City Health Care Partnership CIC

BD256

Other specialist services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
		Termination of pregnancy	

This report describes our judgement of the quality of care provided within this core service by City Healthcare Partnership CIC. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by City Healthcare Partnership CIC and these are brought together to inform our overall judgement of City Healthcare Partnership CIC

Summary of findings

Ratings

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

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Summary of findings

Overall summary

City Healthcare Partnership CIC was contracted by Hull and East Riding clinical commissioning groups (CCGs) and city councils to provide an integrated sexual health service for patients from the areas of Hull and East Riding. Sexual health services were provided as part of Care Group Two, which also provided community paediatrics and public health services.

Services were provided under the name of 'Conifer Sexual and Reproductive Healthcare Services', which provided the range of contraception and sexual health (CASH), HIV and gynaecology services and medical abortion up to 9 weeks gestation. The service also provided pre and post termination counselling as well as contraception advice and screening for sexually transmitted diseases. Staff referred any patients requiring surgical abortion or medical termination of pregnancy of greater than 9 weeks gestation to alternative termination of pregnancy providers. The service also provided vasectomy.

The premises were situated at a large treatment centre in the town centre and were easily accessible by public transport or car. Facilities were modern and suitable to meet the needs of the service. The services were open from 8am until 8pm Monday to Saturday and 9.30am to 4.30pm Sundays.

The termination of pregnancy service assessed and treated patients of all ages, including those aged less than 18 years and could treat young people and children as young as 12. Seven hundred and forty four patients had accessed this service between October 2015 and September 2016, 13 of these were under 16 years. No children under 13 years had accessed the service during this time. Staff caring for patients less than 18 years of age followed strict safeguarding and management processes. The service was provided in an integrated manner with the local acute trust to allow women access to abortion services up to and including 9 weeks. Women who were more than 9 weeks pregnant were referred to other providers of later termination services. The majority of patients treated were NHS funded and lived within the boundaries of Hull and East Riding.

The integrated sexual health service employed 4.43 whole time equivalent (wte) consultants, 0.75 wte GPs with special interests, and 2 wte specialty and associate specialists. Two of the consultants were involved in providing the termination of pregnancy service including; clinical assessment, confirmation that the lawful grounds for abortion were met, and prescribing of abortifacient medicines.

The integrated sexual health service employed 17.12 wte registered nurses at band 5 and above, 1.8 associate practitioners at band 4 and 8.01 wte support staff at bands 2 and 3. There was an additional 0.19 band 6 vacancy and 1.06 band 3 vacancy, which had been recruited to but staff were not in post yet.

The service was also support by an administration team, which included 7 wte receptionists.

We carried out an announced comprehensive inspection of the termination of pregnancy service between 8 – 11 November 2016 and an unannounced inspection on 22 November 2016. The staff and services we inspected were those delivered from Wilberforce House.

We spoke with 3 patients and carers, and 15 staff, including managers, doctors, nurses healthcare assistants and receptionists. We attended a number of focus groups and we observed staff deliver care. We looked at 10 sets of medical records for termination of pregnancy patients and three vasectomy patients and reviewed the service performance data.

Summary of findings

Background to the service

We regulate this service but we do not currently have a legal duty to rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary

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

There was a culture of reporting and learning from incidents, across the service and within the service. Staff could demonstrate their understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse. Staffing levels, medicines management and record keeping were good. However, patients did not routinely receive a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.

Care was provided in line with national best practice guidelines. Patient assessments were thorough and staff followed clear pathways of care. The service managers used a performance dashboard, which measured quality standards and facilitated improvement in the quality and safety of clinical standards. Staff were competent and had received training relevant to their role.

We observed interactions between patients and staff in the public areas of the service and during their consultation and treatment and saw that staff treated patients with compassion, dignity, and respect. They focused on the needs of each patient and responded quickly to their needs. Staff were very aware of the additional needs and risks associated with the care of young people. However, patients were not informed of the requirement to submit HSA4 (abortion) data to the department of health.

All patients had checks and tests before procedures. Information and advice were available from staff, leaflets and on-line to patients at all stages of their care. Interpreting and counselling services were available to all patients and staff made every effort to meet individual patients' needs. There were systems in place to ensure sensitive disposal of pregnancy remains, in accordance with national guidelines. The service was accessible for patients of all diversities including those with disabilities. However, although waiting times were monitored, the service did not assure us that delays outside of the DH standard were entirely because of patient choice or delay for an appropriate clinical reason.

Senior managers had a clear vision and strategy for this service and quality of care and patient experience were seen as the responsibility of all staff. Staff felt supported by their managers and were confident they could raise concerns and have them dealt with appropriately. There were effective governance systems in place and staff received feedback from their managers. Local risks were evident on the risk register and these had been reviewed, the service had an improvement action plan in place and was working its way through the actions identified.

The service met Department of Health requirements. The organisation had a proactive approach to staff engagement and innovation, learning, and development were encouraged.

Our inspection team

Why we carried out this inspection

How we carried out this inspection

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the clinic MUST take to improve

- The provider must put in place a system to assure itself of HSA1 and HSA4 compliance against legal requirements.
- Implement a safer surgical checklist for vasectomy patients.
- Inform patients of the requirement to submit abortion data to the Department of Health and explain how this information is anonymised.

Action the clinic SHOULD take to improve

- Review how waiting times for termination of pregnancy patients are monitored against Department of Health requirements of 5 working days from referral to consultation and 5 working days for consultation to treatment to provide assurance that extended waiting times are due to patient choice or appropriate clinical delay.
- Improve compliance with children's safeguarding training at levels 2 and 3.
- Consider providing patients attending for medical abortion a time alone with the assessing nurse or consultant to give them a private opportunity to disclose any concerns regarding abuse or coercion.

City Health Care Partnership CIC

Other specialist services

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

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

- Patients, attending for termination of pregnancy consultation, did not routinely receive a private, initial consultation without anyone else present. Although this is not a requirement under the DH Required Standard Operating Procedures (RSOP)s or Royal College of Gynaecology (RCOG) guidance it would be considered best practice to provide this to give patients a protected time to disclose any potential coercion or abuse in a safe environment.
- The service did not use a safer surgical checklist for vasectomy patients however, the managers were aware this needed to be implemented.
- Children's safeguarding training compliance at levels two and three were not meeting targets. However,
- There was a culture of reporting and learning from incidents within this service and across the organisation.
- Staff we spoke with demonstrated a good understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse.
- Staffing was sufficient and appropriate to meet the needs of patients in their care.
- Staff ensured medicines were stored and administered safely.
- Pathway documents and clinical risk assessments were completed fully and legibly.

Incidents

- Incidents were reported and investigated, staff we spoke to were aware of their responsibilities in relation to incident reporting and notification.
- There were no serious incidents or never events at the service in the 12 months before the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The integrated sexual health service reported 42 incidents between October 2015 and October 2016. There were no particular themes among the incident within those reported. Two of the incidents were in relation to the termination of pregnancy service.
- Managers told us that information from serious incident investigations, elsewhere in the organisation, was

cascaded out to them for dissemination to their staff. Staff told us they received this information by email. Managers told us they had received incident investigation training.

- A nurse gave us a recent example of a patient not returning for the second part of abortifacient treatment and told us how this had been reported and action taken to ensure the patient was contacted and received the necessary treatment. The nurse told us that she had not received feedback from the investigation of this incident although when we spoke to managers this appeared to have been because this had not been signed off as completed yet and that the incident was reported as a no harm incident. As this incident was reported as 'no harm' it had not undergone a full root cause analysis (RCA) investigation. Although this incident had not resulted in harm the patient underwent an originally unplanned procedure at another hospital and the outcome may have been more serious if the patient was not traced and treated.
- It would have been appropriate for the organisation to undertake an RCA investigation for this incident to determine; the likelihood of the incident occurring again if the current systems/process remained unchanged; and the potential for harm to patients should the incident occur again. This would have been best practice in line with NHS England serious incident framework, guidance.
- Staff we spoke with understood the principles of "being open" and "Duty of Candour". A Quality Management and Performance (QMP) dashboard showed that 3 out of 5 sexual health staff audited could describe the circumstances when Duty of Candour would be triggered.
- Staff told us they received Medicines and Healthcare products Regulatory Agency (MHRA) Alerts and Safety Notices by email.
- The service reported incidents externally where required such as adverse drug events and equipment failures were reported to the Medicines and Healthcare products Regulatory Agency (MHRA).

Cleanliness, infection control and hygiene

- The consulting rooms, waiting areas and other clinical rooms were visibly clean and tidy.
- Cleaning schedules and standard operating procedures were available for each individual room or area.
- Facilities for hand hygiene were provided and soap dispensers we reviewed were in good working order. We observed staff washing hands and using gel appropriately.
- Disposable curtains were in use in the clinical areas and were marked with the date of last change.
- Personal protective clothing was available in all areas we visited.
- The latest 'Essential Steps' audit for 'Care Environment and Infection Control' for May 2016 had showed 98% compliance for integrated sexual health services.
- We saw waste was appropriately segregated and disposed of and sharps bins were used correctly.
- The service undertook annual assessments of hand hygiene practice. Records provided indicated that 31 out of 38 assessments had been completed and all staff assessed in the last 12 months were competent.
- There was a policy in place regarding safe disposal of clinical waste and a service level agreement was in place with a waste contractor for removal.
- An infection control audit for the sexual health service showed 97% compliance with only two areas not meeting 100%. These were regarding a wall that needed plastering repairs and postoperative wound care information for patients. An action plan with corrective actions had been produced to address these. However, this had not been updated at the time of our inspection.
- A sharps bin audit in June 2016 showed generally good levels of compliance although there were some areas for improvement; five of 13 bins had some inappropriate items in them, three bins were overfull and one had not been dated and signed.
- Training records showed that 86% of staff were compliant with hand hygiene training, 87% of clinical staff were compliant with other infection control training and 100% of non-clinical staff were compliant with infection control training.

Environment and equipment

- We saw the premises the services were provided from were in a good state of repair and the suite of rooms were appropriate for the needs of the services provided.
- Staff told us and we saw that there were processes in place with the landlord to ensure any issues with the building maintenance and repairs were dealt with.
- We saw there were maintenance contracts for equipment and electrical safety testing of equipment was evident.

Are services safe?

- Staff told us that stock was rotated and all stock we checked was in date and stored in an appropriate manner.
- We saw that resuscitation equipment and drugs were checked daily when the unit was open and that trolley drawers were locked.
- We saw that every clinic had an anaphylaxis box, which was sealed, and expiry dates were on the outside of the box so staff could identify when they needed stock replacing.

Medicines

- There was a medicine management policy in place and staff had access to regular pharmacy support from within the organisation.
- The service dispensed prescriptions for analgesia, antibiotics and contraceptives.
- We observed nurses providing antibiotics and contraceptive medications and checking that patients understood what the medications were for and the importance of taking them as prescribed.

We observed the nurse also described what side effects could be experienced.

- We saw nurses advise patients to contact the service if they vomited soon after taking abortifacient medication to determine if a second dose was needed.
- We checked medication cabinets, which were clean, tidy and well organised. We saw that nursing staff checked drug stocks regularly and stored them safely and securely.
- The service kept a small supply of testosterone, which is a controlled drug. We saw that this was stored securely and staff followed correct procedures when administering this. There was a register of stock and staff checked and signed the register, in line with medicine management policies.
- Staff recorded fridge temperatures in line with good practice medication guidelines. Recordings were all within recommended range. Staff told us the fridges were connected to an automatic data logger, which meant temperatures were also automatically recorded and uploaded to an IT system. Pharmacy staff could see this system and download reports where they identified problems.
- All medicines within the termination of pregnancy service were prescribed on an individual basis, this included, abortifacient medication, pain relief, and antibiotics.
- The outreach team ordered and collected medicines from the centre and carried a limited supply of medicines securely in a locked case.
- Staff carried out quarterly stock checks and a pharmacy technician carried out spot checks.

Records

- Patient records were a combination of electronic and paper based. Sexual health records had recently been moved on to an electronic system but medical abortion records were still paper-based. HSA1 and HSA4 forms were stored with the patients' clinical records.
- Patient information and records were stored safely and securely in line with the Data Protection Act.
- Patient records included speciality pathways and risk assessments for venous thromboembolism (VTE), sexual health and safeguarding for patients under 18 years of age.
- We looked at 10 sets of records of patients who had attended the termination of pregnancy service and found them to be, in the main, up to date, complete and legible. Records indicated risk assessments were completed and referrals made to other services where relevant. In one record the tests and information section was incomplete without there being a rationale for this and in another record the decision to proceed section had only been completed by one consultant, not two.
- We reviewed three sets of electronic vasectomy records, which were fully completed.

The sexual health service had been audited against the standards for record keeping in May 2016, and had shown compliance of 92%, which was better than the organisational target of 85%.

- Medical abortion information leaflets gave patients information regarding "How we use your Information". Although this explained that information would be shared for specific purposes it did not cover submission of HSA4 (abortion) data to the DH.

Safeguarding

Are services safe?

- Good systems were in place to safeguard vulnerable adults and children and young people. Staff we spoke with were all aware of their responsibilities and demonstrated experience of using safeguarding pathways appropriately.
- Children safeguarding risk assessments were completed and held on an electronic system, this meant that any flags associated with risk of harm (for example; safeguarding or mental health risks such as self-harming behaviour) could be seen by staff in any of the integrated sexual health services if the child presented.
- We saw two examples of safeguarding assessments in the records we reviewed and where relevant one of these demonstrated appropriate referral to social services.
- Safeguarding risk assessments prompted staff to provide a professional analysis and to consider coercion. The nurse told us there was a similar risk assessment for use with vulnerable adults such as those with a learning disability and that they could use this if they suspected a patient was a victim of coercion or domestic abuse.
- We saw from records that patients under 18 years were risk assessed and asked a range of questions intended to encourage patients to disclose any issues of concern or coercion.
- Staff told us that patients did not routinely receive a private, initial consultation without anyone else present. Although this is not a requirement under the DH Required Standard Operating Procedures (RSOP)s or Royal College of Gynaecology (RCOG) guidance it would be considered best practice to provide this to give patients a protected time to disclose any potential coercion or abuse in a safe environment.
- We saw that the clinic room contained contact details for local safeguarding teams. The staff told us they had good links with the local safeguarding board and could contact their local safeguarding teams when needed.
- Staff we spoke with had undertaken the training programme for protection of vulnerable adults and children's safeguarding training at level three.
- Staff told us and we observed that they carried out safeguarding risk assessments for all patients under 18 years and when there was any suspicion of abuse of older adults. Staff we spoke with told us of safeguarding referrals they had made to the local authority.
- For those aged 13 to 18 years, a safeguarding risk assessment was completed and decisions were made or further action was taken on the outcome of the assessment. We saw that this risk assessment was completed for all relevant patients in the records we looked at.
- Organisational policy was that if a 12-year-old girl used the service then staff would automatically make a safeguarding referral in line with the Sexual Offences Act 2003.
- The nurse told us she would check with the local authority safeguarding team regarding whether there were any known safeguarding concerns, if she had any concerns herself. The nurse gave examples of communications with social workers where young people had been identified at risk of harm.
- The organisation had policies and procedures for staff to follow if cases of female genital mutilation (FGM) or sexual exploitation were discovered and staff were clear what actions they needed to take in this situation. There was an identified service for FGM and women could be referred into this or refer themselves.
- Staff told us that a consultant saw all children under 16 years old, at their initial appointment, when attending the termination of pregnancy service.
- The clinical staff we spoke with were aware of the 'spotting the signs review' in relation to child sexual exploitation.
- The service used a competency framework regarding The British Association for Sexual Health and HIV (BASHH) and Brook 'child sexual exploitation' (CSE) proforma.
- Staff told us if they identified abuse or a patient disclosed they had been raped they would refer the patient to the local Sexual Assault Referral Centre (SARC), which provides services to victims/survivors of rape, or sexual assault. Staff told us they had a pathway to follow if they needed to do this.
- Safeguarding training compliance for the integrated sexual health service was; 78% for adult safeguarding; 67% for PREVENT and 94%; 25% and 66% for children safeguarding levels 1, 2 and 3 respectively. The training staff received included child sexual exploitation and FGM awareness.
- We saw that nurses and doctors delivering this service had DBS checks performed within the last 3 years and that managers had a process in place to ensure sub-contracted staff had also undergone these checks.

Mandatory training

Are services safe?

- All staff received mandatory training, which included; anaphylaxis and basic life support, conflict resolution, cervical shock training, control of substances hazardous to health (COSHH), equality and diversity, infection prevention and control, moving and handling, fire safety, information governance, safeguarding adults, PREVENT, and safeguarding children
- There was a programme of training available for staff to access updates when required.
- All staff told us they were up to date with their mandatory training. Training data indicated that there were some areas where training compliance was below target, such as practical moving and handling, PREVENT, safeguarding children levels 2 and 3 and adult safeguarding.
- Training was provided through a combination of online courses and updates and face to face from external trainers.
- All staff received basic or intermediate life support training relevant to their role.
- Nursing and medical staff we spoke with said they accessed mandatory training on line or in block events to cover several modules at one time.
- Doctors told us they completed advanced life support including defibrillation skills annually.

Assessing and responding to patient risk

- We saw that staff used treatment criteria, which, clearly laid out the medical conditions that would exclude patients from accessing termination of pregnancy treatment, and those medical conditions, which, required risk assessment by a doctor.
- For patients who were not suitable for treatment at the service on medical grounds or because gestation was over nine weeks there were referral pathways in place to the local NHS trust for surgical abortion up to 12 weeks or to another independent provider who provided termination of later pregnancy.
- We observed that before the first treatment, patients were assessed for their general fitness to proceed. This assessment included obtaining a medical and obstetric history and measurement of vital signs, including blood pressure, pulse and temperature. The nurse told us that the patient's vital signs were repeated before the second part of treatment, after delivering pregnancy products and again before discharge home. If the nurse was worried about a patient's medical condition, she would speak with one of the consultants in the clinic or contact by telephone if necessary.
- We observed from records and staff told us that all patients received an ultrasound scan to confirm gestation. Scanning was undertaken by fully trained ultra-sonographers who provided this service as part of a contract with the local NHS trust. Staff told us if the scan indicated an abnormality or possible ectopic pregnancy then the service made an immediate referral to the local early pregnancy unit and a member of staff would ring the unit to discuss their findings with the doctor on-call.
- Blood tests were performed on all patients to establish those patients who had rhesus negative blood group. These patients received treatment with an injection of anti-D to protect against complications should the patient have future pregnancies. Other relevant laboratory testing was undertaken as appropriate and as agreed with the patient.
- The service undertook all aspects of pre-assessment care including, date checking scans to confirm pregnancy and to determine gestational age and other assessments such as sexually transmitted infection (STI) tests. These tests could include haemoglobin level, chlamydia and HIV testing.
- We observed that staff made positive identity checks before commencing a consultation, treatment and before administering abortifacient drugs.
- We observed a second nurse checked the first stage abortifacient drug administration and that the nurse checked the patient understood that once the first stage medicine had been taken then the termination must be completed due to effect of the medicine on the foetus.
- We observed staff giving patients advice and information regarding accessing emergency medical health services, should they suffer heavy blood loss following treatment. We saw a nurse explain to patients what an excessive amount of blood loss was. Aftercare and helpline numbers were included in the information leaflets, given to all patients who had a termination of pregnancy.
- The nurse told us that if patients were delivering products in the Sunday clinic and an excessive bleed

occurred they could contact one of the consultants by telephone to discuss and obtain a prescription for syntometrine administration to reduce haemorrhage if needed.

- We saw that the nurse used a discharge checklist to ensure all termination of pregnancy patients had all of the information they needed prior to leaving the department. Discharge letters were given to patients to keep for their information, regarding the treatment they had received. They could give this to other healthcare professionals if they needed to access emergency services. Patients were also asked if they would like a copy of the letter sent to their GP, copies were only sent to the GP with the patient's consent.
- There was an emergency transfer agreement in place with the local NHS trust. Patients were transferred to the local hospital by ambulance if an emergency arose. Staff told us that if they transferred a patient to the hospital the on call gynaecology team would review them.
- We saw that EMA patients were given a 24-hour helpline number to contact should they need advice or support following discharge from the service. Staff told us that calls automatically went to the GP out of hours service when their service was closed.
- The nurse described how she had given emergency advice to a patient who was showing signs of an anaphylactic reaction and how the patient had subsequently received treatment in A&E.
- Staff and managers told us that there was not a safer surgical checklist in place for vasectomy patients however, they were aware this needed to be implemented.
- There had been no emergency transfers, for termination of pregnancy patients in the data provided for the period October 2015 to September2016.

Nursing staffing

- The integrated sexual health service employed 17.12 wte registered nurses (RN)s at band 5 and above, 1.8 associate practitioners at band 4 and 8.01 wte support staff at bands 2 and 3. There was an additional 0.19 wte band 6 vacancy and 1.06 wte band 3 vacancy, which had been recruited to but staff were not in post yet.
- The integrated sexual health service was staffed with registered nurses, healthcare assistants (HCA)s and reception staff Monday to Saturday 8am-8pm.
- There was one RN and a HCA on duty to care for medical termination patients on Sundays 9.30am to 4.30pm.

Medical staffing

- Medical staff providing services relating to termination of pregnancy and integrated sexual health were either employed by or sub-contracted to CHCP CIC.
- The medical director was responsible for the supervision, appraisal and dealing with concerns relating to the practice of medical staff. Doctors we spoke to told us they had annual appraisals and they in turn provided supervision for junior staff on rotation.
- We saw evidence that the medical staff in this service had active GMC registration, indemnity insurance and DBS checks within the last 12 months
- The integrated sexual health service employed 4.43 whole time equivalent (wte) consultants, 0.75 wte GPs with special interests, and 2 wte specialty and associate specialists. Two of the consultants were involved in providing the termination of pregnancy service including; clinical assessment, confirmation that the lawful grounds for abortion were met, and prescribing of abortifacient medicines.
- Doctors reviewed patients' paper records and assessments including information relating to why a patient wanted a termination of pregnancy, to make their clinical and legal assessments. As doctors were on site when reviewing records they could easily ask, nurses for more information if needed or make arrangements to see the patient if required.
- Nursing staff told us that if they needed any clinical advice regarding a patient they were able to speak to doctors directly or by telephone. They told us that doctors responded quickly and were approachable and supportive.

Major incident awareness and training

- There were local contingency plans in place, such as fire or loss of utilities. Fire plans were visible in clinical areas.

Are services effective?

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

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

- Care was provided in line with national best practice guidelines.
- Patient assessments were thorough and staff followed pathway guidance.
- Pain relieving medications were routinely given to patients undergoing termination of pregnancy or vasectomy.
- In the records we looked at, staff recorded discussions to show they adhered to Fraser guidelines in respect of children and young people and patients gave their consent in writing.
- There were good links with local safeguarding teams, the local NHS hospital and other agencies.
- Staff were competent to undertake their roles and specialist staff were contracted to undertake aspects of care such as ultrasound scans and counselling.

However;

- We did not see a clinical audit programme in place with specific regard to all of the elements of the DH RSOP 16.

Evidence-based care and treatment

- Treatments for Early Medical Abortions (EMA) were given at 24 hour or 48 hour intervals that were in line with Royal College of Gynaecologists (RCOG) guidance.
- All staff had access to up to date policies and procedures through the intranet. We observed staff adhering to policies and procedures, for example, with regard to consultation and treatment and infection, prevention and control.
- We observed staff following patient pathways for termination of pregnancy.
- Information leaflets provided to women undergoing termination of pregnancy gave data regarding risks and side effects of treatments.
- We observed that staff discussed the relative risks of different treatment options during patients' consultations. This included the option to have the second part of their treatment as a day patient or go home to deliver the pregnancy remains.
- Counselling services for EMA and other integrated sexual health service patients were sub-contracted to ensure patients could access specialist counselling when needed. Staff told us they provided patients with a hotline number to access this service but they could also ring the service or turn up at the clinic. Staff would then direct them to the counselling line or help them make contact if needed.

Pain relief

- The nurse told us and we saw from records that patients who delivered products in the clinic setting were prescribed and given pain relief and anti-sickness medications as needed.
- We observed and saw from records that nurses gave patients good information and advice regarding what to expect post abortion treatment and how to alleviate pain.
- We saw from patient records that vasectomy patients were given pain relief.
- The service stocked a small range of pain relieving medications such as diclofenac, paracetamol, and codeine.

Nutrition and hydration

- Water and hot drinks were available for patients in the waiting areas.
- We observed a nurse advise patients who were staying at the clinic on a Sunday for the second part of their treatment, to bring a snack with them and that drinks would be available for them.

Patient outcomes

- During 2014-15 the termination of pregnancy service had undertaken an audit against 'RCOG evidence based guideline 7 (November 2011) guidance in relation to pre-abortion assessment, abortion procedures and care after the abortion'. Forty medical abortion case notes

were audited against; determination of rhesus status, rhesus prophylaxis, VTE risk assessment, Chlamydia screening, STI risk assessment and the prevention of infective complications. All standards were met in 38 sets of records; there were two omissions of Rhesus status and one omission of reason for declining STI screening. All records documented discussion of the full range of contraception including long acting reversible contraception (LARC). The auditor also found that time from referral to procedure was not deducible from all records and was therefore unable to tell if a patient had accepted the first offer of appointment or if ultrasound scan (USS) and first assessment had been deferred due to very early presentation.

- Further audit carried out in accordance with RCOG guidelines included checking compliance on record keeping, sexual health screening and rhesus status, contraception including LARC offered and provided, take-up of follow-up telephone assessments, complication rates, failure rates and referral to assessment and treatment times.
- Compliance rates were good: rhesus status and prophylaxis, VTE risk assessment and STI risk assessment were all 100% and 39 out of 40 patients had chlamydia screening. Three out of 40 patients had not taken part in a telephone follow-up although it had been offered.
- Patients undergoing medical abortion received a telephone follow up appointment and were asked to carry out a self-test pregnancy test. If a pregnancy test was positive, women were given a second follow up appointment and were asked to repeat their urine test a week later.
- The nurse recorded outcomes and complications following each telephone consultation.
- Locally, the service monitored complications and reported them to relevant commissioning groups. If performance or outcomes were outside of expectations then the service provided exception reports to explain why this situation had arisen. For example, one of the sexual health services had not achieved a follow up target but it was evident that this was due to patient choice.
- We saw that patient information clearly gave the complication rates of each treatment and we observed staff discussing these with patients.
- All termination of pregnancy patients were offered screening for sexually transmitted infections (STIs). If a positive result was returned, processes were in place to track partners and offer treatment. Staff told us this was a benefit of working as an integrated sexual health service as there were other trained staff to help with this.
- We did not see a clinical audit programme in place with specific regard to all of the elements of the DH RSOP 16. However, we saw from commissioning reports that the service collected and reported data regarding; numbers of patients referred to secondary care services; numbers of women who do not proceed to termination; failure rates; and number of repeat abortions. Repeat abortion information was not collected in relation to whether the women had previously left the service with LARC. Information regarding complaints, critical incidents and number of follow up appointments was also collected and reported. The managers were aware that they did not audit against all of the performance indicators identified in Department of Health (DH) required standard operating procedure (RSOP: 16). For 2017-18, they told us they intended to include; patient experience, rates of complications, waiting times and pathways into specialist services.
- The termination of pregnancy service reported two complications within the last 12 months; one patient failed to attend for second part of treatment and one patient developed side-effects following administration of Buccal Misoprostol and diclofenac.
- Data provided to Hull CCG indicated that 128 patients were referred to secondary care between April and September 2016 but reason for referral was not given. Three patients chose to continue with their pregnancy during this time, 98 patients were referred for surgical termination, 49 elected to change provider (no reasons given), 15 patients needed to return for subsequent treatment, and no other complications were reported during this time.
- No vasectomy patients had suffered complications between April 2016 and September 2016. And two were referred to secondary care

Competent staff

- Managers told us that all new staff worked as supernumerary until assessed as competent in their role.
- One of the consultants was able to deliver training to other staff to enable them to work towards the 'Faculty of Sexual Health Certificate'

Are services effective?

- Managers told us that RNs in the service had received training regarding family planning and sexually transmitted infections. Recently appointed staff had undertaken the Faculty of Sexual and Reproductive Healthcare's (FSRH) electronic Knowledge Assessment (eKA) which assesses a candidate's theoretical clinical knowledge. They planned to ask staff that had been trained prior to this becoming available to also complete this assessment and then staff would be expected to refresh their knowledge and assessment periodically in the future. The assessment involved a self-assessment of knowledge and skills, which was then confirmed and signed off by the line manager.
- Managers were also planning to source an online training package from the FSRH in the New Year regarding abortion.
- Managers told us that RNs were expected to have competence of implant fitting and removal assessed annually. This was audited and results showed nursing staff had completed training and had patient group directives (PGDs) available for implant provision.
- The service had an agreement in place with the local trust to provide gestational scanning for medical abortion patients. This meant that fully trained and qualified ultra-sonographers performed the gestational scans.
- The service sub-contracted specialist counselling services to ensure their patients could access specially trained and skilled counsellors.
- The nurse delivering medical abortion treatments told us she had completed the first part of her family planning training when she took up her post in this service and had been competent to fit and remove implants. She told us the service had supported her to complete the second part of this training.
- The nurse had been able to access continuing professional development events such as a women's health event earlier in the year and was to attend a market stall event in December relating to early medical abortion.
- A consultant surgeon generally managed the whole of the vasectomy patient pathway from consultation to surgery. Recently one of the nurses had been trained to undertake the patient's first consultation.
- One of the senior staff was trained to provide training for other staff regarding basic life support, anaphylaxis and cervical shock.
- Some of the nurses and HCAs in the integrated sexual health service were trained in microscopy so they could identify pus cells from patient test samples; this meant treatment could be initiated immediately for sexually transmitted infections. Due to the specialised nature of the termination service and other integrated sexual health services staff told us they were supported to take part in national training and national networks, share learning, and attend national conferences.
- We saw from personnel records that checks and requirements for doctors were up to date.
- We reviewed four sets of staff personnel records; these were well organised, well recorded and all staff had up to documented induction, training records, sickness records and disclosure and barring service (DBS) checks.
- Records evidenced completion of job specific induction programmes for registered staff and healthcare assistants.
- The nursing staff we spoke with were aware of revalidation requirements and managers told us they aimed to provide clinical supervision / 1-1s for RNs on a six weekly basis to support with this.
- One of the HCAs told us she was being supported to achieve an NVQ 3 qualification.
- Organisation wide data showed that 88.4% of staff had received an appraisal in the last 12 months.
- Doctors told us their appraisals were up to date and the process was effective, they had protected time for education and research and were encouraged to undertake continuing professional development.
- All counselling staff were required to be registered with a professional counselling body and be qualified to diploma level.

Multidisciplinary working

- There were local agreements and referral pathways in place with the local NHS trust and another independent termination of pregnancy provider to ensure patients, who did not meet the criteria for this service, were seen and treated in a timely manner. Staff told us they had good relationships with the trust and referral and appointments were facilitated easily.
- There was a service level agreement with the local NHS trust for laboratory services such as blood tests and sexually transmitted screening and testing.
- Staff told us that they had close links with other agencies and services such as the local safeguarding

teams and staff at the local emergency, pregnancy assessment unit. Staff gave examples of when they had needed to contact the local emergency pregnancy assessment unit to discuss and refer patients.
- The service had service level agreements with the neighbouring NHS Trust, which allowed them to transfer a patient to the hospital in case of medical or surgical emergency.
- Staff told us they had worked with the local NHS maternity service on the development of patient pathways for contraception as part of postnatal care.
- Managers told us they invited local health visitors, school nurses, head teachers, looked after children leads and schoolgirl mums' representatives to Care Group meetings.
- Staff told us that the service delivered courses such as the Course of 5 (faculty accredited training) to GP's and practice nurses within the area, delivering sexual and reproductive healthcare. They also delivered an Intrauterine device (IUD) / intrauterine system (IUS) master class and menopause masterclass, which was open to all applicants including the implant fitters' forum.
- As part of the Hull Integrated Sexual Health Service, the service worked in partnership with other agencies who delivered the preventative services within Hull. As part of this arrangement, staff told us they delivered a holistic service to working women within the Saunas and Parlours service providing accessible prevention advice, support and screening and contraceptive services.
- Staff told us the service worked closely with Police Community Support officers who would refer women working on the street to the service

Seven-day services

- The integrated sexual health service was open from 8am to 8pm Monday to Saturday each week and 9.30am to 4.30pm on a Sunday for EMA patients only.
- Patients were able to access termination of pregnancy services every day except a Saturday.
- The service provided a 24 hours per day and seven days a week advice line for post-abortion support and care. This was in line with Required Standard Operating Procedures set by the Department of Health. The advice line was a subcontracted service manned by trained and experienced counsellors.

Access to information

- Patient notes were electronic for most sexual health services, and paper records for termination of pregnancy patients were kept within the service and were easily accessible.
- Staff told us they could easily access relevant guidelines, policies and procedures in relation to termination of pregnancy and other integrated sexual health services.
- Staff were able to access diagnostic tests/blood results in a timely manner.
- Clinic letters from integrated sexual health services and community gynaecology clinics were typed by a subcontracted service. The turnaround time for letters was one to two days. Letters were checked by the consulting doctor before being sent by post to GPs

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had not received specific training regarding informed consent although some elements of this were covered in adult and children safeguarding training.
- We saw that consent forms included guidance for staff as well as information for patients.
- All care records we reviewed contained signed consent from patients. Possible side effects and complications were recorded and the records showed that these had been fully explained.
- We saw that patient information clearly gave the complication or failure rates of each type of treatment and we observed staff discussing these with patients.
- Staff told us the time between appointments meant patients could have to wait for treatment. This allowed for a cooling-off period so that the patient could confirm her decision or change her mind about the treatment. We observed the nurse take a call from a patient who had taken time to consider her decision and was now contacting the service to go ahead with a termination of pregnancy.
- We observed staff asked for permission before carrying out tests.
- We were told that consultants saw all patients less than 16 years who were seeking an abortion and took their consent. We saw evidence in records of face-to-face consultation and consent taken by a consultant in a young patient's records.
- Staff we spoke to were aware of Fraser guidelines to obtain consent from young people regarding contraception.

Are services effective?

- There was access to guidance and policies for staff to refer to concerning Mental Capacity Act (MCA). Staff we spoke with told us they had received training regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) which was delivered as part of protection of vulnerable adults training.
- When police requested assistance from staff, or forensic evidence was needed for a criminal investigation, there was a process in place, which involved the police gaining consent from the service user and then providing evidence of this to the service before information, or samples were released.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

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

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

However,

- Staff did not inform patients that their anonymised data from HSA4 forms was shared with the Department of Health for statistical purposes.

Compassionate care

- We observed consultations and staff interactions with medical termination patients and those close to them throughout our inspection and we saw how they involved and treated patients with compassion, kindness, dignity and respect.
- We observed professional, caring, and sensitive interactions between staff and patients in public areas, before, during and after consultations.
- Staff told us the service offered to patients on a Sunday was organised so that no other patients or visitors were present in the building and patients could be reassured their privacy and dignity were maintained when undergoing the second stage of the medical termination process. Patients were provided with a private room as well as being able to access public areas to walk, sit, or watch.
- We saw a nurse rearrange a second stage appointment from the morning to afternoon for a patient when she discovered the patient's partner was on night shift. (even though the nurse had intended to finish early that day and this would mean she had to stay late)
- Staff told us that patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care. Staff told us younger patients were supported to involve their parents or family members and their wishes were respected. However, we noted and staff confirmed they did not ensure patients were seen alone at some part of the consultation to ensure they felt safe, at ease and were not under any pressure for any reason from a partner or the person attending with them.
- Patient comments and concerns were collected and acted upon in a timely way. When a patient gave contact details staff made every effort to speak to them directly to address their concerns quickly. Staff discussed anonymous concerns in team meetings to agree the most appropriate way to meet patient requests.
- Staff had provided chairs in changing cubicles when a patient pointed out there had been nowhere to put their clothes when getting changed.
- Staff told us how they had made changes to improve privacy and dignity for patients.
- Patients were given a token to place in a voting box to show whether they had received a "fabulous or frightful" experience. This provided a visual display of customer satisfaction and tokens were counted with results fed back to staff.
- We saw that staff introduced themselves to patients.
- Managers told us they were intending to trial a text service for patients to give feedback on their experience.

Understanding and involvement of patients and those close to them

- Nursing staff told us and we observed that, during consultations for termination of pregnancy, they explained all the available methods for termination of pregnancy that were appropriate, depending on the gestation of the patient's pregnancy and their clinical assessment.

Are services caring?

- We observed a nurse explaining risks, complications and failure rates of a medical termination and they asked the patient who would stay with them at home for the duration of the abortion process. The nurse provided verbal information about what to expect following each appointment and encouraged the patient to contact the clinic should they be worried or concerned.
- We saw that explanations were given in a way the patients could understand and that the nurse checked their understanding of the information given.
- The service offered a full range of sexual health care and staff told us they offered patients treatment for and encouraged uptake of services such as contraception and testing for STIs.
- We asked staff if there were occasions when patients changed their minds about a procedure. They told us that patients could attend for consultation only and that they may change their minds or use another service if they wanted a different procedure for example if a woman preferred a surgical termination or if they needed a later termination. When patients wanted a treatment the service could not offer staff made a referral to the service of the patient's choice.
- Staff were not aware that patients should be told about the statutory requirements of the HSA4 forms and should be informed that the data published by the Department of Health for statistical purposes was anonymised.

Emotional support

- All patients spoke to a registered nurse for consultation and assessment prior to their treatment. Nurses were empathetic and listened actively to patients when they needed support.
- A professional counselling service was also available to patients at any time before or after a termination procedure. This service was also available to patients using other parts of the integrated sexual health services who needed therapeutic counselling.
- Staff told us they gave patients written information about accessing help from the staff at the clinic during service opening hours and the 24-hour telephone service following their procedure. An out of hours service helpline was provided by local GP services and staffed by personnel trained to answer calls from sexual health and termination of pregnancy patients. The records we reviewed recorded the post discharge support offered to patients and those close to them.
- Staff provided patients' partners, and those supporting them, with information and support should they require it. Staff spoke to people face to face, provided a leaflet they could take away or signposted them to on line information. They also provided details on how to contact "Relate" for counselling should a partner express a different opinion about a termination from the woman seeking treatment. Staff explained to us that their priority was always the decision of the patient.
- Staff signposted or referred patients, to other organisations, that could offer practical help and support should a patient need them. Staff gave an example of providing support to a young patient and those supporting them, allowing time and space for the patient to come to a decision in a quiet and safe environment. Staff offered refreshments and guidance and listened to questions the patient had. Staff said the patient and their family had thanked them for their support and understanding.

Are services responsive to people's needs?

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

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- The service was accessible for the booking of appointments and for advice and support 24 hours, seven days a week.
- Staff could arrange referral to appropriate providers for patients with complex or additional medical needs or who did not meet usual acceptance criteria.
- The service had an effective complaints procedure and shared learning from complaints.
- Interpreting and counselling services were offered to all patients and the centre was accessible for those with disabilities.
- Staff tested patients for sexually transmitted infections prior to any treatment and provided further screening and treatment as necessary.
- There was an appropriate process should a woman wish for pregnancy remains to be disposed of sensitively.

However

- The service could not be assured that reasons for waiting times for termination consultations and treatment, outside of the five working day targets, were entirely down to patient choice.

Service planning and delivery to meet the needs of local people

- Treatment was carried out under NHS contracts with Hull and East Riding CCGs and Hull and East Riding City Councils (CCs) to provide a termination of pregnancy service for the patients of Hull and East Riding.
- The service also provided services for out of area patients as required, including students temporarily residing at the local universities and colleges. There was a process in place for recharging CCGs or CCs where necessary.
- Long acting reversible contraception could not be provided to out of area patients however, emergency contraception was given and patients were signposted to the relevant service.
- The clinic undertook procedures for self-funding patients on request.
- Appointments were offered at the Conifer centre on Monday to Saturday 8am to 8pm. The service was open for EMA patients only on Sundays from 9.30am to 4.30pm. The EMA treatment service was not available on a Thursday; however, treatments were planned around this to coincide with 24 or 48-hour treatment intervals as required.
- The sexual health outreach team worked closely within the local community to include those with cultural differences. There were strong links with the travelling community, commercial sex groups, homeless people and hostels, and the rehabilitation of offenders' service.
- A BME (black, minority and ethnic groups) lead ensured close links with different ethnic communities including mosque leaders.
- The outreach team ran clinics within the community, in schools and colleges and made domiciliary visits to patients who were unable to leave their home. An example of this was nurses visiting young people at home to ensure they understood how to use their chosen method of contraception.
- Patients were able to choose their preferred treatment option, subject to their gestation and medical assessment. Patients were able to attend the most suitable appointments for their needs and as early as possible.
- Facilities were modern and suitable for their use with good accessibility and adequate space to facilitate privacy and dignity.
- During times of peak demand, the service was able to provide additional or longer clinics.
- The service was hoping to expand its Sunday service further to meet the needs of local people.
- Service level agreements were in place with local laboratories for screening and blood testing.

Access and flow

- The termination of pregnancy service assessed and treated patients of all ages, including those aged less than 18 years and could treat young people and children as young as 12. Most patients accessed the service by self-referral and some were referred by GPs or other health services.
- Between October 2015 and September 2016, 744 patients accessed this service, 370 received assessment

and treatment for medical termination of pregnancy, 266 were referred to secondary care for treatment , 105 were discharged from the service as other and 1 was discharged as 'did not attend' (DNA).

- Thirteen patients accessing the service were under 16 years; six of these progressed to medical termination of pregnancy. No children under 13 years had accessed the service during this time.
- Department of Health (DH) Required Standard Operating Procedures state that patients should be offered an appointment within five working days of referral and the abortion procedure should be carried out within five working days of the decision to proceed. Data indicated that between April 2016 and September 2016, on average 71% of medical abortion patients were seen for their consultation within five working days of referral (monthly range 58% to 85%).
- For the same period on average 45% of patients were treated within 5 working days of consultation (monthly range 30% to 71%). The service gave a number of probable reasons for this such as; a scan may be delayed to ensure a pregnancy can be detected if it is thought to be at less than five weeks gestation, or if ectopic pregnancy cannot be ruled out because of early gestation then the patient is asked to return for a subsequent dating scan. Patients also may delay the process themselves to give time to consider their choice, they may wish to attend counselling prior to making their decision, patients can also choose to delay the procedure if they have other commitments. Although the service gave probable reasons for delays this information was not systematically collected or audited.
- Hull CCG had a local measure of four weeks for referral to treatment for vasectomy patients, 46% of patients were seen within this timeframe, and this was an improvement trajectory rather than a fixed target. Ninety five percent of patient had been treated within 18 weeks.
- Patients could make appointments for the service via telephone to the clinic number, which diverted to an out of hours service when the clinic was closed.
- The centre offered a walk-in service for all sexual health needs and staff operated a 30-minute triage target. When waiting times exceeded this during very busy periods, staff told us they displayed times on a white board. Patient information advised patients they could telephone the service to find out about less busy times to attend if they could not wait for a long period.
- Reception staff could book assessment and scan appointments for patients considering a termination of pregnancy.
- Staff told us and provided data to show patients attending booked appointments were usually seen on time.
- Staff told us that sexual health clinics at peripheral sites were usually very busy and staff could add further sessions or change appointment timings to improve the service to patients.
- Consultations for termination of pregnancy patients were face to face with a nurse or consultant who discussed medical history and treatment options. When a decision to proceed was made, an appointment was made for treatment. We were told that a consultant always saw patients under 16 years of age.
- The patient pathway involved the patient attending for three appointments after an initial telephone discussion with a nurse or receptionist where patients gave demographic details and staff booked a sonographer appointment.
- The patient first attended the centre for an ultrasound scan to determine gestation of pregnancy and to exclude any abnormalities or possibility of ectopic pregnancy. The nurse or consultant saw the patient following their scan to undertake a clinical assessment and gain information regarding the patients' reasons for seeking an abortion. If a nurse or doctor were not available at that time, the patient would have an appointment for a telephone consultation where the assessment process would begin.
- Following the initial assessment two doctors completed the HSA1 form. The second appointment involved a nurse completing the patient assessment, checking that the HSA1 form had been signed by two registered doctors and they had agreed that the same grounds for termination had been met. The doctor prescribed the drugs for both parts of the medical abortion and the nurse administered the first part of the medical termination drugs. The patient attended a third appointment 24 or 48 hours later for the second part of the abortion treatment.
- If patients decided not to go ahead with an abortion at any time before administration of the first part of the treatment, they were given advice regarding booking in with their GP or midwife for antenatal care and advised to start taking folic acid.

Are services responsive to people's needs?

- Patients assessed as having a gestation of 9 weeks or over, were referred to the local NHS hospital or an alternative termination of pregnancy provider to suit their needs and choice of treatment. If there was suspicion of an ectopic pregnancy, staff would refer them to a local NHS acute hospital for further assessment and or treatment.
- Aftercare advice was available all day every day. This was accessed by calling the clinic number, which was diverted to an out of hours service when the clinic was closed.
- Patients could access pre termination counselling and post-abortion counselling up to one year after their treatment, by telephoning the service or by ringing the counselling service directly. All medical abortion patients were given a counselling leaflet with details of how to access this service.
- If a patient did not attend and had been referred by a GP, a letter was sent to notify them of this; however, self-referring adult patients who did not attend were not followed up.
- We saw that community gynaecology and other sexual health services were well within the referral to treatment time (RTT) target of 18 weeks. Average RTT for gynaecology for the 3 months leading up to the inspection was 7.3 weeks and the average for other sexual health services RTT was 4.7 weeks.
- The service treated and discharged 220 patients for vasectomy between October 2015 and September 2016.

Meeting people's individual needs

- The centre was accessible to wheelchairs users via a lift. Disabled toilets were provided.
- Patients had access to comfortable chairs and private facilities if they chose to deliver the pregnancy remains on site.
- Nursing staff had a supply of blankets and hot water bottles, which they could give to patients to promote their comfort during their treatment.
- A professional interpreting service was available to enable staff to communicate with patients for whom English was not their first language.
- The largest ethnic population locally included people whose first language was Polish. A Polish member of the medical team had helped to design a range of referral forms and provided treatments including LARC. Staff could access information in other languages or signpost patients to the Family Planning Association (FPA) website and NHS Choices where a range of sexual health information was available in several languages and formats.
- Patients could choose whether they had their friend or partner accompany them for their consultation and examination.
- Patients could request a chaperone to be present during consultations and examinations and there were signs on display to inform patients that this was available.
- We observed a nurse giving a patient leaflets and booklets to read once they returned home. These included information on how to access support at any time should they have any worries or concerns. Patients were given information leaflets at the first consultation about different options available for termination of pregnancy including what to expect when undergoing a medical termination. These included details of potential risks, counselling services and options regarding sensitive disposal of pregnancy remains.
- We saw patients being given the opportunity to discuss sensitive disposal of remains during their consultation. We saw that there was a specific section of the paper record to complete following this discussion to record the discussion and if a leaflet has been provided. We observed nurses give patients a pot to take home if they wished to collect the remains and return to the service for sensitive disposal. The nurse explained how remains were cremated and how long the service stored pregnancy remains before cremation, so that the patient knew, she could contact the service if she wished to make individual arrangements for disposal, during this time.
- The patient guides included information on what to expect following the procedure and the advice line numbers that patients could ring to seek any advice if they were worried or wished to access counselling either before or after the termination. Staff gave patients the clinic direct number to ring for advice and guidance and encouraged patients to use this during opening hours.
- Patients could choose to go home following the second part of their treatment or stay in the centre until they had passed the pregnancy remains.
- The unit was open 9.30am until 4.30pm on a Sunday for EMA patients only to ensure privacy and dignity.

Are services responsive to people's needs?

- We saw a nurse arrange an appointment for someone who had accompanied another patient and who mentioned she needed to access the service herself.
- A nurse showed us a mobile phone App that she recommended to patients to help them remember to take their oral contraception.
- Counselling was provided to patients and if the service could not offer the treatment the woman had chosen, staff helped them to decide where, when and how they could access the treatment they required.
- Unit staff followed a standard operating procedure with patients regarding the foetus and the disposal of pregnancy remains. Staff had a flow chart to refer to which enabled them to follow the correct procedure. The discussion and plan for private disposal of pregnancy remains would be documented in the case notes. However, due to the very low gestational limits (up to 9 weeks) for medical termination procedures at this centre, staff explained that there should be little or no evidence of pregnancy remains and no patients to date had requested a sensitive disposal.
- Nurses and medical staff undertaking pre-surgical and medical abortion assessments had a range of information to give to patients. There was also a range of leaflets and posters displaying information, easily accessible within the waiting area. This included advice on contraception, sexually transmitted infections and services to support patients who were victims of rape or domestic abuse.
- Patients could request that clinic staff made anonymous contact calls on their behalf if STI test results were positive.
- Staff provided referrals to other services and providers such as Relate and outreach services.
- Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the abortion. Patients who had their treatment were provided with the contraception of their choice before leaving the clinic. This included long acting reversible contraceptives (LARCs) such as injections and implants or intrauterine devices or systems (IUD/IUS).The service had implemented a love bus campaign to help deliver health promotion to communities that may have limited access to mainstream services and to support the young people's outreach work in the community. Services through this campaign included; advice, condoms, screening and signposting into mainstream services.
- Staff told us about a community gynaecology clinic specifically for clients with learning disability – the patient leaflets where specifically designed to support the client in attending the clinic The staff within this clinic had attended training around learning disability and how to support clients with their health needs.

Learning from complaints and concerns

- The integrated sexual health service had received five complaints in the 12 months leading up to the inspection. The service had upheld four of these.
- We saw there were no particular themes from the complaints and the service clearly identified where mistakes had been made or improvements could be made. The service apologised to patients and gave feedback to staff regarding improvements to be made.
- Staff confirmed they were informed of any lessons or improvements to be made from complaints received. For example, staff received competency updates for the removal of LARC, following one complaint.
- There were posters and leaflets on display in the waiting area advising patients how to raise concerns and give feedback. The information clearly stated how feedback could be given and how concerns would be dealt with. This included expectations about timescales and how to escalate complaints to the Parliamentary Health Service Ombudsman if they were dissatisfied with their response.
- An example of a patient complaint had been logged, actions documented and we saw work had been carried out. This was regarding privacy and dignity at the reception area. Patients felt that the open plan environment allowed people in the waiting area to overhear private conversations when registering at the reception desk. Staff had arranged for a frosted glass screen to be built and a sign provided to ask patients to wait behind for privacy at the reception desk. Staff told us they felt this had made significant improvements to privacy and they told us patients had commented positively about it.
- All patients were given a patient survey/comment card entitled 'Your Views Matter. There were boxes at the unit for patients to submit their cards.

Are services well-led?

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

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- Senior managers had a clear vision and strategy for this service and there was strong local leadership of the service.
- Managers were approachable, available, and supported staff within the service.
- There was good staff morale and staff felt supported.
- There was a committee and meeting structure that facilitated effective governance, risk and quality management. The governance structure enabled oversight of local risks and allowed for performance benchmarking.
- Managers had clear processes in place regarding the governance of sub-contracted services such as counselling and ultrasound scanning.
- The organisation had a clear mission to provide for safe and effective care for termination of pregnancy.
- Quality of care and patient experience was seen as the responsibility of all staff.
- The organisation had a proactive approach to staff engagement.

However,

- Although staff completed and submitted Department of Health documentation, the service was not assured that they were fully compliant with HSA1 completion and HSA4 submission.
- There was a lack of a structured audit programme to include all aspects of RSOP 16 in relation to termination of pregnancy and also a lack of assurance that delays between consultation and treatment were all because of patient choice and or valid clinical reason.

Leadership

- The termination of pregnancy service was part of a wider integrated sexual health service and care group, led by a senior operational manager supported by a number of nursing team managers responsible for different parts of the service. The leadership of the service included clinical leadership from named consultants. There was a lead clinician for the termination of pregnancy service.
- One of the nursing team managers had specific responsibility for the termination of pregnancy service. Managers and staff told us that this was a new development and that the team manager had been appointed within the last three to four months. Prior to this, the termination of pregnancy service did not have an identified nursing lead and the nurse who delivered the service covered the responsibilities.
- Staff told us they valued the new nursing team lead role, this was particularly valued by the termination of pregnancy staff that had previously not had the support or oversight from a senior nurse.
- Staff told us that leaders were visible and approachable and that there was developing nurse leadership through appointment to new team leader posts and development of nurse-led services.
- Staff felt that the leaders of the organisation recognised the value of education and gave staff a fair training allowance.
- Staff told us managers encouraged and supported continuing professional development and gave us an example of a member of the admin team being supported to become a healthcare assistant and undertake an NVQ3 qualification.
- The service had developed a leadership and management postgraduate certificate in partnership with the local university business school. This was accessible to staff in bite-size learning modules.
- The Human Resources department delivered sessions to staff and managers at the centre on topics such as recruitment and dealing with challenging behaviour.
- A responsible officer was accountable for supervision and revalidation of medical staff.
- The staff we spoke with told us they felt well supported by managers Staff told us senior managers were easy to contact and had a regular presence in their centre. The lead nurse and operations manager were available on a daily basis and staff felt able to approach them at any time if needed.

Are services well-led?

- We saw records showing managers held team meetings and staff told us these were effective and they were able to express concerns and ideas for improving processes and services. They were listened to and ideas were adopted where feasible.
- The service held a licence from the Department of Health to undertake termination of pregnancy procedures. The licence was displayed in the main reception area.

Vision and strategy for this core service

- The service mission / aim was to deliver gold standard holistic care to the people of Hull. Literature we saw stated an integrated approach to delivering male and female sexual health services as a priority, creating resilient, healthy and empowered communities. Termination of pregnancy was one of the services provided by a large, focused and integrated team.
- We saw there was a service wide action plan and staff were aware of the actions and improvements made, to date.
- The service vision and mission were an integral part of staff performance and development reviews. We saw staff displayed the values of the organisation by their behaviour and attitude to patients throughout our inspection.
- The service managers were knowledgeable about the organisation strategy and understood how this affected local provision of services.
- Managers told us the service had undergone wide organisational change when they were awarded the sexual health contracts from commissioners. They had planned for a small and safe service and were now looking to develop it further. Plans were being drawn up to provide a minor procedure suite as part of a Commissioning for Quality and Innovation (CQUIN) programme.
- Staff were aware of local action plans relating to their service / area of work.

Governance, risk management and quality measurement for this core service

- The performance team collated and reviewed key performance information against national and local targets. Results were shared with staff through quality management and performance (QMP) dashboards. The service benchmarked standards in relation to 'Essence of Care' which included record keeping, infection control and hygiene, privacy and dignity, safeguarding, governance, medicines management, pain management and equality and diversity.
- All scores for May 2016 had exceeded the organisation's target of 85%. All categories had scored 92% compliance or above, except for one which was measured at 83%. This had been identified as a governance target when only three out of five staff questioned could describe the circumstances that would trigger a duty of candour for the organisation. The process required the score to be logged on the incident reporting system and we saw it was amber rated on the dashboard. The governance framework stated that an action plan should be drawn up to address the low compliance rate and staff should re-audit in six months' time. We did not see a copy of the action plan.
- We saw from minutes and notes of local meetings that complication rates, incidents, complaints and patient experience were discussed in these forums, as were proposed changes to services and training requirements and opportunities. However, we saw from these records and were told by staff and managers that these meetings were not as frequent or as formal as they had been previously, due to changes in governance structure and reporting. Managers told us they were working to rationalise frequency and type of meetings to ensure good communication with staff but ensuring sensible use of time.
- Managers maintained risk registers detailing financial, organisational, and strategic risks to the service. These included lack of staff knowledge of electronic patient record systems and records management problems. The register showed assessment of risks and subsequent actions planned. The register had last been reviewed the month before our inspection.
- Risks for termination of pregnancy and integrated sexual health services were recorded on the care group risk register. Recorded risks included the rollout of the electronic patient record, as there was no project manager and an identified lack of specialist IT support to manage and develop the system.
- Although staffing pressures were not on the care group risk register this was recorded on the integrated sexual health service plan as an area that needed to be addressed. Other local risks included IT integration of

laboratory tests, which was currently a manual process of matching results to the correct patient record. The third major risk related to the scanning, archiving and storage of sexual health records.

- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same ground for a termination of pregnancy is met and sign a form to indicate their agreement (HSA1 Form).
- The process for HSA1 was laid out in a standard operating procedure and accompanying flowchart. This showed that doctors should sign HSA1 after reviewing the care pathway and / or discussing the case with the nurse who had seen the patient in the clinic. It was clear this could only be done provided they form an opinion in good faith that one of the legal grounds for abortion A-E applied. Both signatories to the HSA1 form must agree the same grounds. If the doctors could not agree to the abortion request on the grounds given, they must immediately refer to another doctor to complete the HSA1. Staff told us that if this situation arose then a case conference between the doctors involved would be convened.
- We looked at 10 patient records and found that all forms included two signatures and both doctors had clearly documented the reason for the termination under 'decision to proceed'. In all cases, doctors had agreed that one and the same grounds for abortion had been met.
- We observed that nurse / midwives checked the HSA1 forms were completed correctly before any aspect of treatment was initiated. However, we did not see a specific audit or data collection process to be assured that the service was 100% complaint with this legal requirement.
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit data following every termination of pregnancy procedure performed. These contribute to a national report on the termination of pregnancy (HSA4 form).
- We were told that each doctor who prescribed the medication for termination of pregnancy was the person who authorised the HSA4 on a paper form immediately following administration of the medication. The service had a standard procedure in place that formed part of the patient care pathway, to log any repeat administration of medicines to ensure both dates were entered onto the same HSA4 form.
- Nurses who had administered abortifacient medicines kept a log of each treatment administered and passed this to the department secretaries to complete the electronic forms. Secretaries uploaded all HSA4 forms electronically to DH on a daily basis to ensure the HSA4 reports were made within the 14-day requirement. Managers told us they had been unable to audit HSA4 compliance against the 14-day target because records were completed on paper and transferred to the electronic system. However, plans included electronic completion of HSA4 forms by clinical staff, which would provide the capability to audit compliance and assurance that legal requirements were met.
- The operations manager had a system in place to check nurses and midwives maintained their registration with the Nursing and Midwifery Council and that medical staff had active GMC registration. We saw that all staff involved in the provision of termination of pregnancy had active registration and DBS checks within the last three years and doctors were covered by indemnity insurance. The service repeated DBS checks every three years for directly employed staff.
- Managers had a system in place to monitor the governance of sub-contracted services such as counselling and ultrasound scanning. For example, they told us the sub-contract for counselling services required an annual review of counselling staff qualifications to ensure they met at least the minimum requirements to work with termination of pregnancy patients. They also ensured staff had DBS clearances and insurances.

Culture within the service

- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the service.
- Staff told us the service had an open culture and felt they could approach managers if they felt the need to seek advice and support. They told us they would be comfortable to raise concerns with them and that they would be taken seriously.
- Nursing staff and managers, we spoke with, all liked working for the organisation.
- Staff described a culture that encouraged teamwork, generation of ideas, professional development and valued the contribution of staff at all levels. They told us that all staff worked hard to provide a good service.

Are services well-led?

- Staff we spoke with told us that learning from incidents, safeguarding and daily practice was shared locally within the team and staff told us there was a formal mechanism for sharing learning and elements of good practice with the wider organisation through clinical governance and business meetings as well as local case based discussions.

Public engagement

- The service encouraged patients to leave comments cards although these could not be disaggregated from the integrated sexual health service 103 comments cards were left between October 2015 and October 2016. Sixty of the cards were positive feedback and the remainder expressed varying levels of dissatisfaction with the service.
- The service had taken action to improve based on patient feedback, for example, communication issues were addressed with relevant staff and cleanliness was picked up with contractors.
- Managers collated patient feedback comments cards and discussed results with the staff team. We saw a "You said – We did" board displaying comments received the previous year and examples of how the service had addressed these.
- The most recent results from the Friends and Family Test for sexual health services showed 96.2% of patients would recommend the service.

Staff engagement

- CHCP CIC had a staff engagement strategy, action plan and undertook various activities / ways in which to engage with staff. For example, the chief executive had a blog, an 'Ask Andrew' space on the staff intranet, he attended staff meetings, the organisation produced newsletters and staff were rewarded through recognition awards for individuals and teams. There were also forums for staff shareholders and community groups.
- Staff in sexual health services were aware of the above and told us they received regular updates, through staff bulletins and email messages, which provided news, updates, training information, finance, service improvements and clinical changes. Staff told us the shareholder scheme provided positive benefits.
- Staff told us they were valued as members of the organisational team.
- Staff survey results were provided for care groups and managers were able to provide results to their teams. The sexual health team results showed 51.5% of staff felt positive about the service. Although this was a low score, staff explained it was an improvement on previous years. Representatives from each service attended a staff survey action group and the senior management team addressed actions from this.
- Staff produced a care group newsletter and each service wrote an entry. Staff felt their ideas were listened to and that the integration of the termination of pregnancy staff and the CASH team was a positive change and provided better cover for holidays and sickness.
- Staff were proud of their team, felt they worked well together providing a good service to patients and were working towards improving patient outcomes. They felt their team was resilient and had coped with recent service changes well.

Innovation, improvement and sustainability

- The service was in the process of piloting a Skype clinic with community gynaecology patients and was planned to expand to male sexual dysfunction and HIV clients. This reduced the need to attend face-to-face appointments and lowering barriers to access.
- The service had recently developed a children's play area in the Wilberforce clinic as, many clients attend the sit and wait service with young children. The service also invested in bottle warmers so mothers could utilise these whilst waiting in the clinic.
- The clinic had developed an FGM specific service; this service was accessed by self-referral or healthcare professional referral.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 9(3) (g) providing relevant persons with the information they would reasonably need (about the provision of care and treatment). Inform patients of the requirement to submit abortion data to the Department of Health and explain how this information is anonymised.

Regulated activity	Regulation
Termination of pregnancies	Regulation 20 (Registration) Regulations 2009 Requirements relating to termination of pregnancy Ensure that there is assurance processes for Abortion Notification Forms HSA1 completion and HSA4 submission to the Department of Health within the legal timeframe of 14 days.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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