The Brandon Centre

Quality Report

26 Prince of Wales Road
London
NW5 3LG
Tel:020 7267 4792
Website:www.brandon-centre.org.uk

Date of inspection visit: 14 and 15 November 2017
Date of publication: 08/02/2018

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

Overall summary

We do not currently rate community sexual health services.

The Brandon Centre provides contraception and sexual health services to young people aged 12 to 24 in the London Boroughs of Camden and Islington. We carried out an announced inspection of the service on 14 and 15 November 2017.

We found the following areas of good practice:

- The service demonstrated how learning took place from incident investigations, including from near misses and the review of individual cases.
- Staff understood and adhered to the principles of the duty of candour.
- We saw excellent safeguarding practices including multidisciplinary working and a rapid response for urgent safeguarding concerns.
- Staff achieved a balance between appropriate risk management and meeting the sexual health needs of young people who presented with complex or high-risk behavioural needs.
- Staffing was provided by an experienced and competent multidisciplinary team. Clinical staff practiced at other services and demonstrated their commitment for children and young people. The service had good systems in place to ensure continuity of care when patients were seen by different members of the team.
- The service ensured that when something goes wrong, young people received a sincere and timely apology. We saw that young people were told about any actions taken to improve processes to prevent the same happening again.
- Staff gave sufficient priority to the safeguarding of vulnerable adults, children and young people and focused on early identification.
- The service monitored patient outcomes regularly to improve care including treatment for sexually transmitted infections and care plans for pregnant patients.
- There were extensive opportunities for staff to undertake continuing multidisciplinary professional development and to progress in their clinical competencies. Each individual also had access to regular supervision and appraisal to support the effective delivery of care and treatment.
- Multidisciplinary working was embedded in practice and staff used a range of established links with social services, safeguarding teams and genitourinary medicine providers to ensure patients received coordinated care. We saw examples of excellent proactive work from clinicians when patients were under the care of multiple doctors in different specialties.
- The centre team invested considerable time and resources in developing health promotion

Summary of findings

interventions and strategies that met individual needs. This included highly individualised contraception, sex and sexual health advice for people based on their identity, experience and age. The service monitored outcomes from health promotion work and used this to further develop the service and identify unmet need.

- Staff used consent and mental capacity assessments in line with legislation and guidance for patients based on their age and level of need, such as the Fraser guidelines.
- Patient survey results and feedback from patients was consistently good and all of the patients we spoke with were passionate about the service. There was evidence of long-term care for patients and individuals frequently cited the individualised and confidential service as important factors in their decision to go there. Individuals gave examples of significant levels of support staff had provided that had improved their lives for the better.
- Staff recognised and respected the totality of young people's needs.The service adapted care and advice options to the changing needs of the patient population and local young people. This was an ongoing process and we saw substantial evidence the service was proactive in ensuring individual needs were understood and met.
- Staff used rapid access pathways and partner services to ensure patients who were vulnerable received coordinated care, including in urgent circumstances such as suspected sexual exploitation.
- Facilities and premises are appropriate for the services being delivered.
- There was a consistent, demonstrable focus on improving the service for patients and improving work processes for staff that paid attention to detail. The service ensured a consistent focus on this through structured clinical governance and a programme of meetings that enabled all staff were involved in the running of the service.
- The overall culture of the service was demonstrably passionate and positive and this was reflected in all elements of the operation.
- The leadership team was highly respected and demonstrated how they engaged with staff in the running of the service, including for development and improvement.

This was a dynamic service led by a motivated team of experienced specialists and professionals keen to develop their career in sexual health. The service went above and beyond the expectations of young people and meeting the needs of its local community.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health (sexual health services)		The Brandon Centre provides contraception and sexual health services to young people aged 12 to 24 in Camden and Islington.

Summary of findings

Contents

The Brandon Centre

Services we looked at
Community health (sexual health services)

Summary of this inspection

Background to The Brandon Centre

The Brandon Centre is commissioned by Camden and Islington Public Health along with two other providers as part of the Camden and Islington Young People and Sexual Health Network (CAMISH) to deliver level one and level two contraception and sexual health services (CaSH) to people aged 12 to 24 in Camden and Islington. As a level 2 CaSH service, The Brandon Centre provided contraception, asymptomatic screening, treatment for sexually transmitted infections and prescriptions and health promotion.

The Department of Health national strategy for sexual health and HIV defines the three levels of service, including levels of sexually transmitted infection (STI) management. Levels increase in the scope of complexity and range of care from basic advice at level 1 to testing and treatment at level 3.

The service also provided:

- Outreach and sex and relationship education (SRE) services to secondary schools and colleges.
- Delivery of the national 'c-card' programme, which aims to improve young people's use of condoms and safer sex practices. This involved providing condoms and self-test kits for sexually transmitted infections.
- A workforce development specialism that delivers training to the children's workforce to ensure they are competent in supporting young people with SRE.

Psychotherapy and counselling services were provided on the same premises. Although our inspection did not include these services as they are not regulated by CQC, we spoke with staff to gain a better understanding of the patient journey and experience.

In the period of October 2016 and September 2017, the service saw 3120 patients and delivered 4183 individual appointments.

We last inspected the service in August 2013 and found it to be compliant with all the fundamental standards we inspected.

There was a registered manager in post.

Our inspection team

The team that inspected the service comprised two CQC inspectors with clinical experience in sexual health and children and young people services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive sexual health inspection programme.

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 the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- Spoke with 18 members of staff across all roles including clinical, administrative and managerial staff. This included GPs, nurses, the sexual health support team, the reception team and sex and relationship education (SRE) facilitators. We also spoke with the organisation's senior leadership team and staff who provide services for the psychology and psychosexual service in the same building.
- Spoke with three patients who used the service.
- Observed interactions between staff and patients.
- Looked at 10 care and treatment records of patients.
- Looked at 12 risk assessments for patients under the age of 18.
- Reviewed the medicines management procedures, including storage and administration.
- Looked at a range of policies, procedures and other documents relating to the running of the service. This included incident and complaint investigations and risk management documents.

What people who use the service say

We spoke with three people who used the service and looked at the feedback gathered through the team's engagement work. Overall people were very positive about the service and a number of people remained with the service for several years or until they passed the maximum age the service was commissioned to provide care for.

People said they appreciated the 'community feel' of the service and said it was a significant factor when choosing where to go for their sexual health and care needs. Young people in particular said the non-clinical and non-corporate image, environment and branding of the service was important to them.

Common themes in our discussions with young people were trust in the staff and a reliance on them to be unfailingly friendly, non-judgemental and able to provide advice in an appropriate context.

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?

- An incident reporting system was embedded in the service and staff demonstrated how this contributed to safer standards of care and practice.
- Effective infection control audits were in place and had demonstrably led to improved practice and environmental maintenance.
- Safeguarding was a priority for the whole team, which was evident in our review of clinical governance processes and in the practice of staff.
- Staff achieved a balance between appropriate risk management and meeting the sexual health needs of young people who presented with complex or high-risk behavioural needs.
- Staffing was provided by an experienced multidisciplinary team. Clinical staff practiced at other services and demonstrated their commitment for children and young people. The service had seamless systems in place to ensure continuity of care when patients were seen by different members of the team.
- A mandatory training programme ensured staff met the needs of patients and the service manager maintained oversight of this.

Are services effective?

- People's care and treatment was evidence-based against national guidance from appropriate organisations including the British Association of Sexual Health and HIV, the British HIV Association and the Faculty of Reproductive and Sexual Health.
- Staff had established working links with a range of multidisciplinary professionals that enabled them to refer patients to other specialties. We saw examples that these relationships resulted in better patient outcomes, including through the use of internal referral pathways to the counselling and psychotherapy service.
- The service monitored patient outcomes including treatment for sexually transmitted infections and care plans for pregnant patients'. This information was used to improve and develop services.
- The service had a track record of 100% success in initiating partner notifications for patients who received a positive test

result for a sexually transmitted infection. The completion rate consistently met national standards. This meant the risk of onward infection from each person's sexual network was decreased.
- Staff provided sexual health promotion information to patients to help them also look after the health of their partner(s). This included providing young men with information on female sexual health and vice versa.
- Significant focus was placed on developing staff competencies and professional practice and each individual underwent regular supervision and appraisal. Learning opportunities were multidisciplinary and the service manager facilitated an annual away day for staff to access the professional expertise of other clinicians.
- Health promotion formed a significant element of the service and staff delivered this in line with the latest national guidance and tailored to each individual. Outcomes were monitored for further service development.

Are services caring?

- The service promoted open and honest feedback from people who used the service and used this to identify areas of good practice and for improvement.
- In the patient survey carried out between April 2016 and June 2017, 100% of respondents described their care as very good. They also rated dignity and respect highly.
- Feedback from patients was unwaveringly positive. Frequent comments about the service cited individual service, a non-judgemental attitude from staff and accessibility.
- Patients gave examples of how staff involved them in their care and provided emotional support when needed. This had led to word-of-mouth recommendations amongst the young people in the local area.

Are services responsive?

- The organisation demonstrated adaptability to meet the increasingly complex needs of local young people. This included through service reconfiguration, the implementation of more streamlined teams and significant partnership working.
- Staff had developed communication techniques to help them more effectively and efficiently understand the needs of individuals.
- Staff delivered services with recognition of the principles of equality and diversity and patients said they felt they were never judged.

Summary of this inspection

- Young people had contributed significantly to service development to ensure it continued to meet their needs, particularly through a period of challenge when a substantive local service closed.
- Systems were in place to ensure patients who were vulnerable received appropriate care that were coordinated by local teams such as safeguarding and mental health. Staff used rapid access care pathways where they suspected domestic violence or sexual exploitation.
- Patients could access the service on a pre-booked or walk-in basis and the senior team had reconfigured the service to meet the demands of increasingly complex needs and the overall 11% increase in young people in 2017.
- In 2017, the service cancelled 15 clinics due to late-notice of non-availability of staff. In each instance a member of staff contacted the affected young person to find out if a service could be provided without clinical input, such as free condoms. All young person were offered another appointment and signposted to the next most appropriate service in the case of urgent need.

Are services well-led?

- The service manager had improved clinical governance systems in 2017 and we saw a positive track record of performance and quality review and improvement.
- The leadership structure was stable and coherent and all of the staff we spoke with were positive about this.
- The service had developed a service charter with young people to establish expectations and minimum standards.
- The senior team with their counterparts in the psychotherapy service met regularly to ensure decision-making was completed with all service users in mind.
- The senior team placed value on the work-life balance of staff and ensured support was in place for any circumstances that added pressure to the team.
- Engagement with young people who used the service and the local community was embedded in practice and the entire team demonstrated how this contributed to development and improvement. This was also evident in the decoration of the environment, staff approach to communication and the types of appointments offered.

Detailed findings from this inspection

Notes

We do not currently rate community health (sexual health services).

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health (sexual health services) safe?

Incident reporting, learning and improvement

- The senior team used a clinical governance system to manage and review safety performance.
- In the year leading to our inspection the service reported no incidents that resulted in harm to a patient and no never events. . Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The Brandon Centre had policies and procedures that guided staff on the reporting of any incidents or concerns, investigation and learning procedures. These policies and procedures were available in hard copy for staff. We saw that staff were confident in reporting incidents and there was a learning culture within the service.
- The service reported 15 incidents for the period of January 2017 and November 2017. Of these seven were clinical incidents, four were related to information or communication; two related to thefts, one was an incident of verbal abuse and one related to an insurance issue. We looked at the investigations and outcomes for each incident. We found the senior team had identified the level of severity in each case according to their risk assessment tool and took appropriate action as a result. In addition, a senior member of staff had documented the action taken and identified learning. For example when a person left the clinic shortly after undergoing a contraceptive procedure and fainted, staff reviewed the clinical policy to conduct a visual assessment of each patient and ensure they remained in the clinic for at least 15 minutes after the procedure. This incident did not result in patient harm.
- The electronic incident reporting system was also effective when staff used it during outreach sessions in colleges or the community. For example staff reported an incident when four screening samples were completed during an outreach session but did not have the name or date of birth of the person on the label. This meant the laboratory could not process them and the people who submitted samples could not be contacted. As a result, the service manager reviewed remote screening policies and worked with staff to embed a more consistent approach.
- All members of the team were trained to use the incident reporting system and said they felt confident in using the system.
- Staff told us the service manager always provided feedback after an incident investigation and they felt there was consistent feedback from the senior team.
- We saw evidence staff were proactive in identifying contributing causes to incidents and working to reduce future risk. For example a recent incident involved the loss of samples sent to a laboratory for screening. The clinical lead liaised with the laboratory manager and the lead microbiologist and identified a change in documentation procedures in the laboratory contributed to this. As a result, the laboratory and the service agreed a new test-ordering system and the laboratory manager reported this as a significant incident on their own reporting system.
- Following an incident in which a group of young people caused service disruption through inappropriate behaviour in the waiting area, the service manager mandated conflict resolution training for all staff. In addition staff changed the c-card policy, related to the national condom scheme, which meant they saw new patients on a one-to-one basis for their first consultation.

Duty of Candour

Community health (sexual health services)

- 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) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. All of the staff we spoke with demonstrated an understanding of the principles of the duty of candour, including being open and honest with patients.
- We saw evidence that when things went wrong staff were open and honest with people who used the service and offered an explanation. The service manager or other member of the senior team communicated with patients following the outcome of an incident or complaint investigation.

Safeguarding

- Staff completed safeguarding children and young people training to the level appropriate to their role. At the time of our inspection, 88% of staff had up to date training in safeguarding level 1 and level 2 and while 73% of staff had up to date level 3 safeguarding. This did not meet the target of 100% and reflected new members of the team who were due to undertake training.
- Staff maintained regular contact with local safeguarding and mental health coordinators who also facilitated police liaison if needed.
- Staff were competent in the use of referral pathways and each individual was able to show us how they would use them in practice. This included in cases of sexual assault and female genital mutilation (FGM). In the previous 12 months the service had made one formal safeguarding referral.
- An in-house safeguarding committee met monthly and the clinical lead attended a six-weekly safeguarding group with members of the Camden and Islington Young People and Sexual Health Network (CAMISH). The service manager attended monthly meetings with the Camden multi agency sexual exploitation panel (MASE).
- The clinical lead held a monthly safeguarding meeting to review patients who were under the care of local authority safeguarding teams or young people they had identified as vulnerable.
- All staff working in the service, regardless of patient contact, had an up to date Disclosure Barring Service (DBS) certificate. Management used DBS check to ensure that staff are fit and proper to work with children and young people
- All clinical staff were trained in the use of Fraser guidelines and documented use of this for all patients under the age of 16. Fraser competent is a term used to describe a child under 16 who is considered to be of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge or consent.
- Staff used a discreet colour-coded sticker on each patient's file to identify if they had known safeguarding needs. This meant clinical staff could prepare in advance if a patient had a pre-booked appointment.
- Clinical staff from the sexual health service worked with their colleagues in psychotherapy to coordinate care of patients who had safeguarding needs. For example if a young person was seen in the sexual health service who had complex social needs, staff from both teams would coordinate care with social services and child protection teams.

Medicines

- Staff managed medicines appropriately. This included the storage, stock control and disposal of medicines. A member of staff recorded the temperature of the medicines room and medicines fridge every day to ensure it remained within the manufacturer's safe limits.
- Prescribing staff issued medicines directly from the clinic and kept a central log of these. The clinical lead included prescriptions and medicine administration in their weekly records audit. In the three months prior to our inspection the clinical lead noted 100% compliance with centre standards. This included checks of documented allergies whenever medicine was administered.
- During the period between January 2017 and December 2017 the service reported two incidents relating to medicines. One incident involved a period of persistently hot weather in which the storage environment exceeded the safe maximum recommended by the medicines manufacturers. In response the clinical lead liaised with a pharmacy consultant to ensure it was safe to continue using the medicines. The service additionally purchased a cooling unit for the room and implemented a stock rotation system that ensured all affected medicines would be used within six months. The second incident involved a prescribing error. No harm came to the patient and the clinical lead worked with a pharmacy consultant to review the prescribing process.

Community health (sexual health services)

Environment and equipment

- The organisation adhered to the principles of the Control of Substances Hazardous to Health Regulations (2002) (COSHH) including in the safe storage and disposal of hazardous substances. We saw staff used safe processes to store and dispose of hazardous waste. In addition, 77% of staff had up to date COSHH training, which was lower than centre's standard of 100%.
- The service manager maintained an up to date record of premises safety checks including fire detection and alarm systems, panic alarms and gas safety. All 14 routine checks were up to date at the time of our inspection.
- The premises were well maintained and fit for purpose, including through fire and emergency systems and management of clinical areas. All electrical equipment in clinical areas and other areas used for patients had a current portable appliance test (PAT).

Quality of records

- The clinical lead carried out audits on a sample of patients' notes written by other clinicians. This took place within one month of a new clinician starting and every six months for other clinicians. This was a quality and safety audit to assess the appropriateness of examinations, advice and the quality of documentation. Also, the clinical lead carried out a three monthly audit of a sample of 20 risk assessments carried out for patients under 18 years to check compliance with the Fraser guidelines. We looked at the results of audits for the previous six months and found there had been 100% compliance.
- Between October 2016 and November 2017, 90% of the risk assessments completed for patients under the age of 18 met the organisation's standards.
- We looked at 10 patient records. In each case staff had completed details of allergies, the tests carried out and evidence of a discussion about speaking with the patient's partner(s) as well as a discussion of alcohol and drug use. Staff had legibly signed and dated each record, which meant clinicians could more easily identify who completed notes in case of future queries or appointments. Clinical records met the requirements of the Faculty of Sexual and Reproductive Healthcare (FSRH) clinical standards for record keeping.
- A system was in place to ensure the records of patients seen remotely outside of the clinic were stored securely.

Cleanliness, infection control and hygiene

- We observed staff used appropriate personal protective equipment and practised effective hand hygiene and infection control when examining patients and in between appointments.
- All areas of the environment were clean, tidy and hygienic.
- Staff practised infection control in line with the organisation's policy, which was in date and had recently been updated to reflect changes in local health protection team recommended practice. The policy was evidence-based and followed the guidance of the Hazardous Waste (England and Wales) Regulations 2005 and the Department of Health Technical Memorandum 07-01 in relation to waste disposal.
- The centre manager normally carried out an infection control audit every six months to assess practice against the organisation's policies. This included observations and spot-checks of clinical practice, the overall environment, waste disposal, clinical equipment, handwashing technique and sharps handling and disposal. The most recent audits indicated overall improvement. For example in March 2017, the audit score was 93% and in May 2017 the result showed this had improved to 98%. These were average scores and reflected consistent 100% compliance with waste disposal and clinical equipment and scores varying from 81% for infection control management in March 2017 to 94% for handwashing in both audits. The manager carried out the May 2017 audit as an additional assessment to check on improvements recommended from the March report.
- The service had a variety of water hygiene risk assessments in place to monitor safety, including for legionella and water heater testing. We looked at all of the latest test results and found 100% compliance with expected safety standards. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

Mandatory training

- The centre had a programme of 14 mandatory training modules for all staff and an additional seven modules for staff with specialist roles. Training was delivered through a blended learning approach of online training and face-to-face training. Overall compliance with

mandatory training was 75%. This reflected recent new members of the team and the service manager had scheduled training dates for all staff due for refresher or new training.

- The range of training provided was appropriate for both the patient group and the types of services provided. For example staff were required to take training in child sexual exploitation, female genital mutilation (FGM), prevent radicalisation and domestic violence awareness. In November 2017, 57% of staff had up to date training in these four subjects.
- GPs and nurses completed most training with their main employer and the service manager at the Brandon Centre monitored this to ensure it was up to date and the content met the centre's needs. The senior team provided additional training whenever needed.

Assessing and responding to patient risk

- All GPs and two nurses held up to date training in cardiopulmonary resuscitation (CPR) and anaphylaxis. All clinical staff held up to date first aid training.
- All staff who saw patients were trained in the escalation of urgent or emergency cases of safeguarding, domestic violence, sexual exploitation and suspected radicalisation.
- An anaphylaxis kit was available in the main clinical room and signs to the location were posted in other areas. The kit included life-saving medicines, which the clinical lead ensured were up to date.
- Staff carried out a risk assessment for all patients who attended the clinic under the age of 18. They used this to identify any risks in relation to safeguarding or sexual health specific to young people. We looked at a sample of seven risk assessments and found them all to be fully completed with documented consent to care, a capacity assessment, completion of the Fraser guidelines checklist and details of other professionals involved in their care.
- The clinical lead and safeguarding lead provided an on-call service for staff at all times the centre was open.

Staffing levels and caseload

- A team of 18 staff led sexual health and contraception services at the Brandon Centre. Three GPs and three specialist nurses provided clinical care and four sexual health support workers provided one-to-one patient support. The clinical lead was a GP and two other GPs were in practice elsewhere and provided weekly clinics. Nurses were in post in acute hospitals and provided weekly scheduled clinics in the centre.
- The clinical lead provided 17.5 hours over two clinics each week. Other GPs and nurses provided services over six days from Monday to Saturday. Clinical staff did not maintain their own caseloads and instead provided services as-needed to patients.
- A sexual health support worker (SHSW) was on site at all times the centre was open. When clinics were in session, two SHSWs were on shift to ensure patients who attended for the drop-in service could be triaged and seen.

Managing anticipated risks

- A fire warden and first aid staff were on shift at all times the centre was open.
- Access to the centre was controlled through a security system and the number of people in the centre at any one time was monitored by the reception team.
- Patient records were stored in locked, fire-proof cabinets.
- The centre had a major incident and business continuity plan. This was up to date and the service manager reviewed it annually. Staff knew who was in charge of the building and service at any given time and were able to explain their responsibilities in the event of an evacuation. The business continuity plan ensured patients could be seen by other services in the network and information will be posted to the website and recorded on the telephone in the event the building became uninhabitable.

Are community health (sexual health services) effective?

(for example, treatment is effective)

Evidence based care and treatment

- The service was part of the Camden and Islington Young Person's Network (CAMISH). This enabled the service to deliver care benchmarked by the standards of a multi-provider network and to offer a wider range of

specialist services. This also meant staff had access to learning and resources from partner organisations, which they used to deliver more specialised and knowledgeable care.
- Staff delivered care and treatment in line with national guidance from the British Association of Sexual Health and HIV (BASHH). For example, risk assessments used for patients under 18 years of age were based on BASHH templates.
- Links to guidance from the Faculty of Sexual and Reproductive Healthcare (FSRH), the National Institute for Health and Care Excellence (NICE) and the British HIV Association (BHIVA) were available on desktop computers and a process was in place to ensure the most up to date guidance was always available.
- The service had identified evidence-based and outcome-focused practice as core elements of the mission. This included applying evidence to the desired outcomes young people identified themselves.

Technology and telemedicine

- Clinicians and sexual health support workers provided on-demand support and guidance to patients who accessed the service by phone.
- The Brandon Centre website provided straightforward access to sexual health and contraception information for young people as well as signposting to other services. People who used the service had contributed to the design of the website to ensure it promoted access and was understandable.
- The service planned to introduce electronic patient records in 2018.

Patient outcomes

- The clinical team monitored and benchmarked treatment delivered to patients as part of the Camden and Islington Young Person's Network (CAMISH) network. Between October 2016 and September 2017 the service:
  - Provided 329 long-acting reversible contraception (LARC) procedures
  - Provided care and treatment for the 17% of patients who received a positive test result for and STI or HIV
  - Provided 218 courses of treatment for chlamydia and gonorrhoea
  - Carried out 789 pregnancy tests of which less than 0.5% resulted in referral to a termination of pregnancy service
- Staff used a confidential partner notification system when a patient received a positive test result. This meant they could contact the sexual partners of patients to encourage them to undertake screening themselves to prevent the onward transmission of infections. Between October 2016 and September 2017, the service initiated partner notification within four weeks of a test result in 100% of cases.
- The service had seen an increase in the number of patients who required swabs that could not currently be provided such as rectal swabs. This meant a clinician provided as much treatment as possible and then referred the patient to another service.
- Clinical staff proactively and opportunistically provided patients with contraceptive advice to help improve the health outcomes of their sexual partners. For example staff provided male patients with information on the contraceptive pill and female patients with guidance on how to fit a condom. Staff used this strategy to provide holistic care to drive an overall improvement in sexual health and knowledge.
- Clinical staff had improved the follow-up system so that patients received more consistent contact after test results or after a procedure that affected their sexual or reproductive help.
- The sexual health support team saw 75% of patients for follow-up after termination of pregnancy provided elsewhere and results management for sexual health and HIV testing.

Competent staff

- All staff currently working in the service had completed an induction, which they told us was useful and helped them to understand the ethos of the service.
- A system was in place to ensure all clinical staff received appropriate clinical and safeguarding supervision and competency monitoring. For example, the clinical lead provided supervision for all clinicians in the service and an external doctor provided supervision for the clinical lead.
- The sexual health support team had group supervision sessions each month. The team used this to carry out case reviews of patients with complex cases to ensure

the team could effectively coordinate their care. The service manager carried out monthly supervisions with each member of the sexual health support worker team and the administration team.

- As GPs and nurses worked primarily in other acute or primary care services, the clinical lead and sexual health manager maintained a record of clinical competency checks and certification. For example all GPs and one nurse held competencies in contraceptive implants and all three nurses held prescribing qualifications.
- Staff had access to specialist training every three months as part of their arrangement with the CAMISH network. This had previously included providing care for patients with disabilities, those with mental health needs and young people who used recreational drugs.
- The clinical lead carried out an annual appraisal with each GP and nurse who worked in the service.
- Staff attended an annual continuing professional development away day that provide the whole team with access to specialist training. Most recently this involved training from a psycho-pharmacologist and a visit to the Royal College of Physicians to ensure their practice met the latest best practice guidance.
- The service supported clinical staff to develop their own professional projects and to attend national conferences relevant to their role, including the annual BASHH conference and those offered by the FSRH. Sexual health support workers told us they were paired with clinicians who worked in an area they were interested in, such as contraception, so they could develop their skills in that area.
- The clinical lead carried out a clinical observation and a one-to-one supervision with all new nurses or GPs to ensure their practice met the service's standards.
- Staff came to work in the service from a wide range of background working with young people. For example sexual health support workers had experience volunteering in young people's services, working with young people aged 14 or under who became pregnant and working with young people to reduce the risk of gun crime. Staff described this as an asset to the service and said it meant they provided clinics that built on the strengths and experiences of each individual.
- Staff had access to training with colleagues from the psychotherapy service. This included child safeguarding and child sexual exploitation. Staff in the psychotherapy service were completing continuing professional development in gender identity and would provide peer training to the sexual health team upon completion.

Multi-disciplinary working and coordinated care pathways

- Clinical staff and sexual health support workers noted an increase in the needs and complexity of patients presenting in the service. This coincided with the closure of a nearby level 3 genitourinary medicine (GUM) service in 2016 that provided more complex treatment. As a result, the team liaised with level 3 services elsewhere in London, including a walk-in service for young people under the age of 16.
- Clinical staff demonstrated a proactive approach to multidisciplinary working across services. For example when one patient disclosed sexual activity following a high-risk transplant, the clinical lead contacted the patient's transplant consultant to discuss how best to offer contraception advice. The clinical lead also shared information, with the patient's consent; about medicines they were prescribed to ensure there were no counter-indications.
- Staff used in-house referral pathways to enable patients to have rapid access to counsellors and psychotherapists. For example when a patient had presented with support needs following a termination of pregnancy, a clinician was able to refer them to a counsellor the same day. The sexual health and psychotherapy services were in the same building and staff from both services were able to refer patients the same day to each other. This meant if a patient attended for a sexual health appointment and the clinician identified benefit to them of accessing psychotherapy, they could make an immediate referral. This meant patients had access to a wider range of support from professionals in both services, such as when patients presented with sexual health needs and would also benefit from gender identity counselling.
- Staff worked closely with social workers and local authority teams to coordinate care. This included holistic care when patients were known to multiple services such as primary care, safeguarding and community medical teams.

Referral, transfer, discharge and transition

Community health (sexual health services)

- Staff used referral pathways for patients who needed level 3 GUM care, which meant patients who had more complex treatment or diagnostic needs were referred to the nearest level 3 clinic. Staff coordinated care with health advisors in other clinics where needed and also provided care to patients when they came back to the centre on completion of level 3 treatment. Staff used a standard CAMISH referral form to ensure consistency amongst local services.
- Between October 2016 and September 2017, the service referred 14 patients to GUM services.
- Staff worked with the Camden MASH team to coordinate care for young people with complex needs, including safeguarding, mental health and domestic support needs.
- Where patients were known to social services or under the care of the community mental health or safeguarding teams, Brandon Centre staff worked collaboratively during their transition between services. This meant staff met the patients with their family support worker or social worker to help them identify the ongoing support they might need.

Access to information

- Sexual health case notes were confidential and staff shared these with GPs or the psychotherapy service only with the patient's consent.
- Where staff referred patients to level 3 GUM services, their information was only shared if clinically necessary and if the patient had given consent.
- When patients passed the maximum age limit of the service, staff worked with them to identify other suitable services. This included transferring clinical notes with the patient's consent.

Health promotion

- Between October 2016 and September 2017, 29% of patients attended the service for health promotion advice and information. In the same period, 45% of patients received free condoms, of which 44% were part of the national c-card programme.
- There was a demonstrable focus on health promotion in all elements of the centre's work. The team demonstrated adaptability in providing health promotion tailored to the needs of individuals and patient groups. For example to meet the needs of a recent increase in men who have sex with men (MSM) attending the service, clinical staff provided advice on post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) and then signposted the patient to the nearest clinic that could provide these. PEP and PrEP refer to anti-retroviral medicines prescribed after an HIV exposure or to prevent future infection.
- Patients gave positive feedback about their experience of health promotion in the centre. For example one patient said they had improved their use of contraception and quit smoking as a result of their health promotion information received. Patients also said they were pleased with the number of options staff helped them to understand in terms of sexual health.
- A dedicated outreach and c-card coordinator provided sex and relationship education (SRE),health promotion and education to all patients on demand or where clinical staff identified an unmet risk. For example where patients disclosed they did not routinely practice protected sex, staff would discuss the infection risks around this. The sexual health support worker team lead delivered SRE in local secondary schools as part of a strategy to improve sexual health knowledge amongst young people before they became sexually active.
- The sexual health support team had collaborated with the CAMISH network to make a video for young people on accessing sexual health services in the local area.
- Clinical staff provided health promotion signposting on an opportunistic basis, such as for patients who smoked or used recreational drugs.
- Health promotion information and advice was available for patients who identified as lesbian, gay, bisexual or transgender (LGBT). The service manager planned to introduce training for providing sexual health services to LGBT people in the near future to ensure staff practiced to the latest national guidance.
- It was clear from our discussions with the sexual health support team they had a good understanding of the wider health needs of patients. For example the team told us the health education needs they came across most often related to substance misuses, risky sexual practices and family issues. The team ensured they maintained up to date information on local and national services for effective signposting. One support worker said, "It's about myth-busting and calming people down and just helping them with the things they might be really stressed about. People get bad advice from the internet and their friends so we need to make sure we are accurate and consistent."

Community health (sexual health services)

- Staff utilised the capability of network partners to provide health promotion in areas other than sexual health, such as for healthy eating and alcohol management.
- People we spoke with said the service's focus on health promotion was important to them. One person said, "They [the team] make sex feel normal. Which it should be but other services I know don't go out of their way to give advice and guidance you can understand and that helps you to make your own choices." Another person said, "I wanted contraception advice and they gave it to me. Straightforward facts taking into account my sexual practices and no judgement. That's exactly what I wanted."

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- All staff were required to complete Mental Capacity Act (2005) training. At the time of our inspection 72% of staff were up to date with this.
- Staff asked each patient for consent to share care and treatment information with their GP. This was not necessary to obtain treatment but meant staff could refer patients for treatment that could only be provided by their GP, such as colposcopy.
- Clinical staff completed a capacity assessment, Fraser guidelines checklist and consent to care record for each patient who was under the age of 18.

Are community health (sexual health services) caring?

Compassionate care

- In the patient survey carried out between April 2016 and June 2017, 100% of respondents said the following statements were certainly true:
  - The people who saw me listened to me
  - I was treated with respect and dignity
  - Young people who are under 16 years old would feel safe coming here
  - If a friend needed this sort of help, I would recommend that they come here
  - Overall I feel the care I have received here is very good
- We observed interactions between staff and patients during our inspection. In all instances we saw staff spoke to people in a way important to them. For example they moved between formal and informal communication depending on how well they knew they person. Staff showed compassion and kindness in all interactions. During our conversations staff demonstrated their understanding of kindness and how to speak to people with sensitivity and appropriately based on their age. For example staff understand the differences in how young people approached the subject of sex and how to discuss this with them sensitively and respecting their knowledge and use of specific vocabulary.
- We spoke with a patient who said, "I've found them super supportive and reassuring. I've had difficult times and they've never judged me. I always see the same doctor; there's a human connection here you don't get in other clinics. I can't tell you what it means to have this support."
- Patients described a focus on confidentiality and privacy from staff. For example one patient said, "When they come to get you in the waiting room they don't just shout out your name. They're very discreet and I think that's important."

Understanding and involvement of patients and those close to them

- The senior team said they consistently received positive feedback from patients about the approachability of the reception team. They said patients appreciated the team's discretion and their understanding of the need for sensitivity when scheduling appointments, such as when asking the patient information about their sexual health.
- In the patient survey, 92% of patients said they were as involved as they wanted to be in decisions about their care.
- A patient said, "It's not just my [medical] needs they're good with. When I come in with my buggy the receptionist jumps up to help me. The whole team have this really strong focus on understanding what you need."
- Patients told us they felt the care provided was consistent. One patient said, "The doctors seem to want to build a relationship with you. This has been a great comfort, especially as I've needed long term care."
- Staff facilitated an atmosphere of positivity for young people and focused on reducing barriers they experience in exploring sexual health.

Community health (sexual health services)

- One patient said, "I used to go to my local chemist for the morning after pill but they were incredibly judgemental. A friend told me to come here and I've been here ever since. I like being able to choose a female [member of staff] and I like that they'll always listen if you have questions or need advice."
- One patient said, "They always explain who I need to see and why. It's never just a case of telling you; they always make sure you understand."
- Staff we spoke with demonstrated their ability to adapt communication techniques to the individual needs of patients. For example, SHSWs said they noticed young people approached communication about sexual health in different ways and so they had adapted how they spoke with them to get information that would help care and treatment. For example one SHSW said, "Each patient presents differently. Young people tend to approach a problem without directly talking about it to start with. Quite often the first time they're experiencing something they come to us to talk about it so it's essential we are good listeners and can interpret what they're saying."

Emotional support

- All clinical staff were trained to provide emotional support to patients, such as if they received a positive test result for a sexually transmitted infection or unplanned pregnancy. Clinical staff were also trained in post-test counselling when a patient received a positive test result for HIV. Where staff were unable to meet the emotional needs of patients they referred them to the in-house psychotherapy and counselling service.
- Emotional care formed part of the service's vision and staff demonstrated how this was embedded into all levels of practice.
- Patients told us they felt the service met their emotional needs. One patient said, "Especially when I was a teenager they always seemed to know the right thing to say. I always felt that I was coming somewhere that the staff really cared." Another patient said, "I'll soon be too old to keep coming here and I'm really not looking forward to going to another service, they've always taken such good care of me here."
- Patients said they felt staff offered positive emotional support. One patient said, "Doing a pregnancy test here was really nerve-wracking but I know I'm in the best hands and shouldn't have worried."
- Patients told us they felt favourably about the support staff provided at this service compared with others they had used. For example one patient said, "A doctor here referred me to a specialist, who was rude and made me very upset. I came back and they found someone else for me to go to and just made me feel better about the whole thing."

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

Planning and delivering services which meet people's needs

- The organisation delivered a seamless service between sexual health and counselling and psychotherapy services. For example patients seen by clinicians or support workers in sexual health could be referred directly to a psychologist.
- The senior team had developed the crossover between services to meet the increasingly complex sexual health needs of the young people they served. For example sexual health staff identified a need to provide rapid access to specialist therapy without the need to send the patient to another provider if possible.
- The service was developing direct partnerships with local schools to embed sex and relationship education as an opportunity to improve education and health outcomes. We spoke with staff about this and one individual said, "We need to keep playing a role in the local community and make sure services for young people don't evaporate."
- The service demonstrated flexibility and the ability to adapt to meet changing demand. For example the sexual health support worker (SHSW) team transitioned from being partially responsible for administration into full patient services in 2017. A dedicated administration and reception team was recruited as part of this reconfiguration to ensure a well-defined organisation of teams.
- The closure of a local level 3 genitourinary medicine (GUM) clinic meant the centre saw an increasingly diverse group of patients with more complex needs, such as men who have sex with men (MSM). The team had adapted to meet their needs but were restricted with the range of clinical practices they could carry out.

For example it is recommended that MSM are vaccinated against hepatitis B but the service could not provide this. Instead staff ensured patients had accurate and timely signposting to help them access appropriate services.

- A nurse said, "This is a brilliant place for young people. They have time and space to explore sexual health and they always seem very grateful for that." Another member of staff said, "Putting patients at the centre of everything we do. Every meeting, every patient record we look at is always about putting the patient first and looking at how we can improve their experience."

Equality and diversity

- Staff at all levels of the organisation demonstrated how they embedded the principles of equality, diversity and inclusion into service delivery. This included through involving young people systematically in service developed and redesign. For example sexual health support workers had worked with young people to design a photovoice project as a strategy to express themselves and develop self-identity and build personal and emotional resilience.
- Patients consistently said they felt treated as an individual and without judgement from staff, regardless of their personal identity or sexual practices.
- Equality and diversity training was a mandatory part of the organisation's staff training plan. At the time of our inspection 83% of staff had up to date training.

Meeting the needs of people in vulnerable circumstances

- Staff offered each patient who needed an intimate examination a chaperone. Posters in clinical and waiting areas provided information on the service and we saw staff documented the patent's decision in their notes. All staff who acted as a chaperone had undergone training.
- Accessibility was a key element of the service's mission and included the requirement that young people shape the service. We saw this happened in all elements of the service.
- The service had a policy of not turning away anyone who was vulnerable even if they fell below the minimum age limit of the service. For example if a young person under the age of 12 presented in the clinic, staff worked with the safeguarding lead and local safeguarding team to address any immediate care needs and then structure a care plan for the patient.
- Where staff had a concern about safeguarding or a patient presented at a walk-in clinic with pain, they were always seen on the day even if all of the available slots were taken.
- The service had established links with a number of specialist local services to ensure patients who were vulnerable could be seen urgently. For example where staff suspected child sexual exploitation, they referred to a local agency that maintained a register of vulnerable children. In addition where staff saw patients who presented with risks associated with mental health, alcohol or drugs misuse or domestic violence, they referred them on the same day to the appropriate support service.
- Staff had access to a telephone interpretation service when a patient was unable to communicate in English.
- The premises had been adapted to meet the needs of patients with limited mobility, included level access from the street to treatment rooms and toilets.

Access to the right care at the right time

- The service offered clinician-led appointments that were bookable in advance as well as on-the-day appointments and a walk-in service. Sexual health support workers triaged walk-in patients to ensure the most appropriate clinician saw them. Patients could self-refer to the service or be referred by their GP or other health professional. Clinicians provided 38 clinical hours per week and client support workers provided a combined total of 68 hours of clinical time per week.
- Between September 2016 and October 2017 the service:
  - Delivered 392 hormonal emergency contraception appointments
  - Completed a chlamydia screening for 55% of patients
  - Completed a full STI and HIV screening for 10% of patients
  - Provided 306 point of care HIV tests
- In 2017 the service had recorded an 11% increase in patients seeking sexual health services since the closure of a nearby level 3 GUM service 12 months previously. We saw this had added significant pressure to the team. For example in July 2017 the service manager closed the walk-in service for one day to enable staff to catch up on administration and clinical notes that had been generated by increased demand. We saw from looking

at clinical governance documentation the senior team were addressing this appropriately, including through service reconfiguration, liaison with the clinical commissioning group and with network partners.

- In the patient survey carried out between April 2016 and June 2017, patients responded variably about the ease of getting appointments. However, all of the people we spoke with during our inspection spoke positively about access to the service, including for the walk-in service.
- Clinics were offered by GPs and nurses whose substantive posts were in other organisations. This meant if a clinician was unavailable due to unforeseen circumstances, cover could often not be provided. Between January 2017 and November 2017, the service cancelled 15 clinics due to non-availability of staff. Where this happened, staff contacted each booked patient to find out if there was anything they could still offer. For example sexual health support staff could provide point of care testing for HIV, STI screening where the patient did not have symptoms and condoms.
- Patients spoke positively about their experiences of accessing the service. One patient said, "It's a very efficient service. I always get a text message reminder about my appointment. And when I phone to book an appointment if they can't sort it on the phone there and then they always call back. I've never had a cancelled or rescheduled appointment and they're almost always on time."
- A new receptionist role had been created to enable sexual health support workers to dedicate all of their time to patient contact. The new receptionists were being trained in chaperone duties and had been trained in the c-card scheme and basic health promotion for patients over 18 years of age. This meant patients could attend on a drop-in basis and the receptionist could give them condoms and an STI home screening kit, which reduced the need to wait for a clinician.
- All clinical staff supported patients with telephone advice whenever they were in clinic, such as when patients phoned for advice on missed medicines or symptoms.
- Clinical staff used seamless processes to refer patients to colleagues for follow-up or further review. For example if a GP saw a patient in the Friday afternoon walk-in clinic, they could arrange a follow-up appointment with a colleague the following week while the patient was with them. This meant patients did not need to wait for confirmation times or to join a waiting list.

Learning from complaints and concerns

- The complaints procedure was clearly displayed in the reception and waiting areas and on the service's website. Patients or visitors could make complaints in person, by phone, online or by e-mail.
- Complaints training was part of the service's mandatory training, including for staff who worked in the clinic once each week. At the time of our inspection, 94% of staff had up to date training.
- In the year prior to our inspection the service had received one formal complaint. This related to a data breach and we saw evidence the senior team had completed a root cause analysis and implemented changes to the service as a result. The team investigated and resolved the complaint in a timely manner.

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

Leadership of this service

- A clinical director, service manager and clinical lead had oversight of the daily running of the service, including responsibility for governance, clinical safety and operations.
- Department heads from both sexual health and psychotherapy services met monthly to discuss key issues in the operation and the safeguarding sub-committee joined this meeting.
- A team leader led the sexual health support worker team.
- All of the staff we spoke with said they had a good working relationship with the service manager and said this individual had provided stability and a support structure. For example one member of staff described the "excellent rapport" they had with the manager and said they appreciated being able to contact them at any time for help or support.
- Staff described a "flat hierarchy" and said although management support was always available, they were free to make decisions and work within the boundaries of their training and expertise.

Community health (sexual health services)

- Staff said they felt the period of change, in which a new service manager and CEO had taken up post, had been handled smoothly. They said training days and an away day were used so everyone could spend time together and find out more about each other's roles.
- The service manager facilitated a monthly meeting with the front office team. We looked at the minutes for meetings between July 2017 and September 2017. In each case we saw the meetings were well attended and included extensive discussions of incidents, patient and staff feedback and changes to the service. There was a consistent, demonstrable focus on improving the service for patients and improving work processes for staff that paid attention to detail. For example staff noted the wording of the code of conduct poster in the waiting room needing updating to reflect more appropriate use of language by young people. In addition staff noted there was sometimes confusion around the types of appointments offered on a Monday. As a result stickers were added to documentation used on these days to help staff who had contact with patients.

Service vision and strategy

- The service had an established vision that focused on ensuring young people had access to effective support to help them build their strengths, reach their goals and maintain good sexual and reproductive health. In addition the service had a mission that identified accessibility, evidence-based and outcome-focused practice as key to the service.
- The senior team planned to introduce an electronic patient records system (EPRS) in 2018 and this formed their immediate vision for the service. An EPRS would streamline results management and make communication with patients and other providers much faster.
- Staff had worked with young people who used the service to develop a service charter. This was prominently displayed in the waiting room and was divided into 'What you can expect of us' and 'What we expect of you.' This included a commitment to confidentiality, minimal waiting times and being treated with respect. In exchange the centre asked people to behave respectfully to each other, not to use their mobile phones and to attend whilst not under the influence of alcohol or drugs.

Governance, risk management and quality measurement

- The organisation had appointed a service manager to ensure the service remained sustainable as demand and complexity of needs increased. Staff spoke positively of this and told us they felt clinical governance had improved as a result.
- The contraception and sexual health (CaSH) team met monthly as part of a clinical governance process. We looked at the minutes of meetings between July 2017 and September 2017. We found the team reviewed incidents, complaints and feedback from staff and patients at each meeting. The service manager documented actions and follow-ups and we found consistent processes for ensuring updates to the service were clearly communicated. For example when the times of drop-in sessions changed due to staff availability, the service manager proactively updated the website. This meant people could rely on 'live' information without having to reschedule when they arrived.
- The centre manager had improved information governance systems following a data breach that comprised the confidentiality of a patient. We saw they adhered to the duty of candour by telling each person involved what had happened and what they had put in place to prevent a future recurrence. For example the service had changed their e-mail information management system to better protect confidential data.
- Information governance was a mandatory training module and 94% of staff were up to date with this.
- Clinical staff met with colleagues in the network every three months as part of the governance and operational processes. This meeting included time for continuing professional development and sharing of learning from complex cases.
- Staff told us team meetings were always underpinned by risk discussions and quality improvements.
- The clinical lead was a member of a local child sexual exploitation committee group, which helped coordinate care to young people who had known high levels of risk.
- Staff from the CaSH service had meetings with colleagues in the psychotherapy service as part of their risk management strategy for individual patients at high risk or with complex needs. This ensured the two services could ensure appropriate care plans were in place.

Community health (sexual health services)

Culture within this service

- All of the staff we spoke with described their sense of pride in working for an organisation that had served young people and the local community for 50 years. We also saw evidence of this in how staff were empowered to contribute new ideas for service delivery and engaging with people. One member of staff said, "We have a unique place in the community and we see the same people for years. It feels good to be part of young people's support so they have good sexual health." Other comments from staff included, "I'm proud to work at a service where sexual health is front and centre and clearly prioritised," "This is an approachable, well –coordinated team. I'm always kept in the loop and I'm confident if I need help I'll get it," and "I'm never afraid to share and discuss anything with colleagues; if I don't know the answer to something then someone else will."
- Staff were able to pursue opportunities for development and progression. For example a sexual health support worker had progressed to a new team leader role
- The senior team had placed value on a motivated and energetic workforce and this was reflected in their approach to working hours and flexibility. For example one of the clinical leads ensured no staff worked over their planned hours and that they had some form of supervision every week. This often included a 'check in' with them from a senior member of the team to make sure they had everything they needed. In addition where staff were experiencing challenges in their personal lives, the senior team ensured they did not provide direct support to patients with the same needs. This helped to maintain staff wellbeing and ensure patient care remained effective.
- Appraisals and supervisions reflected the significant focus the senior team placed on team cohesion and staff welfare as tools to deliver a highly tailored, responsive service. For example staff could use the sessions to identify future learning and development needs as well as to discuss their ideas for the service and discuss case reviews to help them learn from practice.

Public engagement

- The clinical and senior teams had established a reputation of trust amongst young people in the local community. The acting clinical director had been part of the team for over 20 years and said they regularly saw patients from being a teenager up to their 24th birthday; the maximum age the centre was registered to see. Staff told us young people consistently provided feedback that the voluntary nature of the organisation and the non-clinical appearance or corporate branding were appealing factors for them. This was reflected in our conversations with young people who used the service. For example one person said, "When I was much younger they were on the same page as me. I always liked that it didn't feel like a hospital or clinic and it doesn't have that clinic smell!"
- A new chief executive officer (CEO) had been appointed shortly before our inspection and a panel of young people who used the service had joined the interview panel. This group had also contributed to the design of the recruitment process including key interview questions. This demonstrated how the organisation embedded engagement with patients and the local community into the operation and future sustainability.
- Where staff identified a need for changes or improvements to communal or clinical areas, they routinely consulted with young people who used the service to help identify how changes would impact them.
- The organisation demonstrated how feedback and continuous engagement with young people led to improvements in the service. For example as a result of discussions with young people, the organisation had implemented feedback fetes and Saturday clinics. The service team used feedback fetes to talk with young people about what had changed as a result of their input and to opportunistically provide sexual health promotion information.
- The manager used a rolling feedback programme to ensure they maintained a continual understanding of how patients felt about the service. The survey captured a range of information from patients that helped the team to adapt the service to changing needs. In addition staff used a system to capture narrative feedback offered in the survey and unsolicited feedback patients gave to staff. For example one patient had commented that the best sexual health service they had ever experienced was at this centre and another commented that staff had made an awkward conversation about a sexually transmitted infection much easier to have.

Community health (sexual health services)

- The centre was planning to celebrate its 50th anniversary in 2018 and the team were working with young people to ensure they were involved in the events.
- The c-card and workforce development practitioner was planning a focus group with young people to gather feedback about the c-card scheme.

Staff engagement

- In May 2017 the CaSH service was restructured to provide more dedicated administrative and reception cover and wider clinical opening times. The service manager carried out a consultation exercise with all of the staff who would be affected and took into account their feedback on the proposed changes. As a result, the service recruited additional staff to accommodate these changes and the service manager took into account staff concerns, including a review of the sexual health support worker role.
- A third year trainee psychologist contributed to the interview panel for the recruitment of a new CEO.
- All of the staff we spoke with said they felt that the team working spirit was a positive element of working in the service. One member of staff said, “Even though, I’m only there once a week, I feel like I’m closer to the team than my own! It’s a very welcoming place and I never feel left out of the loop.”
- The clinical lead provided weekly updates to other clinical staff who worked in the service by phone or e-mail. All of the staff we spoke with said communication was consistently good and they always felt updated about changes or improvements in the service.

Innovation, improvement and sustainability

- The senior team demonstrated a clear understanding of the need to adapt services to changing government priorities in sexual health services. For example, following the closure of the nearest level 3 genitourinary medicine (GUM) centre, the clinical and senior teams developed a collective approach to discussing contingency plans with the network and commissioners. In addition the organisation provided services to young people in three London boroughs. Following a reduction of funding in one borough, the senior team had initiated strategy meetings with commissioners to ensure this did not negatively impact service continuity.
- The whole team demonstrated tangible enthusiasm and passion for continuing to deliver and improve the sexual health and psychosexual services delivered to young people in the local community.
- The service planned to introduce an electronic patient records system to improve information management.
- The closure of a nearby level 3 GUM service had a demonstrable impact on the team. The service that was closed gave patients only two weeks’ notice and signposted them to the Brandon Centre without including the information that the centre could only see patients under the age of 25. The service had seen a 30% increase in the number of patients who needed sexual health screening following the closure of the level 3 service. As a result, the clinical lead was carrying out an assessment of the service capacity and demand to ensure the service remained sustainable.

Outstanding practice and areas for improvement

Outstanding practice

The organisation had served the local community for 50 years and the pride and passion both staff and young people felt as a result of this were demonstrable. Young people were involved in the running and development of the service at all levels and there was a culture of listening and acting on feedback that every member of staff incorporated into their work.

A panel of young people who used the service contributed to interviews for new members of staff. This group had also contributed to the design of the recruitment process for a new chief executive officer including key interview questions. This demonstrated how the organisation embedded engagement with patients and the local community into the operation and future sustainability.

Where staff identified a need for changes or improvements to communal or clinical areas, they routinely consulted with young people who used the service to help identify how changes would impact them.

The organisation demonstrated how feedback and continuous engagement with young people led to improvements in the service. For example as a result of discussions with young people, the organisation had implemented feedback fetes and Saturday clinics. The service team used feedback fetes to talk with young people about what had changed as a result of their input and to opportunistically provide sexual health promotion information.

Multidisciplinary working was integrated into the service beyond the scope of its requirements and staff had used this to develop patient-centred working and support for vulnerable people. This meant people with complex needs received highly individualised care that was coordinated with community services, network partners, acute and specialist services. We saw examples that when something went wrong with a referral staff did their best to help the patient even if this was outside of their role. This approach to meeting individual needs was also reflected in the adaptability of the service as staff supported patients who had been redirected from a closed service that resulted in an 11% increase in demand.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure all staff complete 100% of mandatory training as a priority.