British Pregnancy Advisory Service

BPAS - Bournemouth

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We previously inspected this service in 2016, however it was not rated at that time. This was the first time we rated this service. We rated it as requires improvement because:

- The service did not always ensure the correct legal documentation was completed before surgical terminations.
- The service did not always provide care and treatment following current national guidance to ensure pregnancy remains were treated with respect.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the service did not use a specific early warning system designed for children under the age of 16.
- Systems to safely prescribe, administer and record medicines were not always in line with national regulations and guidance. However, medicines were stored safely.
- The service provided mandatory training in key skills to all staff but not everyone had completed it.
- The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers mostly investigated incidents and shared lessons learned with the whole team and the wider service.
- Waiting times from contact to consultation and treatment did not always meet standards in line with national standards and commissioning requirements.
- Leaders did not always operate effective governance processes. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Although leaders had the skills and abilities to run the service, they did not always have capacity to provide leadership as they had dual roles.
- Not all staff understood the organisation's vision and strategy, and they were not all aware of the freedom to speak up guardian and how to contact them.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Summary of findings

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to BPAS - Bournemouth

BPAS Bournemouth is operated by British Pregnancy Advisory Service also known as BPAS. The service provides a termination of pregnancy service in Bournemouth, Dorset.

The service is provided from a building owned by the service and provides termination of pregnancy as a single speciality service.

The service is registered to provide the following regulated activities:

• Termination of Pregnancy

• Family Planning Service

• Treatment of Disease, Disorder or Injury

• Diagnostic Imaging Services

• Surgical procedures

Under these regulated activities, the services provided are:

• Pregnancy Testing

• Unplanned Pregnancy Counselling

• Early Medical Abortion (EMA) (up to nine weeks and six days gestation)

• Medical termination of pregnancy

• Surgical termination of pregnancy

• Abortion Aftercare

• Sexually Transmitted Infection (STI) testing and treatment

• Contraceptive advice and supply

As part of the care pathway, patients are offered sexual health screening and contraception. Surgical termination of pregnancy can be undertaken under local anaesthetic, general anaesthetic, conscious sedation and no anaesthetic according to patients wishes.

The service also operates a Telemed Hub, which provides a telephone consultation and remote early medical abortion services referred to as 'Pills by Post'. This service is available for women over 18 years of age and for medical termination of pregnancy up to nine weeks and six days.

Summary of this inspection

The government legalised / approved the home-use of misoprostol in England from 1 January 2019. On 30 March 2020, the Secretary of State for Health and Social Care made two temporary measures that superseded this previous approval. These temporary arrangements were aimed at minimising the risk of transmission of coronavirus (COVID-19) and ensuring continued access to early medical abortion services during the COVID-19 global outbreak.

The first temporary measure meant that pregnant women would be able to take both Mifepristone and Misoprostol for early medical abortion, up to nine weeks and six days gestation, in their own homes without the need to first attend a hospital or clinic.

The second temporary measure meant medical practitioners could provide a remote consultation and or prescribe medication for an early medical abortion (EMA) from their own home, rather than travelling into a clinic or hospital to work. In June 2022, this arrangement was made permanent.

Activity

In the 12 months prior to our inspection from 1 July 2021 to 30 June 2022, the service completed 8,527 abortions, of which 6,863 were EMA by telemedicine (remote consultation and supply of abortifacient medicines to take at home). The clinic provided 976 surgical terminations and 686 medical terminations

The service was last inspected in May 2016. The inspection highlighted one area where the provider needed to make improvements. This included making sure staff offer and record patients were provided with information about disposal of pregnancy remains, and patients' wishes were respected in accordance with guidance on the disposal of pregnancy remains following pregnancy loss or termination (Human Tissue Authority). During this inspection we found that these issues had been addressed.

How we carried out this inspection

We carried out an unannounced inspection on 28 and 29 June 2022. The inspection team included a lead inspector, a second inspector and a pharmacist specialist.

During the onsite visit, we spoke with five patients and 21 staff members, looked at five patient records and 12 staff records. We looked at documentation and patient outcome data before, during and following the inspection. After the inspection, we held telephone interviews with key people we were not able to speak with during the unannounced inspection.

The inspection was overseen by Head of Hospitals Inspections Catherine Campbell.

Following the inspection, we issued a Warning Notice to the provider because there had been two breaches of the Human Abortion Act 1967 which was also a breach of the Care Quality Commission (Registration) Regulations 2009 Regulation 20 (2).

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

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The service must review processes to ensure legal documentation and authority is obtained before terminations are carried out. This includes the supply of medicines to prepare the cervix for a termination. (Care Quality Commission (Registration) Regulations 2009 Regulation 20 (2).
- The service must assess the risks to the health and safety of patients receiving care and reasonably mitigate such risks. The service did not use a specific paediatric early warning score tool for use with children under the age of 16 years undergoing surgical termination of pregnancy. Waiting times did not meet standards in line with national guidance. Regulation 12 (2) (a) (b).
- The service must ensure the proper and safe management of medicines. Medicines administered during surgical terminations were not administered in line with national legislation and standards. (Regulation 12 (2) (g).
- The service must ensure required information in respect of persons employed or appointed for the purposes of a regulated activity is obtained and updated to comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment and employment records of staff and consultants working under practising privileges did not include the required information. (Regulation 19 Schedule 3).

Action the service SHOULD take to improve:

- The service should ensure audits are carried out in line with the corporate audit schedule. (Regulation 17 (2) (a)).
- The service should ensure national guidance is followed to ensure pregnancy remains are treated with respect. (Care Quality Commission (Registrations) Regulations 2009 Regulation 20 (11)).
- The service should consider carrying out risk assessments for infection prevention and control during surgical procedures and review the auditing of cleanliness in clinical areas. The service should consider a review of the frequency of cleaning audits in line with national guidance.
- The service should consider embedding processes to show when equipment had been cleaned and was ready for use.
- The service should consider agreements to share information about the conduct of medical staff working under practicing privileges with NHS trust where consultants hold their substantive posts.
- The service should review the packing of medicines 'to take out' (TTO) in line with best practice for the protection of medicines and legislative labelling requirements.
- The service should review processes for the review and updating of all policies and local standard operating procedures so that they are up-to-date and support staff to access these.
- The service should promote the local vision, strategy and corporate values to enhance staff engagement.
- The service should review and update the local risk register so that it captured all risks to the service.
- The service should share information about freedom to speak up guardians.
- The service should consider how they can make it easier for patients to distinguish between the different grades of staff, so they are clear who they are speaking with.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Termination of pregnancy

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Termination of pregnancy safe?

Requires Improvement

This was the first time we rated the service. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but not everyone had completed it.

Staff received and kept up to date with their mandatory training. Records showed most staff had completed their mandatory training. However, compliance with infection prevention and control for staff working in the hub was reported at 77% and compliance with immediate life support training for registered staff in the clinic was 85%. This data was affected by staff on long term sick leave. Staff were supported to complete mandatory training when they returned to work. Following the inspection, the service confirmed the compliance for mandatory training had improved to 90%. It was not evident there was a corporate training compliance target the service was measured against to ensure staff were kept up to date with mandatory training and refresher training.

Medical staff received and kept up to date with their mandatory training. Medical staff working under practicing privileges (a license agreed between the individual medical professional and a private healthcare provider) received their training in the NHS trust where they held substantive contracts. Mandatory training compliance was reviewed annually as part of the practising privileges review.

The mandatory training was comprehensive and met the needs of patients and staff. Simulation exercises had been introduced to provide further training in a number of topics including sepsis, business continuity to manage adverse events, safeguarding, major haemorrhage (bleeding) and anaphylaxis (a severe allergic reaction). Feedback was used to learn from these exercises to improve practice.

Clinical staff completed mandatory training on basic or immediate life support relevant to their role, safeguarding training (level three), health and safety, fire awareness and infection control. Mandatory training also included recognising and responding to patients with mental health needs and learning disabilities, 'prevent' (possibilities of extremism**)** training and information protection.

Staff received an email alert when they needed to complete refresher training. Staff could access the electronic learning platform from their home computers and were paid for the hours they spent completing mandatory training modules.

Managers monitored mandatory training completion rates. Changes to the learning platform were in development that would enable managers to be alerted when their staff needed to complete refresher training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All nursing and administrative staff received safeguarding at level three. This training included adult safeguarding and child protection at level three in line with national guidance. This training was designed to enable staff to recognise and report abuse. In addition, nurses and midwives received safeguarding master class training to help them understand and identify some of the harder to detect nuances of safeguarding concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. There was a safeguarding policy which was available to staff on its computer system. In addition, the electronic patient record system allowed staff to highlight if there was a safeguarding concern and to document actions taken when concerns were escalated. Staff gave us examples of when patients had faced harassment and discrimination and how they had protected and supported them.

Safety was promoted in recruitment practice and included safety checks such as 'Disclosure and Barring Service' checks. However, we observed recruitment records did not contain a full employment history, which was not line with legislation.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff worked closely with adult and children's services to manage safeguarding concerns.

Staff followed safe procedures for children visiting the service. All patients under the age of 18 were required to attend with a responsible adult. Staff confirmed the identity of the responsible adults before any treatment was given.

Staff recorded the numbers of adult and children safeguarding referrals they made and what follow up action was required.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We did not see any dirt or dust in hard to reach places.

The service generally performed well for cleanliness. For example, the cleaning record for the treatment room showed it was cleaned every day it was in use. The service monitored cleaning by auditing cleaning records. Quarterly cleaning audits showed 95% to 100% compliance across 31 measures. Records showed cleaning audits were carried out once a quarter and not every week in line with National Standards of Healthcare Cleanliness (2021).

Records showed there had been no healthcare acquired infections in the 12 months before our inspection. Staff used aseptic techniques in the treatment room and had access to appropriate personal protective equipment (PPE) for the tasks they were carrying out. However, we observed that not all staff washed their hands immediately after they removed their gloves in line with national guidance.

Staff followed infection control principles including the use of PPE. Specific COVID-19 risk assessments had been undertaken and risks concerning staff from COVID-19 vulnerable groups had been considered. Staff followed infection control principles including the use of face coverings and completed twice weekly lateral flow tests. All patients were asked COVID-19 screening questions before they entered the building and had their temperature checked on arrival and were asked to wear facemasks whilst in the building.

Staff wore PPE in the treatment room when surgical abortions were carried out under general anaesthesia including the use of FFP3 masks and gowns. However, a surgeon we observed was not wearing a surgical gown nor a visor during a surgical termination. This did not comply with national guidance for infection prevention and control, which recommends a surgical gown and visor are used to minimise the risk of exposure to bodily fluids. Staff had access to a BPAS Personal Appearance and Uniform Policy and Procedure (March 2016), which did not include reference to any surgical gowns as being required for staff working in the treatment room/operating theatre. There was no evidence that this policy had been reviewed and there were no references included to show that the policy was based on best practice guidance.

Staff cleaned equipment after patient contact but did not label equipment consistently to show when it was last cleaned. In the Telemed Hub, we saw signs used to show when workstations had been cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections. Staff mostly followed national guidance around the prevention of infections and provided patients with information about precautions they should take following surgical abortions. Patients on surgical pathways were prescribed antibiotics to minimise the risk of infection following the surgical procedure in line with local protocol and national guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The facilities and equipment were safe for patients to receive treatment although the building was not designed to be used as a termination of pregnancy clinic. The clinic was located within a residential area. Patients could reach call bells and staff responded quickly when called.

There was restricted access to the building and to clinical areas to prevent unauthorised persons from entering. There was CCTV monitoring of outside areas to deter people who had no right to access or enter the premises.

The treatment room and adjoining clinical areas were furnished to ensure floors, surfaces and equipment could be easily and effectively cleaned.

Staff carried out daily safety checks of specialist equipment. Records showed staff checked emergency equipment daily when the facilities were used. Emergency medicines and equipment were stored on two tamper proof trollies on the ground floor and in theatre recovery area. We observed the top of these trollies were cluttered and contained three boxes of emergency medicines. These medicines were for the treatment of anaphylaxis and cardiac arrest. Staff had access to emergency equipment suitable for 13 to16 year olds and patients of small stature.

The service had suitable facilities to meet the needs of patients' families. During the COVID-19 pandemic, restrictions had been introduced which meant women could not always have their partner, relative or friend with them when they were waiting for treatment. However, all children and young people under the ages of 18 were required to have a responsible adult with them on the day they received surgical treatment.

The service had enough suitable equipment and consumables to help them to safely care for patients. Records showed all equipment was regularly serviced and maintained to ensure it was safe to use.

Fire safety was assessed, and staff received training, including scenario training in evacuation of patients, twice yearly. There were processes to test fire alarms and equipment was checked annually by an external company.

Staff disposed of clinical waste safely. Waste was separated into clinical waste and general waste and disposed of safely. There were sharps bins which were labelled and closed when they were not in use, in line with national guidance. There was a service level agreement with an external provider for the collection of clinical waste.

Staff in the Telemed Hub had completed display screen equipment (DSE) assessments and the desks, chairs and other equipment were fit for staff use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the service did not use a specific early warning system designed for children under the age of 16.

Staff completed risk assessments for each patient on admission for surgical termination of pregnancy. The service had strict eligibility criteria for who could safely be treated at the clinic. Patients who had a surgical termination were risk assessed for deep vein thrombosis using an appropriate tool. Additional information about allergies to medicines was obtained as part of the surgical safety check list.

Staff were aware of specific national guidance and legislation relating to the termination of pregnancy according to the gestation (the time from conception based on menstrual cycle). Individual risk assessments were completed for all patients who attended the clinic or through telephone consultations. There were specific eligibility criteria to assess if patients were safe to receive a medical abortion in their own home or a surgical termination at the clinic.

Staff used a modified Surgical Safer Checklist based on the World Health Organisation's (WHO) five steps to safer surgery. The WHO checklist is a tool designed to improve patient safety during surgical procedures. We observed staff in the treatment room completed each stage of the WHO checklist throughout all the procedures we observed.

Staff in the hub completed risk assessments as part of the process of assessing patients' suitability for treatment. They followed an escalation process when risk was detected during the medical and social assessment and made relevant referrals for support from other agencies to mitigate risk.

Changes to the assessment process for early medical abortions (EMAs) had been made in response to an increasing trend in the number of patients passing a larger than expected foetuses. To try and mitigate this risk, the service introduced a series of additional questions in order to determine gestation date of pregnancy. This was to establish if

there was a likelihood of a greater gestation than the patient had calculated based on their menstrual cycle. If there was any doubt about the length of gestation, arrangements were made for ultrasound scanning, so precise pregnancy gestation could be established prior to a medical termination. If gestation was greater than nine weeks and six days when the consultation took place, patients were offered a surgical termination in line with national guidance.

All young people, under the age of 16, had their gestation established through ultrasound scanning. They were assessed at the clinic and were also referred to a safeguarding team for a more detailed exploration of individual circumstances. Young people between the age of 16 and 18 were assessed using a video link rather than telephone call. If there was not a supportive adult on the call, who could verify there were over 18 or over, the patient was required to attend the clinic for assessment, or arrangements were made so the identification of the supportive person could be verified via another video call.

If there was not a supportive adult on the call, who could verify they are over 18, the patient was required to attend the clinic for assessment.

Staff knew about and dealt with any specific risk issues. Staff received resuscitation training at a level appropriate to their role. Staff who worked in the treatment room during surgical terminations under conscious sedation, received additional training in the monitoring of patients and airway maintenance. Staff had access to emergency equipment including resuscitation trolley, anaphylaxis kits, difficult airway management trolley and a major haemorrhage trolley.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, the service did not have specific paediatric early warning scores to support the monitoring of vital observations for children under the age of 16 who had surgical terminations. Staff were aware of the risk associated with blood loss in children, in women of small stature and in those with a low body mass index. Medical staff we spoke with were confident any patient deterioration would be recognised and escalated for review. There was ongoing work at corporate level to design an early warning score system for children and young people having surgical terminations.

Staff shared key information to keep patients safe when handing over their care to others. Staff held a safety briefing each morning when surgical terminations were carried out. During the safety briefing, staff were made aware of specific patient risks or needs. Each member of staff was assigned a role in the event of a clinical emergency, including the transfer of a patient to an NHS hospital. We observed a safety briefing during our onsite visit and found information was clearly shared and all staff were engaged with the safety briefing.

There was specific guidance and documentation for patients who needed to be transferred to a local NHS facility and staff knew how to access this.

Staff shared information about counselling services and referred patients to BPAS counselling if required. When patients were discharged, staff ensured they knew they could access counselling at any point in the future if this was required, with concerns or issues relating to the termination of their pregnancy.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants matched the planned numbers. The service completed regular reviews of the nursing team to ensure staffing levels could meet demand.

The service had low vacancy rates. At the time of our inspection, there was one vacancy for a full-time healthcare assistant. The hub had enough nursing staff to keep patients safe. Staff told us they had recently recruited more administrative staff but still needed to employ additional support staff for some roles.

The service had a high turnover rate. Records showed 14 staff had left the Telemed Hub and seven staff had left the clinic in the last 12 months. Managers monitored the reasons for staff leaving the service and these included promotion or other employment and some staff left because they did not think the job suited their expectations.

The service had fluctuating sickness rates. Most sickness was due to COVID-19 or as close contacts to someone with COVID-19.

Managers used bank staff when it was needed to provide safe treatment and care. There was a bank of staff who was familiar with the service. Bank staff received induction and completed mandatory training in line with staff who were employed on permanent contacts.

Medical staffing

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

The service had enough medical staff to keep patients safe. The service did not employ any surgeons directly, these were employed by the BPAS organisation. The surgeons travelled to the clinic on the days surgical terminations were carried out.

The service employed six consultant anaesthetists under practising privileges (a 'licence' agreed between individual medical professionals and a private healthcare provider) to facilitate general anaesthetics for patients who were booked for surgical terminations at a later gestation stage or if that was the patient preference.

There were processes for the granting and reviewing of practising privileges arrangements annually, but the documentation we looked at for an anaesthetist did not include a review of disclosure and barring checks and did not include information about when these checks should be renewed. The granting of practicing privileges included an interview and the service also facilitated an induction for consultants.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used electronic patient records and additional paper-based records for patients who had surgical terminations. They were comprehensive and all staff could access them easily.

There was a system of internal alerts which would highlight information about the patient such as specific wishes regarding pregnancy remains, if the termination was due to foetal abnormality and information to highlight there may be two patients with similar names.

Requires Improvement

Termination of pregnancy

When patients transferred to a new team, staff completed specific patient documentation to ensure staff at the NHS hospital had the information they needed.

Records were stored securely, and computers were password protected to prevent unauthorised access.

The services completed documentation audits to ensure patient records were completed as they were intended, this included specific assessment of compliance with relevant risk assessment and legal documentation to authorise the termination of pregnancies.

There were electronic processes to obtain legal authorisation from two separate medical doctors who worked remotely to assess information for the certification of opinion in line with the Abortion Act 1967. We observed staff check the authorisations by two doctors were obtained before any treatment was commenced. However, we found there were two occasions where staff had not followed these processes.

Medicines

Systems to safely prescribe, administer and record medicines were not always in line with national regulations and guidance. However, medicines were stored safely.

Staff sometimes did not follow systems and processes to prescribe and administer medicines safely. Medicines administered during surgical termination of pregnancy procedures were not prescribed and/or signed for by the surgeon although a record of the amount given, and the time of administration was recorded.

Staff stored and managed all medicines and prescribing documents safely. Medicines, including controlled drugs and medical gases cylinders, were stored securely. However, the destruction of controlled drugs was not in line with legislation. The service did not have a 'T28 exemption' form allowing staff to denature controlled medicines before disposing of these. Following the inspection, we received confirmation the service had requested and obtained the exemption.

Records indicated medicines requiring refrigeration and those stored at room temperature in one room were kept within their recommended temperatures. Room temperatures were monitored in some, but not all areas where medicines were stored. Due to the lack of room temperature records for these areas, we were not assured that medicines were managed safely.

Medicines as 'to take out' (TTO) packs were issued by nursing staff either against Patient Group Directions (PGD) or against a prescription from a prescriber. PGDs are written instructions which allow specified healthcare professionals to supply or administer certain medicines in the absence of a written prescription. Whilst the PGDs were appropriately authorised and in date, we identified concerns with some TTO packs. These included one medicine in the TTO pack which was not dispensed in suitable packaging in line with the manufacturers guidelines and labelling not consistent with the legislative labelling requirements for a few other medicines.

Staff provided advice to patients about their medicines. Staff reviewed patient's medicines regularly and provided specific advice to patients and their next of kin about their medicines. Patients were informed what medicines they were taking, in what order to take them and what side effects could occur from the medicines. Where patients were supplied with medicines to take at home, a 24-hour contact number was available for advice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. If patients presented for treatment under the influence of substances, staff explained why treatment could not go ahead and made appointments for them to re-attend as soon as possible.

To support patients from other countries who were unable to access the service, there was information on the provider website about the risks associated with buying medicines for EMA online from unreliable sources. They gave information about other services that provide genuine EMA medication, advice, and support, to women around the world.

Incidents

The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers mostly investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents, near misses and positive outcomes on the electronic incident reporting system. This information was used to identify risks, and individual and group learning and training needs. For example, incident reporting showed there was a trend in nurse and midwife practitioners having difficulty booking very early pregnancy scans and scans for women choosing surgical termination. This led to the service making additional scanning appointments available and ring fencing them for this client group.

The service had not reported any never events (a serious incident or error that should not occur if proper safety procedures are followed) between June 2021 and May 2022. The service had an electronic incident reporting system which some staff found complicated and asked for help to complete the reporting of an incident.

Staff reported serious incidents clearly and in line with the service policy. In the hub, staff knew what incidents to report and how to report them. One member of staff had day to day responsibility of ensuring all risks that were entered onto the system were followed up in a timely manner. A senior leader had overall responsibility for monitoring and managing the system.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw information about incidents and associated learning that had been shared with staff following incidents. There was an electronic process that staff followed to record that they had read and understood the feedback.

Learning from other BPAS units was shared during safety briefing to improve patient care. We observed information being shared about patients being transferred to NHS facilities because of clinical deterioration.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, staff told us about how their concerns about the shortage of timely ultrasound scans for patients had, in part, led to additional ultrasound appointments being introduced.

Serious incidents were mostly investigated immediately after the incident had happened to identify actions to improve practice. This was followed by a more in-depth investigation carried out by an BPAS corporate team. However, we noticed there had been three reported incidents of when terminations had been carried out without the required legal documentation being present or fully completed. These incidents had not been investigated as thoroughly as they should have been at the time the occurred.

Requires Improvement

Termination of pregnancy

Managers debriefed and supported staff after any serious incident. Staff told us they were debriefed and supported by senior leaders as well as national teams following serious incidents.

Are Termination of pregnancy effective?

Requires Improvement

This was the first time we rated the service. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on current national guidance and evidence-based practice.

Staff did not always follow national guidance. Pregnancy remains were not always treated with respect. Pregnancy remains were collected into a shared vessel. Collecting several pregnancy remains in one receptacle separate from clinical waste was the default position. However, there were safeguards to ensure that patients were informed of their choices around this. Patients were given the option of having their pregnancy remains collected separately prior to their procedure.

In response to the COVID-19 pandemic and specifically to episodes of national lockdown, the Government temporarily amended the legal procedure for women to obtain drugs to have early medical abortions at home, rather than at a clinic or hospital. This amendment to the Abortion Act 1967 also defined a registered medical professional's home as a suitable place to have a telephone consultation and to prescribe the drugs allowed for the termination. The policy that was implemented in the hub to facilitate new ways of working in line with the amendment to the law were introduced locally and at pace. Some local policies were replaced with national policies as BPAS expanded the number of clinics that offered 'pills by post'. Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, for example, the Abortion Act 1967, Royal College of Obstetricians and Gynaecologists (RCOG) 2011 and National Institute of Health Care Excellence (NICE) guidelines (NG140).

There was a list of local policies available to staff such as emergency contingency plans, safeguarding and staff induction. There was clear overview of when the local policies should be reviewed and by whom. These policies were in addition to corporate BPAS policies. Policies were stored on the service's intranet only to ensure staff had access to latest and up-to-date policies. However, not all staff were aware of how to access these on the service's intranet.

Staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Information was flagged up and shared as required both on patient records and in the morning staff briefing.

At safety briefing meetings and in handover messages, staff routinely referred to the social, psychological and emotional needs of patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Termination of pregnancy

Staff offered refreshments to patients who attended for surgical termination of pregnancy. All patients were offered drinks and snacks following their surgical procedure as part of the post-procedure recovery. There were some adjustments for patients with specific allergies or preferences.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients with specific risks such as diabetes were put first on the list of surgical terminations under general anaesthetic.

Staff in the hub assessed the nutritional and hydration needs of women especially those with nausea and vomiting in pregnancy (morning sickness) and gave advice to make sure women had enough to eat and drink.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The observations recorded did not include pain/comfort scores although we observed staff monitor this. Most patients we spoke with confirmed they had received enough pain relief when they needed it.

Staff prescribed, administered and recorded pain relief accurately. Nurses gave pain killers from a list of agreed Patient Group Directions (PGDs) or against a prescription from a prescriber. Medicines administered were accurately recorded in the records we reviewed.

Staff in the hub gave patients advice and information about pain control and management for patients choosing early medical abortion and prescribed strong pain relief if they requested this.

Patient outcomes

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

There were agreed standards against performance which could be audited, and these had a specific focus on activity, outcomes and processes. There were agreed targets to be met with clinical commissioning groups and regular review meetings to discuss performance.

The service monitored outcomes of treatment in line with national guidance. These included patient satisfaction feedback, complaints, complications, incidents and safeguarding referrals. There was a process for the service to be informed about clients who were admitted to a local NHS Trust. However, we were not assured about how effective this process was. Staff were not aware of the process and told us they would only find out if the patient contacted them for advice. The service took care to follow up patients they knew had required to seek medical assistance.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. There were processes to use patient outcome audits to improve services. For example, the pathway for pre-abortion assessment had been reviewed as a response to incidents, to ensure as far as possible, the eligibility criteria for early medical abortions in patients own homes were assessed as safe.

The service held the required license from the Secretary of State for Health and Social Care to legally carry out termination of pregnancies. These were displayed behind the reception area in the waiting room.

Requires Improvement

Termination of pregnancy

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was a competency framework that was designed to demonstrate staff had the required skills and knowledge to provide safe care and treatment. Leaders reviewed competency completions, and nursing rotas were designed to ensure staff with the correct skills and knowledge were rostered to work.

Managers gave all new staff a full induction tailored to their role before they started work. Nursing and midwifery staff in the hub told us they were supernumerary during their induction period which lasted eight weeks, or longer if needed, while they completed their training.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection, records showed 81% of staff in the clinic and 87% of staff in the hub had received an appraisal in the last 12 months. All outstanding appraisals were booked. Staff told us they received clinical supervision three times a year and found this was useful.

Medical staff working under practicing privileges received their annual appraisal in the hospital where they held their substantive post. However, there was no formal process to obtain or share information with NHS providers, about the conduct of medical staff working under practising privileges, outside of the annual appraisal documentation they were required to submit.

Managers identified poor staff performance promptly and supported staff to improve. Managers received support and guidance from the corporate team when this was needed.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked with local authorities and the police to ensure patients, and their family, friends, or carers, were not harassed during times where people opposed to abortion would hold vigil outside the clinic. The service had applied for a protected buffer zone many times, but this had not yet been agreed.

When patients were discharged, they were given a discharge letter containing relevant information about their treatment that could be shared with other healthcare professionals in the event of an emergency. Discharge letters were also shared with patients' GPs if the patient consented to this.

Staff in the hub referred patients, who showed signs of mental ill health such as depression, for mental health assessments to their GP. If patients did not consent to a referral, staff sign-posted patients to other support as required.

Seven-day services

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

All patients had access to a 24-hour helpline they could call for advice and support following medical or surgical terminations of pregnancy.

Requires Improvement

Termination of pregnancy

Appointments for suitability for Early Medical Abortion (EMA) and surgical treatment could be booked by patients for between 8am and 8pm Monday to Thursday, on Fridays between 8am and 2pmand between 8am and 2pm on Saturday. The Telemed Hub was open Monday to Friday between 8am and 5pm and on Saturdays between 8am and 2pm.

Health promotion

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

The service had relevant information promoting healthy lifestyles. We saw leaflets available in waiting areas that promoted a healthy lifestyle.

Staff gave advice and information about contraception as part of post treatment care and support. In some cases, they were able to provide a three-month supply of a contraceptive pill by post or other forms of contraception.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

The electronic patient care recorded included checks and evidence that authorisation from two medical clinicians were obtained before any medical or surgical terminations of pregnancy was provided.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. We observed staff provide clear information about the termination of pregnancy procedure and any risks involved. This included opportunities for patients to ask questions.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. All patients under the age of 18 years of age were required to attend the clinic with a responsible adult. If the patient did not have an adult that could escort them the safeguarding team would act on their behalf.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. On occasions, patients detained in prisons attended the clinic for termination of pregnancy. When this happened, a patient centre individual plan of care was agreed in advanced.

Are Termination of pregnancy caring?

Good

This was the first time we rated the services. We rated it as good.

Requires Improvement

Termination of pregnancy

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed patients being treated with kindness and respect, and staff made sure their dignity was maintained as far as possible.

Patients said staff treated them well and with kindness. Patients we spoke with said staff were kind and had explained everything well. The service obtained feedback from patients and this was consistently positive. Data from patient satisfaction survey between 1 April 2021 and 31 March 2022, showed satisfaction scores between 8.81 and 9.27 out of a possible 10 and more than 95% of patients would recommend the clinic to friends and family (based on 195 responses). Feedback from patients about the Telemed Hub was equally as positive in the same period. Data showed the satisfaction scores were between 9.06 and 9.32 out of a possible score of 10 and more than 97% of patients would recommend the service to friends and family (based on 1528 responses).

Staff followed policy to keep patient care and treatment confidential. Staff stored patients written records securely. We observed staff using patient's first names only when they called them in from the waiting area to protect their identity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude. Staff were passionate about respecting and meeting the needs of each patient. They built relationships with patients based on a non-judgmental attitude and trust. One patient who left feedback said, "staff made me feel extremely at ease and normal, not just another person".

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff interact with patients providing them with support and advice as required. This was done in an unhurried, clear, supportive and compassionate way.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff understood when patients became distressed and drew curtains around to provide privacy. Staff offered assurance and support to help patients as far as they could.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff ensure patients were aware that they could access counselling before and after their treatment. This included having counselling at any time in the future if they needed it.

Understanding and involvement of patients and those close to them

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

Requires Improvement

Termination of pregnancy

Staff made sure patients and those close to them understood their care and treatment. Staff took care to include patients' partners, parents or designated responsible adult when patients were discharged. This included an opportunity for them to ask questions, or for advice or re-assurance as needed.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff supported patients to make informed decisions about their care. Staff checked that patients understood the process and procedures around the termination of pregnancy and communicated this clearly.

Patients gave positive feedback about the service. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were feedback forms that patients could complete before they left the clinic and patients could give feedback via the providers website.

Staff supported patients to make informed decisions about their care. Staff provided clear information about the procedure and possible complications and supported patients to ask questions about their treatment.

Are Termination of pregnancy responsive?

Requires Improvement

This was the first time we rated this service. We rated it as requires improvement.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The service had increased the available appointments for surgical terminations to meet an increase in demand. During the COVID-19 pandemic there was a reduced need, but this had increased, and the service now offered surgical terminations on two days each week. A decision was taken to close a satellite service in Weymouth during the COVID-19 pandemic. Leaders felt the needs of patients in this area could be met through the Telemed Hub appointment systems or by accessing the clinic in Bournemouth or other BPAS locations.

In the Telemed Hub, managers planned and organised services, so they met the needs of the local population. The number of telephone appointments offered each day meant that patients did not have to wait long for assessment.

The service was accessed by a door on the ground floor and this was restricted so only patients and the person accompanying them could access the service. The main clinic was on the second floor and there was a lift for people unable to use the stairs.

The Telemed Hub comprised of multiple rooms so that calls were not being taken in rooms with lots of background noise. Most staff worked from home and calls took place in a peaceful environment. Staff wore headphones and spoke into a microphone, this meant patients could not be overheard if another person came into the room.

Staff monitored and took action to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted. Staff were not required to report these as incidents but were required to record this on individual patients' case notes. There was a policy which provided guidance for staff about the required actions they should take.

In the hub, there were four leads on call to support the nurse midwife practitioners (NMPs). If an NMP was off work, one of the hub leads would stand in and cover the absent staff member to avoid cancelling assessment appointments.

The service had systems to help care for patients in need of additional support or specialist intervention, including access to emergency mental health support for patients with mental health conditions. The service had information about a range of support services they could refer patients to. Referrals would be done either through the patients GP or directly to services, with the patients' consent.

Meeting people's individual needs

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

We observed staff being inclusive and took account of patients' individual needs. Staff were compassionate about meeting the needs of patients, including those with protected characteristics. Staff provided support for all patients and were non-judgmental in their approach. They took account of individual's situations and assessed risks and how best to support patients in line with their needs and wishes, including for people with physical or mental health needs. Staff supported patients from the transgender, non-binary or intersex community and patients who attended for repeat treatments were provided with additional support to meet their complex needs.

Staff told us about how they worked together as a team to meet the needs of women who needed treatment within a given timeframe so that they could carry on with their lives.

All women were offered counselling at the time of the termination of pregnancy and at any time in the future if this was required related to the treatment. There was a pool of BPAS counsellors who provided this service and staff were aware of how to refer patients when this was needed.

Staff identified, flagged up and shared information about patients' communication needs to meet their requirement and to ensure effective communication using recognised interpreters when needed. Staff had access to communication aids to help patients become partners in their care and treatment. The service used an interpretation service that could provide telephone and face to face foreign language interpretation, as well as British sign language and Makaton. The service's website is available in 64 languages to reflect languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. For example, staff in the Telemed Hub told us they offered two or three assessment calls with an interpreter each day. Managers monitored the use of these slots and more were booked if the base line appointments were filled.

Access and flow

Waiting times from contact to consultation and treatment did not always meet standards in line with national standards and commissioning requirements.

Termination of pregnancy

Managers monitored waiting times, but patients could not always access services within agreed timeframes and national targets. However, staff told us about how they worked as a team to meet the needs of individual patients who required treatment within a short timeframe to enable them to carry on with other commitments.

In the hub outcomes for patients found suitable for early medical abortion were positive and consistent. Staff told us patients could receive an appointment for assessment within five days and often in less than 48 hours. Once assessed, staff worked to enable patients to have a medical or surgical termination of pregnancy within five days. This sometimes meant patients would have to travel long distances for a scan, to determine gestation of pregnancy, and for the procedure itself. Staff worked hard to get patients appointments in their local area and as soon as possible, if this was their preference. Staff logged any delays in booking scans or procedures for women on the incident reporting system so that managers had oversight of this.

Data showed the service did not always meet the national standard for waiting times for 'contact to consultation' and 'consultation to treatment'. Records showed between 27% and 91% of patients were given a consultation appointment within seven days of contacting the service, and between 77% and 92% of patients received treatment within seven days from their consultation (1 June 2021 to 31 May 2022). This was not in line with their commissioning contract and national standards. However, sometimes these waiting times were not met due to patient choices or ability to reach their appointment.

The service transferred patients when there was a clear medical reason. Staff supported patients when they were referred or transferred between services. The service had a service level agreement with a nearby NHS trust for the transfer of patients who became clinically unwell during surgical termination of pregnancy or where ectopic pregnancy (pregnancy outside of the womb) was suspected.

Managers and staff worked to make sure they started discharge planning as early as possible so that patients could leave the unit safely as soon as they had recovered following surgical terminations. Staff in the hub gave aftercare advice and information at the assessment appointment so that patients were clear on what to do if something went wrong during or after their treatment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Information was available on the service's website about how to make a complaint or raise a concern. Information was also displayed in the reception/waiting area. The website contained detailed information about the complaints process including the timescales patients' complaints were handled in.

The service had received ten informal complaints and two formal complaints in the 12 months before our inspection. Staff contacted patients to resolve local informal complaints but did not fully investigate these to review opportunities for learning or making improvements. However, complaints and patient feedback was shared in staff meetings to promote actions to improve the service.

Requires Improvement

Termination of pregnancy

Are Termination of pregnancy well-led?

Inadequate

This was the first time we rated this service. We rated it as inadequate.

Leadership

Leaders did not always have capacity to provide leadership as they had dual roles. However, they had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge, experience and integrity to run the service. There had been a change in the registered managers position during the last 12 months. In the clinic, the current manager and lead nurse both had dual roles, which had impacted on their ability to have a focused approach to patient safety issues and service development. We were told these arrangements were for a limited time and due to end soon after our inspection.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Leaders understood the availability of assessments, scans and surgical appointments were paramount to delivering a quality service that met the needs of patients. They had introduced systems to improve service delivery.

Staff told us leaders were visible and approachable. They said managers operated an open-door policy and they could also get support from regional and national managers and teams when needed.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, not all staff understood and knew the provider's vision and strategy.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. However, not all staff in the BPAS clinic knew and understood what the vision, values and strategy were, and their role in achieving them.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans was monitored and reviewed.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, not all staff were aware of who the freedom to speak up guardian was and how to contact them.

Staff felt supported, respected, valued and were positive and proud to work in the organisation. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority. Clinic staff told us it was "a nice place to work where staff are friendly and supportive" and staff worked hard "to do the right thing" whether this was to follow guidance and policy or to be the advocate for patients contacting the service. Staff in the hub told us they felt "really supported by managers" or "had never felt so supported in the workplace before". All of the hub staff said they felt valued.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, and in response to incidents. Staff in the hub knew who the freedom to speak up (F2SU) guardian was and how to contact them. However, staff we spoke with in the clinic were not aware of who the F2SU guardian was but said they could raise concerns to leaders within the clinic if needed.

There were mechanisms for providing all staff at every level with the development they needed and to develop the service further. Staff were supported to undertake further qualifications to undertake scanning appointments in the clinic, but they found it difficult to complete enough scans to achieve the required level of competence.

Staff received six monthly high-quality appraisal and career development conversations. There was a strong emphasis on the safety and well-being of staff. Equality and diversity were promoted within and beyond the organisation.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively. Staff told us there was great teamwork and they had good support from colleagues and senior staff when they needed it.

Governance

Leaders did not always operate effective governance processes. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were mostly effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Some of these processes were managed corporately in line with the governance structure. However, a review of reported incidents where termination of pregnancies without the required legal documentation had not been investigated appropriately. We reviewed patient records and investigation reports and found two incidents where the Human Abortion Act 1967 had been breached. Staff had not obtained two signatures to authorise the termination in line with legal requirements set out in the Human Abortion Act 1967. The investigation of the incident was not of required standard and had not been reported to the Care Quality Commission, which was in breach of the provider's conditions of registration.

Processes to ensure timely completion of legal documentation following terminations did not always ensure these were submitted to the Secretary of Health within the 14-day response time. During the site visit, we asked staff to run a report about outstanding forms (HSA4) that was due to be submitted. One form was due to be submitted on that same date, but still required a notification to be sent to the surgeon who performed the surgical termination, and for them to complete and submit the form the same day. We were not assured there were embedded processes to review and demonstrate the timeliness of the submission of HSA4 forms in line with legalisation.

There were processes to ensure managers had oversight of training, competences and appraisals. These arrangements were in the process of being improved so managers received notifications when staff training needed updating.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. We reviewed the minutes of the last two meetings which were held in October 2021 and February 2022. There were mostly regular meetings at each level of BPAS governance structure. Minutes of meetings confirmed there were set agendas to ensure quality and performance was discussed. However, local team meetings did not seem to follow a set agenda and were not held regularly.

Audits were carried out to evaluate the effectiveness and compliance with internal standards. These audits included medicines management, documentation audit (including safeguarding) and checking of emergency equipment. When non-compliance was identified, leaders drew up an action plan to improve compliance to ensure safe care and treatment was provided.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. There was a service level agreement (SLA) between the service and a nearby NHS hospital for the onward referral or transfer of patients who became clinically unwell. Following the onsite inspection, we requested the SLA, but this had not been signed or dated. Information shared with CQC after the inspection, demonstrated that the development of the SLA was work in progress and had not yet been completed.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. Risks were mostly aligned between recorded risks and what staff said was 'on their worry list'. Leaders spoke of risks regarding procurement of equipment/consumables and of working in dual roles. These risks were not aligned to the risks raised on the risk register for the service.

The service had assurance systems and performance issues were escalated through clear structures and processes. There were separate risk registers for the clinic and for the TeleMed Hub. Risks were rated and actions were identified to mitigate risks.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. The incident reporting system was used alongside a series of audits to review performance and devise action plans to implement and drive improvements. The service was commissioned by clinical commissioning groups. We reviewed the arrangements as set out by a local commissioning group and the arrangements for review and reporting of quality standards.

Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Telemed Hub staff we spoke to were aware of the top three risks facing the service and were invested in making changes within the systems and processes to reduce risk. For example, the team had identified a risk with the way in which safeguarding referrals were recorded and monitored. They worked together to devise a more robust recording system and were awaiting the implementation of the new system.

Information Management

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

Information was used to measure improvement, not just assurance. Both quality and sustainability received coverage in relevant meetings at all levels. Information was shared with staff, including staff working under practicing privileges, in meetings, through emails and in daily safety briefings.

Staff had access to information and challenged it when necessary. Staff in the hub knew how to locate local and national policies. However, not all staff in the clinic were aware of how to access policies and procedures on the service's intranet.

There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data or notifications were submitted to external bodies as required. The service had reported ten serious incidents to the Care Quality Commission between June 2021 and May 2022.

There were also arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards.

Patients were made aware how their personal information would be used on the provider's website. There were clear links to further information when patients used the website to book their appointment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups, people who used services, and those close to them. All patients who attended the clinic had the opportunity to provide feedback. The response rate was low at around 15% but feedback was positive with an overall satisfaction score of between 9.2 and 9.4 out of a maximum score of ten (January to March 2022). The response rate from the Telemed Hub was much higher. For example, between April and June 2021, there were 471 responses from patients contacting the hub compared to 50 responses from patients attending the clinic.

Termination of pregnancy

There was an annual corporate staff survey, but results were not broken down to reflect each BPAS location. The overall staff survey for 2021 stated 91% of 475 respondents would recommend BPAS to friends and family and 88% reported they believed they had a worthwhile job and 58% reported they were satisfied with their work-life balance. Some staff (54%) reported they felt unwell due to work-related stress. The staff took part in regular staff surveys, including those with a protected characteristic, and their views were reflected in the planning and delivery of services and in shaping the culture. Staff in the hub told us their views were taken seriously by managers and gave us examples of when things had changed as a result of their feedback.

It was difficult for patients to identify the job roles of the staff they spoke to. Staff had access to uniforms and laundry services, but there was no uniform code requiring staff of different grades or professions to wear different uniforms. There was a uniform policy (2016) but role identification was not included or considered as part of the policy.

There were collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance. The service provided free educational and training resources for schools and colleges, and for professionals on their website.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Leaders and staff aspired to continuous learning, improvement and innovation. This included the introduction of the Telemed Hub during the COVID-19 pandemic.

Learning from internal and external reviews was shared to improve patient safety.

Staff regularly took time to work together to resolve problems and to review individual and team objectives, processes and performance which led to improvements and innovation. For example, the service had identified access to scanning of patients was not always easy to arrange. The service had introduced access to additional qualifications for staff to increase capacity to provide more scans. There was also plans to extend the skills of midwives and nurses to fit contraceptive devices.