

Brook Milton Keynes

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Summary of findings

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Summary of this inspection

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Location name here

Services we looked at

Community health (sexual health services)

Summary of this inspection

Background to Brook Milton Keynes

Brook Milton Keynes provides sexual health information, contraception, pregnancy testing, referrals for termination of pregnancy, screening and treatment for sexually transmitted infections and counselling services. Some services are also provided through an outreach service within schools and youth settings. Services are provided to people under the age of 25.

From February 2016 to January 2017, there were 9,310 visits to Brook Milton Keynes and 1,273 outreach clinic visits. Of all visits, 1,246 service users were under the age of 16, and six were under the age of 13.

Along with clinical services, Brook Milton Keynes also provides educational services including; sexual and relationship education in schools and youth settings, targeted work with young people on a one to one or group basis and training for other professionals.

Brook Milton Keynes is recognised as a level 2 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 provide at each recognised level. As a level 2 service, Brook Milton Keynes provides planned contraception, emergency contraception, and condom distribution. They also provide screening and treatment for sexually transmitted infections, pregnancy testing, termination of pregnancy referrals and counselling.

Brook Milton Keynes provides services to children, young people and their families within Milton Keynes and the surrounding area. Milton Keynes has a higher than average under 16 population.

We do not rate this type of service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in sexual health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an announced visit on 22 February 2017. During the visit we talked with people who use services. We observed how people were being cared for and talked

with carers and/or family members and reviewed care or treatment records of people who use services. We spoke with staff that worked for the service and obtained their views of the organisation and services provided.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

Summary of this inspection

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

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?

- Medicines were not managed or maintained in a way that ensured they were suitable for use. There were not robust systems to manage and oversee expiry dates of medicines, particularly those where a three month supply was being provided.
- Not all staff had received the level of safeguarding children training appropriate for their role. However, staff understood their responsibilities in relation to safeguarding service users and safeguarding risk assessments were completed.
- Confidential documents and staff identification cards were not always stored securely within clinics.
- Staff did not always use personal protective equipment and follow infection control procedures in line with Brook policy.

However:

- There were effective systems to report, investigate and learn from incidents. Staff were aware of their responsibilities in relation to reporting untoward incidents.
- The environment was generally clean, tidy, however high level dusting was not carried out.
- All equipment had been appropriately tested and was suitable for use.

Are services effective?

- Care and treatment did not always reflect current evidence-based guidance, standards and best practice. The service did not conduct clinical audits to monitor compliance with best practice.
- Brook Milton Keynes did not provide data to show they monitored their local service user outcomes. They submitted data for national Brook audits, but did not provide service-specific information; therefore we could not be assured that young people who used the service were receiving effective care

However:

- Staff worked with multidisciplinary teams to understand and meet the range and complexity of young peoples' needs.

Summary of this inspection

- Nurses received additional training to gain competencies in fitting subdermal implants and intrauterine devices (IUDs or coils). Four nurses were qualified prescribers meaning the service could provide additional care and treatment.
- Consent was obtained in line with relevant national guidance and legislation.

Are services caring?

- Staff were kind and caring throughout all interactions with patients.
- The service encouraged non-judgemental, supportive delivery of services to ensure all services users felt comfortable and relaxed.
- Feedback regarding the service was positive, especially in relation to the friendliness of staff.
- Service users were involved in making decisions about their care and were provided with the information they required to make those decisions.
- Short and long term emotional support was provided to service users where required.

Are services responsive?

- Services were planned and delivered to meet the needs of local children and young people.
- Young people could access sexual health and contraceptive services within 48 hours, in line with national guidance.
- The facilities were appropriate for the care and treatment provided.
- Staff could access interpreter services for people whose first language was not English.
- Outreach nurses and education staff visited local schools, colleges, youth hostels and prisons to promote services to young people who may be in vulnerable circumstances.
- Complaints were managed in line with Brook policy.
- Technology and telemedicine was used to increase children and young people's access to contraception and sexual health care and treatment.
- Young people were included in staff interview processes with Brook at a national level.

However:

- There were long waiting times in drop-in clinics and Brook Milton Keynes did not routinely monitor or review waiting times.

Summary of this inspection

- The appointment system did not facilitate timely running of clinics and could cause young people to wait on-site for long periods of time.

Are services well-led?

- Not all risks present within the service were documented within the local risk register.
- Initiatives were not in place to engage service users who had been identified as low attenders.
- Local leadership had little impact on the running of the service and relied solely on Brook providing management at a corporate level.
- Staff morale was low, and staff felt there was a top down approach with minimal channels for them to share ideas or improvements.

However

- There were clear committees at a corporate level to oversee risk, finance and clinical practice. Brook Milton Keynes featured within these meetings and this was documented within minutes.
- There was a clear vision of the service and this was shared at a corporate and local level.
- Staff demonstrated a clear focus on providing young people with high quality care.

Detailed findings from this inspection

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health (sexual health services) safe?

Summary

- Medicines were not managed or maintained in a way that ensured they were suitable for use. There were not robust systems to manage and oversee expiry dates of medicines, particularly those where a three month supply was being provided.
- Not all staff had received the level of safeguarding children training appropriate for their role. However, staff understood their responsibilities in relation to safeguarding service users and safeguarding risk assessments were completed.
- Confidential documents and staff identification cards were not always stored securely within clinics.
- Staff did not always use personal protective equipment and follow infection control procedures in line with Brook policy.

However:

- There were effective systems to report, investigate and learn from incidents. Staff were aware of their responsibilities in relation to reporting untoward incidents.
- The environment was generally clean, tidy, however high level dusting was not carried out.
- All equipment had been appropriately tested and was suitable for use.

Detailed findings

Incident reporting, learning and improvement

- Appropriate systems were in place to allow reporting, investigating and learning from incidents. Staff understood their responsibilities to report incidents and were provided with feedback once they had been investigated.
- An electronic system was in place to report incidents throughout the service. Staff initially completed incident details on a paper form and this would then be inputted onto the electronic system for investigation and further review. Incidents were reviewed by either the nurse or service manager dependant on the nature of the incident.
- From February 2016 to January 2017, 45 incidents were reported. Incidents were categorised into either information governance, medicines management, other clinical or non-clinical. Incidents were graded according to their severity. The main type of incidents reported were in relation to laboratory errors or problems (16 out of 45 incidents), laboratory issues had been longstanding and were present as a risk within the services risk register. All incidents had action points and learning documented.
- From February 2016 to January 2017 there had been no serious incidents within the service.
- We saw evidence of incidents was shared to staff through the clinical newsletters by e-mail and also discussed at daily pre-clinic meetings. The newsletter then listed recent incidents reported and the lessons learnt.
- We observed through minutes of meetings that incidents were discussed at clinical advisory group meetings and also within risk committee meetings. If learning points or actions were created from other Brook locations, these would also be shared during these meetings to allow cross organisational learning.

Duty of Candour

Community health (sexual health services)

- From March 2015, all independent healthcare providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident. The service had a policy in place that defined when the principles of duty of candour should be followed.
- From reviewing meeting minutes we saw that when an incident had occurred, the person involved in the incident was told when they were affected, given an apology, and informed of any actions taken as a result.

Cleanliness, infection control and hygiene

- Staff did not always utilise correct personal protective equipment during contact with bodily fluids. We observed staff dispensing urine into a container and handling blood without using gloves or aprons on several occasions. This was not in line with national guidance or Brook policy.
- Staff were not required to wear uniform for their role, however, the service did have a policy to show that staff which items of clothing were acceptable and what was required during clinical care. We observed three staff during our inspection who were carrying out clinical tasks and were not 'arms bare below the elbows' and were also wearing scarves/long necklaces. This was not in line with Brook policy. Non-compliance with uniform standards and infection control practices had been identified in previous infection control audits but no further actions taken.
- Weekly infection control audits were carried out within the service. These did not result in a compliance score so decline or improvement in compliance could not be continuously monitored. There were no action plans relating to areas of low compliance.
- Clinical and non-clinical areas were generally clean and tidy; however, dust was present on some surfaces, inside cupboards and on signs. Cleaning services were

contracted to an external provider. Staff were required to complete records to show they were adhering to cleaning schedules. Cleaning records were not audited within the service.

- Alcohol gel was available on entry to the clinic and also in all consulting rooms. Hand washing facilities were also available in consulting rooms.

Environment and equipment

- The design, maintenance, and use of facilities and premises kept people safe from avoidable harm. There were systems in place to ensure the safety and maintenance of equipment.
- On entering the clinic, service users presented at the reception desk. There were clear signs to ask people to keep a reasonable distance from others, to maintain confidentiality. There was a large waiting room for use following booking in. Eight clinic rooms were available in the service for consultations, assessments and treatment.
- We observed that items of a confidential nature were kept in unlocked clinic room drawers and were not being stored securely. These items included minutes of safeguarding meetings. We also found three staff identification badges easily accessible within clinic rooms that were unattended.
- All equipment had received a service or electrical safety testing within the necessary time-period. Equipment did not have stickers on to show the date it was last serviced, but did have barcodes so that this could easily be checked by staff if they were unsure of its' safety and suitability for use. Records of services and electrical safety testing histories were kept electronically. The electronic record contained details of when each item of equipment required its next service.
- Equipment stores were organised and well maintained, however, some items were stored on the floor which was not in line with national guidance, leaving them susceptible to damage and also contamination with dirt and dust. Equipment was secured and only accessible to authorised staff. The nurse manager was responsible for stock checks and ordering of equipment.
- Arrangements were in place for managing clinical waste and the service had a policy which outlined key staff responsibilities relating to this. Each clinic room had sharps and clinical waste bins for safe disposal of

Community health (sexual health services)

clinical and potentially infectious waste. Larger waste bins were located within a locked room which was only accessible by staff and the company who collected the waste.

- There were service level agreements in place with a waste provider to allow efficient and safe disposal of bodily fluids and other contaminated waste. Staff had an understanding of these agreements.
- We observed appropriate fire safety precautions in place throughout the service. There were clear signs to demonstrate where fire escapes were located, and fire extinguishers were accessible and had been serviced appropriately. By the main entrances, information was visible about who fire marshals were. Staff completed fire safety training as part of their mandatory training.
- All windows throughout the service were opaque, allowing privacy of those using the service.

Safeguarding

- Systems were in place to ensure people were kept safe. However, staff training was not in line with national guidance.
- Brook had a policy for protecting children and young people. There were six procedures for staff to follow under a detailed safeguarding policy. The policy was in line with up to date safeguarding guidance, and referenced relevant legislation and guidance.
- There were no specific policies for safeguarding of children and young people living with a learning disability.
- Brook had recently updated their safeguarding training standards to show all staff who provided care and consultations to children and young people were required to complete level 3 safeguarding training. This was in line with the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 2014. Prior to this change in training standards, only registered nurses were asked to complete the training, which did not meet the RCPCH guidance. At the time of our inspection only 61% of required staff had completed this training.
- At the time of our inspection, 100% of staff had received level 2 safeguarding training. All staff had access to a colleague who had received level 3 training and the safeguarding lead for the service was on site during clinic hours to provide guidance where needed. Out of hours, staff could access a national or executive member of staff for safeguarding support.

- Staff were provided with quarterly safeguarding supervision, whereby the manager shared learning and discussed cases on a one to one basis.
- Staff received further safeguarding training on relevant topics for the local population; these courses were provided by the council.
- We reviewed the safeguarding assessments of five service users and found them to be detailed and containing appropriate information. Where necessary service users had been discussed with the safeguarding lead for the service to ensure the correct process was being followed and reported correctly.
- Safeguarding proformas were paper-based records. Service users with previous safeguarding concerns were flagged through the use of discreet stickers to indicate concerns to other staff members.
- There was a national safeguarding committee within the Brook organisation, which reviewed safeguarding issues and reported from around the country. Information was shared through minutes of the meeting, at team meetings and in the clinical newsletter.
- Staff were provided with training regarding female genital mutilation (FGM) and child sexual exploitation (CSE). There had been some cases of FGM and CSE within the clinic and staff could describe how these were escalated and the steps taken to protect not only the service user but also any other children and young people at risk.
- The service had worked closely with other agencies in relation to safeguarding and participated in multi-agency risk meetings.

Medicines

- Medicines were not always stored or managed in a safe or secure way. The service had a range of contraceptive medicines, vaccinations and antibiotics which were provided during care and treatment.
- At the beginning of each clinic, all medicines cabinets in clinics room were unlocked; they remained unlocked at all times until the clinic closed. Clinic rooms were left unattended and were not separated from the main waiting area. This meant the medicines were at risk of theft or tampering when left unattended. We escalated these concerns to service managers. Following our inspection the service advised new procedures were put in place to ensure medicines cabinets were locked at all times when not in use.

Community health (sexual health services)

- We found 13 vials of Ceftriaxone (treatment for gonorrhoea) and one dose of Fluconazole (treatment for thrush) that were past their expiry date. Regular stock checks of medicines cabinets were not carried out, only stock checks of the main store.
- There was no system in place to allow staff to easily identify medicines that were due to go out of date within the coming months. This is particularly important when dispensing oral contraceptives as three months' supply is given at one time. Staff told us that they would always check expiry dates prior to administration. We escalated these concerns to service managers. Following our inspection new sticker systems were put into place to enable monitoring of expiry dates.
- A medicines management policy was in place within the service that applied to all Brook locations.
- Patient group directions (PGDs) were used by staff within the service. PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. We reviewed PGDs and found them all to be within the necessary timeframe for review. We also that staff had completed competency checks to allow them to supply and administer under the PGD. PGDs were in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Some nursing staff within the service were qualified as nurse prescribers. To qualify as prescribers nurses must have taken a Nursing and Midwifery Council (NMC) accredited prescribing course and recorded their qualification on the NMC register.
- All new staff were required to demonstrate competency with PGDs during their induction into the service. Completion of this was documented within their induction pack.
- There were emergency anaphylaxis kits available for staff within clinics and outreach services. We found these packs to contain the correct medicines which were within their expiration date. Some of these packs were overstocked with syringes and needles, which meant there was a risk of loose vials becoming damaged or dropping out on opening.
- The service utilised some medicines which required refrigerated storage. At the time of our inspection the medicines fridge was faulty and therefore not in use. We observed that fridge temperatures were monitored daily and escalated if they exceeded the minimum or maximum temperatures defined in the Brook policy for

medicines management. There was not a contingency in place for when fridges became faulty; this meant at the time of our inspection the service could not offer care that required refrigerated medicines, including hepatitis B vaccines.

Quality of records

- Individual care records were written legibly and were contemporaneous. However, audits of records were not completed regularly to ensure continuing quality.
- Records were a combination of paper and computerised notes. All staff we spoke with told us this was a significant frustration and it meant a vast amount of repeated data and was time consuming. This also led to a large amount of stored hard copies of notes within the building.
- During our inspection we reviewed 12 sets of care records from the previous six months of patients ranging from 13 years old to 24 years old.
- All records we reviewed were clear and complete. Records provided sufficient detail about service users' care and treatment.
- Each care record contained a client core record. This was completed during a service user's initial visit and was then updated each time they returned. This core record documented areas including the service user's medical history, family history and social history. It also included key factors in relation to sexual activity, social media use and lifestyle choices.
- Audits of care records were not conducted regularly. Staff carried out peer reviews of each other's care records and safeguarding referrals were reviewed, but the service did not have a structure in place to monitor quality of records.

Mandatory training

- Mandatory training was carried out by the service on topics including, fire safety, equality and diversity, infection control and information governance. At the time of our inspection 100% of staff had attended the necessary mandatory training.
- Staff told us that mandatory training was easy to access and was a mixture of face to face training and online learning. Staff received prompts when they were due to update any training.

Assessing and responding to patient risk

Community health (sexual health services)

- Staff we spoke with were able to describe the procedures they would follow if a patient deteriorated. We were told emergency services would be called if a patient collapsed and was unresponsive.
- Emergency anaphylaxis kits were available within the service and staff we spoke with knew where to find these and in which situations they would be needed.
- Staff took detailed patient histories during assessments. These allowed them to identify any potential health risks for either pre-existing conditions or social/lifestyle factors.
- Service users were given advice by staff if any risk areas were identified, including relating to smoking cessations, limiting alcohol intake and recreational drug use.
- Staff routinely updated core client records to ensure that any risk factors were accurate and current; this allowed monitoring of overall service user risk.
- Assessments for service users were comprehensive, covering physical health, mental health, and social circumstance. In a review of health services for children in Milton Keynes conducted by CQC in October 2016, it was identified that the Brook sexual health assessment process did not include family or sibling detail. This was raised as a missed opportunity to identify other children who may be at risk. The service had responded to this by the time of our inspection and the sexual health assessment proformas included details of family and living arrangements.
- The service used several risk proformas to assess risks present to service users from medical, social and psychological views. These were routinely completed by staff.

Staffing levels and caseload

- There were 32 staff employed at Brook Milton Keynes. This was a combination of registered nurses, counsellors, client support workers, education and wellbeing staff, reception staff and managers.
- The service had 11 qualified nurses employed, four of these were nurse prescribers and one was a clinical nurse specialist. All nurses worked on a part time basis.
- There was one employed doctor who worked one day per week. Managers told us that if medical advice was required from the doctor outside of their working day they were easily contactable. The doctor was also working as a general practitioner and maintained their revalidation through this role.

- The service had had seven substantive staff leave from January 2015 to December 2016.
- At the time of our inspection, the service had a vacancy rate of four whole time equivalent staff. The service covered vacant shifts with bank staff as required. From September 2016 to December 2016, 18 shifts had been covered with bank staff. Bank staff had received inductions into the service and regularly covered shifts so they were familiar with the service.
- The service had a number of staff due to retire and this was an item on their risk register as they were concerned how these staff would be replaced.
- The service recognised that there was a national shortage of fully trained sexual health nurses and a shortage of training courses across the country. To help remedy this, the service was looking to recruit student nurses, with the hope they would remain with Brook Milton Keynes post registration.

Managing anticipated risks

- Brook Milton Keynes had a business continuity plan in place that had been reviewed in January 2017. This plan detailed mitigating actions against possible risks to the running of the service including inclement weather, fire, damage to premises and any unplanned closures.
- The service did not have contingency plans for replacing faulty equipment at short notice. During our inspection the fridge, which some medicines were stored in, was found to be faulty. Whilst a replacement had been ordered there was not a timescale for how long this would be. This meant some Hepatitis B vaccinations and contraceptive rings could not be provided to service users.

Are community health (sexual health services) effective?

(for example, treatment is effective)

Summary

- Care and treatment did not always reflect current evidence-based guidance, standards and best practice. The service did not conduct clinical audits to monitor compliance with best practice.
- Brook Milton Keynes did not provide data to show they monitored their local service user outcomes. They

Community health (sexual health services)

submitted data for national Brook audits, but did not provide service-specific information; therefore we could not be assured that young people who used the service were receiving effective care

However:

- Staff worked with multidisciplinary teams to understand and meet the range and complexity of young peoples' needs.
- Nurses received additional training to gain competencies in fitting subdermal implants and intrauterine devices (IUDs or coils). Four nurses were qualified prescribers meaning the service could provide additional care and treatment.
- Consent was obtained in line with relevant national guidance and legislation.

Detailed findings

Evidence based care and treatment

- Our observation of practice, review of records and discussions with staff confirmed that the service did not consistently follow defined pathways or protocols to ensure care was delivered in line with evidence-based guidance, best practice or legislation. There were national Brook policies based on guidance from the British Association of Sexual Health and HIV (BASHH), the Faculty of Sexual and Reproductive Health (FSHR) and the British HIV Association (BHIVA). However, they were not routinely followed at a local level.
- There was an inconsistent approach to sexually transmitted infection (STI) testing that did not always reflect national guidance, particularly when a service user received a positive result. The UK National Guidelines for HIV Testing 2008 from BASHH and BHIVA state that HIV tests should be offered to anyone who is diagnosed with an STI. However, not all nursing staff we observed followed this. We also saw evidence in a service user's clinical record where a HIV test had not been offered after a positive STI result. We raised this with senior management who confirmed that members of staff worked differently, meaning national guidance was not always followed.
- Brook Milton Keynes did not provide evidence of any local clinical audits to monitor compliance with best practice. The service submitted data for Brook national

audits and could access their local results; however, they did not provide us with this information upon request. This meant we could not be assured that they had oversight of the quality of care they provided.

- The service followed national guidance for partner notification when young people were diagnosed with an STI. Partner notification allows the notification of an STI risk to service users' previous sexual partners. Service users who were diagnosed with an STI were encouraged to provide information on their previous sexual partners during treatment and consultations, and had the option to decline if they wished.
- Care for looked after children (those who have been under the care of a local authority for over 24 hours) was provided in line with national guidance from the National Institute for Health and Care Excellence (NICE).
- All young people who attended the clinic were asked to give a urine sample for chlamydia testing when they arrived.
- As four nurses were trained as nurse prescribers, the service could offer additional treatments.

Pain relief

- Pain was discussed during consultations and appropriate advice was given regarding use of analgesia. We observed pain being discussed with service users when they contacted the telephone helpline.
- Staff advised service users to self-administer pain relief when they booked appointments for fitting subdermal (under the skin) implants or intra-uterine devices (IUD or coil). The service provided analgesia where required.

Nutrition and hydration

- Staff offered glucose tablets and provided light refreshments, such as biscuits, to service users who felt faint or unwell after having an implant or IUD fitted.
- There was a water dispenser in the waiting area for service users and visitors.

Patient outcomes

- The service participated in the Brook national audit programme that included an emergency contraception audit, STI audit and an abortion audit. These audits provided information on Brook national performance, but did not show local service user outcomes for Brook

Community health (sexual health services)

Milton Keynes. We requested results specific to Brook Milton Keynes but this was not provided, meaning we could not be assured on the outcomes for young people using this service.

- Results from one national Brook audit showed they were meeting the Brook target of one third of service users being offered an STI test before having their implant removed. Brook monitored the proportion of young women who were offered an STI screening before having an implant removed for irregular bleeding, to rule out infection as the cause of bleeding. This was advised to prevent the unnecessary removal of long-acting reversible contraception.

Competent staff

- Nursing staff met the minimum national requirement for working in sexual health services, as set out in the Faculty of Sexual and Reproductive Health (FSRH) Standards 2016. The standards state that the minimum requirement is the national FSRH Diploma or equivalent accredited training. One of the eleven nurses had the FSRH diploma and the remaining had gained equivalent experience
- A doctor employed by Brook Milton Keynes had recently become a qualified FSRH trainer. This meant they could run training sessions for healthcare professionals to gain competence in sexual and reproductive healthcare. No training sessions had been held at the time of inspection. All nurses had completed family planning training on courses run by local universities.
- There was an induction programme for new staff that included orientation to the clinic, introduction to Brook policies, patient group directives (PGDs) and clinical supervision.
- Newly recruited staff were given a supernumerary period to ensure they felt confident in delivering their role.
- All registered healthcare professionals that worked in the service had valid registrations. This confirmed that nurses and doctors were trained and eligible to practise within the UK. There was a process in place to check registrations were renewed and the nursing lead prompted individuals when revalidation was required. The Brook intranet had guidance for staff going through revalidation and the nurse manager had held a support session.
- We reviewed five personnel files of staff including medical, nursing and admin staff. All files contained

evidence of appraisals, qualifications and two professional references. All staff members had up to date Disclosure and Barring Service (DBS) checks to ensure they were suitable to work with young and vulnerable people.

- Staff received annual appraisals to identify their training needs. At the time of inspection, 93% of staff had completed their appraisal for the year. The remaining staff members who required an appraisal had theirs booked in.
- One nurse had been trained in fitting inter-uterine devices (IUD or coils) and appointed as a clinical nurse specialist. Prior to this, IUDs could only be fitted by the doctor.
- Nine nurses had gained competencies in fitting subdermal implants. The remaining nurses were enrolled on training courses.
- There were four nurse prescribers in post who received prescribing supervision to ensure safe practice. The nurse prescribers allowed the service to offer treatment to service users who were not covered by Brook PGDs.
- Nurses and wellbeing support workers received training to provide alcohol interventions to young people with an alcohol score indicating increased risk. Staff also received training on smoking interventions and providing stop smoking advice to young people.
- Staff in the education team were trained to provide sexual health and contraceptive advice to children and young people. Wellbeing support workers had been given clinical training, such as carrying out pregnancy tests, chlamydia screening tests and provision of condoms to young people.
- Reception staff had health and wellbeing training and customer satisfaction training that involved triaging for STIs and signposting to other services. This allowed them to cover the telephone helpline and online clinic when support workers were unavailable.
- There was a midwife available on Thursday afternoons who was a specialist in teenage pregnancy.
- Service users could access a counsellor who was qualified to provide cognitive behavioural therapy (CBT). CBT is a talking therapy that can help manage problems by changing the way people think and behave.

Multidisciplinary working and co-ordinated care pathways

Community health (sexual health services)

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Care was delivered in a coordinated way when different teams or services were involved.
- We observed positive working relationships between on-site nursing staff, outreach nurses, support workers and admin staff. Support workers and nurses could refer people to the in-house counselling service for one-to-one appointments. Staff we spoke with described having regular communication with counsellors that facilitated appropriate referral. Service users who did not meet Brook criteria for counselling could be referred to a local youth counselling service, where appropriate. Staff could also refer young people to NHS child and adolescent mental health services (CAMHS).
- The chlamydia screening office of the local NHS trust was based at Brook Milton Keynes. This aided communication and multidisciplinary working with the service. Brook Milton Keynes carried out chlamydia tests and results were then managed and communicated by the chlamydia screening office. If staff from either department had queries or concerns, they could easily speak to each other in person.
- Pregnant young people could be referred to a specialist midwife for support and healthcare. The specialist midwife also referred young women for contraceptive services at Brook Milton Keynes as early intervention. However, staff told us that delivering co-ordinated care could not always be achieved as they were unable to share service user information or assessments with the midwife as she was not employed by Brook.
- Multidisciplinary working included input from social and education providers. The Brook Milton Keynes education team and outreach nurses worked closely with school nurses and pastoral care teams in local schools and colleges, to provide sexual health advice and guidance.
- The nurse manager attended monthly multi-agency review meetings with social workers and external organisations to discuss and share information on young people who may have been at risk of abuse. Meetings were comprehensive and involved CAMHS, local sexual assault referral centres (SARC) and

representatives from local NHS sexual health services. The nurse manager also attended Milton Keynes Child Sexual Exploitation Project meetings to follow up service users who had been referred to other agencies.

- Brook Milton Keynes worked with local pharmacists to provide training on safeguarding and providing emergency hormonal contraception to children and young people.
- Staff described working with GPs from other areas where their service users attended college or university. In such cases, consent was obtained to share information on the student's sexual health and contraception when requested. This promoted service users' sexual health when they could not access the clinic.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way when young people moved between teams and services. However, there was not always a consistent approach between staff members.
- Referral pathways for young people who required level 3 sexual health services were not always followed. Level 3 services provide specialist genitourinary medical care. Brook policy states that service users presenting with certain symptoms should be referred to local level 3 services, for example the local NHS trust. However, we saw occasions where this had not been followed. For example, one service user's records showed that they had been given treatment for urethral discharge, rather than being referred to a level 3 service, in line with national guidance. We raised this with senior management who confirmed that staff members were not all clear on the referral pathway. Following our inspection, managers provided us with an action plan that stated the clinical nurse specialist would observe practice and review competencies of all nurses and support workers by September 2017.
- Service users who reached the age of 25, and therefore, were no longer eligible for Brook services, were offered the option of continuing treatment with their GP. For those who wished to do so, consent was obtained before sharing information.

Community health (sexual health services)

- Standardised templates were used when referring young people for further care or treatment, for example, specialist psychosexual counselling. Staff referred young women who were considering an abortion to a local termination of pregnancy provider.
- If a service user received a blood test that indicated HIV, they were immediately referred to the local NHS trust blood-borne virus clinic. Staff from Brook Milton Keynes would liaise with the NHS service to ensure the person had attended and been followed up.

Access to information

- Information needed to deliver effective care and treatment was available and accessible to relevant staff. This included risk assessments and test results.
- The service used a combination of paper-based and electronic systems for recording information. Processes were not efficient as it meant staff had to transfer information from written forms onto the electronic system for storage; therefore, duplicating their work. There were plans in place to upgrade the IT systems so that all service user information would be recorded and stored electronically, however this was not in place at the time of inspection. Following our inspection, we were provided with an action plan that stated the IT systems would be updated from April to June 2017.
- There were computers throughout the clinic for staff to access service user information and policies. Staff had secure log in details and could demonstrate how to access information they needed.
- The electronic system used to store service user information included a core client record for each person. This allowed staff to share information on safeguarding concerns or those in vulnerable circumstances.

Consent

- Consent was obtained in line with national guidance and legislation, such as the Mental Capacity Act (MCA) 2005 and the Children's Acts 1989 and 2004. Staff understood the guidance and their responsibilities when obtaining consent.
- Verbal consent was required for the care and treatment provided, though written consent was obtained when staff were sharing personal information with other services. Consent discussions and decisions were recorded in all clinical notes we reviewed.

- Staff could describe how they would assess a young person's competence in line with national guidance, such as Fraser guidelines and Gillick competence. Gillick competence is used by healthcare professionals to determine whether a child aged under 16 years old can consent to medical care or treatment. Fraser guidelines are specifically used to determine whether a child should be given contraceptive or sexual health advice or treatment, without informing their parents. Fraser assessments were recorded in all service user notes we reviewed, where applicable.
- National guidance states that Fraser assessments must be completed and reviewed on each visit by a child aged under 16 years old. This had been appropriately completed in all notes we looked at.

Are community health (sexual health services) caring?

Summary

- Staff were kind and caring throughout all interactions with patients.
- The service encouraged non-judgemental, supportive delivery of services to ensure all services users felt comfortable and relaxed.
- Feedback regarding the service was positive, especially in relation to the friendliness of staff.
- Service users were involved in making decisions about their care and were provided with the information they required to make those decisions.
- Short and long term emotional support was provided to service users where required.

Detailed findings

Compassionate care

- Staff showed a clear understanding of people's social and personal needs, and showed care and compassion to all those using the service.
- From October 2016 to December 2016, the service received 171 compliments about the care provided; 158 of these related directly to the helpfulness and friendliness of staff. Comments feedback included; "extremely welcoming and made me not feel embarrassed", "very friendly staff. Respected my views" and "very supportive team every visit has been genuine and caring."

Community health (sexual health services)

- The 2015/2016 user survey showed that 100% of children and young people would recommend the service provided at Brook Milton Keynes. The response rate for this survey was 53% of service users. The survey also showed that 96% of service users would rate the service as good or excellent.
- Brook carried out client satisfaction surveys regularly. Survey results from September 2016 to February 2017 showed that 83% of service users felt they were treated in a caring and supportive way. Service users were asked within these surveys to rate the service from excellent to poor. From September 2016 to February 2017, 77.8% of service users rated the service as excellent, 19.6% rated it as good and the remaining 2.6% rated it as OK or poor.
- We observed staff speaking to services users in a kind, sensitive and non-judgemental way. Privacy was maintained throughout their care and staff regularly asked if anything could be done to make the person using the service more at ease or relaxed.
- Upon entering the service patients were given a unique number and colour so staff did not call their name when they were due to be seen.

Understanding and involvement of patients and those close to them

- Staff communicated with people in a way that enabled them to understand the care they were receiving and what may be required in the future. Services users we spoke with were pleased with the way staff communicated with them and felt it was done in a way they could understand.
- We observed consultations and found that services users were encouraged to describe how they felt and have an input in their care going forwards. Staff did not interrupt service users at any point and listened to what they had to say. Staff always ended consultations and treatment by asking if the service user had any questions, prior to leaving the service.
- People using the service were able to have partners, family members or friends sit in on consultations if they wished.
- Staff were clear about confidentiality throughout consultations and treatments. Service users were provided with further information regarding confidentiality and privacy when using the service.

- Staff could refer service users to internal counselling services if they felt this was beneficial to their care and treatment.

Emotional support

- Staff showed a thorough and sensitive understanding of the potential emotional and social impacts on service users.
- Throughout the service there was a strong focus on supporting service users and enabling them to cope with their care, treatment and condition.
- Service users were empowered to make their own decisions not only about care but about their sexual and relationship choices.
- Staff demonstrated a good knowledge of potential long term and complex needs that may come with a diagnosis of a sexual transmitted infection and also resulting from sexual assault/abuse.
- Brook Milton Keynes worked closely with voluntary agencies and advocacy services to ensure service users could be signposted correctly and the necessary support provided to them.

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

Summary

- Services were planned and delivered to meet the needs of local children and young people.
- Young people could access sexual health and contraceptive services within 48 hours, in line with national guidance.
- The facilities were appropriate for the care and treatment provided.
- Staff could access interpreter services for people whose first language was not English.
- Outreach nurses and education staff visited local schools, colleges, youth hostels and prisons to promote services to young people who may be in vulnerable circumstances.
- Complaints were managed in line with Brook policy.
- Technology and telemedicine was used to increase children and young people's access to contraception and sexual health care and treatment.

Community health (sexual health services)

- Young people were included in staff interview processes with Brook at a national level.

However:

- There were long waiting times in drop-in clinics and Brook Milton Keynes did not routinely monitor or review waiting times.
- The appointment system did not facilitate timely running of clinics and could cause young people to wait on-site for long periods of time.

Detailed findings

Planning and delivering services which meet people's needs

- Information about the local population was considered when planning and developing services. For example, it was identified that Milton Keynes had a high 18-21 year old student population who were mobile during the academic year. As a result, Brook Milton Keynes increased prescriptions to one-year for oral contraception for non-complex clients, to make it easier for them to continue with contraceptives when they were away from home.
- Brook Milton Keynes was part of a local sexual health strategy group working with commissioners and other local providers to co-ordinate their approach to sexual health services across Milton Keynes. They formed part of the Milton Keynes Sexual Health Strategy 2014-17 that aimed to promote access for groups of young people with a higher risk of poor sexual health and those who face discrimination. Brook Milton Keynes was working towards this aim via their outreach and education services that visited schools, colleges, prisons and hostels.
- The local sexual health strategy group identified that the number of GPs who fitted coils as emergency contraception was reducing. To meet this need, Brook Milton Keynes had trained one of their nurses to fit coils. The doctor employed by the service could also fit coils, meaning they could offer the service four days per week.
- Brook had national young people panels who were involved in reviewing and developing services, however there was no local engagement or young people's groups involved in planning for Brook Milton Keynes. To improve this, managers had recently started working with Young People's Healthwatch Milton Keynes to develop their services. A group of young people aged

13-18 years old conducted a review of the clinic to provide feedback on the facilities, information provided, interactions with staff and privacy and confidentiality. The visit was carried out after the clinic had closed to maintain service users' privacy. Senior managers were in the process of reviewing the information to identify areas of improvement.

- A young person had formed part of the interview panel during the recruitment of the manager and nursing lead. This was part of Brook's national procedure.
- Brook Milton Keynes had recognised that females accessed their services much more than males. For example, from April to December 2016, they had 6046 female attendances; compared to 892 male attendances. There were not clear plans in place to improve young male attendances, but some advertising work was being carried out with a local football team.
- The Department of Health sets quality criteria that health services should meet to be young people friendly. Services can gain accreditation in this by taking part in 'You're Welcome' audits. Brook Milton Keynes had gained the accreditation and passed a self-assessment, but this had not been reviewed since 2014. The recommendation was to review the self-assessment each year. However, the guidance was due to be updated in 2017 and Brook Milton Keynes were planning to review the criteria once it was updated.
- The clinic was located in central Milton Keynes and was easily accessible by public transport. The premises accommodated the drop-in clinics and appointment services provided.
- Drop-in clinics were available Monday, Wednesday and Friday from 12pm to 5.45pm and on Tuesdays and Thursdays until 7.45pm. On Saturdays they were open from 10am to 3pm. The opening hours were based on young peoples' availability, for example, at lunch times during breaks from education or work and after school hours.

Equality and diversity

- Brook had an equality and diversity policy that outlined responsibilities for staff and managers. Staff we spoke with were aware of the policy and knew how to access it on the intranet.

Community health (sexual health services)

- Translator services were available over the phone to support service users whose first language was not English. Staff described examples of when they had used this service. However, there was limited written information available in languages other than English.
- The clinic was wheelchair accessible and had disabled toilets.
- Outreach nurses and education staff held awareness sessions in local schools and youth clubs to promote gender and sexuality equality. The counselling service encouraged young people from all backgrounds, particularly those who identified as lesbian, gay, bisexual or transgender.
- There were local schools and colleges that did not routinely work with Brook Milton Keynes on the basis of religious beliefs. These organisations could contact the service if they had concerns about an individual or groups of young people. Outreach nurses and education staff held ad-hoc sessions tailored to the particular group and areas of concern.
- Outreach nurses and education staff attended local youth offending services, prisons and youth hostels to promote access to young people in vulnerable circumstances. Outreach nurses also offered visits in service users' homes for young people who found it difficult to access the clinic. We spoke with an outreach nurse who described visiting young people in rural areas who would otherwise be unable to access contraceptive and sexual health services.
- There were locations that had been risk assessed, for example clinical rooms in schools where school nurses worked, where outreach nurses could fit implants. This enabled young women who may not be able to access the clinic to receive long-acting reversible contraception.
- In a review of health services for children in Milton Keynes conducted by CQC in October 2016, it was identified that Brook Milton Keynes did not routinely inform the local authority Looked After Children nursing team if they were treating a looked after child. This was highlighted as a missed opportunity to share information for health assessments of vulnerable children. During our inspection, we saw that improvements had been made and staff routinely shared information with the looked after children nursing teams when they saw these children.

Meeting the needs of people in vulnerable circumstances

- Services were planned and delivered to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.
- Wellbeing support workers, nurses and doctors completed vulnerability assessments each time a service user visited. The assessment was used to identify young people living with a learning disability, safeguarding concerns, social vulnerabilities or those who may require additional support. Staff could then refer young people to appropriate specialist agencies, where appropriate.
- Information from vulnerability assessments was recorded on service users records on the electronic system used. Wellbeing support workers could then monitor these service users more closely and provide additional support where possible. For example, a wellbeing support worker we spoke with described regularly contacting a young person with safeguarding concerns over the telephone to build a positive relationship and promote access to the service. Staff escalated safeguarding concerns to the local authority where appropriate.
- There were baby changing facilities available at the clinic and toys and children's books were available in the waiting area.
- The main reception had a hearing loop for people with hearing impairments. There was written information on a variety of topics, including advocacy services, eating disorders, pregnancy and alcohol abuse.
- There was a male sexual health advisor available for service users if they preferred.
- Support workers and receptionists were trained to act as chaperones and were available for all appointments. Information on requesting a chaperone was displayed in reception and staff discussed this with service users during consultations.

Access to the right care at the right time

- Young people could access care and treatment at times to suit them; however, there were often long waiting times for appointments and at drop-in clinics. Services,

Community health (sexual health services)

such as sexually transmitted infection (STI) testing, were not always offered on the day and young people had to come back at a later date. This was always within 48 hours, in line with national guidance.

- The appointment system did always not facilitate timely access to treatment. Service users could book a time slot for an appointment, for example, for repeat contraception or fitting a coil, but specific nurses were not allocated to these appointments. Because nurses' individual competencies varied, young people faced delays if they had to wait for a suitable nurse to become available. Service users' notes were placed in a queue based on appointment time but they could only be seen when an appropriate nurse was available, which could result in long waits.
- The service did not monitor how long people waited for appointments or drop-in services. Feedback forms gathered information on waiting times but this was not reviewed.
- There was a whiteboard in the waiting area that informed young people that the maximum waiting time would be two hours. This was not updated to reflect current waiting times. Reception staff advised young people of waiting times when they signed in. The whiteboard displayed the names of nurses and support workers who were in the clinic that day.
- The service monitored occasions when they had to turn young people away due to lack of capacity, for example, when waiting times exceeded two hours or when they were approaching closing time. Their data from June to December 2016 showed that, on average, six young people were turned away per month. This was less than one percent of their clinic attendances for this period. Young people who were turned away were directed to other similar services or signposted to places where they could access emergency contraception, such as local pharmacies. This information was displayed at the clinic entrance outside of opening hours.
- Young people aged under 16 years old were prioritised for appointments and at drop-in clinics. This was in line with national guidance as this age group was deemed higher risk. All young people attending the clinic were given forms to fill in on arrival that captured age and reason for visit. Receptionists highlighted under 16s to nurses running the clinics so that they could be seen promptly. During particularly busy periods, reception staff accepted only under 16s to prioritise this higher risk group.
- There had been no cancelled clinics between February 2016 and January 2017. If the service cancelled individual appointments, for example, due to a staff member being off sick, appointments were rescheduled within six weeks. Appointments for coil fitting were rearranged with the specialist nurse where possible.
- The service monitored how many service users did not turn up for their appointments. The average did not attend (DNA) rate from August 2016 to February 2017 was 10%, which was in line with the England average. Brook Milton Keynes were aiming to reduce this with the introduction of a text message reminder service for appointments.
- Face-to-face follow-up appointments were offered to all service users who were under the age of 16. Telephone follow-up appointments were offered to service users of all ages.
- There was a webchat service and telephone advice line available between 9am and 12pm from Monday to Friday. Support workers could recommend young people visit the clinic for drop-in services or appointments. We observed phone calls and saw that staff advised service users that there may be waits of up to two hours.
- Staff had a direct telephone line to the local NHS trust genito-urinary medicine department and sexual health services. This allowed them to fast-track service users with urgent needs.
- The main clinic telephone line had an answering machine that asked people to leave their name and contact details if they could not get through. We observed phone calls being returned within 15 minutes during our inspection. Out of hours, the answering machine included information on where to access emergency contraception.
- Results from STI tests were provided within the national standard of ten working days. Wellbeing support workers distributed results via text or telephone, depending on the service user's preference and the nature of their results.
- The service offered point-of-care testing for HIV so that service users could receive results during their visit, to minimise delay and distress. Young people who were at higher risk of HIV, for example those from Black African communities, could also order at-home HIV testing kits via a link on the Brook Milton Keynes website.

Community health (sexual health services)

- There was a six-week waiting list for one-to-one counselling services at Brook Milton Keynes. Staff referred young people who needed more timely access to external youth counselling organisations.

Learning from complaints and concerns

- From January to December 2016, Brook Milton Keynes reported eight complaints. Five of these complaints were upheld and no complaints were referred to the ombudsman.
- The service investigated and responded to all complaints within 20 working days, in line with the Brook complaints policy. The complaints policy was accessible to service users and was on display in the waiting area and consultation rooms.
- Staff we spoke with were aware of the complaints procedure, and were confident in dealing with complaints if they arose. Complaints management was included in mandatory training for all staff.
- The most common themes from complaints were reception wait times, communication of test results and communication of drop-in clinic and appointment policies.
- Staff could describe recent complaints and lessons learned. For example, there had been a complaint from a service user who had attended the clinic for STI treatment but was turned away as Brook Milton Keynes did not have the particular medication in stock. The learning included developing an improved stock ordering system to prevent this from happening again. Since the new system had been in place, no service users had been turned away due to lack of stock.
- Service users were given feedback forms to complete after each visit. Questions included length of wait, being treated in a caring and supportive way and knowledge gained from the visit. This information was collated; however, staff we spoke with said that feedback was not always shared with them.

Technology and telemedicine

- Technology was used to enhance the delivery of effective care and treatment, and to promote access to the service.
- Service users could access support through the webchat and telephone helpline, which were accessible through the Brook Milton Keynes website. The webchat and phone line were staffed by a wellbeing support worker who offered advice, answered questions and arranged

appointments for STI testing, implant fitting and repeat contraception. There had been technical issues with the accessibility of the webchat service on the Brook website that had contributed to a decline in the number of online visitors. The issue was being resolved by the national IT team at the time of inspection.

- We observed calls to the telephone advice line during our inspection. Assessments included pain, emotional wellbeing, physical health and social circumstance. Support workers tailored their advice and decision depending on the service users' needs. For example, a young person who described symptoms of an STI was advised to visit the drop-in clinic that afternoon for a screening. Others were advised that they may benefit from counselling and referrals were made to the in-house Brook counselling service.
- Text messages were used to contact service users, for example, with appointment reminders and with STI results. Young people could also directly text outreach nurses for emergency contraception. Mobile numbers were accessible on the Brook Milton Keynes website and given out during visits and education events.
- Social media accounts were used to promote services and raise sexual health and contraception awareness.
- There was a text message service for sending anonymous notifications to young people's previous sexual partners when they were diagnosed with an STI. Service users who received a diagnosis could provide Brook staff with telephone numbers to put into the system. This sent anonymous texts to inform people that they had been in contact with someone with an STI and recommend a screening, without identifying the service user involved.

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

Summary

- Not all risks present within the service were documented within the local risk register.
- Initiatives were not in place to engage service users who had been identified as low attenders.
- Local leadership had little impact on the running of the service and relied solely on Brook providing management at a corporate level.

Community health (sexual health services)

- Staff morale was low, and staff felt there was a top down approach with minimal channels for them to share ideas or improvements.

However

- There were clear committees at a corporate level to oversee risk, finance and clinical practice. Brook Milton Keynes featured within these meetings and this was documented within minutes.
- There was a clear vision of the service and this was shared at a corporate and local level.
- Staff demonstrated a clear focus on providing young people with high quality care.

Detailed findings

Leadership of this service

- Brook Milton Keynes was managed by a nurse manager (who was the registered manager) and also overseen by a service manager. Staff told us they generally were well supported and would be happy to approach the nurse manager if they had any problems. Staff said the visibility of any managers above the nurse manager was minimal.
- The service was overseen at a national level along with all other Brook locations. There was a clear structure of senior managers within the organisation and who was accountable at a corporate level. There was minimal improvement work or local initiatives; leaders relied on influence from Brook at a corporate level.
- The board of trustees for Brook carried out quarterly meetings and there were also three governance sub-committees.
- The risk, finance and assurance committee had oversight of the financial risks to the organisation and also managed the charitable objectives of Brook.
- The clinical advisory group was responsible for the governance of quality, safety and patient experience, and complaints, with overall direction to continually monitor and improve the quality of clinical services.
- There was a national safeguarding advisory committee, which provided national governance with operational oversight provided by the deputy chief executive and safeguarding lead nurse.

Service vision and strategy

- Brook's national vision wanted a society that valued all children, young people, and their developing sexuality.

They wanted all children and young people to be supported to develop the self-confidence, skills and understanding they need to enjoy and take responsibility for their sexual lives, sexual health and emotional well-being.

- Brook's mission statement was to ensure that all children and young people have access to high quality, free and confidential sexual health services, as well as education and support that enables them to make informed, active choices about their personal and sexual relationships, so they can enjoy their sexuality without harm.
- Staff told us they shared this vision of providing children and young people with skills and understanding and also putting them at the centre of all they do.
- The service did not have a documented strategy in place, but worked towards Brook's national strategy in line. Due to negotiations and retendering there were some uncertainties about how the service would develop and therefore, the strategy going forward.
- In the 2015 Brook provider survey, 78% of staff said they didn't think Brook had a clear vision for the future. This correlated with what staff told us at Brook Milton Keynes during our inspection. Staff did not feel clear about how the service was intending to move forwards and felt very uncertain of their future.

Governance, risk management and quality measurement

- Governance, risk management and quality measurement procedures were not sufficient to ensure full oversight of the service.
- There was a local risk register in place for Brook Milton Keynes. This identified three risks to the service.
 - Staffing levels and recruitment of staff.
 - Problems with laboratory services.
 - Non-compliance with key performance indicators relating to long-acting reversible contraceptive uptake and completion of computer automated checkboxes.
- We observed that the risk register was updated monthly with any new risks. However, it did not detail the date a risk was entered, who was the owner of the risk or any review dates.
- The risk register did not accurately reflect risks identified within the service. We identified concerns relation to non-compliance with safeguarding training guidance, clear pathways for screening and non-compliance with

Community health (sexual health services)

infection control policy. Managers told us they were aware of the some concerns; however, they had not been entered into the local risk register. This meant that there could not be continuous monitoring or management of these risks.

- Brook's executive team reviewed corporate risks on a monthly basis. These risks were recorded in Brook's corporate risk register. Risks in individual Brook services were escalated by service managers to establish whether they required to be placed onto the corporate risk register. The corporate risk register was reported to the risk, finance, and assurance committee quarterly.
- Within the corporate risk register, a reduction in organisation income due to the re-tendering of existing Brook contracts was their top risk. Managers within Brook Milton Keynes were aware of this risk.
- We viewed a selection of policies and procedures, found them to be in date, and had been reviewed within their review dates. Staff were able to access the policies through the clinic's intranet and staff we spoke with said they would know how to locate a policy if required.
- There were not always clear quality measures throughout the service. Audits were not completed in relation to completion of records, waiting times or consistency of clinical care. Some areas of clinical care were measured within key performance indicators, including uptake of long-acting reversible contraception, as they were required by commissioners. This meant that leaders could not be assured or have full oversight of the quality of the service being provided.

Culture within this service

- Opinions of the culture and morale varied within the service. All staff we spoke with told us they felt they were providing great care to service users, but that morale was low due to uncertainty about retendering and also due to no significant motivation to move the service forward and improve it further.
- There was a clear focus on the children and young people who used the service and all staff told us caring for this group of people was why they came to work each day.
- The national Brook 2015/2016 staff survey results showed that:
 - 87% of staff felt Brook treated staff who made a mistake fairly

- 75% of staff gave positive feedback about Brook's communications
 - 89% staff said they felt Brook treated staff with dignity and respect
 - 93% of staff said they were proud to work for Brook
 - 82% of staff would recommend Brook as an employer.
- There was no data relating to Brook Milton Keynes staff specifically.

Public engagement

- The service worked with local schools, within their education and wellbeing part of the organisation. They promoted use of the service and encouraged young people to access services in relation to sexual health and well-being.
- There was a significantly lower number of young males accessing the services at Brook. Managers of the service told us that they had identified this, and whilst small advertising campaigns were being considered, there were not clear plans to attempt to further engage this group of service users.
- The service had recently engaged with Healthwatch to improve interactions with young people in the community. Whilst this was a new project, some young people from Healthwatch had been for an initial introductory visit to the service.

Staff engagement

- Staff were provided with the opportunity to raise any areas of concern or improvement each day in small meetings prior to clinics, but felt that there were no direct forums to encourage staff to help shape the service.
- We asked leaders if any methods were in place to engage staff and involved them in improving and developing the service but were told there were no formal channels for this.
- Staff told us that they would speak to a manager if they found any areas to improve, but felt that it was usually a top down approach from a corporate level that decided how the service would run or improve.

Innovation, improvement and sustainability

- There were plans to introduce a virtual waiting system if this proved to be successful within Brook locations that were trialling this process.

Community health (sexual health services)

- Brook Milton Keynes was going through a period of retendering which made future planning and stability difficult within the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- Ensure staff compliance with effective infection control practices.
- Improve medicines management processes to ensure medicines are in date, stored securely and available for use.
- Review pathways for sexual health screening to ensure they meet national guidance and evidence based care.
- Ensure level 3 sexual health services are accessed and referred to for service users who meet the criteria.
- Ensure all relevant staff have received level 3 safeguarding training in line with intercollegiate guidance.
- Ensure risks are accurately presented within local risk registers to allow quality and risk management.

Action the provider **SHOULD** take to improve

- Review methods for ensuring quality of records, including regular audits.
- Review contingency plans for medicines requiring refrigeration.
- Support staff to develop through training courses and further education.
- Review recording systems to ensure they support the delivery of effective care.
- Monitor waiting times of service users and review the appointment system to improve efficiency and reduce the time service users spend within the clinic.
- Consider further initiatives to engage young male service users with the service.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>12.—(1) Care and treatment must be provided in a safe way for service users.</p> <p>(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—</p> <p>(a) assessing the risk to health and safety of patients receiving care or treatment,</p> <p>(f) where equipment or medicines are supplied by the service provider, ensuring that there</p> <p>are sufficient quantities of these to ensure the safety of service users and to meet their</p> <p>needs;</p> <p>(g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.</p> <p>The service failed to meet this regulation because</p> <p>Level 3 sexual health services were not always referred to when a service user met the criteria.</p> <p>Sexual health screening pathways were not always in line with national guidance, or being utilised fully to ensure service users received the appropriate screening.</p> <p>Staff did not utilise personal protective equipment in line with Brook policy.</p> <p>Staff did not comply with infection control standards in line with Brook policy.</p> <p>There were no effective stock check and audit systems in place in relation to medicines.</p>

Requirement notices

Regulated activity

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

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

13.—(1) Service users must be protected from abuse and improper treatment in accordance with

this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of

service users.

(3) Systems and processes must be established and operated effectively to investigate,

immediately upon becoming aware of, any allegation or evidence of such abuse.

The service failed to meet this regulation because:

Only 61% of required staff had completed level 3 safeguarding children training.

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person,

in particular, to—

(a) assess, monitor and improve the quality and safety of the services provided in the

carrying on of the regulated activity (including the quality of the experience of service

users in receiving those services);

This section is primarily information for the provider

Requirement notices

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The service failed to meet this regulation because:

Local risk registers did not accurately reflect all key risks within the service.