South Manchester Private Clinic

Quality Report

136 Chester Road
Hazel Grove
Stockport
Greater Manchester
SK7 6HE
Tel: 0161 4872660
Website: www.nupas.co.uk

Date of inspection visit: 4 and 25 February 2016
Date of publication: 15/07/2016

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

South Manchester Private Clinic offers NHS and private termination of pregnancy (abortion) treatments including early medical abortions up to nine weeks, surgical abortion under local anaesthetic up to ten weeks and surgical abortions under general anaesthetic up to 20 weeks, pregnancy testing, sexually transmitted infections screening for patients aged 25 and under and contraception to patients who undertake a termination of pregnancy.

We inspected this service as part of our comprehensive inspection programme of termination of pregnancy services. We carried out an announced inspection on 4 February 2016 and an unannounced inspection on 25 February 2016. As part of our inspection we reviewed medical and termination of pregnancy services. The service also offered vasectomy services however this service had not been provided in the 18 months prior to our inspection and therefore we did not inspect this part of the service provision.

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

Are services safe at this service

There were processes in place to report, investigate and monitor incidents. However, incidents were not always reported appropriately and we were not assured that staff fully understood their role and responsibilities in relation to reporting of incidents. There was no robust system embedded in practice to share lessons learnt from incidents with staff although this had been recognised by the management team and steps were being taken to implement a new monthly newsletter. Staff were not familiar with the Duty of Candour (DOC) regulation but did recognise the importance of informing patients when things went wrong. A policy for Duty of Candour had recently been developed and staff training was due to commence in March 2016. Safeguarding processes were well understood and well embedded into practice. There was high usage of bank and agency staff (nursing) to ensure staffing numbers were in line with planned levels. The service had an induction checklist for new staff (including bank and agency) which included orientation to the service, awareness of policies and competency checks. The service had a service level agreement with a neighbouring NHS hospital in the event of a required transfer and a policy and flowchart directing staff to what action was required during an emergency and an urgent/non-urgent referral was clearly documented. Risk assessments, such as venous thromboembolism risk assessments were not always consistently completed for patients. There were no clear guidelines available or risk tools used on the wards or in the theatre recovery room to support the recognition of the deteriorating patient. This had been identified as an area for improvement by the Medical Advisory Committee (MAC) who planned to review the NHS modified early warning score system in order to adapt it for use within the service. There was no timescale for completion of this action however.

Are services effective at this service

Care and treatment took account of best practice guidelines although the service did not provide chlamydia screening to all women in line with RSOP 13. Patients were offered appropriate pain relief post operatively. The service had clear standards agreed with commissioners for their service. Key performance indicators were recorded and presented at the monthly performance and quality meetings. The service collated and monitored a range of data in relation to the service delivered in line with RCOG and Department of Health Required Standard Operating Procedures (RSOPs). Figures for January 2016 indicated the percentage uptake of contraception, including LARC post termination of pregnancy (ToP) procedure was below the service's performance target. Whilst the recommended data was collated in relation to service delivery in line with RSOP 16, the service was not routinely auditing and applying the data to identify and understand issues and then drive service improvement. Any new policies or amendments to existing policies were reviewed and signed off by the Medical Advisory Committee prior to implementation. There was a system in place to review practising privileges. Appropriate systems were in place to obtain consent from patients (including the use of the Fraser Guidelines for patients under the age of 16 years old) and consent was well documented in the patient record.

Summary of findings

Are services caring at this service

Feedback from people who used the service was mostly positive about the way they were treated. People were treated with dignity and respect by staff and we observed staff being considerate and compassionate to patients particularly in the recovery room where patients were transferred after surgery. The service offered bereavement counselling to women, the service ran twice a week and was accessible to all women who underwent a termination. All patients were provided with a feedback form prior to discharge. The completed questionnaires were returned to a secure lockable box in the reception area. The majority of feedback received was positive; feedback and results were discussed during managers' meetings to inform service improvement.

Are services responsive at this service

People were able to access services in a timely manner and the service was performing within the recommended target timeframe of ten days from contact to treatment. The service met regularly with commissioners to plan the service according to needs of the patients across Greater Manchester. However, due to the layout of the service and limited space, the waiting room was often overcrowded and we saw evidence of this at the time of our inspection. Patient's needs were assessed to clearly identify the patient's treatment pathway. The service worked to clear inclusion and exclusion criteria and did not accept clients with certain underlying medical conditions. If a patient had complex needs and was identified as high risk, they were referred to a local NHS trust to ensure all their needs were met appropriately. The team had access to translation support services if required. The service had processes in place to manage the needs of women who sought an abortion for fetal abnormality. The service offered women counselling; however we did not see any information about referring women to specialist services as per Royal College of Gynaecology guidance 14. People were given information how to complain and raise concerns and the service responded to complaints.

Are services well led at this service

The service had a client philosophy however staff we spoke with were unaware of this at the time of our inspection. Whilst the registered manager and head of clinical services could clearly articulate the vision for the service there was no clearly defined and documented strategy in place. It was clear the management team were committed to improving governance processes but systems were not yet embedded and further work was still required. There were robust systems in place to ensure the service adhered to the Abortion Act 1967 and the associated regulations. There was a system in place to review practising privileges. We reviewed employee information that showed the service had followed the 'fit and proper person' regulations. The management team were visible and accessible to staff throughout the service. However, there was a lack of day to day clinical leadership in theatres due to the use of agency staff and this was identified within the February 2016 theatre services audit as a potential negative effect on the continuation of good clinical standards. There was a lack of clear process for staff to raise concerns. The development of a whistleblowing policy had been identified as a required action in the November 2015 'Preliminary inspection' report but there was no specified date for completion. The organisation did have a 'Public Interest Disclosure' policy that contained information on whistleblowing. However, none of the staff we spoke with made reference to this when asked about raising concerns. Senior managers were proactively offering staff opportunities to continually learn new skills.

Our key findings were as follows:

Overall service leadership

- The registered manager and head of clinical services were knowledgeable about the service and were aware of the risks and challenges within the service.
- The management team were visible and accessible to staff throughout the service.
- However, there was a lack of day to day clinical leadership in theatres due to the lack of continuity of staff.

Cleanliness and infection control

- The areas we visited were visibly clean and treatment rooms were well organised.

Summary of findings

- The theatre had a separate scrub area, a sluice, and an area for sterile equipment. The sluice and the sterile area were close together, small, and were separated by a plastic curtain. A recent audit of operating theatre services performed in February 2016, identified that infection control advice should be taken as chemical cleaning would not be effective for this hanging mechanism. Monitoring visits to the service by a third party consultation service in January 2016 confirmed satisfactory cleanliness of facilities using ultra-violet surface inspections. Swab readings identified organic matter on surfaces to be within accepted levels.
- Hand gel and sanitizers were readily available on entry to clinical areas and on entering the ward. Signage above sinks displayed the correct way for staff, patients and supporters to wash their hands. The display boards were clear and visible reminding everyone to wash their hands to reduce the risk of infection.
- However, it was evident during our observations that staff in all areas did not always adhere to current hand hygiene guidelines. We observed six members of staff not washing their hands (or using hand gel) after performing a variety of clinical procedures which included; inserting a cannula, taking temperatures, examining patients and measuring blood pressures.
- All staff we observed adhered to the 'bare below the elbows in clinical areas' guidelines.
- At the time of our inspection we observed two laundry cages in the corridor outside theatre next to each other; one had dirty linen in red bags which were split, the other had clean linen in clear bags which could present a risk of cross infection. Later the same day we observed the clean linen from one of the cages on the floor in front of the lift.
- We also observed two trolleys on the corridor near the linen cages. Both trolleys were unlocked and there was sterile theatre equipment in one trolley which had been delivered to the service that day, the other had dirty equipment that was ready to be collected. There was no clear labelling on the trolleys to identify which was 'clean' and which was 'dirty'.

Staffing levels

- There was high usage of bank and agency staff to ensure staffing numbers were in line with planned levels. The service used regular agency staff where possible to ensure they had the correct skill set and were familiar with the service.
- The staffing level met the recommended staffing standard identified by the Association for Perioperative Practice (AFPP).
- We were informed that a member of staff should be present in the Rose room (pre-operative and post operative room) at all times. However, at the time of our inspection we entered the Rose room and found no staff present in the room for 10 minutes despite the room having three post-operative patients present. The member of staff allocated to this room had been assisting with transporting a patient from theatre.
- At the time of our inspection there were 10 registered general nurses and two health care assistants employed at South Manchester Private Clinic. There were vacancies out to advert at the time for one senior nurse post and two health care assistant posts.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges with the South Manchester Private Clinic. Practising privileges were reviewed annually by the medical director, registered manager and head of HR. The service linked with the surgeons' base NHS trust to discuss revalidation and any concerns with practice. Similarly if the service had any concerns with a surgeon's practice the medical director would contact the surgeon's responsible officer directly to discuss. The process for review of practising privileges also ensured consultants were practising within their scope of practise.
- There was no evidence of escalation guidelines or any modified early warning system (MEWS) used during recovery or post operation and there was no clear process to 'hand over patients' from surgery to the recovery ward or to ensure broader information was cascaded amongst the wider team. Communication books were available to communicate key messages amongst staff but we found these were not consistently used during the inspection. This meant there was a risk that any communication relating to patient safety and care may not shared with all staff.

Summary of findings

Nutrition/hydration

- Patients were given advice and information on restricting diet and fluids prior to attending surgery.
- Patients were given biscuits and water after surgery to aid recovery.
- There was a coffee machine for patients' supporters available in the waiting room on the ground floor.

Pain management

- Women were offered pain relief during and after surgical or medical abortion.
- We observed women being regularly asked if they were in any discomfort or pain and of the 15 records we reviewed, 13 had a completed pain assessment.

We saw areas of outstanding practice including:

- The service proactively provided all clients with a pregnancy test to encourage them to repeat a pregnancy test within an agreed timeframe. This was further followed up by an aftercare call 4.5 weeks post procedure. This was to ensure women who did not return for a post-operative check up were following all advice and not experiencing any adverse effects or symptoms that could indicate post operative infection or an on-going pregnancy.

However, there were areas of practice where the provider needs to make improvements.

Importantly, the provider must ensure:

- There is a robust incident reporting system whereby staff are fully aware of their roles and responsibilities in relation to incident reporting.
- There is a recognised process or tool to identify and escalate the deteriorating patient following surgery and that there is a clear process for the hand over of information between staff from theatre to recovery to ensure patient care information is clearly communicated to all relevant staff.
- That a VTE risk assessment is completed for all patients prior to treatment in line with NICE practice guidance.
- The 5 steps to safer surgery checklist is completed for all surgical patients.
- There is appropriate access to suitable resuscitation equipment throughout the service at all times.
- There is a process to ensure staff remain competent in the use of any equipment relevant to their role.
- Staff adhere to infection control guidelines in relation to hand hygiene and the storage and handling of laundry.

In addition the provider should:

- Continue work around the development of the staff newsletter to ensure that robust processes are in place to learn from incidents and share learning with staff.
- Work with commissioners to ensure chlamydia screening services are provided in line with RSOP 13.
- Ensure there are clear, robust and embedded processes in place so that access to clinical areas is secure.
- Ensure patient's privacy is respected at all times.
- Develop systems to ensure learning and improvement from complaints.
- Adhere to best practice guidelines and policies to ensure patients are provided with clear information regarding the disposal of pregnancy remains.
- Outcome data is audited and applied to identify and understand issues and drive service improvement.
- Improve staff awareness of their role should a major incident occur.
- Ensure all areas of the service, including the Rose room are staffed appropriately at all times in line with identified requirements and patient need.
- Review the measures in place to ensure there is a robust embedded system to restrict access to controlled areas throughout the premises.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Overall summary

There were processes in place to report, investigate and monitor incidents. However, incidents were not always reported appropriately and we were not assured that staff fully understood their role and responsibilities in relation to reporting of incidents. Safeguarding processes were well embedded and clearly understood by all staff. There was high usage of bank and agency staff (nursing) to ensure staffing numbers were in line with planned levels. The service had an induction checklist for new staff (including bank and agency) which included orientation to the service, awareness of policies and competency checks. However, there was no robust system in place to monitor and re-assess staff competencies.

All areas we visited were visibly clean and tidy. Staff adhered to 'bare below the elbows in clinical areas' guidance. However, staff did not always adhere to policies and guidelines in relation to hand hygiene and the management of laundry to reduce risk of cross infection. Wards and surgical areas, including theatres were not controlled access areas. This meant that patients, visitors and members of the public could potentially move freely through the service and there was no embedded culture amongst staff to check and challenge people on the premises. The facilities available compromised patients' privacy and dignity at times as we observed overcrowded wards where all patients were not offered privacy.

The service provided care and treatment that took account of best practice policies and evidence based guidelines. There were robust systems in place to ensure the service adhered to the Abortion Act 1967 and the associated regulations. The service had clear standards agreed with commissioners and key performance indicators to monitor performance and standards of service delivery. Whilst the recommended data was collated in relation to service delivery in line with RSOP 16, the service was not routinely auditing and applying the data to identify and understand issues and then drive service improvement. For example, the number of previous terminations and the uptake of LARC. Records we reviewed were clear, legible and up to date. However, Venous Thrombosis Embolism (VTE) risks assessments were not always completed prior to termination of pregnancy (TOP) surgery and the 5 steps to safer surgery checklist was not always completed fully for each patient undergoing TOP surgery. There were no clear guidelines or risk tools in use to support the recognition of the deteriorating patient.

There was a clear system in place for the service to review medical staff practising privileges. The review process also checked to ensure surgeons were operating within scope of practice. Data showed 100% of medical staff and 95% of nursing staff had received an appraisal from November 2014 to November 2015.

Feedback from people who used the service was mostly positive about the way they were treated. People were treated with dignity and respect by staff and we observed staff being considerate and compassionate towards patients. People were able to access services in a timely manner and the service was performing within the recommended target timeframe of ten days from contact to treatment. Plans were in place for patients with complex needs. However if a patient was identified as high risk, they were referred to a local NHS trust to ensure all their needs were met appropriately. Systems were in place to obtain consent from patients and consent was well documented in the patient record. There was evidence of effective multidisciplinary working amongst teams.

The service had a client philosophy however staff we spoke with were unaware of this at the time of our inspection. Whilst the registered manager and head of clinical services could clearly articulate the vision for the service there was no clearly defined and documented strategy in place. It was clear the management team were committed to improving governance processes but systems were not yet embedded and further work was still required. Learning from audits, incidents and manager meetings should have been cascaded via team meetings. However, due to service demand and the use of bank and agency staff, team meetings did not happen regularly. The management team had recognised this issue and as a result had developed a newsletter that was sent out with monthly payslips. The first edition had been issued in January 2016 and so it was not yet fully embedded at the time of our inspection.

Summary of findings

Contents

South Manchester Private Clinic

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to South Manchester Private Clinic

South Manchester Private Clinic (SMPC) began operating as a termination of pregnancy service in 1978. The service is part of the National Unplanned Pregnancy Advisory Service (NUPAS) group (Formally known as Fraterdrive Limited). SMPC offers NHS and private termination of pregnancy (abortion) treatments including early medical abortions up to nine weeks, surgical abortion under local anaesthetic up to ten weeks and surgical abortions under general anaesthetic up to 20 weeks, pregnancy testing, sexually transmitted infections screening for patients aged 25 and under and contraception to patients who undertake a termination of pregnancy.

The service is situated in a converted detached residential house and has two screening rooms, four consulting rooms, four recovery wards: Rose, Buttercup, Marigold and Daffodil ward, (with a total of 23 day care beds/recovery chairs) and a theatre. The reception area is located at the entrance to the premises with a waiting area on the ground floor and a further waiting room on the first floor.

Services provided include:

Prescribing abortifacient medication

Administering abortifacient medication for early-medical abortion

Surgical abortion (under general and local anaesthetic)

Contraception to clients who undertake a termination of pregnancy. As well as offering sexually transmitted infection screening for clients aged 25 and under.

The service does not carry out abortion after 20 weeks gestation. All patients are treated as day cases with no overnight beds. SMPC can accommodate 37 day case patients per day. If, for any reason, a patient required an overnight stay they would be transferred to the local NHS hospital with which the service has a service level agreement.

The service is registered with the Care Quality Commission to carry out the following regulated activities:

Diagnostic and screening procedures

Family planning

Surgical procedures

Termination of pregnancies

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

At the time of inspection the Registered Manager had been in post since January 2016.

We carried out this inspection as part of our comprehensive inspection programme of termination of pregnancy services. As part of our inspection we reviewed medical and surgical termination of pregnancy services. The service also offered vasectomy services however this service had not been provided in the 18 months prior to our inspection and therefore we did not inspect this part of the service provision.

Our inspection team

Our inspection team was led by:

Inspection Lead: Emily Harrison, Care Quality Commission inspector manager

The team included two CQC inspectors and an obstetrics and gynaecology theatre manager (specialist advisor).

Summary of this inspection

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we held about South Manchester Private Clinic. The announced inspection of South Manchester Private Clinic took place on 4 February 2016 and we visited all areas within the service including the theatre, recovery areas, consultation rooms and waiting areas. We also carried out an unannounced inspection on 25 February 2016 to see how patients were cared for during a busy surgery day.

To inform our inspection we reviewed data provided by the service and spoke to 18 staff which included: registered nurses, a consultant, an anaesthetist, the lead nurse (also lead nurse for safeguarding), the infection control lead nurse, the HR manager, the registered manager, administration staff, healthcare assistants, the theatre manager, the lead for clinical governance and the head of clinical services.

We spoke with six patients and one patient's relative. We observed care and treatment and looked at 26 records for both medical and surgical patients. We also reviewed other relevant records held by the service such as complaints, incidents and relevant policies.

We would like to thank all staff and patients for sharing their views and experiences of the quality of care and treatment provided at South Manchester Private Clinic.

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

Information about South Manchester Private Clinic

South Manchester private clinic provides a six day service with appointments for consultations and termination of pregnancy procedures.

The service offers a range of provisions which includes: early medical abortion and surgical abortion treatment, full contraceptive services to patients who undertake a termination of pregnancy and sexual transmitted infection screening for patients aged 25 and under. The service also offered vasectomy services however this service had not been provided in the 18 months prior to our inspection and therefore we did not inspect this part of the service provision.

The service operates a dedicated telephone helpline 24 hours a day throughout the year to provide service users with a contact for support and advice during periods when the service is closed. The service also offers telephone consultations, booking appointments and after care through the telephone helpline.

Detailed findings from this inspection

Notes

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

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

- There were processes in place to report, investigate and monitor incidents. However, incidents were not always reported appropriately and we were not assured that staff fully understood their role and responsibilities in relation to reporting of incidents. There was no embedded process in place to share lessons learnt from incidents with staff. However this had been recognised by the management team and steps had been taken to implement a new monthly staff newsletter.
- Staff did not always adhere to policies and guidelines in relation to hand hygiene and the management of laundry to reduce risk of cross infection.
- Access to resuscitation equipment was compromised in some areas of the service and there was no evidence that this situation had been risk assessed. We raised this with the provider and they had taken mitigating action to address our concerns by the time of our unannounced inspection. The anaphylaxis kit was not on site at the time of our unannounced inspection and staff were unaware, which could have compromised patient safety in the event of an emergency. Wards and surgical areas, including theatres were not controlled access areas. This meant there was the risk that patients, visitors and members of the public could move freely through the service without being checked or challenged.
- Venous Thrombosis Embolism (VTE) risks assessments were not always completed prior to termination of pregnancy (TOP) surgery and the 5 steps to safer surgery checklist was not always completed fully for each patient undergoing TOP surgery. There were no clear guidelines or risk tools in use to support the recognition of the deteriorating patient. This had been identified as an area for improvement by the Medical Advisory Committee (MAC). The MAC planned to review the NHS MEWS in order to adapt it for use within the service. There was no timescale for completion of this action however.
- There was high usage of bank and agency staff (nursing) to ensure staffing numbers were in line with planned levels. The service had an induction checklist for new staff (including bank and agency) which included orientation to the service, awareness of policies and competency checks. We were informed that a member of staff should be present in the Rose room (post-op and pre-op room) at all times. However, at the time of our inspection we entered the Rose room and found no staff present in the room for 10 minutes despite the room having three post-operative patients present. The member of staff allocated to this room had been assisting with transporting a patient from theatre.
- There was no clear process to 'hand over patients' from surgery to the recovery ward or to ensure broader information was cascaded amongst the wider team. Communication books were available to communicate key messages amongst staff but we found these were not consistently used during the inspection. This meant there was a risk that any communication relating to patient safety and care may not shared with all staff.

However;

- All areas we visited were visibly clean and tidy. Staff we observed, adhered to 'bare below the elbows in clinical areas' guidance. There were systems in place to protect patient confidentiality which included patients being given a number and this being called instead of the patient's name. Safeguarding processes were well embedded and clearly understood by all staff.
- Medicines were prescribed, stored and administered appropriately. Medicine fridge temperatures were checked routinely when the service was open, all drugs

were in date and stored securely. We found clear documentation relating to allergies and all prescriptions we reviewed had been prescribed after the HSA1 form was signed by two doctors.
- Records we reviewed were clear, legible and up to date.

Incidents

- The service had reported no 'never events' between January and December 2015. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The service reported no serious incidents between January and December 2015. The last serious incident was reported in October 2014 during a surgical abortion procedure. A full internal investigation was undertaken using a root cause analysis (RCA) approach. An RCA is a systematic investigation of adverse incidents, which can identify system failures and areas for improvement. The incident was reported via the official notification process. Actions to avoid recurrence were identified and implemented including the use of ultrasound scanning in surgical termination of pregnancy procedures.
- Staff were aware of how to report incidents, a critical incident form was completed when an incident occurred. This was a paper based system, which was kept in the administration office. Managers reviewed reported incidents and took appropriate responsive actions. However, it was not evident that staff knew about the types of things to report. At the time of our inspection we found incidents that had occurred but had not been reported. For example, the anaphylaxis box had been sent to pharmacy to be replenished and was not on the premises between operating hours of 7am-10.30am on the day of our unannounced inspection. Staff did not report this as an incident.
- Whilst on inspection we found that two of the beds on the ward did not have call bells, senior managers were informed and arrangements were made for call bells to be installed following our inspection. However, on the unannounced inspection, we checked incident forms and these incidents had not been reported. We also noted there was inconsistency in the reporting of termination failures in 2015 as incidents; four had been reported but there had been five incidents in total.
- There was no robust system embedded to share lessons learnt from incidents with staff. For example, lessons learned from incidents were not shared with staff through emails or staff meetings.
- However, following an internal 'preliminary inspection' review in November 2015, the management team had recognised the need for a more consistent way to share learning and as a result had developed a monthly newsletter called 'Learning SACS'. The first edition had been issued with staff payslips in January 2016 and was therefore not embedded at the time of our inspection.
- Whilst staff were not familiar with the term 'Duty of Candour' they did recognise the importance of informing patients when things went wrong. A policy for Duty of Candour had recently been developed and staff training was due to commence in March 2016. Duty of Candour is a regulation that means as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred the registered person must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person.

Cleanliness, infection control and hygiene

- There were no methicillin-resistant-staphylococcus aureus (MRSA) cases reported by the service between January 2015 and January 2016.
- The daffodil and buttercup wards, the rose room, and the theatre recovery room were visibly clean and treatment rooms were well organised. The theatre had a separate scrub area, a sluice, and an area for sterile equipment. The sluice and the sterile area were close together, small, and were separated by a plastic curtain. A recent audit of operating theatre services performed in February 2016, identified that infection control advice should be taken as chemical cleaning would not be effective for this hanging mechanism.
- Monitoring visits to the service by a third party consultation service in January 2016 confirmed satisfactory cleanliness of facilities using ultra-violet surface inspections and adenosine triphosphate swab readings identified organic matter on surfaces to be within accepted levels. However, actions in relation to the environment, facilities and staff were identified and included: clear policies to be disseminated to staff, improve staff awareness in relation to infection, clear lines of authorisation and risk assessments to be in place.

- Hand gel and sanitizers were readily available on entry to clinical areas and on entering the ward. Signage above sinks displayed the correct way for staff, patients and supporters to wash their hands. The display boards were clear and visible reminding everyone to wash their hands to reduce the risk of infection.
- However, it was evident during our observations that staff in all areas did not always adhere to current hand hygiene guidelines. We observed six members of staff not washing their hands (or using hand gel) after performing a variety of clinical procedures which included; inserting a cannula, taking temperatures, examining patients, and measuring blood pressures. However, all staff we observed adhered to the 'bare below the elbow in clinical areas' guidelines.
- Cleaning schedules were displayed in toilets; these were signed on a daily basis. We observed cleaning schedules in the recovery room which had been signed on the days the room was being utilised. Cleaning schedules were in place in theatre however, the operating theatre services audit completed in February 2016 had identified these were not always documented as completed.
- At the time of our inspection we observed two laundry cages in the corridor outside theatre next to each other; one had dirty linen in red bags which were split, the other had clean linen in clear bags which could present a risk of cross infection. Later the same day we observed the clean linen from one of the cages on the floor in front of the lift.
- At the time of our inspection there were two trolleys on the corridor near the linen cages. Both trolleys were unlocked and we observed sterile theatre equipment in one trolley which had been delivered to the service that day, the other had dirty equipment that was ready to be collected. There was no clear labelling on the trolleys to identify which was 'clean' and which was 'dirty'.
- An annual report of infection prevention and control practices within the service had been completed by an external consultancy for 2015/2016. The report was mapped against the criteria set in the Department of Health's Code of Practice. The report identified that the majority of criteria were being met. Three areas were identified as being partly met: policies on the environment, policy on sharing information when transferring patients; matters raised at appraisal and supervision. Where action was identified, there was a plan in place and this was monitored via the medical advisory committee and managers' meetings.

Environment and equipment

- The service was located in a large Victorian house that was extended at the rear. It had three floors and a basement area. The upper floor was used as an assessment area. The initial consultation with the coordinator, scan to determine the gestation, bloods and a consultation with the doctor took place on this floor.
- A nurse's station (room) and three rooms which contained beds or reclining chairs for recovering patients were located on the second floor. This floor was known as the ward. At the time of the inspection two of the rooms on the ward contained reclining chairs. The marigold ward contained six beds. At the time of our announced inspection we identified that two of the reclining chairs did not have access to a call bell. We raised this with the registered manager and immediate action was taken to address our concerns. The chairs were taken out of use and call bells were fitted the following day.
- A waiting room, and an administration office were located on the ground floor, the theatre area and other ward rooms in the basement could be accessed from this floor.
- The entrance to the service, wards and surgical areas, including theatres were not controlled access areas. This meant that patients, visitors and members of the public could potentially move freely through the service and there was no embedded culture amongst staff to check and challenge people on the premises.
- The service held two emergency resuscitation trolleys and a portable defibrillator; one resuscitation trolley was housed in the theatre recovery room alongside a portable defibrillator and the other was on the 2nd floor in the nurse's room (Daffodil ward) together with an anaphylaxis box.
- Whilst there was a system in place to check emergency equipment it did not include forward planning to avoid the expiry of items or the replacement of missing items in advance of treatment days. For example, the anaphylaxis box contained adrenaline that was replenished by a local pharmacy. However, on the unannounced inspection we found that the anaphylaxis

box was missing; this had been sent to pharmacy on 23 February 2015 because medication was of out date. At the time we attended the inspection, the kit had not been returned. The service manager was informed and the box was returned for 10.30am.

- We raised concerns with the clinical manager about the box being absent during operating hours, and that only one member of staff from the ten who were asked knew that the box was not on the premises and why it had been removed.
- All required equipment on both resuscitation trolleys was in place. In the recovery room, the trolley was checked on days when surgery was performed. There was a completed check list on the day of our inspection; however the date was not recorded so it was not clear if it had been checked that day. On the day of our unannounced visit it was completed and dated.
- There was no dedicated resuscitation trolley in the theatre room however; there was equipment available to manage an emergency that included emergency tracheostomy kits. We saw no checklists to confirm that the resuscitation equipment in theatre was checked prior to surgery although the staff told us it was. There was no recording book that monitored who and when checks had been completed on the trolley in the nursing area on daffodil ward (2nd floor).
- Transportation of the resuscitation trolleys to the first floor was difficult due to the narrow staircases and stair. All floors had portable oxygen and a suction pump. However, a risk assessment had not been conducted by the service to determine if the location of the trolleys was safe. We raised this with the provider and they had taken mitigating action (the use of a resuscitation equipment bag) to address our concerns by the time of our unannounced inspection.
- There was a lift in the corridor outside the recovery room that took patients to the wards on the second floor and had a portable oxygen cylinder. The lift was identified on the risk register as requiring upgrading. The action identified to control the risk was stated as: "Give authorisation to [lift installation company] to install a new lift that meets all health and safety standards as well as British standards". Although there was a date included next to the risk (January 2016) it was not clear if this was the date the risk was added, the date it had been reviewed or the date the action was due for completion.
- Suction machines in recovery were noted to be maintenance checked and in date. Medical and electronic equipment on the daffodil ward and on the assessment floor had not been maintenance checked and were not labelled; the service did not keep a log for maintaining or PAT (portable appliance testing or electrical testing) testing equipment such as fans and blood pressure machines. This meant that there was no indication when they were next due to be tested/ checked.

Medicines

- Medicine fridge temperatures were consistently checked, recorded, and were within the safe temperature ranges. All medications in fridges were labelled and systematically stored. Medication that had been opened was dated so that staff were able to discard them if they exceeded the expiry date. Medicines were stored correctly and consistently and checked daily at the start of the clinic.
- Controlled drugs were stored in a locked cupboard in the staff office outside theatre recovery and there was a nominated staff member that held the keys. Staff we asked could name the nurse that had the keys at the time of our inspection. We observed a completed comprehensive controlled drugs book that recorded when medication was used and demonstrated drugs were checked by two staff. We checked two boxes of ampoules and found medication to be in date.
- There were separate locked drug cupboards in the theatre; one for controlled drugs and the other for anaesthetic drugs and analgesia. There was a nominated staff member holding the keys. Any medication used during theatre procedures was recorded in the patient record and was also recorded in the theatre book which we observed.
- Any ampoule where the whole content of the drug was not required for a patient was disposed of.
- There was clear documentation of information about allergies; this was documented on prescriptions as well as patient records.
- We reviewed 10 prescriptions, these had all been completed after the HSA1 form had been signed by two doctors.

Records

Termination of pregnancy

- We reviewed ten early medical abortion patient records. The records we reviewed were legible, complete and up to date.
- Records showed that prior to surgery patients underwent a pre-op assessment to identify any areas of concern. However, we found three out of 15 instances where a VTE assessment had not been completed. All patient notes were securely stored in the administration office in a locked cupboard; notes were coded with blue (medical abortion), orange (surgical with local anaesthetic) and purple stickers (surgical abortion with general anaesthetic).
- Patient notes were kept on the premises for up to 3 months and then securely sent to the head office site via courier for them to be stored accordingly.

Safeguarding

- The service had clear systems in place to identify and report any safeguarding concerns, this included seeing the patient by themselves for at least part of the consultation.
- Staff in all areas were familiar with the service's safeguarding policy and were aware of female genital mutilation and child sexual exploitation risks.
- All staff in contact with children were aware of their roles and responsibilities to report safeguarding concerns.
- The service reported treating 88 children aged 13-15 years old between July 2014 and June 2015. The service did not treat any children under the age of 13. If a child under the age of 13 years old requested an abortion, the service informed the local authority safeguarding team and referred the patient to a local NHS hospital for treatment.
- Staff received online safeguarding training. 87.5% of staff who were involved in caring for patients aged 18 or under had completed level 2 safeguarding children and 93% of staff had completed level 3 safeguarding children training. 82% of staff had completed level 2 adult safeguarding training and 84% of staff had completed level 1 safeguarding training. The service did not have any training completion targets.
- The service had policies in place to safeguard women and good links with the local safeguarding team and the local police. We saw evidence that the service had taken appropriate action in relation to a patient they believed was in involved in trafficking.
- Staff were aware of the systems in place to make sure the identity of women accessing the service remained confidential at all times. For example, a colour coded numbering card system was used to identify patients; patients were given a numbered card in a specific colour so that staff did not announce full names in the open reception area.

Mandatory training

- Nursing staff, health care assistants (HCA's) and medical staff were all trained in basic life support (BLS). Medical staff were also trained in advanced life support (ALS).
- Staff received mandatory training on a range of subjects including: infection control level one and two, safeguarding children and adults level one and two; conflict resolution, equality and diversity, information governance, fire, health and safety, and manual handling.
- The service maintained a training matrix to identify training completion levels however, although dates were included for each member of staff it wasn't clear whether these dates indicated when training had last been completed or when it was next due. Of the 32 staff, 84% had completed all aspects of mandatory training apart from fire (75% had completed this) and 88% had completed infection control level one.

Assessing and responding to patient risk

- Between January and December 2014 the service reported that no patients had a venous thromboembolism (VTE) risk assessment prior to having a surgical abortion. The service had identified this as an area of practice that needed to be implemented and had begun carrying out VTE assessments from mid-2015. We reviewed 15 randomly selected surgical patient records at the time of our announced inspection and found the VTE risk assessment was not completed in three records. Best practice guidance recommends that all patients undergoing an abortion should undergo a VTE risk assessment prior to treatment.
- The 5 steps to safer surgery checklist is a system to reduce errors and adverse events for patients having surgery. We found that the surgical checklist was not completed in seven of the 15 patient records we reviewed. During our unannounced inspection we reviewed an additional patient record and found the surgical checklist completed fully for a patient in the recovery room who had undergone general anaesthetic.
- Pre-op assessments were performed by the anaesthetist and we observed this during our inspection.

Termination of pregnancy

- We found that following general anaesthetic patients were monitored in the recovery room for at least 30 minutes prior to being taken back to one of the wards. This was in line with the provider's policy. We observed one patient's journey: on transfer to the recovery room at 10:25am there was no verbal handover from theatre staff, the patient was given oxygen and vital signs were recorded at 10:25am and repeated at 10:45am, the patient was then assisted to stand and was transferred out of recovery via a wheelchair at 11:50am.
- We saw no evidence of escalation guidelines or any modified early warning system (MEWS) used during recovery or post operation. This had been identified as an area for improvement by the Medical Advisory Committee (MAC) and minutes from the meeting held in November 2015 showed the MAC planned to review the NHS MEWS in order to adapt it for use within the service. There was no timescale for completion of this action however.
- There was no clear process to 'hand over patients' from surgery to the recovery ward or to ensure broader information was cascaded amongst the wider team. Communication books were available to communicate key messages amongst staff but we found these were not consistently used during the inspection. This meant there was a risk that any communication relating to patient safety and care may not shared with all staff.
- Patients who had received priming medication prior to surgery were returned to the Rose room which was staffed by a health care assistant who was responsible for recording and assessing patient vital signs. We asked two health care assistants about the process to escalate concerns and found there were no clear guidelines in relation to parameters of vital signs; they explained they would use the call bell or telephone to contact a nurse if they had any concerns.
- We were informed that a member of staff should be present in the Rose room at all times. At the time of our inspection we entered the Rose room and found no staff present in the room for 10 minutes despite the room having three post-operative patients present. A family member confirmed there had been periods of time that morning when no staff were in the room. As we were leaving the room to get assistance a health care assistant entered pushing a patient in a wheelchair and advised us that they would be staying in the room.
- There were no complications reported for any of the medical abortions between November 2015 and January 2016 but the service reported four medical abortion failures, which were promptly referred for surgical procedure in house.
- Protocols were in place to identify if women were medically eligible for a termination, for example bloods were taken to make sure iron levels were within normal ranges. If women were anaemic the service would transfer them to a local NHS trust to avoid complications during and after surgery.
- Plans were in place for patients with complex needs. However if a patient had complex needs which were identified as high risk and it was deemed clinically unsafe to perform the procedure, they were referred to a local NHS trust to ensure all their needs were met appropriately.
- The service had a service level agreement with a neighbouring NHS hospital in the event of a required referral (both emergency and non-emergency); we reviewed the agreement that stated the trust would provide additional level of consultant support if required. A flowchart directing staff to what action was required during an emergency and an urgent/ non-urgent referral was clearly documented. Staff were aware of the process.
- In the event of an emergency transfer, patients would be transferred by a "member of clinical personnel with at least two years' experience in the appropriate specialty and they must be chaperoned with an adequately trained assistant, in a paramedic ambulance." (SMPC Procedure for the transfer of clients V2, p1).
- The service had identified that the transfer of a patient would leave the theatre team short of either a surgeon or anaesthetist. This was included on the service risk register. The identified control measure was to "have a standby consultant surgeon and anaesthetist on the rota. Source local recruitment agencies that can possibly provide emergency cover if required during a GA list". However, although there was a date included next to each risk (January 2016), this was the date the risk had been added but there was no identified date for review or completion.
- SMPC operated a strict policy on exclusions which included: patients with high body mass index, and other high risk conditions were referred to the National Health Service (NHS). There were a total of 322 patients transferred from the service to the NHS between

January and December 2014 of which one was an emergency transfer. The remainder were as a result of patients being unsuitable for treatment in the independent sector.

- The provider had a nurse on-call 24 hours a day seven days a week. All clients were given details of their aftercare line at the time of discharge. The provider had also introduced a post procedure telephone call whereby the clients were contacted by a member of the nursing staff approximately four weeks after their treatment. The nurse would ask the patient if they had any problems such as heavy bleeding following their surgery, pain or any other symptoms. The patient was also asked if they had used the pregnancy test given upon discharge following their procedure.
- There were arrangements in place to support women with complex and long term needs. These patients were taken straight to a bed in the recovery room where they returned following surgery, and remained until they were discharged home from the service. For example a diabetic patient would be taken to recovery and remain their pre and post-surgery so that nurses could regularly observe them.

Nursing staffing

- At the time of our inspection there were 10 registered general nurses and two health care assistants employed at South Manchester Private Clinic. There were vacancies out to advert at the time for one senior nurse post and two health care assistant posts.
- The service did not use any tools to monitor or review the skill mix of the nursing team in each area.
- There was high usage of bank and agency staff to ensure staffing numbers were in line with planned levels. For example, in November 2015, of the 25 days the service was open (of which 12 days were surgical treatment days) bank staff were used on 12 days and agency staff were used on two days. Similarly, in January 2016, of the 26 days the service was open (of which 13 days were surgical treatment days) bank staff were used on 13 days and agency were used on one day.
- The service used regular agency and bank staff where possible to ensure they had the correct skill set and were familiar with the service. The service had an induction checklist for new staff which included orientation to the environment and awareness of service policies including: infection control and cardio-pulmonary resuscitation. Competencies recording pre-operative observations, awareness of the emergency procedure using the emergency bell, and escorting patients to and from theatre were identified on the checklist and all were to be signed off by a senior nurse.
- The planned nurse staffing in the theatre recovery was three trained nurses with a health care assistant to transport patients back to the ward, there were a total of 12 beds in the recovery room. At the time of our inspection we observed this number of staff present in the recovery room.
- Nursing staff vacancies were identified as a risk on the service risk register. The control measure in place was to "Continue with recruitment drive and advertise on NHS jobs. Increase the number of bank staff". Although there was a date included next to each risk (January 2016), this was the date the risk had been added but there was no identified date for review or completion.

Medical staffing

- The service only utilised experienced doctors in the provision of termination of pregnancy (TOP) treatments. The consultants were on the General Medical Council (GMC) Specialist Register for TOPs. All the medical doctors and surgeons had undergone an annual medical appraisal between January and December 2015.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually in the NHS) in substantive posts and had practising privileges with the South Manchester Private Clinic. Practising privileges were reviewed annually by the medical director, registered manager and head of HR.
- When patients were undergoing a general anaesthetic, the theatre was staffed with a surgeon, an anaesthetist, an operating department practitioner (OPD), a scrub nurse and two health care assistants. At the time of our inspection the staffing level met the recommended staffing standard identified by the Association for Perioperative Practice (AFPP).
- The anaesthetist and the OPD were present in theatre for the duration of time that a patient was receiving a general anaesthetic.

Termination of pregnancy

- There were always two consultants on site. One consultant saw patients in the assessment area and the other consultant was called the 'cyber doctor', they reviewed the patients' information and signed HSA1 forms after considering the individual circumstances.
- We did not observe any handovers taking place between any staff during our inspection.
- A 24 hour telephone line was available if a patient deteriorated outside service opening hours. In the event a patient deteriorated, nurses assessed the patient over the phone and gave advice or offered an appointment with a consultant. Appointments with a consultant were available seven days a week. In the case of an emergency, patients were advised to go to A&E.

Major incident awareness and training

- An emergency backup generator was stored in the garage in case of electricity failure; apart from one senior nurse all other staff we asked during our inspection were unaware that the service had a backup generator.
- Staff were unaware of their roles and responsibilities during an major incident, we found no contingency planning in place.

Are termination of pregnancy services effective?

- There was no robust system in place to monitor and re-assess staff competencies. There had been no audit of the theatre services from 2012 to 2016, a period of four years. The audit performed in February 2016 identified a notable decline in clinical practices.
- There was clear evidence of effective multidisciplinary working amongst teams but there was limited communication between the different teams across the service.
- Figures for January 2016 indicated the percentage uptake of contraception, including LARC post ToP procedure was below the service's performance target.
- Whilst the recommended data was collated in relation to service delivery in line with RSOP 16, the service was not routinely auditing and applying the data to identify and understand issues and then drive service improvement. For example, the number of previous terminations and the uptake of LARC.
- Patients were offered pain relief during and after medical and surgical abortions. Pain assessments were completed and we observed staff asking patients about pain.

However;

- The service provided care and treatment that took account of best practice policies and evidence based guidelines. The service had clear standards agreed with commissioners and key performance indicators to monitor performance and service delivery.
- The service monitored waiting times to ensure patient outcomes were in line with the Royal College of Obstetricians and Gynaecologists' guidelines.
- Appropriate systems were in place to obtain consent from patients and consent was well documented in the patient record.
- Practising privileges were reviewed by the medical director, registered manager and head of HR. The service linked with the surgeons' base NHS trust to discuss revalidation and any concerns with practice. Similarly if the service had any concerns with a surgeon's practice the medical director would contact the surgeon's responsible officer directly to discuss. The review process also checked to ensure surgeons were operating within scope of practice. Data showed 100% of medical staff and 95% of nursing staff had received an appraisal from November 2014 to November 2015.

Evidence-based care and treatment

- Staff took account best practice and policies such as National Institute for Health and Care Excellence (NICE)/Royal College guidelines/The Abortion Act and abortion legislation. In consulting rooms, guidelines were displayed for staff to view. For example, women were offered a choice of procedure within appropriate timeframes, processes were in place to support women with options for future contraception. However, chlamydia screening services were only offered to women under the age of 25 years which was not in line with RSOP 13. This was because they were not funded to provide this service by commissioners. RSOP 13 states that "All women should be offered testing for Chlamydia, offered a risk assessment for other STIs (e.g. HIV, Syphilis etc.), and tested as appropriate." (Department of Health, May 2014).

Termination of pregnancy

- The service recorded the number of women who were screened for chlamydia. We reviewed this data and found the service achieved over their CQUIN target of 66%. In January 2016 the service screened 75% of women.
- The service was compliant with the Royal Obstetricians and Gynaecologists (RCOG) guidelines, requirements of the Abortion Act 1967 and regulation 20 (requirements relating to the termination of pregnancies) of the Care Quality Commission Registrations Regulations 2009. The service offered early medical abortion to women who were no more than eight weeks and six days gestation. Women could also have a manual vacuum aspiration up to nine weeks gestation and surgical intervention under local or general anaesthetic was available up to 20 weeks gestation. Those who opted for surgical abortion were also offered the contraceptive injection, contraceptive implant or the coil fitted at the same time as the procedure. The service did also offer all women condoms and other forms of contraception.
- Contraception was discussed during the consultation and at discharge. We were shown audits that were based on the uptake and promotion of contraception.
- Patient's needs were assessed and supported by a comprehensive record which clearly identified the patient's treatment pathway. The patient record was informed by the best practice guidelines.
- Patients were given prophylactic antibiotics to reduce the risk of infection post-surgery.
- The service did not carry out any terminations after 20 weeks gestation and therefore methods such as feticide were not performed.
- The service recorded the number of failed termination of pregnancy procedures and early medical abortion (EMA's) so that trends could be identified. As a result women were scanned in theatre to make sure that all products of pregnancy were removed from the uterus.
- We observed evidence that the Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2011) day case and short stay surgery guidelines were followed, which included a clear escalation process to a nearby NHS provider should a medical emergency occur, and sufficient staffing during time in the recovery room.
- An audit of 'Operating Theatre Services' was completed in February 2016 by an independent operating theatre consultant. The audit assessed adherence to best practice standards. The audit identified an overall score of 85% which equated to 'average' in the scoring system. This was a decline from the previous audit where the overall score was 92% (identified as 'good'). There was no target identified within the audit however a score of 100% would represent best safe practice. At the time of our inspection there was no action plan in place. There had been a four year period in auditing the theatre as the previous audit took place in 2012.
- The services and quality of patient care provided in the pre-operative, and intra-operative phase both scored below average in the audit with a lack of continuity of qualified staff being present in theatre identified as an issue.
- Any new policies or amendments to existing policies were reviewed and signed off by the Medical Advisory Committee prior to implementation.

Nutrition and hydration

- Patients were given advice and information on restricting diet and fluids prior to attending surgery.
- Patients were given biscuits and water after surgery to aid recovery.
- There was a hot drinks machine for patients' supporters available in the waiting room on the ground floor.

Pain relief

- Women were offered appropriate pain relief during and after surgical or medical abortion.
- We observed women being regularly asked if they were in any discomfort or pain and of the 15 records we reviewed, 13 had a completed pain assessment and where identified as experiencing pain, patients were given pain control in a timely manner. We spoke to two patients who both said they had received pain relief when required.
- Medication was prescribed prior to a patient entering theatre and additional medication could be prescribed and administered whilst the patient was in theatre.
- If patients had consented they could receive analgesia administered via the rectum as a prophylaxis for pain and intravenous medication was also available during theatre.

Patient outcomes

- The service monitored waiting times to ensure service delivery was in line with best practice. Waiting times for

consultation from initial contact and treatment from initial contact were within the Royal College of Obstetricians and Gynaecologists' recommended timeframes.

- The service had clear standards agreed with commissioners for their service. Key performance indicators such as contraception uptake, complaints, waiting times, rates of complications and screening were recorded and presented at the monthly performance and quality meetings.
- From January to December 2015 the service reported five failed early medical abortions (one in February, April and May and two in October).
- In January 2016, the service reported they had completed 378 ToPs, these terminations took place over 14 clinics; data on key performance indicators were collected and reviewed. The service exceeded their chlamydia screening target of 70% and tested 75% of their patients who were 25 years old or younger for chlamydia. The service did not offer HIV and syphilis screening to women as this was not part of the commissioned service and had raised this with commissioners.
- The number of women who had repeat abortions and whether they left the service with suitable contraception including the uptake of long acting reversible contraceptives (LARC) was recorded. There were robust methods of collecting data on the uptake of different types of contraception. LARC uptake in January 2016 was 33%, this was below the service's target of 45% and only 37% of women took oral contraception, the service target was 70%. The service reported that all women took condoms. At the time of inspection, there was no clear action plan or strategy to demonstrate how the service planned to increase the uptake of different contraceptive methods. However, the head of clinical services informed us the organisation had recruited a head of nursing in January 2016 and key aspect of their role would be to develop the contraceptive element of the service. The organisation was also supporting nursing staff to obtain the Diploma from the Faculty of Reproductive and Sexual Health. This would develop nurses' competence to deliver all methods of contraception including LARCs.
- The service recorded the number of women who reported having previous terminations. Between January and December 2015, 1161 women were recorded to have already had one or more abortion.
- The rate of complications was also documented. Information on complications such as perforation of the uterus, uncontrolled haemorrhage and any other scenario which required a transfer to the NHS on an emergency basis was collated and reviewed. The service reported no complications or safeguarding cases between October 2015 and January 2016.
- However, whilst the recommended data was collated in relation to service delivery in line with RSOP 16, the service was not routinely auditing and applying the data to identify and understand issues and then drive service improvement. For example, the number of previous terminations and the uptake of LARC.
- The service had introduced new protocols following a serious incident to scan women in theatre, this was to prevent and reduce any further risks to the women's health. For example for those women who required a termination and were beyond 12 weeks gestation, an ultrasound-scan guided procedure took place they were asked to do a pregnancy test post procedure and offered counselling.
- A total number of 323 consultations took place in January 2016 and 66% of the women seen at the service went on to have an abortion.
- All patients received an aftercare call four weeks post procedure to check they were recovering well and had no complications.

Competent staff

- Data showed that 100% of medical staff and 95% of nursing staff had undergone an annual appraisal from November 2014 to November 2015.
- The service ensured that all nursing and medical staff were appropriately qualified. Three nursing staff records we reviewed confirmed that all appropriate pre-employment checks had been carried out including: evidence of professional qualifications and registration, disclosure checks, references from previous employees and the reason for any employment gaps.
- Practising privileges were reviewed by the medical director, registered manager and head of HR. The service linked with the surgeons' base NHS trust to discuss revalidation and any concerns with practice. Similarly if the service had any concerns with a surgeon's practice the medical director would contact the surgeon's responsible officer directly to discuss. The review process also checked to ensure surgeons were operating within scope of practice. A review of two

surgeon HR files confirmed that all appropriate checks had been carried out and there was evidence of up to date registration with the General Medical Council (GMC), indemnity insurance, appraisal and Disclosure and Barring Service checks.

- Nurses were supported to undertake a sonography course at the University of Birmingham to support the current sonographer. A competency framework was used to make sure staff had the relevant level of clinical experience and ability to determine the gestation when scanning women. Competency and ability was assessed and signed off by an assessor from the University who observed direct practice.
- However, competency lists were unavailable to demonstrate that staff had been trained to use equipment that they used as part of their role. Staff had an initial competency list to complete when they were first employed but there were no records of any competency reviews having taken place. At the time of our inspection the healthcare assistants we spoke with were unable to explain the principles and standard limits in relation to patient observations. A healthcare assistant that had been working in the service for several years had not had her competencies reassessed. When we asked two health care assistants if they had received training on how to use the blood pressure recording machine correctly, they told us it was "self-explanatory".

Multidisciplinary working

- We observed good team working between all the nurses, health care assistants, anaesthetists and consultants. However this was only seen within each area and each area worked in silo from the rest of the service. For example when the anaphylaxis box was missing from the ward, staff did not communicate this to all areas and those areas reliant on the box in an emergency were unaware it was absent from the premises.
- There was a service level agreement in place with a local NHS provider should an unplanned transfer be required.
- Letters were sent to the patients' general practitioner (with patient consent) to inform them of the procedure and share information.
- A routine counselling service was available to women pre and post abortion. A counsellor was always on site if and when women required their services.

Seven-day services

- The service offered treatment six days a week and advice and support seven days a week throughout the year via a 24 hour helpline.
- The management team identified that staffing was the main challenge to providing a full seven day service.

Access to information

- Staff had access to policies and procedures; these were all kept in the administration office however staff we spoke with were unfamiliar with how to access them.
- Discharge letters were sent to the patients' general practitioner (with patients' permission). We reviewed 20 letters and found they were informative and contained the relevant information regarding the termination procedure and outcome. This was to allow the practitioner to manage any complications in the event a patient deteriorated.
- At the time of the inspection all women were given information about post-operative care and information about their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed nurses, doctors and health care assistants obtaining consent from women before clinically assessing them. Staff spoke to women about any care and treatment that was being carried out before they went ahead with the procedure.
- The service made sure that women and young people were seeking abortions voluntarily. They did this by discussing reasons why and how they had reached their decision to terminate their pregnancy. This discussion was also picked up by the consultant before forms were signed. If at any point a healthcare professional doubted the information the woman provided, the woman was asked to come back again after she had thought about her options or the senior nurse was approached to discuss safeguarding concerns.
- Staff across the service were aware of appropriate procedures in obtaining consent. They described how they established if a child could make their own decisions and understood the implications of the treatment by using the Fraser guidelines. For example,

we found the Fraser guidelines were used to ascertain information about a girl's mental capacity when parents were absent from the conversations relating to intercourse and contraception.
- We reviewed signed consent forms prior to treatment whilst we were on inspection.
- All women were offered a telephone or face to face consultation after they had made initial contact with the service. By doing so, the service made sure women were certain of their decision and understood how the procedure they chose would be performed.
- An interpreter was used upon request and was asked to stay with the woman until she was discharged, so that consent could be obtained.

Are termination of pregnancy services caring?

- Feedback from people who used the service was mostly positive about the way they were treated. People were treated with dignity and respect by staff and we observed staff being considerate and compassionate to patients.
- Staff were proud of the care they gave, were non-judgemental, and responsive to patients' needs. We observed staff using a caring and compassionate approach particularly in the recovery room where patients were transferred after surgery.
- A routine counselling service was available to women pre and post abortion. A counsellor was always on site if and when women required their services.

However;

- Patients were not informed about the statutory requirement of HSA4 forms. Staff did not explain to patients that these details were sent to the Department of Health and that it was a legal requirement.

Compassionate care

- Most patients were cared for with dignity and respect. Curtains were closed around patients' bed areas on the wards and theatre recovery room when staff were providing personal care.
- Staff took time to interact with women; they were attentive to their needs and spoke in a compassionate manner. We spoke with five young people on one ward; they all gave positive feedback about the attitude of the staff who attended to them. However, we spoke to the mother of a patient who told us she had found one nurse quite abrupt when providing care to her daughter.
- Patients were complimentary about the friendliness and professionalism of staff, the care and treatment they received and the standards of cleanliness at the service. Patients were particularly appreciative of the care and understanding they were shown to help them overcome their fears and anxieties.
- All patients were provided with a feedback form prior to discharge. The completed questionnaires were returned to a secure lockable box in the reception area. The threshold for responses to the feedback questionnaire was 75%. The feedback form asked questions about the staff and the process from start to finish. The majority of feedback received was positive; feedback and results were discussed during managers' meetings to inform service improvement.
- Feedback comments included "Just a note to thank you all for the care and kindness you gave to my daughter. It was a tough decision for us as a family to make but the kindness of all the staff made it somewhat easier."

Understanding and involvement of patients and those close to them

- Staff recognised when women needed additional services such as an interpreter to support them to understand about the care and treatment they were to receive. Children under the age of 16 years old were allowed to be accompanied by a parent or carer to ensure that they understood all aspects of care and treatment.
- Where women were responsible for payment of care or treatment a discussion during their initial consultation would take place, informing them of the cost. This discussion took place once the service established the women's eligibility for treatment; it was carried out in a private room and handled sensitively.
- Patients were not informed about the statutory requirement of HSA4 forms. Staff did not explain to patients that these details were sent to the Department of Health and that it was a legal requirement.
- Women were given the opportunity to make an informed choice about all available ToP methods during the initial assessment, the risks were discussed with the consultant and women were asked to sign a form to declare they understood the implications.

Termination of pregnancy

- Staff provided patients with information leaflets relating to the different procedures. This meant patients could take information away with them to consider and inform their decision making. Women who had telephone based consultations were directed to the services website. Prior to discharge, patients were given advice and written information about potential postoperative care and possible complications. They also advised patients of the 24 hour telephone support service that the service provides.

Emotional support

- Staff demonstrated that they understood the importance of providing women with emotional support. We observed staff providing reassurance to women who were anxious.
- A routine counselling service was available to women pre and post abortion. A counsellor was always on site if and when women required their services.
- We observed one patient leaving the service at the time of our inspection thanking a nurse for all their support.

Are termination of pregnancy services responsive?

- The service was planned and delivered to meet the needs of patients. The service provided a 24 hour telephone advice/help line that patients could use for information, support, or post-operative concerns.
- People were able to access services in a timely manner and the service was performing within the recommended target timeframe of ten days from contact to treatment. The service accepted self-referrals from patients as well as referrals from other professionals.
- People were given information how to complain and raise concerns and the service responded to complaints.

However;

- Outcomes and actions from complaints were not clear and there was no robust system in place to share learning from complaints with staff.
- The facilities available compromised patients' dignity at times as we observed overcrowded wards where all patients were not offered privacy.
- Patients were not routinely given information about the disposal of pregnancy remains and options that were available unless the patient raised the matter directly.

Service planning and delivery to meet the needs of local people

- The service was provided from Department of Health approved premises. The service clearly displayed the certificate of approval that was issued by the Department of Health on the ground floor at the service entrance.
- The service offered women telephone consultations, this was to help reduce waiting times, improve patient experiences and to help women work around personal circumstances.
- To meet the needs of local people, the service operated six days a week, offering surgical procedures on Thursday and Saturdays. Senior staff advised this was so working women could attend appointments at the weekend and have time to recover before Monday.
- We reviewed minutes from meetings with commissioners to plan the service according to needs of the patients across Greater Manchester. For example, in February 2016, HIV and syphilis screening was discussed with commissioners and it was decided that it was important to offer women this test. The service was in the process of adding this to their screening tariff and adding it to their key performance indicators (KPIs).
- The service actively sought ways to improve. We reviewed, an action plan detailing agenda items from the January 2016 quality and performance meeting. Agenda items included reviewing and updating the KPI data. Data on contraception uptake was collated and presented as an overall percentage to commissioners, however it was deemed more useful to divide the data into what contraception method women left with so that it was reflective. For example, recording the number of women who left with LARC was better than recording the percentage LARC uptake across the service.
- Consulting rooms were for single consultations and were used to speak to women privately.
- The service had a female doctor onsite for consultations but they could not offer women a female surgeon to perform the surgical abortion. However, we were informed at the time of inspection that the service was in the process of recruiting a female surgeon
- The theatre and recovery area was dated; we noted general deterioration of doors and windows. The

management team were aware of the general need for redecoration and the flooring had been replaced in January 2016, although this was not identified on the service risk register.

Access and flow

- Data provided by the service showed the average waiting times for a consultation from initial contact was one day. This was within recommended timeframes from the Royal College of Obstetricians and Gynaecologists (RCOG) which indicate that women should not be waiting more than five working days for a consultant from the first day of contact.
- Key performance data showed the average waiting times for a ToP between January and December 2015 was six days from initial contact; this was within RCOG guidance which indicates that a woman should not be waiting more than ten days.
- Between January and December 2015, 74% women were treated within 10 working days of initial contact. The service reported three reasons to why 26% of women were not treated within 10 working days; 20% of women they treated were from another country and needed to confirm travel arrangements, other women had childcare issues and lastly some women presented too early as a result of modern pregnancy tests and they were unable to confirm an intrauterine pregnancy and gestational age.
- Opening hours and clinics were run to ensure the minimum of delay to patients in the consultation process, and to enable access to same day treatment. SMPC recorded the date the clients made contact with the service. Any delay in appointment dates were due to patient choice. The service ran reports of patient waiting times. If a client attended and following an ultrasound scan was determined to be at an inappropriate gestation period, then the client was re-booked to return to the service for a further ultrasound scan within seven to 14 days. At this time the patient was advised of treatment options.
- The service received women from a variety of referral methods; these included GPs, hospitals, family planning service, intranet, self-referrals and recommendations. The service collected data on the different referral methods across areas of Manchester and used the information to inform commissioners of their regional referral rates. For example, in January 2016, the service received 42% of their referrals from GP's in Salford and 49% of women from south Manchester found out about the service from the internet.
- A 24 hour telephone line was available if a patient deteriorated outside service opening hours. In the event a patient deteriorated, nurses assessed the patient over the phone and gave advice or offered an appointment with a consultant. Appointments with a consultant were available seven days a week. In the case of an emergency, patients were advised to go to A&E.

Meeting people's individual needs

- The service had processes in place to manage the specific needs of women who sought an abortion for fetal abnormality. The service offered women counselling and a discussion about the options of burial services. However we did not see any information about referring women to specialist services as per Royal College of Gynaecology guidance 14.
- If an ectopic pregnancy was detected, women were referred to a local NHS hospital.
- We did not see any evidence that patients were routinely given information in relation disposal of pregnancy remains. However, at the time of our inspection the service was in the process of setting up a service level agreement with a funeral director that was able to offer single cremation for patients opting to choose this service.
- The waiting room on the top floor was small and cramped. Supporters of patients were asked to wait on the ground floor because seating was limited.
- At the time of our inspection, all beds in the Rose room were occupied with patients waiting to have surgery, plus there were an additional two patients dressed in theatre gowns, with bare feet, sat on two chairs placed either side of the nurses desk. This could compromise patients' dignity and privacy as there was no facility to provide them with private space should they require it. Due to the overcrowding in this ward at this time, confidentiality could also be compromised.
- We observed one chair in the corridor between the rose room and the theatre. At the time of our inspection we did not see anyone occupy the chair; however, a nurse told us that patients were brought to the chair from other wards whilst they were waiting to be taken into theatre.

Termination of pregnancy

- The service could be accessed on the ground floor level to the rear of the building, by patients who had mobility difficulties and all care could be provided on this level. This level contained a ward and the theatres. However it was unclear how patients were managed if the ward was full and lifts were out of access or deemed unsafe to use. The service only had one lift in the building.
- The team had access to translation support services if required. An interpreter was allowed to stay with the patient if they did not speak English.
- Women who used the service had access to a dedicated team of nurses available 24 hours a day, seven days a week, 365 days a year. The team provided telephone consultations, counselling and after care telephone support.
- Women were offered information leaflets relating to the different procedures after their consultation.
- We observed patients being given packs which contained information of the 24 hour telephone service, condoms, antibiotics, and a pregnancy test.

Learning from complaints and concerns

- Patients and supporters were able to raise their concerns through a number of ways, women were able to telephone the service, speak to a member of staff, or write to the service formally.
- Posters were displayed in the waiting rooms to advise and encourage women to speak directly to a member of staff with any concerns or complaints they had during their consultation, procedure or post-operative care.
- The service received five complaints or concerns between January 2015 and January 2016; all patients received a letter from the service, which addressed the concerns they had raised.
- It was evident that the service acted upon complaints they received by formally writing to women and there was evidence that action had been taken following patient complaints to improve service delivery. However, we found there was a reoccurrence of women complaining about staff attitude and that the information they received in response to their complaint, was confusing and not explained properly. From the meeting minutes we reviewed, it was not clear whether this had been identified as an issue or if action had been taken. Similarly, this was not identified as an area for improvement during our interviews with the management team.

Are termination of pregnancy services well-led?

- The service had a client philosophy however staff we spoke with were unaware of this at the time of our inspection. It was clear the management team were committed to improving governance processes but systems were not yet embedded and further work was still required.
- The service had a risk register in place. This was a relatively new document developed following a review of the governance systems in place. The register identified the majority of issues we found whilst on inspection. Although some issues such as access to chlamydia screening in line with RSOP 13, maintenance of environment and access to theatre and recovery areas were not included. Each identified risk had an identified control measure(s) and a responsible person. However, although there was a date included next to each risk (January 2016), this was the date the risk had been added but there was no identified date for review or completion.
- Whilst the registered manager and head of clinical services could clearly articulate the vision for the service there was no clearly defined and documented strategy in place.
- The service produced a location specific quality report each month. The registered manager was responsible for compiling the report which was then sent to the head of clinical services and discussed at the monthly managers' meetings. The report was then escalated up the provider's Board.
- Learning from audits, incidents and manager meetings should have been cascaded via team meetings. However, due to service demand and the use of bank and agency staff, team meetings did not happen regularly. The management team had recognised this issue and as a result had developed a newsletter that was sent out with monthly payslips. The first edition had been issued in January 2016 and so it was not yet fully embedded at the time of our inspection.

However;

Termination of pregnancy

- There were robust systems in place to ensure the service adhered to the Abortion Act 1967 which included two certificates of medical opinion, HSA1 forms signed by two practitioners prior to abortion and recorded with the Department of Health.
- The service had employed a consultant clinical governance manager to review clinical governance processes in place and identify areas for improvement. The registered manager and head of clinical services were knowledgeable about the service and were aware of the risks and challenges within the service. At the time of inspection, the team were reviewing the action required to improve quality and governance systems following the governance preliminary inspection in November 2015.
- Staff were supported to learn new skills.

Vision and strategy for this this core service

- The service had a client philosophy; this was to "provide quality, safe and affordable service in accordance with professional standards to both NHS and private clients for TOP, sterilisation and vasectomy". However, staff we spoke with were unaware of the philosophy.
- Whilst the registered manager and head of clinical services could clearly articulate the vision for the service there was no clearly defined and documented strategy in place. This was particularly important in light of the areas of risk and challenges identified. For example, in relation to staffing, premises and governance processes.
- The service clearly displayed the certificate of approval that was issued by the Department of Health on the ground floor at the service entrance.

Governance, risk management and quality measurement for this core service

- The service had robust processes in place to ensure that abortions followed the Abortion Act 1967. The HSA1 form was completed, signed, and dated by two registered medical practitioners before an abortion took place. The reason for a patient's decision for termination of pregnancy was assessed against the criteria set out in the Abortion Act 1967. The HSA1 was completed by both practitioners certifying their opinion. The certification takes place in light of their clinical judgement of the circumstances of the pregnant woman's individual case. The form contained the full address of the place at which the patient was seen or examined. All HSA1 forms were stored with the patient's record in line with best practice guidance. Patients were made aware that the procedure was free on the NHS. Overseas patients were asked for a fee after consent from two doctors was obtained.
- All the surgical records we reviewed had a certificate of opinion (HSA1) which was signed by two medical practitioners in line with the requirements of the Abortion Act (1967) and associated regulations.
- The service kept a comprehensive record of each HSA4 reference number and the date it was sent to the Department of Health. The records showed this information was sent to the Department of Health within 14 days.
- The registered medical consultant maintained responsibility for the patient and prescribed all abortion medication.
- A register of women undergoing a TOP was updated and completed; this was kept onsite for three years. The service held an electronic record of the number of TOPs they performed, this was updated on to a central database and password protected.
- The service had employed a consultant clinical governance manager to review clinical governance processes in place and identify areas for improvement. On 12 to 14 November 2015, the governance manager carried out a preliminary inspection using the CQC's five key questions. The subsequent inspection report noted that safeguarding knowledge amongst staff was good and staff were compassionate and dedicated. Infection control practices were described as being "generally good" and theatre and anaesthetic services were found to be good with both staff and patients feeing well supported.
- The report also identified a number of areas for improvement including: themes and trends from incidents should be collated, analysed and reported on to aid quality improvement, service development and enhanced learning; repair and maintenance of the lift; improve completion of VTE assessments and 5 safer steps to surgery checklist; formulate a whistleblowing policy and a duty of candour policy. At the time of our inspection, some progress had been made with the areas identified (such as the management of controlled drugs). However, this progress appeared to be limited and several of the issues identified in November 2015 were still evident during our inspection in February

2016. It was clear the management team were committed to improving governance processes but systems were not yet embedded and further work was still required.

- A management meeting was held each month to discuss governance matters such as incidents (and trends across the region), audits, operational issues and information governance issues. This was attended by the service managers from across the region but there was no other multidisciplinary attendance.
- Learning from these meetings should have been cascaded via team meetings. However, due to service demand and the use of bank and agency staff, team meetings did not happen regularly. We reviewed the managers meeting minutes from October 2015; agenda items included incidents and safeguarding. Actions identified included that learning was to be shared with staff and that team meetings should be taking place with minutes of meetings available to staff using notice boards. We did not see such minutes available during our inspection and staff confirmed that regular team meetings were a challenge. The management team had recognised this issue and as a result had developed a newsletter that was sent out with monthly payslips. The first edition had been issued in January 2016 and so it was not yet fully embedded at the time of our inspection.
- The service produced a location specific quality report each month which included details of monthly activity, patient feedback analysis, sexual health and LARC screening uptake, mandatory training figures, incidents, complaints and waiting times. The registered manager was responsible for compiling the report which was then sent to the head of clinical services and discussed at the monthly managers' meetings. The report was then escalated up the provider's Board.
- A medical advisory committee (MAC) met quarterly. The meetings were chaired by the medical director and were attended by the surgeons within the region, the registered manager, the head of clinical services and the governance manager. The MAC's role was to review any changes to best practice guidance, clinical incidents, audit findings and any changes to clinical process or policy.
- We reviewed minutes from the MAC meeting held in December 2015; agenda items included serious incidents; staff training, the completion of VTE risk assessments and review of the early medical abortion policy. However, attendance of medical/surgical staff at the meeting was poor with only three out of six medical/surgical staff attending.
- 80 to 85% of the treatments carried out by the service were for NHS patients. As a result, there were arrangements in place with commissioners that identified locally agreed standards, and performance against standards was audited. The service met with commissioners on a quarterly basis to discuss performance and review service provision.
- However, whilst the recommended data was collated in relation to service delivery, there was no clear, robust clinical audit process or clinical audit plan in place to routinely and continuously monitor and improve patient outcomes. For example, the number of previous terminations and the uptake of LARC.
- Practising privileges were reviewed by the medical director, registered manager and head of HR. The service linked with the surgeons' base NHS trust to discuss revalidation and any concerns with practice. Similarly if the service had any concerns with a surgeon's practice the medical director would contact the surgeon's responsible officer directly to discuss.
- The head of HR confirmed that surgeons were contacted prior to renewal of practising privileges (or before any documents such as GMC registration or indemnity insurance) expired requesting up to date copies of all documentation. If documents were not received, this would be escalated to the medical director and head of clinical services that would then speak with the individual and notify the registered manager. If necessary, practising privileges would be suspended until all relevant documentation was received.
- The service had a risk register in place. This was a relatively new document that had been identified as being required by the consultant clinical governance manager. The register identified the majority of issues we found whilst on inspection. Although some issues such as maintenance of environment and access to theatre and recovery areas were not included. Each risk had an identified control measure(s) and a responsible person. However, although there was a date included next to each risk (January 2016) it was not clear if this was the date the risk had been added, the date it had been reviewed or the date the action was due for completion.

Termination of pregnancy

- Screening for chlamydia was only offered to patients under the age of 25 years; this was not in accordance with RSOP 13. However, we did not see this issue identified on the risk register or how this inequity of service was being managed.
- The service checked that staff held Indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014. We reviewed three employment records which held certificates of insurance.

Leadership / culture of service

- We reviewed employee information that showed the service had followed the 'fit and proper person' regulations.
- The registered manager and head of clinical services were knowledgeable about the service and were aware of the risks and challenges within the service. At the time of inspection, the team were reviewing the action required to improve quality and governance systems following the governance preliminary inspection in November 2015.
- The management team were visible and accessible to staff throughout the service.
- There was an audit of the operating theatre services in February 2016. The audit should be completed annually but the last previous audit was performed in 2012. The overall score across all sections and standards was 85% (rated as 'average'). This was a significant reduction to the score in 2012 which was 92% (rated as 'good'). This had not been identified as a risk on the service risk register.
- There was a lack of day to day clinical leadership in theatres due to the lack of continuity of nursing staff and this was identified within the theatre services audit as a potential negative effect on the continuation of good clinical standards. The healthcare assistants within theatre that had worked there a long time were relied upon to alert the team of things that need to be done; however, their level of role was not accountable for the service.
- There was a lack of clear process for staff to raise concerns. The development of a whistleblowing policy had been identified as a required action in the November 2015 'Preliminary inspection' report but there was no specified date for completion. The organisation had a 'Public Interest Disclosure' policy that included guidance on how to raise whistleblowing concerns but none of the staff we spoke with were aware of this guidance or referred to this policy.
- Staff we spoke with enjoyed their job and were compassionate and proud of the care they gave.

Public and staff engagement

- The service routinely engaged with patients to gain feedback about how they could improve their service. Feedback sheets were left at bedsides for patients to complete. Feedback forms and comments were reviewed as part of the managers' meetings and was used to inform service development.
- Staff had been asked to participate in a staff survey in 2015. The results for the provider as a whole were generally positive with all staff that responded (89 in total) saying they would recommend the organisation's service to a family member or friend. The results however, were not broken down to service level so it was not clear how South Manchester Private Clinic had performed specifically.

Innovation, improvement and sustainability

- Senior managers were proactively offering staff opportunities to continually learn new skills. For example nurses had the opportunity to complete sonography courses to assist with scanning.
- Senior managers had identified the overall location and standard of the building could be improved. At the time of inspection, the possibility of relocating the service to a more central location with newer facilities was being explored.

Outstanding practice and areas for improvement

Outstanding practice

The service proactively provided all clients with a pregnancy test to encourage them to repeat a pregnancy test within an agreed timeframe. This was further followed up by an aftercare call 4.5 weeks post procedure. This was to ensure women who did not return for a post-operative check up were following all advice and not experiencing any adverse effects or symptoms that could indicate post operative infection or an on-going pregnancy.

Areas for improvement

Action the provider MUST take to improve

- There is a robust incident reporting system whereby staff are fully aware of their roles and responsibilities in relation to incident reporting.
- There is a recognised process or tool to identify and escalate the deteriorating patient following surgery and that there is a clear process for the hand over of information between staff from theatre to recovery to ensure patient care information is clearly communicated to all relevant staff.
- That a VTE risk assessment is completed for all patients prior to treatment in line with NICE practice guidance.
- The 5 steps to safer surgery checklist is completed for all surgical patients.
- There is appropriate access to suitable resuscitation equipment throughout the service at all times.
- There is a process to ensure staff remain competent in the use of any equipment relevant to their role.
- Staff adhere to infection control guidelines in relation to hand hygiene and the storage and handling of laundry.

Action the provider SHOULD take to improve

The provider should:

- Continue work around the development of the staff newsletter to ensure that robust processes are in place to learn from incidents and share learning with staff.
- Work with commissioners to ensure sexually transmitted infection screening services are provided in line with RSOP 13.
- Ensure there are clear, robust and embedded processes in place so that access to clinical areas is secure.
- Ensure patient's privacy is respected at all times.
- Develop systems to ensure learning and improvement from complaints.
- Adhere to best practice guidelines and policies to ensure patients are provided with clear information regarding the disposal of pregnancy remains.
- Outcome data is audited and applied to identify and understand issues and drive service improvement.
- Improve staff awareness of their role should a major incident occur.
- Ensure all areas of the service, including the Rose room are staffed appropriately at all times in line with identified requirements and patient need.
- Review the measures in place to ensure there is a robust embedded system to restrict access to controlled areas throughout the premises.

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
Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (a) (b) (c) (e) (h) HSCA (Regulated Activities) Regulations 2014 Safe care and treatment The provider did not always ensure care and treatment is provided in a safe way for service users by assessing the risks to the health and safety of service users of receiving the care or treatment, and doing all that is reasonably practicable to mitigate any such risks This is because; There was no robust process to identify and escalate the deteriorating patient following surgery; VTE risk assessments were not completed for all patients prior to treatment in line with best practice guidance; The 5 steps to safer surgery checklist was not completed for all surgical patients; Access to resuscitation equipment was compromised in some areas of the service and there was no evidence that this situation had been risk assessed; Medical and electronic equipment on the daffodil ward and on the assessment floor had not been maintenance checked and were not labelled; Staff did not always adhere to infection control guidelines in relation to hand hygiene and the storage and handling of laundry; There was no robust system in place to monitor and re-assess staff competencies; There was no robust hand over system in place between theatre and recovery ward staff to ensure patient care information was shared with all relevant staff.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (b) (f) HSCA (Regulated Activities) Regulations 2014 Good governance The provider did not always ensure there are robust systems in place to assess, monitor and mitigate the risks relating to health and safety of service users. This is because; Incidents were not always reported appropriately and we were not assured that staff fully understood their role and responsibilities in relation to reporting of incidents; Whilst the recommended data was collated in relation to service delivery in line with RSOP 16, the service was not routinely auditing and applying the data to identify and understand issues and then drive service improvement; Identified actions to improve quality and safety within the service were not always completed in a timely manner.