Tooting Medical Centre

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Tooting Medical Centre provides a range of private pregnancy services. There is no NHS provision at the clinic. The services available include pregnancy testing, unplanned pregnancy counselling/consultation, early medical abortion, abortion aftercare, miscarriage management referral, sexually transmitted infection testing, contraceptive advice, and contraception supply. Women pay for these services at a fixed rate. This inspection focused on the termination of pregnancy service, because we had concerns about the management of the service in earlier inspections in 2014. The service had been suspended for some time and restarted in June 2015. We do not give ratings for services like this.

Our key findings were as follows:

Safe

- The centre was clean and staff followed infection control practices.
- Staff reported incidents of harm or risk of harm, investigated them and took appropriate action. The service shared with staff lessons learned from incidents and information about actions required to prevent them happening again.
- Women's records were written legibly and assessments were complete. Records were stored securely.
- Staff were aware of safeguarding procedures and had received training in safeguarding adults and children from abuse. When there was a suspected case of abuse, staff carried out safeguarding risk assessments appropriately and made referrals to the local safeguarding team when appropriate.
- Staff managed medicines appropriately to ensure they were safe to use.

Effective

- The service provided care in line with national guidelines from the Department of Health and the Royal College of Obstetricians and Gynaecology (RCOG).
- Policies were accessible for staff and staff had developed these in line with Department of Health standard operating procedures and professional guidance.
- Staff offered women appropriate pain relief, and post-abortion contraceptives.
- Although the organisation had not yet performed audits recommended by Royal College of Obstetricians and Gynaecology (RCOG), the service in its current form had been running for less than seven months.
- Managers appraised staff's work performance annually. Staff had access to specific training to ensure they were able to meet the needs of the women having a termination of pregnancy.
- Patients could call a 24-hour telephone line after treatment for advice in Polish (the language of most women using the service) or English.

Caring

- Staff were caring and compassionate and treated women with dignity and respect.
- Women's preferences for sharing information with their partner or family members were established, respected, and reviewed throughout their care.
- Staff had a non-judgemental approach to women receiving treatment.
- Staff respected women's wishes and took their beliefs and faith into consideration regarding the disposal arrangements for pregnancy remains.

Summary of findings

- During the initial assessment, the gynaecologist explained the method of termination of pregnancy at this clinic, and carried out an ultrasound scan. If the scan showed the pregnancy to be over nine weeks, they referred the woman to another provider.
- Women considering termination of pregnancy had access to counselling from the psychologist at the clinic or from other local counsellors.

Responsive

- Women could book appointments through the clinic booking service that was open 9am to 9pm, seven days a week. Women could have an initial discussion with a doctor over the telephone.
- The service was available in English and Polish.
- The service gave women information to help them to make decisions.

Well led

- The service monitored risk and quality using a spreadsheet held by the manager. This was adequate in relation to the small number of terminations carried out so far, but to comply with national guidelines there should be more formal clinical audits when the service has been running for longer.

We saw good practice including:

- The opportunity for Polish-speaking women to discuss their concerns in their own language.

There are areas of poor practice where the provider needs to make improvements

- The provider should assess and monitor the quality of the service through auditing outcomes for women such as the number of women who do not proceed to termination, the number of women who use the post procedure advice service and the number of calls requiring further action and the number of women who leave the service with suitable contraception.
- The clinic should assess and monitor the risks relating to the termination of pregnancy as required by the Standard Operating Procedures.
- The clinic should obtain and retain written references for all staff employed

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Our focused inspection on 30 November 2015 followed up an inspection in October 2014 where weaknesses in processes had been identified. The provider suspended the service for some months and restarted termination of pregnancy in June 2015. We inspected the service as it runs now that a, new gynaecologist is in post.

At our last inspection there had not been a registered manager RM). There was now an RM who had been in post since 4 September 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers have responsibility for meeting the legal requirements in the Health and Social Care Act and associated Regulations in the running of the service.

We found that the provider was meeting the requirements of the Department of Health for a termination of pregnancy service.

We looked at the care and treatment records of women using the service, talked to staff, and reviewed other documentation to ensure that the processes safeguarded women's safety and welfare.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		The private termination of pregnancy service Tooting Medical Centre followed recommended procedures that provided safe care to women. Women paid a fee for the service. There were enough suitably trained staff, the environment was clean, and staff followed infection control procedures. Staff were aware of safeguarding procedures and had received training in safeguarding adults and children.Staff managed medicines appropriately managed to ensure they were safe to use. There were appropriate procedures to provide effective care. The gynaecologist and other staff provided care in line with Department of Health Required Standard Operating Procedures (RSOPs). Women had access to a 24-hour emergency helpline if they had concerns after their procedure. Women received compassionate care and their privacy and dignity was respected. Women could access counselling at the clinic. Women's wishes were respected regarding the disposal arrangements for pregnancy remains. The centre was responsive to women's needs. Appointments were often available on the day but otherwise women would only have to wait three or four days. The centre was predominantly for Polish speaking women and documentation was available in Polish and English. The manager of the service used appropriate procedures and protocols. No audits have yet been carried out in line with the Department of Health requirements.

Summary of findings

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Background to Tooting Medical Centre

Tooting Medical Centre provides a range of medical and dental services. Part of the medical service is early medical abortion procedures for women with a gestational age of up to nine weeks. This service is available between Monday and Thursday. Between June 2015 and November 2015 the service carried out 85 abortions.

The manager for this centre had registered with the Care Quality Commission (CQC) in September 2015 and had been in post three months at the time of our inspection

Our inspection team

Our inspection team was led by Inspection Manager Margaret Lynes, Care Quality Commission.

The team of four included the CQC inspection manager, two CQC inspectors and a specialist advisor who was a gynaecologist at a hospital trust.

Why we carried out this inspection

We carried out this inspection to ensure that the service was meeting the requirements of the Department of Health and the Royal College of Gynaecologists, and because of concerns at previous inspections. The clinic had suspended the service early in 2015 and then restarted it in June 2015 once a new gynaecologist had been appointed.

How we carried out this inspection

We reviewed documentation including the care and treatment records of women using the service and spoke to the gynaecologist and other clinic staff.

Information about Tooting Medical Centre

Tooting Medical Centre provides a range of private pregnancy services for which women paid a fee. This includes pregnancy testing, unplanned pregnancy counselling/consultation, early medical abortion, abortion aftercare, miscarriage management referral, sexually transmitted infection testing and contraceptive advice and contraception supply.

The service is a small part of a wider primary medical and dental care service used mainly to the Polish speaking community in this area of London.

Detailed findings from this inspection

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Tooting Medical Centre is a private medical and dental centre that mainly serves the Polish speaking community of southwest London. Women pay for services provided by the clinic and prices are displayed at reception. A termination of pregnancy service is offered on Monday to Thursday for women in early pregnancy, up to 9 weeks gestation and offers medical abortion only. Women come to the clinic on two consecutive days for the procedure. This service was the subject of a focused inspection.

Tooting Medical Centre provides pregnancy testing, unplanned pregnancy counselling, medical abortion, sexually transmitted infection testing and contraceptive advice and supply.

Tooting Medical Centre has a licence from the Department of Health to undertake termination of pregnancy procedures which was on display. Consultations take place in the gynaecologist's consulting room and associated treatment room. Administration was provided by staff in the reception area and the office area.

We inspected on 30 November 2015 and spoke with seven staff members including receptionists, registered nurse, gynaecologist, registered manager and nominated individual. We reviewed care records of 10 women.

Summary of findings

The termination of pregnancy service at Tooting Medical Centre followed recommended procedures to provide safe care to women. The clinic employed enough trained staff. The environment was clean and staff followed infection control procedures. Staff were aware of safeguarding procedures and had received training in safeguarding adults and children. Medicines were appropriately stored and managed.

The clinic provided terminations in line with the Department of Health Required Standard Operating Procedures. Women had access to post-procedure advice 24 hours a day.

Women received compassionate care and staff respected their privacy and dignity, as well as their wishes regarding the disposal of pregnancy remains. Almost all women using the clinic were Polish and appreciated being able to seek help and advice in their own language. There were minimal waiting times for appointments.The centre was responsive to women's needs. Appointments were often available on the day, but otherwise, women would only have to wait three or four days. The centre was predominantly for Polish speaking women and documentation was available in Polish and English.

The manager running the service used appropriate procedures and protocols. Staff did not carry out regular audits to improve the quality of the service, although data was kept on a spreadsheet which enabled some analysis. There was no risk register specific to termination of pregnancy.

Termination of pregnancy

Are termination of pregnancy services safe?

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

Managers encouraged staff to report incidents. Incidents were investigated and the learning and actions required as a result of incidents were shared with the staff. The environment was clean and staff followed infection control practices. The manager ensured that equipment was maintained and checked regularly to ensure it continued to be safe to use. Drugs to induce early medical abortion were prescribed by a doctor, after consultation with a woman, and only after a second doctor had agreed the same legal grounds for abortion. The gynaecologist completed women's medical records appropriately and managers stored them securely in the administration area of the clinic. There were enough suitably trained staff available to care for women and staff were up to date with mandatory training. Staff were aware of safeguarding procedures and had received training in safeguarding adults and children. The gynaecologist checked women's health and medical history before administering treatment.

Incidents

- The clinic used a paper-based system for reporting incidents. Staff we spoke with were confident about reporting incidents, but records showed there had been no incidents in connection with termination of pregnancy.
- We saw that staff followed up incidents. For example, when a staff member sustained a needle stick injury, a doctor provided appropriate treatment with a blood test and inoculation.
- Staff understood the duty of candour requirement which requires that senior staff tell patients and their families about incidents that affect them and any investigations, give an appropriate apology and support them to deal with the consequences.

Cleanliness and infection control

- The clinical and non-clinical areas we visited were clean and well maintained. We saw staff complied with good practice on infection prevention and control. There were hand washing facilities, antiseptic gel and a supply of personal protective equipment, which included gloves and aprons. Antibacterial wash, skin disinfectants and wet and dry wipes were available and in date.
- Two domestic staff were self- employed but had worked at the clinic for three years and understood the cleaning schedules and routines. The duty manager carried out weekly checks as well as spot checks.
- Staff segregated domestic and clinical waste. The clinic adhered to a management of clinical waste policy specifically for the disposal of pregnancy remains. There was provision for these to be collected and stored separately from other clinical waste before being sent for incineration. Staff at the clinic would maintain a full audit trail.
- We noted that a sharps container did not record either the name of the person who assembled it, or the date of assembly, contrary to good practice.
- Not all relevant items were on the Control of Substances Hazardous to Health (COSHH) inventory in the clinic, in line with best practice; for example, the air freshener sprays in the toilets were not on the COSHH list.

Environment and equipment

- All patient-care equipment was clean and ready for use. Electronic equipment had been routinely checked for safety and was labelled to indicate that portable appliance testing had been carried out to ensure it was fit to use. A few items of other equipment, for example the staff kettle, did not display a label indicating they had been tested.
- Resuscitation equipment was available in case of an emergency and staff knew where the equipment was stored. The equipment was checked to ensure that all supplies were available and fit to use. Single-use items were sealed and in date, and emergency equipment such as defibrillators had been serviced. We found one item, Salamol CFC free, which had become out of date in 0ctober 2015, the previous month. Staff replaced this. Emergency equipment for children such as masks, were available, but they were not stored separately from adult equipment which could lead to delay in the event of a child collapsing.
- Fire extinguishers were in date and tested, ceiling smoke alarms and fire instructions were present, and an

evacuation assembly area was marked. The Fire Service inspected the clinic in June 2015. We saw a fire risk assessment and noted that a fire drill had been carried out. However, there had been no weekly testing of fire alarms since the previous month, October. Staff needed The Health and

Medicines

- Clinic staff had system for the management of medicines to ensure they were safe to use. This included weekly monitoring of the stock levels, stock rotation and checking expiry dates of medicines. We saw that tablets for termination of pregnancy were on a regular order and in stock at all times. They were stored in a locked cupboard, accessible only to the gynaecologist and the staff member responsible for stock checks.
- Drugs that induced early medical abortion were prescribed by a doctor, as required by law. The gynaecologist did this after a face-to-face consultation with the woman, and, as the law required, drugs were administered at "the approved place", when another medical practioner had signed the form, in addition to his own signature and agreed the same grounds..
- We checked stocks of Mifepristone and Misoprostol, the two drugs used to induce abortion. For each tablet there was a record of who administered it, the woman's name and the date of administration. We noted there was one more tablet in stock than recorded. Staff were not clear why this discrepancy had arisen. All drugs were in date.
- We noted that staff checked and recorded the temperature of the medicine fridge daily. Other medicines kept for use with women undergoing an abortion such as Stemetil for sickness after the first tablet and Diclofenac for pain after the second tablet

Records

- Women's records were on paper. They were stored securely in locked cabinets so that data remained confidential.
- We reviewed ten sets of women's medical notes in detail and scanned 20 more. The women's medical notes were mostly well completed with clear dates, times and designation of the person documenting. In two sets of notes the date of the woman's second clinic appointment was not recorded. Good practice requires every sheet in patient notes to have the patient's name and date of birth. This was not the case in every set of notes.
- The manager confirmed that clinic would retain the HSA1 forms for three years from the date of termination. The manager kept HSA1 and HSA2 forms separately from the medical records of women who saw other doctors at the clinic. This was out of respect for women's wishes not to have evidence of an abortion on their permanent medical record.
- We saw three HSA4 forms due for return. We noted that the confirmation section did not always have the box ticked to show the gynaecologist had seen the woman. At TMC the gynaecologist saw all woman before termination, and we drew this to the attention of the gynaecologist. They told us the gynaecologist was responsible for completing the forms that the manager sent to the Department of Health (DH) by post within 14 days of each abortion. The Department of Health uses this form to check compliance with the Abortion Act 1967.

Safeguarding

- The manager was the designated safeguarding lead and could give advice. The telephone number for reporting safeguarding in Merton, the local borough, was on display on the staff noticeboard.
- The clinic had suitable safeguarding policies and procedures. The gynaecologist did not see any women under 18 for termination of pregnancy. The gynaecologist and the manager were aware of what action to take in the event of suspected abuse but had not encountered such a case.
- All staff we spoke with had received training about safeguarding children and adults. They were clear about their responsibilities. The manager gave an example of offering counselling to help support a woman's decision-making when staff had suspected external pressure on her to terminate her pregnancy. This enabled the psychologist to confirm that the woman had made an independent decision and understood the consequences and risks. All women had an opportunity to speak with the gynaecologist without their partner present.

Termination of pregnancy

- We saw evidence that the gynaecologist had child protection level 3 training certificate (14/7/15), and the nurse had level 2 training in child protection. Both had training in safeguarding adults.
- The price for the service was fixed and we did not consider that women were at risk of exploitation.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling and infection control. Staff told us they were up to date with their mandatory training.

Assessing and responding to patient risk

- The clinic treated fit and healthy women over 18 years old and without an unstable medical condition. The gynaecologist would refer women with a medical condition to a hospital.
- Prior to a termination of pregnancy women should have a blood test to identify their blood group. It is important that any woman who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the woman have future pregnancies. The records we reviewed demonstrated that all the women had a blood test prior to the termination and those who had a rhesus negative blood group received an anti-D injection. All women had an ultrasound scan to assess whether the pregnancy was less than 9 weeks. If the woman was more than 9 weeks pregnant the gynaecologist would refer the woman to an abortion clinic able to undertake later abortions.
- The gynaecologist prescribed prophylactic antibiotics after the procedure, in line with standard practice.
- If a woman chose to return home staff advised that someone should be with her for 2 hours after the first tablet and for 2 – 4 hours after the second treatment, and check on her every 30 minutes. The gynaecologist explained thatwomen should telephone the 24-hour emergency telephone number if they had any increase in temperature or very heavy bleeding. A duty doctor answered the telephone out of hours and would contact the gynaecologist if necessary. The gynaecologist was available on Mondays 11-8, Tuesday to Thursday 9-8 and Fridays 9-10.
- We noted that the clinic had not been the subject of anti abortion protests, which was a risk that many such clinics had to deal with.

Nursing and reception staffing

- The clinic employed a nurse , but said that most women coming for a termination had an appointment only with a gynaecologist. However, the nurse, phlebotomist and the reception staff had all received training to act as chaperones when doctors were carrying out examinations or procedures. These staff were able to outline the content of this training and would act as chaperones as needed.
- We checked two staff files for administrative staff and found evidence of identity checks and Disclosure and Barring checks. There were no written references for administrative staff and the manager told us she would take verbal references and not necessarily recorded these. It is good practice to retain written references. The file for a nurse showed evidence of identity check, qualifications, nursing PIN number from the Nursing and Midwifery Council, and two written references. Both of the staff whose files we checked had signed to say they had read the policies and procedures, including the chaperone policy.
- The clinic did not use any agency staff.

Medical staffing

- An obstetrics and gynaecology consultant held a general outpatient gynaecology clinic five days a week, early medical terminations was offered. The gynaecologist had undertaken specific training in termination of pregnancy (certificate dated 17/05/15). Medical support or advice could be obtained from other doctors working at the clinic. The gynaecologist told us that clinic doctors were always accessible support where needed.
- If the gynaecologist was absent, staff would refer women to another local provider to minimise delay in treatment. There was currently no arrangement for cover for the holiday or sickness period of the sole gynaecologist.
- We reviewed the staff file for the gynaecologist and saw that the manager's checks before granting practicing

privileges included checking qualifications, evidence of identity, insurance, registration and Disclosure and Barring Service checks (DBS) but not appraisals. The gynaecologist had a contract to August 2016.

Are termination of pregnancy services effective?

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

The gynaecologist undertook three or four medical terminations a week. Each procedure required the woman to attend the clinic on two occasions for the administration of the treatment. The gynaecologist provided treatment in line with national best practice guidelines. Women were offered appropriate pain relief, prophylactic antibiotics and post-abortion contraceptives. The clinic had not yet carried out any routine audits as recommended by Royal College of Obstetricians and Gynaecology (RCOG). Staff said they planned to audit performance at the end of a year. All staff had an annual appraisal. Staff had access to specific training to ensure they could meet the needs of the women attending the clinic for abortion. There was 24-hour telephone support for women from a doctor after treatment

Evidence-based care and treatment

- As required by the Department of Health RSOPs, the gynaecologist, in consultation with the woman established the legal reason for the proposed termination. They then ensured the woman was sure she wanted to proceed, before asking for her informed consent in writing. Consent included whether the woman wanted to stay at the clinic or return home after receiving the second treatment. Consent forms were available in both English and Polish.
- At the first appointment, the gynaecologist also took a short medical history, and tested the woman's blood and urine and recorded details on the woman's notes. He performed an ultra sound scan to determine gestation of the pregnancy. This was in line with the standard clinical guideline for all abortions. Receptionists advised women travelling from a distance to stay in the area until the end of the process. Women could have the initial treatment on the day of their first appointment and then return 24-48 hours later for the second treatment. He recommended that women spend 4 hours at the clinic on their second visit, but many chose not to stay. There were protocols covering support after the treatment.
- The centre adhered to the Royal College of Obstetricians and Gynaecology (RCOG) guidelines for the treatment of women whose scan revealed a concern such as a suspected ectopic pregnancy. The gynaecologist had not so far identified an ectopic pregnancy among woman coming for termination of pregnancy.
- A manager ensured that a second signature for the form HSA1 was obtained from another doctor at the clinic.
- RCOG guidance 'the care of women requesting induced abortion' suggests that information about the prevention of sexually transmitted infections (STI) should be made available. The guidance does not require the clinic itself to offer testing, however, TMC advised women to have a test for chlamydia before treatment. The gynaecologist told us that a woman could have a test for STIs on request or if he considered a test was indicated. There was a charge for the testing. The gynaecologist could refer women to sexual health services for further screening and treatment.
- RCOG guidance also suggests that all methods of contraception should be discussed with women at the initial assessment and a plan should be agreed for contraception after the abortion. The gynaecologist confirmed that these discussions took place and that women could be given contraceptive options and devices at the centre. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Centre for Women's and Children's Health.

Pain relief

- The gynaecologist prescribed pain relief and recorded this on women's medication records. He followed best practice in prescribing non-steroidal anti-inflammatory drugs (NSAIDs). These are recognised as being effective for the pain experienced during the termination of pregnancy. If NSAIDS were not fully effective, other appropriate analgesia was suggested.

Termination of pregnancy

Patient outcomes

- The clinic had not carried out audits of outcomes for women in line with the RSOP recommendations. We discussed with the manager audits that a small service might find useful: the number of women who did not proceed to termination, the number of women who left the clinic with contraception, proportions of women having follow up appointments, failure rates or rates of complications. Some of this information could be gleaned from a spreadsheet maintained by manager, as the number of terminations to date was relatively small, 81. However the manager told us she planned to undertake more formal audits periodically and share the results with staff.
- As the only gynaecologist at the clinic was male, the clinic could not fulfil the requirement that a woman doctor should be available for women, but this is common in a small service.
- Women were advised to take a pregnancy test three weeks after the procedure. They could instead come to the clinic for an ultrasound scan within two weeks of their termination if they wanted earlier confirmation of success.
- We asked the manager about failure rates or how many women changed their mind after taking the first part of the treatment. This information was not recorded and staff said that in order to monitor outcomes they relied on women contacting them and most were unlikely to do so. The gynaecologist was aware of two cases where women had gone to hospital after treatment, but he had not documented this in the women's notes or recorded the occurrences as incidents, both of which would have been good practice.
- TMC had an aftercare policy that outlined the availability of a doctor during and after the termination procedure. Women could choose whether to stay at centre after the second tablet or go home. There was a room on the first floor that women could use if they chose to stay in the centre. A woman remaining at the clinic was given a radio so they could communicate with the doctor at any time.

Competent staff

- The manager told us most staff had regular appraisals. We asked about the gynaecologist's appraisal and were told another doctor had undertaken this, but the clinic did not have a copy. It was good practice to obtain and keep copies of all such documentation.
- New staff had an induction to the clinic and its procedures. Staff had competence based training relevant to their role and staff confirmed the training met their needs.
- The RSOP set by the Department of Health says that all the staff involved counselling women in relation to abortion should be trained to at least diploma level in counselling. Counselling at this clinic was from a qualified psychologist so this requirement was met.

Multidisciplinary working

- The gynaecologist worked with other medical staff in the clinic, with the psychologist and the managers, as a team.
- The clinic had a referral policy that outlined the steps that need to be taken if a woman was referred on to, for example, a hospital or another abortion provider.
- The gynaecologist did not provide a discharge letter unless the patient wanted to inform their GP that they had undergone a termination of pregnancy.

Seven-day services

- The gynaecologist prescribed drugs for medical abortion by appointment at TMC between Monday and Thursday only. There were no terminations on Fridays for safety reasons, because the gynaecologist was not available at weekends.

Access to information

- Policies were held in the manager's office at the clinic where all staff could access them. Staff had developed the policies for termination of pregnancy in line with Department of Health. We reviewed policies and procedures to confirm they were in line with good practice, and we noted that the clinic also had copies of guidance from the Department of Health and the Royal College of Obstetricians and Gynaecologists, the Human Tissue Authority and the General Medical Council and TMC policies were in line with national guidance

Termination of pregnancy

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw from records that women were consented appropriately and correctly, and had information about possible side effects. Women could be offered a second consultation if they were not entirely sure about their decision to terminate their pregnancy.
- A woman's consent was required to communicate with her GP. Women's decisions were recorded and their wishes were respected. Most women did not want to inform their GP for cultural reasons.
- Staff were not very familiar with the requirements of the Mental Capacity Act 2005.

Are termination of pregnancy services caring?

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

The gynaecologist and other clinic staff treated women with dignity and respect. The staff were discreet and compassionate. Women's preferences for sharing information with their partner or family members were established, and reviewed throughout their care.If women needed time to make a decision, the gynaecologist accepted this. All the women considering termination of pregnancy had an access to counselling from a psychologist at TMC. Post- termination counselling was available if required. Counsellors respected women's wishes and took their beliefs and faith into consideration regarding the disposal arrangements for pregnancy remains

Compassionate care

- We did not observe care because no women had appointments for termination during our inspection.
- Staff told us women's preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care..

Understanding and involvement of women and those close to them

- The gynaecologist explained to women the methods available for abortion up to nine weeks gestation.This clinic did not offer surgical termination but could refer a woman to an alternative abortion provider if that was her preference.
- We were told that if women needed time to make a decision, this was supported by the staff and women were offered an alternative date for further consultation.
- Women could request a chaperone to be present during consultations and examinations.
- Women were involved in their care. The gynaecologist gave women the option to insert their own pessaries (a pessary is medication that is inserted directly into the vagina or cervix) and gave them instructions on how to do this.
- Records reviewed showed that there were a few occasions when women had changed their minds about terminating their pregnancy. Staff we spoke with told us that if a woman informed them she had changed her mind, they would refer the woman to antenatal care, but they might only know because the woman did not return for a second appointment.

Emotional support

- All women seeking termination had access to a counselling discussion if they wished before treatment, and could have counselling after a termination if required. Women were warned they might feel a mix of emotions afterwards. One counselling session was provided as part of the service; for further sessions there would be an extra charge. If a woman had counselling this would be recorded in the medical notes.
- The gynaecologist said women were asked their views about the disposal of pregnancy remains. We saw one woman's wishes for respectful incineration recorded in her notes.

Are termination of pregnancy services responsive?

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

Termination of pregnancy

Women could book their appointments between 9am and 9pm seven days a week. Most women referred themselves.There were minimal waiting times.The clinic manager dealt with formal complaints. A full investigation of a complaint was carried out and feedback was given to the woman and staff.

Service planning and delivery to meet the needs of women

- Not all women using the clinic for terminations were registered patients at TMC. Many came to the clinic having heard about it within their community. They chose this centre based on its reputation, because staff spoke Polish, and written information was available in both languages. A small number of women came from Poland and some came from Ireland.
- Women had to pay a fixed fee for termination at this clinic. They were told in advance that they could have the treatment free on the NHS but women who had chosen to come to a Polish clinic preferred to remain with this service
- Women were given written information about the process including risks and contraindications, and about support following an abortion procedure.
- Consultations were in Polish or English. There was no demand for other languages.
- The gynaecologist gave women leaflets to inform them what to expect after the procedure. The leaflets were in both Polish and English and contained comprehensive information. Consent forms were also available in both languages.

Access and flow

- Between June 2015 and 30 November 2015 TMC carried out 81 early medical terminations of pregnancy. A few more women had had initial appointments but changed their minds.
- Contraception was offered at the clinic.
- Women could book appointments with the gynaecologist 12 hours a day, seven days a week, throughout the year. The manager told us that an initial telephone discussion could be arranged if the woman wanted that. Appointments were often possible on the day of booking. Women had the choice of whether to proceed with a termination after discussion with the gynaecologist. Records showed fewer than 4% of women had changed their minds after their initial consultation.
- Department of Health Required Standard Operating Procedures state that women should be offered an appointment within five working days of referral. At this clinic women referred themselves. The guidance further says that women should be offered the abortion procedure within five working days of the decision to proceed. Many women chose to take the first tablet on the day of the consultation. Records showed this timescale was met.

Meeting women's individual needs

- The clinic was not easily accessible to wheelchairs users and disabled toilets were not available. The consultation room and recovery room were on the first floor.

Learning from complaints and concerns

- Women were encouraged to raise a concern or make a complaint and staff were positive about learning from complaints. Where possible staff said they tried to resolve incidents through informal discussion. If there was a complaint or incident about a member of staff the manager said this would be treated as a learning point.
- The manager maintained a log of complaints and investigated and responded to these. Where appropriate, the gynaecologist or the manager would apologise and payment could be refunded. If a woman wanted a further consultation, a free appointment and an opportunity for counselling could also be offered. The doctor would write a full letter of apology to the woman. We reviewed the complaints log and it was properly maintained. There had been no complaints raised to the Care Quality Commission about termination of pregnancy in 2015.

Are termination of pregnancy services well-led?

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

Termination of pregnancy

TMC aimed to treat all women coming to the clinic for termination with dignity and respect and provided confidential, non-judgmental services. Staff working in this part of the clinic reflected and followed the values of the clinic.The clinic did not maintain a risk register specifically in relation to termination of pregnancy, nor was there a programme of routine audits to monitor and improve quality.

Staff felt supported by their managers and worked closely with them.The clinic assessed women's satisfaction through correspondence or thanks to staff.The certificate of approval for carrying out termination of pregnancy (issued by the Department of Health) was on display.

Vision and strategy

- TMC provided a wide range of medical services to the Polish community and abortion was a small part of the wider service. Staff aimed to provide a confidential and non-judgmental service.

Governance, risk management and quality measurement

- The manager confirmed that there had been no change of ownership of the clinic. We checked this because it is a requirement to notify the Department of Health of any such change. This is an independent clinic run by the manager and owner.
- The clinic did not have a formal risk management system in relation to termination of pregnancy. They minimised physical risks within the clinic by regular checking and servicing of equipment but had not considered wider risks. There was also no system to monitor quality.
- The woman did not have to pay for their procedure until after the grounds for abortion had been agreed by two doctors. Pricing was transparent so women knew in advance what they had to pay. The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 Form). We noted that two doctors had signed in all cases.
- Every abortion provider is legally required to notify the Chief Medical Officer of every abortion performed in England using form HSA4. These contribute to a national report on termination of pregnancy. The doctor said that this data collection was mentioned to women.
- The clinic would need to notify CQC if a woman died within 12 months of a termination of pregnancy. They had not had to make such a statutory notification but needed to have a process for doing so.
- Staff said formal team meetings were rare because of the limited accommodation but staff saw each other several times a day. As the termination of pregnancy service was small part of the gynaecology service staff did not consider there was a need for regular staff meetings.

Leadership of service

- The staff working at TMC felt well supported by the centre's manager.
- The clinic maintained a register of women undergoing a termination of pregnancy, which is a requirement of regulation 20 of the Care Quality Commission (Registration) Regulations 2009. The manager completed this for each person at the time they had their pregnancy terminated. The manager understood that the clinic must retain the register for three years beginning on the date of the last entry.

Culture within the service

- Staff recognised that it was a difficult decision for women to seek and undergo a termination of pregnancy and they were sensitive to women's wish for privacy. They considered the service met a need in the Polish community in England.
- Staff felt they could openly approach managers if they needed to seek advice and support.

Public and staff engagement

- Reception staff asked women attending the centre if they were happy with the service. Staff told us that due to the sensitivity of the procedure and emotional experience it was not easy to engage with women.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should assess and monitor the quality of the service through auditing outcomes for women such as the number of women who do not proceed to termination, the number of women who use the post procedure advice service and the number of calls requiring further action and the number of women who leave the service with suitable contraception.
- The clinic should ensure that all hazardous cleaning chemicals are recorded in the COSHH inventory and stored securely.
- The clinic should assess and monitor the risks relating to the termination of pregnancy as required by the Standard Operating Procedures.
- The clinic should obtain and retain written references for all staff employed

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 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems in place to:** • assess, monitor and mitigate the risks relating to the health and safety of women using the service, • ensure that audit and governance systems including those for employing staff are effective.