Brook Blackburn

1-1062780166

Sexual health service

Quality Report

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Summary of findings

Locations inspected

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

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

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

Summary of findings

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Overall summary

We found the following areas of good practice:

- Systems were in place for reporting, monitoring and managing incidents.
- Medicines were stored securely and issued in line with good practice.
- Patient details were managed correctly.
- Staff understood the principles of safeguarding.
- Staff were appropriately trained and qualified to provide care, following national and local guidelines.
- Audits allowed staff to monitor performance and compare this with other organisations nationally.
- Multi-disciplinary and team working was evident with links to external community groups and services.
- Consent processes were thorough and reflected guidance.
- Staff providing care focussed on the individual needs of patients, providing care that was respectful, supportive and encouraging, giving privacy and confidence to patients.
- Clinics were run in a timely way. Results of an internal survey of waiting times at Brook Blackburn between April and December 2016 showed 62% of patients were seen within ten minutes and 98% of patients were seen within 60 minutes of their arrival time.
- Some individual needs were met. For example, sign posting to counselling services was in place.

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

- Incident reports did not include information about the level of harm sustained, incident type or whether Duty of Candour had been considered or implemented. This made it more difficult to identify trends or implement and record that Duty of Candour had been implemented following incidents.
- Managers had not received training about Duty of Candour legislation. This posed a risk that managers may be less aware of the principles of this legislation and when to apply it in practice.
- Although safeguarding training was in place, we were not assured that all staff were trained to the levels described in either the corporate policy or national guidance. Additionally, forms to record safeguarding issues did not include information about Female Genital Mutilation (FGM) and the general process for reporting safeguarding concerns was not streamlined. Having a more complicated process could increase the risk of errors.
- One of the treatment rooms was situated immediately adjacent to the street outside. We were concerned that the needs of patients in relation to privacy and dignity may not be adequately met, especially if services expand in future.
- Cleaning records were not always completed. This meant staff were less able to confirm that cleaning had been completed.
- The risk register did not include details of actions to manage the risk over time or who was responsible for the risk.
- Staff ethnicity was not representative of the local ethnic population. Only white female staff were in employment at the time of our inspection.
- Professional registration was not included in staff files. Instead this information was stored on a separate electronic system which meant managers had to check more than one place to obtain important information about individual staff. Having a less streamlined process could lead to more errors when checking staff details.

Following this inspection, we told the provider that it must make one improvement because a regulation was being breached, and should make other improvements, despite regulations not being breached in these areas, to help the service improve. Details are at the end of the report.

Summary of findings

Background to the service

Brook Blackburn is operated by Brook Young People. It is a charitable organisation providing a sexual health service to young people and adults under the age of 65.

Brook Blackburn is regulated to provide the following activities:

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

The clinic is based in Blackburn town centre and has two treatment rooms, a reception area and a meeting room. Staff provide level one sexual health services which include; sexual health information, contraception, pregnancy testing, abortion referrals and screening and treatment for some sexually transmitted infections such as Chlamydia. Education and advice relating to general wellbeing is also provided as well as outreach work, delivered in a range of settings such as colleges, youth groups and homeless shelters and including fundraising and campaigning activities in partnership with local young people. The service welcomes volunteers to help support people in the community.

Services are commissioned by a local NHS trust who have overall responsibility to provide sexual health services to people across Lancashire.

Between October 2015 and October 2016 the service saw 3169 patients, an average of ten patients each day based on the clinic being open six days per week. Approximately 8% of these patients were under 16 years of age, 69% were between 16 and 21 years of age and 22% were over 22 years old.

The clinic primarily serves communities in Blackburn and Darwen in Lancashire, but also accepts patient referrals from outside this area. Approximately 148,000 people live in this area, with 29% aged under 20 years. There is a diverse local population with 12% of residents from Pakistani and 13% from Indian heritage.

The service has been operating for approximately 22 years but first opened under the Brook Young People charity in 2013, with a registered manager in post since November 2013.

Our inspection team

Three experienced inspectors visited the service, overseen by an Inspection Manager.

Why we carried out this inspection

We inspected this service as part of our on going comprehensive inspection programme for independent healthcare providers.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before and after the inspection visit, we reviewed information available to us about the services at this location.

Summary of findings

During the inspection the team:

- Visited the location and looked at treatment rooms, reception and meeting areas.
- Spoke with eight staff including; registered nurses, reception staff, and senior managers
- Spoke with five patients.
- Observed a meeting for a Lesbian, Gay, Bi-sexual and Transgender (LGBT) group.
- Reviewed six patient records and five staff files.
- Carried out checks of medicine management in treatment areas.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

This was our first inspection of this service.

We inspected this service using our comprehensive inspection methodology. We completed an announced inspection on 17 January 2017, along with an unannounced visit on 27 January 2017.

What people who use the provider say

People who used the service told us that staff were always nice to them and that Brook Blackburn was a safe place to come and talk to someone. They also described the outreach work undertaken by staff in local schools and colleges which they felt helped make sure local people knew about the services available to them.

Good practice

Staff worked to empower a range of different groups of young people. We saw evidence of this when we met the award winning lesbian, gay, bi-sexual and transgender (LGBT) youth group, run by staff and volunteers.

We also saw outstanding work to obtain the Lesbian, Gay, Bisexual and Transgender (LGBT) Quality mark in relation to staff employment at the clinic.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that all staff are appropriately trained in safeguarding practice following intercollegiate guidance (2014) and corporate policy and that robust assurance is available to evidence this.

Action the provider SHOULD take to improve

- Review the information recorded in incident reports and include level of harm sustained.
- Consider formally classifying incidents to help make sure particular types of incident can be identified more easily.
- Provide duty of candour training for managers responsible for investigating incidents.
- Include duty of candour prompts on incident forms to help make sure staff consider this and record whether it has been implemented.
- Review the quality of record keeping by staff, through undertaking records audit on a regular basis.
- Liaise with the commissioning organisation with an aim to revising templates used to record safeguarding concerns, to include information about Female Genital Mutilation (FGM).
- Streamline the process for reporting safeguarding concerns.
- Review the appropriateness of the treatment room situated immediately adjacent to the street outside in relation to privacy and dignity for patients, in light of plans to undertake more intimate procedures here in future. Consider using another more suitable room for these procedures.
- Maintain accurate records of all areas cleaned.

Summary of findings

- Review audit information for Chlamydia detection and screening rates in 15-24 year olds to implement actions for improvement.
- Review the risk register to include more detailed information and track changes over time.
- Review recruitment with an aim to improve representation of ethnicity locally.
- Include professional registration details in staff files.
- Consider implementing a local staff survey to capture the views of staff relating to topics such as staff satisfaction, views on service provision and staff requirements.

Brook Blackburn

Sexual health service

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Incident reporting, learning and improvement

- There was an up to date policy and process to support staff reporting incidents. Staff we spoke with were familiar with the process and where to find the policy if required.
- The reporting system was paper-based, with incident forms completed by staff involved. A designated manager investigated every incident before raising actions or escalating if required. Forms included details of the date of occurrence, patient identification number, description of the incident, immediate action taken, or required, and manager comments.
- There was no formal system to classify the types of incidents occurring. Without this we were concerned that managers may have difficulty analysing and identifying trends.
- Between June 2016 and January 2017, 13 incidents were reported by staff. These included aggression towards staff, IT system issues, expired medicines or patients becoming unwell in clinic.
- No serious incidents requiring investigation were reported within this time period.
- The information required from staff reporting an incident did not include the level of harm sustained. This meant there was no record of how many incidents caused harm or no harm. Without this information, managers could not identify how serious an incident had been or identify potential risks in the future.
- Staff received information about incidents in a daily debrief report, which helped make sure learning was shared. Information was also circulated electronically. Learning was shared with staff at monthly team meetings which were minuted. Staff gave examples of reported incidents where individual feedback and wider learning was shared.
- Managers provided a summary of incidents every three months in Quality and Safety reports. Any serious incidents occurring were escalated through the regional and national corporate management hierarchy. These incidents were investigated by a corporate Health and Safety team.

Duty of Candour

- An up to date duty of candour policy helped staff meet the requirements of this legislation should it need to be implemented. The duty of candour is a legal duty to inform and apologise to patients if there have been

mistakes in their care that led to significant harm. The policy provided details about assessing clinical risk and being open and honest when delivering care or reporting issues.

- Staff were aware of the principles of Duty of Candour and the need to be open with patients. The manager responsible for duty of candour confirmed that it had never been implemented because no incidents had occurred where mistakes in care had led to significant harm.
- However, the manager confirmed she had received no training to support her in implementing Duty of Candour. Instead she would use previous experience to make the judgement. We also identified that Duty of Candour information was not included on incident forms. Not including this information posed a risk that staff may not consider these requirements when reporting incidents and that any consideration or implementation of Duty of Candour may not be formally recorded.

Safeguarding

- Up to date safeguarding policy and procedures were available to support staff handling safeguarding concerns. The policy provided details of Brook's six step safeguarding procedure for staff to follow. Steps included identification of the concern and level of risk of harm, the patient's view of the concern raised, any special circumstances and whether the concern resulted in an action plan being instigated.
- We saw a safeguarding "purple file" for staff which contained information about safeguarding practice. This included a copy of the safeguarding policy and procedure, contact details for the designated safeguarding lead and an out of hours contact list. The file incorporated general guidance, such as information to help identify child sexual exploitation, honour abuse, female genital mutilation (FGM) or vulnerable adults, and a pathway for referring victims of sexual assault. We saw that the contents of the file were regularly reviewed by managers which helped make sure it remained up to date.
- Safeguarding training was mandatory, with different levels completed dependent on staff roles. However, we were not fully assured that staff who contributed to assessing, planning, and evaluating the needs of a child or young person had completed level three safeguarding training, as recommended in the Intercollegiate Document (2014) and by Brook's safeguarding committee. Whilst we saw evidence that all staff completed level one training, the evidence provided for level two or above was less robust. For example, we were shown no records which confirmed all staff were trained to level two. Records showed that one manager had received level six training but this did not appear to be in line in with intercollegiate guidance of which the highest training level is five. Other records showed nurses had completed what appeared to be elements of level three training but not a complete level three package. Despite this, we did see that these elements of training covered some of the core aspects of level three such as child sexual exploitation and there were plans for staff to complete level three training in July 2017.
- Staff were able to explain the reporting process and we saw evidence that policies were followed with completed safeguarding concern forms and minutes of safeguarding case discussion in meetings. We also saw records of safeguarding discussions were added to electronic patient records
- An electronic patient record system allowed staff to apply a red flag indicator to certain records to highlight known referrals or social services involvement. We saw that information was flagged appropriately.
- The service worked with the local authority to share safeguarding information and protect patients. Team members attended regular meetings and liaised with other agencies through networking.
- We saw evidence that staff referred concerns to other agencies. This helped make sure that agencies were aware of concerns and could investigate further as necessary. Between April and December 2016 staff completed 33 safeguarding proformas with details of concerns about particular patients. Following internal reviews of these, six external safeguarding referrals were made to Social Services. Additionally, staff told us that they regularly contacted social services to exchange information and check whether they were aware of certain patients.
- Supervision for managing safeguarding concerns took place every three months.
- We reviewed the records of two patients who presented safeguarding concerns. We saw there was regular contact with a social worker and a Child Sexual

Exploitation (CSE) unit. In one of the cases, this helped ensure a child could be supported in appointment visits on a one to one basis by a social worker. Both of the cases had been red flagged on the system to help make sure relevant staff were aware of the circumstances and provide the right support for the patient.

- There was no system in place to prompt staff to query or record concerns relating to FGM, in line with Department of Health guidance. We were concerned that not including this prompt may increase the risk of staff missing opportunities to identify and support victims of FGM. Managers were restricted in their ability to alter templates issued to them by the commissioning organisation or to use alternatives. However, as soon as we raised our concerns, managers took mitigative action by issuing a written reminder to staff to probe and record details about possible FGM on another part of the electronic form.
- Additionally, whilst safeguarding details were recorded, we were concerned that the process was not as streamlined as it should be. For example, the paper proforma was completed initially, followed by an electronic record. The paper proforma was then scanned onto the electronic system. Overcomplicating the process could lead to staff inadvertently missing a part of the process which took longer to complete than was necessary.

Medicines

- Staff used a range of medicines to provide care and treatment for patients. These included contraceptive medicines, antibiotics and medicines to treat allergic reactions.
- Staff followed an up to date policy and procedures for storing or administering medicines, which was available via the staff intranet. These mirrored national guidance and were reviewed annually to ensure they remained up to date.
- Patient Group Directives (PGDs) were used to prescribe and supply medicines. PGDs allow some registered health professionals to supply and administer specific medicines to a certain patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We saw a range of PGDs, including those for contraceptive pills, implants and antibiotics, which were produced and reviewed annually by the corporate provider. Medicines prescribed for patients were documented in their records.
- Medicines were stored securely in treatment rooms and a main storage cupboard upstairs. Anaphylaxis kits (medicine to treat severe allergic reactions) were available in both treatment rooms should they be required urgently.
- A stock control procedure was in place that stated expiry dates on medicines should be checked monthly. Staff maintained a weekly record of stock levels which was over and above the policy requirement. Stock level checks we reviewed were up to date. Stock was rotated to ensure older medicines were used before new stock. Maintaining stock levels effectively helped ensure there was an adequate supply of medicines which were not out of date.
- The temperature of the storage area for medicines upstairs was checked weekly but in treatment rooms temperatures were checked daily. Records showed that these were up to date, which helped make sure medicines were not exposed to temperatures which could affect their efficacy. Staff told us that any temperatures outside of range (for example, above 30 degrees Celsius) were reported to head office and a designated clinical manager.
- Staff were due to adopt new medicines management procedures following collaboration with a new commissioning service. Managers told us this would begin in February 2017 and records showed staff had received or were booked to receive training prior to this to ensure they were adequately trained.

Environment and equipment

- The clinic was situated on a main street in the town centre. Two treatment rooms were situated on the ground floor adjacent to the reception area.
- One of the treatment rooms was adjacent to a busy street where we could hear conversations as people walked by. With only frosted glass and a mobile screen, we were concerned about the impact of this environment on patients' privacy and dignity.
- Toilets were situated downstairs and accessible for disabled people.
- Boxes for the safe storage of clinical waste such as used needles were available in consulting rooms and were not overfilled.
- Fire safety equipment such as extinguishers were available on all occupied floors. These were tested and checked by an external agency on a regular basis.

Are services safe?

- Portable appliance tests had been undertaken to ensure all equipment was safe to use and lighting was tested on a weekly basis to help ensure issues could be addressed promptly.

Quality of records

- Patient details were recorded both on paper and an electronic system.
- Patients completed either a 'new client or a 'returning for appointment' paper form following arrival in the clinic. These details were then entered onto the electronic system before the paper form was destroyed. We observed this process being followed efficiently by reception staff during our inspection.
- We reviewed seven patient records and saw evidence of a full assessment in each of them. Additionally, we saw that important details such as consent or safeguarding concerns and relevant actions were evidenced appropriately.
- The organisation had a policy for auditing standards of record keeping, in which five sets of case records would be reviewed for each member of staff. However, no reviews had been undertaken at the time of inspection. We were advised that the Brook peer review process was in place, but had yet to commence in Blackburn.

Cleanliness, infection control and hygiene

- All the areas we inspected including reception, waiting areas and treatment rooms were visibly clean and tidy.
- Staff used established policies and procedures to help prevent infection and maintain a clean hygienic environment. Policies were up to date with amendment and review dates included to ensure they were kept up to date.
- Clinical staff told us they followed good infection control practice and adhered to policy. Procedures were displayed in prominent areas, such as treatment rooms, to help remind staff to clean areas such as treatment couches and surface areas in between appointments and at the end of the day. However, staff did not document that these procedures were followed. This meant we were unable to check retrospective records to corroborate what staff told us. Despite this, we saw no evidence contradicting what we were told.
- Staff told us that domestic cleaning took place daily and recorded in a log book, however when we asked for this during the inspection, staff could not provide it. We did locate records of toilet cleaning but these only partially supported what we were told. We saw evidence that toilets were cleaned daily except Saturdays, for which records had not been completed since 2014. When we showed staff this, they were surprised and reassured us that cleaning took place on Saturdays without exception.
- Handwashing facilities and personal protective equipment were available in treatment rooms, including disposable aprons and gloves. Handwashing notices were displayed in toilet facilities.
- Disposable equipment and special boxes storing used syringes helped limit the risk of cross infection. Disposal of clinical waste was fortnightly, by contract arrangement with an established company. Bins containing used syringes and sanitary products were removed monthly or more regularly if required. Specimens were collected by another established company four times each week.
- Infection prevention and control audits helped managers monitor adherence to good practice. Results were fed to the corporate provider annually. Results showed annual scores of 98% compliance in 2015 and 99% compliance in 2016. Additionally, smaller local audits were completed each month covering specific areas such as hand hygiene, kitchen cleanliness, waste disposal spillage cleaning, appropriate use of protective equipment, safe disposal of needles and specimen handling. Results for November 2016 showed staff achieved scores of 100% in all areas.

Mandatory training

- All staff working at the clinic completed mandatory training, delivered either by e-learning or face to face by a corporate training provider.
- Training topics included Basic Life Support (BLS), Fire, Health and Safety, Infection Control, Manual Handling, Risk Management, Safeguarding children and vulnerable adults.
- Records showed that 100% of staff (except staff with long term absence such as maternity leave or sickness) were up to date with mandatory training or booked to attend training, with the exception of safeguarding level three training.
- Bank nurses supplied evidence that mandatory training was up to date with their main employer and we saw evidence of this in staff files and training records.

Staffing levels and caseload

Are services safe?

- Five nurses worked at Brook Blackburn (equivalent to 2.1 whole time equivalent staff). There were no nurse vacancies at the time of inspection. The Clinical Manager (also a registered nurse) worked between two sites including Blackburn and one bank nurse was available to substitute nurse staffing levels if required. Between July and September 2016, only one shift required a bank or agency nurse.
- Two clinics were run each weekday by registered nurses. These provided walk in and booked appointments. Saturday morning clinics were also held. We were shown rotas for Saturday clinics confirming two nursing staff would run these.
- Additionally, the clinic employed two reception staff and four bank reception staff, overseen by a senior administrator.
- To assist with outreach and wellbeing work the service employed one community asset development lead and two wellbeing education specialists. There was a vacancy for one volunteer coordinator which was being advertised at the time of inspection.
- The service also had access to 13 volunteers who worked between two local Brook sites, one of which was at Blackburn.
- We reviewed five staff records during our inspection. These included details such as contracts, most recent appraisal, next of kin, annual leave forms, supervision notes, certificates of training, details of professional registration and sickness absence information. However staff files did not include details of professional registration. When we asked managers about this, they confirmed the details were held on a separate electronic system which we reviewed and confirmed. However we were concerned that holding important information in separate places may pose a risk that missing information might be harder to identify.
- Sickness absence was 11.4% between April and September 2016, which was higher than the organisation's target of 8%. This was caused by a period of long term sickness absence for one member of staff with a subsequent reduction in sickness rate to 8% following their return to work.

Managing anticipated risks

- Staff completed risk assessments for service users during their first appointment, based on questions incorporated in British Association for Sexual Health and HIV (BASHH) guidelines. This was documented in the electronic patient record and any changes in condition monitored at follow up appointments.
- To help manage the risk that staff could not provide medical care by a doctor, staff directed service users to GPs for further assessment or advice if required.
- Anaphylaxis kits (kits of prepared medicine for patients who develop a serious allergic reaction requiring immediate treatment) were available. During inspection we saw that only one of the two treatment rooms had a kit. However, as soon as we raised our concerns with staff they rectified this by placing an additional anaphylaxis kit for the second treatment room. This meant that should patients require treatment for anaphylaxis in either room, treatment was immediately available.
- Communication systems were in place with social care services to help manage and share risks identified, such as homelessness or possible child sexual exploitation. This ensured that other agencies were aware of potential risks for patients and where possible, could provide support to manage that risk.
- Weekly fire alarm tests were completed. Checks for fire safety were carried out regularly by an external specialist company, the most recent completed in August 2016.
- Fire drills were undertaken to ensure staff were familiar with procedures. We saw that drills were carried out in June and November 2016.
- Panic alarms were accessible for staff to use in case of emergency in both the treatment rooms and main reception. The system was linked to the police which helped provide a more urgent response.
- Brook Blackburn had a lone worker policy and procedure for staff to follow, which helped reduce risks to staff. This policy provided guidance for staff and volunteers regarding safe working whilst at Brook sites, or in different community settings. We saw staff followed this guidance in various ways during inspection.
- The clinic operated a plan which made sure the clinic only ran if more than one staff member was present in the building. For example, on Saturday mornings clinics ran with one nurse and one receptionist and home visits as part of targeted youth work were always attended by two members of staff. These details were included in a procedure.

Are services safe?

- Staff in the education and well-being service who worked in different community settings used a buddy system and were issued with mobile phones. They also used electronic diaries which were available for colleagues to view and check their whereabouts. In addition to these measures, staff were instructed to phone colleagues at the end of their day and a log book was kept which recorded these details.
- The service was not listed to receive patients should a major incident be declared locally. As such, staff did not receive major incident training.
- However, the service had a business continuity plan which helped make sure business continued in the event of issues such as IT failures.

Are services effective?

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

Evidence based care and treatment

- The organisation worked to national guidelines including those from the National Institute of Health and Social Care Excellence (NICE), British Association for Sexual Health and HIV (BASHH) and The Faculty of Sexual and Reproductive Healthcare (FSRH) which were monitored by the commissioners of the service every three months.
- Local policies and procedures for patient treatment incorporated this guidance and were reviewed annually to ensure the information was up to date.
- Staff used established pathways which followed national standards, such as the National Service Framework document "Every Child Matters" Which was available via the staff intranet. These pathways formalised processes such as referrals for termination of pregnancy. Staff were familiar with these and able to explain them to us during our inspection.
- As part of the delivery of the level one sexual health service a sexual history was taken from patients before a risk assessment was made and patients were treated by the service or signposted to appropriate services.

Pain relief

- Pain relief was not kept on site or administered at the clinic. This was because the majority of patients attended for walk-in appointment, most of which were consultation based with no clinical procedures requiring pain relief undertaken.

Nutrition and hydration

- The clinic did not provide regular food or refreshment for patients and visitors, but water was provided on request. As the clinic was located in a town centre, food and refreshment was readily available from other shops if required and appointments were generally over within 20 minutes.

Patient outcomes

- Patient outcomes were monitored by collecting, analysing and reporting data. Staff used specific software to support the process.
- The service participated in a national audit programme run by the corporate provider Brook Young People. The service contributed data from groups of 40 patients about: implant fitting and removal, sexually transmitted infection testing and treatment, infection control and emergency contraception and abortion referral. Results from these audits allowed Brook Blackburn to benchmark patient outcomes in comparison with other Brook services.
- Compared with other Brook clinics in England, Brook Blackburn had lower results for Chlamydia detection rate in age 15-24 years and the proportion of 15-24 year olds screened for Chlamydia. This meant the detection of Chlamydia in 15-24 year olds and the uptake of Chlamydia screening were lower in Blackburn with Darwen and performance was worse than at other Brook clinics.
- Staff had identified a need to improve audit processes for Chlamydia screening. Through partnership with the local partner NHS organisation, staff identified that the electronic patient record system did not include details about why some patients declined tests. A further internal audit was scheduled to obtain this data and staff recognised that ongoing work to align systems with the NHS organisation would further improve data collection around Chlamydia screening.
- Although the provider had identified issues in the data recording systems, we saw no further actions identified to improve the rates of Chlamydia detection or screening in information provided to us.
- However, results from the 2016 Brook Sexually Transmitted Infection(STI) audit showed out of 44 patients who tested positive for Chlamydia infection, all were given details about where to access information about Chlamydia;14 were tested again three months after the diagnosis of Chlamydia; two continued to have a positive result for chlamydia infection at the time of re-testing.
- Local audits helped identify and address other potential issues. For example, staff identified that lower than

expected numbers of patients were being provided with 12 month supplies of the contraceptive pill. An audit was in progress at the time of our inspection to determine the reasons for this so that numbers could be improved.

- Another local audit was undertaken to investigate why patients from outside the local area attended the clinic. Out of 65 out of area patients, 40% said they did not know of any clinics closer to home. Managers also identified that websites advertising local sexual health clinics incorrectly listed Brook Blackburn as their nearest available clinic. They were liaising with local commissioners to correct this.
- Audit results helped staff set aims for improving services. To do this they set targets, or 'key performance indicators' (KPIs), based on the results. Performance was then tracked annually against these. For example, audit results showed staff were not distributing enough long acting reversible contraception such as implants, intrauterine devices and injections. A key performance indicator was set, to provide 25% of patients with one of these types of contraception. Since introducing the KPI in 2015, staff saw an annual increase in distribution from 21% to 23% of patients. This demonstrated an improving picture in relation to this this care of care. KPIs that were not yet being reached were listed on the risk register.

Competent staff

- Staff in a range of roles were able to develop and we saw evidence that competency was assessed and managed in accordance with standards set by the British Association for Sexual Health and HIV guidelines.
- Both clinic managers received leadership training to help them undertake their management role effectively. However, managers had not completed training for Root Cause Analysis (RCA), in undertaking investigation of incidents.
- Nursing staff had previous experience of working in sexual health but were regularly assessed by senior staff in areas such as specimen management, pregnancy testing and referral to other services.
- Staff working in outreach teams had lead roles as link workers for different community services, such as drug and alcohol services.
- In order to develop services, staff accessed training courses to enhance their knowledge. At the time of the inspection, three out of five nurses had completed courses for implant fitting, run by the Faculty of Sexual Health and Reproduction and one nurse had completed a degree level course in sexual health. This training would help ensure staff were able to provide a wider range of care and treatment such as intrauterine device fitting and screening for blood borne sexually transmitted infections such as HIV.
- In addition to providing a greater range of services, staff were also training to provide a wider range of medicines using Patient Group Directives (PGDs). Patient group directives allow healthcare professionals other than doctors, to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The Clinical Manager completed training for new PGDs in October 2016 and was due to implement a delivery programme to nurses beginning in February 2017 with an aim to complete by April 2017.
- Staff participated in annual appraisals. Records showed that 100% of staff were up to date with their appraisal at the time of inspection. Details of appraisals were held in staff files.
- There was no peer supervision in place for nurses to support and learn from each other. However instead, supervision was done on a one to one basis by the nurse manager.

Multi-disciplinary working and coordinated care pathways

- The service had established systems and processes in place for communication and working with local authority safeguarding teams. These included a safeguarding flow chart, named designated contacts and regular attendance at local authority safeguarding meetings.
- The outreach team worked with community organisations to gather the views of young people about sexual health and well-being services. One worker described 'excellent links' with local mental health services, and close working between community drug and alcohol services, and a local homeless emergency housing service. During our visit, staff went out to visit a local supported housing group.
- Meetings involved liaising with local youth workers to identify initial plans for providing sessions about sexual health, lifestyle and healthy eating. Patients kept a weekly scrapbook of activities and information to refer to in the future.

Are services effective?

- Partnership with a local mental health charity had just begun to help develop sexual health and well-being services for young people with mental health needs.
- Following new commissioning arrangements in April 2016, staff had developed links with a local community learning disability service to assess the needs of people with learning disabilities in relation to sexual health services. Meetings with potential patients and support workers enabled them to source ideas. Action plans were in development at the time of inspection.

Referral, transfer, discharge and transition

- Patients could attend the clinic without referral from another healthcare professional.
- Systems were in place to refer patients to other services, such as sexual assault centres or termination of pregnancy services if required.
- Other services, including local authority social services, could refer people directly to the clinic.
- Young people were signposted to relevant adult services, if the required services were not provided for them at the clinic.

Access to information

- Staff accessed patient details on an electronic patient record system. Staff told us they were able to access information without difficulty when in clinic. However those staff working away from the office did not have access to patient records. Despite this, community staff were provided with mobile phones which enabled them to contact office staff should they require information from office based systems.
- Information sharing took place between services such as local authority safeguarding teams and termination of pregnancy services. Staff described how they shared information appropriately and we saw records confirming this.
- Managers described the limitations of having separate information management systems to the NHS trust they worked in partnership with. This was because information was not always communicated between the systems automatically, which posed a risk that staff may not see it. Managers were working with the commissioning NHS trust to align systems in the future.

Consent and Mental Capacity Act

- Staff assessed young people under 16 in accordance with Fraser Guidelines. These guidelines form a national protocol for assessing a child's ability to make decisions about treatment and understand the consequences of decisions.
- We saw consent documented in electronic records. Staff used a template on the electronic patient record system to document consent for children aged under 16 years. The process helped prompt staff to discuss and record consent for children.

Are services caring?

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

Compassionate care

- Staff focussed on each young person and their individual needs. They demonstrated awareness and sensitivity when interacting with patients. We saw staff show caring and understanding, particularly considering patients' individual emotional needs based on social circumstances. Staff spoke in a supportive way when responding to patients arriving at reception and dealing with telephone enquiries.
- Staff described feeling able to spend as much time as necessary with each patient during appointments and that managers supported them with this rather than meeting appointment timescales. This gave a feeling that care was patient centred, caring and considerate of individual needs. Staff altered their style and approach to patients from different cultural backgrounds using clear language and clarifying details for patients based on their level of awareness about sexual health and well-being.

Understanding and involvement of patients and those close to them

- Patients told us they recommended the clinic to friends based on their own positive experience of care.
- They said they felt supported by staff to make decisions about care and treatment choices. They described staff providing information and directing them to the right support such as counselling and termination of pregnancy services. Even after referral, staff maintained contact with patients with follow up phone calls or appointments.
- Outreach teams worked with different community services to support individual patients in accessing services. This included working with advocacy services in helping patients with learning disabilities during their appointments
- Staff actively involved parents of younger children where possible. For example, nurses described arranging joint appointments with parents and young girls who were pregnant whilst still allowing extra time to meet with the young girl individually.

Emotional support

- Staff we spoke with provided holistic care and support for young people and saw this as a priority, showing an understanding of the impact treatment and care had on patients' wellbeing. For example, staff checked individual circumstances to identify a need for further support such as counselling or housing services. We saw staff speak with patients in a supportive, caring way, acknowledging their individual situation and showing respect for personal circumstances.
- Staff supported patients, providing them with information to help cope with the emotional demands of different situations. For example, where required, staff supported young people accessing termination of pregnancy services by offering multiple appointments to help young people cope with their situation. Clinic staff also routinely had follow up telephone contact with patients who had undergone termination of pregnancy. This helped to ensure support was always available.
- Staff told us they were vigilant in observing patient confidentiality and altered communication styles to maintain privacy when responding to individual patient circumstances. They supported patients, particularly those who were nervous, with a reassuring and encouraging tone. We saw staff use different approaches and language, particularly to encourage patients who appeared subdued or hesitant in attending the clinic for the first time.
- Annual review follow ups were completed for patients receiving services for over a year, enabling staff to check whether further support was needed and action this if required.
- The service worked to help enable people to link with relevant social networks or communities. For example, we observed the support group for Lesbian, Gay, Bi-sexual and Transgender visitors meeting one evening during the inspection. Here a lead staff member involved all members of the group and put new visitors at ease with a friendly, chatty approach, whilst encouraging and empowering individuals to take the lead with ideas and views.

Are services responsive to people's needs?

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

Service planning and delivery to meet the needs of local people

- Managers liaised with commissioners on a monthly basis to review whether the needs of local people were being met and adjust services accordingly.
- Brook Blackburn met the needs of local people through the provision of a level one sexual health service, as defined by the British Association of Sexual Health and HIV(BASHH) standards. This included advice and management of sexually transmitted infection (STI), Chlamydia screening, contraception and emergency contraception, condom distribution, sexual health and wellbeing promotion. However a greater range of services was being planned with delivery of level two services in 2017. This would involve additional services such as Intra Uterine Device (IUD) insertion and removal, contraception and emergency contraception, screening for blood borne infection and referral for vasectomy. The plans included a training package to ensure staff were fully prepared to deliver the new service which was in progress at the time of inspection.
- Treatment rooms were furnished with a treatment couch, equipment trolley and chair which ensured patients were comfortable during appointments and that staff had access to the equipment they needed to provide a service for their patients.
- The environment of one of the treatment rooms was less private. The treatment couch was next to a frosted glass window, which was adjacent to a busy main street.

Meeting people's individual needs

- Staff were familiar with caring for patients living with learning difficulties. They were often accompanied by a support worker and staff worked with them in providing support and advocacy during appointments.
- Previously the clinic had offered a counselling service. However this ceased in April 2016 following new commissioning arrangements. However staff maintained links with local organisations and sign-posted patients so that support could still be provided.
- Signposting to wellbeing services was also in place which met holistic needs such as stop smoking services.
- Managers and staff were working towards gaining a quality mark for employment standards for lesbian, gay, bi-sexual and transgender (LGBT) groups. This involved ensuring sickness policies included support for staff undergoing gender reassignment and that incident reporting measures incorporated issues such as homophobia. Information had been submitted for review but findings had not yet been received.
- Staff involved in outreach work helped make services accessible to minority groups locally. For example, staff met with a group of young south Asian people to gain ideas about how services could be made more accessible to them. They networked with drug and alcohol services for young people to find out about their requirements and promote the service to them. Work was in progress at the time of our inspection to tailor make an education package promoting safe sexual practice for young people
- Translation services were available for patients, however staff told us there was little demand for these services in practice. They said there were no language communication issues generally in the clinic.
- Access to British Sign Language Interpreters could be arranged if required.
- Printed materials with words and pictures were available to support patients with learning difficulties should this be required.
- Staff reached out to people in more vulnerable circumstances at a range of locations including colleges, drug and alcohol services and homeless shelters. On the day of our inspection, staff were due to attend a drug and alcohol service aimed at young people.

Access to the right care at the right time

- Clinics were available on Monday, Wednesday, Thursday and Friday between midday and 5.30pm and on Tuesday midday until 6.30pm, and between 11am to 3pm on Saturdays.
- Some appointments were scheduled for procedures such as contraceptive implants. Under 16 year olds were prioritised for appointment bookings. A website provided further information appropriate for young people who wanted to access the service.
- Clinic appointments were run in response to patients' arrival times and demand in this varied from day-to-day. Staff told us there could be a rush for drop-in

appointments at the end of the day, coinciding with when the local college finished and staff worked flexibly to meet these varying demands. For example, staff would always try to see patients for emergency contraception and did not turn any patients away if they arrived requesting this service. Other patients were referred to nearby chemists for advice, should staff be unable to accommodate them at the end clinic.

- The service audited 4117 patient wait times between 1 April 2016 and 31 December 2016. Results showed that approximately 62% of patients were seen within 10 minutes, 16% were seen within 11-20 minutes, 10% were seen within 20-30 minutes and 10% were seen within 31-60 minutes.
- Some services were delivered in outreach areas to make accessibility easier for patients. This included condom distribution which was in place at 30 different sites locally. Distribution was managed by health and wellbeing champions (staff with special interest in this area).
- Chlamydia screening services were provided as part of a regional chlamydia testing scheme. Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at highest risk. The aim was to detect and treat chlamydia in young adults, to reduce onward transmission and the consequences of the infection. Screening was offered at the point of first contact with new sexually active patients, as patients change partners, annually or upon request.

Learning from complaints and concerns

- Staff used a policy to help them manage complaints. Compliments were also covered under this policy. The policy was up to date and contained details of responsible staff, the definition of a complaint, how to manage a complaint and maintain confidentiality, how to handle publicity and ensure treatment of complainants was equitable.
- Managers produced an annual complaints report and quarterly reports produced internally fed into this.
- One manager was the designated complaints lead and investigated all complaints as a result. The manager used a complaints register to record details about complaints. Within the previous 12 months (January 2016 to January 2017) only one complaint had been received which related to staff attitude. We saw evidence that the complaint had been investigated by meeting with the staff member involved and communicating with the complainant via telephone and in writing. We saw that this complaint was dealt with in a timely way, and that the response outlined what had been done to investigate and act on the concerns raised.

Are services well-led?

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

Leadership of this service

- The organisation's leadership was clearly structured and staff knew where to access support. Managers were clear about their roles and responsibilities and we saw systems in place for effective communication with staff in the service. For example, staff received information updates from managers in weekly emails and at monthly staff meetings.
- Staff we spoke with felt supported and well informed by local managers. They spoke positively about their work and the organisation, were enthusiastic about their roles and described working together as a strong, supportive team. Whilst staff said changes in commissioning arrangements had been demanding, they felt motivated and were optimistic about future working and service development.
- Staff attributed the support from managers and other team members as helping them provide care and treatment to the best of their abilities. We saw how managers supported staff through difficult times such as challenging behaviour from members of the public or distressed patients trying to make important decisions about care.
- Senior managers felt supported by leaders regionally and nationally. They felt they could approach them for support or answers to queries at any time if required and received information and advice which was helpful.

Service vision and strategy

- The service was eight years into a ten year strategy encompassing three work streams; clinical and support service, education and wellbeing, and campaigning for young people. Managers steered the service through challenges such as changes to commissioning arrangements and financial restrictions, whilst making efforts to protect the values of Brook Young People.
- The service vision was to broaden services, provide a 'one-stop shop' for a diverse range of patients and develop more volunteer roles. We saw evidence that the service was on track to meet these goals, for example, through staff training and partnership with other local providers.
- The service took pride in providing support to any patient regardless of where they lived. However, new commissioning arrangements required managers to reduce the number of visits made by patients living outside the local area. In response to the arrangements the centre was consulting with patients and working to identify how many this would affect and what other service they might access instead.

Governance, risk management and quality measurement

- The clinic had a clear structure in terms of staffing with one manager having overall responsibility and another manager with clinical responsibility. The wider organisation had elements which supported these managers, such as a clinical leadership team and safeguarding leaders.
- Governance processes were in place. For example, meetings to discuss elements of governance took place each month. Standard agenda items for the meetings included: staffing levels, safeguarding, finance, key concerns and administration. A monthly report was also compiled by a designated manager which covered these topics and additionally, business, development requirements, capacity and contract performance.
- Monthly governance meetings were held with stakeholder such as the NHS trust that commissioned clinic services. During this meeting, leads from both the clinic and the trust discussed achievements, the contents of a monthly quality report, updates, compliments and concerns raised and incidents.
- Quality reports were produced every three months. These contained details about governance, leadership, quality and management issues or information, as well as communications and promotional work being done to achieve the requirements of the strategy. Specific agenda items were also included so that staff could confirm the latest infection, prevention and control audits, whether any Patient Group Directives were due to expire, whether any incidents had occurred, any external safeguarding referrals had been made, any current areas of risk and outstanding complaints.

Are services well-led?

- A risk register was used to record and monitor risk. However, this was not a live document where changes could be made and viewed simultaneously by designated individuals. Instead only one person could view the document and any changes overwrote existing information.
- A designated manager trained in risk management compiled a report, detailing current risks which were discussed at meetings each month. The report was also sent to the corporate provider Brook Young People each month. The risk register included details including a description of the risk, a rating (red, amber or green) and mitigation (descriptions of how the risk was minimised). However, we noted that no responsible staff members were identified for each risk, actions to reduce the risk or provide mitigation were also not listed, nor was there a timeline to show how the risk was being managed or reduced over time. The manager confirmed that the risk register was a template document provided by the corporate provider; Brook Young People. She told us that actions to reduce risk were discussed during monthly meetings and noted on minutes rather than being listed on the register. However, the manager agreed that it would be useful to list the extra details on the register itself.
- Risk assessments were completed to help managers review the level of risk for certain circumstances. These were often completed following incidents. We reviewed a risk assessment for managing children that attend with patients following a child becoming unwell in clinic. The assessment included a description and location of the risk, potential hazards (such as staff being unable to manage both the patient and an unwell child), current controls (leaflet detailing parental responsibility when on site) and updates.
- Staff had access to a governance framework of six "pillar" policies covering areas such as: protecting young people; managing resources; managing people; engaging with stakeholders; managing health, safety and risk; ensuring clinical quality and safety. Further policies were aligned under each pillar policy which made locating them easier. We saw one example where managers instigated a new policy to manage unwell children following a risk assessment and investigation of the incident involving an unwell child in clinic.
- Service standards were in place to formalise required levels of quality and performance.

Culture within this service

- All staff we spoke with were positive about working for Brook. They said they "loved working here" and "thoroughly enjoyed working at Brook".
- Staff described the culture as good; saying this was due to staff having respect for each other and working well together as a team. A number of staff had worked in the clinic for over ten years.
- We heard from a staff member with experience of working in contraceptive and sexual health services for some years and how they felt Brook provided an extra special young people's service, where "they get the essence of it".
- Managers said they found the challenges of this type of service manageable because of the team culture. They told us that service changes had occurred rapidly over the last 12 months but the team had supported each other through these.
- The clinic used a corporate policy to help ensure care was provided equally to a diverse population. This involved making sure that recruitment practices were fair. The policy was within review date and described the responsibilities of managers and staff in meeting objectives.
- Despite the work done to reach out to a diverse range of people, managers confirmed that only white British female staff were currently employed in the clinic. The manager assured us that they did have some male volunteers but again, they were all white British. We were concerned that this was not representative of the local population

Public engagement

- Staff asked visitors to complete short questionnaires which provided an opportunity to improve services and better meet the needs of local people. One questionnaire asked visitors for preferences with opening hours and types of service. Between June and July 2016 84% of patients said they wanted an appointment based service rather than just offering drop in appointments. Managers responded and at the time of our inspection were offering appointments or drop in sessions for patients. Other plans were in place to introduce 'you said we did' feedback for patients having trialled this in another local service nearby.
- Staff took every opportunity to work with patients in order to improve service provision and enhance services

in line with changing requirements. For example, having identified a group of south Asian male patients taking advantage of local condom distribution, staff were now working with the group to improve accessibility to this particular ethnic group.

- The service hosted a Lesbian, Gay, Bisexual and Transgender (LGBT) youth group, with volunteers meeting each week to work on campaigns, information sharing, and general discussion. The group entered and hosted a regional competition in 2016 and were proud to win the 'Youth Group to be Proud Of' award and came second overall in the 2016 Pink Box Competition, an event run to showcase the talents of young people and raise the profile of issues they may face.
- Staff supported young people involved in campaign work. For example, staff regularly engaged with a young person's parliament group who lobbied against the closure of another local clinic. They also liaised with the group to raise awareness of other local clinics and advertised these in the local college to help make sure young people could access services.
- Managers described challenges engaging with a local youth group, but work was continuing to develop engagement with young people from different backgrounds. The service identified potential opportunities to engage with young people from different ethnic and cultural backgrounds. This was a result of recognising there was less engagement with young people from some ethnic groups.

Staff engagement

- Managers facilitated mid-morning debriefs with staff and a second shorter debrief at the end of each day. Here, staff could discuss a range of issues to do with incidents, safeguarding concerns, health and safety, staffing, complaints or compliments.
- Monthly meetings took place where information was shared.
- Staff completed an annual national survey about the organisation. This took place in January. The most recent results available at the time of inspection were those published for January 2016. With a response rate of 53% nationally, 95% of staff recommended the service as a sexual health service provider, 88% said they had clear goals and strategies and 94% understood their roles and responsibilities.
- Despite the national results, managers confirmed that there were no local measures of staff satisfaction or opinion.

Innovation, improvement and sustainability

- The service were undergoing assessment in relation to their application for a Lesbian, Gay, Bisexual and Transgender (LGBT) Quality mark. The evidence submitted for this application provided details of service provision, staff support and overall developments for LGBT patients and staff. This included information about the service's equality monitoring process; weekly LGBT support group for young people; trans-awareness training for counsellors and volunteers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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