BPAS Birmingham Central Clinic

Quality Report

1st Floor
Guildhall Buildings
12 Navigation St
Birmingham
B2 4BT
Tel: 03457 30 40 30
Website: www.bpas.org

Date of inspection visit: 19 May 2016
Date of publication: 27/06/2017

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

Ratings

Overall rating for this location

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BPAS Birmingham Central is part of the national charitable organisation British Pregnancy Advisory Service (BPAS).

The service was registered as a single speciality termination of pregnancy service. BPAS Birmingham Central provided consultations and medical terminations of pregnancy up to 10 weeks gestation. It provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was termination of pregnancy.

We carried out an announced inspection of this service on 19 May 2016 and attended. This formed part of the first wave of inspection of services that provide a termination of pregnancy. This inspection was carried out using the Care Quality Commission's methodology.

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 peoples' needs?
- Is it well-led?

Are services safe at this service

- The service had a culture of safety. Staff reported incidents and incidents were logged, investigated and learned from.
- Quality and safety audits were completed by the clinic and submitted monthly to the regional clinical lead.
- Staff followed procedures in place for good hygiene and control of infection, safe storage and administration of medication, safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping.
- There were sufficient nurses and doctors available to treat patients.
- Staff were aware of their duty of candour responsibility.
- One area of the clinic used solely by staff could not be effectively cleaned for control of infection.

Are services effective at this service

- Treatment was based on up to date good practice and staff followed policies and procedures.
- Managers regularly audited clinical practice to maintain good standards of patient care and continuously improve outcomes for patients.
- Staff were competent, well trained and experienced with access to information systems. They worked collaboratively for the benefit of patients.
- Staff gave patients good information on which to base their decisions and spent time explaining options and procedures.

Summary of findings

- The service did not participate in any relevant local audit programme or peer review to bench mark its outcomes against other similar provider services. The provider told us it took whatever opportunities to bench it was offered by NHS services.
- There was not a clear best interest decision making protocol in practice for women with learning disabilities who may need it or signposting to an independent advocacy service.

Are services caring at this service

- Staff in all roles treated patients and those close to them with kindness and respect and put them at ease.
- Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers.
- Nurses checked along the way that patients were sure of their decision. Additional information and counselling could be offered or the procedure postponed if they were unsure.
- BPAS offered ongoing counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Are services responsive at this service

- The clinic opened six days each week and was situated in the city centre near to transport links.
- Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients.
- Patients were generally offered an appointment within seven calendar days of contact with the service and seen promptly when they arrived at the clinic. Most patients had their procedure within 10 working days of making a decision to proceed.
- Translation services were available and there was a free ongoing counselling service for patients.
- The clinic encouraged patients to give feedback on the service.
- Access to this clinic was difficult for patients with disabilities and means to support patients with a learning disability to understand and give informed consent to procedures were limited.

Are services well led at this service

- Staff were committed to the BPAS vision of women being in control of their fertility.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings.
- Clinic performance was measured through audits and reported on a monthly dashboard to the regional operations director. Action plans were developed for areas that required improvement.
- The clinic was well run by a manager registered with the CQC and staff felt confident about speaking up, learning from incidents and trying out new ways to improve the service. The registered manager had easy access to directors in the organisation for support and advice.
- Staff encouraged patients to give feedback about the service they received and contribute to improving the service.

We saw several areas of good practice including:

Summary of findings

- The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the effectiveness of questions to identify young women who were isolated, at risk of abuse or exploitation.

However, there were also areas in which the provider needs to make improvements.

Importantly, the provider must:

- Ensure that protocols are put into practice for obtaining consent for all patients including access to best interest decisions for those who may lack capacity to consent, including such patients with learning disability.

In addition the provider should:

- Put in place a local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.
- Review the environment of the staff locker room and make improvements where necessary to ensure effective cleaning of the surfaces and floors.
- Consider participating in relevant local or national audit programmes or peer review to bench mark outcomes against other similar provider services.
- Ensure that where patient's consent to simultaneous administration of abortion medication for medical abortions, they are clearly informed this method could increase the risk of failure.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		We have not provided ratings for this service. 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 it provides.

Summary of findings

Contents

Summary of this inspection

Page

Background to BPAS Birmingham Central Clinic 8

Our inspection team 8

How we carried out this inspection 8

Information about BPAS Birmingham Central Clinic 8

The five questions we ask about services and what we found 9

Detailed findings from this inspection

Outstanding practice 26

Areas for improvement 26

Action we have told the provider to take 27

BPAS Birmingham Central Clinic

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to BPAS Birmingham Central Clinic

BPAS Birmingham Central is part of the national charitable organisation British Pregnancy Advisory Service (BPAS). It is situated in central Birmingham very close to New Street rail station.

BPAS Birmingham Central opened originally in 1971. The service was consultation only and patients travelled for treatment. The service has developed over the years and at the time of our inspection was providing consultation and medical abortion treatments up to 10 weeks gestation.

BPAS Birmingham Central provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was termination of pregnancy.

The manager of the service was registered with the CQC and also managed a service for the provider in south Birmingham and in Brierley Hill, West Midlands.

We inspected this service as part of our Comprehensive Inspection programme of acute medical services.

Our inspection team

Our inspection team comprised two CQC Inspectors and we had access by telephone to a Consultant Obstetrician and Gynaecologist.

How we carried out this inspection

Prior to our visit we asked the provider organisation to send us information and data about the service covering the period 2015. During our visit we looked at data for 2016 and we also asked for some additional information after our visit.

We made an announced visit to the service on Thursday 19 May 2016.

We spoke with three patients and followed their treatment pathway. We also spoke with two nurses, reception staff, the registered manager and regional operations director for the service.

We looked at records and looked around the environment of the clinic.

Information about BPAS Birmingham Central Clinic

The clinic opening times were Monday to Saturday with time variations including a late evening on Thursdays. The clinic was not accessible to wheelchair users or easily accessible to people with hearing loss.

The clinic has four screening rooms and three consulting rooms. During 2015 the clinic undertook 1511 medical terminations of pregnancy (representing 96% of all procedures) and 57 surgical terminations of pregnancy representing 4% of all procedures. During that period, one child aged under 13 years old was treated and 14 children aged between 13 and 15 years were treated.

BPAS submitted applications to the CQC for the removal of surgical activity at BPAS Birmingham Central in March 2016 as surgical services were no longer provided at this location.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- We saw the provider had a system in place for staff to report incidents and incidents were logged, investigated and learned from.
- A quality and safety dashboard was in place that was completed by the clinic and submitted monthly through the provider's assurance system to the regional clinical lead.
- Staff followed procedures in place for good hygiene and control of infection, safe storage and administration of medication, safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping.
- There were sufficient nurses and doctors available to treat patients.
- Clinical staff were aware of their duty of candour responsibility.

However we also found:

- The environment in some areas used by staff was old and worn and could not be effectively cleaned.
- There was no formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.

Are services effective?

- Staff provided best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. The organisation was monitoring outcomes from this treatment
- Care and treatment was based on up to date good practice and supported by policies and procedures which underpinned legal requirements. For the most part staff provided care in line with national best practice guidelines.
- Policies were framed and treatment was offered in line with the Royal College of Obstetrician and Gynaecologists guidelines and by required standard operating procedures.
- A clinical advisory group brought together internal and external clinical experts in abortion care to review and advise on clinical guidelines.
- There were systems in place to regularly audit clinical practice and these worked to maintain good standards of patient care and continuously improve outcomes for patients.

Summary of this inspection

- Staff employed at the clinic including doctors, nurses and administrators and receptionists were competent, well trained and experienced. They had access to information systems and worked together, and with staff in local acute hospitals when necessary, for the benefit of patients.
- Operational/clinical policy and procedures for consent to examination and treatment were in place that addressed responsibilities under the Mental Capacity Act 2005. Staff generally gave patients information on which to base their decisions and give informed consent and spent time explaining options and procedures and giving advice on contraception.

However we also found:

- The service did not participate in any relevant local audit programme or peer review to bench mark its outcomes against other similar provider services. The provider told us it believed other services did not do so either as the commissioning market was competitive.
- The use of simultaneous administration of abortifacient drugs for early medical abortion (EMA) is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance and staff did not make sufficiently clear to patients when they consented, this method could increase the risk of failure. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit. This also demonstrates that the process of sharing our concerns during the inspection drives improvement.
- There was not a clear capacity assessment protocol in practice for obtaining consent for all patients, including access to best interest decision for those who may lack capacity to consent, including such patients with learning disability.

Are services caring?

- Staff in all roles treated patients and those close to them with kindness and respect and put them at ease.
- Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers.
- Nurses checked along the way that patients were sure of their decision. Additional information and counselling could be offered or the procedure postponed if they were unsure**.**
- BPAS offered on-going counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Summary of this inspection

Are services responsive?

- The clinic opened six days each week and was situated in the city centre near to transport links.
- Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients.
- Patients were offered an appointment within seven calendar days of contact with the service, seen promptly when they arrived at the clinic and were able to have their procedure within 10 working days of access.
- Translation services were available and there was a free on-going counselling service for patients.
- The clinic encouraged patients to give feedback on the service including making a complaint and the provider used this to improve the service.

Are services well-led?

- Staff were all committed to the BPAS vision of women being in control of their fertility. The service was patient centred and caring.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings. Messages were communicated to staff through email and a team brief.
- Clinic performance was measured through audits and reported on a monthly dashboard to the regional operations director. Action plans were developed for areas that required improvement.
- BPAS conducted annual staff surveys and there was a staff forum. The registered manager reported they had easy access to directors in the organisation for support and advice.
- The clinic was well run by a manager registered with the CQC and staff felt confident about speaking up, learning from incidents and trying out new ways to improve the service.
- Staff encouraged patients to give feedback about the service they received and contribute to improving the service in a range of ways including through social media.
- There were systems in place to ensure the HSA1 forms were fully completed and that HSA4 information was submitted to the Department of Health.

Detailed findings from this inspection

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

BPAS Birmingham Central clinic opened six days each week. It offered medical terminations of pregnancy (up to 10 weeks gestation) together with sexual health screening and contraception advice. It did not provide surgical termination of pregnancy.

It opened Mondays, Tuesdays and Wednesday from 8.15 am to 4.45 pm; Thursdays from 9.30am to 7pm; Fridays 8.15 am to 3.30pm and Saturday mornings from 8.30am to 1pm.

The clinic was staffed by nurse specialists, reception and administration staff. Doctors were present four days per week from 8.15am to 4.15pm and on Saturday from 8.30am to1pm. They were available for telephone advice and for electronic prescribing at other times.

The clinic had four screening rooms, three consulting rooms, a waiting area and reception situated in an office suite in Birmingham City Centre.

Patients could access the service through a national phone service for appointments.

Summary of findings

Staff reported incidents and incidents were logged, investigated and learned from. The quality and safety of the services provided at the clinic were checked regularly by the manager who had to send this information to senior managers and the clinical team which is then reported to the Board who ran the organisation.

Patient's care and treatment was based on up to date good practice and staff followed BPAS policies and procedures that supported legal requirements.

Managers regularly checked clinical practice to maintain good standards of patient care and continuously improve outcomes for patients.

Staff employed at the clinic including doctors, nurses and administrators and receptionists were competent, well trained and experienced.

Staff gave patients good information on which to base their decisions and give informed consent. They spent time explaining options and procedures and giving advice on contraception.

All staff treated patients and those close to them with kindness and respect and put them at ease. Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers**.** Nurses checked along the way that patients were sure of their decision.

A booklet called 'My BPAS Guide' was given to every BPAS patient and BPAS offered on-going counselling support to all patients with patients under 18 years old counselled before treatment as a matter of policy.

Termination of pregnancy

The clinic opened six days each week and was situated in the city centre near to transport links. Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients.

Patients were generally offered an appointment within a few days and treatment within ten working days of making their decision.

The clinic was well run by a manager registered with the CQC and staff were all committed to the BPAS vision of women being in control of their fertility.

There was an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings.

Clinic performance was measured through audits and reported on a monthly dashboard to the regional operations director. Action plans were developed for areas that required improvement.

However we also found:

Access to this clinic was difficult for patients with disabilities. Support offered to patients with a learning disability to understand and give informed consent to procedures or obtain a best interest decision was limited.

It was not made sufficiently clear to patients during consent for EMA that simultaneous administration of the medications carried a higher risk of failure for a patient than having the medications with an interval of 24 hours or more between. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit. This also demonstrates that the process of sharing our concerns during the inspection drives improvement.

Are termination of pregnancy services safe?

Summary:

- We saw the provider had a system in place for staff to report incidents and incidents were logged, investigated and learned from.
- A quality and safety dashboard was in place that was completed by the clinic and submitted monthly through the provider's assurance system to the regional clinical lead.
- Staff followed procedures in place for good hygiene and control of infection, safe storage and administration of medication, safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping.
- There were sufficient nurses and doctors available to treat patients.
- Clinical staff were aware of their duty of candour responsibility.

However we also found:

- The environment in some areas used by staff was old and worn and could not be effectively cleaned.
- There was no formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.

Incidents

- The provider reported no never events, never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- No serious incidents had occurred at this location in the twelve months before our inspection. The last serious reportable incident occurred in February 2015. This was a missed ectopic pregnancy.
- We saw the provider had a system in place for staff to report all incidents through their line manager. The registered manager for the service was responsible for

ensuring reported incidents were investigated and learned from. The provider used a paper based incident reporting form. These paper forms were then scanned and sent by email to the clinical team..

- We tracked a serious incident reported in February 2015 and noted from a range of records the incident was investigated, lessons learned and discussed at regional quality governance forum level and local team level.
- Action was identified and planned with timescales for achieving improved practice including reviewing the ectopic pregnancy guidelines and providing refresh training for nurses and midwives. These actions were audited for effectiveness.
- Staff we spoke with confirmed they had received feedback and training and their practice had changed. The provider had put in place a 'red top' bulletin page. This brought to staff attention immediate changes that needed to take place after an incident or complaint within the organisation, with links to policies and procedures, while the full governance process went on. Each member of staff was expected to read the red top alert and then the subsequent incident report and sign to confirm receiving the information. The signed sheet was then sent back to the head office to be logged centrally with the provider. The registered manager told us a serious incident investigation team could attend the clinic and investigate an incident. They would discuss learning individually with nurses, midwives and doctors.
- We noted details of all serious incidents from across the organisation were sent to the local clinics. This included the details of the serious incident, the investigation and the learning outcomes. Each member of staff was expected to read the incident report and sign to confirm receiving the information.
- Staff we spoke with confirmed they did this and we saw the sign off sheet for the February 2015 ectopic pregnancy incident. The signed sheet was then sent back to the head office to be logged centrally with the provider.
- Doctors were sent three- monthly reports indicating the number of procedures undertaken, complaints and complications. Outliers were identified in this way and were reviewed by the medical director.
- All clinical staff members we spoke with were aware of the duty of candour. The registered manager described to us the system in place to respond to this regulation including sharing outcomes from the investigation with the patient and offering an apology. The provider confirmed managers had training in this area as they dealt directly with compliments, feedback, complaints and incidents.

Cleanliness, infection control and hygiene

- The provider had a hygiene and control of infection policy and procedures in place in line with the Health and Social Care Act (2008) code of practice on the prevention and control of infections and related guidance.
- We saw from records one nurse practitioner had undertaken the providers infection control link practitioner workshop in February 2016.
- We noted infection prevention was a safety and quality dashboard item audited each month by the registered manager. The dashboard submission for April 2016 showed standards as 'achieved' for the clinic.
- An audit undertaken by the provider's infection control lead dated May 2016 found 96% compliance against a target set by the provider of 100%. We saw an action plan was subsequently put in place which included improving staff use of personal protective equipment and eye protection.
- During our visit we observed three clinical consultations/procedures and noted staff used personal protective equipment as appropriate. All staff changed aprons and gloves between patients.
- We observed staff hand washing and noted it was satisfactory. Posters with steps to correct method of hand washing washing were on display to prompt staff in consistent good technique.
- We noted the clinic was visibly clean with treatment room floors, toilets and staff kitchen not carpeted and could therefore be effectively cleaned. Other floors of the clinic such as reception and waiting areas were carpeted.

Environment and equipment

- We noted clinical waste was separated appropriately from other waste and bins were not overfilled.
- Appropriate arrangements were in place for the disposal of sharps, bins were not overfilled and they were correctly labelled, within date and wall mounted.
- The waiting room was not overcrowded, it had a calm atmosphere and comfortable chairs and fans were available if the room became too warm. Drinking water was provided in the waiting room.

Termination of pregnancy

- We noted current Department of Health licence and CQC registration certificates prominently displayed.
- Although the porcelain fittings in the staff toilet were visibly clean we noted the environment was poor with old and breached floor and wall covering that would be difficult to clean effectively. There was a build-up of dirty splash on the interior of the cubicle door finger plate that indicated poor hand washing practice.. It was stocked with soap and paper towels.
- The registered manager told us plans were in place to improve the staff toilet and locker room area.
- Patient's toilets were visibly clean and well stocked but wall coverings were torn in places from friction by hands for example, under the paper towel holder. This could not be cleaned effectively.
- Access to the clinic was controlled by an intercom at the entrance of the building for security.
- Emergency equipment was cleaned and checked and ready for use.
- Electrical equipment had been checked for safety.

Medicines

- We noted the quality dashboard April 2016 monthly submission form the provider sent to us prior to our visit showed 'achieved' for medicines management at this clinic.
- During our visit we observed medication administration to two patients. We saw the patients' details were confirmed with the patient; allergies were also checked with the patient and were indicated correctly on the prescription chart. All medications were prescribed correctly and signed for with the doctor or nurses printed name and signature.
- We heard a clear explanation given to the patient about how to take the medication and the expected side effects.
- A doctor prescribed all abortifacient medicines and nurses provided some non-abortifacient medicines under patient group directions (PGDs). PGDs are written instructions for the supply and administration of medicines to groups of patients who may not be individually identified before presentation for treatment. BPAS PGDs were produced in line with national guidance. We noted PGD's at the clinic were appropriate and contained adequate information.
- We saw the storage of medication in the clinic was appropriate, including those stored in the fridge. There were no controlled drugs held at the clinic.
- Signed prescription charts were appropriate and completed as required by the Abortion Act 1967, following the signing of the HSA1 form.

Records

- We looked at 10 sets of patient notes and saw they were detailed and included a risk assessment involving medical and social history. Patient notes were in the form of individualised care pathways; all 10 of the notes we viewed were completed appropriately including consent and discussion regarding choices and information about continuing the pregnancy.
- We saw certificates for termination of pregnancy (HSA1 forms) were present in each set of patient notes and signed prescription charts where appropriate as required by the Abortion Act 1967.

Safeguarding

- Staff knew how to access the safeguarding policies and demonstrated a good understanding of the processes involved for raising a safeguarding alert. The BPAS policies and processes reflected up to date national guidance.
- Patients identified as at safeguarding risk for example, less than 18 years of age underwent a safeguarding risk assessment. We noted the assessment was thorough and included questions aimed to identify individuals who were isolated, as at risk of abuse or exploitation.
- Staff told us patients under 18 years were highlighted on the central booking system when they contacted the organisation and appropriate pathways were then put into place to support their needs.
- If the clinician assessed a patient of 14 years or younger to be at low risk of exploitation they proceeded with the treatment; we observed this.
- If the assessment indicated other than low risk the patient was treated after assessment with the involvement of the provider's safeguarding lead that assessed whether to involve social services or the police. Staff told us the local police attended whenever BPAS reported an underage pregnancy.
- The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the ability of questions to identify young women who were isolated, at risk of abuse or exploitation.

- Staff we spoke with were aware of female genital mutilation (FGM) and the pathway they would follow if they came across a patient with FGM.
- All staff were trained to level three safeguarding for adults and children. The registered manager told us nurses checked during assessment if young patients were known to other agencies.
- BPAS produced an annual safeguarding report and audit to monitor compliance with section 11 of the Children Act 2004. The February 2016 report showed 100% compliance with the Act.
- All staff were aware of their responsibility under the Fraser guidelines in relation to gaining consent from underage patients.

Mandatory training

- All staff we spoke with including administrative and support staff confirmed they had completed mandatory training. The training matrix for the staff team confirmed this. Staff said the clinic closed once every two years for staff to receive mandatory training.

Assessing and responding to patient risk

- We saw nurses documented clinical observations of patients prior to administration of medication, including identification of allergies and for post procedure reviews.
- We noted from records, Some basic health information is collated over the phone at the booking interview. Risk assessments were completed and a detailed medical and social history was taken for each patient during the consultation . Patients were referred to other providers such as the NHS if the pregnancy was high risk and we saw this from records. BPAS had a specialist placement team to facilitate a patient being referred for care and treatment in another organisation.
- We saw Venous Thrombo Embolism (VTE) risk assessment completed in all 10 notes for the patients whose care and treatment we followed on the day of our visit.
- A training matrix showed all clinic staff had updated basic life support training in April 2016. The lead nurse and one nurse practitioner also had up to date immediate life support training. The Resuscitation Council (UK) training guideline advise that anaphylaxis training is part of this course.
- The provider had a service level agreement with the local NHS hospital to accept a patient in an emergency. Staff told us they had telephone access to local acute trust emergency department doctors and the early pregnancy advice unit (EPAU) midwives.
- Patients were discharged with clear information about what to expect and their recovery. This was also included in the 'My BPAS guide booklet' together with the number of an aftercare phone line service.
- We noted on discharge patients were given a letter providing sufficient information about the procedure to enable other practitioners to manage complications if required. Patient's consent was requested to send a copy of the letter to their GP and we noted the letter contained adequate information for the GP to respond to complications.

Nursing staffing

- The provider employed six nurses in total on a part time basis. We noted during our visit sufficient staff were available to assist, treat and care for the patients who had appointments for consultation or for treatment that day. There was a lead nurse, three nurse practitioners and a client care co-ordinator on duty.
- The clinic did not open every day and there was a dedicated staff team for the clinic. The registered manager and the administration co-ordinator moved around and supported the two Birmingham clinics and the Brierley Hill clinic through the week. Staff went to other clinics to cover when required.
- The provider reported there was no use of agency or bank nurses during 2015.

Medical staffing

- The provider reported one doctor was employed part time for the clinic. Doctors were present four days per week 8.15am - 4.15pm and on Saturday 08.30am -1pm. They were available for telephone advice and for electronic prescribing at other times.
- The provider reported there was no use of agency doctors throughout 2015.

Major incident awareness and training

- We noted there was a protocol in place to transfer a patient to a local NHS Hospital .
- The registered manager told us there was no major incident plan for the clinic beyond the fire evacuation plan for the shared building. There was a written

emergency contingency plan in place specific to the clinic and this covered failure of supply such as gas, water and electricity. We found there was no formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.

Are termination of pregnancy services effective?

Summary:

- Staff provided best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. The organisation was monitoring outcomes from this treatment
- Care and treatment was based on up to date good practice and supported by policies and procedures which underpinned legal requirements. For the most part staff provided care in line with national best practice guidelines.
- Policies were framed and treatment was offered in line with the Royal College of Obstetrician and Gynaecologists guidelines and by required standard operating procedures.
- A clinical advisory group brought together internal and external clinical experts in abortion care to review and advise on clinical guidelines.
- There were systems in place to regularly audit clinical practice and these worked to maintain good standards of patient care and continuously improve outcomes for patients.
- Staff employed at the clinic including doctors, nurses and administrators and receptionists were competent, well trained and experienced. They had access to information systems and worked together, and with staff in local acute hospitals when necessary, for the benefit of patients.
- Operational/clinical policy and procedures for consent to examination and treatment were in place that addressed responsibilities under the Mental Capacity Act 2005. Staff generally gave patients information on which to base their decisions and give informed consent and spent time explaining options and procedures and giving advice on contraception.

However we also found:

- The service did not participate in any relevant local audit programme or peer review to bench mark its outcomes against other similar provider services. The provider informed us following the inspection that in a competitive commissioning market it did as much as was reasonable to benchmark its service and welcomed peer review with its NHS colleagues at every opportunity that was offered to it.
- The use of simultaneous administration of abortifacient drugs for early medical abortion (EMA) is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance and staff did not make sufficiently clear to patients when they consented that this method could increase the risk of failure. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit. This also demonstrates that the process of sharing our concerns during the inspection drives improvement.
- There was not a clear protocol in practice for best interest decision making for women with learning disabilities who may need it or signposting to an independent advocacy service.

Evidence-based care and treatment

- The provider reported it had a system in place for ensuring care and treatment provided was evidence based and current.
- Each clinical guideline, policy and procedure was regularly reviewed by a responsible officer. The policy on specialist professional bodies used to inform BPAS clinical practice laid down those reliable and robust sources of research and guidance that formulated care and service delivery at BPAS.
- The BPAS medical director monitored national and international developments in care and service delivery and reported to the BPAS clinical governance committee on developments that were recommended for adoption within BPAS and those that were not.
- BPAS had a clinical advisory group which brought together internal and external clinical experts in abortion care to review and advise on clinical guidelines.
- We found for the most part, policies were framed and treatment was offered in line with the Royal College of

Obstetrician and Gynaecologists guidelines as required by required standard operating procedure (RSOP) 10. However, an exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologists guidelines.

- We saw nursing staff carried out an ultrasound examination on all women prior to discussing abortion methods; medical risk assessments were incorporated into the patient pathway, complications were clearly explained.
- In line with RSOP 12 contraception was offered to all women and all methods of contraception were available and discussed. We observed administration of the contraceptive pill; sexually transmitted infection information was discussed at discharge and was in the patient information booklet.
- We noted from our observation and review of 10 sets of patients records that all methods of termination of pregnancy were discussed with patients and options offered.
- In line with RSOP 3 nurses gave patients information on signs and symptoms to be aware of, at discharge they discussed which presenting signs and symptoms should raise concern and these were also highlighted in the patient information booklet nurses handed each patient.

Pain relief

- We observed patients were provided with appropriate pain relief to go home with after taking medication for a medical abortion.
- Anti-sickness drugs were prescribed if required.
- Staff provided patients with a copy of the 'My BPAS Guide' which contained information on pain control and suitable medicines to take after the procedure.

Patient outcomes

- The provider had put in place systems to regularly internally audit its clinical practice. The registered manager told us told BPAS had a planned programme of audit and monitoring including the patient helpline service, patient satisfaction and contraception uptake.
- Audit outcomes and service reviews were reported to governance committees such as infection control (IC) and the regional quality, assessment and improvement forum. Registered Managers were expected to complete action plans for areas of non-compliance which were then reviewed by the BPAS clinical department and regional quality and improvement forum.
- We saw the registered manager completed an outcomes audit each month and completed a clinical dashboard which was sent to the regional clinical lead.
- This included for example, an audit of case notes for a record of patient's medical history. We noted where the standard of practice was not completely maintained in May 2016 the registered manager submitted an action plan for improvement.
- The patient journey was also audited monthly by the registered manager following through the experience of a sample of a standard percentage of patients.
- Scans were regularly audited for consistency by the provider's diagnostics and screening lead. The provider collected data that compared the outcomes of the two different regimens for medical termination of pregnancy treatment.
- We saw data collected for clinical complications including outcomes of failed medical terminations of pregnancy from May 2015 to April 2016. This showed very low (0.24%) occurrences of major complications such as haemorrhage requiring transfusion, declining over that period. Minor complications including continued pregnancy and incomplete abortion, fell from 5.85% in May to August 2015 to 3.77% in September to December 2015 and rose to 4.04% in January to April 2016.
- We noted the provider was monitoring the risk of an increased failure rate from simultaneous administration of medication method for medical terminations of pregnancy. The provider undertook an evaluation of the effectiveness and feasibility of simultaneous administration in 2015. It included 891 patients who chose to take medications (mifepristone and misoprostal) simultaneously and 1,194 patients who chose to take the medication with a 6 to 72 hour window. This evaluation found there was a 2.7% risk of the patient retaining a non-viable pregnancy or gestational sac if they took both medications at the same time and a 0.7% risk if they took these within a six hour or more delay. The risk of continued pregnancy was 2.5% in simultaneous administration and less than 1.2% with a gap in administration. The evaluation also included the risk of further treatment and any extra procedures necessary. The provider informs patients of

the risks through information available on their website and at initial consultation. However the provider has found many patients prefer to take the medications simultaneously as it negates the need of a return to the clinic.
- The provider's 2016 audit plan included audit of medical treatments. The provider is currently reviewing data from all medical abortions undertaken in respect of complications seen at clinics. However the medical director informed us there is little difference in geographical terms but more difference in optimisation in terms of length of pregnancy.
- The registered manager told us the service did not participate in any relevant local audit programme or peer review, to bench mark its outcomes against other similar provider services. The provider informed us following the inspection that it did as much as was reasonably possible to do to benchmark its service and welcomed peer review with its NHS colleagues at every opportunity that was offered to it. 'However, it operated in what had been developed by commissioners as a competitive business environment. One of the results of this was an absence of data on which to base benchmarking or peer audit'.
- Staff provided patients a pregnancy test after the medical abortion procedure. Patients were advised to use the test and to re-contact the clinic or aftercare line if the test was positive or they had any concerns.

Competent staff

- We reviewed the registration status of all nurses on duty on the day of our inspection and noted all were up to date.
- Nurses said they had adequate time for supervision and were being supported with the revalidation process.
- The provider reported all nurses, doctors and administration staff had an annual appraisal during 2015/16 and staff we spoke with confirmed this.
- The clinic undertook routine ultrasound audits to establish staff competency. All nurses had ultrasound competency. This had been supported through an education programme and was overseen by the lead nurse for the clinic and the corporate ultrasound lead. We observed supervision of one nurse's ultrasound practice during our visit.
- The BPAS Birmingham Central manager was an experienced registered manager and they said they were supported by the regional operations director.

Multidisciplinary working

- We observed nursing, midwife and doctors working collaboratively. The administration team worked effectively to support these clinicians.
- There were clear lines of accountability that contributed to the delivery of effective care.
- Staff told us they had links with other local agencies for safeguarding and counselling support.
- There was a service level agreement in place with acute NHS services local such as early pregnancy advice units so patients could be quickly transferred for specific advice or in a medical emergency.

Seven-day services

- There was patient access to a 24-hour patient's helpline. Staff told us if a patient accessed the helpline they were followed up by the clinic staff the next working day.
- The clinic opening times were Monday to Wednesday 0815-16.45, Friday 08.15-15.30, Saturday 08.30-013.00 and a late evening on Thursdays 09.30-19.00.

Access to information

- We noted all BPAS guidelines and protocols were available to staff online on their intranet site.
- Patient's notes were available electronically for two doctors including those not present in the clinic to assess their medical history. These notes included other information necessary to independently agree and certify in good faith that they fulfilled one of the legal criteria for termination of pregnancy as required by the Abortion Act 1967 and 1991 Regulations.
- Patient prescriptions and HSA1 certificates were available to doctors to complete and sign online when a doctor was not present in the clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed informed consent was sought from each patient before the early medical abortion procedure and this included giving information about possible complications and implications. The consent was checked by the nurse administering each medication.
- However, we noted it was not made clear on the patient consent form, when simultaneous abortion medication was administered rather than having the medications with an interval of 24 hours or more between, that this

method could increase the failure rate for a patient.The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit.
- All patients were initially seen by the nurse without the presence of whoever had accompanied them to the clinic. For patients under 18 years of age a Gillick competency assessment was completed and Fraser guidelines followed as appropriate for contraceptive advice and we observed this in practice.
- The provider had in place operational/clinical policy and procedures for consent to examination and treatment. This addressed responsibilities under the Mental Capacity Act 2005. However, we found from discussion with staff and the registered manager there was not a clear protocol in practice for best interest decision making, in keeping with required standard operating procedure (RSOP) 8 for women with learning disabilities. Nor was there signposting to an independent advocacy service. Staff were not clear about capacity assessment processes for patients with learning disabilities; their understanding was it was not necessary to trigger a 'formal' capacity assessment if a patient had someone accompanying them such as a supportive parent or care worker. This put this particular patient group at risk because not undertaking a mental capacity assessment and using an independent mental capacity assessor (IMCA) meant the provider could not assure themselves that the person was not being coerced into the decision.

Are termination of pregnancy services caring?

Summary:

- Staff in all roles treated patients and those close to them with kindness and respect and put them at ease.
- Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers.
- Nurses checked along the way that patients were sure of their decision. Additional information and counselling could be offered or the procedure postponed if they were unsure.
- BPAS offered on-going counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Compassionate care

- We observed nurses treated patients with kindness and respect. Administrative and reception staff were sensitive and skilled at putting patients at their ease and confirming personal details discretely. Confidentially was respected, and patients were introduced to members of the healthcare team during their consultation.
- Patients reported kind, compassionate care when we spoke with them. They said "I was so worried but all the staff were lovely", "they didn't make me feel guilty at all, I was really supported", "I felt I could be completely honest with them."
- We observed staff going beyond requirement in a non-judgmental way to help patients feel at ease.

Understanding and involvement of patients and those close to them

- We observed a patient's mother being involved in the care at the patient's request. The nurse offered an opportunity for the parent to also ask questions and be involved in the treatment process.
- We noted nurses established and respected patients' wishes about sharing information with a partner or family members or carers. For example, they made a record of whether correspondence could be sent to the patient's address. A 'safe word' was set up at the booking consultation and this ensured information was kept confidential when a patient sought advice over the telephone.

Emotional support

- We noted counselling support from the client care co-ordinator was offered to all patients and we observed patients under 18 years old were counselled prior to treatment as a matter of policy.
- The nurse administering the termination of pregnancy medication asked question prompts to check if the patient had any anxieties and if they were sure of their decision and their response was recorded in the notes. In line with RSOP 14 additional information and counselling could then be offered or the procedure postponed.

Termination of pregnancy

Are termination of pregnancy services responsive?

Summary:

- The clinic opened six days each week and was situated in the city centre near to transport links.
- Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients.
- Patients were offered an appointment within seven calendar days of contact with the service, seen promptly when they arrived at the clinic and were able to have their procedure within 10 working days of access.
- Translation services were available and there was a free ongoing counselling service for patients.
- The clinic encouraged patients to give feedback on the service including making a complaint and the provider used this to improve the service.

However we also found:

- Access to this clinic was difficult for patients with disabilities. There were limited effective means in practice to support patients with a learning disability to understand and give informed consent to procedures.

Service planning and delivery to meet the needs of local people

- The clinic was situated a few hundred yards from Birmingham New Street train station and bus routes from the city suburbs and nearby towns. It served patients living in the Midlands conurbation and those who wished to have their treatment at a distance from their home. It offered appointments via a national telephone service. It opened six days a week including Saturday morning and a late evening on Thursdays.
- The registered manager told us the provider's business development managers were responsible for overseeing capacity management and clinic managers amended their appointment templates, adding additional appointments when necessary.
- The provider told us a BPAS Aftercare Line was accessible for 24-hours, 7 days a week. Callers to the aftercare line would speak to registered nurses or midwives.
- Patients could self-refer to the services as well as through traditional referral routes. Patients were offered appointments to suit their needs, there were enough appointments available to suit the need for treatment and patients we spoke with confirmed this.
- Patients could also contact BPAS via a dedicated telephone number in order to make an appointment for post-abortion counselling. Post abortion counselling was a free service to all BPAS patients, and could be accessed any time after their procedure, whether this was the same day or many years later.
- The clinical staff had the support of three part time administrators who moved between the Brierley Hill and the two Birmingham clinics through the week. Three client care coordinator's who were counselling trained were on the team. One was on duty each day. This supported the service to meet national guidelines relating to the 'Care Of Women Requesting Induced Abortion (2011)'.

Access and flow

- A centralised electronic triage booking system offered patients a choice of dates, times and locations. This ensured women were able to access the most suitable appointment for their needs and access treatment as early as possible.
- Patients were able to choose their preferred treatment option and location, subject to their gestation time and a medical assessment and patients we spoke with confirmed this.
- The system recorded what appointments were available within a 30 mile radius of the patient's home address at the point of booking. This enabled the provider to analyse waiting times and evidence patient choice.
- The provider had systems in place to ensure as far as possible the total time from access to procedure was not more than 10 working days in line with the Department of Health standard operating procedures (RSOP's) and requirements of licence. RSOP11 requires patients should be able to access an appointment within five working days of referral and should be offered abortion treatment within five working days of making the decision to proceed.
- For the period October to December 2015 the proportion of women who had their consultation within

seven calendar days (CCG target seven calendar days) of initial contact was 84%. The proportion of women who could have had their consultation within seven calendar days was actually 95%.

- The provider reported across Birmingham during 2015, the number of patients that waited longer than 10 days from first contact to termination of pregnancy was 148 (9%).
- We noted from data submitted to the CCG's for Q4 2015/16 the provider shared with us: the mean average number of days from first contact to treatment for BPAS Birmingham services (which included Birmingham Central clinic) was 12.5 days but the median average was10 days; the mean and medium average number of days from 'decision to proceed' to 'treatment' were five days; 97% of patients were seen within 30 minutes of their appointment time.
- Patients could be offered consultation and treatment all in one day if required. The service reserved appointment slots in the afternoon to ensure this one day service could be accessed if needed.
- If a patient required treatment on a day when the clinic was not available they would be offered an alternative clinic to attend.

Meeting people's individual needs

- Physical access to this clinic was limited. It was situated on the first floor of a Victorian period building with steps to the front door. Entry to the clinic required use of an intercom system for security reasons. This meant that access could be challenging to patients with mobility issues and hearing loss. However, the provider has assured us 'any mobility issues were identified when patients booked their initial appointment and were therefore directed to the most suitable clinic. There is a lift in the building but clients would have to negotiate a number of steps into the building. All reasonable adjustments have been made.'
- We observed the booklet 'My BPAS Guide' was given to every patient. This provided written information about their post treatment care. The guide had a section dedicated to recovery, which detailed what would normally be expected following treatment. Abnormal symptoms following treatment were also listed, with information on what patients should do if they experienced these, including details of the BPAS Aftercare Line which was accessible for 24 hours, 7 days a week.
- The provider had a policy and procedure in place in for safe and dignified disposal of pregnancy remains including patient consent. The manager had established from the 'following the patient pathway' audit in early June 2016 that staff needed more support to improve their confidence in providing patients with the opportunity of making an informed choice about the disposal of pregnancy remains.
- We noted there were no specific means of supporting patients with a learning disability to understand and weigh up the issues involved, as is required by the RSOP 8. For example staff confirmed the 'My BPAS guide' booklet had no easy read page or accompanying leaflet to signpost a patient through its contents. The provider told us they specifically train staff to speak with people with learning disabilities as part of their safeguarding training.
- Staff had access to translation services over the phone or if necessary face to face. We observed this in use during our visit. Staff were aware a patient may not have a comparable level of skill at reading and speaking English as a second language. Policies were in place to aid translation via language line telephone services.

Learning from complaints and concerns

- The provider had a system in place for patients to raise concerns, make a complaint or just provide feedback. The provider reported it received and investigated two complaints about the service during 2015. We saw the outcome and learning from complaints were displayed on the staff room notice board.
- We observed all patients were given a client survey/comment form entitled 'Your Opinion Counts' and there were boxes available at the clinic for patients to leave their forms or post directly to the providers head office. We noted a poster and leaflets on display encouraging and guiding patients to make a complaint or give feedback.
- The registered manager told us completed forms left at the clinic were initially reviewed by the clinic manager and then sent to the head office for collation and reporting. This meant the manager could begin to immediately address any adverse comments.
- The provider's client engagement manager produced satisfaction survey reports which were collated by the unit and local clinical commissioning groups (CCG) contracts. A report of all complaints and a summary of

service user feedback (including return rates and scores) were reviewed by the provider's regional quality assurance and improvement forum (RQuAIF) and clinical governance committee.
- Survey results were shared with the clinic and we saw examples of these on the staff room notice boards and data on complaints included in the CCG quarterly monitoring report the provider shared with us.
- The patient booklet 'My BPAS Guide' also included a section on how to give feedback and how to complain, as did the provider's website.

Are termination of pregnancy services well-led?

Summary:

- Staff were all committed to the BPAS vision of women being in control of their fertility. The service was patient centred and caring.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings. Messages were communicated to staff through email and a team brief.
- Clinic performance was measured through audits and reported on a monthly dashboard to the regional operations director. Action plans were developed for areas that required improvement.
- BPAS conducted annual staff surveys and there was a staff forum. The registered manager reported they had easy access to directors in the organisation for support and advice.
- The clinic was well run by a manager registered with the CQC and staff felt confident about speaking up, learning from incidents and trying out new ways to improve the service.
- Staff encouraged patients to give feedback about the service they received and contribute to improving the service in a range of ways including through social media.
- There were systems in place to ensure the HSA1 forms were fully completed and that HSA4 information was submitted to the Department of Health.

Leadership / culture of service

- The clinic was overseen by a manager registered with the CQC. She told us she was available to staff everyday via telephone if not on site. Clinical and administrative staff confirmed the manager planned the week to cover all three clinics and they had regular contact.
- Staff we spoke with in all roles reported the organisational culture was open and honest. They felt confident to approach the registered manager at any time with concerns or questions, 'the door was always open.'
- Staff we spoke with about learning from incidents told us they did not feel victimised when they made mistakes and they were encouraged to be involved in sharing learning from incidents.

Vision and strategy for this this core service

- We saw the service displayed the provider's certificate of approval (issued by the Department of Health to carry out abortions) in a prominent position within the clinic.
- Staff were clear on the BPAS vision of women being in control of their fertility. The service was patient centred and caring.
- The registered manager was aware of the corporate strategy and understood how this affected local provision of services for BPAS in Birmingham.

Governance, risk management and quality measurement

- The provider had a system of governance in place at national and regional levels. It comprised of a Board of trustees, a clinical governance committee, research and ethics committee, infection control committee, information governance committee and regional quality, assessment and improvement forums.
- We noted the arrangements in place for risk management, quality assurance and legal compliance. These were followed by the registered manager, audited and reported on up through the organisation by effective governance structures.
- In 2015 BPAS implemented the clinical dashboard to measure quality and safety, which was an improvement tool for measuring, checking, and analysing clinical standards. We noted the registered manager monitored clinic performance and submitted monthly data on the dashboard to the regional operations director. The dashboard included results on medicines management, staffing levels, clinical supervision, infection prevention,

case note audits, serious incidents, safeguarding, complaints, laboratory sampling, labelling and staff sickness. Clinic performance was compared and monitored at the RQuAIF meetings.

- The Birmingham Central clinic maintained a 'high risk log'. We noted incidents were assessed and given 'RAG' rating status that identified the level of risk and level of investigation required to be undertaken.
- We saw BPAS Birmingham Central contributed to data routinely collected by the organisation from each clinic on clinical complications and year on year comparisons. These included data comparison for simultaneous and 48-hour gap administration of abortifacient medication for early termination of pregnancy.
- We saw a quality and safety dashboard was in place that was completed by the registered manager and submitted monthly through the provider's assurance system to the regional clinical lead.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 form), in line with the requirements of the 1967 Abortion Act. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. A doctor on site at BPAS Birmingham Central reviewed the completed documentation following the initial assessment by the nurse and either authorised the HSA1 as the first doctor or declined and requested further information. If a second doctor was available on site they would review the information and similarly authorise the HSA1 as the second doctor or decline and request further information. If a second doctor was not available onsite, BPAS used the electronic central authorisation system to ensure information and the HSA1 form was accessible and signed by doctors located at other BPAS units. Authorising doctors had access to information including the patients' medical history, blood test results, reason for seeking a termination and scan measurements, although the actual scan pictures were not available electronically. When the HSA1 form was fully completed the termination of pregnancy procedure could take place legally.
- Data from the provider reported the Birmingham Central clinic December 2015 audit recorded a score of 100% compliance with accurate completion of the HSA 1 form.
- We saw certificates for termination of pregnancy (HSA1 forms) were present in each set of patient notes we looked at and signed prescription charts where appropriate.
- The Department of Health required every provider undertaking termination of pregnancy to submit specific data following every termination of pregnancy procedure performed (HSA4 form). We observed staff recorded this data. There was an email reminder process to prompt doctors to submit the HSA4 information to the Department of Health. The HSA4 was signed online within 14 days of the completion of the abortion by the doctor who terminated the pregnancy. For medical abortions, where patients delivered pregnancy remains at home, the doctor who prescribed the medication was the doctor who submitted the HSA4 form.

Public and staff engagement

- Staff encouraged patients to give feedback about the service they received in a range of ways including through social media. The provider had consulted and involved young patients in the content of and questions in the safeguarding assessment form
- Reception staff told us they had they had been encouraged to improve the booking through system by developing a new check form to assure the process.
- The 'client engagement manager' reviewed any comments left about the service on the NHS Choices website. We saw an example of one comment being forwarded to the clinic manager on the day of our visit.

Innovation, improvement and sustainability

- The provider told us it has been involved in providing advice and guidance to the Human Tissue Authority (HTA) on production of its document, 'Guidance on the Disposal of Pregnancy Remains Following Pregnancy Loss or Termination', and was part of the team updating the Royal College of Nursing's guidance document, 'Sensitive Disposal of all Foetal Remains'.
- We noted no innovative practice specifically relevant to BPAS Birmingham Central clinic.

Outstanding practice and areas for improvement

Outstanding practice

The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the effectiveness of questions to identify young women who were isolated, at risk of abuse or exploitation.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that protocols are put into practice for assessing consent and obtaining best interest decisions where appropriate, and support for all patients who lack capacity to consent including those patients with learning disability.

Action the provider SHOULD take to improve

- The provider should ensure there is a formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.
- The provider should review the environment of the staff locker room and make improvements where necessary to ensure effective cleaning of the surfaces and floors.
- The provider should consider participating in relevant local or national audit programmes or peer review, to bench mark outcomes against other similar services.
- The provider should ensure that when patient's consent to simultaneous administration of abortion medication for medical abortions they are clearly informed this method, rather than having the medications with an interval of 24 hours or more between, could increase the risk of failure.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 20 (Registration) Regulations 2009 Requirements relating to termination of pregnancy **11 Need for consent** (1) Care and treatment of service users must only be provided with the consent of the relevant person. (2) Paragraph (1) is subject to paragraphs (3) and (4). (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. (4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act. (5) Nothing in this regulation affects the operation of section 5 of the 2005 Act, as read with section 6 of that Act (acts in connection with care or treatment). The provider was not meeting this Regulation because: The provider did not have effective protocols in practice for all patients who may lack capacity to consent, including those patients with learning disability.