

Marie Stopes International Bristol Centre

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Are services safe at this hospital?

There were systems in place to ensure all reported incidents were investigated. Staff were clear on the process for incident reporting and felt able to report appropriately.

There were processes in place to assess and respond to patients' risk.

The staff were up to date with mandatory training and staff had been trained to recognise and act upon suspicions of abuse.

We did not see evidence of a medicines stock control. Staff were unable to account for medicines prescribed against medicines given. Expired medication was not disposed of correctly or recorded appropriately.

We were told that the administration staff had at times sat with patients if they become upset or need to talk through their decisions.

Are services effective at this hospital?

Care and treatment was delivered using evidence based and national guidelines. Staff received training to equip them with the knowledge and skills to care for the patients receiving care in the centre.

Patients received effective pain relief and information about pain management on discharge home. Outcomes of the patients' care and service delivery were monitored in accordance to guidelines. Staff had a good understanding of the importance of providing full treatment explanations and options in order for patients to be able to make informed decisions prior to giving their consent.

Are services caring at this hospital?

Patients were treated with respect and compassion while they receive care and treatment. Patients told us how they had been listened to; they felt safe and were treated with kindness.

We were concerned that patients did not have full access to privacy and dignity when being cared for in the recovery area following surgical procedures.

Are services responsive at this hospital?

We found the service to be responsive to meeting people's needs and requirements. Patients did not wait longer than three days for consultations and were offered appointments to suit them. Options were given, if requested, on the disposal of foetal remains following the guidelines as set out by the Human Tissue Authority.

Complaints and concerns were acted upon and changes had been made to the service as a result of some comments made. Staff were involved in the learning from complaints. There was written information available to make a complaint but there were no leaflets available for patients to take away with them.

Are services well led at this hospital?

The Bristol Centre was well led, staff felt valued and respected and enjoyed working there. There was a good governance framework with information being passed to the board and information being disseminated to the local team. We found the HSA forms to be completed appropriately in accordance with The Abortion Act 1967 (as amended) and The Abortion Regulations 1991. Information about each termination of pregnancy was sent to the Department of Health in a timely and secure manner.

There was a good response (50%) from the patient feedback which was directly used to improve the services provided.

Summary of findings

We saw several areas of outstanding practice including:

- Staff were described and observed as being non-judgemental
- The service provided was tailored completely according to patient's needs.
- The service was highly responsive to individual needs

However, there were also areas of practice where the provider should make improvements:

- Improve the control of medicines and disposal of expired drugs.
- Improve the design of the World Health Organisation surgical checklist and include observations of practice in the audit process.
- Provide visible information for patients and visitors detailing how to raise complaints or concerns.
- Improve the privacy and dignity within the recovery area.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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Marie Stopes International Bristol Centre

Services we looked at

Termination of pregnancy;

Summary of this inspection

Background to Marie Stopes International Bristol Centre

Marie Stopes Bristol is part of the provider group Marie Stopes International. The Bristol clinic provides early medical termination of pregnancy up to nine weeks and four days and surgical termination of pregnancy until 18 weeks and six days. The clinic also provided counselling and contraceptive services, long acting reversible contraception and vasectomy procedures.

Services were provided to both NHS and privately funded patients. The clinic provided services for seven clinical commissioning groups in South West England. There were three consulting rooms, one operating theatre and six day care beds in the centre. The registered manager has been registered with the Commission since May 2006.

We inspected the clinic as part of our schedule of independent hospitals.

Our inspection team

Our inspection team was led by:

Amanda Eddington, CQC Inspection Manager, who is also a specialist within CQC for termination of pregnancy services. The team also included a CQC Inspector.

How we carried out this inspection

We analysed information that we hold as well as additional information requested from the service prior to our inspection. We carried out an announced onsite

inspection on 5 -6 November 2015 where we observed practice, spoke with staff, patients, visitors and the registered manager. We followed up with an unannounced visit on 13 November 2015.

Information about Marie Stopes International Bristol Centre

Marie Stopes International, Bristol centre is a clinic that provides termination of pregnancy and family planning services to private and NHS patients. It has one operating theatre where day case procedures are undertaken. No overnight accommodation is provided. The clinic is registered to provide the regulated activities:

- Diagnostic and screening procedures

- Surgical procedures
- Treatment of disease, disorder or injury
- Family Planning
- Termination of Pregnancy

Detailed findings from this inspection

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Marie Stopes Bristol provided early medical termination of pregnancy up to nine weeks and four days of pregnancy and surgical termination of pregnancy treatments up to 18 weeks and six days. The clinic also provided counselling and contraceptive services, including long acting reversible contraception and vasectomy procedures. The Bristol centre was supported by two satellite clinics in Dorchester and Glastonbury, where early medical terminations were carried out. Services were provided to both NHS and private patients. The Bristol centre worked with seven clinical commissioning groups in the area.

The clinic had three consulting rooms, one operating theatre and six day care beds. In the previous 12 months 1,053 women underwent medical termination and 1,834 had a surgical termination procedure. Vasectomies were carried out on alternate weeks an average of eight to ten were completed in one day. Counselling services were offered to all patients prior to and post treatment.

Summary of findings

There were systems in place to protect patients from avoidable harm, with good governance reporting structure to support this. Staff were trained to provide the services with 97% of staff up to date with mandatory training. An appraisal system was in place with the majority of staff having received a recent appraisal.

Care and treatment was delivered in accordance to best practice and guidance, patient outcomes were measured and monitored.

Patients were treated with respect and in a dignified way. Patients reported feeling safe and well cared for.

The service was responsive to patient needs and requirements, treatment options were provided wherever appropriate. Patient's feedback, complaints or concerns were well received and actions were taken as a result.

We did find some of areas for improvement; this included the need for visible information for patients and visitors detailing how to raise complaints or concerns. We found systems needed to be improved in order to effectively monitor and dispose of medicines. The world health surgical checklist was not completed appropriately throughout the surgical procedures and after surgery patients did not always receive privacy as needed.

Termination of pregnancy

Are termination of pregnancy services safe?

We found people who used the services provided at Marie Stopes International, Bristol centre were protected from avoidable harm.

There were systems in place to ensure all reported incidents were investigated. Staff were clear on the process for reporting and felt able to report appropriately. There were processes in place to assess and respond to patients' risk.

Staff were up to date with mandatory training and had been trained to recognise and act upon suspicions of abuse with their patients.

We did not see evidence of a medicines stock control; staff were unable to account for medicines prescribed against medicines given. The expired medication was not disposed of correctly or recorded appropriately.

Incidents

- The service had a comprehensive incident policy with responsibilities set out for specific team members. All staff attended training on what constituted an incident and how to report it.
- Staff were open, transparent and honest when incidents occurred. Systems were in place to ensure incidents were reported and investigated appropriately. All staff told us that they would have no hesitation in reporting incidents and were clear on how they would report them.
- There had been no serious incidents or never events reported during the previous 12 months.
- Staff reported incidents through an electronic incident reporting system. Once reported, there were triggers to inform appropriate senior management. A response to the incident was made locally and sent to the central (national) team within one week. Here incidents were further reviewed for trends. Serious incidents were investigated by other senior staff out of the region to ensure impartiality and within an allocated time frame.
- All incidents, including safeguarding, were reviewed for learning opportunities; the learning took place during team meetings and one to one meetings. Any incidents

occurring in other centres were also discussed and learning actions taken from them. We were told of an incident regarding out of date intravenous fluids administration at another location; learning from this was disseminated to all teams.

- Duty of candour was embedded in the organisation with staff aware of how and when to apologise, letters were written to reflect the apology. We saw an incident whereby the costs of flights were reimbursed due to a failed treatment procedure and an apology made.

Cleanliness, infection control and hygiene

- There was an infection prevention and control policy in place. The infection control lead nurse had attended an infection prevention and control course and was provided with regular updates. The company intranet provided guidance on infection control issues.
- Six monthly infection control audits were completed; the recent audit was 100% compliant against the standards the organisation set. We saw evidence of six monthly hand hygiene audits having been completed; this captures both nurses and consultants. The audit results were above 95.8% compliance.
- We saw full containers of antibacterial hand gel in the consultation rooms, reception and within the operating theatre. Although none of the waiting areas had access to antibacterial hand gel increasing the risk of transfer of infection.
- The building was visibly clean, tidy and well maintained. There was a contract with a cleaning company to clean the inside of the building four times per week. We saw a schedule of cleaning and the appropriate cleaning materials required for individual pieces of equipment. A deep clean took place every six months, this included the theatre space. The contracted company was reported to be responsive to any issues raised.
- The theatre was cleaned at the end of each session by the staff. We saw a daily cleaning check list and this had been fully completed. Theatre clothing was laundered by an external company. There were changing room facilities including a shower for the staff, however this was at the top of the building and accessed via the staff rest room.

Environment and equipment

Termination of pregnancy

- All the equipment we saw had been maintained by a contracted company and maintenance dates were visible on the equipment. The contracted company were able to respond to the needs of the clinic should a piece of equipment require repair. The equipment had also undergone portable appliance testing.
- Surgical instruments were sterilised by an external company, the dirty instruments were collected on a weekly basis. They kept on average 30 sterilised theatre packs.
- Blood pressure recording machines were replaced on an annual basis to ensure they were always fully functioning and correctly calibrated.
- Oxygen cylinders were stored correctly. Oxygen was supplied to the clinic through a contract with another company.
- There was access to resuscitation equipment including an automated external defibrillator (AED). These devices were able to diagnose life threatening cardiac conditions in a patient, and were able to treat them through defibrillation. Monthly checks of this machine had been undertaken and an annual maintenance check also completed.

Medicines

- Marie Stopes had contracts with three suppliers for the purchasing of medication; the contracts were open ended. Orders were placed electronically and checked by an authorised person. Supplies were sent directly to the centre. The medications were stored in a locked cupboard within the recovery area. We saw daily monitoring of the medication fridge temperatures.
- All medications were prescribed by doctors remotely via an electronic system. Medication was given as per prescription and signed for electronically.
- We did not see any evidence of stock control and the staff were not able to evidence the number of drugs given against the prescribed medications. In particular the oral abortion medication was not audited against usage.
- Antibiotics were given to patients as per treatment guidelines.
- Allergies were clearly documented on the electronic patient records. Patients with a latex allergy were always allocated the first surgical slot of the day.

- There were no controlled drugs stored or given in the clinic.
- Expired medicines were not subject to audit or correctly disposed of. The centre used a standard sharps container and documented in a diary which was not signed by the staff disposing of the medication.

Records

- An electronic system was used for documenting patients care. There was some paper records maintained such as the World health organisation (WHO) surgical safety check list.
- Patients were given the option to receive an initial medical assessment by phone or at the Bristol Centre. The consultation covered a comprehensive medical history check which identified any existing health conditions. Pre-existing conditions (PECs) were risk assessed in accordance with the PEC Policy. If necessary and with the patients permission they made contact with the relevant General Practitioners to obtain additional medical information. Where a medical condition was identified and did not require onward referral to another centre, a comprehensive treatment plan & pathway involving all relevant specialists was developed. The lead clinicians made a decision as to the most appropriate treatment for the patient.
- Bi-Monthly audits of 30 sets of notes were carried out. The audit included correct completion of the HSA forms, consent and various other documentation standards. Results for the last six months showed a compliance rate of 99%.
- We reviewed six sets of patient notes. All were fully completed with appropriate risk assessments. Treatment decision flow charts were seen to be used, consent forms for treatment were signed and dated and two independent signatures obtained to authorise the termination procedures.
- At the end of every day, medical notes were checked by the reception staff. Any issues were raised immediately and recorded on the electronic incident reporting system and addressed with the individual concerned
- All paper documentation was stored securely within the clinic for four months post treatment. After this time they were stored off site with a secure document storage company.

Termination of pregnancy

Safeguarding

- Safeguarding systems and processes were in place to keep people safe. Staff were trained to recognise and act upon abuse or suspicions of abuse of vulnerable people. There was a comprehensive safeguarding policy in place, using the relevant guidance and legislation to underpin their duty, it included, Working Together to Safeguard Children 2010. The policy set out how health professionals working within Marie Stopes International worked together to safeguard and promote the welfare of vulnerable people and those at risk, and protected them from abuse and neglect.
- Staff were trained at a level appropriate to their role. All clinical staff were trained to level two and all non-clinical were trained to level one. The training took place every two years. We saw evidence that safeguarding issues or concerns were discussed at team meetings.
- Team members were supported by a corporate safeguarding advisor and two safeguarding leads within the centre at Bristol. The leads were trained to safeguarding level three. They attended local safeguarding board meetings. Cultural background and origins were addressed in safeguarding level one on line training and level two face to face. Issues surrounding female genital mutilation (FGM), honour based violence and hate crimes were part of the programme. All team members were required to access and complete the Home Office FGM online training. This training had recently become available for staff on female genital mutilation. At the time of the inspection only two members of the team had completed this. Face to face training was in the process of being rolled out.
- There were domestic violence leaflets available in the female toilets and staff were alert to concerns such as trafficking, with input from women's aid and Salvation Army.
- Under the Sexual Offences Act 2003, children under the age of 13 are considered, legally, to be unable to consent to any form of sexual activity. In line with national and Marie Stopes International UK policy, all clients who accessed the service
- Women under 16 years of age were asked probing questions during their consultation to establish if there were any safeguarding concerns.
- All patients were seen on their own at some point during the patient journey. The centre was equipped with a small private room where young people and vulnerable adults were taken ensuring a discreet service. If staff felt that a person was at risk they were asked (discreetly and sensitively) to determine what the risk was. Where possible staff sought permission from the person before reporting but if the risk was high they contacted the local social services emergency number or the police depending on the perceived requirement.
- Counselling was offered to all patients regardless of age and young people under 16 had mandatory face to face counselling.
- Team members were trained in information governance and confidentiality and it was embedded in the culture at the Bristol Centre. Staff addressed patients by their first name only in public areas.

Mandatory training

- 97% of staff were up to date with mandatory training which was provided internally and externally. Annual mandatory training consisted of information governance and intermediate life support. All other mandatory training was three yearly. The reception staff were provided with basic life support training. The company who provided intermediate life support training also provided ad-hoc 'mock-up' emergency situations on average every three months. Feedback was provided to staff after these sessions.
- All team members were trained to level one in safeguarding (including The Mental Capacity Act 2005); all clinicians were trained at level two or three.
- New starters were provided with an initial four day induction and introduction to the systems and completion of online training. Staff were required to work shadow shifts and complete a set of competencies to be signed off by the clinical lead.
- We looked at two personal records and found that they were both up to date with their mandatory training and had certificates available for us to see. This information was stored on a spread sheet for the manager to have oversight of training.

Termination of pregnancy

- Equality and diversity training was a new module that had been recently added to the e-learning system and team members were required to have completed the module as part of their mandatory training portfolio by December 2015.

Assessing and responding to patient risk

- Patient's risks were assessed by staff during the face to face consultation by following a treatment decision flow chart.
- The reliance was on the patient for providing correct medical information about themselves particularly in the instances where patients declined their GPs to be informed
- Pre-operative guidelines were followed. If risks were identified the anaesthetist was advised in advance. If the risk was too high for the centre the patient was referred to another centre or to the NHS for treatment. For example women with a BMI over 35 were seen and assessed by the anaesthetist. Women whose BMI was greater than 45 were automatically referred to a local NHS hospital as the anaesthetic risk was deemed too great.
- We saw evidence of venous thromboembolism (VTE) risk assessments having been completed on all patients.
- Patients were checked against the WHO surgical checklist prior to commencement of surgery. The WHO checklist forms part of their medical records. However, staff did not carry out the WHO checklist appropriately, mainly due to the design of their forms. Staff were observed completing the 'sign out' prior to the procedure commencing. This section is designed to record the correct number of swabs and instruments after a procedure has been conducted to ensure none are retained. The WHO audit did not identify this practice as it was a paper led audit and did not have any observations of practice.
- After surgery patients observations were recorded. An early warning scoring system was in place although it was rarely required. In the event of a patient collapse staff were able to alert other staff members in the building by using a paging system on the telephone.

Nursing staffing

- Marie Stopes employed registered and non-registered nurses. The staffing numbers fluctuated each day according to the type of treatment being provided on any given day. All staff rotated from consultation to working in the theatre in order for them to have an all-round knowledge and understanding of the service provided. Staff were therefore able to work in all areas providing cover in the event of sickness.
- Staff turnover at the centre was low; during the last 12 months the centre had employed only one new registered nurse. There were no nursing vacancies at the Bristol centre.
- The centre employed two bank nurses who worked shifts on a regular basis to maintain their competencies. Marie Stopes, Bristol did not employ the services of an agency.

Medical staffing

- Medical staffing was provided by doctors working both remotely and within the centre. The remote doctors were employed by Marie Stopes International and worked in the call centres; their role was to review patients' case notes and medical histories prior to signing the HSA1 forms and prescribing medications.
- Surgery was performed at the centre two days per week. During this time there was an anaesthetist present who was employed on a sessional basis and worked at another local trust as an anaesthetist. Their revalidation was completed in the NHS hospital and reviewed by the medical director of Marie Stopes International to ensure it was complete.
- The surgeon was employed by the organisation. Appraisals were carried out by the organisational lead surgeon. The surgeon also underwent an external review of practices.
- Marie Stopes had internal processes for monitoring licences to practices; all were monitored via the clinical Leads group and kept centrally.
- The doctors were required to undertake competency based training which was signed off, a copy was placed in their personnel file at their main centre of work.
- All medical staff complete their mandatory training as for the other clinical staff.

Major incident awareness and training

Termination of pregnancy

- There was a contingency business plan in place in the event of an emergency. The centre had a backup emergency battery should the power fail and was classed as a priority for restoring failure with the power company should the need arise. In the event of bad weather patients were contacted and offered alternative dates for treatment if they wished.

Are termination of pregnancy services effective?

People had good outcomes because they received effective care and treatment that met their needs. Care and treatment was delivered in accordance with evidence based and national guidelines. Education was delivered to staff to equip them with knowledge and skill base to care for the patients receiving care in the centre. Outcomes of the patients' care and service delivery were monitored in accordance to guidelines.

Patients received effective pain relief and information about pain management on discharge home.

Staff had a good understanding of the importance of providing full treatment explanations and options in order for patients to be able to make informed decisions prior to giving their consent.

Evidence-based care and treatment

- There were policies and guidelines in place to ensure care and treatment was given in accordance to best practice. The policies and guidelines were written and produced by the lead consultant and anaesthetist for the organisation.
- The service followed the framework as set out by the Abortion Act 1967 and amendments in 1990. Women were provided with information about the available options open to them, given the opportunity to discuss the risks and benefits as well as the emotional, psychological and social issues of continuing or not continuing with the pregnancy.
- Nurses led the service provided under the guidelines of the Royal College of Nursing and supervision of a registered medical practitioner. In line with the legal requirements of the Abortion Act 1967 authorisation of a termination remained the responsibility of two medical practitioners.

- Staff followed the compliance of the Required Standard Operating Procedures (RSOP) 13 in providing contraception and sexually transmitted infection (STI) screening. STI screening was based on an opt out system. Future contraception was discussed with patients during the treatment process. In October 2015 there was an uptake of 54% (target set at 50%) of patients receiving Long Acting Reversible methods of Contraception (LARC).
- Guidance from the Department of Health (DOH 2004), RCOG (2011) and HTA (Human Tissue Authority Code of Practice) was followed in the disposal of foetal remains and options offered to patients should they wish to make alternative arrangements.

Pain relief

- Patients undergoing medical termination were advised on pain relief medication to administer should they require it. This information was provided verbally and in written form. Prior to administering the medication, staff checked with the women to ensure they had taken pain relief in advance and had access to additional pain relief once home.
- Patients were offered pain relief after surgical procedures. If the patient was nauseous further medication was offered to resolve this. We saw patients given warm pads to place on their abdomen post-surgery to alleviate the discomfort.
- On discharge home patients were given advice on the type of pain relief to take should they require it.

Patient outcomes

- The centre benchmarked against the Department of Health Abortion statistics annually. Data on failed procedures were continually collected and analysed using a web based management system. On a quarterly basis, clinical reports were produced which included failure rate by both surgical and medical treatments, infections and transfers. The clinic was reliant on patients notifying the clinic of any concerns such as infections, therefore any data may not be reliable.
- The percentage of patients who did not proceed (DNP) with termination was 13% in the Bristol centre, this number included those patients who were ambivalent in their decision and may well have returned at another time to complete treatment.

Termination of pregnancy

- Failure rates were monitored. Medical terminations required the administration of two separate medicines given on separate occasions. Staff explained the increased risk of failure if women elected to have a six hour gap between medication administrations.
- The rate for repeated abortions due to failures for the Bristol centre was 1.3% in a 12 month period.
- Clinical outcomes were reviewed by a practitioner within the whole Marie Stopes group in order for comparisons and benchmarking to occur. Outcomes were also benchmarked against national outcomes to ensure individuals practices fell within the norm.

Competent staff

- Staff competencies were assessed and additional one to one training provided if necessary. All staff were rotated within the clinic to maintain their skills, with some staff also attending satellite clinics,
- Nursing staff were required to undertake accredited ultrasound scan training. Nursing staff attended a 4-day classroom style course, before completing a required number of scans within the centre observed and signed off by the ultrasound scan mentor. An external assessment was required to complete the process. For existing team members, refresher days were completed every three years to ensure skills and knowledge were maintained and any changes in techniques were implemented. A total of seven staff had been fully trained to complete ultra sound scanning.
- Family planning courses were not a compulsory part of the health care assistant or registered nurse training. However, staff were encouraged to undertake a Contraception and Sexual Awareness Course (CASH) or update session. Six out of eight contracted clinical team members had attended training. Five team members had completed training on HIV testing.
- Staff reported being able to access additional training from the company if it could be demonstrated it was appropriate to their role, with one staff member telling us “the development has been brilliant”.
- There were 11 team members eligible for appraisals, at the time of the inspection nine had been completed and two were new starters. This equated to 82% completion.

- Vasectomies were performed by consultant urologists who undertook the work on a sessional basis. Competency and revalidation was assessed nationally by the clinical director in conjunction with the individuals’ main place of employment.

Multidisciplinary working (related to this core service)

- Staff at the centre liaised with a variety of other health care professionals, such as local pathology department, GPs and local social service and safeguarding teams.
- Patients were asked that GPs be informed of their procedure. However, if this consent was denied patients were given a letter to give to a health care professional in case of complications.

Seven-day services

- The centre did not operate seven days per week; however patients had access to the Marie Stopes International 24 hour helpline. If necessary, the call centre could access appointments at the centre for the client to be assessed, including ultrasound investigation if indicated.
- During the discharge process possible complications were explained to the client as well as advice around their recovery process. Each client was handed a discreet purse sized booklet detailing arrangements to contact the centre or helpline at any time.

Access to information

- Patients were asked for permission to share information with their GPs, and as a result, wherever possible the patients GP was informed of the treatment given.
- Staff at the centre had access to GPs to request further information on the health of the patient if necessary. At times GP’s did not respond very quickly, however this did not have an effect on the patient care or treatment.
- If patients required transfer to another health care setting, the doctor co-ordinating the care of the patient communicated with the accepting health care. Depending on the condition of the patient determined who accompanied during the transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Termination of pregnancy

- Staff had a good understanding of the legislation surrounding consent including that of women less than 16 years of age. All nursing staff were able to take consent; training had been provided and staff had their practice observed.
 - If women under the age of 16 years attended, they were encouraged to involve a parent or guardian, however staff applied the Fraser guidelines when obtaining consent from those women.
 - When patients had their initial consultation prior to treatment, they were all offered the opportunity to have access to counselling, be it face to face or telephone counselling. This included offering counselling services to the partners of men requesting vasectomies.
 - If staff felt the patients were not certain of their decision for treatment they suggested the patients went home to consider their decision further. The staff were aware not to add any pressure to the patient during decision making.
 - All patients were given the option of having a chaperone. Patients' privacy and dignity were respected during examination by the use of a screen in the consulting rooms during examinations and scans.
 - Patient feedback was collected. Response rates were 50%. From the feedback response, 95% of patients reported of having their questions answered completely, 98% of patients felt they were treated with dignity and respect. Patients told us staff "couldn't have done more for either of us".
 - Staff told us they aimed to make the processes as normalised as possible. The recovery area was described as being 'spa like' with the layout and couches giving a less clinical appearance. However, there was little privacy in the recovery area. Women entered the area from the immediate recovery area adjacent to the operating theatre following a surgical termination. At this point they had a sarong around their waist. One woman was seen to be quite sleepy after sedation and required two staff members to help her onto the couch, there were no curtains to pull around whilst transferring women onto the couches, however, there were screens available. On this occasion, staff did not use screens and the transfer was carried out in full view of other women. Staff told us these were used if a patient was experiencing nausea and vomiting or was particularly upset. Women were then left to recover slowly, with tea and biscuits. The system meant a new post-operative client was brought through every 15 minutes.
 - The vasectomy service was held on a separate day to the termination of pregnancy services, this ensured that males and females did not meet during their treatments.
- Patients were respected and valued as individuals. They were treated with respect and compassion while they receive care and treatment, however dignity was not always maintained. Patients told us how they had been listened to, they felt safe and were treated with kindness. Staff were non-directive and non-judgemental
- We were concerned that patients did not have full access to privacy and dignity when being cared for in the recovery area.

Are termination of pregnancy services caring?

Compassionate care

- Patients told us they felt safe and were treated with kindness, understanding and respect. We followed six patient journeys through the clinic. Patients appreciated the clinic being private and 'tucked away' from the city centre.
- Staff introduced themselves to patients choice for childbirth was evident amongst the staff providing the care.

Understanding and involvement of patients and those close to them

- Information booklets were given to all patients by staff who explained side effects and complications of treatments. Patients were given the time to ask questions if required. Patients were reminded of the 24 hour helpline. In addition, the website housed all leaflets for downloading and reading in the privacy of the patients own home.
- Women were given choice over termination method and were also fully informed of reduced success rates when

Termination of pregnancy

the interval times in medical terminations were reduced to six hours. (Medical terminations require the administration of two types of medicines, with an interval of at least six hours between).

- We spoke with one partner and also the mother of another patient. Both described being kept fully informed of the treatment process.

Emotional support

- Counselling was available for all patients accessing services, whether for termination of pregnancy or vasectomy. In addition, counselling services could be accessed at any time following the procedures.
- We saw staff giving support to patients throughout the procedure and giving well after care.
- Administration staff was available to comfort upset patients if necessary.
- Relatives, partners or friends are able to accompany patients during consultations and treatments, however they are unable to accompany during the surgical procedure to protect others privacy and dignity.

Are termination of pregnancy services responsive?

We found the service to be responsive to meeting people's needs and requirements. Patients did not wait longer than three days for appointments and were offered appointments to suit them. Services were tailored to meet individual needs and were delivered in a way to ensure flexibility and choice.

The disposal of foetal remains followed guidelines as set out by the Human Tissue Authority. Options were available to women who wanted to make their own arrangements.

Complaints and concerns were acted upon and changes had been made to the service as a result of some comments made. Staff were involved in the learning from complaints. There was written information available to make a complaint but there was no leaflets available for patients to take away.

Service planning and delivery to meet the needs of local people

- The service displayed the certificate of approval (issued by the Department of Health) in the reception area of the clinic.
- Commissioners and stakeholders were involved in service planning. Commissioners set targets for the service to achieve, these were generally government driven and local targets for example sexually transmitted infections (STI) testing and achieving. In October 2015 the uptake of long acting reversible contraception (LARC) was 54% of patients treated against a target of 50%. Review meetings were held and the commissioners were sent reports and quality data.
- Patients were also able to privately self-refer. Referrals were also made as a result of other NHS services treatment times being too long.
- The service had a protocol in place for the transfer of people using the service in the event of complications; however the two local trusts were reported as being unwilling to sign an agreement. This had not prevented patients being transferred when need arose, however it prevented women being treated who present at over 18 weeks and six days gestation as the local trusts would not accept any complications arising as a result of treatment beyond this date. As a result, women requesting a termination of pregnancy beyond that point had to travel out of the area to access treatment.
- There were translation services available to aid the consent process for patients whose first language was not English. Staff contacted language interpretation phone service or were able to use the Google translation on the computer. All leaflets were provided in various languages and were printed from the computer.

Access and flow

- Days and times were designed to ensure short wait times and access to the full range of services. There was flexibility to re-arrange appointments at very short notice to meet the needs of the client. This was done via a team who monitored and managed capacity on a daily basis. They were able to react quickly to increased demand by adjusting list structures or adding extra lists at very short notice. They met their internal target for every type of appointment to be available within 3 working days. Information was made available to the centre on a weekly basis outlining their waiting times.

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- Vasectomy surgeries were held on a two monthly basis, patients were able to book their own procedure slot. A telephone consultation took place seven to 10 days prior to procedure. The size of theatre list was able to be variable in order to meet the fluctuating demand.

Meeting people's individual needs

- Consultations were delivered either face to face or via telephone to meet people's needs. There was not a requirement for them to attend the clinic ahead of the procedures if they did not wish, however the option was available to them.
- Counselling was offered to everyone, it was available via telephone or if preferred face to face. The wait time for telephone counselling was one day with appointments arranged by the one call service (provided by MSI). We spoke with one patient who had accessed telephone counselling. They described initially feeling it would not be as beneficial as face to face counselling, but described it as immensely positive and helpful.
- All patients were offered the option to have counselling prior to receiving treatment. If patients appeared to be ambivalent about their decision they were advised to take time to consider their options. A room was provided for patients to sit and think quietly about their decision if necessary. Reception and administration staff were trained to sit and speak with patients if this was required. Patients reported as being supported to make their decision and not rushed.
- Women under 16 years of age were provided with compulsory counselling as part of their treatment to ensure they were fully aware and informed of their decisions.
- There was information in the centre detailing alternatives to termination should the woman choose.
- The service was highly responsive to individual needs. For example, we were told of a patient who had presented at 18 weeks and six days gestation which was too high to be treated at the Bristol centre. The staff arranged for her treatment to take place at the Birmingham centre that same day. She was transported by staff using a pool car to the other centre. As the patient was from Ireland, staff also re-arranged her return flights from Birmingham.
- Patients were informed of the options for foetal disposal on request. A client information leaflet was provided which detailed the options available. They were advised what documentation was required in order to procure a cremation or burial. Where possible (and with the clients permission) staff liaised with the funeral directors to facilitate a smooth process.
- The disposal of foetal remains followed the Human Tissue Authority Code of Practice. A MSI policy described the standard process (Management of Foetal Tissue Policy). The disposal of foetal remains was undertaken by an external company.
- Incineration of foetal waste is recognised as the appropriate method of disposal (when a client does not express any personal wish for any other method of disposal). MSI stored the tissue in a sealed waste receptacle in the clinical specimen freezer until the tissue was collected for incineration by clinical waste contractor. Where products were required to be retained for DNA testing or criminal investigation, new equipment was used and a separate storage container was utilised. The contents are labelled with the patients name, MSI number, the patient's date of birth and date of procedure. Any non-standard disposal option was documented in the patient's record and on a freezer log sheet indicating reason for keeping and date for either collection or disposal. Where products had not been collected, the client was contacted to ask for further instruction or a decision was made to dispose of products after three months.

Learning from complaints and concerns

- Peoples concerns and complaints are listened to and used to improve the quality of care. Both verbal and written complaints were recorded on the incident reporting system.
- We did not find any information leaflets but complaints advice was given in patient literature and displayed in the patient information folder in waiting areas. If a patient was to raise a concern before leaving the centre they were able to meet with a senior member of the team to discuss the issue. If it was a complex issue the patient was encouraged to put their complaint in writing.
- Issues could be raised via patient feedback questionnaires. If a patient indicated less than 'very

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good' response or documented a particular issue, a record of this was sent to the centre management team. Positive and negative feedback was communicated team meetings and the published feedback reports were shared with the team on publication.

- The centre received very few complaints about the service or staff members. One of the regular complaints was about the type music played in the centre, so this is now changed on a regular basis.

Are termination of pregnancy services well-led?

MSI Bristol centre was well led; staff felt valued and respected by their leaders. The centre operated an open door policy And staff felt able to raise concerns at any time.

There was a good governance framework with information being passed to the board and information being disseminated to the local team. We found the HSA forms to be completed appropriately and correct information was sent to the Department of Health in a timely manner.

There was a good response (50%) from the patient feedback which was directly used to improve the services provided.

Vision and strategy for this this core service

- The vision for Marie Stopes International (MSI) is that every pregnancy is a wanted one and where women have children by choice. This was fully reflected in the staff and services provided at the Bristol centre.

Governance, risk management and quality measurement for this core service

- There was an integrated governance framework. The corporate integrated governance committee met three times per year. Local integrated governance committees met four times per year; the minutes from this meeting were reviewed in the Bristol team meeting. On a quarterly basis MSI UK governance support team produced national clinical governance reports that were shared with the Bristol centre to ensure best practice was recognised and benchmarks were set. There was a

comprehensive audit plan in place to support the benchmarks set. Local audit, activity and performance data was reported through regionally and then nationally.

- The centre held monthly team meetings which were minuted. At these, staff were able to discuss any issues they may have, and new policies were introduced as well as outcomes monitored.
- There was a risk register held locally which contained 14 low level risks. These were reviewed on an annual basis.
- We discussed how conscientious objections would be managed within the realms of human resources values and behaviours. However this was an area that was discussed during recruitment of staff and it was thought this would not become an issue.
- HSA1 forms were only completed once a full medical history and criteria had been established. Two doctors, either the surgical team or the remote doctors signed the form, and the form was held in the medical record to be checked prior to any treatment being initiated.
- Information was gathered directly from the client record system and automatically populated the HSA4. At the point of discharge the HSA4 data was checked by the receptionists for completeness before sending to the Department of Health (DH). If the electronic process was not available hard copies were kept on site and were completed by the doctors once the procedure has taken place and were sent by post to the DH. The clinician signing the HSA4 form accessed the DH site to authorise the form. This ensured completion of forms complied with the law.

Leadership / culture of service

- The staff we spoke with said the service was well led. The team said they felt listened to and were able to discuss any issues or concerns. They were able to get support from senior staff if they needed it. The staff said they were valued and respected by their managers.
- There was an overall sense that all staff members were proud of the service they provided for their patients.
- The manager operated an open door approach and encouraged team members to discuss issues and work together to find solutions, the staff reflected this approach.

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Public and staff engagement

- Every client was given an anonymised client feedback questionnaire, once completed they were sealed and sent to an external organisation for analysis. The response rate was 50% and feedback on the quality of care received by patients was consistently above 97%. Any urgent issues were reported to the governance team and regional manager within 24 hours.
- The manager disseminated any findings during team meetings & local integrated governance committee meetings. An example of this was a patient had asked if legs could be put up in stirrups after being sedated for dignity reasons. This was discussed with the team, due to potential issues of physical harm to patients and a manual handling risk for staff, a compromise was reached to aid patients' dignity during the procedure.
- There was a yearly staff feedback questionnaire available to be completed where views were feedback into the larger organisation. We did not receive any data from this feedback.

- The service was working closely with local and national charities, this promoted awareness for staff of domestic violence.

Innovation, improvement and sustainability

- The services provided were continually reviewed through audit process and a good governance structure throughout the organisation. Change was managed through a consultative basis with staff members. Quality and patients' choice was of paramount importance to the team.
- The organisation had a rewards and recognition scheme, whereby individuals could be nominated for 'above and beyond' awards and a STAR award. The winner was awarded a trip to visit MSI in another country.
- The Bristol centre were recognised as a centre of excellence by MSI in 2011.

Outstanding practice and areas for improvement

Outstanding practice

We found the following areas to be outstanding practice

- Staff were described and observed as being non-judgemental
- The service provided was tailored completely according to patient's needs.
- The service was highly responsive to individual needs

Areas for improvement

Action the provider **SHOULD** take to improve

- The control of medicines including audit of medication usage and appropriate systems for the disposal of out of date medicines
- Ensure correct completion of the World Health Organisation surgical safety checklist.
- Ensure patients and visitors are easily able to identify how to raise a complaint or concern.
- Improve patient privacy within the recovery area.