BPAS - Streatham

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

BPAS Streatham provided medical and surgical termination of pregnancy services, screening for sexually transmitted diseases, contraception advice and counselling. The service was providing surgical terminations up to 23 weeks plus six days gestation and medical abortions up to nine weeks plus six days gestations. The service treated NHS and private patients.

We visited the Streatham location by announcement on 10 and 11 May 2016.

Ratings have not been published for this location and the services offered, as the CQC does not currently have a legal duty to award ratings for services that provide solely or mainly termination of pregnancy.

We report on whether they are safe, effective, caring, responsive to people's needs, and well-led. We have highlight areas of good practice and areas for improvement.

Overall, we found there were areas for improvement related to safety and the leadership of the service. The services provided by staff were in the main effective and responsive to people's needs. Staff provided treatment and support, which was caring.

Are services safe at this service

Improvements were required to ensure a safe service was consistently delivered.

- A formal incident reporting process was used by staff, which included investigation and outcome learning. However, the required actions were not addressed in a timely manner.
- Infection prevention and control practices were not sufficiently robust with respect to the operating theatre environment, and the use of cleaning equipment.
- The recording of accurate information in the controlled drug register needed to improve, and storage of temperature controlled medicines and other medicines were not sufficiently safe.
- There were sufficient staff with relevant skills and competencies to cover the service.

However;

- There were suitable transfer agreements with the local NHS to ensure patients who required higher levels of medical treatment had their needs met.
- Safeguarding guidance and practices were embedded in staffs knowledge and behaviours. There were appropriate individuals available to oversee safeguarding.

Are services effective at this service

The services provided at the location were effective.

- Evidence based care, treatment protocols and guidance were used to support the delivery of services.
- Corporate policies and procedures were accessible to staff, although these did not always provide detailed information.
- Patient outcomes were monitored and benchmarked within the national group, and local audits contributed to the broader organisational monitoring of the quality and effectiveness of services.

Summary of findings

- Revalidation and practising privileges were managed corporately; ensuring only appropriate medical personnel were working at the service.
- Staff were trained with regard to consent, the Mental Capacity Act (2005), and deprivation of liberty safeguards. Consent processes were used to ensure individuals were provided with sufficient information on which to make a decision.

Are services caring at this service

Staff provided a good standard of treatment and care.

- We observed staff to be kind, compassionate, and caring when responding to the needs of people using the service. Emotional support, including counselling was available to everyone.
- Information was provided to individuals using the service in a range of formats, which enabled them to make informed choices.
- People were encouraged to feedback on their experience, and information was compared within the broader organisation.

Are services responsive at this service

We found the services available were responsive to the individual needs of people who sought treatment and care.

- Services were planned to enable access to the main locations as well as satellite sites, and alternative locations outside of these hours.
- Staff were able to meet the individual needs of people attending the service. Specific support was available, which included interpreters, literature written in a range of languages, advice, and counselling.
- The service was fully inclusive, but took into account safety and legal guidance when making decisions to proceed with appointments and treatment.
- Complaints were acknowledged, investigated, and responded to within a specified time. Learning arising from complaints was communicated to staff.

Are services well led at this service

Improvements were needed to ensure the service was well led.

- Governance, risk management, and quality measurements were established at a corporate level. There was a lack of local risk register and oversight of the monitoring of best practices.
- There was a lack of autonomy within the local leadership team, which was overseen by the corporate executive team. As a result, the ability to be innovative, creative and flexible was limited.
- The culture required attention with respect to team working and attitudes.

Our key findings were as follows:

- Staffing levels were appropriate for the levels of activity. Where agency staff were used, they were subject to assurance checks and local induction.
- Leadership needed to be more proactive and responsive to the challenges that affected staff working relationships, and role requirements.
- Actions required to minimise risks to women following surgical procedures were not addressed as quickly as they could have been.

Summary of findings

- Most areas within the service were clean. However, the arrangements for cleaning the operating theatre floor were not sufficient. There was an absence of directives for cleaning the floor and confusion about the frequency of cleaning. Staff did not follow corporate policy when using colour coded cleaning equipment.

From our inspection at location level we identified shortfalls in the corporate policy on decontamination. We raised this with the provider who took steps to address this. In addition, we raised concerns regarding the lack of location risk register, and leadership autonomy, which the provider took action to improve.

In addition the provider should:

- Follow medicines management standards with regard to storage and controlled drug record keeping.
- Review and monitor staffs adherence with infection prevention and control professional guidance, in order to maintain standards to a consistent level.
- Provide staff with information so they understand what a Never Event is and that they are made aware when such an event occurs within the organisation. In particular, any learning arising from this is subsequently acted upon.
- Provide staff with relevant training to enable them to understand what the duty of candour means and how the regulation applies to the service.
- Review treatment pathways with an aim of improving waiting times and flow through the service.
- Provide separate waiting areas for women who are attending for termination of pregnancy for fetal abnormality (TOPFA).
- Review the ability to meet patient's choices with regard to attending alternative locations for medical termination.
- Improve accessibility to competency-based training within the induction period.
- Where shortcomings in compliance with best practice are identified, they are addressed promptly.
- Identify local risks and actions to mitigate these, ensuring staff are aware and understand the impact of these.
- Develop enhanced and effective working relationships across all staff grades.
- Increase visibility and approachability of senior staff.
- Explore and develop ways of increasing engagement with the public and staff.
- Consider payment for training where attended by temporary staff.
- Provide temporary staff with a performance review.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Improvements were required to ensure a safe service was provided and that effective leadership supported this. This was because:

- Procedures for recognising and responding to the deteriorating person had not been addressed in a timely manner.
- Infection prevention control (IPC) procedures did not adhere to The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines.

Summary of findings

- Systems to manage and monitor the prevention and control of infection were not fully implemented and acted upon. The cleaning arrangements for the operating theatre were not specified and the floor was not to the required standard of appearance and cleanliness.
- Attention was required for recording accurate information in the controlled drug register.
- The storage of temperature controlled medicines and other medicines were not sufficiently safe.
- The local governance and quality monitoring processes did not always identify and take actions to address shortcomings where best practice was not being adhered.
- There was work to do to ensure effective working relationships across all staff grades, and that staff were able to see issues raised were addressed in a timely manner.
- There was some engagement with the public and staff but a top down approach meant it was less easy to be innovative at a local location level.

However, positive aspects of the service were identified with regard to safety, effectiveness, responsiveness, caring, and leadership. This included:

- Treatment was mostly delivered in accordance with professional guidelines, which were accessible to staff.
- Audit and outcomes for clients were monitored to ensure effective pathways were achieved.
- Training specific for individual roles was provided to staff to ensure they were able to meet the needs of the patients they cared for.
- Staff ensured vulnerable individuals were referred to external agencies in line with safeguarding protocols.
- Patients were offered appropriate pain relief, precautionary antibiotic treatments, and post-abortion contraceptives.
- The privacy, dignity, and respect of patients was fully considered in all aspects of the consultation and treatment pathways. Patients' choices were mostly respected and they had a chance to speak with a nurse or midwife on their own to make sure they were not being pressurised to make a decision.
- Patients received information in a sensitive manner and were treated with kindness and compassion. Staff provided attention to their emotional and social needs.
- The service was accessible and afforded flexibility and choice.
- Complaints were minimal but where raised were responded to in a timely manner.
- Performance targets were generally indicative of an efficient and responsive service.
- Staff understood the organisational strategy and ethos.
- Organisational governance arrangements meant there was some oversight of performance, incidents, and complaints.
- Senior staff understood their responsibilities under the duty of candour regulation.
- Whilst there was no local risk register, there was work in progress to identify location specific risks.
- Staff were supported to develop their skills and were provided with service specific information through a range of methods.
- People who used the service, as well as staff were encouraged to feedback on the service in order to make improvements.

Summary of findings

Contents

BPAS-Streatham

Services we looked at:

- Termination of pregnancy
- Diagnostic & Screening Procedures
- Family Planning Services
- Treatment of Disease, Disorder and/or Injury
- Surgical Procedures

The services provided under these activities were:

- Pregnancy Testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Surgical Abortion Local Anaesthetic/conscious Sedation
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice
- Contraception Supply

Summary of this inspection

Background to BPAS - Streatham

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy, by surgical or medical methods. BPAS Streatham provides services for women of reproductive age from all areas of the UK, and sometimes overseas, although the majority of the clients come from within London based clinical commissioning groups (CCGs).

The service was registered as a single speciality service for termination of pregnancy and was registered for the following regulated activities:

- Diagnostic & Screening Procedures
- Family Planning Services
- Treatment of Disease, Disorder and/or Injury
- Termination of Pregnancy
- Surgical Procedures

The services provided under these activities were:

- Pregnancy Testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Surgical Abortion Local Anaesthetic/conscious Sedation
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice
- Contraception Supply

The Registered Manager has been in post since 12 April 2011.

Our inspection team

Our inspection team was led by Stella Franklin, Inspection Manager, Care Quality Commission. The team included two specialist advisors in nursing and midwifery.

Why we carried out this inspection

We carried out this inspection as part of our inspection programme.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We have not provided the 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 which it provides.

Summary of this inspection

Although we do not currently have the powers to rate these services, we report on whether they are safe, effective, caring, responsive to people's needs and well-led. We have highlight areas of good practice and areas for improvement.

Prior to the inspection, we requested a provider information report, the information submitted to the commission was analysed and considered both in the planning and as part of the evidence gathering process.

We visited the Streatham location by announcement on 10 and 11 May 2016. During our visit, we spoke with one patient attending the service and observed staff interactions with one another, patients, and their partners. We reviewed 19 treatment and care records, in addition to other requested documentary evidence. We spoke to 13 staff including the registered manager, the clinical manager, registered nurses, midwives, healthcare assistants, and administrative staff.

Patient feedback cards were provided to the service prior to our inspection, and we reviewed nine of these.

Information about BPAS - Streatham

Regulation 20 of the Care Quality Commission (Registration) Regulations 2009 sets out a number of requirements relating to the termination of pregnancy. This regulation applies to a registered person who carries on or manages the regulated activity of termination of pregnancies and who is not an English NHS body. To meet this regulation the provider must follow the requirements of the regulation and the procedures and guidance issued by the Department of Health in May 2014, concerning procedures for the approval of independent sector places for the termination of pregnancy (Abortion), and guidance in relation to requirements of the Abortion Act 1967.

The service, along with its satellite location hold a licence from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967.

The location is registered with the Care Quality Commission as a provider of termination of pregnancy (TOP) services. Registration began on 12 April 2011. The Registered Manager for the location has been in post since 14 April 2011.

Services are provided to both NHS and privately funded clients.

BPAS Streatham provides support, information, treatment, and aftercare for people seeking help with regulating their fertility and associated sexual health needs. In addition to this, the service includes pregnancy testing, unplanned pregnancy counselling and consultation, and abortion aftercare. Patients have access to miscarriage management, sexually transmitted infection testing and treatment, contraceptive advice and contraception supply.

The main activity is termination of pregnancy, via medical or surgical methods. The service prescribes and administers abortifacient medication for early-medical abortion, where a pregnancy is up to nine weeks and six days gestation. They also provided early surgical abortion, between seven and 14 weeks gestation, using local anaesthesia and or conscious sedation. Surgical abortions are undertaken under general anaesthetic up to a gestation 23 weeks and six days. Medical feticide is provided before late gestation surgical abortions.

BPAS Streatham has one early medical unit (EMU) satellite branch, BPAS Southwark, Blackfriars Medical Practice, 45 Colombo Street, London SE1 8EE. The location is fully accessible, and is open on Thursday and Fridays 9am – 4pm and provides an early medical abortion service, contraceptive advice, and prescription. We did not inspect this EMU service on this occasion.

5080 patients used the service between January 2015 and December 2015. Of these: 1502 (31%) had an early medical abortion (EMA), surgical abortion accounted for 3354 (69%), and there were 224 abortions after 20 weeks of gestation. Abortions are not undertaken for gestation above 23 weeks and six days.

Patients of all ages, including those aged less than 18 years are treated at both locations. Between 1 April 2015

Summary of this inspection

and 31 March 2016, 222 clients under the age of 18 were treated at BPAS Streatham for TOP. Three clients under the age of 18 were treated at BPAS Southwark during the same time-period.

What people who use the service say

- We spoke with one patient during our visit, who told us everyone had been very friendly, and commented on the speed of the visit.
- Nine CQC feedback cards had been completed by patients who attended the service. All the comments were positive, and included description of staff as warm, friendly, polite and professional. One patient had indicated having been 'treated with respect and dignity throughout.' Another described the nurse as 'a star'. Other comments made were of feeling safe and well cared for.
- The results of the BPAS Client Satisfaction Survey showed high levels of satisfaction with care. 90% of patients gave a rating of excellent to the care and attention given by nursing staff, and 82% rated the patient experience as excellent.

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?

Improvements were required in order to ensure people using the services were safe.

- There were client risk assessments and procedures for recognising and responding to the deteriorating person; however, actions required to implement improved practices were not addressed in a timely manner.
- The cleaning arrangements for the operating theatre were not specified, and the floor was not to the required standard of appearance and cleanliness. The local Infection prevention control (IPC) procedures did not adhere to The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines.
- Systems to manage and monitor the prevention and control of infection were not fully implemented and acted upon. Staff were not following the corporate policy when using separate colour coded cleaning equipment.
- Attention was required for recording accurate information in the controlled drug register.
- The storage of temperature controlled medicines and other medicines were not sufficiently safe.
- Anaesthetic risk assessments were not undertaken on patients having a general anaesthetic.

However;

- There was a formal incident reporting and investigation process, with evidence of learning from this.
- Senior staff understood their responsibilities to be open and honest with people where mistakes or errors were made.
- Safety checks and servicing of equipment had been carried out.
- Staffing arrangements and their skills supported the delivery of services.
- Staff had received training in safety related subjects and had access to regular training updates. They understood and carried out their responsibilities to safeguard vulnerable people.
- Doctors taking responsibility for abortions were in the majority of instances notifying the Chief Medical Officer (CMO) within 14 days of the termination.

Summary of this inspection

Are services effective?

We found an effective service was provided at the service. This was because:

- Treatment was mostly delivered in accordance with professional guidelines.
- Audit and outcomes for patients were monitored to ensure effective pathways were achieved.
- Policies, procedures, and guidance were accessible for staff and were generally developed in line with department of health standard operating procedures and professional guidance.
- Patients were offered appropriate pain relief, precautionary antibiotic treatments, and post-abortion contraceptives.

However;

- Although training specific for individual roles had been provided to staff to ensure they were able to meet the needs of the patients they cared for, we were not assured that paediatric life support training had been provided to the required level.

Are services caring?

We found that staff provided a caring service. This was because:

- The privacy, dignity, and respect of patients was fully considered in all aspects of the consultation and treatment pathways.
- We observed and patients reported feeling safe and well cared for by staff that were non-judgmental in their approach.
- Patients had a chance to speak with a nurse or midwife on their own to make sure they were not being pressurised to make a decision. They received information in a sensitive manner, and were treated with kindness and compassion.
- The emotional and social needs of each person were respected by staff, and embedded in their care and treatment.

Are services responsive?

We found the service was generally responsive to the needs of patients. This was because:

- The service was accessible and afforded flexibility and choice. The appointment system took into account specific needs of patients with higher gestational pregnancy, and those having complex needs.
- Information was available to support patients in making decisions and choices around their needs.
- Complaints were minimal but where raised were responded to in a timely manner.

Summary of this inspection

- Performance targets were generally indicative of an efficient and responsive service. The percentage of patients treated at less than 10 weeks gestation was above the national average at 87%.

However;

- Although the individual needs of patients were considered, and taken into account in arranging appointments, treatment, and care, they were not always able to obtain appointments of their choice at other locations.
- The pathway through the service was disjointed and resulted in some patients having to wait in different areas to be seen by different staff.

Are services well-led?

We found improvements were required to ensure the local service was well-led. This was because:

- The local governance and quality monitoring processes did not always identify risks and take actions to address shortcomings where best practice was not being adhered to.
- Where actions were required to minimise risks to patients using the service, these were not addressed in a timely manner.
- The addition of new staff and improved stability was contributing to a developing culture of openness. There was however, work to do to ensure improved and effective working relationships were established and maintained across all staff roles. In particular, leadership needed to provide visibility and demonstrate a commitment to managing inappropriate behaviours, and to address issues raised by staff.
- There was some engagement with the public and staff but an organisational top down approach meant it was less easy to be innovative at a local location level.

However;

- Staff understood the organisational strategy and ethos.
- Organisational governance arrangements meant there was oversight of local performance, incidents, and complaints.
- Whilst there was no local risk register, there was work in progress to identify location specific risks.
- Staff were supported to develop their skills and were provided with service specific information through a range of methods.
- People who used the service and staff were encouraged to feedback on the service, and to contribute to making improvements.

Summary of this inspection

- Information was provided to the Department of Health in accordance with Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.

Detailed findings from this inspection

Notes

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

There are two buildings at BPAS Streatham. The 'lodge' has two consulting rooms, two clinical rooms and a separate doctor's room. In the main building, there is one operating theatre, with a separate recovery area. A lift provides access between the ground and first floor. There are 11 recliner chairs making up the post-operative ward area, which is divided into units with either three or two chairs, hand washing facilities and privacy curtains. A nurse-led discharge room is located in the ward area.

Methods of termination of pregnancy provided at the service include medical abortion, using prescribed medicines, surgical abortion under a general anaesthetic, and surgical abortion under local anaesthetic/conscious sedation.

The location was previously inspected under our former methodology on 18 February 2013, where it was found to be meeting all the required regulations.

Summary of findings

Improvements were required to ensure a safe service was provided and that effective leadership supported this. This was because:

- Procedures for recognising and responding to the deteriorating person had not been addressed in a timely manner.
- Infection prevention control (IPC) procedures did not adhere to The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance or associated national guidelines.
- Systems to manage and monitor the prevention and control of infection were not fully implemented and acted upon. The cleaning arrangements for the operating theatre were not specified and the floor was not to the required standard of appearance and cleanliness.
- Attention was required for recording accurate information in the controlled drug register.
- The storage of temperature controlled medicines and other medicines were not sufficiently safe.
- The local governance and quality monitoring processes did not always identify and take actions to address shortcomings where best practice was not being adhered.
- There was work to do to ensure effective working relationships across all staff grades, and that staff were able to see issues raised were addressed in a timely manner.

Termination of pregnancy

- There was some engagement with the public and staff but a top down approach meant it was less easy to be innovative at a local location level.

However, positive aspects of the service were identified with regard to safety, effectiveness, responsiveness, caring, and leadership. This included:

- Treatment was mostly delivered in accordance with professional guidelines, which were accessible to staff.
- Audit and outcomes for clients were monitored to ensure effective pathways were achieved.
- Training specific for individual roles was provided to staff to ensure they were able to meet the needs of the patients they cared for.
- Staff ensured vulnerable individuals were referred to external agencies in line with safeguarding protocols.
- Patients were offered appropriate pain relief, precautionary antibiotic treatments, and post-abortion contraceptives.
- The privacy, dignity, and respect of patients was fully considered in all aspects of the consultation and treatment pathways. Patients' choices were mostly respected and they had a chance to speak with a nurse or midwife on their own to make sure they were not being pressurised to make a decision.
- Patients received information in a sensitive manner and were treated with kindness and compassion. Staff provided attention to their emotional and social needs.
- The service was accessible and afforded flexibility and choice.
- Complaints were minimal but where raised were responded to in a timely manner.
- Performance targets were generally indicative of an efficient and responsive service.
- Staff understood the organisational strategy and ethos.
- Organisational governance arrangements meant there was some oversight of performance, incidents, and complaints.
- Senior staff understood their responsibilities under the duty of candour regulation.
- Whilst there was no local risk register, there was work in progress to identify location specific risks.
- Staff were supported to develop their skills and were provided with service specific information through a range of methods.
- People who used the service, as well as staff were encouraged to feedback on the service in order to make improvements.

Termination of pregnancy

Are termination of pregnancy services safe?

Incidents

- The BPAS organisation had a 'client safety incidents policy and procedure', which set out the procedures for reporting and reviewing incidents. All staff we spoke with were familiar with how to report incidents, and some gave examples of incidents they had reported.
- The system for reporting clinical and non-clinical incidents was paper based using an incident-reporting book, held by the registered manager. Three copies of the incident report were made: one remained in the patient notes, one remained in the book, and one was sent to head office. Incidents were then escalated to the corporate risk and safety team who would record them on a central electronic register.
- Findings were discussed at the regional clinical governance committee, the regional quality, assessment and improvement forum (RQuAIF) and regional management meetings.
- There were no never events reported at BPAS Streatham between January 2015 and December 2015. However, there had been one never event at another BPAS treatment unit in September 2015, but staff were not aware of this, and therefore any lessons learned from the investigation were not shared. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
- There were two serious incidents requiring investigation (SIRIs) at BPAS Streatham between January 2015 and December 2015. Notes from the most recent London and South East Regional Management meeting held on 2 March 2016, confirmed learning about complaints and serious incidents requiring investigation (SIRI) had been discussed, and action points agreed.
- A SIRI had also occurred in January 2016, and whilst we saw some of the investigation work for this, and a root cause analysis (RCA) had been carried out, the matter had not been closed. The patient this SIRI related to had not received a written communication updating them of progress with the investigation, or the outcome, with an apology. When questioned regarding this, the registered manager advised the individual had declined contact from the service. A record of attempts made to contact the individual had been retained. We found the action taken by the service was in line with the duty of candour regulation.
- Serious incidents were discussed at quarterly BPAS clinical governance meetings. Where serious incidents had occurred investigations and analysis of the root causes were carried out by the national risk management and safety lead and the clinical director. Regional directors and treatment unit managers then disseminated lessons learned to staff, and action plans were developed to reduce the risk of a similar incident reoccurring. This was generally managed regionally and learning was shared with staff in all BPAS treatment units in the region.
- Staff confirmed they were made aware of incidents at team meetings and other forums. They indicated the type of incidents that had occurred at the location, including the predominance of incidents related to management of blood samples. In the majority of cases reported incidents for blood samples related to samples being too small for testing, mislabelling and haemolysation (This is the destruction of red blood cells before their normal life span is up). We were told of the measure taken to reduce further such incidents. This included additional training, printed labels for samples, and ensuring the courier collected samples within timeframes.
- There was a policy to guide staff in relation to the duty of candour. Staff knowledge about this was variable, with staff explaining it was about apologising directly to clients about such matters as long waiting times. There was no evidence of training or information available to staff or patients about this.
- Senior staff understood their responsibilities to speak up when things went wrong or not as planned. They were aware of the need to be open and honest with patients and other relevant persons. We found there was a robust process to investigate and feedback to individuals, as well as the provision of a written apology.

Cleanliness, infection control and hygiene

- A director of infection prevention and control (DIPC), based at BPAS head office was responsible for leading the organisation's infection prevention team. The DIPC

was part of the organisation's clinical governance and patient safety teams and structures. The DIPC was supported by the regional operations director, and the registered manager, to ensure local policies and practices were correctly implemented.

- We were told the unit manager was responsible for implementing cleaning standards, and the support service co-ordinator had been given devolved responsibility for cleaning standards.
- There was guidance available to staff with respect to infection prevention and control measures, some of which we reviewed during our inspection.
- The 'Health and Social Care Act 2008: code of practice for health and adult social care on the prevention and control of infections and associated guidance, 2015' requires the service to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Infection prevention and control (IPC) training was mandatory and after induction was expected to be completed each year. Annual IPC training had been provided to staff, and there were IPC link staff at the location.
- The location had an infection prevention and control (IPC) annual plan. This indicated the expected level of compliance with standards and the actions required to address areas of non-compliance.
- There was a corporate IPC team and access to a consultant in communicable disease control, available through Public Health England.
- Staff had access to IPC policies and procedures to guide and support them in delivering safe practices, although some of the detail contained therein was limited.
- Despite all the arrangements and available guidance, we found there were inadequate systems for safely managing the risks if infection in the operating theatres. This was particularly concerning, given that late surgical terminations were undertaken.
- In our review the corporate Environmental Cleaning Guidelines ICT/16, issued June 2015, did not contain any specific guidance with regard to the cleaning of the operating theatre surfaces, including the floor. The policy stated: All clinical sites must have their own written cleaning schedule. This schedule should specify the persons responsible for cleaning each area, the frequency of cleaning, and the methods to be used. Further, the policy stated: Cleaning schedules should be monitored regularly (6 monthly), and cleanliness must be audited regularly (at least every 3 months). The last cleaning audit indicated cleaning of theatre and the whole clinic took place three monthly, and had been completed on 25 April 2016.
- Corporate Decontamination Guidelines ICT/07, issued June 2015 did not make any reference to environmental decontamination practices.
- Systems to manage and monitor the prevention and control of infection were not fully implemented and acted upon. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. Criterion two of the code of practice relates states: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Responsibilities included ensuring all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition; the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request.
- Cleaning of the environment was carried out daily by the on-site domestic staff. The exception to this was the operating theatre and recovery area, which clinical staff were responsible for cleaning.
- We found the operating theatre floor was heavily stained and marked. The skirting to the floor was dusty.
- We asked to see cleaning schedules and evidence that cleaning was taking place and was being monitored. Cleaning schedules detailed the area, frequency of cleaning, responsibility, method to be used, and products. Although there were checklists signed by cleaning staff for most areas, these were not used in the operating theatre or recovery area. Cleaning schedules were not in evidence in the theatre department.
- We were told clinical staff took responsibility for cleaning the operating theatre; including ensuring a deep clean was undertaken. There was inconsistency in

staff reports of the frequency and extent of the theatre cleaning. We were told by one nurse the theatre was deep cleaned monthly, and another told us it was weekly. Other information provided to us indicated it was cleaned twice a year.

- National Patient Safety Agency April 2007, provides guidance, which states; 'the complete floor including all edges, corners and main floor space should have a uniform finish or shine and be visibly clean with no blood and body substances, dust, dirt, debris or spillages'. We noted the floor surface was dull in appearance, and when we asked about the cleaning of the floor we were told it was not polished and staff had not been able to remove the marks.
- The operating theatre floor was not included in the deep clean checklist we viewed, and we were advised via an email response to our question about the deep cleaning arrangements, that it was not necessary as it was disinfected at the end of each day. The Environmental Cleaning Guidelines ICT/16, issued June 2015, indicated disinfectants should not be used for general cleaning.
- Staff told us the floor was cleaned by an outside contractor. There was no formal evidence to support this and no record to indicate that it had been deep cleaned since 2014.
- The National Patient Safety Agency Safer practice notice 15 'Colour coding of hospital cleaning materials and equipment, 2007' was not correctly followed. This system is universal and is designed to minimise risks of cross contamination and to provide a consistent approach across healthcare providers. The corporate 'Environmental Cleaning Guidelines ICT/16' indicated that to avoid cross contamination a colour coding system for cleaning equipment must be in place. The appendices of the policy indicated the colour coding system to be used. We found this was not adhered to. For example, red coloured items were used in theatres but the policy stated yellow for this area. Red items were to be used in bathrooms, toilets and for sanitary items.
- We saw information, which indicated the matter had been escalated two years previously, and at the time was deemed as satisfactory. However, by not following the recommended colour coding system there is a risk of using items to clean in the wrong area.
- Following our inspection we requested an update with regard to the issues we had identified. were provided with information to indicate the staff were now following the recommended practices with regard to the use of colour coded equipment for cleaning respective areas. We saw evidence of regular cleaning of the theatre, although we noted the checks did not include the skirting of the floor.
- Staff were responsible for cleaning equipment daily. Items checked by us were noted to be clean and fit for use.
- Handwashing sinks, soap, and alcohol hand rubs were in good supply and we saw instructions for their use clearly displayed. Staff were observed cleaning their hands during the course of their duties.
- A BPAS IPC essential steps audit undertaken in November 2015 indicated 100% compliance with hand hygiene, use of personal protective equipment (PPE), and sharps management. Further IPC audits carried out in January and February 2016, also showed 100% compliance.
- We observed PPE, including disposable gloves and aprons were readily available, correctly stored, and worn by staff. Staff were bare below elbow, and theatre staff wore appropriate theatre clothing and covered their hair.
- An appropriate 'scrub' sink was provided in the operating theatre, with elbow-operated taps.
- Disposable curtains impregnated with an antibacterial covering are recommended in areas where treatment is carried out, and clearly labelled with a date to show when last cleaned or changed. Fabric curtains were in use in the recovery area. Staff were unable to confirm whether they had an antimicrobial covering or when they were last cleaned or changed. We were subsequently informed they were last changed in January 2016.
- We noted the guidance to staff set out in the environmental cleaning policy indicated fabric curtains were to be checked daily and should be laundered every six months. There was no instruction regarding the actual laundering process, such as the temperature at which curtains should be washed.

- There was segregation of clean and dirty waste, and safe disposal of clinical waste including sharp instruments and objects. Staff were observed to adhere to the management of clinical waste policies and disposal of sharp objects.
- A spillage kit for the safe disposal of body fluids was provided and was in date. Staff knew where to locate it, and correctly described the procedure for managing spillages in accordance with the local policy.
- Legionella risk preventive maintenance was carried out four times per year, with two yearly risk assessments. We saw information, which showed the most recent air handling unit safety check was undertaken in January 2016.

Environment and equipment

- We were told staff had to work within the constraints of the building. They added the health and safety environmental manager visited every 14 months, and the fire service undertook checks regularly. We reviewed the most recent reports from the visits carried out prior to our inspection. We saw where actions had been required, these were addressed and recorded.
- We observed the environment was arranged to accommodate separate consulting rooms, day ward areas, waiting rooms and one operating theatre. There was sufficient space and all areas provided privacy and access to toilet facilities. Shower rooms were available on the day ward area. There was access for people with a disability, including a lift between the two floors in the main building.
- The operating theatre environment was suitably laid out, with separate areas for preparation of clean surgical items and a dirty utility room. The theatre was adjoined by a recovery area.
- As standard, the theatre was equipped with oxygen and suction. Suction liners, suckers, and tubing for suction were disposable.
- We were told the support service co-ordinator had designated responsibility for facilities, equipment, repairs, health and safety and first aid. They reported to the registered manager and the BPAS corporate estates department and health and safety manager.
- We observed health and safety checks, such as fire certification and waste management were complete and up to date. There were no actions arising from the most recent health and safety report, carried out in April 2016.
- An environmental audit was performed annually as part of BPAS on-going quality assurance programme. This was last undertaken in December 2015 and information reviewed by us did not identify any concerns.
- We observed resuscitation equipment, including oxygen and suction was accessible, had been checked routinely and was ready for use in an emergency.
- We reviewed information, which showed up to date safety, and maintenance checks, including electrical testing, had been carried out on all equipment used for patient treatment and care. The next safety checks were due in June 2016. All electrical appliances checked by us had been tested for electrical safety to the requirements of the electricity at work regulations. Operating theatre equipment, including the anaesthetic machine and emergency items had been checked daily, and were all ready for use. These checks met required standard operating procedures (RSOP) 22.
- We found oxygen cylinders were stored correctly. First aid equipment was available in case of an emergency and was checked on the days the treatment unit was open to ensure it was available and fit for use.
- Single-use items we checked were sealed and in date, and emergency equipment had been serviced.
- We found there were emergency bells to summon assistance were located in each treatment area, and were in good working order.

Medicines

- BPAS had a centrally managed contract for the purchasing of medicines. Medicines were supplied by an approved pharmacy supplier. Orders for medicines were placed electronically and checked by an authorised person.
- The Royal College of Nursing guidance on abortion care for nurses, midwives and specialist community public health nurses (2008) sets out good practice in this area and on wider abortion care. A nurse or midwife may administer the drugs used for medical abortion at any gestation, once these had been prescribed by the doctor taking overall responsibility.

Termination of pregnancy

- We were told BPAS staff involved in the supply and administration of medicines were required to comply with the BPAS' medicines management policy, 2015', which set out systems and staff responsibilities in line with national standards and guidance. We noted the policy included general guidance as well as specific information, such as the drawing up of medicines in advance, abortifacient medicines, and patient group directions (PGDs). The policy also addressed the responsibilities of staff in relation to controlled drugs. Controlled drugs are medicines subject to additional security measures.
- We noted the policy complied with the appropriate legislation and with standards laid down by the relevant professional regulatory bodies, for example the Nursing and Midwifery Council (NMC), the General Medical Council (GMC) and the Health Professions Council (HCPC). For example, we found medicines were prescribed by an on-site doctor or a doctor who prescribed remotely using a secure electronic prescribing system at other BPAS licensed premises. We observed they had access to the electronic patient record.
- The Controlled Drug Accountable Officer was the registered manager. Controlled drugs (CD) used in the operating theatre were stored safely. Safety checks of CDs were carried out, and recorded twice a day by two registered health care professionals.
- We observed general medicines used in the operating theatre and recovery were managed safely and in accordance with guidelines. This included stock checks, monitoring, and recording of temperature controlled storage, and preparation of prescribed medicines. Registers were in use for some items, including Anti-D (This was only given to a patient with RH D-negative blood following a termination of pregnancy), and Depo-Provera.
- We found there was no list of authorised signatories for the CDs, and the registered manager, as the accountable officer could not identify all of the entries.
- We were told a CD audit was undertaken at least every six months and included stock count and reconciliation. No concerns were identified from the most recent audit shown to us.
- We observed the destruction and wastage of CDs had been recorded to the requirements.
- We identified the abortifacient medicines were administered in accordance with the BPAS policy, and Nursing and Midwifery Council (NMC), standards for medicines management.
- Some medicines were supplied and administered 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.
- The BPAS 'medicines management policy, 2015', required that only nurses and midwives who had attended the relevant training for a PGD could supply or administer according to the PGD. Records were to be kept locally by the unit manager of those nurses or midwives who had attended the training and been signed off to use a particular PGD'. Training records and signatures of the nurses using PGDs at BPAS Streatham were in evidence and complete.
- A number of nursing staff were trained to administer medicines under a PGD and we saw examples of nine medicines supplied and administered under a PGD. Examples of these included; codeine phosphate, diclofenac, ibuprofen and paracetamol, as well as contraceptive implants. All had clear inclusion and exclusion criteria of specific circumstances for their use.
- Legal requirements for using PGDs are these need to be signed by each individual member of the multidisciplinary group (doctor and pharmacist), the clinical governance lead on behalf of the NHS organisation authorising the PGD, and the individual health professionals working under the direction.
- All PGDs at BPAS Streatham were authorised by the director of nursing and operations, BPAS consultant pharmacist, the medical director, clinical governance committee and BPAS chief executive officer. In addition each PGD required the signature of the treatment unit manager to authorise the local use of the PGD in each specific location, and we saw this happened.
- The BPAS policy was that the practices surrounding PGDs would be audited every six months. The last audit was completed in May 2016 and no concerns or outstanding actions were identified.

- BPAS had a centrally managed contract for the purchasing of medicines. Medicines were supplied by an approved pharmacy supplier. Orders for medicines were placed electronically and checked by an authorised person.
- Medicines safety alerts were sent to all treatment units by BPAS central office, and acted upon.
- Most medicines were stored in a locked cupboard, or, where they needed to be stored below a certain temperature, in a designated refrigerator for this purpose. The minimum and maximum temperature of fridges used to store medicines was expected to be monitored and recorded to ensure medicines were kept at the required temperature. We saw most fridges used for this purpose were locked, clean and tidy, and found no surplus or expired stock. However, we found the recently purchased fridge used for medicine storage in the consulting rooms area (the lodge) had numerous entries indicating the temperature was outside of the safety limit. There was no evidence this had been recognised, reported or acted upon. When staff were questioned, there was conflicting information as to who this matter should have been reported to. We also found some emergency medicines stored in a box on the floor in an office. The clinical room in the consulting area had a secure key pad access but was open during our visit. The key to the medicines fridge door was in the lock, making it easy to access the contents.
- There were systems for checking stock levels and expired medicines. All the medicines we looked at were in date and correctly stored in line with manufacturers' instructions.
- Medicines for use in an emergency such as the treatment of anaphylaxis were required to be checked. A check list had been commenced five days prior to our visit. However, since it was introduced no checks had been recorded. Not all of the staff knew where this emergency medicine was located.

Records

- We observed the patient treatment and care records were paper based and could only be accessed by relevant staff. They were held securely in locked cupboards and were stored in the basement outside of clinic opening times.
- Monthly audits of consultation notes had been carried out. These showed 98% – 100%. Compliance with record keeping standards.
- We reviewed 19 sets of patient records, including those related to young people. Records contained pre-printed treatment pathways, depending on the procedures planned by the patient and nurse assessor.
- All records were well maintained and completed with clear dates, times and designation of the person documenting, and that staff complied with prescribed care and treatment.
- Records contained detailed information relevant to the client's assessment, treatment and care, including risk assessment, allergies, medical and surgical history.
- An electronic register for all surgical procedures was completed. Records of all procedures were entered on to each patients computer based BIS record.
- Notes needed by other services providers, in the case of clients transferring, were taken by recorded delivery. If they were needed at head office, they were collected and delivered by a designated employed driver. Notes could also be uploaded onto the electronic client assessment system.
- RSOP 3: Post Procedure recommends that wherever possible the patient's GP should be informed about treatment. Patients were asked if they wanted their GP to be informed by letter about the care and treatment they received. Their decisions were recorded and their wishes were respected.

Safeguarding

- We were told there were no safeguarding concerns at the time of our visit. The registered manager was the designated member of staff (safeguarding lead) responsible for acting upon adult or child safeguarding concerns locally, co-ordinating action within the treatment unit, escalating to the BPAS national safeguarding leads as necessary, and liaising with other agencies, such as social services and the police.
- There had been 16 safeguarding referrals for BPAS Streatham for all abortion services in the previous 12 months, 1 May 2015 to 30 April 2016.
- The registered manager ensured staff were trained on issues related to safeguarding through completion of the BPAS 'safeguarding vulnerable groups' training. Records confirmed the majority of staff were trained to safeguarding level 3 for adults and children. This was in line with Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document, 2014. This sets out a competency framework

with a set of abilities, which enable staff to effectively safeguard, protect, and promote the welfare of children and young people. Level 3 training is required of clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

- We found 86% of staff had undertaken level 3 safeguarding children's training. There was further training arranged for June 2016, which staff were due to attend.
- We saw one patient records where a safeguarding concern had been raised, which indicated good engagement and support between social services and a vulnerable individual.
- We found there were separate polices to guide staff on safeguarding clients under the age of 18 years of age and for adults. Staff knew how to access the safeguarding policies and demonstrated a good understanding of the processes involved for raising a safeguarding alert.
- The BPAS safeguarding policies and processes were found to reflect up to date national guidance on sexual exploitation of children and young people, and female genital mutilation. Staff we spoke with recalled these principles being included in their most recent safeguarding training and were able to describe them.
- Staff we spoke with were knowledgeable about safeguarding and the reporting processes. They also understood their responsibilities for patient confidentiality but where their safety was compromised, the need to raise concerns appropriately.
- Staff knew they needed to report any identified female genital mutilation (FGM) to the police where the individual was less than 18 years of age.
- The BPAS policy required that before treatment all patients under the age of 18 must be seen by a member of BPAS staff who had completed safeguarding training, and must be seen alone to allow for private discussion. Staff confirmed this action was applied not only with patients under 18 but with all patients, in order to ensure there was no coercion to end the pregnancy.
- Information about local organisations providing support in case of domestic abuse was displayed.
- Staff told us they routinely took the opportunity to ask clients about domestic abuse in line with NICE guidelines Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively.This guidance is for everyone working in health and social care whose work brings them into contact with people who experience or perpetrate domestic violence and abuse. All patients were seen in a one to one consultation with a nurse or midwife. All the records we looked at showed that a routine question was asked to confirm the patient was 'safe at home'.
- Staff told us it was the organisational policy that if a girl under 14 years of age used the service then a safeguarding referral would be discussed with the safeguarding lead, and for children under 13 they would always make a safeguarding referral.

Mandatory training

- We were told safety training was provided in-house, and also by external providers. Staff confirmed they had completed training in a range of subjects both within their induction and at regular intervals. This included for example; basic life support, health and safety, fire safety, moving and handling and safeguarding training. We saw life support training figures showed 13 out of 19 staff had completed this either in 2015 or 2016. The remaining staff were either new starters or had booked training sessions. One staff member was not up to date with IPC training, and another was on long-term sick, meaning they too would require this.
- Other training information provided to us prior to the inspection visit showed a range of subjects were required to be completed at intervals ranging from two-yearly up to every four years. We were not provided with absolute figures in the information but were able to see the majority of required subjects had been completed or were booked. Most gaps seen were with respect to health and safety training, with nine out of 17 clinical staff not having a date recorded.
- We did not see training figures for medical staff, although the duty surgeon who spoke with us told us they had completed intermediate life support training, safeguarding adults and children.

Termination of pregnancy

Assessing and responding to patient risk

- All patients underwent an initial risk assessment to determine their suitability for treatment at the centre. If risk factors were identified, they were referred to the NHS for on-going care and management as required.
- Prior to termination procedures, all patients were required to have a blood test to identify their blood group. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications, should the woman have future pregnancies. The records we reviewed demonstrated all the patients had received a blood test prior to the termination procedure, and those who had a rhesus negative blood group had received an anti-D injection.
- We saw evidence staff were complying with the National Institute for Health and Care Excellence (NICE) quality standard related to venous thromboembolism (VTE) risk assessments and management. The service reported 100% for risk assessing patients who attended for a surgical abortion for their risk of developing venous thromboembolisms (VTE) or blood clots. Precautionary medicines were given to patients who required it and anti-embolic stockings were supplied where required.
- Staff followed the corporate policy for assessing patients suitability for general anaesthetic. This ensured only those with a risk category score of one or two were accepted.
- The location was not following guidelines from the National Institute of Clinical Excellence (NICE) clinical guideline 50, the National Patient Safety Agency (NPSA) (2007), the department of health; competencies for recognising and responding to acutely ill patients in Hospital (2009) and the royal college of physicians; standardising the assessment of acute illness severity in the NHS (2012). There was no tool in use to assess and monitor the condition of patients, and in particular to identify deterioration, such as a modified early warning system (MEWS). We were concerned that despite their being a serious incident in January 2016, where a patient needed to be transferred to the local NHS, such a tool was yet to be put in to use. Staff told us a tool was under development.
- The National Patient Safety Agency recommended in 2010 that The World Health Organisation (WHO) 'five steps to safer surgery' checklist should be used for every patient undergoing a surgical procedure in the NHS. The WHO check list could be adapted for use in other services, with the focus on specific safety checks before, during and after surgery. The service was using an adapted form of safety checks and reported 100% compliance with the required checks.
- Following surgical procedures patients were monitored in the immediate post-operative period by a registered nurse in the recovery area until they were fit for discharge. A systematic and regular assessment of patients was undertaken, which included recording their blood pressure and heart rate, as well as monitoring for pain during this period. Patients were not discharged until they were deemed sufficiently well.
- We saw information, which demonstrated there was a formal transfer agreement in place with a local NHS hospital for emergencies. A total of 10 patients were transferred in an emergency during 2015. There were three transfers between January 2016 and May 2016. This included one patient who had a perforated uterus.
- Clinical and non-clinical staff we spoke with were able to describe the actions required in the event of a medical emergency and how to act in case of emergency.

Nursing staffing

- Information provided to us in advance of our visit was there were 17 registered nurses. 7.6 of whom worked full time equivalent hours. The remaining worked part time hours. There were no reported vacancies at the time the information was provided. During our visit we were told there was a vacancy for the deputy theatre manager.
- During our visit we reviewed the staffing arrangements in order to check if these complied with RSOP 18: Staffing and emergency cover. In addition to the clinical nurse manager, deputy theatre and ward managers, there were two nurses and six practitioner midwives. Seven healthcare assistants (HCA) supported the delivery of clinical services. The nursing staff arrangements met the requirements of RSOP 18.
- Corporate information provided to us indicated paediatric nurses were not used to care for young patients. There was however, access to corporate lead for paediatrics for advice and guidance.

- We were told staffing was arranged according to clinical activity, with flexibility in shift patterns during the working day.
- There was no formal handover between staff, as shifts did not overlap.
- We were told regular agency staff worked in the operating theatre and recovery, particularly on a Sunday, when a routine list was held. The total number of shifts where agency cover was provided by registered nurses or operating department practitioners (ODP) between October 2015 and December 2015 was 93. We saw completed induction records for agency staff.
- There was a minimum requirement for agency staff to have experience of working in an abortion service and to be pro-abortion.

Medical staffing

- Information provided to us in advance of our visit was there was one doctor. However, whilst on site, we were told medical practitioners were available and rostered for duty according to surgical activity. The medical staffing included two surgeons, who we were told had with practising privileges, and one on rotation from the local NHS hospital. Three anaesthetists, also from the local NHS trust covered the services. The location had one doctor who provided on-line prescriptions and completed the HSA1 forms. They also undertook hormone implants.
- Appropriate medical cover was available for surgical procedures undertaken under general anaesthetic and conscious sedation.
- In addition, we were told doctors provided remote services, including assessment, confirmation that the lawful grounds for abortion were fulfilled, and prescribing of abortifacient medicines, from other licensed premises.
- Corporate information provided to us indicated doctors were not required to have training in paediatric surgery. This was said to be unnecessary in the context of abortion care.

Major incident awareness and training

- BPAS major incident and business continuity plans provided guidance on actions to be taken in the event of a major incident or emergency. Staff we spoke with were aware of the procedure for managing major incidents.

Are termination of pregnancy services effective?

Evidence-based care and treatment

- We reviewed a range of policies and procedures, and spoke with staff in order to evaluate how the service ensured treatment was based on professional evidence.
- Required Operating Standard (RSOP) 9 relates to the gestational limits with respect to termination. We were told the maximum gestational age accepted for termination was 23 weeks and six days. The service was prescribing and administering abortifacient medication for early-medical abortion, where a pregnancy was up to nine weeks and six days gestation. They also provided early surgical abortion, between seven and 14 weeks gestation, using local anaesthesia and or conscious sedation. Surgical abortions were undertaken under general anaesthetic up to 23 weeks and six days, including where there was a fetal abnormality. Professional guidance indicates two main surgical methods for TOP, which includes; vacuum aspiration, recommended at up to 15 weeks gestation and dilatation and evacuation (D&E), which is recommended where gestation is greater than 15 weeks. We were told fetacid was provided prior to late surgical abortion.
- RSOP 2 relates to medical terminations including early medical abortion (EMA), delegation of duties and protocols. This also related to the provision of terminations at different gestation including early medical abortion (EMA). We were told different methods were available to terminate a pregnancy, depending on the pregnancygestation. The medical method involved the use of the abortifacient drug Mifegyne (mifepristone, also known as RU486). Nurses were administering the drugs used for medical abortions, once these had been prescribed by a doctor. Where they had undertaken the relevant training and approval to administer medicines under a PGD, they were administering misoprostol for cervical preparation. This is in accordance with the Abortion Act, which requires that only a registered medical practitioner (RMP) may carry out an abortion. However, provided the RMP personally decides upon, initiates, and takes responsibility throughout the process, the protection provided by the Act will apply to the RMP and to any other person participating in the termination under his or her authority.

Termination of pregnancy

- Royal College of Obstetricians and Gynaecologists document titled 'The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7' provides detailed guidance and professional recommendations with respect to the treatment and care pathway. We found for example; patients had an ultrasound scan at the treatment unit to determine gestation of the pregnancy. This was in line with the BPAS guideline for all abortions but was outside of the guidance issued by the RCOG, which states the use of routine pre-abortion ultrasound scanning is unnecessary, as there is no direct evidence that routine ultrasound improves either the safety or efficacy of abortion procedures. However, BPAS use ultrasound to determine the gestation, and most appropriate method for termination.
- In line with the RCOG 'guideline number 7', patients were informed that infection of varying degrees of severity may occur after medical or surgical abortion and was usually caused by pre-existing infection. We found prophylactic antibiotic prescribing was happening as a means of reducing this risk.
- Blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to patients who were found to be rhesus negative. This was in line with RCOG 'guideline 7'.
- We found patients were screened for the risk of venous thromboembolism (VTE), in accordance with RCOG guidelines.
- Where patients had their procedure performed under conscious sedation, an anaesthetist was responsible for managing the patients' safety and well-being.
- Children's Surgical Forum of The Royal College of Surgeons of England 2013 outlines various standards. This included; the surgeon and anaesthetist remaining on site until arrangements have been made for the discharge (or transfer) of all patients under their care. Staff confirmed the medical staff remained on site until the patients had been discharged.
- Required Standard Operating Procedures (RSOP) 7: Service Provision for Children, Vulnerable Young People, and Adults includes guidance about compliance and prompts relevant to termination of pregnancy. This includes that children, vulnerable children and adults (where appropriate) should be asked; if they agree for their parents or guardians to be involved in decisions they need to make. They should also benefit from an environment that is appropriate to their age and individual needs; be treated by staff who are appropriately trained to provide care, treatment and support for children. Such training should include Children's Workforce Development Council Induction standards. With the exception of not having specific child friendly environment, the registered manager indicated they adhered to this standard. Although we did not see the content of training, the registered manager provided confirmation of training on the seven standards. This included understanding the principles and values essential for working with children and young people, which they said was covered by safeguarding training. This also covered communicating effectively with young people, barriers to communication, and peer pressure. In addition, the registered manager informed us safeguarding training and consent also covered staffs understanding of the development of children and young people, particularly when discussing development of children physically and mentally at different stages, for example the training looks at reasons why some 13/14 year olds may be more mature than others, dependent on lifestyle/ exposure.
- RCOG guidance and RSOP 13: 'Contraception and Sexually Transmitted Infection' (STI) Screening suggest that information about the prevention of sexually transmitted infections (STI) should be made available and all methods of contraception should be discussed at the initial assessment. A plan should be agreed for contraception after the abortion. We found staff provided such information during the consultation and encouraged patients to choose between the ranges available. We found contraceptive options were discussed at the initial assessments and a plan was agreed for contraception after the abortion. Patients were provided with contraceptive devices at the treatment unit. These included long acting reversible methods of contraception (LARC), which are considered to be most effective by the National Collaborating Treatment unit for Women's and Children's Health.
- All patients were tested for chlamydia infection (a sexually transmitted bacterial infection) prior to any

treatment. Where a positive test result was identified, they were referred to sexual health services. Patients were also referred to sexual health services for further screening for other STI and treatment.

Pain relief

- RCOG 7. 14 states services should be able to provide surgical abortions without resort to general anaesthesia. Where general anaesthesia is not used conscious sedation should be available. (RCOG 7.15), and be undertaken by a trained practitioner. We observed both types of procedure were available. A designated anaesthetist was on duty and took responsibility for the management of patients care whilst having either method.
- Pre and post procedural pain relief was prescribed on medication records. Best practice was followed as non-steroidal anti-inflammatory drugs (NSAIDs) were usually prescribed. These are recognised as being effective for the pain experienced during the termination of pregnancy.
- Staff we spoke with were clear about which medicines would be offered and in which order. For example for a medical abortion procedure, NSAIDs would be administered first, and then paracetamol would be offered.
- The patient records we reviewed showed 15 patients out of 19 had their pain levels assessed.
- Patients were advised to purchase over the counter medicines for use at home and were advised about when and how to take them.

Patient outcomes

- The regional quality, assessment and improvement forums and national clinical governance committee (CGC) monitored and reviewed treatment complication rates to ensure they were at or below accepted national levels. Between January 2015 and December 2015, BPAS Streatham carried out 1502 early medical abortions (EMAs).
- Between January 2015 and December 2015 there were 3354 surgical abortions. Of these, 224 abortions took place after 20 weeks of gestation. Abortions were not undertaken for gestation above 23 weeks and six days.
- Patients of all ages, including those aged less than 18 years were treated at both locations. Between 1 April 2015 and 31 March 2016, 222 clients under the age of 18 were treated at BPAS Streatham for TOP. Three clients under the age of 18 were treated at BPAS Southwark during the same time period.
- Patients who had a medical abortion were asked to ensure a pregnancy test was completed two weeks after their treatment to ensure that it had been successful.
- The Required Standard Operating Procedure (RSOP) 16 relates to performance standards and audit. There were no reported major complications resulting from medical terminations for the period January – December 2015. Incomplete abortion accounted for 1% of complications for the same period. There were three continuing pregnancies during the aforementioned period.
- We were told the BPAS Aftercare Line was used to report concerns, such as ill health or uncontrolled pain. If the clinic was informed there had been a complication, a form would be completed and it would be documented in patients' notes to ensure the information was captured. This was monitored by the quality leads and cascaded through meetings.
- Simultaneous administration of medicines for early medical abortion (EMA) was piloted by BPAS in 2015. The minutes of the clinical governance committee (March 2015) highlighted the pilot phase, which involved nearly 2000 patients to determine the outcomes and acceptability before it was implemented across all BPAS clinics. Results of the pilot study reported this method was effective but the risk of failure increased as gestational age advanced. The increased risk for medicines taken at the same time compared with 24-72 hours apart were retained products of conception and continuing pregnancy.
- Information about simultaneous EMA was included in the booklet 'My BPAS guide', which was given to all patients before making a choice.
- We found abortifacient medicines, were administered using two options, either be administered over a two-day period, returning to a BPAS treatment unit the following day, or both the medicines could be administered simultaneously in one visit. The patient's choice was always taken into account.
- The uptake for Long Acting Reversible Contraception (LARC) had been low. The registered manager told us

they had gone through a process of audit and discussion and improvement had been seen. We saw the contraception audit for the period 1-122 January 2016 indicated 68% of patients chose a method of contraception, of which 80% chose LARC. Figures for February 2016 audit were 56% and 83% respectively.

- BPAS had a planned programme of audit and monitoring, which included audits recommended by RCOG: consenting for treatment, discussions related to different options of abortion, contraception discussion, confirmation of gestation and medical assessments audits. Audit outcomes and service reviews were reported to governance committees such as infection control and regional quality, assessment and improvement forums (RQuAIF).
- BPAS Streatham demonstrated compliance rates for various elements of service audit in April 2016. For example, they achieved 98% with regard to processes around general anaesthetics, 98% for conscious sedation, 100% for completion of HSA1 forms, and 95% for EMA. We noted a small sample of patients (two) informed the results. These patients provided information ranging from reception of patients; consent for treatment, discussions related to different options of abortion, contraception discussion, confirmation of gestation and medical assessments audits.
- We saw there was 100% compliance with testing for sexually transmitted infections at point of care testing.

Competent staff

- Appraisal and revalidation information pertaining to the doctors was managed corporately. We were able to review evidence of the confirmation of revalidation in one doctor's personnel file. We were told all the doctors had received an annual performance review during 2015. A member of the medical staff told us they had 360 degree feedback as part of their appraisal and revalidation, and another confirmed they had revalidation and an annual review.
- Staff had regular annual appraisal and were supported through 'job chats' at least once a year. We reviewed evidence of both the appraisal process and half-yearly 'job chats'. We found staff were able to identify their training and development needs, and had feedback on their performance.
- We were shown training information was available on the BPAS main intranet site. There was also a training calendar indicating available training, such as patient group directives, safeguarding and people management.
- We saw information related to the 12 week competency based training programme for newly employed staff. This included all the mandatory training topics, client support skills training, and topics including sexually transmitted infection, ultrasound scanning and HIV.
- Staff confirmed they completed an induction process and this was a mix of formal training sessions and shadowing colleagues. Competence based training and assessment formed part of the induction process. Most staff expressed positive comments about the induction, such as being very impressed and having exemplary training'.
- Concerns were expressed by some staff of the induction being "disjointed". For example, some session on the induction had to be booked and there were insufficient places provided. In one case, names had been picked out of a hat, resulting in a staff member taking a longer period to complete the required elements. A member of staff reported to us they sometimes found they were moved to an area where they had already met the required skills whilst they were trying to complete their competencies, such as scanning.
- Agency staff were required to complete a local induction, and we saw this included, a confidentiality bond, infection prevention and control, emergency procedures, medicines and equipment. We reviewed agency worker placement checklists, and completed induction checks.
- We reviewed information to demonstrate the content of the induction programme, as well as evidence of competency assessments. Staff undertook training and assessment of competence in ultrasound scanning. For accreditation of first trimester scans (up to 12 weeks of pregnancy), staff were required to undertake 50 abdominal, 20 vaginal and five gynaecology scans. For second trimester accreditation (from 13 to 27 weeks of pregnancy), they were required to undertake 50 scans of the foetal head and five scans of the placental site.
- We were told immediate life support training included the management of difficult airways was required for

staff working in the operating theatre to complete. The lead nurse, nurse manager or deputising nurse, theatre operating department practitioners, recovery and ward nurses were required to complete immediate life support yearly. We saw from information provided to us there were 11 clinical staff within this group, two of whom were on long-term sick and one was a new starter, six had completed the training in 2015/16. One staff member was booked on training in June 2016.

- We were told the anaesthetists had advanced life support training, and saw from the pre-inspection information they needed to complete this every four years. We did not see evidence to corroborate this training was completed.
- Job descriptions were clear about role related responsibilities and evidence of required training was seen to support these.
- The RSOP 14: 'counselling' sets out that all the staff involved in pre assessment counselling should be trained to diploma level in counselling. Information provided by the registered manager indicated internal training was provided to staff who offered pre-treatment counselling and pregnancy options support. Although we did not see any formal evidence of the content of such training, the training we were told training consisted of attendance on two-day face-to-face training that covered a range of topics including for example: What is empathy?; understanding boundaries, knowing our own beliefs, Understanding body language, and questioning techniques. The training was said to be delivered by two very experienced BPAS Client Care Co-ordinators, who supported pregnancy options decision making every day. Over a period of months, trainees worked through a competency framework in which they were observed on the job by an allocated assessor. Supervision sessions were offered to this group of staff, and annual attendance as a minimum was compulsory. These were facilitated by a BACP registered counsellor. Post-treatment counselling training builds on the above, and a further specific 1-day face to face workshop was required. This could only be completed after providing competent pre-treatment support for at least 12 months.
- Initial contact for any of the services provided by BPAS was made through a national contact centre. The treatment unit was run by dedicated BPAS staff who we were told had completed a competence based training specific to the role.
- Staff told us staff referred to as 'client care co-ordinators', who provided the pre and post abortion counselling service had completed 'BPAS Client Support Skills and Counselling and Self Awareness' course and had completed the client care co-ordinator competencies framework. Group supervision for staff providing counselling was also available and was provided three times a year. Records confirmed staff had undertaken group supervision at least twice in the reporting period.

Multidisciplinary working

- Medical staff, nursing staff, client care co-ordinators, and other administrative staff worked well together as a team. There were clear lines of accountability set out in job descriptions, which contributed to the effective planning and delivery of care.
- There were established arrangements with the local trust for supporting the service where a patient required transfer. Annual meetings took place to review this and to discuss appropriateness of transfers.
- Staff reported good working relationships with the local trust, with one of the doctors working across both sites. They reported close working with BPAS Richmond.
- The service had links with the police and local safeguarding authority to ensure appropriate support was available to women who used the service.

Seven-day services

- RSOP 11 relates to having access to timely abortion services. The Streatham centre operated five days per week, Monday and Tuesday: 7:45am – 6pm, Wednesday: 7:45am – 5pm, Thursday: 9am – 2pm and Sunday: 7:45am – 6pm. Surgical terminations were performed on Sundays and Mondays.
- Southwark satellite clinic was open Thursday and Fridays, 9am – 4pm.

Termination of pregnancy

- Across the main location and Southwark satellite site, medical terminations were offered six days per week. Contraception, screening for sexually transmitted infections and counselling was available during opening hours.
- RSOP 3: Post Procedure sets out that clients should have access to a 24-hour advice line, which specialises in post-abortion support and care. BPAS Aftercare Line was available 24 hours per day and seven days a week. Callers to the BPAS Aftercare Line could speak to a registered nurse or midwife who performed triage and gave advice. The dedicated team of nurses and midwives had received training for the role from BPAS. Patients were followed up by staff at the treatment unit they had attended, either by a phone call or by appointment at the clinic.

Access to information

- Staff had full access to patient's records.
- Information required to assist staff in undertaking their duties was accessible both in paper format and via the organisations intranet. This included policies, procedures, and guidance.
- Staff told us there were regional clinical leads who were available to answer clinical questions.
- GP discharge letters were provided where a patient gave permission for the sharing of such information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- RSOP 8 relates to consent, including adults and individuals under the age of 16 years. The BPAS corporate policy for consent for examination and treatment was provided to staff. Written consent was required for all medical abortions, surgical procedures, and contraception fitting or removal under general anaesthetic or conscious sedation.
- We were told where mental capacity to consent was identified as lacking, an Independent Mental Capacity Advocate (IMCA) was provided to support patients whose treatment was arranged by the NHS.
- We asked about the consent process and staff demonstrated clear and accurate explanations of the options for termination of pregnancy and for contraception.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). They confirmed they had completed training in all of these areas, including Gillick competence. (Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- The 19 patient records reviewed showed consent had been obtained and recorded in all cases.
- Consent was obtained by the nurse during the consultation. Staff told us the consent form was produced in different languages, and we saw an example of one in French.
- We were told a trained pregnancy counsellor offered clients the opportunity to discuss their options and choices in line with Department of Health RSOP 14 'counselling' as part of the consent process. We were told all patients under the age of 18 discussed their options with a counsellor prior to being asked for their consent.
- Nurses completed a checklist to assess whether a child under 16 was competent to give consent, based on Gillick competence and Fraser guidelines. Gillick competence refers to the assessment that doctors make in regards to whether a child under 16 has the capacity to consent to treatment without parental or guardian consent. Fraser guidelines are a set of criteria which must apply when medical practitioners are offering contraceptive services to under 16's without parental knowledge or permission.
- We saw evidence in all relevant care records where Gillick and Fraser guidelines had been followed.

Are termination of pregnancy services caring?

Compassionate care

- We heard all staff introduce themselves prior to the consultation and on arrival to the theatre. Staff applied a personal and sensitive approach in their discussions and mannerisms.

- We spoke with one patient during our visit, who told us everyone had been very friendly. They commented on the speed of the visit,
- Nine CQC feedback cards had been completed by patients who attended the service. We reviewed the comments and found positive responses had been made in all cases. Staff were described as warm, friendly, polite and professional. One patient commented how they had been 'treated with respect and dignity throughout.' Another described the nurse as 'a star'. Other comments included, feeling safe and well cared for.
- The results of the BPAS Client Satisfaction Survey showed high levels of satisfaction with care. 90% of patients gave a rating of excellent to the care and attention given by nursing staff, and 82% rated the patient experience as excellent.
- We observed staff respected patients and their partner's privacy and dignity throughout their attendance at the service. Interactions with patients and their accompanying partner were observed to be compassionate, kind, and supportive.
- Patients had commented positively about the 'non-judgmental approach' of staff and of being made to feel calm and relaxed. Staff were described as considerate, helpful, and caring. One comment card indicated, 'staff were absolutely amazing. I felt safe and cared for at all times'.
- We observed staff Consultations took place in a private room, and privacy was respected at all times in all areas of the location.

Understanding and involvement of clients and those close to them

- The preferences of each patient for sharing information with their GP and others were established, respected, and reviewed throughout their care. Patient's choices were respected. Their preferences for sharing information with their partner or a supporter were established and reviewed throughout their treatment.
- We observed during the case tracking of one patient, that staff provided detailed information throughout and checked their understanding. This included options for early medical abortion and the effectiveness of medicines if given on a single day or over two days.
- During the initial assessment of patients attending the service, we found staff explained all the available methods for termination of pregnancy that were appropriate and safe. The staff considered gestational age (measure of pregnancy in weeks), and other clinical needs whilst suggesting these options. We heard staff check the individuals understanding and clarifying information.
- We observed staff providing verbal information, supplemented by information leaflets and the 'My BPAS Guide', which had information regarding different methods and options available for abortion, and how pregnancy remains would be disposed of. If more time was needed to make a decision, this was supported by the staff, and an alternative date for further consultation was offered.
- Patients were involved in their care, and were given the option to administer their own pessaries (prescribed medication inserted directly into the vagina or cervix) and given instructions on how to do this.

Emotional support

- Patients who were considering termination of pregnancy should have access to pre-termination counselling. Patients who attended the service were provided with pre-termination counselling. We were told this was undertaken by experienced support workers (client care co-ordinators) who had completed the BPAS Client Support Skills and Counselling and Self-Awareness courses and were required to be fully competent with the 'client care coordinator competencies framework'.
- There was access to advice and counselling before and after their procedures, either face to face or by telephone. The BPAS Aftercare Line, a telephone service operated by registered nurses and midwives, was available 24 hours, 7 days a week.
- Staff were heard dealing with patients in a calm manner, recognising the sensitivity and need for appropriate support. The emotional and social needs were valued by staff and embedded in their care and treatment.

Termination of pregnancy

Are termination of pregnancy services responsive?

Service planning and delivery to meet the needs of local people

- The senior management team were involved in developing the facilities and the planning of the service, along with commissioners.
- Appointments could be booked through the BPAS telephone booking service, which was available 24 hours a day throughout the year. The electronic triage booking system offered a choice of appointment to help ensure patients were able to access the most suitable appointment for their needs and as early as possible.
- BPAS offered a web chat service, via their internet page, for patients who wanted to know more about the services provided.
- A fast track appointment system was available for patients with higher gestational age or those with any complex needs.
- BPAS was able to offer treatment at other BPAS treatment units within the region for patients who preferred a different location, or where a convenient appointment was not available at Streatham. However, such choices could not always be met.

Access and flow

- Patients were referred from a variety of sources such as GPs, and through self-referral. The treatment unit undertook all aspects of pre-assessment including counselling, dating scans to confirm pregnancy and determine gestational age, and other assessments of health and wellbeing.
- RSOP 11: 'access to timely abortion services state that patients should be offered an appointment within five working days of referral and they should be offered the abortion treatment within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the department of health. BPAS measured the number of patients who had their consultation within seven consecutive days. Between July 2015 and September 2015, 74% of patients had their consultation within seven working days of referral.
- The percentage of patients treated at less than 10 weeks gestation is a widely accepted measure of how accessible abortion services are. So far, in 2015/16, over 87% of patients had been treated below 10 weeks, which was significantly above the national average.
- BPAS monitored the average number of days patients waited from initial contact to consultation, from consultation to treatment and the whole pathway from contact to treatment. For the period January to December 2015, 466 (10%) of patients waited 10 consecutive days from first appointment to termination of pregnancy. This was mostly down to patient choice.
- The service received regular emails with details of appointment waiting times. We saw from examples provided, that patients rarely waited more than the target of three days. The report of the waiting times was also provided to the commissioners on a quarterly basis.
- The location monitored did not attend (DNA) rates or appointments self-cancelled on the day. For the period 1 April 2015 to 31 March 2016, 564 DNA/cancellations were recorded for Streatham.
- Did not proceed to treatment at the Streatham site was reported as 414 between 1 April 2015 and 31 March 2016.
- Between 1 April 2015 and 31 March 2016, 152 cancellations for all treatment types were made by the location. Of these, 12 were cancelled due to the surgeon being unavailable to work at short notice. During January 2016, five patients were cancelled due to the transfer of one particular patient with complications to the NHS.
- An audit was carried out in April 2016 to check waiting times. Out of the 42 patients who attended for medical abortion, the average wait time between the appointment time and being seen by a health care assistant (HCA) was 20 minutes. The average wait time after seeing the HCA to see the nurse was 45 minutes. The average time for the consultation was one hour and 40 minutes. For same day consultation and treatment, admission to discharge times averaged one hour and 10 minutes for early medical abortion, and four hours for surgery.
- However, we observed that patient's choice was not always met with regard to attending alternative

locations. For example, an individual requested a second appointment at a specified clinic in order to have the second part of the medicines. They were told the appointment system would not support the request. As a result, they selected the same day treatment.

- We followed one patient who underwent a surgical abortion. Her attendance at the treatment unit took four hours and 15 minutes from initial consultation to discharge. There were many positive aspects of her experience, including information provision and adherence with safe practices; however, the pathway through the service was observed by us to be fragmented. She had to go into different rooms, in different buildings, with different staff in order to complete the initial pathway. This resulted in returning to waiting areas.

Meeting people's individual needs

- Patients were given information and choice about early medical abortion (EMA) where the gestation was up to nine weeks and six days. For surgical procedures up to 23 weeks plus six days, patients had information about conscious sedation or local anaesthetic.
- Termination of pregnancy for fetal anomaly (TOPFA) was available to patients where the gestation period was 23 weeks plus six days. Information was provided verbally and was supported by a booklet titled, 'ending a pregnancy because of fetal anomaly.'
- The Human Tissue Authority published guidance about the sensitive handling of pregnancy remains following pregnancy loss or termination in England, Wales, and Northern Ireland, March 2015. This was followed by Royal College of Nursing Guidance for staff to follow where the pregnancy, including medically or surgically induced termination of pregnancy ended before the 24th week of gestation.
- There was a corporate policy to guide staff with respect to the sensitive area of providing patients with the opportunity of making informed choice about disposal of pregnancy remains, including burial or cremation. Additional information was provided in booklet form, and this included links to supportive organisations. We saw evidence of best practice guidance having been followed in one set of care records reviewed.
- Patients attending for termination of pregnancy due to fetal abnormality (TOPFA) waited in the same area as other patients. This arrangement did not appear to acknowledge the possible psychological needs of individuals. There was a separate recovery room, with two chairs divided by a curtain, which affected privacy at a sensitive and distressing time.
- Chaperones were available and partners were encouraged to remain with the patient. There was however, a point in the consultation where the individual would always be alone with the nurse to ensure they were not being coerced.
- Where individuals had a learning disability or lacked capacity a carer or family member was able to accompany them.
- The registered manager told us they adapted the appointment schedule to suit individuals, for example, they added Saturday morning lists where demand required. Outside of working hours, they could be contacted by mobile phone. They also worked closely with BPAS Richmond, facilitating split site treatment if required.
- Staff ensured patient care records were transferred in a timely and accessible way and in line with BPAS protocols.
- Patients had access to a 24-hour aftercare telephone line that was operated by registered nurses who were trained to assess and provide advice over the telephone. Patients could be booked for further assessment at BPAS treatment units if required.
- Follow up telephone calls were made after surgery to check on the patients wellbeing.
- The treatment unit was accessible to wheelchair users and disabled toilets and a shower were available.
- A professional interpreter service was available, and had been used 56 times via telephone in the period January to end of April 2016.
- Literature could be accessed in a range of alternative languages, including, Romanian, German, Spanish, Italian, and Portuguese.
- Leaflets were given to patients informing them what to expect after the treatment. We saw large print and Braille versions of the 'My BPAS Guide.'
- There was a clearly defined referral process for patients who required a specialist service. BPAS treated fit and healthy patients without an unstable medical condition. Where the criteria was not met, a referral form was completed, and managed by a specialist referral

placement team. This was a seven-day service. Such patients were referred to the most appropriate NHS provider to ensure they received the treatment they required in a timely and safe way.

- Nurses undertaking assessments had a range of information, which they could give to patients. This included advice on contraception, sexually transmitted infections, and miscarriage. They also provided information about services to support victims of domestic abuse, and how to access sexual health clinics.
- Staff who worked at the treatment unit were required to be pro-choice, and were supported by the organisation to promote the values through training and ongoing support such as 'Welcoming Diversity' training to ensure they recognised different cultural needs and beliefs. Training records showed this had taken place.

Learning from complaints and concerns

- The BPAS complaints procedure was discussed as part of the corporate induction days and we saw the programme, which confirmed this happened.
- Complaints were received locally and on-line. There were targets for acknowledging, investigating, and responding to matters raised. The regional director was made aware of the complaint, and received information related to the investigation and outcome.
- A summary of complaints, feedback, and patient satisfaction survey results were reviewed by each regional quality assurance and improvement forum (RQuAIF) and the clinical governance committee.
- The service reported nine complaints during the 2015/16 period. We reviewed five of these and noted a detailed complaint report had been completed, and a letter sent to each complainant explaining the outcome of the investigation, any actions taken if relevant, and an apology.
- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint formally or informally. Information on how to make a complaint was also included in the 'my BPAS Guide'.
- A separate form entitled 'Your opinion counts' was available inviting patient feedback. The treatment nurse asked patients to complete this form before leaving the treatment unit. Staff told us patients usually wanted to leave immediately after the treatment and the majority left without completing the form.
- We observed positive and negative comments provided via the feedback forms. Positive comments made included 'fantastic staff', 'very caring staff' and 'great service.' The most common complaint and negative comments related to waiting times. We did not see any information to indicate what staff were doing to address this.

Are termination of pregnancy services well-led?

We found improvements were required to ensure the local service was well-led. This was because:

- The local governance and quality monitoring processes did not always identify risks and take actions to address shortcomings where best practice was not being adhered to.
- Where actions were required to minimise risks to patients using the service, these were not addressed in a timely manner.
- The addition of new staff and improved stability was contributing to a developing culture of openness. There was however, work to do to ensure improved and effective working relationships were established and maintained across all staff roles. In particular, leadership needed to provide visibility and demonstrate a commitment to managing inappropriate behaviours, and to address issues raised by staff.
- There was some engagement with the public and staff but an organisational top down approach meant it was less easy to be innovative at a local location level.

However;

- Staff understood the organisational strategy and ethos.
- Organisational governance arrangements meant there was oversight of local performance, incidents, and complaints.
- Whilst there was no local risk register, there was work in progress to identify location specific risks.
- Staff were supported to develop their skills and were provided with service specific information through a range of methods.

- People who used the service and staff were encouraged to feedback on the service, and to contribute to making improvements.
- Information was provided to the Department of Health in accordance with Regulation 20 of the Care Quality Commission (Registration) Regulations 2009.

Vision and strategy

- There was a corporate vision, and staff were aware of this. They were expected to adhere to the organisation's aim, which were to provide high quality, affordable sexual and reproductive health service'. The organisation had clearly defined corporate objectives to support these aims.
- The organisation's ethos was to treat all patients with dignity and respect, and to provide a caring, confidential, and non-judgemental service.
- Staff were encouraged to promote the values through training and ongoing support. BPAS policies and procedures reflected the patient's right to influence and make decisions about their care, in accordance with BPAS quality standards of confidentiality, dignity, privacy, and individual choice.

Governance, risk management and quality measurement

- The BPAS regional quality assessment and improvement forum (RQuAIF) met three times a year and maintained oversight of all services in the region. The forum consisted of a lead nurse, a client care manager, doctor, nurse, clinical lead and associate director of nursing. At each meeting members reviewed complaints, incidents, including those classified as serious, audit results, complications, patient satisfaction, and quality assurance for point of care testing and declined treatments. The forum recorded detailed information, with a focus on shared learning. This forum reported to the organisation's clinical governance committee.
- The organisational structure chart supplied by the provider showed clear lines of accountability to the chief executive officer and the board of trustees.
- Minutes from RQuAIF were also shared at the regional management meetings who were then expected to hold local meetings to ensure learning was shared to a wider audience.
- We saw notes from the most recent London and South East Regional Management meeting held on 2 March 2016. These confirmed shared learning about complaints and serious incidents requiring investigation (SIRI) had been discussed, and action points agreed.
- A corporate risk register was provided to us, and this included general risks related to service delivery. There was no local risk register and we were told by the registered manager this was to be completed by the end of the week of our visit. We asked what the top three risks were for the location but these had not yet all been identified. Staff told us the main risk was the lift being out of order. This affected patients who had surgery on the ground floor and then needed to be recovered on the ward area on the first floor.
- A key performance indicator quality dashboard, most recently updated in April 2016, was made available to staff via email or print out. This included a range of information, for example, medicines management, safe staffing, clinical supervision, record keeping, and infection control and treatment audits. The dashboard was sent to the regional manager and corporate office, along with evidence to support the finer detail. The registered manager told us escalation of the dashboard was upwards to the board for any issues, via the clinical governance team. They added that the recently appointed regional director would be working with units to improve scores where required.
- A team brief was circulated to all staff and included generic, financial marketing and clinical elements.
- Both locations held a licence from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967. Services were provided to both NHS and privately funded clients.
- Legislation requires that for an abortion to be legal, two doctors must agree in good faith, that the grounds for abortion in the Abortion Act are met, and documented in a certificate of opinion. Arrangements were established to ensure that certificate(s) of opinion known as HSA1 forms, were signed by two medical practitioners in line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991.
- We found the registered manager ensured a register of service users undergoing a termination of pregnancy was maintained in accordance with Regulation 20 (6) of the Care Quality Registration Regulations 2009.

Termination of pregnancy

- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit demographical data following every termination of pregnancy procedure performed by completion of HSA4 forms. This contributes to national reports on the termination of pregnancy.
- We saw from information provided to us HSA4 forms had not always been completed and submitted electronically to DH on the day of the termination procedure. An alert system provided a prompt to the location where the form had not been submitted, so that the 14-day target was met.

Leadership of service

- The organisational chart for the location indicated the service was led by the 'treatment unit manager', who reported to the regional operations director. We had concerns about aspects of leadership at the location. This included their lack of oversight of standards related to infection prevention and control, as well as staff behaviours and staff feeling unable to raise concerns directly. In addition, staff reported issues related to training, which had not been addressed.
- Within the two years prior to the inspection, there were two changes in senior management, which were overseen and supported by other members of the senior leadership team. Whilst we received positive information about the supportive nature of line managers, some concerns were expressed by staff about the visibility and approachability of managers. Staff told us they sometimes did not feel supported and were, "just left to get on with it." We were also told there was a lack of flexibility in duties where staff had family matters to respond to.
- We were told suitable checks were carried out to enable medical staff to practice at the treatment unit: including example professional registration, qualifications, insurance, disclosure and barring and revalidation. We reviewed one doctors file provided to us and noted they had up to date revalidation, an appraisal, and a full job description.
- 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. We observed from the records reviewed the necessary HSA1 form met these requirements.
- We found the electronic system for HSA1 forms used by the on-site doctor was securely accessed, and could not be progressed unless each section was completed fully. This included having two separate signatures. We observed the completion of the HSA1 form when we case tracked one woman.
- BPAS treatment units completed monthly audits to ensure accurate completion of HSA1 forms in accordance with legal requirements. During 2015, the majority of months achieved a 100% rating at Streatham, with the lowest score of 95% recorded in February 2015. Similarly, Southwark scores ranged between the lowest 95% in February 2015 and 100% for nine of the months. Where the scored were less than 100%, we could not identify the reasons for this.
- The doctor taking responsibility for an abortion is legally required to notify the Chief Medical Officer (CMO) within 14 days of the termination. This is done through the department of health, and includes the submission of demographical data following every termination (HSA4 form). We found this information had been correctly gathered and reported on. However, in two of the treatment records reviewed there was no record of the HSA4 form, one patient did not progress to treatment at the location and the other there was no reason stated. An alert system we viewed provided information to the site where forms had not been completed. We explored this with the registered manager and found where patients had split location treatment, (termination at another location), there was potential to miss this part of the process out.
- The human resource department and medical director were said to be supportive and helpful. However, we did not see any specific evidence of driving things forward to the benefit of patients.
- We were told off-site senior managers were supportive and, for clinical staff, the BPAS associate director of nursing was accessible and available for advice and support for clinical or professional issues.
- A director's brief was issued quarterly, which was also discussed at regional team meetings. Treatment unit managers then held local quarterly team meetings to cascade information to the unit staff. These meetings were structured, had an agenda, and were documented.

- BPAS held a biennial national managers day for all managers. Biennial clinical forums were held for all staff and treatment units closed to facilitate attendance. The recent clinical forum had discussed the future direction of the company, nurses and midwives' revalidation and scanning.

Culture within the service

- The culture was said by a number of staff to have improved since new staff had joined the service. New staff were described as enthusiastic, motivated and of having a pro-active approach. The registered manager told us there was some adjustment to new ways of working taking place.
- We received comments from some staff about difficult working relationships they experienced. Staff gave examples of feeling disrespected and of witnessed others being shouted at in public and staff using an aggressive tone. They indicated nothing had been done to address their concerns when reported and there was a level of fear of raising matters directly.
- We saw staff displayed a compassionate and caring manner. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.
- Most staff spoke positively about the services they provided and enjoyed working for BPAS. We were told staff demonstrated compassion for those attending the service and "clients are treated well'.
- Staff had access to a free counselling/support telephone service, which they could call in relation to any work related or personal problems. We saw details of the service were accessible through the staff intranet.
- Clinical supervision was also provided and staff reported these were useful for discussing situations in a safe and confidential environment. One staff member told us they had found the supervision sessions a positive experience.

Public and staff engagement

- A survey entitled 'Your opinion counts' was used to gather feedback from people who used the service. Results viewed by us indicated a high level of satisfaction, (above 90%) with the service.
- Staff meetings took place monthly and staff reported these had a business focus and had a non-participative, top down information sharing approach.
- Temporary (Bank) staff reported not having payment for attending training and of not receiving a performance review.
- Staff told us they had been advised that protected time would be arranged to complete the training but this had not yet happened .
- Team meetings were said by the registered manager to be limited by the lack of active participation. Although they encouraged attendees to contribute to discussion, in the main the meetings were used to share information.
- We were told staff were encouraged to come up with ideas and suggestion but had become frustrated when these could not then be delivered. For example, the suggestion of having evening clinics.
- A staff forum was available for staff to contribute to decision making. However, there was no representative from the location and no one had applied to take up this role.
- Staff reported that a staff survey was given out in front of others, which made them reluctant to complete because of the lack of assurance around confidentiality. The survey results we viewed were not broken down by location, so we were not able to evaluate the results objectively.

Innovation, improvement and sustainability

- We were told it was difficult and slow to effect change locally as there was a corporate approach to the business. Flexibility was indicated as being a possible benefit to the provision of service, particularly being able to offer alternative sessions and timings.
- The TOPFA pathway was recognised as innovative, and improved the pathway for those patients experiencing a difficult decision.
- The location was seeing improvements in uptake for LARC, which would need to be demonstrated through regular audit.
- Staff reported a good service for young people.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Review corporate infection, prevention and control policies and monitor staffs compliance with required practices.
- Follow medicines management standards with regard to storage and controlled drug record keeping.
- Provide staff with information so they understand what a Never Event is and that they are made aware when such an event occurs within the organisation. In particular, any learning arising from this is subsequently acted upon.
- Provide staff with relevant training to enable them to understand what the duty of candour means and how the regulation applies to the service.
- Review treatment pathways with an aim of improving waiting times and flow through the service.
- Provide separate waiting areas for women who are attending for termination of pregnancy for fetal abnormality (TOPFA).
- Review the ability to meet patient's choices with regard to attending alternative locations for medical termination.
- Improve accessibility to competency-based training within the induction period.
- Where shortcomings in compliance with best practice are identified, they are addressed promptly.
- Identify local risks and actions to mitigate these, ensuring staff are aware and understand the impact of these.
- Develop a local vision and strategy, which supports the broader organisational aims.
- Develop enhanced and effective working relationships across all staff grades.
- Increase visibility and approachability of senior staff.
- Explore and develop ways of increasing engagement with the public and staff.
- Consider payment for training where attended by temporary staff.
- Provide temporary staff with a performance review.

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.

This section is primarily information for the provider

Enforcement actions

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.