British Pregnancy Advisory Service

BPAS Northampton Central

Inspection report

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

Ratings

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

Summary of findings

Overall summary

The service had not been rated before. We rated it as good because:

- The service had enough staff to care for clients and keep them safe. Staff had training in key skills, understood how to protect clients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to clients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave clients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of clients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated clients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to clients, families and carers.
- The service planned care to meet the needs of local people, took account of clients individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of clients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with clients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Written records did not always contain the required client identification details, equipment servicing details were not always available and there had been no risk assessment around the suitability of the recovery area or equipment used within it.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Good 	The service had not been rated before. We rated it as good. See the summary above for details.

Summary of findings

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Summary of this inspection

Background to BPAS Northampton Central

BPAS Northampton Central provides a termination of pregnancy (abortion) service to its clients through the Northampton region Monday to Wednesdays and Fridays between the hours of 9.30am and 5.30pm. The majority (99%) of clients are funded by the NHS integrated care board in the local area.

The service provides medical (early medical abortion) treatment for clients of a gestation up to 9 weeks and 6 days. Surgical treatment under local anaesthetic or conscious sedation is provided for clients up to 13 weeks and 6 days gestation.In addition, the service also provides contraception advice and contraception, testing for and treatment of sexually transmitted infections, such as gonorrhoea and chlamydia.. Pills by post were not offered at this service location.

Between April and June 2022, the service treated 720 clients, of this, 10% or 72 were by surgical treatment. Between 1 January and 31 December 2022, the service completed 67 treatments, 49 early medical abortions and 18 surgical abortions of children and young adults between the ages of 14 and 17.

The service has been registered since 2016 to carry out the following regulated activities;

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

Since this time a registered manger has been in place. The last inspection that took place at the service was in May 2018. This inspection was not rated and no enforcement action was issued. The link to the previous inspection report can be found at https://www.cqc.org.uk/location/1-2896561882/inspection-summary

How we carried out this inspection

Our inspection was announced (staff knew we were coming) to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology. One inspector and a specialist advisor, with support from an offsite inspection manager, carried out the inspection on 17 January 2023.

During the inspection we reviewed a range of documents related to running of the service including, staffing rotas, performance data, risk assessments and emergency equipment checks, policies and procedures, an independent website browser platform and servicing records of equipment. We spoke with 8 members of staff including service leaders and 4 clients who had used the service. We reviewed 5 sets of client records and 3 staff record practising privilege agreements.

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

Summary of this inspection

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that the surgical treatment room is free from clutter and not used as an additional storage area. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1)(c)
- The service should ensure that equipment service scheduling is undertaken in line with manufacturers recommendations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1)(d)(e)
- The service should ensure it has appropriately carried out a risk assessment of size and suitability of the premises (recovery area) and equipment used (recliner chairs). Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1)(d)
- The service should ensure that it assesses and demonstrates a process to minimise the likelihood of risk and impact on people who use the service around client identification in written documentation. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2)(b)
- The service should ensure that emergency medication and equipment is located in line with that set out by the service. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(b)

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Termination of pregnancy

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

Is the service safe?

Good

The service had not been rated before. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Information provided by the service showed that mandatory training set out by the service ranged from 90 to 100% for all staff, clinical, medical and non-clinical. This met the service target of 90% and the national core skills for health standard.

The mandatory training was comprehensive and met the needs of clients and staff. Staff received training on how to recognise and respond to sepsis, training about consent and training on infection prevention and control.

Clinical staff completed training on recognising and responding to clients with mental health needs, a learning disability and autism and staff that we spoke with knew how to recognise and support clients with these complex needs.

Managers locally monitored mandatory training and alerted staff when they needed to update their training. This was in addition to an organisation wide learning and development team who sent out monthly reports as part of the governance process to managers locally, as well as reporting to the operational group to demonstrate mandatory training compliance.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Information provided by the service demonstrated that all staff within the service were trained to adult and children level 3 safeguarding training. And a safeguarding policy set out adverse child and adult experiences including a specific section of child sexual exploitation.

Good

Termination of pregnancy

At the last inspection, female genital mutilation (FGM) was not routinely risk assessed or discussed with clients over the age of 18. At this inspection we found that a FGM risk assessment was now part of the electronic client notes for all clients and considered current risk, risk to siblings and risk of the client being taken out of the country. Mandatory reporting was in place for any concern or suspicion of FGM and the lead nurse for the service managed this process locally. A local safeguarding audit was undertaken monthly and included FGM consideration.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. This included protecting clients from protesters outside of the building, domestic violence and coercive reproduction.

Staff completed a safeguarding risk assessment for all clients under the age of 18 to identify children at risk of, or suffering, significant harm. If a child or young person was identified as being on a child protection plan the service liaised with the general practitioner and social worker. The service did not have access to the child protection information sharing service (CPIS)system at the time of the inspection although the wider organisation had begun a workstream with NHS digital colleagues to support appropriate information sharing. This meant that the service was reliant on the disclosure from the child or young person that they were on a child protection plan.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding lead was available to offer support and guidance always of business operation and the service had completed a training scenario around the recognition and referral of a safeguarding case so that staff felt confident and able to make a referral. All safeguarding concerns were recorded on the electronic incident reporting system so that the appropriate manager was also informed. This was in line with the safeguarding adult and child policy set out by the service which was within review date and referred to up to date statutory literature.

Within the child and young adult safeguarding policy the service had set out age specific processes. For example, for clients aged 13 and under there was mandatory first alert to local authority safeguarding teams and police. For clients aged 13 to 16 a process of discussing consent to establish if the sex was consensual was undertaken, the client would be monitored to ensure they attended all treatments and appointments and parental support was advised. In the absence of this, the service liaised with the general practitioner, school nurse and or police.

A series of safeguarding screening questions were asked of all clients over the age of 18, to enable staff to assess whether additional support was required, whether the client was in contact with other agencies and whether they were safe at home. If there was concern or suspicion of harm or abuse then a more in-depth adult safeguarding risk assessment was completed and referral made to the local authority safeguarding team.

In December 2022 the safeguarding structure for the wider organisation altered to enable specialist safeguarding midwives to be aligned to each region within the organisation. This meant that the service had a designated specialist safeguarding midwife to support with referrals, guidance and training in addition to working with other agencies to protect women and children including integrated care boards. At the time of the inspection, a multiagency safeguarding operational group was in the process of being set up. In addition to this new role, a new safeguarding supervision policy was awaiting ratification meaning that all staff would have access to regular drop in sessions and those staff with enhanced contact to safeguarding issues would have mandatory supervision twice yearly.

Coloured stickers were used on client case notes to indicate that there may be a safeguarding issue. This was discreet and meant that client confidentiality was maintained.

Good

Termination of pregnancy

Cleanliness, infection control and hygiene

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

All areas within the clinic were visibly clean and had suitable furnishings which were clean and well-maintained. Any equipment which was damaged, for example a rip in the fabric of a trolley would be removed from use and replaced by a wider estates team. This was checked as part of a monthly environmental audit undertaken by the service.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. A theatre cleaning schedule set out the requirement for frequency of cleaning to be undertaken. On the days where the service was not in operation the schedule clearly identified that cleaning had not been undertaken meaning the service had an up to date record of all cleaning which had been undertaken.

Staff followed infection control principles including the use of personal protective equipment. During the inspection staff demonstrated appropriate technique and use of personal protective equipment. Covid-19 guidelines were monitored and updated regularly by the wider organisation and distributed via a communications team weekly. These communications could be accessed by all staff members meaning everyone was kept informed of any important updates and changes. A dedicated reporting system meant that managers could easily track members of staff who were absent due to COVID-19 infections and take the appropriate action to prevent further spread.

Staff cleaned equipment after client contact and labelled equipment to show when it was last cleaned. This included equipment, such as finger oxygen saturation probes and blood pressure machines.

Staff used draping techniques and sterile equipment in line with national guidelines and the service infection, prevention and control policy.

Ultrasound probes were decontaminated in line with the infection prevention and control guidance lines set out by the service and decontamination certificates were completed for any equipment being set off site to the manufacturers for example. This was in line with the Department of Health and Social Care Health Technical Memorandum on decontamination. Annual ultrasound audits completed for each member of staff including the decontamination process and all staff read the decontamination guidelines as part of their training in carrying out ultrasound.

Information provided by the service demonstrated that the infection control audit undertaken in February 2023 achieved 98% compliance. This audit included hand decontamination, the use of personal protective equipment, sharps management, care of equipment, medicine management, the surgical procedure room, waste management, infection prevention and COVID-19 precautions.

Environment and equipment

The design and use of facilities did not always keep people safe. The service was well maintained and staff managed clinical waste well.

The design of the environment did not always follow national guidance. The recovery area of the service consisted of three recliner chairs in a small room each divided by a disposable curtain. This meant that confidential discussions and client privacy was difficult to maintain due to limited distance between each recliner. The last inspection carried out in 2018 also described how "Privacy was limited in the recovery area due to the close proximity of the recliner chairs".

The recliner chairs used within the recovery area did not recline to a flat position, which meant that in the event of a client collapsing requiring emergency resuscitation following a surgical procedure, they would need to be manually moved onto the floor.. The service had not undertaken a risk assessment around this and there was no emergency manual handling equipment to support staff in doing this and the lack of space between recliners meant that it would be difficult to fit the client, staff members and equipment required to be able to carry out emergency first aid.

At the time of the inspection, 2 boxes of theatre drapes and several other boxes of equipment were being stored within the theatre of the service. This posed a trip hazard to staff and clients and meant that infection prevention and control management was more challenging.

Facilities and equipment were maintained regularly to keep clients safe. Annual service schedules and portable appliance testing was undertaken. And safety checks such as water safety were undertaken under a service level agreement annually. The oxygen saturation probe, blood pressure monitor and ultrasound machine used within the theatre area did not display servicing dates, this information was requested from the service however, was not provided. Information which was provided by the service demonstrated that new oxygen saturation probes and blood pressure monitors had been ordered on the 19 January 2023.

Staff carried out daily safety checks of specialist equipment. Including resuscitation equipment and equipment used for treating life threatening allergic reactions and a weekly fire alarm test was undertaken within the building. Fire extinguishers were located throughout the service which had been checked and tested in line with professional guidance.

Clients could reach call bells and staff responded quickly when called. Daily checks on both the emergency buzzer and client call bell tests were undertaken.

Staff disposed of clinical waste safely each week and the service had enough suitable equipment to help them to safely care for clients. Equipment used by the service was mostly disposable.

Due to conscious sedation being used rather than general anaesthetic, anaesthetic equipment was not used in this service.

Assessing and responding to client risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon clients at risk of deterioration

Staff used a nationally recognised tool to identify clients at risk of deterioration and escalated them appropriately. A Modified Early Warning System (MEWS) was used to monitor for deterioration. This was assessed by the lead nurse and surgeon prior to and throughout the surgery and monitored by recovery nurses after surgery. An escalation plan was used in line with the escalation policy set out by the service which included a red, amber and green (RAG) rating setting out specific actions. This included an individual risk assessment, increased monitoring and the use of treatment such as intravenous fluid and tranexamic acid when required. Surgeons remained on site until the last client had left the service.

During surgical procedures, staff monitored oxygen saturation levels continually and recorded them every 10 minutes. This was in line with the Royal College of Anaesthetists guidelines for conscious sedation and meant that oxygen could quickly be administered if needed. There had been no incidents related to conscious sedation at the service between January 2021 and January 2022.

Good

Termination of pregnancy

A transfer policy was in place within the service and set out immediate actions to be undertaken in the event of an emergency, such as a major haemorrhage, ectopic pregnancy, sepsis or anaphylaxis reaction. This policy was available to all staff electronically and a printed version was also stored on the side of the resuscitation trolley making it quickly accessible to staff in the event of an emergency. Over the last 5 years, 7 clients had been transferred out of the service. Local transfer agreements were set out within the policy meaning that clients had more direct and better access to assistance. including when to transfer clients to the early pregnancy assessment unit of the local NHS trust and when to transfer to the emergency department meaning that clients could get the most appropriate care for them.

Staff completed a situational, background, assessment and response (SBAR) form when clients were transferred so that key information was shared to keep clients safe when handing over their care to others.

Staff knew about and dealt with any specific risk issues. A safety huddle was held daily before the first client was treated. The huddle was well attended and considered specific risks to each client including allergies, safeguarding risk and past medical history.

Staff completed risk assessments for each woman using a recognised tool. Individual risk assessments on venous thromboembolism and sepsis were undertaken on admission for all clients as part of the pre-operative assessment.

The abortion and complication guidelines included the process for managing sepsis within the service. This included a sepsis checklist which was completed for anyone presenting to the service feeling unwell and also a post treatment screening tool for all clients. Any sepsis red flag symptoms prompted an immediate transfer to the local NHS emergency department, amber flags a discussion with the clinical lead and antibiotics could be prescribed under a client group directive if the client met specific criteria. Staff that we spoke with during the inspection understood the sepsis policy and records checked during the inspection demonstrated that sepsis screening was undertaken routinely.

The service followed the World Health Organisation (WHO) surgical safety checklists throughout all surgical procedures. During the inspection we observed the safety checks being undertaken and a review of 5 client records demonstrated this had been documented appropriately. Swab counts were completed at the beginning and end of the treatment and a post-operative checklist was also completed at the end by the surgeon. During the inspection we observed that although the surgeon was responsible for completing this form, all members of staff contributed and acknowledged their agreement prior to it being signed. Monthly audits were completed by the treatment managers and quality matron which included WHO surgical safety checklist completion this meant the service could be assured that compliance with the national standard was being observed.

Clinical pathways were in place for clients with pre-existing health conditions to ensure that treatment at the service was appropriate. A past medical history was taken from the client and treatment suitability guidelines accessible to all staff indicated contraindications or cautions. An SBAR form was completed on the electronic client record and a doctor from the wider organisation reviewed.

Clear advice was provided both verbally and by a booklet to clients about what to do if problems were experienced following discharge (for example, excessive bleeding). A 24 hour 7 day a week aftercare telephone number meant that clients could telephone for advice at any time and in addition, the telephone number of the clinic was provided on all medication boxes.

Staff were trained in basic life support which included training on choking and resuscitation of young people. Managers monitored staffing rotas to ensure staff were appropriately trained in Life Support. Information provided by the service demonstrated that all 13 members of staff had completed either immediate life support or basic life support training

A resuscitation and major haemorrhage trolley were located next to the theatre and recovery area of the service meaning staff could access the necessary equipment quickly in an emergency. Daily checks had been completed on this equipment. Medication used to treat anaphylaxis which was located on the resuscitation trolley was moved into the theatre with the client. This meant that in the event of a client suffering a life threatening allergic reaction in an area other than the theatre the medication could not easily be obtained, particularly if a client was undergoing surgical treatment at the time.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep clients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

The service had enough nursing and midwifery staff to keep clients safe and managers used a skill mix template and reviewed staff rosters to ensure the levels were enough.

Managers accurately calculated and reviewed the number and grade of nurses, midwives and healthcare assistants needed for each shift in accordance with national guidance. The service followed safe staffing guidelines and had a process for escalation in the event of reduced staffing levels. For surgical treatments to be undertaken the minimum safe staffing level set out in the staffing policy of the service was 2 conscious sedation trained registered nurses or midwives, 2 nonconscious sedation trained registered nurses or midwifes and 2 healthcare assistants.

For early medical abortion where surgical treatment was not required, the minimum safe staffing level set out within the service staffing policy was 1 registered nurse or midwife per client list.. In the event of minimum staffing levels not being met an Acute Service Disruption meeting was held. A regional email was sent to the relevant clinical staff in an attempt to cover the shift from other services within the organisation and 2 continuity practitioners, staff who flexed between services to cover gaps would be utilised. If this was not possible then the theatre list would be amended so that no conscious sedation was undertaken, only local anaesthetic, meaning a wider pool of staff could be utilised and as a last resort the list would be cancelled and rescheduled as quickly as possible.

Information provided by the service demonstrated that the number of registered nurses, midwives and healthcare assistants matched the planned numbers.

The service did not use agency staff and had 1 healthcare assistant working on its bank.

At the time of the inspection, the service had 1 temporary vacancy and was otherwise fully established. The hours of sickness between October and December 2022 ranged from 99 to 118 hours.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep clientssafe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep clients safe. The service used a mixture of employed medical staff and those working under practicing privilege agreements for the service. Practicing privilege agreements were managed by a team from the wider organisation in conjunction with the responsible officer for the organisation. All practicing privilege agreements were reviewed and accepted or not, by the responsible officer advisory group. This took place on the initial application of employment and then again, every 2 years.

Good

Termination of pregnancy

A doctors onboarding group had created a standard operating procedure for doctors onboarding to ensure standardisation across the wider organisation.

The medical staff matched the planned number at the time of the inspection.

Records

Written records did not always contain the required client identification. Staff kept detailed records of clients care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

At the time of the inspection we reviewed 5 sets of records and found in all cases that the written surgical procedure booklet had the client details written on the front cover but not on every subsequent page. This was not in line with records management code of practice for health and social care and meant that if the notes were scanned or the front page was lost, there were no identifiable client details meaning the records could easily be mixed up.

In all other aspects, the clients notes were comprehensive, and all staff could access them easily. Records were a mixture of paper based and electronic records due to the service rolling out its transition to electronic records. At the time of the inspection this meant that a discharge letter was created by administration staff manually for each client. If consent was given for the records to be shared, then a photocopy was sent to the general practitioner of the client. A copy of the discharge letter was also attached to the electronic file under documents and a copy was given to the client.

Paper records including consent forms, scan images and surgical notes were stored securely and kept at the service for 3 months before being transferred to the archiving department which was part of the wider organisation.

A monthly documentation audit was undertaken by the service which reviewed 5 sets of notes. In December 2022, the audit demonstrated 100% compliance and included, permission to contact general practitioner was documented, accurate obstetric history and social history. This audit also considered whether care and treatment were carried out in line with the Abortion Act 1967 by ensuring that the required HSA1 forms were completed appropriately and that the reasons for the treatment were fully documented.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Prescriptions were pre-printed and client group directives for antibiotics and Anti-D (Rh0) immunoglobulin used to prevent rhesus disease in pregnant clients were used by the service. Client group directives were signed, within review date and accessible to the staff member using it via an electronic system. The service did not have any nursing prescribers at the time of the inspection.

At the last inspection client group directions were used to supply and administer medicines for cervical preparation in surgical abortion but did not contain all of the relevant information to administer this medication. Since the last inspection client group directions were no longer used in cervical preparation in surgical abortions.

Staff reviewed each client's medicines and provided advice to clients and carers about their medicines in the form of a post treatment advice booklet. This meant that clients knew what to expect and when to seek further advice or support.

Staff completed medicines records accurately and kept them up-to-date including controlled medication used for conscious sedation. The lead midwife for the service completed a monthly medicine management audit which was submitted to the quality department of the wider organisation for monitoring of themes and trends across the wider organisation. In addition, the audit results featured as part of the electronic dashboard available to all managers within the service.

At the last inspection in 2018, medicines were not always stored securely. During this inspection we found that staff stored and managed all medicines and prescribing documents safely and carried out daily checks in line with national professional standards. Days where the service was not in operation were clearly highlighted. Take home medications were prepacked.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff knew what incidents to report and how to report them. Between January and December 2022, 149 incidents had been reported within the service. The incidents ranged from clinical, near miss, infection prevention and control and treatment, procedure and service which was in line with the incident reporting policy in place. Staff also reported when a complication had been encountered which showed that there was a positive and open culture to incident reporting. Staff that we spoke with during the inspection told us they felt confident in reporting incidents that they were supported in doing so.

The service had no never events between January 2022 and January 2023.

Staff reported serious incidents clearly and in line with trust policy. The last serious incident occurred in quarter 4 of 2021/2022. Information provided by the service demonstrated that the incident had been investigated, duty of candour completed, an action plan created from recommendations which led to a change in practice. Lessons learnt were shared with all staff across the wider organisation. Staff that we spoke with during the inspection were able to tell us about the information they had received following the serious incident.

At the last inspection in 2018, staff were not trained in the duty of candour or aware of their responsibilities to be open and honest with clients when things went wrong. During this inspection we found that all the 13 staff members (both clinical and non-clinical) had undertaken duty of candour training as part of the mandatory training set out by the service. Staff that we spoke with understood the duty of candour. They explained how they would be open and transparent and give clients a full explanation if things went wrong.

Learning was shared throughout the service and staff met to discuss the feedback and look at improvements to client care. Following a serious incident in the wider organisation, the serious incident report was anonymised and then discussed between managers and staff, staff then signed to agree they had read the information. Immediate actions were shared by the quality team with managers in the service to ensure any changes were actioned quickly. Staff that we spoke with during the inspection could give an example of a serious incident which had occurred elsewhere in the organisation.

Is the service effective?

Good

Termination of pregnancy

Good

The service had not been rated before. We rated it as good.

Evidence-based care and treatment

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

Staff had access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. A specialist team dedicated to clinical policy throughout the wider organisation made sure that clinical policies were aligned to evidence based practice. This included monitoring key organisations and publications included the Association of Anaesthetists, Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Care Excellence. From this, any amendments were taken to the clinical advisory group where it was reviewed and approved or declined. All policies and guidelines were reviewed every three years. The information was then shared with treatment managers who in turn made sure that all staff understood and had access to the information.

The service carried out regular local audits to ensure that staff followed the up-to-date policies set out by the service, medicine management, client group directive, records and infection prevention and control audits were all undertaken monthly. Any areas of non-compliance were reviewed, and an action plan put in to place. Actions were then monitored by managers to ensure they were completed, and a repeat audit was then undertaken. An audit undertaken in September 2022 highlighted that aprons were not worn during cannulation. This was discussed at the safety huddle and a repeat audit was undertaken.

Nutrition and hydration

Staff gave clients enough food and drink to meet their needs and improve their health.

Staff made sure clients had enough to eat and drink, including those with specialist nutrition and hydration needs. Biscuits, hot and cold drinks were available and easily accessible to clients in the Recovery room after surgical treatment. A water cooler and a hot drinks machine are also accessible in the waiting room, meaning that clients and escorts could help themselves to drinks.

Pain relief

Staff assessed and monitored clients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed clients pain using the abbey pain scale which was a recognised tool and gave pain relief in line with individual needs and best practice. For clients who may have difficulty in communicating their pain level verbally the service used pictorial faces which was also a recognised tool. The pain control during abortion and other related procedures document in place within the service clearly set out scope of practice, aims, methods of assessment, preparation and administration of medicines, as well as complications. The documented included the reference sources so that staff could undertake further reading should they wish to however be provided sufficient instruction if they did not wish to undertake further reading.

Good

Termination of pregnancy

During the inspection we reviewed five client records and found that clients received pain relief soon after requesting it in all cases.

Medicines were prescribed, administered and used within the service. They consisted of paracetamol, codeine and meptazinol. Suppositories and dissolvable ibuprofen were available for clients unable to swallow tablets. Ibuprofen could be given by nursing and midwifery staff under client group directive.

Client outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for clients.

Managers and staff carried out a comprehensive programme of repeated audits to check treatment regimens and client outcomes demonstrating improvement over time. A quarterly audit of treatment complications was undertaken by a clinical risk team across the wider organisation and shared with managers in the service. This included the number and rate of complications in relation to each procedure that had been undertaken. All complications were broken down in to major and minor categories and tracked back to show whether they were improving or in decline. This meant the service could quickly identify any outliers and act upon any themes and also share learning with other teams across the wider organisation to improve clients outcomes.

Annual discharge audits were undertaken by the service and spot check audits were undertaken by service leads in response to themes of incidents and complaints across the wider organisation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of clients. All new staff undertook recruitment checks in line with statutory requirements and regular checks of professional registrations and disclosure barring checks and professional indemnity checks meant that any restrictions to practice, gaps in insurance or criminal convictions would be identified.

Managers gave all new staff a full induction tailored to their role before they started work which included supernumerary working. Each staff member was assigned a 'buddy' and had regular (monthly) one to one meetings with the clinical lead and service manager. Following induction staff had 6 monthly formal conversations.

Managers supported staff to develop through yearly, constructive appraisals of their work. Information provided by the service demonstrated that of the 6 clinical practitioners, 75% had completed an annual appraisal within the last 12 months. This figure was lower than the 85% target set by the wider organisation however, related to absence. All other disciplines including administration, healthcare assistants, lead midwives and doctors were 100%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. This included doctors were line managed by a clinical director and nursing and midwifery staff who were managed by a clinical lead within the service both in conjunction with the unit manager.

Good

Termination of pregnancy

A regional team supported medical staff to develop through regular, appraisals and constructive clinical supervision of their work.

Managers made sure staff received any specialist training for their role. Ultrasound was carried out by nursing practitioners that had undertaken an accredited in house training programme. Each member of staff undertaking ultrasound underwent annual clinical supervision which assessed their competency to continue carrying out the diagnostic assessment.

Managers identified poor staff performance promptly and supported staff to improve. The service monitored individual surgical complication rates which were reviewed both locally and at the clinical governance committee. A unit level dashboard of incidents and complaints was in the process of being created to help with monitoring at a local level. Any concerns were reported via the incident reporting and risk management system and if a doctor or health professional was dismissed then the relevant professional body such as the General Medical Council or Nursing and Midwifery Council was alerted.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit clients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for clients. This included safeguarding services, a designated lead within the wider organisation worked with integrated care boards and worked with multiagency safeguarding hubs across including the Northampton service. A sexual health clinician attended the service once a monthly.

Staff could refer clients for mental health assessments with a specialist mental health midwife when they showed signs of mental ill health and depression.

Quarterly meetings with integrated care boards were also undertaken to ensure that the services provided were aligned to the needs of the local population.

Seven-day services

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

Client could access help and support 7 days a week via an emergency telephone number. Clients could contact an initial booking telephone line within the wider organisation 7 days a week. Services provided at Northampton took place across 4 days a week, Monday to Wednesday and Friday 9.30am until 5.30pm.

Health Promotion

Staff gave clients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support displayed on its noticeboard. This included contraception which was available and distributed by the service.

Good

Termination of pregnancy

Staff assessed each client's health at the initial consultation and provided support for any individual needs to live a healthier lifestyle. Smoking cessation and healthy eating advice was provided and sexual health testing for gonorrhoea and chlamydia was offered. A 2 week response for results of sexual health testing was the standard. Staff made telephone contact with clients and offered the appropriate treatment by prescription if required. Partners were also signposted to their general practitioners for treatment.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. The electronic client records system had a prompt for consent and whether the client had capacity to make that decision. Staff that we spoke with during the inspection understood the process and how to check for capacity, as well as what to do if they suspected the client did not have it.

Staff gained consent from clients for their care and treatment in line with legislation and guidance and clearly recorded consent in the client's records. In all five records checked during the inspection consent had been recorded and we observed on three occasions consent being appropriately obtained.

When clients could not give consent, staff made decisions in their best interest, considering clients wishes, culture and traditions. This included whether the treatment was in the client's best interest. Staff explained that this decision was not taken in isolation by one member of staff but with advice and following the BPAS capacity to consent assessment flow chart..

Staff made sure clients consented to treatment based on all the information available at each step of the journey including telephone and face to face consultations, prior to treatment and on any contact inbetween.

Staff that we spoke with during the inspection understood Gillick Competence and Fraser Guidelines and supported younger clients who wished to make decisions about their treatment. Training on mental capacity and consent for both adults and children was part of the new employee induction and revisited twice yearly as part of the monthly training scenarios.

Is the service caring?

Good

The service had not been inspected before. We rated it as good.

Compassionate care

Staff treated clients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During the inspection we observed that staff were discreet and responsive when caring for clients. Staff took time to interact with them and those close to them in a respectful and considerate way.

Clients that we spoke with said that staff had treated them well and with kindness and were pleased with their care.

Staff followed policy to keep clients care and treatment confidential including taking clients to a sub waiting area to establish personal details so that they were not discussed in the main waiting area.

Staff understood and respected the individual needs of each client and showed understanding and a non-judgmental attitude when explaining how they would care for or clients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of clients and how they may relate to care needs.

Emotional support

Staff provided emotional support to clients, families and carers to minimise their distress. They understood clients personal, cultural and religious needs.

Staff gave clients and those close to them help, emotional support and advice when they needed it. A folder in the waiting room contained information about local services available to support clients and during the inspection we observed that at each consultation clients were offered counselling services both before and after treatment. A team of specialist counsellors within the wider organisation could be accessed and up to three sessions were offered. Further sessions were accessed by the client through their general practitioner if required.

Staff at the service were not trained in bereavement however demonstrated an understanding of the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were able to refer clients to BPAS counselling services and were able to signpost clients to external agencies as well their general practitioner for specialist support.

Staff supported clients who became distressed in an open environment, and helped them maintain their privacy and dignity. Private spaces were available for clients who may be distressed. Staff told us how they would take time to sit with the clients and ensure they were sure about the decision they were making.

A termination of pregnancy in the case of foetal abnormality (TOPFA) policy was in place and all clinical staff had completed an electronic training module about this. There was a TOPFA lead within the service and a specialist pathway was always in place which included keeping their partner or chosen person with them if they wished. Discussion about what the client wished to happen to the foetal remains was undertaken and work with specialist services, such as undertakers and burial services, could be undertaken. Clients over 17 weeks gestation were not treated at this service but instead at a specialist unit elsewhere.

Assessment for anxiety and depression was undertaken by talking to each client to establish whether they had experience of mental health services or help from their general practitioner. Staff explained how they would request the client for consent to liaise with the general practitioner if more support was required.

Understanding and involvement of clients and those close to them

Staff supported and involved clients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure clients and those close to them understood their care and treatment. This included the treatment methods available and the other options available that were alternative to termination, such as adoption. This

discussion was recorded on the electronic client records. In addition, an information booklet was given to the client to take away so that they had time to take in the information and raise any questions they may have had. If the client wanted additional time, then this was accommodated. Antenatal care could be arranged for clients deciding against treatment.

Staff talked with clients, families and carers in a way they could understand, using communication aids such as pictures and translation services where necessary.

Clients and their families could give feedback on the service and their treatment and staff supported them to do this. Clients gave positive feedback about the service. In October 2022, 87% of the 24 clients that gave feedback the service provided suitable care and 100% of respondents said they had not had trouble in accessing a treatment package.

Staff supported clients to make informed decisions about their care including whether the client would like a burial of the fetus and pregnancy remains or not. Leaflets were provided to clients detailing how medical records were kept and anonymised data from the statutory HSA4 form was used for statistical purposes by the Department of Health and Social Care.

The service made sure that there was appropriate support and discussion about the cost involved in cases where clients were responsible for full or partial cost of care and treatment. Largely, clients met the funding criteria set by the integrated care boards and for those that did not a dedicated funding department worked closely with the client to support then where possible. Managers told us that only 2 private clients had been treated by the service in the last 12 month period.

Information about post-operative care and complication was given the clients along with a 24 hour 7 day a week telephone number where they could access help and advice.

In the case of early medical abortions where the service supplied the second medication (misoprostol) to the client to take away and administer at home, an early medical abortion leaflet with step by step instructions, pictures, and conversation about best way to administer the medication, as well as what to do afterwards was given to the clients. This meant the service could be as assured as it could that the client understood how to administer the medication.

Is the service responsive?

Good

The service had not been rated before. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. This included a reintroduction of face to face consultations following the COVID-19 pandemic and ringfenced appointments for clients living in the local area so that they did not need to travel out of area unless they wished to.

The service was in an area with several types of transport including train and buses. Car parking was located nearby and although standard time of operation were within office hours, managers told us they would work to accommodate requests for care and treatment outside of these times if required.

Facilities and premises were appropriate for the services being delivered included secure access to the building which was accessed via electronic buzzer.

Managers ensured that clients who did not attend appointments were contacted and that any appointments cancelled by the service were rescheduled as quickly as possible.

Meeting people's individual needs

The service was inclusive and took account of clients individual needs and preferences. Staff made reasonable adjustments to help clients access services.

Staff supported clients living with a learning disability in making adjustments to support the client. The person of choice supporting the client was able to remain with them throughout their treatment journey and adjustments, such as scheduling the client first on the list meant they could attend the service when it was less busy and could be treated in as timely a way as possible. Pre attendance visits could also be accommodated if required.

Staff understood and applied the policy on meeting the information and communication needs of clients with a disability or sensory loss.

The service had information leaflets which could be printed out in languages spoken by the clients and local community. All information was also listed electronically online where the language could be changed to suit the clients' needs.

Staff had access to communication aids to help clients become partners in their care and treatment. This included access to British Sign Language and pictorial leaflets and managers made sure staff, clients, loved ones and carers could get help from interpreters when needed.

Clients showing an issue with on their initial medical assessment were referred to specialist centres within the wider organisation. Who in turn then accessed specialist NHS services, such as intensive care when required so that clients individual needs could still be met. Clients attending with a late gestation (later on in the pregnancy) were referred to a dedicated NHS unit.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes. In quarter 1 2022/23 the average pre-appointment booking waiting time for the 720 clients seen in that quarter was 2.8 days. This was better than the national target of 7 days. The average time from decision to proceed to treatment was 4.8 days and the average time from first contact to treatment was 8.6 days. .

At the time of the inspection the service had completed a trial using an electronic operational dashboard. This demonstrated waiting times such as telephone call to consultation and waiting times for surgery. It was in real time which meant that it could be reviewed as needed rather than when a report was generated. Managers told us how they

could adjust the planned schedule to meet the demand and prevent a backlog. For example, if face to face consultations were full one week, then additional consultation slots could be generated the following week. Quarterly meetings with integrated care boards took place and a business development team for the wider organisation also monitored waiting times.

Managers and staff worked to make sure clients did not stay longer than they needed to. Ultrasound scans, blood tests and clinical observations were taken and where suitable, early medical abortions were offered as same day treatment. Surgical treatments were not offered as a same day treatment option. At initial booking, the client was assessed to the suitability of receiving pills by post preventing the need to attend face to face.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. In quarter 1 2022/23 none were cancelled by the service. The percentage of clients that did not attend was also monitored and reported. These were broken down into did not attend for pre-appointment and did not attend for treatment. Contact and an offer of further support was attempted to all clients that had not attended.

Learning from complaints and concerns

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

Clients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in client area in the form of a feedback and complaints leaflet. Information inside the leaflet signposted clients to the unit manager, an online satisfaction survey, contacting the engagement manager and or visiting NHS choices website. It clearly set out how to share experience and make a formal complaint. Information explaining how to raise concerns was also listed on the noticeboard within the service.

Staff that we spoke with during the inspection understood the policy on complaints and knew how to handle them. Staff could give examples of how they used clients feedback to improve daily practice including increasing the frequency of monitoring pain which was created as part of an action in response to client feedback.

Managers investigated complaints and identified themes which were shared across the wider organisation and policies and procedures were reviewed in response to incidents and complaints to ensure that the most up to date and appropriate practices were in use. The last formal complaint received by the service was in April 2022. the service had investigated the complaint, fed back the findings to the client making the complaint and shared feedback with the staff members involved.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service at regular training sessions held by the service and attended by all staff. For staff who were unable to attend these training sessions, emails, and one to one discussions with clinical leads were undertaken so that these staff did not miss key updates or changes.

Is the service well-led?

Good

Termination of pregnancy

Good

The service had not been inspected before. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for clients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders within the service undertook accredited leadership training to ensure they had the skills and ability to run the service. Leadership peer support was in place and close working and collaboration with leaders across other services throughout the organisation provided a network of support. Managers understood their priorities. Information provided by the service demonstrated that clinical leaders completed a development programme workbook to support and consolidate their skills.

Staff that we spoke with during the inspection told us that managers were visible, and we observed positive working relationships during the inspection between managers and staff. Staff within the service could progress and there was opportunity for development including 'acting up' responsibilities when required. This supported succession management and made staff feel values and supported.

Staff felt proud to work for the organisation.

Vision and Strategy

The service was working on a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how they would develop, apply and monitor progress.

The service was working to implement organisation-wide strategy and priorities, including those on workforce race equality. Staff told us that there had been a pace of change at senior level within the wider organisation across previous recent months and that this was positive. Managers from the service were due to attend a strategy planning day on the 9 February 2023. Managers would take forward ideas and suggestions from operational and clinical staff, and client satisfaction and staff survey results to contribute to the input of future strategies.

Culture

Staff felt respected, supported and valued. They were focused on the needs of clients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

A transgender policy for staff members was in place within the service, and prochoice questions were included as part of the selection process to ensure there were no prejudices within the service.

An equality policy set out workforce disability equality and also workforce race equality in its aim to ensure equal opportunity for all members of staff. Staff completed an annual employee survey.

Staff that we spoke with during the inspection told us they felt supported in the workplace and that they would be able to raise concerns if needed. A whistleblowing policy was in place and accessible to all members of staff meaning that if staff wanted to, they could raise concerns anonymously.

A police liaison officer worked with the service to provide support and guidance around protestors who may attend the site.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service operated an effective governance process which included staff at all levels. Intranet and a private instant messaging service included all staff and a separate one for local managers was in place. Regular staff bulletins were circulated via email and saved on the Intranet for all staff to access.Formally, governance was separated between clinical and corporate governance with the board having oversight of both. Several committees including strategic leadership, clinical advisory groups, research and ethics and infection prevention and control meant that the flow of information could be achieved top to bottom and vice versa. Staff that we spoke with during the inspection knew how to escalate concerns, risks and incidents and felt supported in doing so.

The local governance lead in place was the clinical director for the service and worked closely with the quality matron of the service.

Audits, such as safeguarding were undertaken monthly along with quality matron audits and local manager audits to ensure both local and strategic oversight. These audits were red, amber and green (RAG) rated and had an action plan attached to them. In December 2022, 11 local clinical audits were undertaken the percentage compliance was then loaded on to a local clinical audit dashboard which all managers could access. This gave a visual sense check and meant further scrutiny could be given where necessary. Between July and December 2022, the service consistently scored between 95 and 100% in each audit.

Service level agreements were managed by a specialist team within the wider organisation, the manager within the service did not manage these agreements. Inclusion and exclusion criteria (suitability for treatment) was set out in a formal document which included a suitability assessment and also senior leader contacts where advice could be sought. Clients on antiplatelet medication for example, meant that the client could not be cared for suitably.

A transfer alert system in place recorded any client transfer meaning both the service and organisation could track them and look for themes and trends. This was in line with the transfer policy within the service.

A process was in place within the service to ensure that care and treatment was provided in accordance with the Abortion Act 1967. This included mandatory prompts on the electronic client record that would not allow progression through the record until it had been completed appropriately. Monitoring of the compliance was done via monthly audits and discussed within the governance structures of the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively.. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. The service did not always identify or escalate relevant risks and issues.

Good

Termination of pregnancy

The service had a risk register which at the time of the inspection contained 12 risks. Risks could be identified by any member of staff within the service and were recorded on the electronic incident reporting system. Each risk had a description, responsible manager and a current level of risk. Measures to manage the level of risk were listed as well as actions to mitigate and monitor. Risks were reviewed weekly by managers in the service and regionally on a monthly basis. A quarterly quality and risk committee chaired by the director of risk and governance across the wider organisation reviewed ineffective or 'uncontrolled risks' to each service and supported the service to put in place more robust actions when necessary. In turn risks were escalated into either finance, audit and risk committee and clinical governance committee before ultimately rising to board level at the quarterly board of trustees meeting when required. This meant that the service had an effective system in place to identify, record, manage and review risks it faced. However, the service had not recognised the risk relating to the recliner chairs within the recovery area nor the risk relating to client identification within the surgical client booklet.

A local business continuity plan was in place within the service which set out actions to be taken relevant to the service. At the time of the inspection, an issue with power occurred, staff and managers accessed the policy quickly and rectified the issue before continuity was affected.

Information Management

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

A process was in place to make sure that necessary documentation and records required under the Abortion Act 1967 were being properly maintained. Checks undertaken as part of the World Health Organisation surgical safety checklist were completed on the electronic client record which prevented the record from being progressed until the correct signatories were recorded and the regular documentation audit also reviewed this.

A regulatory team for the wider organisation managed statutory notifications to regulatory bodies which meant that timely notification was received by them.

Staff had access to enough electronic computer systems which were password protected and controls built into the electronic medical records prevented non-compliance. For example, the drug Misoprostol used in early medical abortion could not be prescribed if the gestational age (term of pregnancy) was over 9 weeks and 5 days.

Electronic reporting dashboard meant that managers could access and analyse data in real time.

In the event of a client being transferred from the service to an NHS organisation, a secure NHS email account was used to ensure security in the transfer of confidential information.

Engagement

Leaders and staff actively and openly engaged with clients and staff to plan and manage services. They collaborated with partner organisations to help improve services for clients.

The service reviewed client feedback quarterly, actions plans were created and monitored locally, and all clients were asked to provide feedback as part of their discharge process. The client satisfaction report generated from client feedback in the period of October to December 2022 demonstrated that of the 22 respondents, 100% would recommend the service to someone they knew needing similar care. All the respondents felt enough time was given, that the client was involved in their treatment decisions and that a suitable explanation about the treatment was given.

Scenario based education was provided to staff each month, surgeons were included in this 2 hour training and education session and all staff were required to attend 4 sessions per year. The learning from these sessions was put onto the unit upload (intranet site available to all staff) so that those staff members not present had the opportunity read the information. The last education session provided to all staff included a safeguarding scenario of a client under the age of 18 years and a pregnancy in an unknown location (possible ectopic pregnancy).

The service collaborated with local NHS trusts, commissioner colleagues and local authority. Managers had visited the local NHS early pregnancy unit where staffing levels related to strike action and direct client access had been discussed.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff understood the importance of improvement and the service had a clear understanding of client safety and client experience. Work was underway to progress to fully electronic records and staff were developing additional skills to be able to offer a wider range of services including contraceptive implants. Focus around safeguarding clinical supervision meant that the service could support staff further in recognising and reporting abuse and harm as well as the wellbeing of its staff in doing so. At the time of the inspection the service was not involved in any research activity however, maintained close links to the research committee within the wider organisation.