

The policing of abortion services in England

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INTRODUCTION

In 2012, abortion services in England came under intensive scrutiny, with the Care Quality Commission (CQC) conducting synchronised inspections of all abortion providers. In the light of some procedural irregularities that were found, doctors and nurses were reported to their professional bodies. A team set up by the Metropolitan Police continues to investigate possible criminal activities. This article examines the laws that may have been infringed, what brought about this reaction, the detailed findings, whether or not the inspections were justified and their knock-on effects, and ends with some proposals on what should happen next. It may be concluded that rather than contributing to an improvement in abortion services, this inspection process has undermined some positive developments.

BACKGROUND

More than 30 Western European countries allow abortion without restriction as to reason.¹ British abortion law with its socio-economic grounds² is more restrictive; it has requirements for medical approval and for notification.

The law on abortion is the same in England and Wales, but is different in Scotland and very different in Northern Ireland.³ However, the regulation of abortion is different in England and Wales, with English services overseen by the Department of Health (DH) and Welsh services overseen by the Welsh Assembly. Abortion providers in Wales were not subject to any targeted inspections in 2012.

The remainder of this article will therefore address the situation in England only. It is set in the context of an ambivalent Conservative-Liberal Democrat coalition government whose approach has been described as one of 'abortion pragmatism'.⁴ A policy that supports improving access to abortion sits alongside a politics estranged from the idea of reproductive choice.

THE LEGAL SITUATION SINCE 1967

The Abortion Act 1967 brought an end to the serious medical and social problem of 'backstreet abortion'.⁵ It was amended by the Human Fertilisation and Embryology Act 1990, which imposed a statutorily defined 24-week gestation limit and allowed selective reduction of multiple pregnancy. Until the enactment of David Steel's Bill in 1968, abortion had been largely illegal (Offences Against the Person Act 1861) or legal only to save the life of the mother [Infant Life (Preservation) Act 1929]. The 1861 Act refers to the unlawful administration of any poison or other noxious thing or use of an instrument or other means with intent to procure a miscarriage. Before 1968, it was not clear in what circumstances abortion was lawful; the Aleck Bourne case⁶ was the main case law being followed. In *R v Bourne* in 1938, the jury was directed to accept as lawful a situation in which a doctor believed in good faith that continuation of the pregnancy would cause the woman to become a "physical and mental wreck".

The Abortion Act 1967 renders lawful doctors' conduct that would otherwise be unlawful under the 1861 and 1929 Acts.⁷ The Abortion Act is widely drafted, giving doctors a broad margin of discretion in assessing a woman's request for abortion.⁸ In assessing any risk to the health of the woman or any of her existing children, account may be taken of the woman's actual or reasonably foreseeable environment. Since 1986, only one successful prosecution has been brought against a doctor for not forming in good faith an opinion about the need for abortion.⁹ In this case the sum total of the records of the doctor's assessment of his 19-year-old patient was: "No illness: not pregnant before: mother knows: unwilling to marry: depressed". The jury in 1973 felt that this was inadequate.

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REGULATIONS SURROUNDING THE LAW

The premises used for abortion must be either a hospital vested in the Secretary of State, a National Health Service (NHS) Trust, Primary Care Trust or NHS Foundation Trust, or an approved independent sector clinic. Registration of all premises is now obtained from the CQC. Abortion is prescribed as a regulated activity under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Schedule 1 No. 12. Since 2009, NHS providers as well as independent providers have been subject to inspection by the CQC. The Care Quality Commission (Registration) Regulations 2009, Regulation 20, requires that the registered person must ensure that abortions are not carried out unless there are two certificated opinions, reached in good faith before the treatment commences. The two doctors giving these opinions both sign the HSA1 form (see next section). Only clinics that are registered with the CQC to perform abortion as a regulated activity will be approved by the Secretary of State for Health. The independent sector has long experience of being inspected; the NHS is relatively naïve in this respect.

HSA1 AND HSA4 FORMS

The Abortion Act 1967 requires that two registered medical practitioners give their opinion, formed in good faith, that the woman's ground for abortion fulfils one or more of the grounds set out in Section 1 of the Act. The ground under which an abortion is legally sanctioned is Ground C in 98% of cases:¹⁰ that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman. Interestingly, the Regulations do not require either of the practitioners to see the patient or to examine the notes.^{11 12}

The Abortion Act 1967 lays down that the Secretary of State for Health shall by statutory instrument make regulations to provide for certification of an abortion. The Abortion (Amendment) Regulations 1976 and the Abortion (Amendment) (England) Regulations 2002 specify that the form must state:

- ▶ the full name and address of each doctor;
- ▶ the full name and address of the pregnant woman;
- ▶ whether or not each doctor has seen, or seen and examined, the pregnant woman;
- ▶ that each doctor is of the opinion formed in good faith that at least one and the same ground is fulfilled;
- ▶ that the certificate of opinion is given before the commencement of the treatment for the abortion to which it refers and relates to the circumstances of the pregnant woman's individual case.

The HSA1 form must be kept for a period of at least 3 years. The form, as designed at present (last revised in 1991), also requires the doctors' qualifications to be included.

The Abortion Act requires that all abortions are notified to the Chief Medical Officer within 14 days

of the procedure being completed. The current form for this purpose is HSA4 (last revised in 2006). Part 6 of this form is for recording the ground(s) ringed on form HSA1. For Ground C, there is a box to state whether or not there was a risk to the woman's mental health. If there is not, the doctor is required to state the main medical condition. The DH monitors abortions mainly through scrutiny of HSA4 forms.

SCIENTIFIC AND SERVICE DEVELOPMENT WITHOUT ASSOCIATED ADMINISTRATIVE MODIFICATIONS

The 1967 Act pre-dates the development of medical abortion using modern, effective and safe drugs, which started in the 1980s. Medical abortion avoids the need for surgery and anaesthesia. There has been a gradual increase in availability of medical methods of abortion throughout Great Britain, with 47% of all abortions now being performed medically in England and Wales¹⁰ and 74% in Scotland.¹³

The National Strategy for Sexual Health and HIV^{14–16} supported the commitment to tackling inequalities in access to abortion. There was evidence of wide geographical variation in access to NHS abortion services and to the methods available, together with delays in appointments for assessment of up to 4 or 5 weeks in some parts of the country. Delays in accessing abortion cause distress to women and increase the risks of both morbidity and mortality from the procedure.¹⁷ Such delays have serious implications for vulnerable groups such as pregnant teenagers, who tend to seek professional advice later than older women do.¹⁸ There is also a financial benefit to the NHS in that reducing abortion waiting times allows more women to have less costly early gestation procedures, with accrued savings estimated at up to £30 million per year.¹⁹

To that end, in 2001 the DH set a performance indicator for abortion as part of the NHS performance ratings for Primary Care Trusts in England and Wales. This indicator is the proportion of NHS-funded abortions performed at under 10 weeks' gestation. Substantial amounts of central funds were made available to Trusts to apply for abortion service development; it appears that this money was well spent. There has been a significant trend towards performing abortions at earlier gestations in recent years, the indicator rising from 51% in 2002 to 76% in 2010²⁰ and further to 78% in 2011.¹⁰ There is also clear evidence that the variation in access is becoming narrower.

Amongst the DH and local commissioners there has been a considerable push to modernise abortion services in order to improve early access and to give greater choice to women. One of the initiatives developed has been that of direct access, allowing self-referral without a general practitioner letter or a first HSA1 signature;²¹ this contributes to the reduction in delays before assessment. Many early medical abortion services are now

nurse-led.⁷ Such services are part of Government policy.²² They allow doctors to be off-site during a clinic and to give their opinion remotely; as their associated staffing costs are less they allow for a lower-cost service without loss of quality or reduction in safety.

The House of Commons Science and Technology Committee recommended in 2007 that nurses and midwives be able to prescribe mifepristone and misoprostol for abortion and to sign the HSA1 forms.¹¹ However, Parliament was denied the opportunity to take a view on the various liberalising amendments that Members of Parliament (MPs) had tabled on the law on abortion when the Human Fertilisation and Embryology Bill was being passed into law in 2008. The Government changed the order of debate and imposed a guillotine motion, thus removing any possibility of reform.

Despite all these changes, it remains the case that abortion is an approved health care intervention that is governed by a criminal law drafted 152 years ago and an abortion law drafted 46 years ago. English abortion law is now archaic, over-medicalised and out of step with scientific progress.⁷

THE RISK OF CHILDBIRTH VS THE RISK OF ABORTION

Data from the USA show that the risk of death associated with childbirth is about 14 times higher than with abortion.²³ Using statistics from the UK triennial Confidential Enquiries into Maternal Deaths,²⁴ Table 1 shows that the risk of death associated with childbirth in Britain is about 18 times higher than with abortion.

As the risk to a woman's life is statistically less if she has her pregnancy terminated than if she goes to term, it can be argued that the Abortion Act allows abortion for every pregnant woman. Lawyers call this the statistical argument.²⁵

In 1981, several doctors were referred to the Director of Public Prosecutions because they had failed to give details of the 'main medical condition' by failing to complete the box on the HSA4 form required by the Regulations to be sent to the DH after every abortion. Following police investigations, the Attorney General announced that in all cases there

were medical reasons for the abortions. This included a case of Professor Peter Huntingford's, where he had filled in the HSA4 box as "None", according to his usual practice. Professor Huntingford was of the view that the medical condition was the pregnancy itself and that statistically it would always be safer for the woman for her pregnancy to be terminated.²⁵ It is likely that many doctors nowadays apply this fact when they are considering requests for abortion. However, the HSA4 form insists on a main medical condition being recorded unless there is an affirmation that there is risk to the woman's mental health.

HOUSE OF COMMONS SCIENCE AND TECHNOLOGY COMMITTEE REPORT 2007

In 2005, the House of Commons Science and Technology Committee recommended that a joint committee of both House of Commons and House of Lords be formed to consider the scientific, medical and social changes in relation to abortion that had taken place since 1967.¹¹ As this did not materialise, the Committee decided to undertake this task itself. Evidence was taken in 2007 by the Committee of eleven MPs, chaired by Mr Phil Willis.

Dr Vincent Argent made oral and written submissions to the Committee that the HSA1 form "is often considered to be just an administrative process where doctors make no attempt to form an opinion, in good faith, that the patient fulfils the grounds for an abortion".¹¹ He reported that he had witnessed practices that included:

- ▶ signing batches of forms before patients are even seen for consultation;
- ▶ signing the forms with no knowledge of the particular patient;
- ▶ signing forms after the abortion had been performed;
- ▶ faxing the forms to other locations for signature;
- ▶ use of signature stamps without a consultation.

The Committee reported that if requests for abortion were being 'rubber stamped' by doctors, either the requirement for two signatures did not play a meaningful role in abortion practice or the law was not being properly applied.¹¹ It is noteworthy that following this very public declaration by Dr Argent, no individual doctors or service providers were pursued or investigated by any regulatory body:

Table 1 Relative mortality from childbirth and abortion in the UK

| Triennium | Maternities (n) | Direct deaths (n) | Rate per 100 000 | Abortions (n) | Deaths (n) | Rate per 100 000 |
|------------------|------------------|-------------------|------------------|------------------|------------|------------------|
| 1997–1999 | 2 123 614 | 106 | 5.0 | 550 398 | 2 | 0.36 |
| 2000–2002 | 1 997 472 | 106 | 5.3 | 557 034 | 2 | 0.35 |
| 2003–2005 | 2 114 004 | 132 | 6.2 | 579 511 | 1 | 0.17 |
| 2006–2008 | 2 291 493 | 107 | 4.7 | 608 929 | 2 | 0.32 |
| 1997–2008 | 8 526 583 | 451 | 5.3 | 2 295 872 | 7 | 0.30 |

Data sources: *The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*²⁴ and *Abortion Statistics: England and Wales: 2011*.¹⁰

neither the police regarding criminal offences, nor the DH, nor the General Medical Council (GMC), nor the Health Care Commission (as the CQC then was).

The conclusion of the Committee on this issue was that there was no evidence that the requirement for two doctors' signatures serves to safeguard women or doctors in any meaningful way, or serves any other purpose.¹¹ Quite the opposite: the requirement contributes to delays in access to abortion services; this runs contrary to the Government's pursuance of its policy to increase the ratio of early to late abortions and to reduce waiting times. Professional bodies expressing concern over delays in women accessing abortion included the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing and the British Medical Association. Professor Sally Sheldon gave evidence that the requirement for two doctors' signatures runs counter to the concept of patient autonomy. The Committee recommended that the requirement for two doctors' signatures be removed. It was unfortunate that this proposed change was not passed into law, as this cumbersome and unnecessary paperwork adds no benefit for women.

Up to March 2012, a situation had developed where, in the light of a lack of prosecutions and lack of criticism from the Health Care Commission and its successor the CQC, abortion providers had concentrated on providing safer and higher quality services with better access^{17 20} and had adapted their administrative procedures to achieve these improvements. Some degree of flexibility in signing HSA1 forms had become widespread, especially in the NHS where there are fewer available doctors willing to be a signatory. As a result of these changes, many services achieved a situation in which waiting times had been reduced and procedures were being performed at earlier gestations with a resultant improvement in both safety and quality. The concept of pre-signing of HSA1 forms evolved from the desire to improve responsiveness and reduce delays. Much of the pressure to reduce delays had come from service managers as their response to DH initiatives. A senior barrister has postulated that the practice of nurses obtaining the opinion of two doctors working off-site is not illegal.²⁶

CQC INSPECTIONS OF ENGLISH ABORTION PROVIDERS

In February 2012, the *Daily Telegraph* newspaper conducted a 'sting' operation in relation to nine pre-selected abortion services.²⁷ Four pregnant women recruited through modelling agencies and who had undergone briefing sessions went into these services with hidden cameras, requesting abortions on the ground of not wanting a female baby. There was extensive media coverage, most of it critical of the abortion services ensnared by this operation. Following the newspaper reports, the Health Secretary ordered the CQC to inspect the clinics suspected of performing abortions on the ground of gender selection. The police are

investigating this and the GMC has either suspended or taken action against three doctors, whose careers hang in the balance while the investigations continue. The Nursing and Midwifery Council (NMC) is also carrying out investigations.

The following month, during the week of 19 March 2012, the CQC conducted a 'targeted inspection programme' of all 249 English abortion services, focusing on the use of HSA1 forms.²⁸ Unannounced inspections were carried out on CQC outcome 21: 'People's personal records, including medical records, should be accurate and kept safe and confidential'.²⁹ It seems that the *Daily Telegraph* exposé triggered inspections that were searching for more minor procedural irregularities that had been uncovered during the gender selection inspections.

Fourteen NHS Trusts were found to be using pre-signed HSA1 forms. No charitable independent sector service was found to be pre-signing. There was evidence in some services of photocopying of signatures as well. The CQC did not find evidence that any women had poor care outcomes at any of these locations. Further CQC investigations following an inspection revealed evidence of pre-signing at a private clinic.¹²

Those providers who were pre-signing forms all had written reports of the inspection sent to them with the following wording:

"The registered provider failed to ensure that people were protected against risks of unsafe or inappropriate care and treatment. There was a lack of proper information about people in so far as certificates of opinion, required as part of the management of the regulated activity of termination of pregnancy, were not properly maintained".

This judgement about the medical records was graded as a 'moderate concern'. A moderate concern is defined by the CQC as "people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this". The nature of the negative impact of use of pre-signed forms on the 'health and wellbeing' of the women who had abortions under the care of these providers has yet to be explained.

The 14 NHS providers were asked to send the CQC a report within 28 days, setting out the action that they proposed to take to improve their practices. This report was requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The CQC stated that it will monitor the proposed improvements. It also stated that it had shared its concerns with the GMC.

Some abortion service providers who were operating a pre-signing procedure referred the matter to their local Police Force for investigation. All Chief Constables were alerted to this practice and were asked to contact an investigation team (Operation

Monto) at the Metropolitan Police Service, led by the head of homicide and serious crime investigations. A 'Gold Group' has been established at which various agencies are represented: DH, CQC, NMC, GMC and the Crown Prosecution Service (CPS).

All doctors working in the services found to be pre-signing were reported to the GMC. All received letters from the GMC asking them to voluntarily cease this practice. Some nurses were also reported to the NMC. Operation Monto has not yet concluded its investigations. The GMC has said that it will await the police investigation findings and any decision by the CPS before considering the matter further.

DISCUSSION

Lord Scarman said in *R v Smith*⁹ that "a great social responsibility is firmly placed by the law upon the shoulders of the medical profession". The wording of the Abortion Act is simple and clear. The doctors taking part in the certification are asked to give their opinion in good faith, taking into account the woman's actual or reasonably foreseeable environment, which includes her individual circumstances and that of any existing children. Whatever pressures are driving her decision-making can be taken into account by the doctor. The reason behind the request for abortion is not part of the legal process. In practice, the woman's history will often have been taken by a nurse specialist and discussed with doctors.

Millions of pounds were spent during 2012 on an unneeded large-scale investigation into abortion services in England. The CQC diverted resources from inspection of health and social care facilities, disrupting their programme of work in order to be able to descend on all abortion providers in England in a matter of a few days so that the providers were not forewarned of the impending inspections. The professional regulators for doctors and nurses have allocated resources to dealing with the fall-out from the CQC swoop. And the police have mounted a large-scale operation, diverting resources away from investigation of homicide, serious crime and child abuse.

The Secretary of State has a legitimate interest in the quality of abortion services. If there were any suggestion of criminal actions in the services named by the *Daily Telegraph* then this would be a matter for the police. The Health Secretary's response to events was heavy-handed and disproportionate. Additionally, the CQC is an independent body that should not be beholden to the DH. It is sad that politically-driven intense regulation is being played out at a time of major financial pressure on limited resources, without any gain for service users.

A possible outcome of the CQC swoop is that in the 14 NHS Trusts that were censured, waiting times may be extended and average gestations at abortion may creep upward. This would be most unfortunate and might truly lead to poor outcomes of care. Another

possible outcome might be lesser use of nurses in abortion care, which would certainly be another retrograde step.

One clear outcome of the CQC investigation is to add to the significant stigma already experienced by abortion services. This has inevitably lowered morale amongst staff. Many professionals involved in abortion care felt truly fearful at the time of the swoop, and some continue to live with the uncertainty of the long-term outcome on their professional lives. Looking towards the future workforce, these events will undoubtedly jeopardise recruitment in a field already struggling with a shortage. It is to be hoped that the police investigation will come to nothing and that clinicians with professional restrictions placed on them will have these lifted.

The next step required is for the DH to provide greater clarity on how it expects abortion services to operate, without issuing unduly restrictive guidance that goes further than the law requires. Consideration should be given to the redesign of the HSA4 form with regard to the grounds for abortion. Clinical staff need to get back to concentrating on doing their jobs to the best of their ability, continuing to place the woman in her distressing situation at the forefront of their attention.

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