BPAS - Middlesbrough

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

BPAS Middlesbrough is part of the British Pregnancy Advisory Service. The BPAS Middlesbrough service opened in 2012 and provided termination of pregnancy services, pre and post termination counselling as well as contraception advice and screening for sexually transmitted diseases. At the time of the inspection, the service was providing medical abortions up to 10 weeks gestation to both private and NHS patients. The service provided termination of pregnancy services to children under sixteen and could provide counselling and treatment for patients of any age. The service planned to offer non-scalpel vasectomies in the near future.

We made an announced inspected of the service on 9-10 June 2016 and an unannounced inspection on 17 June 2016 as part of our independent healthcare inspection programme.

We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities it provides.

Are services safe at this service?

There was a culture of reporting and learning from incidents across the organisation and within the local services. Staff we spoke with demonstrated an excellent understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse. All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment. All staff had completed training to level 3 in safeguarding for children and adults.

Staffing was sufficient and appropriate to meet the needs of patients in their care. Staff ensured medicines were stored and administered safely. Pathway documents and clinical risk assessments we observed were completed fully and legibly. Staff completed and submitted all Department of Health documentation as required.

Are services effective at this service?

Care was provided in line with national best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment.

The complication rate for simultaneous administration at BPAS Middlesbrough was higher than the complication rate across the whole of BPAS. Although higher than that of other centres, the complication rate had not breached the BPAS threshold of 5% and, therefore, had not been viewed as a concern.

We observed that patient assessments were thorough and staff followed pathway guidance. Pain relieving medications were routinely prescribed for patients to take at home following the initiation of treatment.

Observation and assessment of staff competence was an integral part of pathway audit. Staff told us they always made sure patients gave their consent in writing and adhered to Fraser guidelines in respect of children and young people. We observed this in records we saw for patients aged under 18. There were good links with local safeguarding teams and the local NHS hospital.

Are services caring at this service?

Senior managers and staff involved and treated patients with compassion, kindness, dignity, and respect. The results of the BPAS 'Client Satisfaction' reports showed 99% of patients at BPAS Middlesbrough would recommend the service to

Summary of findings

others. Client satisfaction reports showed high levels of patient satisfaction. Client Care Coordinators (CCCs) and nursing staff gave appropriate emotional support to patients. Staff provided all patients with a counselling service before and after termination of pregnancy. There was access to specialist advice and support when needed. We saw examples where staff had gone out of their way to support patients in difficult situations.

Are services responsive at this service?

Service planning monitored activity and staff scheduled sufficient clinics to meet demand. Staff made sure they had enough information and could get further advice when necessary. The service met waiting time guidelines and patients could choose a date or alternative venue for their procedure. The service shared learning from complaints across the organisation, nationally, regionally and locally and staff gave examples of this during the inspection.

Are services well led at this service?

The organisation had a clear mission to provide safe and effective care for termination of pregnancy. Senior managers had a clear vision and strategy for this service and there was good local and regional leadership for the service. Quality of care and patient experience were seen as the responsibility of all staff. There were effective governance systems in place and staff received feedback from governance and quality committees. Staff felt supported by their managers and were confident they could raise concerns and have them dealt with appropriately. There was a corporate risk register in place however a local risk register had not been developed. This was planned to be developed with help from the corporate risk manager. There were some local risks identified and standard operating procedures were in place to ensure business continuity in various situations.

The service was aware of and we observed records and staff working towards Department of Health requirements regarding compliance with the Abortion Act 1967 and the 'Required Standard Operating Procedures 2014'.

The organisation had a proactive approach to staff and public engagement. Innovation, learning, and development were encouraged.

Our key findings were as follows:

- Staffing levels, medicines' management and record keeping were good.
- Staff followed policies and procedures.
- Care was provided in line with national best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment. The complication rate for simultaneous administration at BPAS Middlesbrough was higher than the amalgamated complication rate for the whole of BPAS. Although higher than that of other centres, the complication rate had not breached the BPAS threshold of 5% and, therefore, had not been viewed as a concern.
- There was enough equipment to allow staff to carry out their duties. The service had processes for checking and maintaining equipment.
- Staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses.
- There was evidence of a culture of learning and service improvement.
- There were systems for the effective management of staff which included an annual appraisal and support for revalidation
- The service had a rolling programme of local clinical audits. Managers monitored and benchmarked performance of all units across the organisation using a performance dashboard.
- Leaders were aware of their responsibilities to promote patient and staff safety and wellbeing.
- Leaders were supportive and the culture encouraged candour, openness, and honesty.

We saw several areas of good practice including:

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- Staff went out of their way to provide a caring and holistic service to their patients. They did this by working well with local agencies and charities to provide additional support and services for vulnerable patients.
- Regular, direct observation of staff practice was an integral part of the BPAS approach to ensuring staff maintained an expert level of competence in their individual roles.
- All members of the team worked together to ensure they gave patients the best possible experience of the treatments given and the service offered.
- The provider ensured that all patients received a private initial consultation without anyone else present to protect patients against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.
- Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs, who did not meet usual acceptance criteria.
- Staff knew their own role and remit for safeguarding children and vulnerable adults, and had a heightened awareness of the needs and vulnerabilities of children and young people using their service.
- Completion of records complied with prescribed practice and was consistently of a high standard.

Professor Sir Mike Richards

Chief Inspector of Hospitals

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Background to BPAS - Middlesbrough

The British Pregnancy Advisory Service was established as a registered charity in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. BPAS Middlesbrough opened in 2012.

Durham, Darlington and North Yorkshire clinical commissioning groups contract BPAS Middlesbrough to provide a termination of pregnancy service for the patients of County Durham, North Yorkshire and surrounding areas. The service also treats private patients, which account for a large proportion of activity.

The service was registered as a single speciality service for termination of pregnancy and is registered for the following regulated activities:

- Diagnostic & Screening Procedures
- Family Planning Services
- Treatment of Disease, Disorder and/or Injury
- Termination of Pregnancy
- Surgical Procedures

The services provided under these activities were:

- Pregnancy Testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice
- Contraception Supply

The service planned to provide surgical abortions and vasectomy procedures in the near future.

Our inspection team

Our inspection team was led by:

Inspection Lead: Sandra Sutton, Inspection Manager, Care Quality Commission.

The team included CQC inspectors with additional training in the inspection of termination of pregnancy services.

How we carried out this inspection

To get to the heart of patients' experiences of care, 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?

We carried out the announced inspection of BPAS Middlesbrough on 9 and 10 June 2016 and an unannounced visit on 17 June 2016. We talked with patients and members of staff: including a receptionist, a client care coordinator (CCC), and one registered nurse / midwife. We also spoke with the treatment unit (registered) manager, the regional operations director and the regional lead nurse. We looked at the care records of 12 patients. We observed social interactions and communication with patients and those close to them during our inspection.

Prior to the inspection, we reviewed a range of information and data about the service.

Summary of this inspection

Information about BPAS - Middlesbrough

The BPAS Middlesbrough service provided termination of pregnancy services to both private and NHS patients two full days a week. The service provided termination of pregnancy services to children under sixteen and could provide counselling and treatment for patients of any age. BPAS Middlesbrough provided support, information, treatment, and aftercare for patients seeking termination of pregnancy.

From January to December 2015, the service carried out 303 early medical abortions.

The service provided consulting and treatment rooms, ultrasound scanning and screening equipment, and nursing staff to support patients throughout the consultation and medical treatment. There were contracts in place for pathology and pharmacy services from independent providers.

The Service held a licence from the Department of Health to undertake termination of pregnancy procedures. The licence was displayed in the main reception area.

Medical abortions were carried out on patients of early gestations (up to ten weeks).

The service employed three (0.4 whole time equivalent (WTE) RNs / midwives, one was the lead nurse/ midwife for the service, three (0.7 WTE) CCCs and administrators and a treatment unit manager. The service used no agency staff. The treatment unit manager for the service was the registered manager and was responsible for the day-to-day running of the Middlesbrough unit and was the named, local, safeguarding lead. Medical services were provided by doctors working remotely and one local doctor who visited the unit from the neighbouring Treatment centre . Remote medical services included clinical assessment, confirmation that the lawful grounds for abortion were met, and prescribing of abortifacient medicines.

A regional operations director and a number of corporate specialist advisors, nationally, such as; infection prevention and control, and safeguarding leads supported the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

BPAS Middlesbrough was contracted by Durham and Darlington and North Yorkshire clinical commissioning groups (CCGs) to provide a Termination of Pregnancy service for patients from the areas north and south of Middlesbrough. BPAS Middlesbrough did not have a contract with South Tees CCG which included Middlesbrough and the local areas. The premises were situated at a large treatment centre in the town centre and were easily accessible by public transport or car. The unit accepted NHS patients from any commissioning CCG and private paying individuals from anywhere in the UK. Some private patients from the Middlesbrough area and others travelled from Newcastle, Northumberland and even Scotland. Approximately 96% of treatments across all BPAS centres nationally were NHS funded. However, this unit reported a higher proportion of self-funding patients: 69% of patients from South Tees and 58% from Hartlepool and Stockton who attended for consultation paid their own fees. All of those patients who chose to go on to have their treatment at the centre were self-funding.

The service was open from 9am to 5pm on Thursday and Friday each week. Patients could access termination of pregnancy services on other weekdays at alternative BPAS clinics in the North East of England. Patients who needed or chose to use weekend services could use other BPAS clinics in the UK.

BPAS Middlesbrough treated patients of all ages, including those aged less than 18 years. Two children under the age of 16 had been treated at BPAS Middlesbrough in the 12-month period between January and December 2015. Staff caring for patients less than 18 years of age followed strict safeguarding and management processes.

BPAS Middlesbrough undertook medical abortion and pre and post termination counselling as well as contraception advice and screening for sexually transmitted diseases. Staff referred any patients requiring surgical abortion or medical termination of pregnancy of later than 10 weeks gestation to alternative British Pregnancy Advisory Services (BPAS) such as Doncaster or regional NHS services. The BPAS Middlesbrough manager hoped to add surgical abortion and vasectomy services to the provision at this unit.

All staff we spoke with were dedicated to care for patients who needed termination of pregnancy services. Patients were involved in their care and encouraged to make an informed choice on the method of abortion, subject to their gestation and medical assessment.

A senior leadership team including regional managers and clinical experts supported the treatment unit manager and the Middlesbrough service. The treatment unit manager was the registered manager and safeguarding lead for the service.

Doctors working remotely, and one doctor who visited from the neighbouring NHS treatment centre, provided medical services. Remote medical services included clinical assessment, confirmation that the lawful grounds for abortion were met, and prescribing of abortifacient medicines

Termination of pregnancy

Summary of findings

Termination of pregnancy services were safe, caring, effective, responsive and well led.

There was a culture of reporting and learning from incidents, across the organisation and within the Middlesbrough service. Staff could demonstrate their understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse. All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment. Staffing levels, medicines management and record keeping were good.

Care was provided in line with national best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment.

The complication rate for simultaneous administration at BPAS Middlesbrough was higher than the complication rates across the whole of BPAS. Although higher than that of other centres, the complication rate had not breached the BPAS threshold of 5% and, therefore, had not been viewed as a concern.

Patient assessments were thorough and staff followed clear pathways of care. The service managers used a clinical dashboard, which measured and facilitated improvement in the quality and safety of clinical standards. Staff were competent and observation and assessment of staff competence was an integral part of pathway audit.

We observed interactions between patients and staff in the public areas of the service and during their consultation and treatment and saw that staff treated patients with compassion, dignity, and respect. They focused on the needs of each patient and responded quickly to their needs. Staff were very aware of the additional needs and risks associated with the care of young people and made every effort to ensure young people were supported through their treatment. The results of the BPAS 'Client Satisfaction' reports showed that 99% of patients at BPAS Middlesbrough would recommend the service to family and friends.

All patients had checks and tests before procedures. Waiting times were consistently within the guidelines set by the Department of Health, unless patients chose appointment times outside the recommended timescale. Information and advice were available from staff, leaflets and on-line to patients at all stages of their care. Interpreting and counselling services were available to all patients and staff made every effort to meet individual patients' needs. Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs. There were systems in place to ensure sensitive disposal of pregnancy remains, in accordance with national guidelines. The service was accessible for patients of all diversities including those with disabilities.

Senior managers had a clear vision and strategy for this service and quality of care and patient experience were seen as the responsibility of all staff. Staff felt supported by their managers and were confident they could raise concerns and have them dealt with appropriately. There were effective governance systems in place and staff received feedback from governance and quality committees. There was a corporate risk register in place however a local risk register had not been developed. This was planned to be developed with help from the corporate risk manager. There were some local risks identified and standard operating procedures were in place to ensure business continuity in various situations.

The service strove to meet Department of Health requirements. The organisation had a proactive approach to staff and public engagement. Innovation, learning, and development were encouraged.

Termination of pregnancy

Are termination of pregnancy services safe?

By safe we mean people are protected from abuse and avoidable harm.

- There was a culture of reporting and learning from incidents within this service and across the organisation.
- Staff we spoke with demonstrated an excellent understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse.
- All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.
- All staff were trained to safeguarding adults and children level three.
- Staffing was sufficient and appropriate to meet the needs of patients in their care.
- Staff ensured medicines were stored and administered safely.
- Pathway documents and clinical risk assessments were completed fully and legibly.

Incidents

- There were no serious incidents or never events at the service in the 12 months before the inspection.
- Information from serious incident investigations, elsewhere in the organisation, was cascaded out to all units on a three-monthly basis so all staff could learn from these. Staff told us they received this information through their local team meeting and via email.
- Incidents were reported and investigated, staff we spoke to were aware of their responsibilities in relation to incident reporting and notification. Staff we spoke with understood the principles of "being open" and "Duty of Candour".
- The patient safety policy contained information regarding incident reporting, notifiable safety incidents, and duty of candour and staff had received information about this from the organisation.
- BPAS Middlesbrough had reported 2 incidents in the period February 2015 and March 2016, details of the incidents indicated that these had been acted upon and discussed with staff at the unit.
- We saw from Clinical Governance Committee and Regional Quality Assurance and Improvement Forum (RQuAIF)minutes that incidents were thoroughly investigated. We saw that appropriate actions were taken to reduce the risk of future incidents
- We saw that summaries of the investigation and learning / recommendations from serious incidents, across the organisation, were accessible to staff. Records indicated that staff had read this information.
- We saw that investigation of the incidents had been thorough and recommendations had been implemented. For example, staff told us that because of incidents relating to gestational age scanning in other BPAS units, there was to be a scan audit every 18 months and that the regional lead nurse's role had been developed to include assisting in the training and support of nurse /midwives performing ultrasound scans. Staff who needed upskilling in this area could also go to one of the larger BPAS units to gain practice of scanning at different gestations.
- Staff told us and we saw that they used a "trigger list" to help them report incidents appropriately.
- Staff told us they received feedback from incidents via the central BPAS office. The registered manager was responsible for reviewing all incidents, initiating investigations and noting any required actions. The clinical lead reviewed the investigation reports and action plans for all clinical incidents to ensure the investigations were thorough and the action plan was complete.
- The health and safety manager reviewed incidents and undertook investigations relating to health and safety.
- Incidents were reported regionally and nationally through the Regional Quality Assurance and Improvement Forum (RQuAIF) and clinical governance meetings and learning was shared through a cascade of minutes to the treatment unit manager. An executive summary was produced and every member of staff was expected to read this and sign to say they had done so. The nursing staff we spoke with were aware of recent serious incidents from across the organisation and we saw they had signed record sheets to say they had read the serious incident summaries from the RQuAIF.

- The regional clinical lead's role included investigating serious incidents within their own region, debriefing staff involved and sharing recommendations.
- The BPAS corporate office received Medicines and Healthcare products Regulatory Agency (MHRA) Alerts and Safety Notices and emailed these to the treatment unit manager for the attention of all clinical and nursing staff. Staff told us they received these alerts by email and things that needed immediate action came out as 'red top' alerts.
- BPAS Middlesbrough reported incidents externally where required. Point of care testing errors were reported to Serious Adverse Blood Reactions and Events (SABRE) and adverse drug events and equipment failures were reported to the Medicines and Healthcare products Regulatory Agency (MHRA).
- To reduce point of care testing errors, the registered manager from the Middlesbrough clinic had visited the independent testing laboratory to aid understanding of the testing processes and the impact of labelling errors by BPAS Middlesbrough staff. The learning from this visit had been shared with staff and actions had been taken to ensure common errors such as insufficient fluid or the presence of two swabs in the containers were reduced. Staff at the Middlesbrough unit requested a second practitioner always checked results following BPAS policy.

Cleanliness, infection control and hygiene

- The consulting rooms, waiting areas and other clinical rooms were visibly clean and tidy.
- Cleaning schedules and standard operating procedures were available for each individual room or area. Staff referred to these schedules when undertaking cleaning outside of cleaning contractor hours.
- Facilities for hand hygiene were provided and soap dispensers we reviewed were in good working order.
- We observed staff washing hands and using gel appropriately.
- Disposable curtains were in use in the clinical areas and were marked with the date of last change.
- Personal protective clothing was available in all areas we visited.
- Every month essential steps of hand hygiene was audited by observing a range of procedures and a cleaning audit was undertaken. Both audits demonstrated 100% compliance every month between September 2015 and April 2016.
- Environmental, health and safety and waste Inspections carried out in June 2015 showed good compliance with standards and that mitigations were in place for known risks.
- Results of all audits were submitted formally and IPC was reported formally on a dashboard as a performance indicator.
- There was a policy in place regarding safe disposal of clinical waste and a service level agreement was in place with a waste contractor for removal. We saw waste was appropriately segregated and disposed of. Sharps bins were used correctly and a spillage kit was available if needed.
- We saw that there was a contract with the landlord who was responsible for water testing and management. We saw water testing reports regarding quality of water. We saw there were little used water outlets in the unused treatment room however, we did not see evidence of regular flushing of little used water outlets in line with recommend guidance (Health and safety executive, HTM04 01 part B).
- Training records showed that all staff had received an infection control update in the last 12 months.
- We saw and audit records showed that staff protected and cleaned scanning equipment appropriately in between patients and followed decontamination regimes for all equipment used in patient examinations for example ultrasound probes.

Environment and equipment

- The service was provided from a sub-let suite of rooms in the One-life centre. We saw the premises were in a good state of repair and the suite of rooms were appropriate for the needs of the service.
- Staff told us and we saw that there were processes in place with the landlord to ensure any issues with the building maintenance and repairs were dealt with.
- Maintenance of equipment was managed centrally from the corporate office and electrical safety testing of equipment was evident.
- Evidence of stock rotation was in place and all stock we checked was in date and stored in an appropriate manner.
- We saw that resuscitation equipment and drugs were checked daily when the unit was open and that trolley drawers were locked.

Medicines

Termination of pregnancy

- There was a medicine management policy in place and staff had access to a pharmacist, employed by BPAS on a consultancy basis, if needed.
- The registered manager was responsible for auditing of medicines and the early warning dashboard showed that medicines management had been green since April 2015.
- The unit did not keep or administer any controlled drugs.
- The unit dispensed prescriptions for analgesia, antibiotics and contraceptives.
- We checked medication cabinets, which were clean, tidy and well organised. Drugs were checked regularly and stored safely.
- Staff recorded fridge temperatures in line with good practice medication guidelines. Recordings were all within recommended range.
- A doctor prescribed all abortifacient medicines and nurse / midwives provided some non-abortifacient medicines under Patient Group Directions (PGDs). The PGDs were in line with national guidance, accountable officers were clearly named and they had signed the PGDs correctly.
- All PGDs were within review date and staff undertook training and signed the record sheet when training was complete and they were competent to administer and or supply the prescribed medications.
- Nurse / midwives told us they used PGDs with reducing frequency as the system now allowed for easier access to electronic prescribing.
- PGDs also covered pain-controlling medication, treatment of chlamydia and prophylactic antibiotics to prevent post procedure infection.
- We observed nurse / midwives providing antibiotics and contraceptive medications and checking that patients understood what the medications were for and the importance of taking them as prescribed.
- We observed nurse / midwives administering Depo-Provera injections which acted as a long acting reversible contraceptive (LARC).

Records

- Patient records were a combination of electronic and paper based. Patient information and records were stored safely and securely in line with the Data Protection Act. Medical paper records stayed on site for six months then were archived at the BPAS head office.
- Patient records included speciality pathways and risk assessments for venous thromboembolism (VTE), sexual health and safeguarding for patients under 18 years of age.
- We looked at 12 sets of records across various pathways and found them to be up to date, complete and legible. Records indicated risk assessments were completed and any medical concerns or issues identified were well documented and reviewed following appropriate interventions.
- Case note audits showed consistently good compliance. Audits carried out January, March 2016 and April 2016 showed compliance of 100%.
- Nursing staff told us that on rare occasions doctors asked for more information before agreeing to sign a HSA1. The information we saw recorded in paper notes and on the electronic system met BPAS criteria to be sufficient for doctors to make a judgement.
- There were information leaflets for patients regarding “How we use your health records” this gave points regarding access to records, good practice and information sharing.

Safeguarding

- Good systems were in place to safeguard vulnerable adults and children and young people. Staff we spoke with were all aware of their responsibilities and demonstrated experience of using safeguarding pathways appropriately.
- The registered manager was the local designated safeguarding lead. Staff knew they could also seek advice and support from the regional operations director if the registered manager was unavailable.
- We saw that the unit held a file of local safeguarding policies and contact details for local safeguarding teams. The staff at Middlesbrough had good links with the local safeguarding board and could contact their local designated doctors and nurse / midwife when needed.
- All staff had undertaken the BPAS training programme for protection of vulnerable adults and children’s safeguarding training at level three. Staff were up to date with 90% of their mandatory training requirements. The treatment unit manager had booked places for individuals and requested training for out of date elements.

Termination of pregnancy

- The registered manager was aware of additional multi-agency training provided by or available through member organisations of the local children's safeguarding board. Staff were encouraged to access this training which was often available free of charge.
- Staff told us that support from the unit manager and regional operations director was excellent when dealing with difficult safeguarding issues.
- Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The BPAS corporate self- assessment audit January 2016 indicated compliance across all standards.
- Staff told us and we observed that they carried out safeguarding risk assessments for all patients under 18 years and when there was any suspicion of abuse of older adults. Staff we spoke with told us of safeguarding referrals they had made to the local authority when appropriate following discussion with the BPAS safeguarding lead.
- For patients aged under 18 , a safeguarding risk assessment was completed and decisions were made or further action was taken on the outcome of the assessment. We saw that this risk assessment was completed for all relevant patients in the records we looked at.
- Organisational policy was that if a 12-year-old girl used the service then staff would automatically make a safeguarding referral in line with the Sexual Offences Act 2003.
- Where young people were known to have a social worker, BPAS staff would inform them, without the child's consent if necessary, that the young person had attended the unit.
- Staff told us of local support agencies where they could refer patients who were being abused or if they had been raped. These included the HALO project, Arch and My Sister's Place.
- All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.
- We observed staff and saw from records that patients under 18 years were asked a range of questions to encourage patients to disclose any issues of concern or coercion regarding sexual activity.
- We saw from records that patients under 18 years were given additional information regarding consent, and information sharing.
- The organisation had policies and procedures for staff to follow if cases of female genital mutilation or sexual exploitation were discovered and staff were clear what actions they needed to take in this situation.

Mandatory training

- All staff received mandatory training, which included life support, infection prevention and control, safeguarding children and adults, information governance and other aspects of health and safety at work as part of their induction.
- There was a programme of training available staff to access updates when required.
- Training was provided face to face by internal and external trainers.
- Nurse / midwife practitioners underwent an initial 12 week, training programme, which covered all elements of mandatory and the additional training they required. Records showed that staff were observed as competent.
- All staff told us they were up to date with their mandatory training. However training records indicated that one receptionist needed life support updates, two nurse / midwives needed to complete training regarding female genital mutilation and one member of staff needed information governance training. The unit manager had made arrangements for outstanding training to be completed.
- Training was provided through a combination of online courses and updates and face to face from external trainers.
- All staff had received basic or intermediate life support training relevant to their role.
- Two members of staff were trained to deliver first aid in the workplace.

Assessing and responding to patient risk

- We saw that staff used 'The BPAS Suitability for Treatment Guideline' which clearly laid out the criteria for a patient's suitability for treatment.
- For patients who were not suitable for treatment at BPAS Middlesbrough on medical grounds BPAS had a

Specialist Placement team, which sourced appointments within the NHS. Staff gave us examples of when they had referred patients to the team for placement.

- We observed that before treatment, all patients were assessed for their general fitness to proceed. This assessment included obtaining a medical and obstetric history and measurement of vital signs, including blood pressure, pulse and temperature.
- We observed records and practice and saw that all patients received an ultrasound scan to confirm dating, viability and multiple gestations. Nurses trained in early pregnancy ultrasound also checked the location of implantation to exclude the possibility of ectopic pregnancy. If staff suspected this, they made an immediate referral to the local early pregnancy unit. Staff from BPAS would ring the unit to discuss their findings with the doctor on-take.
- A member of staff also told us that they had been trained to identify and refer any pregnancy, which raised suspicion of a molar pregnancy as this could indicate pre-cancerous cells. The member of staff told us of a recent patient who had presented with a suspected molar pregnancy and how this patient had been referred to an NHS hospital near the patient's home for further investigation and treatment.
- Blood tests were performed on all patients to establish those patients who had rhesus negative blood group. These patients received treatment with an injection of anti-D to protect against complications should the patient have future pregnancies. Other relevant laboratory testing was undertaken as appropriate and as agreed with the patient. These tests could include haemoglobin level, chlamydia and HIV testing. Staff offered all patients the screening tests for sexually transmitted diseases.
- We observed that staff made positive identity checks before commencing a consultation or treatment.
- We observed staff giving patients advice and information regarding accessing emergency medical health services, should they suffer heavy blood loss following treatment. Aftercare and helpline numbers were included in the BPAS guide, given to all patients who had a termination of pregnancy.
- Discharge letters were given to patients to keep for their information, regarding the treatment they had received. They could give this to other healthcare professionals if they needed to access emergency services. Patients were also asked if they would like a copy of the letter sent to their GP, copies were only sent to the GP with the patient's consent.
- There was an emergency transfer agreement in place with the local NHS trust. Staff had a direct link through a named nurse at the local NHS Trust hospital. This enabled urgent referral and access for patients who were suspected of having an ectopic pregnancy or who needed to access NHS specialist services for further assessment or investigation of a pregnancy anomaly.
- There had been no emergency transfers in the data provided for the reporting period January 2015 to December 2015. Staff told us there had not been any recent transfers but they had made a small number of referrals regarding suspected ectopic pregnancy and one other for a pregnancy anomaly.
- Patients referred to the local hospital were given a letter to give to the staff at the early pregnancy unit or A & E regarding tests already performed, scan results and reasons for concern.
- We saw that records of patients with allergies and those with the same name as another patient were highlighted by a sticker system to draw staff attention to this.

Nursing staffing

- The clinic used the BPAS safe staffing policy, which outlined minimum staffing levels. The performance dashboard for Middlesbrough had been green since June 2015 indicating no breaches of the minimum staffing level in this period.
- There were three registered nurses / midwives and three non-registered staff working at BPAS Middlesbrough. Non-registered staff included two administrators and one client care coordinator (CCC). Some of these staff also worked at the BPAS Newcastle clinic. The Middlesbrough clinic used a skill mix of registered midwives (RM), nurses and CCCs. There was always at least one RN/ RM on duty.
- Nurse / midwife practitioners were either a RN or RM. Staff elsewhere in BPAS provided cover, to the Middlesbrough unit, if needed, this could be the regional lead nurse or staff who worked at other units. There were systems in place to request cover for planned and unplanned absence if needed.

Medical staffing

Termination of pregnancy

- BPAS Middlesbrough did not directly employ any medical staff. There was one doctor who worked under practice privilege arrangements, to review clinical records, authorise abortions, sign the HSA1 forms as one of the doctors required and to prescribe treatments.
- BPAS employed doctors at a corporate level, who worked remotely, to undertake assessment of medical information and history, to make judgements regarding the reasons given for termination of pregnancy and sign HSA1 forms, to prescribe treatments and to provide clinical advice to nursing staff as required.
- Doctors accessed information through an electronic system to make their clinical and legal assessments. The electronic system included the facility for doctors to ask further questions of the nursing staff who could contact the patient if needed.
- We saw the remote system working and observed that electronic records gave reasons for abortion, against which the medical practitioner could make a judgement.
- Nursing and midwifery staff told us that if they needed any clinical advice regarding a patient they were able to ring the remote doctors or the regional clinical lead. They told us that doctors responded quickly and were approachable and supportive.

Major incident awareness and training

- There were local contingency plans in place, such as fire or loss of utilities and staff underwent scenario-based training regarding these. Fire plans were visible in clinical areas.
- The main risk was IT failure that could prevent remote signing of HSA1 forms. Staff were aware of the need to escalate this immediately to ensure an alternative solution was put in place quickly.

Are termination of pregnancy services effective?

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

- Care was provided in line with national best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment.
- The complication rate for simultaneous administration at BPAS Middlesbrough was higher than the complication rates for the whole of BPAS. Although higher than that of other centres, the complication rate had not breached the BPAS threshold of 5% and, therefore, had not been viewed as a concern.
- Patient assessments were thorough and staff followed pathway guidance.
- The service managers measured and facilitated improvement in the quality and safety of clinical standards.
- Pain relieving medications were routinely prescribed for patients to take at home following their procedures or initiation of treatment.
- Observation and assessment of staff competence was an integral part of pathway audit.
- In the records we looked at, staff recorded discussions to show they adhered to Fraser guidelines in respect of children and young people and patients gave their consent in writing.
- There were good links with local safeguarding teams, the local NHS hospital and other agencies.

Evidence-based care and treatment

- All staff at BPAS Middlesbrough had access to up to date policies and procedures through the BPAS intranet. We observed staff adhering to policies and procedures, for example, with regard to consultation and treatment and infection, prevention and control.
- Staff told us that updated policies and guidelines were cascaded to staff via email and conference calls were held for staff to dial into. These were recorded for staff to access later if unable to dial in during the live presentations.
- BPAS introduced simultaneous administration of mifepristone and misoprostol (medicines used to bring about abortion) in March 2015. This is not in line with RCOG guidance, which recommends that mifepristone is administered first, followed by the administration of misoprostol 24 – 48 hours later. However, a structured approach had been taken when planning and implementing this pathway and it was kept under regular review.

Termination of pregnancy

- The introduction of simultaneous administration followed a national BPAS pilot study of almost 2000 patients between March 2014 and January 2015. This pilot study demonstrated that simultaneous administration was associated with an increased need for surgical treatment, due to complications, in comparison to a dosing interval of 6 – 72 hours (7% compared to 3.3%). Acceptability to patients was almost the same between simultaneous administration and a dosing interval of 6 – 72 hours (89% compared to 90%).
- The service monitored the outcomes of simultaneous treatments and reported outcomes to the clinical governance committee. Minutes of the clinical governance committee meeting in June 2015 stated 'there was an increase in complications since the introduction of simultaneous administration of mifepristone and misoprostol for EMA, but that these were within what was quoted in the 'my BPAS guide'. The 'my BPAs guide' stated "the risk of continuing pregnancy is two in 100 if the medicines are taken at the same time, and one in 100 if medicines are taken 24 – 72 hours apart. The risk of retained products of conception is five in 100 if the medicines are taken at the same time, and three in 100 if medicines are taken 24 – 72 hours apart. The risk of requiring surgical treatment for failed medical treatment is seven in 100 if the medicines are taken at the same time and three in 100 if medicines are taken 24 – 72 hours apart."
- We saw that there was ongoing monitoring, by the provider, of the outcomes of simultaneous treatments in comparison to interval treatments.
- We observed that staff discussed the relative risks of different treatment regimens including simultaneous treatment with the patients during their consultation and that the differences in failure rates were given verbally as well as pointed out in the BPAS guide. The BPAS guide was given to all patients.
- We observed that patients choosing simultaneous treatment understood there was evidence that this was a less effective option that interval treatments. Data indicated that 94% of patients chose to have a simultaneous treatment between January 2015 and April 2016.
- Staff followed a national work instruction for the counselling of patients prior to termination of pregnancy and best practice, following RSOPs and RCOG clinical guidelines for medical abortions.
- Audits were conducted to assess the quality of care, compliance with policy & procedure and monitor standards. These included; clinical pathway audits, infection control audits and record keeping audit. The Middlesbrough BPAS audit dashboard showed improvements in record keeping from 94% compliance in April 2015 to 100% in July 2015 and consistent ongoing compliance until December 2015. Clinical audit results improved from 99% in July 2015 with actions identified and 100% compliance was recorded in December 2015.
- Regional managers, the registered manager and other members of staff were responsible for different elements of the audit programme.
- Immediate feedback was given to the relevant staff on the day of the audit and this was shared with staff locally. Results were reported centrally for benchmarking and recommendations for action were made where necessary.

Pain relief

- All patients were prescribed pain relief to take home and this was recorded on the medicines administration records.
- We observed and saw from records that nurse / midwives gave patients good information and advice regarding what to expect post treatment and how to alleviate pain.

Nutrition and hydration

- Water and hot drinks were available for patients in the waiting areas.

Patient outcomes

- Patients undergoing medical abortion were asked to ensure that a pregnancy test was completed two weeks after their treatment to ensure that it had been successful. Patients were asked to contact the BPAS Aftercare Line or the Middlesbrough clinic and were invited back to the treatment unit if they had a positive pregnancy test.
- Staff told us that in order to monitor outcomes they relied on patients contacting BPAS by using BPAS Aftercare Line. If the treatment unit was informed that there had been a complication a form would be completed and it would be documented in patients' notes to ensure that the information was captured.

- Monitoring of outcomes took place at corporate level and information was shared through the meeting structures to managers and to individual clinicians as appropriate.
- Locally, BPAS Middlesbrough monitored and reported complication rates to relevant commissioning groups. We saw that patient information clearly gave the complication rates of each treatment and we observed staff discussing these with patients.
- The Middlesbrough unit reported all clinical complications as incidents through the incident reporting system. Between January 2015 and April 2016, the unit reported 21 complications among patients having a simultaneous treatment abortion. Of these, one was a haemorrhage not requiring transfusion, seven were retained non-viable pregnancy, seven were incomplete abortion and six were continuing pregnancy. Data for the four reporting periods between January 2015 and April 2016 showed an increasing complication rate for patients receiving a simultaneous treatment from 1.3% in April 2015, 5.2% August 2015, 5.5% December 2015 and 8.3% in April 2016. National rates for minor complications following simultaneous treatment was 3.4% January 2016 – April 2016.
- Middlesbrough complication rates had not been identified as an issue by the RQuAIF. Although higher than that of other centres, the complication rate had not breached the BPAS threshold of 5% and, therefore, had not been viewed as a concern.
- All patients were offered screening for sexually transmitted infections (STIs). If a positive result was returned, processes were in place to track partners and offer treatment.
- The treatment unit kept a record of all patients that were referred to NHS hospitals with suspected ectopic pregnancy. Staff actively followed up the outcomes for these patients by direct communication with the early pregnancy assessment unit (EPAU) or with the patient.
- We saw that staff checked point of care testing solutions each day when the unit was open to ensure quality of results. Checks and results from testing procedures were recorded in a log book and signed for by the staff who had carried out the tests.
- We saw from commissioning reports that BPAS Middlesbrough collected and reported data regarding; age of patients seeking treatment, uptake of sexually transmitted infection screening, patients who received contraception by type (including long acting reversible contraception), numbers of patients who had a previous abortion, all complications and numbers of patients and reasons for not proceeding to treatment e.g. decision to continue pregnancy or gestation over legal limit. We saw that information collected also included reasons why screening or contraception was declined. Therefore, many of the indicators identified in Department of Health (DH) required standard operating procedure (RSOP: 16) regarding performance standards and audit were met.

Competent staff

- All new staff worked as supernumerary until assessed as competent in their role.
- We saw from HR records that nurse / midwife practitioners had undertaken a 12-week course of extended training and were assessed as competent to; scan patients using ultrasound, obtain consent for procedures and prescribe contraception. These staff needed to have 150 observed and supervised scan procedures before they were able to perform scans independently.
- We reviewed four sets of staff personnel records; these were well organised, well recorded and all staff had up to date training records, competency checks and DBS checks carried out.
- Records evidenced completion of job specific induction programmes for registered staff and healthcare assistants and competency assessments.
- The nursing staff we spoke with were aware of revalidation requirements and had been asked by the organisation to produce a portfolio. One to one meetings and appraisals had been restructured to include a section on revalidation and unit managers had a register of when staff revalidation was due.
- All clinical staff were expected to attend the BPAS Clinical Forum, where expert speakers gave presentations on relevant topics.
- Staff were aware of the most up to date information and told us they received regular updates regarding this through emails, bulletins, team briefs and from reading minutes of governance minutes. We saw that staff had signed record sheets to say they had read important bulletins and clinical updates.
- The registered manager had received training in key areas of their role, such as management training courses and human resource workshops.

- The client care coordinator told us they had completed BPAS counselling training as well as external training they had accessed from other local agencies including drug and alcohol counselling.
- We saw training records that showed they had attended mandatory clinical supervision sessions in the past 12 months. These were peer reflective sessions and facilitated by a trained person. Staff told us they found these supervision sessions very valuable.
- Data from January – December 2015 showed that at the Middlesbrough unit 100% of medical staff, 100% of nursing staff and 70% of administrative staff had received an appraisal.
- There was a defined set of behaviours expected of all staff working at BPAS, which managers used to aid recruitment and inform appraisal discussions.
- Staff told us they received an annual appraisal and had six-monthly job chats with their supervisor or unit manager.
- Senior nursing staff observed staff practice as part of pathway audits; this enabled a review of staff competence and identification of training needs. Managers told us that when audit results identified omissions or areas for improvement this was discussed with staff on a one to one basis to facilitate personal development and maintenance of a high level of skill.
- Regular, ongoing, direct observation of staff practice in a formal and recorded manner was an integral part of the BPAS approach to ensuring staff maintained an expert level of competence in their individual roles. The overall aim was to maintain and improve competence and expertise of nurses and midwives within the team.
- Staff we spoke with valued the direct observation of practice as a way in which to maintain their competence and prevent complacency.
- We saw competency records of observations and written communications between observer and practitioner that gave results and feedback on areas for improvement.
- There were national competency frameworks in place for RNs, RMs and CCCs.
- The regional clinical lead was responsible for overseeing medical staff in terms of competence. There was a structured process with a template available for following up on concerns about a doctor's practice or performance. This included action planning to improve performance.
- To obtain practice privileges the doctors had to provided evidence of GMC registration, indemnity insurance, qualifications and evidence of annual appraisal / revalidation. Doctors had to have disclosure and barring checks prior to appointment and child protection training to level three was mandatory
- BPAS policy was that managers made checks every two years to ensure that doctors remained eligible to practice at BPAS. We saw from personnel records that checks and requirements for this doctor were up to date.
- There was a process in place for ensuring information was checked and updated every two years and disclosure and barring checks were repeated every three years.
- When skills gaps were identified or when staff wanted to develop in their role, staff were encouraged to access additional training. We saw that staff had received additional training with aspects of clinical practice such as counselling and contraception.
- All nursing and midwifery staff had received contraception training. BPAS policy stated that nurses and midwives needed to receive at least two hours contraception training every two years and this was checked at appraisal.
- Midwifery staff received supervision from a named supervisor of midwives at the local NHS trust.
- Clinical supervision was available for all nurses and midwives on a four monthly basis and was facilitated by a member of staff who had training in clinical supervision. Nursing staff found these sessions a positive experience.
- Staff received email notifications of training workshops inviting them to enrol.
- Staff told us they received lots of training through the organisation and that this was of a good quality.
- The organisation had introduced a regional lead nurse role, which helped ensure new staff were appropriately supported through their training period.

Multidisciplinary working

- We saw that nursing and midwifery staff, client care coordinators and other non-clinical staff worked well together as a team and showed respect for each other's roles.
- There were clear lines of accountability that contributed to the effective planning and delivery of care.

- Staff told us that they could easily access medical support and advice when needed. Staff could go to the electronic client assessment system where they could have an online discussion with a doctor regarding suitability for EMA. If they needed other advice about a patient's treatment, they could contact the doctor on call or the clinical lead for the region. Staff at the unit could also telephone to speak to doctors directly or ring the regional clinical director if necessary.
- Staff told us that the medical staff were easy to contact through these systems and responded to requests for advice very quickly. We observed doctors responding to online requests for prescriptions and assessment of additional clinical information regarding suitability for treatment.
- Managers and specialists were available at the end of the phone if staff needed help or support with other issues such as safeguarding or infection prevention and control. Staff told us they found it easy to access any help needed and specialists and managers were responsive and supportive.
- Staff told us that they had close links with other agencies and services such as the local safeguarding teams and staff at the local emergency, pregnancy assessment unit. Staff gave examples of when they had needed to contact the local emergency pregnancy assessment unit to discuss and refer patients.
- Staff went out of their way to provide a caring and holistic service to their patients. They did this by working well with local agencies to provide additional support and services where appropriate.
- BPAS Middlesbrough had service level agreements with a neighbouring NHS Trust, which allowed them to transfer a patient to the hospital in case of medical or surgical emergency.
- Midwifery staff had good links with the supervisors of midwifery at the NHS Trust, who provided advice and support when needed and clinical supervision for the registered midwives working in the unit.

Seven-day services

- The service was open from 9am to 5pm on Thursday and Friday each week.
- If patients needed to use services on other days, they could be signposted to any alternative BPAS clinic. Patients who wanted or needed weekend services could use any other BPAS clinics in the UK
- Staff told us they had extended clinic opening hours, on occasions, to accommodate extra patients during periods of increased demand.
- BPAS provided 24 hours per day and seven days a week advice line, which specialised in post-abortion support and care. This was in line with Required Standard Operating Procedures set by the Department of Health. Callers to the BPAS Primecare service could speak to RNs or midwives who would give advice.

Access to information

- Patient notes were a mixture of electronic information and paper based records, which were kept onsite for six months following patient discharge. If any complications occurred this allowed easy access to notes within this time. Records were archived at a central store following this time but could be retrieved easily if needed.
- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy services.
- Staff were able to access diagnostic tests/blood results in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff were given training at induction regarding obtaining informed consent and all staff had attended a consent workshop.
- All care records we reviewed contained signed consent from patients. Possible side effects and complications were recorded and the records showed that these had been fully explained.
- We saw that patient information clearly gave the complication or failure rates of each type of treatment and we observed staff discussing these with patients. We observed that patients choosing simultaneous treatment understood this had a higher complication or failure rate than the interval treatments.
- We observed staff asked for permission before commencing scans and other tests.
- Staff we spoke to were aware of Fraser guidelines to obtain consent from young people regarding contraception.

Termination of pregnancy

- We observed records and staff were able to provide examples of how they assessed competence of a young person using Gillick competence principles. Posters were also displayed in waiting areas about assessment of Gillick competence.
- There was access to guidance and policies for staff to refer to concerning Mental Capacity Act (MCA).
- Staff told us that Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training was delivered as part of protection of vulnerable adults training.
- Staff told us that very occasionally patients with a learning disability or other complex needs had used their service. When this had happened, a friend had accompanied the patient and had helped ensure the patient fully understood the treatment. Depending on the wishes of the patient, the friend could stay with the patient throughout treatment and examinations.
- BPAS policy on consent for an examination advised staff on how to support a patient lacking capacity to consent to an abortion. An independent medical capacity advocate (IMCA) could be instructed to represent and support patients whose treatment was arranged by the NHS. Staff told us they would not treat a self-funding patient they considered did not have capacity to consent to treatment and would refer them for local NHS treatment.

Are termination of pregnancy services caring?

By caring we mean that staff involved and treated people with compassion, kindness, dignity and respect.

- Staff treated patients attending for consultation and procedures with compassion, dignity, and respect.
- Staff focused on the needs of each patient as an individual and responded quickly to their needs.
- Staff established and respected each patient's preference for sharing information with their partner or family members, and reviewed this throughout their care.
- Staff explained the different methods and options for abortion. If patients needed time to make a decision, staff supported this.
- Patients gave very positive feedback in the BPAS 'Client Satisfaction' reports.
- The service provided counselling for all patients considering termination of pregnancy and post-termination counselling and support to partners and those people close to patients.
- We saw examples where staff had gone out of their way to support patients in difficult situations.

Compassionate care

- We observed consultations and staff interactions with medical termination patients and those close to them throughout our inspection and we saw how they involved and treated patients with compassion, kindness, dignity and respect. We observed professional, caring, and sensitive interactions between staff and patients in public areas, before, during and after consultations.
- Staff told us that patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care. Staff told us younger patients were supported to involve their parents or family members and their wishes were respected. However, staff told us and we observed every patient was seen alone for the first part of the consultation to ensure they felt at ease and were not under any pressure for any reason from a partner or the person attending with them.
- The results of the BPAS 'Client Satisfaction' reports showed that 109 patients had responded in the period from September to December 2015. Of all patients who responded 99% would recommend BPAS Middlesbrough to someone they knew who needed similar care. Between 99 and 100% of respondents felt they were listened to, were involved in decisions, had confidence in staff and were treated with privacy and dignity at all times.
- We saw that staff introduced themselves to patients.
- We observed consultations and staff interactions with medical termination patients and those close to them throughout our inspection and we saw how they involved and treated patients with compassion, kindness, dignity and respect.
- We observed professional, caring, and sensitive interactions between staff and patients in public areas, before, during and after consultations.
- The receptionist told us how the customer care training had made a difference to her dealing with patients and how this had made her more aware of patients anxieties and of observing patients non-verbal signs, behaviours

and interactions with anyone who accompanied her. She told us if she had any concerns or worries about a patient she would highlight them to the client care coordinator or nurse / midwife.

Understanding and involvement of patients and those close to them

- Nursing staff told us and we observed that during the initial assessment with a patient they explained all the available methods for termination of pregnancy that were appropriate and safe to patients. The nurse / midwife would consider gestational age and other clinical needs whilst suggesting these options.
- We asked staff if there were occasions when patients changed their minds about a procedure. They told us that patients could attend for counselling only and that they may change their minds or use another service if they wanted a different procedure for example if a woman preferred a surgical termination or if they needed a later termination.
- Staff told us and we observed that patients were made aware of the statutory requirements of the HSA4 forms and were reassured that the data published by the Department of Health for statistical purposes was anonymised. All patients who responded to the client satisfaction survey told us they felt their personal information was treated confidentially and 96.2% said they had been told how BPAS would use their personal information.

Emotional support

- All patients spoke to a CCC and a RN or RM for assessment prior to their treatment. A counselling service was also available post-procedure. Staff gave patients the service telephone number with details of when the centre was open as well as the main BPAS contact centre telephone number for other times of day or night.
- The records we reviewed recorded the post discharge support offered to patients and those close to them. Staff gave patients written information about accessing help from the staff at the clinic during service opening hours and the 24-hour telephone service following their procedure.
- Staff at BPAS Middlesbrough signposted and referred patients to the HALO Project, Arch, and My Sister's Place; local charitable organisations that could offer practical help and support should a patient need them.
- The BPAS ethos was to treat all patients with dignity and respect, and to provide a caring, confidential and non-judgemental service. The BPAS guide informed patients that personal autonomy for every patient was at the heart of BPAS care.
- BPAS policies, procedures and the care we observed during consultations reflected the patient's right to influence and make decisions about their care, in accordance with BPAS quality standards of confidentiality, dignity, privacy and individual choice.
- Staff provided patients' partners, and those supporting them, with information and support should they require it. Staff spoke to people face to face, provided a leaflet they could take away or signposted them to on line information. They also provided details on how to contact "Relate" for counselling should a partner express a different opinion about a termination from the woman seeking treatment. Staff explained to us that their priority was always the decision of the patient.

Are termination of pregnancy services responsive?

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

- Waiting times were consistently within the guidelines set by the Department of Health. Patients could be signposted to other clinics if they needed treatment on days the Middlesbrough clinic was closed.
- The service was accessible for the booking of appointments and for advice and support 24 hours, seven days a week.
- Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs, who did not meet usual acceptance criteria.
- The service had an effective complaints procedure and shared learning from complaints.
- Interpreting and counselling services were offered to all patients and the centre was accessible for those with disabilities.
- Staff tested patients for sexually transmitted infections prior to any treatment and referred those with positive test results to local sexual health services for further screening and treatment.
- There was an appropriate process should a woman wish for pregnancy remains to be disposed of sensitively.

- The service for surgical abortions was suspended at the time of inspection due to the surgeon's post being vacant.

Service planning and delivery to meet the needs of local people

- Treatment was carried out under NHS contracts with Darlington and North Yorkshire CCGs to provide a termination of pregnancy service for the patients of Middlesbrough and surrounding areas. The clinic undertook procedures for self-funding patients on request.
- BPAS Middlesbrough appointments were offered on Thursday and Friday each week.
- Patients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment. If patients needed to use services on other days, they could be signposted to alternative BPAS clinics in the North of England. Patients who wanted or needed weekend services could use other BPAS clinic s in the UK.
- Patients were able to attend the most suitable appointment for their needs and as early as possible. If treatments were in two parts, the clinic worked with the other BPAS clinics to provide patients with more flexibility.
- During times of peak demand, the service was able to provide additional or longer clinics. The service had provided Saturday clinics during January 2016 to meet demand. The treatment unit manager told us that they had treated 169 more patients than originally budgeted for and there may be potential to open the service for an additional day a week.
- The treatment unit manager was planning to extend the range of procedures offered at the Middlesbrough clinic to include non-scalpel vasectomy.
- Service level agreements were in place with local laboratories for screening and blood testing if needed.
- The Treatment Unit Manager had visited the local screening laboratory to learn more about testing and how staff could improve labelling practice. Following this and a cascade of information to staff, the service had seen a marked drop in test failures.
- Service level agreements were in place with local laboratories for screening and blood testing.
- The receptionist told us that the clinic was able to accommodate extra appointments when they received a request from the call centre for an urgent appointment. If necessary, the clinic would remain open until the patient had been seen and received treatment.

Access and flow

- Department of Health (DH) Required Standard Operating Procedures state that patients should be offered an appointment within five working days of referral and the abortion procedure should be carried out within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the Department of Health. Of all patients who were seen and treated, 82% had a consultation and treatment within seven days (equivalent to 5 working days) and 14 patients (4%) waited longer than 10 days from first contacting the service to termination of their pregnancy). The main reasons for delay were given as patient choice to complete treatment locally rather than travel to a centre further away with an available treatment slot within the ten-day target window, or because a patient needed more time to make a decision about their pregnancy.
- Patients could make appointments for BPAS Middlesbrough via the BPAS Contact Centre, which was a 24 hours a day, seven days a week telephone booking and information service. Patients could self-refer into the service, as well as through traditional referral routes.
- The electronic booking system offered patients a choice of dates, times and locations. This ensured that patients were able to attend the most suitable appointment for their needs, subject to their gestation and medical assessment and patients could access treatment as early in their pregnancy as possible.
- All patients completed a self-completion medical questionnaire. Consultations were face to face with nursing staff who discussed medical history and treatment options. When a decision to proceed was made, an appointment was made for treatment. This was often on the same day subject to full legal procedures being followed. Staff told us the time between appointments meant patients would have to wait for treatment but it also allowed for a cooling-off period of 2 to 3 hours so that the woman could confirm her decision or indeed change her mind about the treatment.

- The centre undertook all aspects of pre-assessment care including, counselling, date checking scans to confirm pregnancy and to determine gestational age and other assessments such as sexually transmitted infection (STI) tests.
- If patients were assessed as having a gestation of over 10 weeks, they were referred to another BPAS centre to suit their needs. If there was suspicion of an ectopic pregnancy, staff would refer them to a local NHS acute hospital for further assessment and or treatment.
- The clinic monitored the average number of days patients waited from initial contact to consultation, from consultation to treatment and the whole pathway from contact to treatment. Staff submitted data to the BPAS corporate office and this was monitored both locally and centrally. When demand peaked and waiting times were likely to exceed recommendations, the service could provide more appointments by adding the treatment unit manager to the rota to carry out consultations or signposting patients to other clinics in the region.
- Aftercare advice was available all day every day via a national helpline or patients could call the clinic directly during opening hours.
- Patients could also contact BPAS via a dedicated telephone number in order to make an appointment for post-abortion counselling. Post-abortion counselling was a free service to all BPAS patients. Patients could access the service at any time after their procedure, whether this was the same day or many years later.
- Staff told us that the electronic systems had improved patient flow and enabled the clinic to offer additional, later appointments due to the improved access to electronic prescribing.
- Staff told us if a patient did not attend and had been referred by a GP, a letter was sent to notify them of this; however, any self-referring adult patients who did not attend were followed up if there was a safeguarding concern. Staff gave an example of a 17 year old woman who had not attended and had a gestation of 20 weeks. They contacted her to check she was safe and she explained that she had decided to continue her pregnancy.
- Telephone consultations were being phased in across the organisation to improve accessibility and choice for patients. At the time of inspection, patients who rang the call centre were offered a face to face or a telephone consultation. All patients under 18 years had a face to face consultation with a nurse. Staff told us that, as yet, few patients in their area had taken up the option of a telephone consultation.

Meeting people's individual needs

- The centre was situated on the ground floor and accessible to wheelchairs users direct from the car park. A disabled toilet was provided.
- A professional interpreting service was available to enable staff to communicate with patients for whom English was not their first language. Leaflets about consent were available in 16 different languages. We observed a care coordinator using the telephone interpreter service with a patient. This was conducted professionally and in a sensitive manner.
- Following their initial private consultation, patients could choose whether they had their friend or partner accompany them for the remainder of their consultation and examination.
- Patients could request a chaperone to be present during consultations and examinations and there were signs on display to inform patients that this was available.
- Although staff had not received bespoke training or awareness regarding people with a learning disability they had undergone diversity training and further information was provided for staff in the Disability Discrimination Act policy.
- Patients were given a BPAS guide at the first consultation about different options available for termination of pregnancy including what to expect when undergoing a surgical or medical termination. These also included details of any potential risks, counselling services and sensitive disposal of pregnancy remains. The guide included information on what to expect following the procedure and the advice line number that patients could ring to seek any advice if they were worried. Staff gave patients the clinic number to ring for advice and guidance and encouraged patients to use this during opening hours.
- A copy of the BPAS Guide was available at reception in Braille for those blind or partially sighted patients who could read it. Copies were available in several different languages on line and in paper form for patients to read.

- Counselling was provided to patients on any method of termination and if BPAS Middlesbrough centre could not offer the treatment the woman had chosen, staff helped them to decide where, when and how they could access the treatment they required.
- Unit staff followed BPAS Policy and Procedure with patients regarding the foetus and the disposal of pregnancy remains. BPAS provided information to staff to enable them to meet those needs effectively and sensitively. The discussion and plan for private disposal of pregnancy remains would be documented in the case notes. However, due to the very low gestational limits (up to 10 weeks) for medical termination procedures at this centre, staff explained that there should be little or no evidence of pregnancy remains and no patients to date had requested a sensitive disposal.
- Nurse / midwives and medical staff undertaking pre-surgical and medical abortion assessments had a range of information to give to patients. There was also a range of leaflets and posters displaying information, easily accessible within the waiting area. This included advice on contraception, sexually transmitted infections and services to support patients who were victims of rape or domestic abuse.
- Patients could request that clinic staff made anonymous contact calls on their behalf if STI test results were positive.
- There was a Young People's resource file, which contained a wide range of information and signposting information to local young people's services including drop in services, counselling, stop smoking, genito-urinary medical services, contraceptive clinics, drug and alcohol services and other support services about abuse, sexuality and bullying.
- Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the abortion. Patients who had their treatment at the BPAS Middlesbrough centre were provided with the contraception of their choice before leaving the centre. This included long acting reversible contraceptives (LARCs) such as injections and implants or Intrauterine devices or systems (IUD/IUS). Self-funding patients could use BPAS services for contraception but we observed that staff explained these were provided for a fee. Staff gave patients advice on where they could access free contraception services if they preferred to do this.

Learning from complaints and concerns

- The patient booklet 'My BPAS Guide' included a section on how to give feedback and how to complain, as did the BPAS website. The Client Engagement Manager reviewed any comments left on NHS Choices website and shared feedback with the BPAS team with regard to lessons that could be learned.
- There were posters and leaflets on display in the waiting area advising patients how to raise concerns and give feedback. The information clearly stated how feedback could be given and how concerns would be dealt with. This included expectations about timescales and how to escalate complaints to the Parliamentary Health Service Ombudsman if they were dissatisfied with their BPAS response.
- All BPAS patients were given a patient survey/comment form entitled 'Your Opinion Counts'. There were boxes at the unit for patients to submit their forms. The treatment unit manager initially reviewed locally submitted forms, prior to sending to the BPAS Head Office for collation and reporting. This meant that staff could act on any adverse comments immediately and learning shared with the team and other units. We saw records to show that a patient's partner had commented that the reception area was too cold. Actions documented showed the estates team had been called and additional heating was provided.
- Staff told us that patients were given an opportunity to raise concerns with any staff member whilst at the clinic. Staff understood the complaints procedure and felt empowered to attempt to resolve situations if needed.
- The service had received no formal complaints in the 12 months between January and December 2015. The manager kept a locally resolved complaints log that showed they had managed concerns raised and actions had been taken where necessary. One comment had been received from a patient's partner who thought the waiting area was too cold. The treatment unit manager confirmed it was a particularly cold spell of weather and contacted the building maintenance staff who adjusted the heating.
- The BPAS Client Engagement Manager was responsible for overseeing the management of complaints. Any case needing escalation would be brought to the attention of the regional operations director and the responsible member of the executive leadership team.

- A summary of Complaints, Feedback and 'Client Satisfaction Survey' results (both national and by unit) was reviewed by each Regional Quality Assurance and Improvement Forum (RQuAIF) and the Clinical Governance Committee. Staff were able to identify themes or trends from a central point and any actions, outcomes and lessons learned were shared across the BPAS organisation and with clinical staff through a series of national and regional governance meetings and local team meetings.
- An example of an action taken from national feedback in 2015 was in relation to what was playing on the TV. All units had been asked to ensure that TVs were set to news channels or programmes following a complaint about the content of TV chat shows. In light of this, the TV in the waiting area at BPAS Middlesbrough had been set to play a radio channel only.
- The receptionist showed us how electronic records from the call centre would be completed if a patient with any additional needs were identified.

Are termination of pregnancy services well-led?

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

- Senior managers had a clear vision and strategy for this service and there was strong local leadership of the service.
- Managers were approachable, available, and supported staff within the service.
- There was good staff morale and they felt supported.
- There was a committee and meeting structure to ensure effective governance, risk and quality management. The governance structure enabled oversight of local risks and the whole of BPAS, and allowed for performance benchmarking between units.
- The organisation had a clear mission to provide for safe and effective care for termination of pregnancy.
- Quality of care and patient experience was seen as the responsibility of all staff.
- The organisation had a proactive approach to staff and public engagement.
- Staff completed and submitted Department of Health documentation correctly.

Vision and strategy for this core service

- The BPAS mission was to support pregnancy choices and trust patients to decide for themselves. They aimed to treat all patients with respect and provide confidential, non-judgmental and safe services.
- We saw that staff were aware of these aims and told us how important they were to their practice.
- Staff displayed the values of the organisation by their behaviour and attitude to patients throughout our inspection.
- Managers told us maintenance of BPAS values was fostered through the proactive recruitment of staff who displayed the values and behaviours expected by the organisation.
- The registered manager was knowledgeable about corporate strategy and understood how this affected local provision of services.
- Staff were aware of strategic plans to; continue and monitor the effectiveness of simultaneous medical abortion treatment; to aim to reduce the numbers of procedures performed under general anaesthetic; and to pilot and evaluate the use of conscious sedation for roll out across the organisation.
- Locally staff were aware of plans to extend services and were up to date with the progress of business cases and tenders.
- BPAS Middlesbrough had a Department of Health Certificate of Approval that was displayed in the patient waiting area.
- We saw from the, regional quality and improvement forum, annual plan that objectives were set at national, regional and local level. Local objectives included; development of risk registers, routine updates for evidencing training compliance and completion of relevant clinical competencies, and piloting a new model of appointment slots to maximise single visit services.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure within the organisation nationally, which included a clinical governance committee and a board of trustees. The organisation had systems and processes in place to ensure all board members and executive managers met fit and proper person requirements.

Termination of pregnancy

- The clinical governance committee had a clear role in reviewing all complications and patient feedback. It also ratified policies and received annual reports such as the infection prevention and control annual report.
- The subgroups of the clinical governance committee were a clinical advisory committee which was an informal group convened by the Medical Director when needed, to provide clinical advice and review clinical policies and procedures. There was also an infection prevention and control committee and three 'Regional Quality, Assessment and Improvement Forums' (RQuAIF.
- The RQuAIF groups reviewed local treatment complication rates to ensure they were at or below accepted, published rates. We saw from minutes of meetings that incidents, complaints and patient experience were also monitored through these forums.
- The governance groups monitored staffing levels at a regional and national level.
- There was a corporate risk register, which was written by the financial director of BPAS. The risk register was reported and managed through the risk management committee to the board. Risks were categorised as economic, which included legal action, political and ethical. The registered manager had a good understanding of corporate risks and how they applied to their own unit.
- Risks were rated red, amber or green depending on their severity. The RQuAIF and the clinical governance committee reviewed the corporate clinical red and amber risks on a regular basis.
- Locally we saw that staff had carried out a number of risk assessments in relation to general risks, health and safety and waste management. There were actions identified and documented to mitigate and manage risks locally.
- Performance data was not displayed for public information.
- There was a local contract with a registered waste carrier to correctly dispose of all categories of waste.
- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same ground for a termination of pregnancy is met and sign a form to indicate their agreement (HSA1 Form). We looked at 12 patient records and found that all forms included two signatures and the reason for the termination.
- We observed that nurse / midwives checked the HSA1 forms were completed correctly before any aspect of treatment was initiated.
- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same legal ground for the termination of pregnancy are met and sign a form to indicate their agreement (HSA1 Form). We looked at 12 patient records and found that all forms included two signatures and the reason for the termination. Documentation of the reasons for seeking termination was clearly documented in the paper record.
- Staff told us the local doctor or a doctor in a BPAS centre or BPAS licenced premises reviewed the completed electronic documentation following the initial consultation and assessment by the nurse / midwife. Staff told us the local doctor reviewed paper records in addition to the electronic records. At this point, if they judged that the patient was medically fit for the planned treatment and the grounds for termination had been met they would sign the HSA1 form. The information would be viewed by a second doctor for them to review the information and sign the form if they agreed that at least one and the same ground was met. Staff told us this authorised the procedure to go ahead.
- We saw HSA1 audits from February, March and April 2016 which demonstrated 100% compliance of completion of HSA1 forms
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit data following every termination of pregnancy procedure performed. These contribute to a national report on the termination of pregnancy (HSA4 form). We observed staff recorded this data in the electronic and paper medical records which met the DH required timescale of 14 days following an abortion. We saw audit results to show between April and December 2015 BPAS Middlesbrough had a 100% compliance with this requirement.
- An administrator uploaded all HSA4 forms electronically to DH on a daily basis.
- We saw that the doctor who prescribed the medication, for termination of pregnancy, was the person who authorised the HSA4 through a personal login, online within 14 days of the completion of the abortion.
- The BPAS Client Engagement Manager produced patient satisfaction reports, disaggregated to each unit for contract performance reports to each CCG. A report of

all complaints and a summary of patient feedback, including return rates and scores, was reviewed by the Regional Quality Assurance and Improvement Forum (RQuAIF) and Clinical Governance Committee. BPAS shared the survey results with unit managers and discussed at regional managers meetings, with staff and commissioners.

- There were accountability frameworks for the unit manager and lead nurse to refer to when faced with financial decisions or human resource issues, such as managing sickness and absence.
- The registered manager had a system in place to check nurses and midwives maintained their registration with the Nursing and Midwifery Council.
- The service used a BPAS clinical dashboard to record measures of quality and safety. Managers used this as an improvement tool for monitoring, checking, and analysing clinical standards. The treatment unit manager measured performance through a programme of audits and communicated to the regional management team and staff at the service.
- The dashboard included results on medicines management, staffing levels, clinical supervision, infection prevention, case note audits, serious incidents, safeguarding, complaints, laboratory sampling and labelling and staff sickness. This enabled all BPAS units to benchmark against each other and provided a real-time indicator of quality and safety in each unit.
- BPAS Middlesbrough had good (green) compliance across all dashboard indicators since between June and December 2015.
- BPAS was developing a new process that would require managers to submit evidence regarding actions taken where there were areas of non-compliance against the dashboard audits.
- Service has an SLA with a nearby NHS foundation trust for occupational health services.

Leadership

- The unit at Middlesbrough had a registered manager who was also responsible for the unit at Newcastle. There was a lead nurse / midwife at Middlesbrough who also worked across both units. The unit was supported by a regional operations director and a regional lead nurse who supported, training, professional development and clinical supervision. Clinical supervision for the regional lead nurse was provided by the associate director of nursing.
- The staff at BPAS Middlesbrough told us they felt well supported by managers and told us they could raise concerns with them. Staff told us senior managers were easy to contact and had a regular presence in their centre, were approachable and helpful. The lead nurse / midwife or unit manager was available on a daily basis and staff felt able to approach them at any time if needed.
- We saw records showing the unit manager held team meetings and staff told us they were able to express concerns and ideas for improving processes and services were listened to and adopted where feasible. The team was small and many discussions took place informally but staff told us they felt these were effective and appropriate for the size of the unit.
- Staff we spoke with told us that learning from incidents, safeguarding and daily practice was shared locally within the team and staff told us there was a formal mechanism for sharing learning and elements of good practice with the wider organisation through RQuAIF and the regional managers meetings.
- Senior nurse / midwife meetings occurred three times a year across the BPAS organisation to share relevant information such as national and organisational policy, education and practice updates, for example, a nurse / midwife revalidation workshop and unit managers met quarterly.
- The associate director of nursing acted as professional lead for nursing in addition to other roles, which included the safeguarding lead and director for infection prevention and control.
- The registered manager had received training in various aspects of management and leadership. Topics covered human resource subjects and leadership skills.
- The registered manager met regularly with the regional operations director for supervision and support.
- Staff told us managers were open to any new idea and encouraged them to try it out.
- The Service held a licence from the Department of Health to undertake termination of pregnancy procedures. The licence was displayed in the main reception area.

Culture within the service

- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for BPAS Middlesbrough.

- Staff told us BPAS Middlesbrough had an open culture and they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.
- Staff felt they could approach managers if they felt the need to seek advice and support.
- Nursing staff and managers, we spoke with, all liked working for BPAS and felt the organisation was a good place to work, very patient focussed, caring, compassionate and supportive of staff.
- There was an employee assistance programme and counselling provision for staff.
- Staff were encouraged to access training when they identified a skills gap through supervision or the appraisal process.
- One member of staff told us how they had started working at BPAS following a long career break and had been anxious that they would not succeed. They told us of the support and training they had received which had helped their confidence and enabled them to succeed and become a valuable member of the team.

Public engagement

- Patients attending the clinic were able to provide feedback by using comments cards, commenting online at BPAS or on the NHS choices websites.
- BPAS staff gave all patients a comment form entitled 'Your Opinion Counts'. There were boxes available at the unit for patients to submit their forms, or they could be posted directly to the BPAS Head Office. The Treatment Unit Manager viewed all forms prior to sending them to the BPAS Head Office for collation and reporting, so that any adverse comments could be acted on immediately. There was a poster and leaflets about how to make a complaint or give feedback.
- The clinic staff routinely asked patients to complete feedback cards and almost always achieved over the 25% response rate, which was the corporate target for feedback. This target had been set to ensure representation of patient feedback.
- Analysis of the responses received consistently showed that 95% of patients felt very satisfied with the care and treatment they had received.
- Of the patients who responded to the BPAS patient satisfaction survey between September and December 2015, 5% of patients said they would have preferred a shorter waiting time between initially contacting BPAS and their treatment. Most patients (93%) said that they waited less than 30 minutes to be seen after arriving at the centre.
- The registered manager monitored all feedback for the units and implemented changes and took action where needed.
- The BPAS website had been upgraded to a mobile phone friendly application to make it more accessible to patients.

Staff engagement

- Staff took part in an annual staff survey and were able to engage with the wider organisation through an online staff forum.
- We were told that nationally the response rate to the staff survey was around 60% and that findings were fed back to all staff as it was not possible to disaggregate local results. Findings were discussed at local meetings to determine their relevance to the Middlesbrough unit.
- There was a conference held for managers every two years.
- BPAS held a two-day event for clinical and counselling staff every two years. Where feedback from the national forums was relevant locally, suggestions and issues were considered in team meetings and changes made as appropriate.
- Staff were able to engage with the wider organisation through an online staff forum and a clinical forum; a one day staff event held every two years.
- A process for cascading the national team briefs was in place and staff could feedback to managers and the executive team through this mechanism.
- Managers and staff told us how telephone consultations with qualified nurse / midwives based in BPAS treatment units were being phased in across the organisation and how they provided feedback through the a specific feedback email address. Staff told us they were positive about the way this change was being managed and staff were listened to.
- Staff received regular BPAS 'Connect' updates, which provided news, updates and training information, and team briefs, which included information about finance, marketing and clinical changes.

Innovation, improvement and sustainability

Termination of pregnancy

- The unit was involved in the ongoing evaluation of simultaneous medical abortions as a sustainable treatment option.
- The service had expanded over the previous 12 months and activity had increased to the point where an additional nurse / midwife had been recruited.
- The staff at Middlesbrough were proactive regarding improving their service, pathways and experience for their patients.
- Managers were working towards providing additional services such as surgical termination of pregnancy and vasectomy.

Outstanding practice and areas for improvement

Outstanding practice

Staff went out of their way to provide a caring and holistic service to their patients. They did this by working well with local agencies to provide additional support and services where appropriate.