MSI Reproductive Choices

MSI Reproductive Choices Regional Treatment Centre - Manchester

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had extensive, specialist training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided consistently good care and treatment that exceeded expectations. There was a strong safeguarding culture that was multidisciplinary in nature and staff demonstrated a rapid response to providing care for people at significant risk of harm and abuse.
- Managers monitored the effectiveness of the service through a programme of continual, ambitious auditing and effective benchmarking. They made sure staff were competent by providing an extensive programme of continual professional development that was based on the latest understanding of patients' health needs.
- Staff worked well together for the benefit of patients and established a wide range of multidisciplinary relationships to explore opportunities for improved care. Staff advised patients on how to lead healthier lives based on deep knowledge of their personal circumstances, supported them to make decisions about their care, and had access to good information.
- Key services were available seven days a week and staff sought an expansion of some services where this would improve patient outcomes, including in rapid response to significant increases in demand from specific patient groups.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients and worked collaboratively with specialist support services to meet cultural and other personal needs.
- The service planned care to meet the needs of individuals and populations groups across the region and made it easy for people to give feedback. People could access the service when they needed it and the service maintained a highly responsive approach to maintaining short waiting times.
- Leaders ran services well using reliable information systems and supported staff to develop their skills through a programme of engagement that challenged each person with stretch goals. Staff understood the service's vision and values, applied them in their work, and used provider standards to challenge the status quo and stigma that impacted people's lives.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and creating a working environment that promoted innovation and development. Staff were clear about their roles and accountabilities. The service engaged meaningfully with patients and the community to plan and manage services and all staff were committed to improving services through research and exploration of new evidence-based practice.

However:

- There were gaps in facilities management safety processes in the satellite clinics we included in our clinical site inspections. This included a lack of emergency equipment and security arrangements in one clinic and poor understanding of the nature of the service by third party reception staff in another.
- There was room for improvement in fire safety standards in the main treatment centre.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Outstanding ☆	We rated this service as outstanding because it was safe, effective, caring, responsive, and well led and demonstrated a wide range of innovation. Please refer to our main summary.

Summary of findings

Contents

Summary of this inspection

Background to MSI Reproductive Choices Regional Treatment Centre - Manchester

MSI Reproductive Choices Regional Treatment Centre – Manchester is operated by MSI Reproductive Choices. The treatment centre is a dedicated standalone building retrofitted for clinical care, including surgical procedures. The treatment centre has three consulting rooms, eight day case beds, a surgical theatre suite, a recovery unit with five chairs, outpatient facilities and ultrasound facilities.

The service provides surgical termination of pregnancy up to 23 weeks and six days gestation and early medication abortion and medical termination of pregnancy up to nine weeks and six days gestation. Surgical procedures are available with a range of sedation options, including general anaesthesia. The service provides consultations, ultrasound scans, contraception, sexual health screening, and vasectomy procedures.

The treatment centre provides the full range of care services and is the registered location. The service offers early medication abortion, consultations, and ultrasound scan services from 10 satellite clinics across the region. Located across the north west, the satellite sites operate from rented clinical spaces in primary care centres.

There are two registered managers in post. One individual is the operations manager and is responsible for the operational aspects of the service and one individual is a clinical matron and leads clinical provision. Both managers share responsibility for the regulated activities.

The service is registered to provide the following regulated activities:

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

In our report we refer to OneCall and RightCare. These are centralised teams within the provider that deliver support and care to patients as part of integrated pathways.

We last inspected the service in August 2018. At that inspection we rated the service good overall and good in each domain except for well-led, which we rated requires improvement. This reflected a need for more embedded governance processes, including around manager access to staff employment records and improvement medicine storage management. At this inspection we found staff had addressed these previous concerns and implemented a wide range of initiatives to improve and sustain care.

How we carried out this inspection

We carried out an unannounced inspection of the regional treatment centre on 29 July 2022. This inspection team included a lead CQC inspector and a second inspector. The inspection was overseen by Karen Knapton, Interim Head of Inspection. We carried out a short-notice announced inspection of a sample of two satellite clinics, in Blackpool on 10 August 2022 and in Liverpool on 11 August 2022. After our inspection we interviewed some senior staff remotely by video chat and asked the provider to send us evidence of care standards.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The service had carried out extensive reviews and research of the needs of people living in the region. This included work to establish the needs of the most vulnerable people living with significant challenges, such as risk of violence and high levels of deprivation. Staff established new referral pathways to specialist support organisations and staff used these if patients identified one or more of these needs during consultations.
- Multidisciplinary working was innovative and sector-leading in its scope. Staff were empowered and passionate about their work and proactively sought to improve people's health through substantive, targeted relationships.
- The provider had a substantive, demonstrable focus on improving access and quality of care for patients living with a learning disability.
- The senior team encouraged innovation. This had led to new safeguarding work led by a newly-introduced senior nurse and the implementation of significant enhanced staff competency and training opportunities. Such work exceeded the medical remit of the provider and demonstrated a commitment to supporting people with diverse needs.
- Staff acted on emerging and specific risks to provide an exceptional level of service access for vulnerable patients with complex needs, particularly to protect those at risk of trafficking, sexual exploitation, and violence.
- A waiting time initiative had increased surgical capacity by 75% and resulted in seven-day opportunities for patients to access care.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that arrangements for facilities management and access to emergency equipment in satellite clinics are maintained effectively.
- The service should ensure fire safety standards in the treatment centre are consistently maintained.
- The service should continue to work towards a solution to the challenge of privacy and dignity in the day room in treatment centre.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Termination of pregnancy	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Overall	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

Outstanding

Termination of pregnancy

Safe	Good
Effective	Outstanding
Caring	Outstanding
Responsive	Outstanding
Well-led	Outstanding

Are Termination of pregnancy safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training, which was comprehensive and met the needs of patients and staff in 18 modules, including sepsis training. At the time of our inspection, training compliance was 96% amongst permanent staff and 88% amongst anaesthetists working under practising privileges. The provider's target for completion was 85%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff spoke positively about the standard of training, which included simulated exercises and online self-study. The provider ensured staff had protected time to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding provision was advanced, commendable in its scope, and evidence-based. The team had established an understanding of regional influencing factors in the safeguarding needs that contributed to people who were vulnerable and at risk.

Staff received training specific for their role on how to recognise and report abuse. Nurses and healthcare assistants were trained to adult and child safeguarding level three. They received safeguarding supervision from senior specialists and at the time of our inspection 95% of staff were up to date. Staff frequently dealt with complex, high-risk safeguarding cases and any individual could arrange a focus group with colleagues to help coordinate care.

Termination of pregnancy

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Patients seeking treatment were diverse and often had multiple vulnerabilities. Staff were trained to deliver care with respect to the Equality Act and the team worked responsively to identify and act on individual needs with respect to this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A UK named midwife for safeguarding children and adults worked at provider level and supported local safeguarding leads at the treatment centre. A safeguarding lead was based in the provider's OneCall service and worked closely with treatment centre counterparts. This meant a named safeguarding professional was always contactable whenever the service was operational. The OneCall team used a safeguarding triage tool to assess each patient at the first point of contact. The senior team monitored referrals and outcomes to ensure the system was effective. For example, 3% of initial referrals resulted in a safeguarding review and 80% of these resulted in a referral to the woman's GP, midwife, or social services.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referral processes were embedded in all aspects of care and staff triggered these in specific circumstances and when they had concerns. The provider facilitated a risk-averse approach that ensured staff always acted on any concern, however small.

Staff followed safe procedures for children and young people visiting the service. In the previous 12 months the service provided care for 273 people under the age of 18. Standard operating procedures were in place for patients seeking abortion who were under 13 years old, under 16 years old, and under 18 years old. Staff worked with social workers, the police, school nurses, parents, and others on a case-by-case basis to ensure safe care. As a child under the age of 13 was below the legal age of consent, staff referred such individuals to the NHS. They encouraged the child to involve a responsible adult and provided consultation and support services before and after NHS care.

Staff automatically logged an internal safeguarding alert for all patients under the age of 18 seeking an abortion. Staff provided young people who presented for an abortion time, space, and support to disclose personal information and concerns privately.

The team had recently implemented a new initiative to reflect the increasingly complex needs of patients. An advanced safeguarding clinical team leader had developed their post into a dedicated safeguarding role in response to a sustained increase in patients presenting with complex, extensive needs. The senior team arranged protected time for the individual to support patients and to liaise with other agencies to ensure care was safe. For example, they liaised between police and surgeons to facilitate termination of pregnancy for young women who had been sexually assaulted by traffickers. Other staff member we spoke with said this role had significantly reduced pressure on them by allowing them to focus on immediate medical and surgical needs.

Nurses working from satellite clinics had on-demand, digital access to safeguarding support and escalation in the provider. This supplemented local relationships with police liaison officers, NHS safeguarding teams, and local authority safeguarding teams.

The provider had a comprehensive policy for the safeguarding of women who continued with a pregnancy after seeking abortion care. This could happen if a woman sought abortion care after 19 weeks gestation or who contacted the service to seek care then did not follow up. Staff understood this presented increased safeguarding risks and safeguarding leads followed the continuing pregnancy policy to protect the child and mother. This included welfare checks and referral to antenatal services, GPs, and/or local safeguarding teams and meant the service could evidence how they provided extended support to people with complex needs.

In the treatment centre, reception staff had a view of the main waiting area. The team demonstrated good knowledge of behaviours that would raise concerns of safeguarding need and how they would escalate these.

Staff used a live digital risk assessment tool to assess level of risk and make urgent referrals to safeguarding staff, teams, or the police.

Staff used a framework and escalation process to manage cases of female genital mutilation (FGM). They submitted an incident report for each occurrence of FGM where the individual did not have children at home. If the patient had children at home, staff contacted their GP as part of an enhanced safeguarding approach. The service had developed an FGM 'passport' that provided women with signposting and guidance for clinical, social care, and legal help.

Staff were comfortable in asking appropriate questions about FGM and they had information and access to helplines for patients who had experienced this. There were posters in the clinic about FGM, signposting patients to helplines.

Staff identified the need for chaperones at the first point of contact. They proactively offered these to patients and where they identified vulnerabilities or safeguarding concerns, ensured a chaperone was always available. Some treatment types, such as long-acting reversible contraception (LARC), required a chaperone to be present.

Posters around the treatment centre and in the satellite, clinics reminded patients of the option to request a chaperone. Staff asked each patient about chaperone needs at the first point of contact. In satellite clinics, the provider had a service level agreement with the facilities organisation to provide a chaperone on demand if this had not been requested in advance. For example, in the Blackpool satellite clinic, trained staff from the host NHS sexual health service provided chaperone support.

The safeguarding lead worked on an agile basis across the provider's regional network. They demonstrated a deep understanding of key safeguarding themes and trends and targeted specific satellite clinics for enhanced support based on known risks. They, or a delegated colleague, were available by online chat or phone call at all times services were in operation.

Staff used the national multi agency risk assessment co-ordinator (MARAC) system for people with specific risks, such as those who required a 'DASH' (domestic abuse, stalking and honour-based violence) referral. This ensured safeguarding processes were evidence based.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. In satellite clinics, building operators employed cleaners who carried out routine cleaning of all clinical areas. Provider staff cleaned their clinical space before and after each list and used antibacterial processes between patients.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. At our last inspection we told the provider to improve the system used to clean and sanitise transvaginal probes. At this inspection we found a substantial improvement in the standard of cleaning and assurance. Staff used an international-standard decontamination system that included competency training and the use of product batch number tracking linked to each patient.

The service generally performed well for cleanliness. In the previous 12 months hand hygiene compliance was 92%, which was slightly lower than the provider's 97% average.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Each area of the treatment centre had a cleaning checklist in place. All the records we checked were up to date. Cleaning in satellite clinics was managed through local service level agreements. While we found clean and well-maintained facilities during our inspection, audits identified there was a need for sustained improvement. In the previous 12 months, the facilities and cleaning audit found 87% compliance with provider standards.

Staff followed infection control principles including the use of personal protective equipment (PPE). In the previous 12 months, PPE audits found 97% compliance with provider standards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 and 00/10 in relation to clinical environment design and infection control in the clinical environment. This included the treatment centre and satellite clinics, which were delivered from healthcare premises. For example, all clinical areas had appropriate flooring that could be cleaned.

Staff carried out surgical terminations in an appropriate theatre environment. This was equipped as a surgical space.

Staff disposed of clinical waste safely in line with DHSC Health Technical Memorandum (HTM) 07/01 (2013) in relation to the safe management and disposal of healthcare waste. They included waste management in monthly environmental audits. In satellite clinics, staff managed waste through service level agreements with each building operator. We saw good standards of practice in the two satellite clinics we visited.

The service carried out regular water safety checks for Legionella in the treatment centre. Building operators carried out these checks in satellite sites and provided assurance of completion.

Staff followed Control of Substances Hazardous to Health (COSHH) Regulations. They stored chemicals securely and maintained up to date safety information on each item.

The service was fully compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste. Staff used the colour-coded sharps system and labelled bins in line with national standards. Audits from the previous 12 months identified areas for improvement, with 86% compliance against provider standards. Managers told us these issues had been addressed and we saw good standards of practice in relation to sharps and waste management during our inspection.

Staff carried out daily safety checks of specialist equipment. They documented safety and stock checks on fixed equipment, medical and surgical consumables, and emergency equipment. All the records we looked at were up to date with evidence of corrective action if staff identified issues.

The senior team used an electronic assurance process to monitor fire safety, including weekly checks of emergency lighting and fire extinguishers. However, during our inspection of the treatment centre, we found area for improvement in fire safety. For example, two doors marked 'fire door keep closed' were wedged open and a fire escape was partially blocked. We spoke with the registered managers about this who initiated a review of daily fire safety practice.

Appropriate emergency equipment was readily available in the treatment centre. This included equipment in the surgical suite such as an intubation kit, cervical tear pack, major haemorrhage kit, resuscitation equipment, and emergency oxygen. Medical Clinical areas of the building had automatic external defibrillators (AEDs), oxygen, anaphylaxis kits, and airway management equipment.

Emergency equipment at satellite clinics differed between sites. The provider maintained a first aid kit in the clinical room and more advanced equipment depended on local arrangements. For example, the Blackpool clinic was based in a community NHS sexual health service and staff had access to a full resuscitation trolley. In Liverpool, third party building reception staff were unsure of the availability of equipment and the AED had been removed by another provider when they completed their tenancy. We spoke with the registered managers about this who addressed the vulnerabilities we found in this location.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. They used an early warning scores system (TEWS), specific to patients having an abortion, to continually monitor the patient's condition. The TEWS chart included space for staff to indicate if the patient was under the age of 18 and staff adapted the escalation process accordingly in the event of deterioration.

An emergency resuscitation team was formed at the beginning of each day and responded to patients who deteriorated. The treatment centre was equipped to stabilise patients who experienced a haemorrhage and the standard operating procedure required staff to transfer such patients to an NHS emergency department. The emergency team consisted of a runner, scribe, resuscitation nurse and a transfer nurse who travelled with the patient to hospital. The team was coordinated by the manager. The provider monitored emergency transfers across all treatment centres to identify trends and opportunities for learning.

Surgeons used an adapted World Health Organisation (WHO) surgical safety checklist to ensure surgical procedures were effective in line with international guidance. The team audited compliance with the checklist. In the previous 12 months the service demonstrated 92% compliance on average

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Known risks included previous abortions. Staff knew about and dealt with any specific risk issues. They used an audit tool to ensure risk assessments were carried out for surgical procedures, including for venous thromboembolism (VTE). Audits from the previous 12 months found 97% compliance with provider standards.

The service had access to mental health liaison and specialist mental health support. National guidance for abortion procedures does not require that providers arrange in-person counselling. However, the service offered counselling to all patients through their OneCall service both before and after treatment.

Termination of pregnancy

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Clinical pathways were designed to minimise the amount of time patients spent alone when in the treatment centre. Staff used an urgent escalation process if patients tried to self-harm on site or disclosed suicidal intent. This was a multidisciplinary process that involved the patient's GP and mental health team, if they were known. Where a patient with known self-harm risk absconded, staff considered this an emergency and contacted police.

Staff acted to protect patients with complex risks and needs. For example, they acted on requests to contact patients using specific means and at pre-determined times where they had privacy or if there were safety concerns at home.

Centralised teams triaged patients before clinical staff made decisions about treatment. These teams provided support to all treatment centres and satellite clinics and clinical staff were based in them to provide remote specialist support.

All staff were trained in life support and resuscitation to a level commensurate with their role. Anaesthetists were trained in advanced life support (ALS). Surgeons and nurses had immediate life support (ILS) training, and healthcare assistants and reception staff had basic life support (BLS) training. Staff undertook periodic simulated resuscitation training and haemorrhage training.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

Staff sometimes experienced aggression and threatening behaviour from patients. They documented this on the electronic patient records system to alert colleagues of the need for support during appointments and the practice education facilitator was developing a plan to secure practical conflict resolution and de-escalation training. The team planned to implement this by the end of 2022.

Escalation protocols were in place where a patient disclosed sexual assault. OneCall staff, who provided a telemedicine and webchat service to patients, liaised with appropriate services to get patients urgent support.

Staff paid attention to detail when completing risk assessments. For example, a patient disclosed a previous blood clot following a past pregnancy. The nurse worked with them to understand more about this and subsequently found evidence of gestational diabetes. They adapted the treatment plan as a result and ensured the patient received the safest form of care.

Staff carried out a surgical huddle each morning to go through the risks for each patient. The management team, surgeon, anaesthetist, senior client care coordinator, nurses and midwives attended this huddle.

Specialist staff prepared patients for treatment. Early medical abortion practitioners supervised risk assessments to make sure patients were suitable for the procedure. This included a check of whether it was safe for the patient to pass the pregnancy at home and a check of known conditions such as damaged fallopian tubes or a previous C-section. Patients more than 19 weeks pregnant attended the day before surgery for cervical preparation.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Termination of pregnancy

The service employed 29 nursing and midwifery, healthcare support, clinical coordinator and management staff to keep patients safe. A matron and deputy clinical matron led the team and an advanced nurse practitioner, three clinical team leaders, and consent nurse worked with the team.

Two airway-trained staff were always on duty whenever surgery was in progress and remained on site for as long as patients were in recovery. This reflected best practice and reduced the risk of harm if a patient deteriorated unexpectedly.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The manager adjusted staffing levels daily according to the needs of patients.

A nurse midwife led each satellite clinic. This was usually lone working with support from senior nurses on rotation and when patients with complex needs were booked to be seen.

The actual number of nurses and healthcare assistants on shift matched the planned numbers. The matron planned for each clinical area, such as the day room and recovery room, to have at least one registered nurse per seven patients, with support from health care assistants (HCAs).

The service had low vacancy rates. The service was recruiting three full time registered nurses following agreement to expand capacity to meet demand.

The service did not use agency nurses.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave sessional staff a full induction.

The service had enough medical staff to keep patients safe. Anaesthetists worked on a sessional basis and worked under practising privileges. Surgeons from other centres in the provider's network provided pre-planned sessions whilst newly recruited local staff underwent training.

Early medical abortion physicians were always available for remote online chat and advice when clinics were in session. We observed this system worked well and nurses contacted them online for live support whilst patients where with them in the clinic. This enabled the service to provide safe, coordinated care.

The service operated a safer staffing levels system and had not had to cancel a surgical list as gaps in staffing due to sickness could generally be covered at short notice.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used an electronic patient record system and staff had access to this across satellite clinics. This was a bespoke system designed for the service and had in-built alerts for safeguarding, age of patient, allergies, other risks such as anaesthetic risks.

Records were stored securely using an industry standard system.

Nurses updated ultrasound scan reports in real time and shared these with doctors and practitioners for review.

We checked five sets of patient notes and found these to be clear and fully completed. They were easily navigable, and additional notes had been added where further information about the patient was required. All the abortion records contained a DHSC abortion form, signed by two doctors with a valid reason for carrying out the termination, in line with national legislation.

Staff audited records for quality compliance in line with the provider's standards. In the previous 12 months the service performed consistently well, with 97% compliance.

The service managed patient records in line with Royal College of Obstetricians and Gynaecologists (RCOG). For example, they provided each patient with a discharge letter that included enough information about their care to allow another practitioner to manage future needs and complications. The discharging member of staff asked each patient for consent to send a copy of the discharge letter to their GP. Staff respected confidentiality and GP involvement was not a requirement of treatment.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Surgeons, early medical abortion practitioners, and anaesthetists prescribed medicines. The provider was in the process of implementing patient group directions (PGDs) to enable nurses to prescribe appropriate medicines in the near future. PGDs are sets of written instructions that enable designated staff to prescribe specific medicines to patients under structured conditions. They reduce delays in prescribing and help staff to better share clinical workload.

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. Doctors reviewed patients' current prescription medicines to ensure abortion medicines were safe and minimise the risk of contraindications.

Staff completed medicines records accurately and kept them up-to-date. Medicines errors were rare. Between January 2022 and June 2022, the service reported eight errors. This reflected less than 0.1% of prescriptions and dispensing and met the provider's target of 0.2%. Managers reviewed each error and investigated it through the most appropriate process, such as a team meeting or discussion with the lead doctor for the type of treatment concerned. There was good evidence of shared learning and corrective action by the senior team. None of the errors resulted in patient harm.

Staff stored and managed all medicines, including controlled drugs (CDs), and prescribing documents safely. They monitored the temperature of storage areas to ensure these remained within manufacturer limits. The airway nurse was responsible for managing CDs and they managed documentation and other aspects of the stock in line with national guidance.

Staff learned from safety alerts and incidents to improve practice. The provider had a dedicated team that monitored national safety alerts and an electronic policy system that provided staff with details of changes to practice.

An external pharmacy supplied medicines to the treatment centre and satellite clinics. Staff could contact a named pharmacist at any time the service was in operation for guidance or advice. We saw this system worked well in practice. For example, staff in the Liverpool satellite clinic recorded temperatures exceeding the manufacturer maximum in the medicines storage area. The on-call pharmacist provided instructions to ensure the medicines remained safe for use and staff adjusted stock ordering accordingly.

Staff dispensed medical abortion medicine in the safest way for the patient to receive it. For example, they could send the medicine in unmarked packages by untracked mail, or by tracked courier. They also arranged for patients to collect the medicines from a treatment centre on request. This system meant patients could choose the most appropriate delivery method for their circumstances and helped them navigate challenges at home, such as not wanting others in the house to be alerted to a delivery.

Medicines in satellite clinics were stored in double-locked safes that only provider staff could access. They maintained up to date stock control documentation as a security assurance tool.

During all our observations we found staff checked and documented patients' allergens.

Surgeons managed the prescribing of post-operative antibiotics and used a national sepsis risk assessment tool to keep patients safe.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They used the provider's electronic incident reporting system for incidents and near misses. A dedicated team with specialist training reviewed incidents and allocated each to a senior member of staff for investigation and resolution.

The service reported four significant incidents in the previous 12 months, three of which resulted in moderate harm and one of which resulted in no harm. There was evidence staff implemented the duty of candour appropriately and designated senior staff carried out investigations. In each case, there was documented evidence of learning and improved standards of practice. For example, the service improved the availability of cervical suturing packs in surgery and improved the lighting in the operating area.

Staff reported serious incidents in line with the provider's policy. All transfers to hospital were reported as a significant incident for follow up and review.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. All staff underwent training in the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. The incident reporting form included space for self-reflection and any initial learning from the reporting member of staff.

Outstanding ☆

Termination of pregnancy

Staff met to discuss the feedback and look at improvements to patient care. A national team reviewed incidents weekly, with representation from each treatment centre.

Managers investigated incidents thoroughly. They involved patients in the investigations if this was appropriate and debriefed and supported staff. The daily huddle included dedicated time to discuss recent incidents.

Are Termination of pregnancy effective?

Outstanding ☆

Our rating of effective improved. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and standard operating procedures were stored and accessed on an electronic system and were available to all staff, including those working remotely from satellite clinics. A policy group ensured policies were reviewed and updated in line with a pre-planned schedule and when national guidance changed.

Care and treatment was based on best practice guidance from relevant organisations such as the Royal College of Obstetricians and Gynaecologists, the National Institute for Health and Care Excellence (NICE) and the Association of Anaesthetists of Great Britain and Ireland. Such guidance meant patients received effective, consistent care, such as intra-operative ultrasound care during each surgical abortion.

The provider included access of policies and procedures as part of the induction programme as part of a strategy to ensure evidence based care and treatment was fully embedded in all aspects of care.

Policies and standard operating procedures were influenced by research and international best practice. The provider had a clear strategy to ensure care provided reflected the most up to date understanding of abortion care and governance processes provided assurance of this.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff provided guidance to patients on required fasting times before surgery. Surgery times were staggered from the early morning, which meant patients did not need to fast all day.

Refreshments were available for patients and visitors throughout the building. Staff provided refreshments and biscuits to patients in the recovery area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. They monitored pain relief continuously during post-surgical treatment.

Patients received pain relief soon after requesting it. Staff used a standard operating procedure to manage pain and prescribe or administer pain relief. This was evidence-based and reflected up to date research on the known pain impact of medical abortions. Staff provided to take away (TTO) pain relief medicine after surgical discharge and telemedicine staff posted pain relief to patients on request after a medical abortion.

Staff prescribed, administered and recorded pain relief accurately. We observed a nurse in a satellite clinic work to find alternative home pain relief options when a patient disclosed previous sensitive reactions.

Staff used a pain audit tool to assess each patient's level of pain during and after a procedure and compared this with their self-disclosed usual level of period pain. The team measured the effectiveness of pain management by asking if patients would choose the same treatment again. In the previous 12 months, 94% of patients agreed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients that consistently exceeded expectations.

The service participated in relevant clinical effectiveness audits in line with Department of Health and Social Care required standard operating procedures (RSOPs) for independent abortion providers. Managers and staff carried out a comprehensive programme of repeated audits to monitor compliance and assurance. The compliance monitoring programme included 25 audits planned to take place at key points during the year. Six clinical audits supplemented this and included reviews of clinical practices in each care specialty.

The service provided care and support beyond patients' immediate clinical need. This approach reflected staff understanding of the long-term needs of some patients and aimed to reduce the risk of repeated unwanted pregnancies. A dedicated team in the provider, called RightCare, managed onward referrals and coordinated post-abortion care. This ensured patients had consistent communication and support for as long as they needed.

Staff sought to continually improve patient outcomes through a holistic approach to continuity of care. For example, while staff always followed up with patients by an agreed means after a surgical abortion, they recognised some patients would benefit from welfare calls between consultations and appointments. The team implemented a system to ensure such follow-ups were driven by patient preferences and level of need, which improved the previous standardised process.

Staff reviewed the gestational impact of pregnancies when planning care. They prioritised patients who presented ahead of nine weeks and six days to prevent unnecessary surgical terminations.

The medical director managed the effectiveness of anaesthetists working under practising privileges through a peer review system. They worked with responsible officers to review incidents, complaints, and patient outcomes to ensure anaesthetist's work in the treatment centre met patient need.

Termination of pregnancy

The clinical effectiveness group benchmarked patient outcomes nationally against all treatment centres. The clinic performed consistently well and met or exceeded provider targets in every measure. For example, in the previous 12 months 100% of patients were offered contraception and the surgical infection rate was 0.05%, which was substantially better than the provider target of 0.5%. In the same period clinical complications occurred in 2% of surgical patients, which was in line with the national average. The emergency transfer rate was 0.5%, which met the provider's target.

The service monitored the rate of retained products of conception (RPOC) as part of national monitoring. This referred to placental or foetal tissue that remained in the uterus after an abortion. In the previous 12 months the service achieved an RPOC rate of 1.6%, which was significantly better than the provider's 3% target.

Competent staff

The service made sure staff were competent for their roles through the continuous development of advanced, specialist skills and knowledge. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The continuing development of staff skills, competence, and knowledge is recognised as being integral to ensuring high-quality care.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Nurses completed specialty training such as first and second trimester scanning, haemorrhage management, and early warning scores management for abortion surgery. Training and development opportunities were wide-reaching, and the service adapted these to meet specific demands from patients. They included caring for patients with gender identity needs, patients who were transitioning between genders, and those with complex identities.

Managers gave all new staff a full induction tailored to their role before they started work. There was a clear focus on understanding patient social care needs and circumstances in the induction in recognition of complex needs in the region.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had undergone an appraisal in the previous 12 months.

Managers supported staff to develop through regular, constructive clinical supervision of their work. The provider had a distinct, evidence-based approach to supervisions. Matrons worked across treatment centres and carried out supervisions with staff not part of their usual team. They focused on safeguarding and 'stretch' professional goals. Senior staff said they recognised the potential for supervision to have a direct impact on staff wellbeing and they structured this process to focus on positive work and opportunities.

A practice education facilitator (PEF) was based in the treatment centre and worked with staff there and in the satellite clinics. They supported the learning and development needs of staff. The PEF was an experienced nurse had worked with the senior team to completely redesign the role. They supported staff to maintain clinical competencies and to maintain professional development through the appraisal process.

The PEF had implemented a buddy system for new starters and worked with nursing and medical students to develop their experiences.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The minutes of team meetings reflected consistently high attendance from staff in all roles and a positive, collaborative work environment in which ideas and learning was valued.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The senior team had established secondments for clinical team leaders and opportunities for staff to cross-train to build their specialty competencies. For example, staff could specialise in scanning or contraception and then gain experience in each other's areas of work.

Managers and the PEF made sure staff received any specialist training for their role. The team was proactive in introducing new training based on staff feedback and demands on the service. For example, they had recently implemented an interoperative screening course for surgical nurses to supplement first and second trimester scanning training.

The matron had completed professional nurse advocate training. Staff valued opportunities for peer support and review, which was embedded in supervision and development processes.

At the time of our inspection, 100% of staff expected to carry out ultrasound scans were up to date with training competencies.

The provider responded quickly to staff requests for training and support. For example, the clinical effectiveness group arranged simulation and role play training for staff who said they lacked confidence in discussing foetal remains with patients. This was an effective, rapid strategy to ensure staff were confident and empowered.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked collaboratively as a team to benefit patients. They supported each other to develop and implement innovative approaches to partnership working that resulted in very high standards of care. Care was holistic, adaptable, and benefited from the dedication of the team to establishing new opportunities for innovative working.

The service was multidisciplinary by nature. Staff had developed substantive, wide-ranging relationships with a variety of service and care providers across the region. Staff provided referrals to key workers, social workers, and community support teams. They held regular and effective multidisciplinary meetings to discuss patients and improve their long-term care based on individual needs.

Staff used a system that enabled them to track the duty of care for each patient. This made it clear, at a glance, which professional or service was responsible for a patient's care at any given time. This enabled staff to provide focused, structured care to people with complex needs and reduced the risk of duplicated work and confusing patients with multiple sources of information.

Staff went to great lengths to implement multidisciplinary working that reflected emerging needs. Processes were advanced, commendable in scope, and evidence-based. For example, the team had identified similarities amongst a number of pregnancies amongst young people below the legal age of consent who noted sexual encounters arranged through social media. The safeguarding lead proactively engaged the local authority, police, school nurse, and district nursing teams to review the trend and coordinate a response. This led to a substantive, multi-agency response to a significant health risk that had previously been undetected.

Termination of pregnancy

The safeguarding lead worked with healthcare commissioners and police commissioners to improve care pathways for patients who were at high risk for abuse and sexual assault. This resulted in streamlined, coordinated working that meant patients needed to explain their circumstances only once, at the first point of contact. This work included the victims of human trafficking and arranged marriages.

Staff accommodated Home Office support workers when they accompanied patients with refugee status and coordinated end-to-end care as far as possible.

While staff worked flexibly across the treatment centre and satellite clinics, they focused on specific sites to build relationships with local specialist organisations. For example, staff at the Blackpool satellite site had developed working relationships with GPs responsible for mental health and with police liaison officers involved in human trafficking initiatives. They joined multidisciplinary meetings with non-profit agencies working to reduce homelessness and modern slavery as part of a substantive approach to embedding care and presence in the region.

The service shared and received information with other unplanned pregnancy services when patients had received previous procedures in other services. They also worked with NHS early pregnancy units to coordinate care.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

Staff coordinated and planned different aspects of the service based on trends in demand. For example, satellite clinic times were planned based on referrals and the treatment centre operated core hours for medical abortion, surgical abortion, and consultations.

Staff offered an online webchat service seven days a week and the OneCall support service operated 24/7. This team always had clinical specialist staff available.

Staff facilitated out of hours appointments where patients' circumstances meant they would be at risk during usual opening hours. This reflected extensive coordinated working with patients who had been trafficked and were under police or social services care and those in highly vulnerable circumstances.

The service responded quickly to increases in demand with substantive improvements to the service, including recruitment of extra staff to offer 'focus weekends'. This enabled the service to offer pre-assessments and consultations at weekends and on bank holidays.

Health promotion

Staff were consistent in supporting people to live healthier lives, including those with complex needs. They took a targeted and proactive approach to health promotion and used every contact with people to do so.

The service had relevant information promoting healthy lifestyles and support in patient areas. Staff actively worked to reduce stigma about abortion care and the provider supported national strategies in this area.

Staff assessed each patient's health at every appointment and provided individualised support to live a healthier lifestyle. For example, staff provided sexually active patients with a timeframe for maintaining good post-treatment health including strenuous exercise and usual sexual activities.

The provider ensured all patients had access to counselling services regardless of the extend of their medical need. Staff had established working relationships with specialist organisations to secure extended services, such as for those experiencing domestic violence.

The service provided sexual health promotion resources and information to patients and their partners. This included free condom packs and printed information on sexually transmitted infections. Staff worked with specialist regional organisations to adapt information to specific communities, such as Gypsy and Roma traveller communities. Staff undertook training in such areas, which enhanced the value and impact of health promotion materials.

Staff ensured health promotion was appropriate to each individual's personal circumstances. For example, one patient noted they had liver issues under investigation and wanted advice about contraception. The nurse worked with them to identify their best options and explained oral contraceptives interfere with oestrogen production, which could exacerbate their liver problems.

Staff gave examples of how they worked regionally to improve sex and relationships education amongst young people. For example, in response to instances of young teenagers who were sexually active with extensive sexual histories, they established relationships with school nurses to provide interventional sexual health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children and young people who wished to make decisions about their treatment.

Staff received and kept up to date with training in the Mental Capacity Act (MCA). Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

The named safeguarding lead was the MCA lead and worked with staff to develop their knowledge, skills, and practice.

A dedicated consent nurse was available in the treatment centre and supported staff and patients to ensure consent processes met national requirements.

Consent processes reflected each patient's preferences and circumstances. Staff obtained consent for specific means of communication and at predetermined times. For example, patients could choose e-mail, phone call, text message, letter, video chat, or live webchat as means of follow-up. The provider's 24-hour central support teams meant they could always meet patient's needs.

Outstanding ☆

Termination of pregnancy

Staff explained risks and potential unexpected outcomes to patients during the consent process. We saw nurses explained the average failure rate of early medical abortions and the potential need for future treatment to remove polyps. They ensured patients understood this information before obtaining consent.

The consent process included a discussion of all potential risks. Staff discussed rare, extreme risks with patients so that they fully understood the procedures to which they were consenting. They made sure patients understood they could withdraw consent at any time.

The service audited consent documentation. In the previous 12 months the service achieved 97% compliance, which was comparable to the provider's national average.

Are Termination of pregnancy caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs by delivering an exceptional and distinctive service.

Staff were discreet and responsive when caring for patients as part of a visible person-centred culture embedded in all aspects of care. During all our observations, staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff provide kind, dignified care to patients who were upset and experiencing a crisis. Staff adapted their approach to patients' age and level of comfort. For example, some patients preferred a formal communication approach with staff, others wanted an informal approach. Where patients attended with a friend, partner, or relative, staff accommodated them and established the level of privacy preferred by the patient.

Staff followed policy to keep patient care and treatment confidential. We observed discreet, private conversations. The day room was a busy space and it was challenging to maintain privacy in this area. Staff utilised side rooms on the same floor of the building if private discussions were needed.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs, including those experiencing anxiety and depression.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They focused on building open and honest relationships with patients and their loved ones and sought creative ways to incorporate cultural needs into care, such as through partnering with specialist organisations.

Patients said staff treated them well and with kindness. Between April and June 2022, the service received 128 compliments. Examples of feedback included, "Staff are amazing at their job," and "The service was amazing, and I felt really safe, can't think of anything that could have been done better."

Staff were reassuring when explaining care to patients, including during unexpected outcomes. For example, when a patient unexpectedly needed a surgical abortion instead of a medical abortion, the nurse explained what would happen at the treatment centre and the roles of different staff they would encounter.

Staff were patient and accommodating when discussing intimate care with patients. They offered them the chance to ask questions, time and space to talk about their feelings, and asked if anything was bothering them that had not been discussed.

Emotional support

Staff provided an exceptional level of intuitive, person-centred emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. During all our observations staff demonstrated attention to detail in understanding patients' personal needs and worked with attention to detail to meet them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. For example, the post-operative day room was an open bay in which maintaining privacy was challenging. We observed staff support patients quickly, discreetly, and with an understanding of their individual circumstances when they became upset.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing. Where patients disclosed social circumstances that impacted their care, staff responded appropriately.

Patients spoke positively about their experiences. In recently feedback one patient noted, "The nurse was fantastic, thorough and kind. Thank you for being non-judgemental, helpful and making a hard situation easier."

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. They anticipated and recognised unmet care needs and had an unwavering dedication to patient involvement.

Staff made sure patients and those close to them understood their care and treatment. Staff used photographs and easy-read documents to explain treatment to patients. For example, during our observations at the Liverpool satellite clinic, the nurse used photographs to show patients how to recognise specific medicines they would take as part of their treatment. They explained the role of each medicine and why it was the best choice for their care. Patient information sheets included clear pictures of exactly where in the mouth patients should place dissolvable medicines.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care. Patients always had access to telephone or webchat support after an appointment or procedure, including medical support.

Outstanding ☆

Termination of pregnancy

Patients gave positive feedback about the service. The provider monitored this nationally and the senior team for this service monitored feedback weekly through team meetings and governance processes. Patients consistently rated all aspects of the service as good or excellent and the service maintained an average 10% return rate on surveys and feedback requests.

Recent feedback included, “Clinically everything the service has provided has been excellent, from my first call to the helpline right through to the discharge process. It was all to help me with no judgement whatsoever in my decision which is particularly important when a woman is in such a vulnerable and even isolating journey.” Another patient wrote, “I cannot fault this treatment. This has been one of the most difficult experiences of my life. From live chat with MSI choices, to being offered funding on NHS; to having the treatment at Blackpool health centre. Thank you to the nurse who went above and beyond for me to be seen despite being 2 hours late almost. This really made me feel strong and I appreciate the compassion. Thank you to [the receptionist] who was so kind and helpful.”

Client care coordinators acted as a single point of contact for patients and helped them navigate the various aspects of their care pathway.

Staff demonstrated a good understanding of the needs of patients based on their individual circumstances. We observed staff skilfully help a patient whose partner wanted to come into the treatment centre with them when the patient preferred to attend alone. We saw proactive use of the treatment centre’s various waiting areas to meet individual patient needs and in the satellite clinics we saw staff communicate clearly with patients to fully understand their needs.

When dispensing medicines, staff discussed side effects with patients to ensure they knew what to reasonably expect and who to contact if they experienced unusual symptoms. Staff gave patients specific timeframes for side effects to help them make arrangements for work or personal life.

Staff explained what to do if the unexpected happened and ensured patients knew who to contact out of hours.

Are Termination of pregnancy responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

Service delivery to meet the needs of people

The service planned and tailored care in a way that met the needs of local people and the communities served. It worked extensively with others in the wider system and local organisations to plan care that was flexible and offered continuity of care.

Managers planned and organised services, so they met the changing needs of the local population. Staff were innovative in their approach to providing integrated person-centred pathways of care that involved other service providers, particularly for vulnerable people with complex needs. Staff proactively sought opportunities for joint working with agencies caring for patients experiencing crisis.

Termination of pregnancy

The service minimised the number of times patients needed to attend by ensuring patients had access to the required staff, scans and tests on one occasion. Staff provided services that were flexible and promoted informed choice and continuity of care.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems and learning disabilities and dementia. The OneCall team operated 24/7 and signposted patients to urgent care support.

Staff used the appointment booking system to flag needs to reception staff. For example, they noted if a patient had a safeguarding, language, or access need, and recorded if someone was expected to attend with the patient. Similarly, staff recorded if a specific person should not be given access into the centre, such as a partner who was known to be abusive. We saw the reception team handled this system and well and used it to meet patients' needs and to keep them safe.

The quality and governance business partner and matron had carried out an extensive programme to better understand the needs of vulnerable patients with life challenges that might impact their care and long-term outcomes. In this region, they found three overriding themes of homelessness, drug and alcohol use, and food poverty as factors influencing people's needs. The service established new referral pathways to specialist support organisations and staff used these if patients identified one or more of these needs during consultations.

Services in satellite clinics were discreet. There was no branding or signage and staff ensured patients knew where to attend in advance of an appointment. This helped to maintain confidentiality and reflected the need for privacy and confidentiality amongst patients attending services.

Staff coordinated care for patients with unusual, ad-hoc needs and did so whilst maintaining their dignity. For example, they worked with HM Prison Service to facilitate safe, dignified care for a detainee who needed treatment but could not be released from restraint.

Staff worked with each patient to balance safety with convenience. For example, during a satellite clinic inspection a patient found their gestation was more advanced than they expected, and the only safe procedure would be a surgical abortion at the Manchester treatment centre. The nurse worked closely with them to understand the demands and pressures on them and helped them understand the time commitment and arrangements they would need on the day of surgery.

Staff planned and deployed care services based on demand and on recognition of population health pressures in local economies. For example, staff had introduced a coil insertion service in the Preston satellite clinic and quickly recognised that this service increased access for patients experiencing social deprivation and financial difficulty. As a result, the team introduced the service in the Blackpool satellite clinic to immediate demand and success.

Staff offered and arrange counselling services in line with Department of Health and Social Care guidance, including offering this to young people aged 13 to 17 year olds who received care under the Fraser Guidelines and Gillick Competencies.

Meeting people's individual needs

The service was inclusive, and staff proactively took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers and worked to reduce stigma and improve accessibility.

Services were coordinated to meet the needs of patients living with autism and learning disabilities. Staff provided quiet, secluded waiting areas for patients and supported parents or carers to attend with them. They worked with specialists to ensure care and treatment was tailored and met the patient's needs.

Staff supported patients living with learning disabilities by using adapted fact sheets to provide easy-to-understand information and patient passports to help staff structure appropriate care. Clinical staff prepared easy-read discharge summaries for patients.

The service had service level agreements with two language translation service. Staff booked a face to face interpreter for longer appointments and arranged telephone translation for shorter appointments or on demand. British sign language interpreters attended appointments, including on short notice requests.

Staff worked tirelessly to plan, coordinate, and deliver care that was tailored to individual needs and ensure patients were partners in their care. This included where patients presented with complex needs that required modifications to treatment. For example, where patients were experience substance addiction, staff worked with a specialist case worker to plan abortion care and psychological support that enabled safe treatment.

Staff facilitated care for patients with complex needs. For example, they arranged taxis for patients who could not afford to travel themselves. Where patients could only travel at certain times due to their home circumstances, staff planned this in advance. This reflected a very high level of personalised service that met the needs of the most vulnerable patients.

Staff recognised the importance of understanding patients' gender identity and worked with them to tailor their care. For example, they made sure the patients' preferred pronouns were included in care documentation and where their gender identity differed from their biological, documented gender in NHS records, they worked together to reduce stress and stigma.

During our inspection staff adapted their communication and approach effortlessly between patients and during difficult conversations. They understood intuitively when a patient had undisclosed vulnerabilities and worked diligently to ensure they received appropriate emotional and psychological support.

We observed staff communicated sensitively with patients about arrangements for foetal remains after a surgical abortion. They explained what happened after surgery and asked patients if they would like to arrange a foetal cremation or take the remains home for a private burial. Staff were understanding and respectful of each patient's personal preference.

Staff acted quickly as part of multidisciplinary teams to protect patients from harm. This had recently included securing transport for a patient at significant risk of violence to leave the clinic with support from appropriate teams.

At huddles and handover meetings, staff routinely referred to the psychological and emotional needs of patients. This reflected the complex needs of many patients, including those under the age of 18. The team held a regional meeting at the beginning of each day. This included the treatment centre and the nurse from each satellite clinic in operation that day.

Staff completed an equality impact assessment for each policy and standard operating procedure and linked these to specific clinical sites. This meant the assessments took account of local trends in demand and population health, which ensured work to embed equality was specific and useful.

The provider had a policy for care amongst patients living with learning disabilities that included consideration of specific vulnerabilities, communication needs, and safeguarding considerations.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were consistently good. The service focused on increasing capacity and access to meet demand.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times were consistently low with an average of 3.8 days across all appointment types from the first point of contact. This reflected a range from one day wait for telemedicine and surgical abortion to eight days' wait for long-acting reversible contraception (LARC) insertion. The service maintained a good referral to treatment (RTT) time of 8.2 days over the previous 12 months.

Staff worked to keep the number of cancelled appointments and operations to a minimum. Staff who worked in satellite clinics worked flexibly and provided cover in the event a colleague was sick. In the previous six months there had been no cancellations for non-clinical reasons.

The number of patients leaving abandoning a care pathway before treatment was low. The service monitored the number of patients who did not proceed (DNP) with a planned treatment, including for long-acting reversible contraception (LARC). In the first quarter of 2022, the DNP rate was 4%. Staff monitored the reasons given for a DNP to identify opportunities for improved care.

The provider had a dedicated, centralised administration and operations support team for patients. Called OneCall, this team triaged queries and booking requests from patients and coordinated consultations and clinical treatment appointments. This system ensured patients had access to the best choice of clinic for their needs and enabled them to access satellite sites if this was convenient for them and clinically appropriate for their medical needs.

The provider used a coordinated system to ensure patients received care at the most appropriate location. The Manchester Treatment Centre (MTC) was equipped for the full range of medical and surgical services the provider offered. Smaller treatment centres elsewhere in the country, and regional satellite clinics, were not equipped to provide surgical care or medically supervised abortion for some gestation times. In such cases, the MTC team saw patients from out of area. The centralised records, bookings, and triage systems meant staff offered coordinated, consistent care regardless of a patient's home location.

Most care was provided through integrated care board (ICB) contracts and patients needed to be registered with the NHS. Most patients self-referred although the service accepted referrals from GPs or other NHS services. The service could facilitate surgery for private patients, such as those not normally resident in the UK. In such cases, surgeons undertook care under their professional indemnity arrangements.

Staff acted on emerging and specific risks to provide an exceptional level of service access for vulnerable patients with complex needs. For example, they arranged temporary opening hours for a satellite clinic so that a specialist support worker could escort young people who had been the victim of honour-based violence and sexual assault to consultations.

Nurses helped patients to book follow-up appointments at the time of their assessment, which reduced the need for patients to make further contact with the service. We observed nurses work with patients to meet their preferences

around work and other commitments whilst remaining within the safe time limits for the type of care they sought. Where patients presented at a satellite clinic outside of the safe gestation period for a medical abortion, nurses completed the surgical abortion consent and booking process there and then. They made it clear patients could always change their mind and reminded them of the limits of abortion times.

Staff worked with patients to make appropriate arrangements for care and treatment based on their individual circumstances. We observed nurses hand-write clinic and appointment information on unmarked cards and provide direct line contact details for the treatment centre. This reflected a dedication to patient privacy and security, particularly for those at risk of domestic violence.

While the service did not officially offer walk-in care, patients often attended a clinic on this basis. Staff worked with them to schedule an assessment and receive care rapidly.

The service monitored demand from patients under the age of 18 and worked with commissioners to extend health education and support across the region. In the previous 12 months, the service saw 459 under 18s, 60% of whom sought an abortion.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and on the website.

Staff understood the policy on complaints and knew how to handle them. Complaints were rare and represented fewer than 0.1% of appointments. In the previous 12 months the service received four formal complaints. In the same period the service received 24 informal requests for improvement. In each case staff worked with patients to understand their concerns and implement improvement strategies. There were no themes amongst the complaints and feedback and senior staff shared learning for individual occurrences across the provider's network.

Managers investigated complaints and identified themes. The most recent theme was that surgical patients said they were in the treatment centre much longer than expected. In response, staff spent more time with patients at the pre-assessment stage to explain the pathway and ensure they planned enough time to safely undergo treatment and recover.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. For example, a theme of feedback was that patients could not always remember the names and roles of staff they encountered. As a result, staff prepared an introduction board that included a photograph and role title of each person in the treatment centre.

Are Termination of pregnancy well-led?

Outstanding ☆

Termination of pregnancy

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and worked tirelessly to address them. They were visible and approachable in the service for patients and staff and had a clear track record of effective, evidence-based leadership strategy. They supported staff to develop their skills and take on more senior roles through 'stretch' goals.

The operations manager and matron were both registered managers. They coordinated time away from work to ensure one was always available whenever the treatment centre or a satellite clinic was open. The managers had distinct roles and responsibilities and staff said they were visible, approachable, and positive to work with.

All the staff we spoke with were positive about the leadership team and development opportunities. Staff said the senior team offered them team leader development pathways and access to clinical leadership training.

Managers were demonstrably invested in the success of the service. They valued honest contribution from staff and empowered everyone, regardless of role, to talk to them about ideas for improvements. This was part of a leadership strategy that valued individualism and contribution and rewarded good work. This was successful in ensuring provider-mandated standards were put in place whilst facilitating staff with the freedom to excel in their roles.

The senior team proactively supported staff to progress and develop into more senior roles. They co-developed new competency frameworks with front of house staff to develop non-clinical senior roles and worked with the client care coordinator and practice education facilitator to develop their work. The health and safety manager had developed from a healthcare assistant role and the deputy clinical service matron had worked with the senior team to develop into their role. Such examples demonstrated the opportunities available.

The duty nurse, deputy matron, and operations team led the operation of the satellite clinics. This was a well-coordinated system and leaders had a clear understanding of activity levels and pressures on the system.

Vision and Strategy

The service had created a new vision for what it wanted to achieve and an ambitious strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitored progress through comprehensive programmes.

The provider had a well-established mission, vision, and values framework. Staff shared this with patients through information printed and displayed in the treatment centre, which reflected an organisational focus on working transparently with patients. The provider's values centred on providing personalised, high-impact services to patients that empowered them to have children by choice. The strategy to deliver this work reflected an ethos of pushing boundaries and stretching goals, which we found staff personified at all levels during our discussions and observations.

The service had a digital strategy to improve access to care and streamline booking appointments and obtaining clinical guidance. The strategy had resulted in the introduction of a live webchat service and digital booking system.

Population health and addressing the significant regional inequalities and impact of deprivation was a core element of the team's strategy. They recognised increasing demands for abortion services from the under 18s and those experiencing challenging home lives. Staff were proactive, bold, and innovative in their work to meet the needs of the most vulnerable people and work with partners to address the challenges of the wider health economy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and proactively sought opportunities for joint working and continuous improvement. The service promoted equality and diversity in daily work and provided personalised opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear and in which senior staff genuinely wanted to understand challenges.

The provider's safeguarding ethos was embedded in all aspects of care and staff demonstrated this during assessments and treatment. The senior team coordinated additional staff to care for patients with complex safeguarding needs. Staff made it clear to patients they would continue to provide safeguarding coordination and support for as long as they needed after clinical treatment.

All the staff we spoke with described a positive working culture and high standards of morale. Staff said they had been supported during the pandemic and felt the provider's competencies and professional development programmes were key factors in their dedication and enthusiasm.

Staff were demonstrably engaged with the provider and its mission and told us they felt invested in its success. A nurse in the treatment centre had been recognised by a national provider award for their work in establishing advanced patient feedback systems, which the senior team recognised as gold standard.

A Freedom to Speak Up Guardian was available on demand to staff. Staff additionally had access to an external, independent equivalent and they could choose to contact either individual to report concerns.

The provider carried out a staff survey in early 2022. The results reflected a confident, cohesive team that was satisfied with their support and opportunities. For example, 100% of staff said they felt trusted to do their job and 100% said they felt their job made a difference.

The provider had carried out a 'just and learning culture assessment' based on the NHS model to ensure working cultures facilitate honesty and transparency. This reflected best practice and meant the team had a deeper understanding of their working practices and ethics. Combined with human factors training, this reflected the importance the provider placed on positive working culture.

The working culture valued diversity and staff were keen to learn more about areas of people's lives that impacted their care. For example, they proactively sought learning and training about gender and sexual identities with which they were unfamiliar to ensure they could offer high standards of care.

Governance

Leaders operated highly effective governance processes, throughout the service and with partner organisations. Governance was measured quantitatively and qualitatively, and the service had substantial evidence of improvement and assurance as a result. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Termination of pregnancy

The provider had a national governance structure that provided regional staff with support and operational frameworks. The UK divisional board included one independent specialist advisor supporting scrutiny of national oversight. The director of nursing, midwifery, and quality and the regional quality and governance business partner led the regional governance system with support from two registered managers. The team used a series of compliance monitoring audits to identify achievements and areas for improvement and these substantively contributed to the wide range of improvements and developments in the service. The team had recently increased the depth of governance activity and noted transformational change as a result. For example, they reviewed actions for improvement from all treatment centres nationally and used these to assess local practice as a strategy to deliver levels of service that exceeded expectations.

Specialist groups provided governance in specific areas such as the policy approval group, medicines management group, and task and finish groups. The structure was appropriate to the complexity of care and treatment delivered and meant the senior team had continual understanding of initiatives, risks, and service needs.

The provider adhered to national requirements in relation to the storage and documentation of storing pregnancy remains for police collection. This met their responsibilities under the Police and Criminal Evidence Act.

There were issues regarding access to chlamydia testing across the Lancashire integrated care board (ICB) responsible for the Manchester treatment centre. In such cases staff utilised the service's own testing kits to ensure all patients received testing if needed.

Staff acted to protect patients at risk of undiagnosed infections by establishing rapid referral pathways to other local services that could provide screening and treatment. Staff worked within local commissioning arrangements at satellite sites, which dictated the services they could offer. Where patients needed a service the provider could not offer, staff used local partnerships to arrange these.

The service had processes in place to ensure compliance with the Abortion Act 1967. This included documentation of a doctor or surgeon-approved reason for abortion using the mandated HSA1 form. The UK government requires providers to report each instance of an abortion to the Department of Health and Social Care within 14 days using the HSA4 form.

The clinical effectiveness group performed a key clinical governance function. They monitored audit outcomes, incidents, complaints, and implemented learning from investigations and outcomes.

The senior team and quality team used a digital scorecard to monitor governance of the service. This included monthly monitoring of 15 key areas that affected service performance and viability, such as staff sickness, training compliance, rate of patient feedback, and incidents. The team benchmarked performance against other treatment centres nationally.

Senior medical staff led the medical advisory committee (MAC), with representation from surgery, medicine, and anaesthetics. The MAC held oversight of practising privileges for anaesthetists and there was an effective system in place to manage performance and quality of work. We reviewed MAC meeting minutes and saw the group was proactive in pursuing clinical excellence and built on the expertise of its members to improve patient care and staff support. For example, the MAC had implemented a new standard operating procedure to hold IV antibiotics on site, which would improve the comfort and outcomes of patients who needed to be transferred to emergency care.

Termination of pregnancy

Management of risk, issues and performance

Leaders and teams used systems to manage, assess, and improve performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk management was holistic, and they had extensive, tested plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The governance and leadership teams used an integrated governance dashboard to benchmark local activity and performance against the provider's national network. The dashboard included incidents and clinical outcomes and enabled the senior team to measure these against national guidance and policies. They carried out local monitoring monthly and national benchmarking quarterly. The integrated governance committee monitored assurance processes and provided the board with escalation and oversight of risks.

The senior team used a risk register to document and track risks. At the time of our inspection there were 64 active risks, including the satellite sites. There was documented evidence of a continual tracking and mitigation by named staff who adopted accountability for specific risks. Key risks related to the potential impact of COVID-19 surges and staff sickness.

The team used an overarching CLIPS ('complaints, litigation, incidents, patient feedback') system to monitor performance weekly. Representatives from every treatment centre joined weekly meetings and used the time to collaboratively solve problems and benchmark outcomes. The clinical director and medical director led this process for surgical services.

The senior team reviewed open incidents weekly alongside the risk register to identify new risks or updates to existing items.

Staff and patients were protected by security arrangements in the treatment centre. The head of health and safety worked with staff to implement policies in relation to emergencies, threats and risks. The OneCall team alerted treatment centre and satellite clinic staff if a patient was aggressive during their pre-assessment process. This enabled clinical staff to make arrangements for their safety.

Senior staff coordinated the regional reach of the service. They led daily briefings with staff in the treatment centre and those delivering care in satellite clinics each day and concluded with an end-of-day handover and debrief. This helped to manage the isolated working of satellite clinics and identified any specific problems or issues to be addressed. We saw staff always had access to immediate, on-demand support from senior or specialist colleagues using online chat. This meant nurses working alone in satellite clinics had access to senior colleagues, including doctors and matrons. Staff in the treatment centre used this system to communicate effectively with colleagues elsewhere in the building, or in one of the national centres, to help streamline care and reduce the time patients were left alone. We observed the system in use and saw it was highly effective and helped manage risks in real time.

Staff recognised the high level of clinical and safeguarding risks amongst patients for whom they delivered care. They had developed escalation pathways for a wide range of circumstances and updated these based on their professional experiences and patient need.

The senior team had worked for several months with local police and the local authority to secure a public space protection order (PSPO) around the treatment centre. The PSPO prevented unauthorised people from loitering or trespassing and protected patients, staff, and visitors from abuse, threats, and violence, after a series of incidents involving protestors and activists. This worked represented the culmination of targeted, complex work to address a risk to people's safety.

The clinical effectiveness group met quarterly and review updates to policies, guidance, and research. The group was multidisciplinary and included clinical and non-clinical staff from across the provider. There was evidence of good standards of learning across treatment centres nationally.

The medical advisory committee (MAC) held a key role in monitoring policies and guidance and reviewed updates from organisational strategies such as the Nursing and Midwifery Council. The MAC sought to make sure its work manifestly improved the service and had a key focus on the impact of increasing deprivation and social needs in the regional health economy.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information governance, data management, consent, and confidentiality policies and standard operating procedures were closely linked. The service required patients to sign a release of information authorisation before staff send discharge information to GPs or other community services, except in circumstances in which a patient's safety was at risk.

The provider had established data sharing agreements for other services that provided termination of pregnancy services, for use in cases where staff found evidence of abuse or a need for safeguarding action. The safeguarding lead was responsible for this policy and worked with their counterparts in other organisations to make sure it met data protection regulations and was in the best interests of the patient.

The service maintained an accessible information standard policy that guided staff in providing clear, accurate, concise information that could be adapted to individual need.

The service submitted data to the Department of Health and Social Care regarding abortion procedures in line with national requirements.

Engagement

Leaders and staff actively and extensively engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. This approach demonstrably led to high quality care.

The service provided patients with multiple means to provide feedback. Staff recognised it could be challenging to obtain feedback from patients through the traditional means of surveys or questionnaires given that many people wanted their care to remain very private and did not want contact after their care. To ensure their voices were still heard, staff created an anonymous feedback board in the treatment centre. Patients used sticky notes to write comments about their care and staff reviewed these weekly. Comments at the time of our inspection included, "Reception staff were really welcoming", "Can't thank everyone enough", and "Wonderful team, you all made me feel extremely relaxed."

The senior team had a consistent, proactive focus on staff engagement. There was evidence of staff engagement and involvement in new initiatives, service reviews, care pathway development, and almost all aspects of the service.

Staff were trained in mental health first aid as part of a provider engagement programme to ensure everyone had access to peer mental health support. The programme included dedicated listening space, counselling, and access to cognitive behaviour therapy. This reflected the potential impact of the nature of care and need for enhanced patient support.

Staff had been given protected time to attend a national roadshow arranged by the provider. The roadshow visited each treatment centre and the head of operations and medical director attended with the goal of engaging staff in giving feedback on their experiences working there. Staff told us this was a very positive experience and said it helped them develop relationships with the senior team and better understand how they could contribute to the service.

Staff spoke positively of the mental health support available to them. They noted the provider arranged cover for their shifts after traumatic events and said colleagues and managers were unwavering in their support.

In the staff survey, 92% of staff said they were able to make suggestions for improvement. Patient feedback reflected their appreciation of the relationship between the provider and staff. One patient wrote, “Keep appreciating your staff, they are amazing!”

Learning, continuous improvement and innovation

All staff were demonstrably committed to continually learning and improving services through inquisitive working, professional development, and research. They had an advanced understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The provider had a substantive, demonstrable focus on improving access and quality of care for patients living with a learning disability. An international specialist organisation had assessed one of the provider’s other treatment centres for accessibility and shared learning nationally across each site. This led to improvements such as new signage that was easier to understand and work with staff to help them apply the learning disability care policy to meet individual needs.

The practice education facilitator (PEF) had redesigned the role, it’s purpose, and intended outcomes. They identified time previously spent on paperwork that could be better used to deliver specialist training to staff through proactive mentoring. They worked with the provider’s national learning and development team to develop new professional development standards and met colleagues from other treatment centres to identify gaps in training and need.

The senior team recognised pressures on healthcare staffing in the region. As part of a strategy for succession planning and future growth, they launched a pilot scheme to attract medical students and student paramedics to carry out rotations in the centre. This supplemented the existing student nurse midwife scheme and helped to build relationships with other services and give developing health professionals a better understanding of abortion care.

While staff were demonstrably proud of the provider’s work, and committed to its cause, the senior team recognised the benefit of facilitating a workplace that valued the local area and region. They reduced the standardised corporate approach of the treatment centre and encouraged staff to celebrate their local accomplishments. This included establishing an ‘innovation inbox’ that staff could use to submit feedback. The managers sent out suggestions weekly and asked staff to provide responses and suggest solutions.

Outstanding ☆

Termination of pregnancy

The team demonstrated a deep commitment to improving access and capacity through sustained, innovative, responsive action to changes in demand. A wait time initiative resulted in the implementation of increased recruitment that enabled weekend and bank holiday access to services and a 75% increase in surgical list capacity. The senior team provided staff with structured clinical competency progression that enabled them to offer a great variety of services and supported surgeons to qualify to carry out procedures at a later gestation.