British Pregnancy Advisory Service

BPAS - Bournemouth

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We carried out a focused follow-up on-site inspection on 23 February 2023 and had remote interviews with some of the management team on 2 March 2023.

We did not inspect all key questions as defined within our methodology. We focused on those areas highlighted in the Section 29 warning notice as requiring significant improvement. We also reviewed progress made where breaches of regulation were identified following our comprehensive inspection on 28 and 29 June 2022.

We did not change the ratings of the service as we focused on the areas previously identified in the warning notice and where breaches of regulation were identified.

The inspection was short notice announced to ensure the registered managers and documentation required to review would be available.

During our focused inspection we reviewed information to ensure the required actions against the Section 29 served against the provider in August 2022 had been completed. We found that:

- Systems and processes to obtain two signatures on the HSA1 forms had improved.
- The service was making progress against their action plan where breaches of regulation were identified.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to BPAS - Bournemouth

BPAS Bournemouth is operated by British Pregnancy Advisory Service also known as BPAS. The service provides a termination of pregnancy service in Bournemouth, Dorset. The service is provided from a building leased by the service and provides termination of pregnancy as a single speciality service. The service is registered to provide the following regulated activities:

• Termination of Pregnancy

• Family Planning Service

• Treatment of Disease, Disorder or Injury

• Diagnostic Imaging Services

• Surgical procedures Under these regulated activities, the services provided are:

• Pregnancy Testing

• Unplanned Pregnancy Counselling

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

• Medical termination of pregnancy

• Surgical termination of pregnancy

• Abortion Aftercare

• Sexually Transmitted Infection (STI) testing and treatment

• Contraceptive advice and supply. As part of the care pathway, patients are offered sexual health screening and contraception.

Surgical termination of pregnancy can be undertaken under local anaesthetic, general anaesthetic, conscious sedation and no anaesthetic according to patients' wishes. The service also operates a Telemed Hub, which provides a telephone consultation and remote early medical abortion services referred to as 'Pills by Post'. This service is available for women over 16 years of age and for medical termination of pregnancy up to 9 weeks and 4 days.

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

Summary of this inspection

The first temporary measure meant that pregnant women would be able to take both Mifepristone and Misoprostol for early medical abortion, up to 9 weeks and 6 days gestation, in their own homes without the need to first attend a hospital or clinic.

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

How we carried out this inspection

We carried out a short notice announced inspection on 23 February 2023 with remote interviews held on the 2 March 2023. The inspection team included two CQC inspectors.

During the inspection we spoke with the management team, we reviewed 6 patient records and documentation relating to the warning notice and where breaches of regulation had been identified.

The inspection was overseen by Deputy Director, Catherine Campbell.

As this was a focused inspection to follow up the warning notice, we did not speak with people who use the service for their views.

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

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Termination of pregnancy	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Termination of pregnancy

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

Assessing and responding to patient risk

The service was in the process of introducing a specific early warning system designed for termination of pregnancy.

At the previous inspection, we found the service did not have specific paediatric early warning scores to support the monitoring of vital observations for children under the age of 16 who had surgical terminations.

During this inspection we found that there had been work at corporate and national level to design an early warning score that incorporated children and young people. This was called the termination of pregnancy early warning system (TEWS) and was adapted from the Modified Early Obstetric Warning System (MEOWS). It had been altered to reflect the physiological parameters and triggers for intervention and escalation for clinically well women and young people undergoing termination of pregnancy (TOP). There was a plan to implement this as soon as it had been printed, with protected time for staff training. The longer-term plan was for the new warning score to be part of the new surgical case notes, which were due to be in use by June 2023.

Records

Staff kept detailed records of patients' care and treatment.

At our previous inspection we found there were two occasions where staff had not followed processes to check the authorisations by two doctors were obtained before any treatment was commenced.

During this inspection we reviewed 6 patient records and all HSA1 forms were completed in full.

Medicines

Systems to safely prescribe, administer and record medicines were not always in line with national regulations and guidance. However, the service was in the process of introducing a new prescription chart and case notes.

At our previous inspection we found medicines administered during surgical termination of pregnancy procedures were not prescribed and/or signed for by the surgeon, although a record of the amount given, and the time of administration was recorded.

Inspected but not rated

Termination of pregnancy

During this inspection we reviewed 6 patient notes and found 2 occasions where medicines administered during surgical termination of pregnancy procedures were not prescribed and signed for by the surgeon. Although a record of the amount given, and the time of administration was recorded. We saw the new prescription charts that had been devised and included sections for signatures as 'prescriber' and 'given by'. These standalone charts were due to be included in the patient notes the following week, with a long-term plan for them to be part of the new surgical case notes which were due to be in use by June 2023. The registered manager planned to audit the prescription charts on 6 March and regularly thereafter.

At our previous inspection room temperatures were monitored in some, but not all areas where medicines were stored.

During this inspection room temperatures were monitored in the 5 rooms where medicines were stored. We reviewed the room temperature audits and found they had mainly been completed, except for the occasional day. We saw the minutes of a departmental meeting in February and saw this had been discussed and a checklist was created. This was due to be reviewed at the next departmental meeting.

At our previous inspection we identified concerns with some Medicines as 'to take out' (TTO) packs. These included one medicine in the TTO pack which was not dispensed in suitable packaging in line with the manufacturers guidelines and labelling not consistent with the legislative labelling requirements for a few other medicines.

We reviewed TTO packs. These included new printed labels in line with the legislative labelling requirements for medicines. A new standard operating procedure (SOP) was introduced whereby two members of staff now checked the TTO packs.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service was providing care and treatment based on current national guidance.

At the previous inspection we found pregnancy remains were not always treated with respect. Pregnancy remains were collected into a shared vessel. Collecting several pregnancy remains in one receptacle separate from clinical waste was the default position.

During this inspection we reviewed the guidance set out by the Human Tissue Authority. '*The practice of collecting several pregnancy remains in one receptacle separate from clinical waste can be the default position, providing there are safeguards in place that ensure women know they have choices, that they are given the opportunity to make their choice and that their wishes are carried out. If the practice adopted by providers is to package them collectively, they should ensure that the information they give to women about disposal options makes it clear that, unless they object, their pregnancy remains will be collected together with others in one receptacle for disposal separate from clinical waste. Some women may prefer that their pregnancy remains are packaged separately; if they make this known, their request should be respected and acted upon.*'

The service had made amendments to the pathway and policy for management of pregnancy remains. There were 4 pathways and 2 disposal logs in use to document how the pregnancy remains were collected. For patients that chose

for BPAS to dispose of pregnancy remains, the pathway included '*Prior to treatment it is imperative that the client understands: Pregnancy remains will not be collected or stored separately unless requested prior to treatment and it is not possible to retrieve specific pregnancy remains once treatment has been completed*'. Discussion regarding disposal was to be recorded on the patients' medical record.

We reviewed 6 patient records, 1 of these patients had requested to privately dispose of the remains. This wish had been documented and respected.

Is the service responsive?

Inspected but not rated

Access and flow

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

At the previous inspection we found managers monitored waiting times, but patients could not always access services within agreed timeframes and national targets. Data showed the service did not always meet the national standard for waiting times for 'contact to consultation' and 'consultation to treatment'. Records showed between 27% and 91% of patients were given a consultation appointment within 7 days of contacting the service, and between 77% and 92% of patients received treatment within 7 days from their consultation (1 June 2021 to 31 May 2022).

During this inspection we found a new standard operating procedure had been introduced for 'waiting times to consultation' to escalate non-compliance and relevant staff to agree mitigating actions. We reviewed the daily percentage of patients that were able to book a telephone consultation within 7 days. Between 27 January 2023 and 16 February 2023 the service scored 90% or above. Records showed from July 2022 to January 2023 between 67% and 90% of patients were given a consultation appointment within 7 days of contacting the service. This showed an improvement since our last inspection but was not in line with their commissioning contract and national standards. However, sometimes these waiting times were not met due to patient choices.

Once assessed, staff worked to enable patients to have a medical or surgical termination of pregnancy within 7 days. Records showed from July 2022 to January 2023 between 75% and 94% of patients received treatment within 7 days from their consultation. A new standard operating procedure had been introduced for 'waiting times to clinic' to escalate waiting times that exceeded 7 days. We reviewed the waiting time report for 21 February 2023. Consultations, scans, post-operative checks, non-surgical terminations and terminations that did not require general anaesthetic met the target of 7 days or less waiting time. However, at the time of the inspection, there was a 13 day wait for a surgical termination under general anaesthetic. This extended waiting time was due to acute service disruptions caused by sudden staff sickness within key roles, which resulted in cancelled surgical lists. These waiting lists were monitored daily by the treatment unit manager and managed regionally. Where possible additional surgical lists were arranged to reduce waiting times for patients. Patients affected by service disruptions at Bournemouth were offered alternative appointments in BPAS Taunton or Richmond.

Is the service well-led?

Inspected but not rated

Termination of pregnancy

Inspected but not rated

Governance

Leaders had improved governance processes.

At our previous inspection we reviewed patient records and investigation reports and found two incidents where the Human Abortion Act 1967 had been breached. The provider was issued a Section 29 warning notice. Staff had not obtained two signatures to authorise the termination in line with legal requirements set out in the Human Abortion Act 1967. The investigation of the incident was not of required standard and had not been reported to the Care Quality Commission, which was in breach of the provider's conditions of registration.

During this inspection we found the service had acted on the risk that clinicians could administer and supply certain medications prior to termination under a Patient Group Direction (PGD), and without the appropriate authorisation. PGDs are written instructions which allow specified healthcare professionals to supply or administer certain medicines in the absence of a written prescription. As a result of this, medication had to be prescribed by a doctor and clinicians could no longer provide cervical preparation for termination under a PGD. The cervical preparation policy had been amended in December 2022 to reflect this. The electronic system would not allow staff to move to prescribing without two signatures on the HSA1 form (form HSA1 is for practitioners to certify their opinion on the grounds for an abortion). This was audited monthly locally but there was also a plan for this to be a centralised automated report. We reviewed the local audits from July 2022 to January 2023 and they were 100% compliant with the HSA1 forms. Therefore, the Section 29 warning notice had been met.

At our last inspection we found audits were not carried out in line with the corporate audit schedule. Processes to ensure timely completion of legal documentation following terminations did not always ensure these were submitted to the Secretary of Health within the 14-day response time. During this visit, we asked staff to run a report about outstanding HSA4 forms that were due to be submitted (form HSA4 is to be completed by the practitioner terminating the pregnancy to notify of the abortion). One form was due to be submitted on that same date, but still required a notification to be sent to the surgeon who performed the surgical termination, and for them to complete and submit the form the same day. We were not assured there were embedded processes to review and demonstrate the timeliness of the submission of HSA4 forms in line with legalisation.

During this inspection we were told that previously, location managers were not sent the weekly review of HSA4 forms due to be submitted. This changed in July 2022 and was now reviewed by the registered manager weekly and was available through the new operational dashboard. Further assurance was also sought with weekly reviews by regional managers. We reviewed forms for the last 2 weeks and found there were no HSA4 forms for Bournemouth outstanding.

At the previous inspection we found there were processes for the granting and reviewing of practising privileges arrangements annually, but the documentation we looked at for an anaesthetist did not include a review of disclosure and barring checks and did not include information about when these checks should be renewed. We observed recruitment records did not contain a full employment history, which was not in line with legislation.

There had been 4 new employees at the location since our previous inspection. We reviewed the 4 recruitment files, and these were compliant with legislation. We reviewed the operational dashboard, which contained oversight of the documentation required for the 5 staff under practicing privileges. All staff had a disclosure and barring check date and renewal date. The registered manager reviewed this dashboard monthly.