Brook Wigan and Leigh

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

Overall summary

Brook Wigan and Leigh provides a sexual health and well-being service for young people aged under 25 in Wigan and the surrounding areas. The service is recognised as a level 2 contraception and sexual health service (CASH).

We inspected Brook Wigan and Leigh using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 and 27 January 2017. We also carried out an unannounced inspection on 1 February 2017.

We do not currently have a legal duty to rate independent sexual health services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- There were clear processes in place to protect vulnerable patients and those identified at risk of abuse. Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients care and treatment.
- The service followed national guidelines and participated in clinical audits in order to improve care and treatment pathways. Staff worked well together as part of a multidisciplinary team and collaborated with external organisations to deliver patient's care and treatment effectively.
- Care and treatment was provided by suitably qualified and competent staff. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. The majority of staff (85%) had completed their appraisals.
- We spoke with six patients and received feedback from 50 patients through comments cards received during the inspection. They all spoke positively about the care and treatment they received. Patient satisfaction surveys also showed patients were positive about the services.
- Patient consent was obtained prior to commencing treatment. Patients were kept involved in their care and staff provided emotional support when needed. Complaints about the services were resolved in a timely manner and shared with staff to aid learning.

Summary of findings

- Services were planned and delivered to meet patient needs. The services were accessible through three clinical sites, outreach and education services. Services had flexible opening times which included evening and weekend clinics.
- There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- There was a clear governance structure in place with routine staff meetings and corporate level committees where the service's risks and performance was reviewed. Key risks to the services were recorded and managed through the use of local and corporate level risk registers.
- There was visible local leadership. The registered manager was due to leave the organisation in February 2017 and a replacement service manager from one the provider's other clinics had been identified to take over this role.
- Staff were positive about the culture within services and the level of support they received from the management team.

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

- The majority of staff had completed mandatory training in topics such as basic life support, safeguarding and infection control. However, records showed none of the eligible staff had completed mandatory training for manual handling or fire safety. There were plans for staff to receive this training during March 2017.
- The failure of the electronic patient record system in December 2016 meant some historical patient information could not be fully retrieved. There were plans to implement a replacement electronic patient record system by April 2017.
- In most cases, staff could retrieve patient information through paper based records. However, 197 patients attending the service between 19 December 2016 and 26 January 2017 had to be reassessed with a new record because their historical records could not be located.
- The loss of the electronic system meant staff working in the outreach clinics could not easily identify if a patient had previously visited any of the service's other clinics. Staff told us they relied on these patients to inform them of previous visits or treatments.
- Staff working at the outreach clinics experienced connectivity issues when working remotely (via laptops). This meant they had limited or no access to the provider's electronic records systems, intranet based policies and other applicable documents.
- Medical staff working in the service did not routinely receive formal medical appraisal through the service.
- There were four incidents reported by the service between January 2016 and January 2017. Staff were able to describe the remedial actions taken to address these issues. However, two of the incident records were poorly documented and did not detail the investigation findings, define responsibilities and timelines for completing remedial actions or include documented evidence to show whether these actions had been completed.
- Staff did not always complete medication reconciliation logs correctly when removing medicines from storage. There were discrepancies in the medication logs indicating the actual medication stock did not reconcile with the recorded quantity.
- The identified concerns around medication reconciliation record errors and remote IT accessibility issues had not been formally reported using the incident reporting system. This meant there was no record of how often these issues had occurred or how to improve these.
- The service reported high staff sickness levels due to staff on long-term sick leave. This impacted in increased workloads for the remaining staff and an increase in patient waiting times during July 2016 to September 2016 compared with the previous nine months.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We have also issued the provider with two requirement notices that affected the sexual health services. Details are at the end of the report.

Summary of findings

Ellen Armistead Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health (sexual health services)		Brook Wigan and Leigh carries out independent sexual health services. We do not currently have a legal duty to rate this service but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Background to Brook Wigan and Leigh

Brook Wigan and Leigh provides a sexual health and well-being service for young people aged under 25 in Wigan and the surrounding areas. During 2015, there were 12,173 contacts with patients across the service. This included 1,960 new contacts.

Brook Wigan and Leigh are commissioned by Wigan Council who are currently undergoing a review of all its sexual health services. The service is based in Wigan town centre directly next to the Wigan Shine sexual health service that is commissioned separately by Wigan council for patients aged 25 and over.

The service 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. Brook Wigan and Leigh delivers a range of services, including:

- Emergency contraception (up to 5 days)
- Contraceptive pill, injection and patch issuing
- Contraceptive implant consultation
- Contraceptive implant fitting and removal procedure
- Pregnancy testing
- Termination of pregnancy (ToP) referrals
- Sexually transmitted infection (STI) screening (Chlamydia and Gonorrhoea)
- Chlamydia treatment
- Intrauterine device (IUD)/ Intrauterine system (IUS) consultation
- IUD / IUS fitting and removal procedure
- Condom issuing

The service also provides health and wellbeing advice and support which includes:

- Healthy and unhealthy relationships
- Consent, sex and the law and delay
- Referrals for help to stop smoking
- Referrals for drug and alcohol issues
- Self-harm and mental health
- Accessing counselling

The main clinic in Wigan is open seven days a week and includes walk in as well as specified appointments for patients. The service also has two outreach clinics in Tydlesley and Atherton which supplement the main clinic.

Brook Wigan and Leigh supported by a Community Education Team which provides sexual health promotion services in schools, colleges and universities and communities. The community education team also provides home appointments for young people in the borough. Whilst the teams collectively run as one service, specific reporting targets are different dependant on the service type.

Commissioners of sexual health services have targeted a number of public health outcomes in their areas. The main focus for the service includes reducing teenage pregnancy, chlamydia screening and genitourinary medicine (GUM) interventions.

Brook Wigan and Leigh is registered to provide the following regulated activities:

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

We have not previously inspected this service. The service manager was the registered manager with the Care Quality Commission at the time of our inspection. However, the registered manager was due to leave the organisation during February 2017. A service manager from another of the provider's locations was scheduled to take the place of the current registered manager.

Summary of this inspection

Our inspection team

The team that inspected the service comprised of two CQC inspectors and a specialist advisor (sexual health nurse). The inspection team was overseen by an inspection manager.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive healthcare provider inspection programme.

How we carried out this inspection

We inspected Brook Wigan and Leigh using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 – 27 January 2017. We also carried out an unannounced inspection on 1 February 2017.

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?

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

During the inspection, we visited the main Wigan clinic and two outreach clinics located in Tyldesley and Atherton. We spoke with a rage of staff including; nurses, receptionists, health and wellbeing workers, an education worker, the doctor, the councelling coordinator, the nurse manager and the service manager. We reviewed 11 sets of patient records. We spoke with five patients and received feedback from a further 50 patients through comments cards received during the inspection. We also looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with six patients and received feedback from a further 50 patients through comments cards received during the inspection. Patients spoke positively about the care and treatment they received. They described the staff as being kind, supportive and non-judgmental towards them.

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?

We do not currently have a legal duty to rate independent sexual health services.

We found the following issues that the service provider needs to improve:

- There were four incidents reported by the service between January 2016 and January 2017. Two of the incident records were poorly documented and did not detail the investigation findings, without any clear investigation findings or clearly defined responsibilities and timelines for completing remedial actions.
- Staff did not always complete medication reconciliation logs correctly when removing medicines from storage. There were discrepancies in the medication logs indicating the actual medication stock did not reconcile with the recorded quantity.
- We identified instances where medication reconciliation record errors and remote IT accessibility issues were raised by staff but had not been formally reported using the incident reporting system. This meant there was no record of how often these issues had occurred or how to improve these.
- The majority of staff had completed mandatory training in topics such as basic life support, safeguarding and infection control. However, records showed none of the eligible staff had completed mandatory training for manual handling or fire safety. There were plans for staff to receive this training during March 2017.

However, we also found the following areas of good practice:

- The majority of eligible staff (71%) had completed adult and children's safeguarding training (level 3). Staff understood how to identify and report safeguarding concerns. There were clear processes in place to protect vulnerable patients and those identified at risk of abuse.
- The staffing levels and skill mix was sufficient to meet patients' needs. There was one nursing staff vacancy at the time of our inspection. Patients received care in visibly clean and appropriately maintained premises.

Summary of this inspection

- Suitable equipment was available to support patients. Staff had access to emergency equipment for use in medical emergencies.
- Medicines were ordered, stored and discarded safely. Medication prescribing was effectively managed through the use of Patient Group Directions (PGDs).

Are services effective?

We do not currently have a legal duty to rate independent sexual health services.

We found the following areas of good practice:

- The service followed national guidelines such as Faculty of Sexual and Reproductive Health (FSRH), British Association for Sexual Health and HIV (BASHH) and National Institute for Health and Care Excellence (NICE) guidelines and these were incorporated in policies and procedures.
- The service actively participated in clinical audits as part of the national corporate level processes. Audit findings were reviewed in order to develop and implement improved care and treatment pathways.
- Care and treatment was provided by suitably qualified and competent staff. The majority of staff (85%) had completed their appraisals and had access to regular supervision with their line managers.
- Staff sought consent from patients prior to delivering care and treatment and understood the relevant legal requirements such as the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and Gillick competencies.
- Staff worked well together as part of a multidisciplinary team to coordinate and deliver patient's care and treatment effectively. Staff worked collaboratively with external organisations in order to deliver joined up care for patients.

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

- The failure of the electronic patient record system in December 2016 meant some historical patient data stored on the system could not be fully retrieved.
- In most cases, staff were able to retrieve patients' visit history through paper based records. However, this was not always

Summary of this inspection

possible due to a complex system used for filing paper records. During 19 December 2016 and 26 January 2017, 197 patients attending the service had to be reassessed with a new record because their historical records could not be located.

- The loss of the electronic system meant staff working in the outreach clinics could not easily identify if a patient had previously visited any of the service's other clinics. Staff told us they relied on these patients to inform them of previous visits or treatments.
- Staff working at the outreach clinics experienced connectivity issues when working remotely (via laptops). This meant they had limited or no access to the provider's electronic records systems, intranet based policies and other applicable documents.
- Medical staff working in the service did not routinely receive formal medical appraisal through the service.

Are services caring?

We do not currently have a legal duty to rate independent sexual health services.

We found the following areas of good practice:

- We spoke with six patients and received feedback from 50 patients through comments cards received during the inspection. They all spoke positively about the care and treatment they received. They described the staff as being kind, supportive and non-judgmental towards them.
- Feedback from patient satisfaction surveys also showed that patients were positive about the care and treatment they had received. For example, 95% of patients surveyed during September 2016 responded they would recommend the service to a friend.
- Patients were kept fully informed and staff were clear at explaining the care and treatment options to them in a way they could understand. Patients were encouraged to have a friend or relative present where they felt this support was needed.
- Staff provided emotional support for patients and provided them with guidance to make informed lifestyle choices. The service employed a part-time counselling coordinator to provide advice and support to patients.

Summary of this inspection

Are services responsive?

We do not currently have a legal duty to rate independent sexual health services.

We found the following areas of good practice:

- Services were planned and delivered to meet the needs of patients. The service covered a large geographical area in Wigan and Leigh through its three clinical sites. Services had flexible opening times which included evening and weekend clinics.
- The service had over 1000 contacts per month and an open access policy which meant that the majority of visits did not require an appointment.
- Staff provided extensive education and training across a wide range of subjects and services including health centres, schools, colleges and social services.
- There were systems in place to support vulnerable patients. The service offered community or home based visits for vulnerable patients or for those that had mobility problems. The services took into consideration communication difficulties if patient's first language was not English and accessed interpreters when needed.
- Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

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

- The length of time patients waited to be seen was worse during July 2016 to September 2016 compared with the previous nine months. Patient wait times were impacted by issues such as staff sickness or leave during this period.

Are services well-led?

We do not currently have a legal duty to rate independent sexual health services.

We found the following areas of good practice:

- The Brook vision, values and strategic objectives had been cascaded across the services and staff had a clear understanding of these.
- There was a clear governance structure in place with regular staff meetings to monitor performance against objectives. Performance information was reported to commissioners and

Summary of this inspection

to the corporate provider. There were corporate level committees such as the clinical advisory group, safeguarding advisory committee and medical advisory committee (MAC) where the service's risks and performance was reviewed.

- Key risks to the services were recorded and managed through the use of local and corporate level risk registers. Audit findings and quality and performance was routinely monitored in order to improve the services.
- There was visible local leadership. The registered manager was due to leave the organisation in February 2017 and a replacement manager from one the provider's other clinics had been identified to take over this role on an interim basis.
- Staff were positive about the culture within services and the level of support they received from the management team. There was routine public and staff engagement.

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

- The service reported high staff sickness rate between November 2015 and November 2016 (28%). This was mainly due to staff on long-term sick leave. This impacted in increased workloads for the remaining staff.

Community health (sexual health services)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health (sexual health services) safe?

Safety performance

- There were no 'never events' reported by the service between January 2016 and January 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were four incidents reported by the service between January 2016 and January 2017.
- There were no serious incidents (that led to patient harm) or patient deaths reported during this period.

Incident reporting, learning and improvement

- There were corporate policies and procedures that guided staff on the reporting of any incidents or concerns, investigation and learning procedures. These policies and procedures were available to staff via the provider's intranet.
- Staff told us they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients. We saw evidence that incidents and concerns were discussed during routine staff meetings and via monthly newsletters so shared learning could take place.
- During the inspection, we identified concerns such as medication reconciliation record errors and remote IT accessibility issues that had not been formally reported using the incident reporting system. We saw evidence that staff discussed these issues during routine team meetings but there was no clear process for recording how often these issues had occurred or records to show how improvements could be made.
- There were four incidents reported by the service between January 2016 and January 2017.
- Two of the reported incidents were for the incorrect logging of a patient's personal information and an incident where a patient's confidentiality was breached,
- We saw evidence that these two incidents were investigated and remedial actions (such as staff training) were implemented to improve patient care.
- The third incident related to contraceptive medication that was incorrectly prescribed outside of the provider's guidelines. The incident report showed a safeguarding referral was made and the service took appropriate actions to address the issue. However, the incident report stated an investigation by the service manager had commenced in August 2016 without any further information recorded. The service manager was able to describe what actions had been taken since August 2016 but this was not appropriately documented on the incident report.
- The fourth incident related to the failure of the electronic patient record system during December 2016, which led to the loss of electronic patient records and previous treatment history as this data was not retrievable.
- The incident report did not include information in relation the reasons for the IT system failure (root cause investigation). There was also no information recorded to show the impact to patient safety or what actions were required to prevent reoccurrence and whether these actions had been completed.
- The Brook 'incident reporting, investigation and learning procedures' defined the types of incidents that should be reported, the process for investigating incidents and how these should be escalated to senior managers regionally and nationally.
- Two of the four incident reports we looked at did not clearly document findings from any investigations,

identify who was responsible for completing remedial actions or document whether these actions had been completed. This meant the provider's policies were not appropriately followed for these two incidents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We found duty of candour was understood by all the staff we spoke with and the provider had a policy that was accessible to staff via the intranet. We saw evidence staff had applied the duty of candour principles in the incident reports we looked at.

Safeguarding

- There were safeguarding policies and procedures in place, which staff in the service knew how to access and understand. The detailed policies included guidance on safeguarding procedures and safeguarding supervision.
- Records showed seven of the 11 nurses (64%) employed by the service had completed adult and children's safeguarding training (level 3). Training compliance was 62.5 % for health and support workers (five out of eight staff). Records showed 100% of education workers (five staff) had completed the level three safeguarding training.
- The staff that had not completed their safeguarding training were mainly new starters or staff on sickness or long-term leave.
- The nurse manager told us training of staff could be difficult in the service particularly for those who were bank staff or only worked a small numbers of hours. The nurse manager also told us that the staff that had not completed their safeguarding training were scheduled to complete this training over the next few months.
- Staff across the service were able to give examples of the types of safeguarding concerns they had faced, how they were reported and also provided us with examples of positive outcomes in the protection of adults and children. In some instances the service was at the forefront of highlighting serious sexual risk towards young people from adults.
- We found safeguarding arrangements were in place for assessing patients' needs and we were provided with examples of how the service provided early help for individuals. The staff evidenced a multi-agency approach to dealing with concerns, including sharing information with other services, when appropriate, including multi-agency panels, child in need meetings and social care teams and the police.
- We found safeguarding was discussed throughout all the structures of the service. The staff accessed safeguarding supervision, when required. The service had a team group safeguarding meeting which was led by its safeguarding nurse champion as well as a team managers meeting on safeguarding on a weekly basis.
- The service structure for reporting on safeguarding was clear and concise. The service had a safeguarding champion who was the nurse manager in the service. We found the nurse manager to be knowledgeable and supportive to staff.
- The safeguarding champion was trained to a level three competency in safeguarding children and delivered practical support to team members as well as structuring the processes of reporting concern in the team The nurse manager linked into regional and national safeguarding structures in Brook for support and supervision.
- The organisation had a national safeguarding committee which provided national governance across all its services. The operational oversight of safeguarding was provided by the deputy chief executive and nurse lead for safeguarding.
- Staff told us there was a national out-of-hours contact for emergencies if staff were working out of normal office hours and needed to contact their line managers.
- In the course of the inspection, we were able to track individual cases through paper records and assess how the services systems kept young people safe. We found that young people who were highlighted as 'at risk' were discussed in personal supervision, team and managers forums. The records also showed high levels of intervention with good record keeping.
- Staff used assessment processes which were based on British Association for Sexual Health and HIV (BASHH), guidelines for assessment, which prompted staff to discuss and record safeguarding issues.
- Arrangements were in place to safeguard and refer victims of sexual assault in accordance with BASHH guidance. The services also had a pathway in place for Child Sexual Exploitation (CSE) and sat on multi-agency partnerships which targeted the issues.

Community health (sexual health services)

- Arrangements were in place to safeguard and refer victims of Female Genital Mutilation (FGM) in accordance with BASHH guidance. The service had a screening process in its assessment documentation and a pathway was in place for referral of victims to the safeguarding team and the police. The nurse manager in the team had provided a team brief on FGM as part of her safeguarding duties.
- The service used an external testing service as part of the national Chlamydia screening programme. Brook Wigan and Leigh did not directly undertake 'partner notification' but there was an arrangement in place where the external service automatically completed partner notification if required. The nurse manager told us they also asked patients about partner notification and sent supplementary information to the external service for partner notification.
- 'Partner Notification' is the process of providing access to treatment or information to the partners of patients who have been at risk of infection due to sexual contact with the patient.

Medicines

- There were a number of policies in place which provided staff with guidance and information on the safe management of medicines. Staff were aware of additional information which was available to them on the website of the 'Faculty of Sexual and Reproductive Health' (FSRH).
- We found that medicines were stored securely in locked cabinets. There were effective systems in place for ordering, transporting and discarding medicines. The service had an arrangement with an external pharmacy provider to supply all medicines used in the service.
- Medicines required for use in the outreach clinics were logged out by the nurse running the clinic. Medicines not used were returned to the main store and logged back into the record to provide an auditable record of the medicines. Staff transported the medicines to and from the outreach clinics in a lockable box to ensure their security.
- Medication prescribing was managed through the use of Patient Group Directions (PGDs). These were approved nationally with input from a pharmacist. PGD's permit the supply of prescription-only medicines to specific groups of patients, without individual prescriptions.
- There were 11 PGD's in use across the service, including for combined oral contraception, progestogen only pill and progestogen emergency contraception.
- Seven nurses were trained and authorised to provide medications through theses PGD's. We looked at the staff records for three nurses which showed that these nurses were trained and signed PGD records were in place and up to date. The PGD's were updated at least every three years.
- Staff told us any medicines issued were recorded on the patient records. We looked at the medication records for five people who used the service. These showed that the medication quantity, dosage, batch number and expiry date were clearly recorded.
- The nurse manager carried out a medication stock audit every three months. The audit for the period of October to December 2016 did not highlight any concerns.
- We looked at the daily medication reconciliation log books. We found four entries between October 2016 and January 2017 where staff had identified discrepancies indicating the actual medication stock did not reconcile with the recorded quantity. The nurse manager confirmed this was due to staff not completing the documentation logs correctly when removing medicines from the cabinets. This was routinely discussed with staff during weekly meetings to raise awareness.
- We identified this as a documentation issue and there was no direct patient impact as all medication issued to patients was recorded in their individual patient records. The nurse manager took immediate actions to improve compliance by implementing monthly medication stock audits.

Environment and equipment

- The services were situated within multi-purpose buildings across the three sites. There were arrangements in place with the building owners so the premises could be suitably maintained. We found the clinic rooms and patient areas were visibly clean and maintained to a good standard.
- There was an agreement in place for equipment to be serviced by external contractors. Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced promptly.

Community health (sexual health services)

- Equipment (such as weighing scales) was appropriately checked and cleaned regularly. The equipment we saw had service and calibration stickers displayed and these were within date.
- Single-use, sterile instruments (such as needles and swab packs) were stored appropriately and were within the manufacturers' expiry dates. All the electronic equipment we saw was clean and we saw evidence that electrical safety testing been completed**.**
- There was medical equipment in each clinical room including blood pressure gauges and other equipment which were used for a physical check before treatment.
- Weekly and monthly health and safety checks of the clinic rooms were carried out and any action required was recorded.
- A water systems risk assessment and survey was completed by an external contractor in December 2016. Routine water checks for legionella were carried out to ensure young people, staff and visitors to the service were not at risk.
- Anaphylaxis emergency medicine was available and an emergency grab bag containing a cylinder of oxygen and masks was available. These were checked on a weekly basis by staff.

Quality of records

- The service used paper based and electronic patient records. However, the electronic patient record system ceased to function properly since 16 December 2016 and only paper-based patient records were in use since then.
- Records were kept securely at all times to ensure the confidentiality of young people who accessed the service. When not in use, paper records were stored in a locked room in the main clinic and locked cupboards at outreach clinics. If records were transported from the main clinics to outreach sites staff were responsible for maintaining the security of the records.
- We looked at 11 sets of paper records during the inspection and tracked three patients who had been flagged as having safeguarding concerns.
- The patient records we looked at were complete and up to date. These included information such as patient's medical and social history, consent, initial assessments, treatment records and care planning processes. The records showed information such as medical and social history was reviewed at subsequent visits to check identify any changes to patient's circumstances.
- We found the service had effective systems in place for tracking and monitoring of patients identified with safeguarding concerns. This included a list of patients with historical or current safeguarding concerns so staff in all areas could promptly identify these patients upon contact. A 'purple' card was placed in the patient's file to flag that there was a safeguarding concern in relation to that patient.
- There was also a weekly review process of open or potential safeguarding cases. All the safeguarding records we saw were complete, legible and included input from other professionals such as social workers and local authority safeguarding teams.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control policy and this was supported by the nurse manager who had a secondary role as infection prevention and control lead.
- Staff were provided with training regarding infection prevention and control and this was part of their mandatory training. Whilst the service had no target for completion of infection control training, the staff training matrix showed the majority of staff (83%) had completed infection control training. Three of the five staff that had not completed the training had recently commenced employment and were scheduled to complete this training. One member of staff was on maternity leave.
- The nurse manager carried out an annual infection control audit to check compliance with eight standards including hand hygiene, environment and disposal of waste. The service achieved 95% compliance in the 2016 infection control audit, which was completed in November 2016.
- The audit showed seven of the eight standards achieved the provider's compliance target of 85%.
- Hand hygiene compliance was 84% as a result of staff with nail extensions and varnish and unavailability of hand wash gel. The nurse manager confirmed this was addressed with staff following the audit.
- The clinical and waiting areas we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. We visited five clinic rooms, three in the main service at Wigan, one at the Tyldesley health centre, and one in Atherton health centre. The clinical areas were visibly clean and well maintained.

- Hand gel dispensers, which were full and ready to use, were located in various places around the buildings and the rooms had hand washing facilities.
- A sharps policy was in place, as were sharps bins. Staff were aware of the policy and yellow sharps bins were stored appropriately and were labelled.
- Appropriate arrangements were in place for managing waste and handling clinical specimens.
- A post exposure policy was in place for infectious diseases and viruses with clear guidance on what to do if exposed. Information was visible to staff on clinic walls.
- Decontamination processes and standard operating procedures were in place to ensure that if any areas were contaminated by blood spills or bodily fluids, staff could clean affected areas and make the area fit for purpose.
- The staff had access to appropriate personal protective equipment, such as gloves and aprons.
- The service had a contract with external cleaning agencies that provided cleaning services on a daily basis. The clinical staff also undertook daily cleanliness checks to maintain hygiene standards.

Mandatory training

- Staff undertook a wide range of courses which were both face to face and also by E- learning. The courses included fire training, anaphylaxis, child sexual exploitation (CSE), safeguarding children, basic life support and manual handling.
- A training matrix was maintained which identified the training staff had attended and the date it was completed. The matrix showed the majority of eligible staff had completed their mandatory training in areas such as basic life support (74%), anaphylaxis (74%), safeguarding (67%), CSE (57%) and infection control (83%).
- The training matrix also showed none of the staff had completed their annual mandatory training in manual handling and fire safety. However, all the staff were scheduled to receive this training during March 2017.

Assessing and responding to patient risk

- When a patient visited the service, staff undertook an assessment to determine if there were any risks or specific needs. The assessment was based on questions incorporated in British Association for Sexual Health and HIV guidelines.
- The service worked closely with partners to help assess and respond to safeguarding risks including the police and social care services as well as other council services.
- There were no medical emergency incidents reported by the services during the past 12 months. In the event of a medical emergency, staff had access to anaphylaxis emergency medicine and an emergency grab bag containing a cylinder of oxygen and masks.
- Staff told us they could seek medical advice from specialist nurses or from doctors who were present within the service or contactable by phone in other Brook services. They also told us that they would call an ambulance if a patient's health deteriorated.
- First aid equipment was available to staff and was checked regularly to ensure it was ready for use.

Staffing levels and caseload

- The staff team consisted of one doctor, eleven nurses, eight health and wellbeing support workers, five education workers, a counselling coordinator and six administrative staff.
- The doctor was a General Practitioner (GP) with a specialist interest in sexual health and contraception and was based at the Wigan clinic for four hours on Monday each week.
- We found the staffing levels were sufficient to meet the needs of patients. There was one nursing staff vacancy at the time of our inspection.
- Staff members and managers told us they felt they had enough staff to have a functioning team and provide the level of care needed by patients. The service had a large number of staff but many were either bank or weekend staff. We found that sickness pressure on the team had occurred due to the fact that two full time staff members were off on long term sick.
- The service manager told us the service did not use agency staff. Staffing cover for leave or sickness was maintained through the use of bank staff. The bank staff consisted of three health and wellbeing support workers, two nurses and two reception staff. The bank staff also attended meetings and received the same level training and supervision as permanent employed staff.
- The service manager told us patients could visit the service and request a consultation at any time, which also made it more difficult to plan for staffing numbers required.

Community health (sexual health services)

- Staff had designated bases and roles within the service but also rotated work between the main clinic and outreach clinics so cover was available when needed.

Managing anticipated risks

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and capacity issues and there was daily involvement by service manager and the nurse manager to address these risks.
- Policies and procedures were available for staff on how to manage violence at work and staff knew where to access them.
- The main Wigan clinic had a panic alarm system installed in all of the clinic rooms and in reception.
- A lone working policy was in place and staff were aware of it and were able to explain what they would do if working alone.
- There was always at least two staff on site to close up the clinic. The education team and staff working at outreach clinics worked in pairs and had a mobile phone in case of emergency.

Emergency awareness and training

- There was a business continuity plan that listed key risks that could affect the provision of care and treatment.
- This included issues such as impact from IT systems failure, failure of utilities, fire, loss or theft of confidential information and changes in commissioning arrangements that could impact on patients using the service. Whilst the service had a business continuity plan the loss of its IT system clearly showed that its effectiveness was limited.
- Staff at the Wigan clinic were aware of how to access this information when needed.
- The two outreach clinics were based in premises that were not owned by the provider. Staff told us they would follow local procedures during the event of a fire or other emergency incident.

Are community health (sexual health services) effective?

(for example, treatment is effective)

Evidence based care and treatment

- The service followed British Association for Sexual Health and HIV (BASHH) guidance. The guidance is developed on a national basis in conjunction with a wide range of experts to promote excellence in the treatment of sexual health and human immunodeficiency virus (HIV).
- The Faculty of Sexual and Reproductive Health (FSRH) clinical guidelines are accredited by National Institute for Health and Care Excellence (NICE). The FSRH is a national specialist committee which develops training, puts on events and provides training resources. We found that the service adhered to FSHR standards, accessed training for staff and attended events where appropriate.
- Good practice was shared across service through documented service meetings every month and supplemented by clinical teams meetings every six weeks. Staff also received a monthly provider newsletter which included updated clinical and policy guidelines.
- The team were actively linked with both regional and national networks of Brook where information on best practice was shared. However, the service manager and nurse manager felt the instigation of a North West management forum would further improve information sharing across the North West region.

Pain relief

- Pain relief medication such as paracetamol and Ibuprofen was available in stock for patients that may require pain relief medication following implant procedures. If required, these were prescribed by the doctor.
- Patients were given information and advice on how to manage their pain symptoms before and after procedures such as intrauterine device (IUD) installation and removal.

Nutrition and hydration

- Patients attending the clinic could access drinking water in the waiting area at the Wigan clinic.
- Staff did not routinely assess patients' nutritional and hydration requirements because of the nature of the services provided. However, staff offered advice and information to patients on lifestyle and healthy eating as part of their routine consultations. Patients requesting implants or IUD's underwent body mass index (BMI) assessments and were given advice on managing their weight

Technology and telemedicine

Community health (sexual health services)

- Staff used a text message service to inform patients of appointments.
- Brook nationally had produced a website which informed the general public about all the sexual health services available across its services. The 'Ask Brook' service on the website identified clinics and outreach addresses as well as opening times and gave advice and information about sexual health and contraception.
- The service had a single point of contact telephone number which provided information, assessment and direction to the services required by patients.

Patient outcomes

- The service participated in local audits and those arranged by the corporate provider or external organisations nationally.
- The annual clinical audit cycle 2016/17 identified a number of planned audits which included: implant fitting and removal, sexually transmitted infection (STI) testing and treatment, infection control, emergency contraception and abortion referral.
- Brook Wigan and Leigh contributed to these audits by submitting data for 40 patients that had received treatment. The audit findings were published nationally by the corporate provider along with recommendations and improvement actions for individual services to implement.
- The Brook implant audit 2016 showed that the services were compliant with three of the five standards when providing care and treatment for implants. A recommendation from the audit was that removal of an implant for irregular bleeding should not be done until an STI had been ruled out and that that counselling should be given to patients regarding implant side effects.
- The nurse manager confirmed remedial actions had been put in place following the implant audit recommendations. This included additional training for staff about implant removal and an updated proforma to include implant side effects during councelling discussions.
- The Brook STI testing and treatment audit 2016 (data from September to October 2016) showed that 81% of patients were seen by a nurse, 99% of the infections diagnosed were Chlamydia and only five patients had gonorrhoea.
- The audit highlighted that almost 75% of patients with Chlamydia were treated with Azithromycin and 18% had Doxycycline. Of the patients identified with Chlamydia. Approximately 25% were tested again after three months.
- The recommendations following the STI audit included to treat with doxycycline first line when there is a risk of a non-genital infection and to offer and encourage retesting at three months in patients with Chlamydia. The nurse manager told us a local action plan was being developed to implement the recommendations into practice.
- The recommendations from the 2015 audit included that all patients should be offered the copper intrauterine device (Cu-IUD) and this should be documented in patient's notes, the offer to quick start contraception must be documented and an STI risk assessment or recommendation of STI testing at the time of pregnancy testing at three weeks should be documented for all patients.
- The Brook termination of pregnancy (ToP) audit 2016 showed that estimated gestation was recorded in 88% of cases and sexually transmitted infection (STI) screening was performed or documented as inappropriate in 60% of cases. The audit also highlighted that 25% of patients had a follow up contact after three weeks of the termination of pregnancy referral taking place.
- National recommendations following the audit were that all patients had a follow up at three weeks (in person or by phone)and that patients referred for a ToP were screened for sexually transmitted infection or it is documented that it is inappropriate.
- The nurse manager told us the findings from the audit were shared with staff and confirmed STI testing was discussed with patients and that each patient with a (ToP) referral was contacted after three weeks. Staff kept a log book with details of patients that had a(ToP) referral. This showed that staff contacted each patient by phone and recorded the outcome of discussions with patients in the log book.
- Patients were provided with advice on the use of contraception and which form of contraception was most suitable for them in order to reduce the likelihood of pregnancy.

Competent staff

Community health (sexual health services)

- Brook Wigan and Leigh had a formal induction process for new staff. The induction gave newly appointed staff basic information about Brook as an organisation and allowed staff to shadow other members of the team for up to four weeks.
- Staff underwent annual appraisals. Records up to November 2016 showed the majority of staff (85%) had completed their appraisals. We saw evidence that the nurse manager had scheduled dates for staff with outstanding appraisals. The service did not have a target in place for the completion of appraisals.
- Supervision or one to one sessions were provided approximately every three months for all staff.
- The doctor (GP with special interest) working from the Wigan clinic had completed their General Medical Council (GMC) revalidation and had indemnity insurance in place. The doctor confirmed they underwent annual appraisal as part of their main NHS role. However, the doctor confirmed they had worked in the service since September 2015 and had not received an appraisal from the service.
- Records showed all staff had completed Disclosure and Barring Service (DBS) checks prior to commencing employment. The service also used volunteers that supported public engagement activities. The service manager told us that volunteer recruitment was managed by a centralised corporate team and they oversaw volunteer recruitment and DBS checks.
- Staff held weekly group discussions to facilitate learning and were also provided with training through the managers in the service**.** Group supervision and peer support for safeguarding cases took place every six weeks.
- Staff were able to access specific courses on sexual health which were provided by The Faculty of Sexual and Reproductive Health (FSRH).
- Staff had competency based appraisal and supervision which was focussed on the competencies within British Association for Sexual Health and HIV guidelines.
- Records showed that the nurses completed specialist accredited training prior to working with implants.
- There was a system in place for checking that nurses had a valid registration.
- All the staff we spoke with told us they felt competent and well supported with their training needs. They told us they had good access to training regarding their professional development.

Multi-disciplinary working and coordinated care pathways

- The services had comprehensive links with other services across its local area. A full range of services supported the work of teams including social care and criminal justice services as well as other health providers for example substance misuse services.
- The Wigan clinic was located in the same building and worked closely with the Wigan Shine sexual health service and Barnado's children's charity.
- The service had a good working relationship with safeguarding teams in other organisations as well as in its own organisation.
- The community outreach team worked closely with organisations that supported individuals with additional needs.
- The service also had links to other services that provided advocacy to young people in the Wigan Borough including; domestic abuse advocates (DIAS), Sexual Assault Referral Centres (SARC), St Marys (Central Manchester University Hospitals NHS Foundation Trust) Sexual Assault Advocates, Embrace, Advocacy for vulnerable young adults and Wigan Family Welfare who provide mental health advocacy and support for carers.

Referral, transfer, discharge and transition

- Brook Wigan and Leigh provided care and treatment for patients less than 25 years of age. Patients over 25 years of age were referred to the 'Shine' sexual health service, which was a separate service located next door to the Wigan clinic. The team had no data which could indicate the success rate for engagement after they referred to the over 25 services or dropout rates of their referrals to over 25 year old services at the time of inspection. However the proximity of the over 25 service, next door, enabled quick and easy access to patients.
- Staff were also able to escalate or refer more complex sexual health and GUM cases (e.g. Gonorrhoea treatment) to the 'Shine' sexual health service.
- The community outreach teams managed and referred a range of vulnerable individuals who could not access mainstream sexual health services.
- Referrals were accepted from health professionals and social care teams as well as GPs and other teams in the boroughs.

Community health (sexual health services)

- This service supported 'looked after' children as well as supporting young people under 16 years of age to help them make informed decisions regarding relationships.
- The service had effective pathways in place for child sexual exploitation (CSE) and referral of victims of female genital mutilation.

Access to information

- Staff used paper–based patient records to record information such as patient assessments, consultation records and for medicines or treatments given to patients. The paper notes we reviewed were clear and concise and showed assessment information, case work and care planning processes.
- The services used a unique numbering system to identify paper-based patient records in the main Wigan clinic. A separate numbering system was used in the Tyldesley and Atherton outreach clinics. Staff retained separate paper-based records at each location.
- Staff had historically used an electronic system to schedule appointments and to store patient's contact information and records of previous visits and treatments.
- When a patient came for care or treatment at the service (main clinic and outreach clinic), staff used the electronic system to identify the patient's unique ID to retrieve the patient's treatment history and their paper-based patient records.
- The service reported on 16 December 2016 that all access to the electronic system had been lost and data stored on the system could not be fully retrieved. This was logged as an incident and reported to the information governance office and to the commissioners of the service at the time of the incident. There were plans to introduce a new electronic patient record system by in April 2017.
- Staff were able to retrieve a list of patients and their unique ID's up to the end of October 2016. This meant that staff could manually locate and access the paper-based records for these patients if they had previously received care or treatment at the service.
- The services kept separate logs for all patients identified with safeguarding concerns, patients referred to termination of pregnancy (ToP) services and patients that had Intrauterine device (IUD) devices fitted. This meant the existing paper based patient records for these patients could also be retrieved by staff.
- The registered manager confirmed that the services were not able to retrieve this information for any routine patients that used the services during the period between November 2016 and the system failure in December 2016. This accounted for approximately 1000 patient visits.
- The services had a large number of paper-based patient records, which meant staff could not easily locate a patient's paper records without the unique ID reference. Where patients could not be located using the retrieved patient list, staff created a new patient record and carried out assessments as if for a new patient.
- The service reported that during the period between 19 December 2016 and 26 January 2017, there were a total of 1,128 patient contacts and 197 of these had to be reassessed with a new record because their previous information and historical records could not be located.
- Staff also told us they relied on these patients to inform them of previous visits or treatments. In one particular case which we reviewed; a patient was asked by staff when they were last seen for treatment because the service was unable to retrieve their records. The notes indicated that the nurse practitioner who was reviewing the patient made a decision on insertion of a new contraceptive implant based on discussions with the patient about when they last had this treatment and without recorded knowledge of when an implant was last put in. There was a potential risk that contraceptive Injections could be administered too early or too late, contravening the provider's Patient Group Directions (PGDs).
- When the electronic system was in use, staff could also identify if a patient had previously visited any of the clinics. The IT system failure meant that this was no longer possible as a separate unique numbering system was used in the Tyldesley and Atherton outreach clinics. Staff retained separate paper-based records for any patient visits in each clinic.
- Staff in the main clinic and outreach clinics were unable to access any historical patient records across each location or share electronic information about ongoing patient contact between the main clinic and outreach clinics.
- There was a risk that a patient could access contraception as staff would be unable to ascertain if individual patients had already received contraception

in any of the other clinics. The lack of an electronic system to check prescribing of contraception meant that an individual could access multiple sites for prescriptions.

- We found this especially concerning given the large number of young people who accessed the service, who could potentially share contraception. We did not find any evidence that this had occurred during our inspection. However, the nursing staff confirmed that without the electronic system, they would not be able to identify if patients had visited other clinics apart from what patients told them. This had not been identified or logged as a risk to the service.
- Staff could access the provider's policies and procedures through an electronic hub (intranet) and staff could use a number of computer terminals to access the internet and emails.
- In the Tyldesley and Atherton outreach clinics, staff told us they had limited or no access to the electronic hub. Staff were provided with portable laptops. However we found that electronic WIFI dongles did not always work and staff told us they could not always remotely access the provider's intranet for information such as policies and other applicable documents.
- Three members of staff in the outreach clinics told us that the connectivity issues were present prior to the electronic clinical record system failure in December 2016. The staff at the outreach clinics were therefore unable to access any electronic clinical record system before the system failure in December 2016 and had created paper-based patient records to document patient care and treatment.
- We found that the connectivity issues had not been reported as an incident or highlighted on the services' risk register. This meant it was unclear if any remedial actions had been taken to improve access for staff working in the outreach clinics.

Consent

- There were a number of policies in place to provide staff with guidance around seeking consent from adult patients as well as patients less than 18 years old and staff had a good understanding of these.
- Staff understood the relevant consent and decision making requirements, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- Staff understood how to apply the Gillick competency (used to decide whether a child is mature enough to make decisions) to balance children's rights and wishes with the responsibility to keep children safe from harm.
- The team offered a confidential service. Young patients gave verbal consent to treatment and advice and levels of maturity were assessed using BASHH guidelines.
- The service accepted referrals via relatives, carers or support workers. However patients had to individually agree to assessment and treatment.
- Staff applied reasonable adjustment principles when providing care and treatment for patients with learning disabilities. This included allowing patients to be accompanied by a carer or by offering treatment for patients at a place of their choosing through the outreach team.
- Patient records showed the service supported the consent process through integration of consent questions in patient records. We found staff gained consent appropriately from each patient and this was documented clearly on all the records we reviewed. Staff also obtained written consent for certain procedures such as Intrauterine device (IUD) implants.
- Staff could ask senior managers or senior clinicians in the service for support and advice around consent, if needed. Patient records showed staff sought support from professionals (such as psychiatrists and social workers) where vulnerable young patients were assessed as lacking the capacity to make their own decisions.

Are community health (sexual health services) caring?

Compassionate care

- We spoke with five patients during the inspection. They all spoke positively about the care and treatment they received. They described the staff as being kind, supportive and non- judgmental towards them.
- We also received feedback from 50 patients through comments cards received during the inspection. All the patient comments we received were very positive and patients described how staff showed them respect and ensured their dignity was maintained.
- The comments received included "The service provided here is professional, safe and supportive. I have always been treated respectfully and have never had any

problems with the services provided" and "The staff at Brook are brilliant and always listen to everything you say. Make you feel so comfortable". Patients collectively described that the service a friendly, good, hygienic, caring and safe.

- Staff sought feedback from patients through patient surveys that were conducted throughout the year. A survey from March 2016 received feedback from 156 patients with 100% of patients responding positively when asked if Brook Wigan and Leigh had helped them during their visit.
- A survey from September 2016 collected 97 patient responses with 95% saying they would recommend Brook Wigan and Leigh to a friend.
- We found staff demonstrated a good understanding of people's needs particularly in terms of the social stigma attached to visits to sexual health services.
- Staff were clear that patients' privacy and dignity was key in the provision of a good service. We saw that discussions with patients took place discreetly.
- We observed positive interaction from staff in waiting areas towards patients, making them feel at ease.
- Staff were passionate about patient care and were proud of the service they delivered. Staff talked about prioritising patients before themselves and making a difference in people's lives, they had a strong commitment to choice regarding treatment and equality.

Understanding and involvement of patients and those close to them

- During the inspection we saw many occasions where young people were accompanied by their friends. Staff allowed peers to support patients whilst in waiting areas even when the waiting are became congested. Staff felt this enabled young people to feel supported and increased the likelihood of engagement in the treatment process.
- Patients told us they were kept fully informed and staff were clear at explaining the care and treatment options to them in a way they could understand.
- Partner notification provides access to treatment or information to the partners of patients who have been at risk of infection due to sexual contact with the patient. Any individuals who were highlighted as needing treatment were referred to another organisation and partner notification was undertaken by them.

Emotional support

- Staff provided emotional support for patients and provided them with guidance to make relationship choices. We observed staff talking with patients in a calm and reassuring manner.
- Patients spoke positively about the support they received from staff. The comments included; "Friendly staff which make you feel at ease throughout each and every visit" and "They make you feel at ease and confident that the information you share will stay confidential."
- Brook Wigan and Leigh had an extensive programme of work targeted towards young people, which included sessions on relationships, self-esteem and boundaries in both group work settings and on a one to one basis.
- The service also supported individuals to access psycho-sexual counselling and sign posted patients to other support services including HIV support and counselling services i.e. rape crisis and abortion / ToP counselling.
- The service employed a part-time counselling coordinator to provide advice and support to patients.

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

Planning and delivering services which meet people's needs

- We found that Brook Wigan and Leigh sexual health services had a flexible, wide range of choice of services in place to meet the needs of the local population. The three service sites we inspected were based with numerous other services which also focussed on the well-being of both young people and adults.
- The main Wigan clinic was situated on the second floor of a shopping centre. Lifts were available to access the building for individuals with mobility problems. The two satellite clinics were based at local health centres and were easily accessible on ground floor level.
- There were two consultation rooms and five clinic rooms in the Wigan clinic. These were suitable for the treatments and diagnosis carried out at the clinic. The waiting area was spacious and enabled reception staff

to have private discussion. The two satellite clinics were less spacious with smaller waiting areas but staff and patients had sufficient space to enable staff and patients to have private discussion.
- The service had extended and variable opening hours in different sites for example colleges, youth cafes and treatment rooms. The service catered for patients on evening appointments and at weekends.
- Patients could access sexual health services directly through drop in and also request visits and appointments.
- Staff were available during the week and worked flexibly on weekends, when needed.
- We found examples of multi-agency pathways for patients with complex needs. High risk patients could be discussed in multiagency forums and services were co-ordinated to meet individual need through a combined approach to care planning.
- The sexual health service provided health promotion, education and training. Advice lines were advertised in information leaflets and on the provider's website to support people seeking help and advice.
- The service worked closely with social care providers and education providers to address the needs of the local population for example training of school nurses and social care staff.
- The clinical outreach team worked with individuals and groups who could not access mainstream services.
- The services focussed on a number of public health outcomes which included reducing teenage pregnancy, chlamydia screening and genitourinary medicine (GUM) interventions.

Equality and diversity

- Staff could access policies which set out key principles for promoting equal opportunities and valuing diversity across the service.
- The staff we spoke with demonstrated a good understanding of people's personal, cultural, social and religious needs.
- The outreach team worked with individuals and groups who have historically found it difficult to access mainstream sexual health services for example Lesbian, Gay, Bisexual and Transgender (LGBT), communities.
- The service provided sessions on relationships, including discussion on abusive relationships and power dynamics which included domestic violence.
- The community sexual health service took into consideration communication difficulties if patient's first language was not English and could access interpreters when needed. Staff had access to interpretation services and could also book translators to attend in person.
- Staff could also access a sign language service where patients with hearing difficulties were identified.
- The services web site has a section which is described as "your life" where issues such as gender and sexuality are discussed in a way which is educational and easily read.
- The buildings were accessible to those with mobility problems.
- Reasonable adjustments were made to buildings so that disabled people could access and use services. There were baby change and feeding facilities available.

Meeting the needs of people in vulnerable circumstances

- The outreach teams took referrals for vulnerable individuals who could not access mainstream sexual health services. This included home visits if requested by the patients.
- The outreach team provided an extensive education, training and community service. The service provided sessions on child sexual exploitation, pregnancy and parenting. The service also provided sessions which explored attitudes towards pornography and how it impacted on healthy and happy relationships. The service also provided a multimedia package which could be accessed on line by young people describing how they could stay safe on line.
- The service engaged in a number of multi-agency forums, an example of this work was participation on working groups for young people who were identified as missing and young people who were at risk of sexual exploitation.
- Staff told us they applied 'reasonable adjustment' principles for patients with learning disabilities. Patients with learning disabilities could be accompanied by a carer during their consultations with staff clinic. The clinical outreach team could also visit and offer advice and treatment patients with learning disabilities at their place of residence if needed.
- The team supported 'looked after children' where needed and supported them to make decisions about relationship choices, skills and knowledge.

Community health (sexual health services)

Access to the right care at the right time

- The service had over 1000 contacts per month and an open access policy which meant that the majority of visits did not require an appointment. Intrauterine device (IUD)/ Intrauterine system (IUS) consultations and procedures were arranged through scheduled appointments. The procedures took place at the Wigan clinic on Monday when the doctor was on site.
- Patients had access to a range of clinics at different times. The Wigan clinic provided operated over seven days, with clinics available from 11am to 5pm on Saturdays and 1pm to 4pm on Sundays. The Atherton clinic was available from 3:30pm to 6:30pm on Wednesdays and the Tyldesley clinic was available from 4pm to 7pm each Thursday.
- The service produced a quality report every three months that included information such as patient waiting times and number of visits. Records for waiting times showed that between September 2015 and June 2016: -
  - Patients waiting less than 20 minutes ranged between 52% - 61%.
  - Patients waiting less than 59 minutes ranged between 31% - 39%.
  - Patients waiting less than one hour 59 minutes ranged between 4% - 5%.
- The quality report for the period of July 2016 to September 2016 showed that patient waiting times were worse than the previous nine months. During this period, 44% of patients waited less than 20 minutes and 18% of patients waited less than one hour 59 minutes. The service manager told us the increased waiting times were mainly as a result of staff sickness or leave during this period.
- There was no formal plan in place to reduce waiting times. However, the service manager told us they planned to reduce patient waiting times by having additional staff available during busy periods.
- Records showed there were no instances where a patient had waited above two hours to be seen between September 2015 and September 2016.
- Records showed that patients that left without being seen ranged between 1% - 5% between September 2015 and September 2016. Patients that left without being seen consultation were followed up by clinical staff if they were assessed as vulnerable or if there were any safeguarding concerns.
- The service had a range of staff including health care assistants, qualified nurses and clinicians who provided a wide range of services and broad level of expertise.
- Referral to specialist services (e.g. termination of pregnancies) was available and could be arranged with the assistance of staff.
- The service was open access allowing patients to see individual teams on a face to face basis promptly.
- The service was integrated providing both genitourinary medicine (GUM) and sexual health services.
- Staff at the Wigan clinic had quick and easy access to the complex sexual health and over 25's sexual health service, which was located next door.

Learning from complaints and concerns

- There was a complaints procedure in place that outlined the process for handling patient complaints.
- Information on how to raise complaints about the service were visibly displayed in the areas we inspected. Information about making complaints and providing feedback was also available on the Brook Young People website.
- The complaints procedure stated that complaints would be acknowledged within three working days and investigated and responded to within 20 working days for routine complaints.
- The service received two complaints during 2016. We looked at both complaints records and these had been investigated appropriately and responded to within the provider's specified timelines.
- Complaints about the services were investigated by the service manager. Complaints were also recorded on a complaint log so they could be reviewed for trends.
- The staff we spoke with understood the process for receiving and handling complaints. Information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.

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

Leadership of this service

- The overall lead for the services was the service manager, who was also the registered manager with the Care Quality Commission.

Community health (sexual health services)

- The service manager was due to leave the organisation during February 2017. A service manager from another of the provider's locations was scheduled to replace the existing service manager on an interim basis. There was a handover process in place to reduce the level of disruption caused by the change in management.
- The service manager reported to a regional operations manager and was supported by the nurse manager. The service manager was responsible for the administrative staff and the education and wellbeing teams
- The nurse manager reported to a regional nurse lead and was responsible for overseeing the clinical staff, including the nurses and the doctor as well as the health and wellbeing workers.
- All the staff we spoke with told us they understood the reporting structures clearly and described the managers as approachable, visible and who provided good support.

Service vision and strategy

- The Brook vision was 'Brook wants a society that values all children, young people and their developing sexuality. We want 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.'
- This was underpinned by a set of six values; confidentiality, education, sexuality, choice, involvement and diversity.
- The Brook strategic framework 2009 – 2019 outlined eight strategic objectives that established the priorities and activity plans for the service. The strategic goals were based on patient involvement, clinical excellence, providing value for money, developing a strong workforce, sharing knowledge and expertise and developing strong relationships with partner organisations.
- The vision and values had been cascaded to staff across the service and they had a good understanding of these.

Governance, risk management and quality measurement

- There was a clear corporate governance structure in place. The provider's board had overall governance responsibility for the organisation and board meetings were held at least four times a year.
- There were four corporate committees in place; risk, finance and assurance, subsiduaries, clinical advisory group and the safeguarding advisory committee. There was also a provider-level medical advisory committee (MAC). Committee meetings were held at least every three months.
- Meeting minutes showed that specific safeguarding or performance concerns relating to Brook Wigan and Leigh and other locations were escalated and discussed at the corporate-level meetings.
- There were routine local staff meetings where information on safeguarding concerns, performance, complaints, incidents and audit results was shared with staff.
- The service manager and nurse manager also attended routine clinical and operational meetings involving the clinic managers from the provider's other locations.
- The service manager logged identified risks to the services on a local risk register. We saw the risk register listed key risks, such as the IT system failure and this was reviewed on a regular basis by the service manager and nurse manager.
- There was a corporate risk register in place and any 'high' rated risks rated were escalated to the corporate risk register. The corporate risk register was maintained nationally and reviewed as part of the corporate clinical advisory group.
- Routine audit and monitoring of key processes took place across the services to monitor performance against objectives. The nurse manager coordinated most of the audit activity and maintained the service's audit schedule.
- The service manager produced monthly and three-monthly activity and performance reports and these were submitted to the service commissioners and the corporate provider.

Culture within this service

- The service was centred on the needs of local people and improving their sexual health understanding. All the staff we spoke with were positive about working for the service. Staff told us they felt valued and respected.
- The staff turnover rate between November 2015 and November 2016 was 8%, with two substantive staff leaving the service during this period.
- The service reported that the staff sickness rate between November 2015 and November 2016 was 28%. During

the inspection, the service manager confirmed one nurse and two receptionists were off on long-term sick leave. A health and wellbeing worker was due to return from maternity leave during March 2017.

- Staff sickness was managed through the use of bank staff. Staff morale was positive but staff sickness impacted day to day activities and the IT system failure also meant additional manual tasks had to be completed which increased staff workloads.

Public engagement

- Staff undertook periodic patient surveys (such as 'did you get what you came for' exit survey) to gain feedback on how to improve the services provided. Feedback from patient surveys we looked at was very positive and showed there was the services encouraged patients to provide feedback.
- Staff also promoted the services and engaged with the public through community-based clinics, educational programmes and supporting campaigns across the local area.
- The services used different media platforms, such as social media, to involve patients and promote the services.
- The service had recently set up a number of volunteer posts and patient participation groups. The two initiatives allowed the local community to share in the future development of services.

Staff engagement

- Staff participated in team meetings and were encouraged to participate in provider-level meetings as staff representatives.
- We saw evidence of an electronic staff information board based on the intranet, which was kept up to date by managers. Staff were able to see information regarding governance and patient feedback as well as information on the trust.
- Staff received information from the corporate provider through national monthly clinical newsletters.
- Brook carried out a national staff survey in 2015 to obtain the views of their staff nationwide. The results were not available on each Brook clinic or region. There were 219 responses nationally, which was 53% of the workforce. The survey asked staff a series of questions about working at Brook and the feedback was generally positive.

Innovation, improvement and sustainability

- The service planned to implement a new electronic patient record system by April 2017. This system was also used by a number of other Brook locations nationally and would allow the service to maintain standardised electronic patient records.
- The service had recently set up a "my life programme" at a local school, which focused on well-being and health rather than contraception and sexual health.
- The service had developed a range of ways to engage with young people such as use of social media platforms and text services to engage with people. The services were actively involved in campaigning for young people's causes, lobbying parliament and fundraising.
- All the staff we spoke with were confident they delivered effective care and treatment to patients. The service was commissioned by Wigan Council, who were undergoing a review of all its sexual health services. This meant there was some uncertainty among staff over the future sustainability of the services.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Take appropriate actions to improve staff training compliance in areas such as manual handling and fire safety training.
- Take appropriate actions to improve reporting of incidents (such as medication reconciliation errors and remote connectivity issues).
- Take appropriate actions to improve incident report records so that investigation findings and remedial actions are accurately documented.
- Take appropriate actions to improve the access and security of patient records so that patient historical records are available when needed.
- Take appropriate actions so that medication reconciliation log sheets are appropriately maintained.

Action the provider SHOULD take to improve

- Take appropriate actions to improve IT connectivity for staff when working remotely (via laptops).
- Take appropriate actions to ensure medical staff working in the service receive appropriate appraisal.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 - Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 12 – 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; d. the proper and safe management of medicines; How the regulation was not being met: Most staff had not completed mandatory training in manual handling or fire safety. This was a breach of regulation 12 (2) (c). Medication log records were not always accurately maintained and did not reconcile correctly with actual medication stocks. This was a breach of regulation 12 (2) (d). Incident reports did not always include documented evidence to show they had been properly investigated

This section is primarily information for the provider

Requirement notices

and monitored to make sure remedial action has been taken, prevent further occurrences and make sure that improvements are made as a result. This was a breach of regulation 12 (2) (a) (b).

Incidents relating to medication reconciliation log errors and remote connectivity issues were not always reported or investigated by staff. This was a breach of regulation 12 (2) (a) (b).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 – Good Governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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— c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; How the regulation was not being met: Electronic patient records were not maintained securely. The loss of the electronic record system meant historical patient records could not be fully retrieved for all patients. This was a breach of regulation 17 (2) (c).