health services. The results of this survey were awaited from the partnership who were collating all the surveys from all partner organisations.

Brook Young People sought feedback from young people who had volunteered to be part of a national forum. There were young people represented on the organisation's board as trustees who helped develop the service. Brook Bristol did not have any local forum or representative groups in operation.

Brook Bristol had worked with an on-line magazine and other providers of sexual health services within the area to create a video which was available on line. This provided information about Brook services locally. The lead actress was local to Bristol.

We saw details in the waiting room of new relationships and sex education forums which children and young people were able to attend.

Staff engagement

Leaders and staff actively and openly engaged with patients

The service captured and acted on feedback from people who used the service. An annual staff survey was carried out, with the last one completed in September 2018. The survey showed staff were generally satisfied with their role at the service, but actions had been taken following the results. For example, the staff meeting had been changed from a weekly to monthly meeting and to a different day to ensure all staff could attend. Minutes were available from the meetings which showed who had attended and actions to take, included who had responsibility to carry out the action. This ensured all staff had full information from the meeting.

Update and important information was shared with staff through email, at team meetings and informally during the working day by the registered manager, transitional manager and the organisation.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. Leaders encouraged innovation and development of staff.

Staff were encouraged and supported to be innovative in their working practices to develop the services provided. For example, staff had suggested new ways to increase public knowledge and engagement with the condom distribution scheme. Staff had put forward a plan to engage with barber shops in the Bristol area. At the time of our inspection this was being explored and discussed with the commissioners of the service.

Good

Community health (sexual health services)

At the time of our inspection outreach services were being reviewed and ideas and suggestions explored regarding how the service could develop to meet the needs of children and young people at schools and colleges throughout the Bristol area.

Staff were encouraged to develop and expand their skills and knowledge by undertaking additional training courses. One registered nurse was completing a nationally recognised sexual health diploma nursing course. Registered nurses were encouraged to complete training and competencies so that they were able to insert intrauterine devices.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the management arrangements at Brook Bristol fully support the staff and young people who use the service. The current arrangements mean that the registered manager is only available by telephone or email three days a week.
- The provider should ensure the staff have access to up to date Patient Group Directions (PGDs) which reflect national guidance.
- The provider should ensure staff were fully trained and knowledgeable regarding the action they were required to take should they suspect female genital mutilation had affected any children and young people.
- The provider should ensure staff reduce the risks from infection and/or cross infection by consistently complying with the infection control procedures. For example, being bare below the elbows when in the clinical environment.
- The provider should ensure that potential risks to children and young people from used syringes and needles are managed.
- The provider should ensure the staff know the procedure to follow should they find themselves at risk and need to summon assistance. Staff should be familiar with the action to take should a colleague summon help.
- The provider should continue to monitor and review staffing levels to ensure services are provided which meet the needs of children and young people both at the main clinic and within schools and colleges.
- The provider must ensure staff comply with the medicines policy and procedure and return medicines to the clinic as determined within the policy.
- The provider should ensure staff are competent of the action to take in the event of a fire or when required to respond to colleagues personal alarms.
- The provider should monitor the provision of feedback to staff following reporting of incidents.
- The provider should ensure that children and young people had access to information regarding domestic violence.
- The provider should monitor waiting times of children and young people attending the clinic and work with partners to ensure they can meet the capacity and demand.