

British Pregnancy Advisory Service

BPAS – Middlesbrough

Inspection report

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

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

This was a comprehensive, unannounced inspection to follow up on enforcement action taken during an inspection in August 2021 where we identified specific areas of concern.

We rated the service requires improvement overall because:

- The service did not have enough staff to offer cover arrangements in the event of staff absence potentially delaying treatment times for women.
- The service did not label medicines appropriately in line with legal requirements.
- Although leaders had begun to operate effective governance processes throughout the service and used systems to manage performance effectively, these were new processes and had not had time to become embedded in practice or show consistent improvements.
- The service did not have a system for the observation of children under the age of 18 years using the modified early warning score (MEWS) to ensure early recognition and safe timely escalation of a deteriorating children.
- The service did not have a process in place to measure wait times between contact to consultation or consultation to treatment, meaning that they were not able to monitor or improve waiting times for women

However:

- The service had improved its processes and systems to safeguard people from abuse and manage patient safety incidents. Staff now comprehensively assessed and documented risk assessments.
- Staff had training in key skills, they received training on how to recognise and report abuse. The service-controlled infection risk well. Staff kept clear and up to date records of patients care and treatment.
- Staff provided good care and treatment, gave women refreshments, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff now recognised and assessed a patient's possible lack of mental capacity to make decisions and documented this.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service

Termination of pregnancy

Requires Improvement

Rating



Summary of each main service

Our rating of this service improved. We rated it as requires improvement. See overall summary for more information. In the reporting period 1 January 2022 to 27 April 2022, the centre carried out 904 surgical terminations of pregnancy (SToP) under local anaesthetic/conscious sedation, 355 early medical abortions. The centre held a current Department of Health licence to practice under the Abortion Act and displayed copies of the licence at each of its registered locations.

- Zero patients were transferred out to another hospital from January 2022 to April 2022.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin- susceptible Staphylococcus aureus (MSSA), Escherichia coli (E.coli) or Clostridium botulinum (C.diff).
- One complaint was received within the reporting period from September 2021 to March 2022.

Summary of findings

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Summary of this inspection

Background to BPAS - Middlesbrough

BPAS Middlesbrough is operated by British Pregnancy Advisory Service. The British Pregnancy Advisory Service was established as a registered charity in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. BPAS Middlesbrough opened in 2012.

The BPAS Middlesbrough clinic undertakes; early medical abortion up to ten weeks (EMA) and surgical termination of pregnancy (SToP) up to 13 weeks and six days, with local anaesthetic and conscious sedation. BPAS Middlesbrough did not provide general anaesthetic (GA). Women requiring later surgical abortions were signposted to BPAS Units at Doncaster, Merseyside or Richmond. The clinic also offered contraception and sexually transmitted infection testing as part of the termination of pregnancy treatment.

The location is registered to provide the following regulated activities:

- Termination of pregnancies
- Surgical procedures
- Treatment of disease, disorder or injury
- Family planning
- Diagnostic and screening procedures

The location has a manager registered with CQC.

BPAS Middlesbrough clinic was last inspected 4 August 2021 following information highlighted at routine engagement with another BPAS location on 15 June 2021. Following the last inspection, we took enforcement action which included the use of our urgent enforcement powers, where we placed conditions on the location's registration in relation to safe care and treatment, consent and safeguarding.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

How we carried out this inspection

This was an unannounced comprehensive inspection, carried out on 27 April 2022 to ensure improvements had been made following the urgent implementation of conditions and following line with the provider's action plan.

During the inspection visit, the inspection team:

- visited all areas of the clinic including, waiting areas, recovery areas and treatment rooms.
- looked at the quality of medicines and emergency equipment and observed how staff were caring for patients

Summary of this inspection

- spoke with the registered manager and operations and quality manager
- spoke with all four staff on site
- reviewed eight patient care and treatment records
- looked at a range of policies, procedures and other documents relating to the running of the service

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>.

Areas for improvement

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

Action the service **MUST** take to improve:

- The service must ensure that medicines issued to clients by staff, known as TTO (to take out) packs, meet legal requirements for labelling. (Regulation 12 (1) (2) (g))
- The service must implement a safe system and process reflecting the observation of children under the age of 18 years using the modified early warning score (MEWS) to ensure early recognition and safe timely escalation of a deteriorating patient. (Regulation 12 (1) (2) (a) (b))
- The service must measure waiting times are in line with best practice guidance. (Regulation 17 (1) (2) (a))
- The service must ensure that governance systems and processes, including operational audits and performance continue to improve and are reflected in practice and processes. (Regulation 17(1) (2) (a))

Action the service **SHOULD** take to improve:

- The service should consider its staffing arrangements to ensure there are enough staff to offer cover arrangements in the event of staff absence potentially delaying treatment times for women.
- The service should consider a process for reviewing the medical history of adults that have sought multiple termination of pregnancies.






Our findings

Overview of ratings

Our ratings for this location are:

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

Termination of pregnancy

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

Are Termination of pregnancy safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training, with clinical staff being 96% compliant with mandatory training and clinical staff being 100% compliant.

The mandatory training was comprehensive and met the needs of women and staff.

Staff told us that the training had significantly improved since the last inspection. All staff were trained to level 3 safeguarding in both children and adults. All staff, including administration staff now received training in the Mental Capacity Act.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A staff member gave an example of a telephone conversation they had heard a woman have in the waiting area, which caused concern that the person may have been coerced to attend the clinic. The staff member had sought appropriate advice from the central safeguarding team who would advise whether an external safeguarding referral was required.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Following the concerns identified at the last inspection, the service had revised its safeguarding algorithm for staff to escalate concerns. This included women who did not attend their appointment in clinic. There was now a process for staff to make three welfare calls and advise women to get in touch to ensure their safety and if unable to reach them make appropriate external professionals such as their GP aware.

Termination of pregnancy

Staff received training specific for their role on how to recognise and report abuse.

Staff completed safeguarding assessments and risk assessments for women thought to be at risk of self-harm or suicide and escalated concerns to the crisis team if required.

Staff followed safe procedures for children visiting the clinic. The service had implemented further protocols to ensure that children's safeguarding needs were identified and actioned appropriately. Staff ensured that children under the age of 16 were mandatorily seen in clinic, and children under 18 years of age having consultations via video call on WhatsApp. This was to reduce the potential of children being coercing into having a ToP procedure against their wishes.

However, staff told us there was no process for reviewing the medical history of adults that have sought multiple termination of pregnancies.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained, audits showed the service was 100% compliant with infection control measures.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact, we saw the use of cleaning stickers in place on equipment that was used during patient contact.

Environment and equipment

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

The design of the environment and facilities were suitable to meet the needs of women.

The service had enough suitable equipment to help them to safely care for women.

Staff carried out daily safety checks of specialist equipment.

Staff disposed of clinical waste and sharps safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration, however, did not have an assessment tool in place to specifically measure signs of deterioration in children.

Termination of pregnancy

Since the last inspection in August 2021, the service had implemented an effective system to assess and manage risks to ensure all women who attended the service were cared for in a safe and effective manner and in line with national guidance. This had reduced the risk of patient harm.

The business continuity plan revised in November 2021 included action required in the event of staff absence including relocating staff within their remit and using members of other services if required. A workforce mapping tool had been developed to inform decision making around staff absence.

The service had introduced a standard operating procedure to respond to emergency situations, including in the event of absence of key clinical staff members. This included a clear escalation and risk assessment process. Staff told us that since the last inspection they attended a 'skills and drills' each month in which they practiced their response to an emergency such as post abortion haemorrhage or anaphylaxis. The service was developing their programme to ensure that staff were prepared to respond in line with the new policies in the event of emergency, staff told us they were attending a training course the following week in simulation-based education.

The service had a service level agreement with a local NHS trust. As part of the reviewed standard operating procedure for acute service disruption, there were algorithms for staff to follow to identify when women require transfer to an NHS service.

Women received information on the risks of their procedure and cervical preparation medications however, this did not stipulate risk that may occur due to additional time between administration cervical preparation medications to SToP if there was any service disruption causing to treatment. Staff discussed with women that after taking Mifepristone (cervical preparation) there was a risk of expelling the pregnancy prior to surgery. They were also given a supporting information leaflet including how to use, and risk of using, Mifepristone which highlighted the risk of miscarrying the pregnancy before a SToP could take place, particularly when used with other forms of cervical preparation.

Staff completed an assessment for each woman on arrival and reviewed this regularly, including after any incident. Patient wellbeing checks had been implemented for women that had taken cervical preparation for their procedure. The waiting room was situated in view of the administration office, the administrator carried out wellbeing checks and escalated any concerns to midwifery staff.

Patients undergoing elective surgery had a pre-assessment as part of this process. This was a means to identify patient's suitability and other pre-conditions that may lead to patient's complications during the surgery or recovery period.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. The service used a Modified Early Warning Score (MEWS), a system adapted for the needs of termination of pregnancy from the National Early Warning Score (NEWS) developed by the Royal College of Physicians for the detection and response to clinical deterioration in adult patients. Records showed staff used this tool to identify deteriorating patients during the surgical procedure and recovery. We reviewed a sample of four MEWS records and found these were all completed, and staff were aware of the threshold for initiating medical support as needed. The service was not using a Paediatric Early Warning Score (PEWS) to assess children, when discussed with staff they could not describe how the MEWS was adapted for use in children. This was a requirement from the last inspection; however, we were advised the provider had begun a review.

Staff knew about and dealt with any specific risk issues. There were policies and procedures in place to recognise and respond to risks such as venous thromboembolism (VTE) a condition in which a blood clot or thrombus forms in a vein, and sepsis (severe blood infection) a rare but serious complication of an infection.

Termination of pregnancy

The service used a safer surgery checklist for service users undergoing a SToP procedure and we observed its use in all records reviewed.

The service had facilities on site to manage significant blood loss and an escalation process if this occurred including using a haemorrhagic pack to stabilise a service user. The service user would be then be transferred to a local NHS trust. Service level agreements were in place with NHS trusts, reviewed and in date until 2023. There was a resuscitation trolley which had weekly and monthly checks which were up to date and included equipment in sizes appropriate for both adults and children.

Staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have cover arrangements in the event of a staff member being absent due to illness, the staff team consisted of seven people in total based on the activity of the service. The service did not use any bank or agency staff and in the event of absence women were offered the next available appointment in clinic or at another of the provider's locations. The manager had informed us of an incident where five women's ultrasound diagnostic scans were rearranged due to staff absence at the ultrasound scan provider contracted by BPAS under service level agreement. Although scans were non-urgent (not required within 48 hours of assessment), women's scans and therefore treatment were delayed by up to three days.

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance.

The service had low vacancy and turnover rates.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction. (Only include if not previously included above)

The service had enough medical staff to keep women safe.

Sickness and vacancy rates for medical staff were reducing. The service was in the process of recruiting a new surgeon and a surgeon had returned from a period of sickness which had reduced staffing pressures to offer SToP.

Records

Record keeping had improved. Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The service used an electronic record system. There was a paper record made available for those patients undergoing a surgical termination of pregnancy procedure. During the inspection we reviewed eight sets of patients' records. The records contained detailed information of patients' assessments, records from the surgical procedure if relevant, including observations during procedures and in recovery, nursing notes and discharge checklists and assessments which were appropriate to the patient's clinical pathway.

Termination of pregnancy

Patient records were stored and maintained securely and there was restricted access to prevent unauthorised access to confidential patients' records.

Access to the electronic patients' notes was password protected and staff ensured they logged off when the computers were not in use.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff continued to not always follow systems and processes when safely prescribing, administering, recording and storing medicines. At the previous inspection we found that medicines issued to clients by staff, known as TTO (to take out) packs, did not always meet legal requirements for labelling. This was raised again during this inspection as a concern and we escalated to the area manager.

However, the governance arrangements for the use of Patient Group Directions (PGDs) were robust and records of the use were clear and uploaded into patient records. PGDs are written instructions which allow specified healthcare professionals to supply or administer certain medicines in the absence of a written prescription.

Records that we looked at for the use of medicines in theatre were clearly written, allergies were recorded and VTE assessments were completed to ensure that patients were safe to continue with their procedures.

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

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines including controlled drugs (CD's) were stored securely and appropriate checks were in place in line with the providers policy.

At the previous inspection we found that medicines which were stored in fridges were not managed safely. At this inspection we found that a new fridge was in place and temperature monitoring records provided assurance that medicines were fit for use.

New trolleys for emergency situations were in place, records showed that checks had been performed to ensure that medicines within these trolleys were fit for use.

Staff followed current national practice/guidance to check patients had the correct medicines.

Policies and procedures were in date. These were available and accessible to staff.

We saw that patients were asked about routine medicines that they took, and this was recorded in the clinical history. We were also shown how this was checked against suitability criteria for access to the service to ensure the right patients accessed the service.

Termination of pregnancy

Incidents and Duty of candour

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

Staff knew what incidents to report and how to report them. The service used an electronic system to internally report and record incidents. Staff we spoke with had received training in the electronic system since the last inspection and told us they knew what incidents to report and were confident in using the reporting system.

Incidents were notified to and investigated by the local Treatment Unit Manager and Lead Nurse with support from the quality matron, operational quality manager and regional clinical director if required. Local managers oversaw any necessary local or immediate action and submitted initial reports and 72-hour reviews and escalated to the risk and governance team who decided whether incidents were escalated as a Serious Incident Requiring Investigation (SIRI). The service had had no SIRI's in the last 18 months. Since the last inspection, the service had introduced a training course in human factors and best practice examples of 24 hour and 72 hour reports to ensure they were capturing all necessary information about patient safety incidents.

Staff told us incidents were discussed at safety huddles and at staff briefs and a staff information board had been created to make outcomes and learning from incidents easily accessible to staff. Staff were able to describe changes that have been made as a result of incidents and the last CQC inspection in August 2021.

Staff understood the Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. At the previous inspection, there was no written confirmation of DoC provided to women. We saw examples of Duty of Candour being provided in an open and transparent way which gave women a full explanation if and when things went wrong, women were asked if they wanted written DoC, and if refused, a copy of the letter was kept with their file in the event they changed their mind.

Staff submitted statutory notification of incidents to external organisations and the Care Quality Commission.

Are Termination of pregnancy effective?

Good 

Evidence-based care and treatment

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up to date BPAS policies to plan and deliver care. At the last inspection we found that policies did not always include best practice and national guidance. Managers now had assurance that staff followed national guidance consistently as audits, including patient records and consent, had been reintroduced since the last inspection.

Termination of pregnancy

Staff followed patient pathways and documented consultations with women in an electronic patient record. We reviewed eight records, all had been completed in line with BPAS policy and procedure. Since the previous inspection, the service had introduced areas within the electronic system for best practice and national guidance. For example, there was a new section within the record that was required to be completed for all women attending clinic to record the assessment of a person's mental capacity, these records were then audited to ensure that capacity and consent was recorded accurately.

Staff referred to the psychological and emotional needs of patients and this was documented in their records.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Women were encouraged to discuss contraception following ToP. Women undergoing SToP were given the option to have long-acting reversible contraception (LARC) in the forms of a contraceptive implant, coil or intrauterine device (IUD) fitted by the surgeon or a long-acting contraception injection, and women undergoing medical ToP were offered a contraceptive pill or signposted to local services for other methods of contraception. The service had plans to make LARC an optional part of the pathway for all women attending clinic.

Women were given information and advice prior to, during their treatment and following discharge. Staff gave information during consultation and information about procedures and medications were available in online format or paper-based if preferred.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Women received appropriate nutritional information for the ToP procedure they were having.

Staff ensured that those with specific dietary requirements, such as being diabetic, fasted prior to their treatment for as minimal a time as possible, such as being booked first on the list for treatment or receiving an alternative treatment to reduce fasting time if needed.

Patients were provided snacks, water and hot drinks after surgery.

Pain relief

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

Staff prescribed, administered and recorded pain relief accurately. Pain relief was clearly and appropriately prescribed during and after theatre. Records we looked at showed the monitoring of the patient for pain and post-surgery pain relief was prescribed to take home. In addition, PGDs for pain relief were available for staff to use and we saw that when a PGD was used it was recorded in people's records.

Women received pain relief soon after requesting it. Staff described how in most cases patients were counselled that they could feel pain post-procedure at home. Medicines were supplied after day case surgery to be taken at home. The service also provided patients a 24-hour help line for those who experienced pain or complications at home.

Termination of pregnancy

Staff assessed women's pain and gave pain relief in line with individual needs both pre- and post- procedure. Records we reviewed showed that pain assessments, called wellbeing checks, had been completed for women who were to have a SToP and had received cervical preparation medications, pain scores were documented following surgical procedures as part of the patient MEWS. As part of surgical procedures pain relief was appropriately prescribed and staff had access to a prescriber in the event of additional pain relief being requested.

Patient outcomes

Managers monitored the local effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The provider monitored outcomes overall and the complication rate was low. There were no women that required transfer to other facilities between September 2021 and March 2022 as a result of complications of their procedure.

Managers carried out audits and compared results to the previous month to monitor performance and improve the service. At the last inspection all audits had been paused except for clinical supervision, infection control and medicine's management as a result of the COVID-19 pandemic. At the last inspection we found incomplete patient records, insufficient safeguarding information, two-stage consent had not been sought. However, the dashboard had been reviewed to include a new audit schedule which had been in place and completed for three months prior to inspection.

Managers shared and made sure staff understood information from the audits through team meetings and a communication board where the results of audits were displayed monthly.

The service was able to provide scans within 48 hours of telephone consultations and on the same day as face to face consultations. The service had extended its opening times, including a weekend clinic, to increase the likelihood that women could access a scan appointment within the required 48-hour timeframe.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave new staff a full induction tailored to their role before they started work made up of face to face and online learning.

Managers supported staff to develop through yearly, constructive appraisals of their work, only one member of staff was awaiting appraisal which was scheduled.

Managers made sure staff attended team meetings and were given access to full notes.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. One midwifery staff member told us they had recently received a first trimester scanning qualification through the University of Bournemouth with support of BPAS lead sonographer and professor to gain experience of scanning women in clinic.

Termination of pregnancy

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women; however, this was not always documented.

Patient records demonstrated that professionals worked together in a timely way to ensure that women were receiving safe treatment.

Managers worked with partner organisations such as substance misuse services, women in care, the multi-agency safeguarding hub, early pregnancy unit and local NHS trusts to ensure women received safe and effective care.

However, meetings continued to not always be structured or documented. Full team meetings were documented and managers told us they were beginning a 15- minute weekly huddle for staff to discuss the service quality. However, these meetings had not yet begun and daily huddles were still not documented which was a concern repeated from last inspection.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support in patient facing areas.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

The service had made improvements to the consent process and documentation of the assessment of mental capacity. We reviewed four patient records for women who had undergone a surgical termination of pregnancy (SToP) which all evidenced staff had documented two-stage consent.

A process had been implemented to evidence the assessment of mental capacity. The electronic recording system had been adapted to include a section detailing mental capacity assessment, staff were unable to complete a patient record without completing the assessment of mental capacity. All patient records reviewed documented all the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005

Staff made sure women consented to treatment based on all the information available. Patient information leaflets were given prior to any procedure to inform women of the risks of a ToP procedure, and now included the risk of travelling significant distances following administration of medications.

Termination of pregnancy

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. A monthly audit of five consultation records and five surgical case notes, including the documentation of consent, had been introduced since the August 2021 inspection to ensure that staff were accurately recording assessments and any shortfalls in the documentation process identified.

Staff received training in the Mental Capacity Act. All staff had attended the training course in mental capacity which was introduced following the findings of the last inspection; staff told us this was a significant improvement as they had not received any training from the service previously in the Mental Capacity Act 2005.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act; staff told us they could escalate any queries regarding mental capacity to the central BPAS safeguarding team for advice and support.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment and documented these decisions.

Are Termination of pregnancy caring?

Good 

Compassionate care

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

Staff were discreet and responsive when caring for women. We observed staff taking time to interact with women in a respectful and considerate way.

A woman told us staff had treated them well and with kindness.

Staff followed policy to keep women's care and treatment confidential. Staff carried out consultations in private rooms and marked these as engaged when having discussions with women. They exited rooms discreetly when in use and locked doors and cabinets where information may have been accessible.

Records captured the individual needs of each woman; staff had completed these showing an understanding and non-judgmental attitude when caring for or discussing women with mental health needs and signposting to appropriate services. We saw evidence of women being offered counselling services through BPAS to discuss their decision to terminate a pregnancy.

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

Emotional support

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

Staff gave women emotional support and advice when they needed it. We observed staff comforting women during their treatment.

Termination of pregnancy

Staff understood the emotional and social impact that a person's treatment had on their wellbeing and on those close to them. Staff demonstrated a genuine caring nature when discussing the needs of women with the inspection team.

Understanding and involvement of women and those close to them

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

Staff supported women to make informed decisions about their care. All treatment options appropriate for the woman's gestation were discussed and their preferences considered when choosing a treatment option.

Women were able to request a chaperone or offered one if under the age of 18. Information was available in the patient waiting areas to make women aware that they were able to have a second member of BPAS staff accompany them.

The service made sure women and those close to them understood their care and treatment. Women received all information in leaflet form relevant to their treatment and were signposted to the 'BPAS Helpbot,' an artificial intelligence communication aid on the BPAS website should they have any difficulties understanding the information.

Staff talked with women in a way they could understand, using communication aids where necessary. We saw appropriate use of interpretation services when required.

Women and their families could give feedback on the service and their treatment.

Women gave positive feedback about the service. We saw several cards of compliments and staff to the service for their caring treatment during their time in clinic.

Are Termination of pregnancy responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so that they met the needs of the local population and worked with services including substance abuse and care services. However, the manager of the service worked across multiple sites and highlighted the lack of safeguarding and sexual health networks in the Tees Valley area.

The service offered appointments routinely two days a week but had extended to four days, including a weekend clinic to ensure that women were able to access urgent scanning when required.

Managers ensured that women who did not attend appointments were contacted, were aware of all options dependant on their gestation and could make informed decisions, respecting the choice of women if they wished not to continue with a termination of pregnancy.

Termination of pregnancy

There was a service level agreement in place with local NHS trusts where patients could be transferred in the event of an emergency. Since the last inspection this had been reviewed, in conjunction with the business continuity plan, to include the risk of staff shortages and to transfer women to the closest available service, including an alternative ToP provider if required.

Facilities and premises were appropriate for the services being delivered.

Pregnancy remains were stored appropriately and disposed of sensitively and complied with the Human Tissue Authority (HTA) Code of Practice (April 2017).

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. The used an external interpretation service and we saw an example of when this had been utilised for a woman using the service.

Patients were able to choose their preferred treatment option at the most convenient location for them, subject to their gestation and medical assessment. If patients needed to use services on other days, they could be signposted to alternative BPAS clinics in the North of England.

Consultations were long enough to enable staff to spend enough time with each patient to meet their individual needs.

Access and flow

People could not always access the service when they needed it to receive the right care promptly. Waiting times were not monitored to ensure referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The service did not offer access to surgical termination of pregnancy services in line with best practice. (Royal College of Obstetricians & Gynaecologists, Best practice in abortion care, March 2022). Following the introduction of early medical abortion (EMA) at home, referred to by BPAS as Pills by Post, demand for surgical treatment had reduced, therefore the service offered surgical lists on a fortnightly basis which resulted in women waiting longer for treatments. Providers should have arrangements in place to minimise delays in women accessing services with best practice stating women should receive an assessment within one week of referral and receive their treatment a week from assessment (NICE QS199). The service had a standard operating procedure in place to minimise waiting times for women and had set a target for women to receive their treatment within eight days from referral. However, wait times showed that women were not receiving their treatment in line with this, for 44 women requiring SToP only 18 women had a wait time of under 10 days.

The service did not measure wait times to minimise delays in women accessing services in line with national best practice guidance. Between 1 January 2022 and 27 April 2022, for women seeking EMA, only 60% of women had received their consultation within seven days of contact, and only 75% received their treatment seven days from consultation. Managers told us that these figures did not reflect patient choice, however there was no audit of wait times and why they occurred to capture the reason for delayed access and attempt to reduce waiting times.

Termination of pregnancy

However, women were given flexible appointment times appropriate to their gestation. The service had a telephone consultation service which carried out an initial consultation and offered patients a choice of appointments suitable to their gestation and individual requirements.

Managers monitored waiting times for women requiring an urgent appointment. The service had had difficulty, following the pandemic, in providing urgent appointments within 48 hours when women met these criteria. The service recorded when urgent appointments were unavailable, the actions taken and any learning to improve the availability of these appointments in future. They had opened the clinic an additional two days including a weekend to better accommodate this need. We spoke to a woman on the day of inspection who told us she was attending clinic within 48 hours of having contacted BPAS.

Staff planned each woman's attendance as early as possible. Women were given the expectation to attend clinic for the whole day with their appointment time being time of arrival as opposed to treatment, this allowed for staff to adapt women's treatment dependent on their consultation and individual needs.

Learning from complaints and concerns

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

Women, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle and acknowledge them.

Managers investigated complaints and identified themes and women received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Are Termination of pregnancy well-led?

Leadership

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was managed by a registered manager (Treatment Unit Manager, TUM) with oversight from an Operational Quality Manager (OQM). The service displayed the certificate of approval to undertake termination of pregnancies as issued by the Department of Health.

Termination of pregnancy

Leadership had improved. The unannounced inspection on 4 August 2021 identified breaches of regulation and the leadership team had provided an action plan to address concerns found across the three sites inspected at that time, with local action plans for each site. Senior leaders had coordinated the implementation of the action plan and provided CQC with a monthly update of its progress at this inspection over 80% of actions had been completed. Local managers then engaged with CQC monthly to demonstrate how the improvements were being embedded at local level.

Local and senior managers were visible, available and approachable. Regional managers met with staff regularly and staff were able to contact clinical leads for advice and guidance as required.

Managers supported staff to attend additional training to enhance their skills and develop into senior roles. All staff we spoke with told us they had the opportunity to accept additional responsibilities to support the running of the service. For example, the lead midwife now operated on a supernumerary basis and had undergone training in audit processes to support the manager in the delivery of the revised governance processes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision and strategy they wished to achieve including values and strategy to achieve. This was informed by best practice guidance and the needs of women nationally. For example, the service was setting up a not-for-profit fertility service to provide fertility treatment for those who did not qualify for NHS funding.

A vision day had been held to inform the business strategy and to share the vision and strategy with all staff. The service had used different forums to collect information from its staff, external stakeholders and healthcare professionals as well as the public about the current and future directions of the business. The manager disseminated any updates through the team meetings.

BPAS national and local strategic plans changed in line with legislation and the needs of women. The service had tailored its provision

The service had been able to tailor its provision community since the introduction of “Pills by Post” during the COVID-19 pandemic and kept up to date with changes in legislation, this had meant fewer women needed to attend the service for consultation or treatment. Learning had been taken from any incidents that occurred to ensure the delivery of early medical abortion (EMA) at home was as safe as possible.

Staff treated patients with respect and provided confidential and non-judgmental care. We observed staff attitudes and behaviour reflected these values.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

Staff worked together as a team with a common focus of delivering high-quality care to women attending. Staff felt the management and senior leadership team were visible and approachable.

Termination of pregnancy

Staff felt proud of the service they provided for their local community and vulnerable women. They spoke passionately about the delivery and importance of ToPs and we saw staff interact with women in a caring and compassionate way.

The service provided met the equality and diversity needs of clients including religious and cultural needs, providing effective translation services and providing additional weekend clinics.

Staff were confident in reporting incidents and concerns internally and BPAS encouraged learning from all incidents and audits. Staff were encouraged to develop professionally and take part in additional training opportunities. The service had a freedom to speak up guardian in place for staff to escalate concerns.

Governance

Leaders had begun to operate effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had improved its quality assurance processes with a new monthly audit plan introduced in January 2022. During the August 2021 inspection, we identified that most audits had been put on hold since February 2020 except for clinical supervision, infection control and medicine's management. Therefore, managers had not been aware if quality issues existed. However, the dashboard had been reviewed to include: surgical case notes, safeguarding adults and children, client wellbeing checks, treatment pathway audits, infection control, crash trolley and medicines management, which had been in place and completed for three months prior to inspection.

The service submitted documentation in line with its legal requirements. To provide termination of pregnancy, it is legally required that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 Form). We looked at eight patient records and found that all forms included two signatures and the reason for the termination documented on the BPAS client administration system (CAS) no patients were treated without two signatures.

The service submitted HSA4 forms to the Chief Medical Officer electronically through the provider's patient record system as recommended by the Department of Health. Registered nurses administering the second stage of medical termination or the surgeon completing the surgical procedure were responsible for submitting the HSA4 form on the system which was then sent to the Department of Health within 14 days of the termination taking place. The TUM reviewed and checked form submissions on a weekly basis to ensure compliance.

However, although medication audits had been improved, they did not identify the issue we found on inspection. At the last inspection medication audits had been postponed due to the COVID-19 pandemic except for a CD count. Medication audits introduced in January 2022 were more comprehensive covering disposal, storage, CD's and emergency equipment, and included the sample size, whether the measures were compliant with standards and comments section to reflect any findings. This however did not identify that the labelling of TTO medication did not meet legal requirements, a repeat finding from the last inspection.

Although governance processes had improved throughout the service, with a revised audit dashboard which allowed for better management oversight of systems and patient care, these had not had time to become embedded in practice or show consistent improvements. Actions identified from audits had not yet been implemented and audits had not yet been reviewed to ensure they captured a full picture of the service.

Termination of pregnancy

The service did not audit waiting times for access to ToPs procedures to improve access and minimise delays for women accessing the service. Managers told us that the data was not reflective of all reasons wait times may be increased, such as women choosing a later appointment, however there was no audit of wait times and why they occurred to capture the reason for delayed access and attempt to reduce them

The service did not measure wait times to minimise delays in women accessing services in line with national best practice guidance. Providers should have arrangements in place to minimise delays in women accessing services with best practice stating women should receive an assessment within one week of referral, and receive their treatment a week from assessment. The service had a standard operating procedure in place to minimise waiting times for women and had set a target for women to receive their treatment within eight days from referral. However, information captured showed that women were not receiving their treatment in line with this. Between 1 January 2022 and 27 April 2022, for women seeking EMA, only 60% of women had received their consultation within seven days of contact, and only 75% received their treatment seven days from consultation. As the service only offered SToP procedures on a fortnightly basis, we saw that for 44 women requiring SToP, only 18 women had a wait time of under 10 days. Managers told us that these figures did not reflect when patient choice, however there was no audit of this information to capture the reason for delayed access and attempt to reduce waiting times.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Since the unannounced inspection on 4 August 2021, which identified a lack of business continuity planning and risk management in the event of an emergency, the leadership team had worked in response to the inspection to improve patient safety. The business continuity plan now included measures in the event of a shortage of key staff members. This was supported by a new standard operating procedure for unforeseen circumstances, such as the absence of a member of the surgical team with robust escalation process, risk assessment tool and staff simulation training to ensure they were familiar with the procedure should an emergency occur.

Managers at local level now had processes in place relevant to their location in the event of an emergency. There was a robust protocol in place in the event of emergency, including staff absence when there were surgical lists in which women had received cervical preparation. This included staff moving to clinics to meet the needs of women, service level agreements with local NHS trusts and other independent ToP providers to reduce a duration of travel, and staff having undertaken skills and drills training to ensure they were competent to assess, document and escalate risk appropriately.

Staff reported incidents and concerns appropriately and according to BPAS policy.

Managers escalated local risks up to a quality and risk committee who discussed risks at a leadership level.

Staff reported performance information to CCGs who monitored contract requirements

The risk register was comprehensive and reflected current risks in the service. Risk were given actions to mitigate them and an owner assigned to ensure actions were completed. Managers included risks that had been found in other BPAS services until actions were completed to ensure this was not a risk locally also. When risks were completed, they were shaded out but not removed completely so that it was easily identifiable if for any reason the risk reoccurred. However, not all risks had a reviewed date which made it difficult to identify whether risks were up to date or completed.

Termination of pregnancy

Information Management

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

The service had developed their quality dashboards to support them in collecting reliable data and analysing it and staff had access to this.

Staff conducted monthly audits that were inputted into the quality dashboards and the findings of these were collated and compared on a monthly basis to enable improvement. Managers also ensured that audit results were displayed in areas used by staff such as offices and staff rooms to make them easily accessible and promote learning.

The service had improved its process for reporting information to external organisations. A new policy was introduced which gave clarity on which incidents should be appropriately notified to the regulator in line with their statutory duty. Leaders had sought advice and clarity from CQC on the efficiency of their policy and local managers had opened dialogue with CQC to ensure that their notifications were made appropriately in line with registration requirements for providers.

Engagement

Leaders and staff actively and openly engaged with patients, staff to plan and manage services, however these were not always documented.

Managers openly engaged with staff and involved them in the management of service. Local team meetings were held bi-monthly which detailed attendees and reviewed safeguarding, audits, complaints and feedback, risks and incidents. Staff were given an opportunity to raise any other business such as training needs or clarity on new policies.

Staff received weekly emails to detail any issues and improvements in the service and receive regular updates. This included satisfaction reports, results of audits such as safeguarding and organisational updates such as changes in opening hours or policy change.

The service collaborated with partner organisations such as substance misuse services, women in care, the multi-agency safeguarding hub, early pregnancy unit and local NHS trusts to ensure women received a holistic approach to their care. Staff reported performance information to CCGs who monitored contract requirements. Managers reviewed service level agreements with third parties.

Staff took part in meetings on the morning of SToP lists to ensure clinicians were clear on their roles and any identified risks

However, meetings were not formalised for EMA lists. The staff team was small, and many discussions took place informally, with any known or identified risks documented in assessments. Managers told us they were beginning a 15-minute weekly huddle for staff to discuss the service quality however, these meetings had not yet begun.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Learning from incidents, safeguarding and daily practice was shared locally within the team. Staff described the formal processes for sharing learning and elements of good practice with the wider organisation through registered managers.

Termination of pregnancy

Staff told us they were proud of the improvements made in the service since the last inspection in August 2022.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Termination of pregnancies
Surgical procedures
Treatment of disease, disorder or injury
Family planning services
Diagnostic and screening procedures

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The service did not measure waiting times in line with best practice guidance. (Regulation 17 (1) (2) (a))

Regulated activity

Termination of pregnancies
Surgical procedures
Treatment of disease, disorder or injury
Family planning services
Diagnostic and screening procedures

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The service must ensure that governance systems and processes, including operational audits and performance continue to improve and were reflected in practice and processes. (Regulation 17(1) (2) (a))

Regulated activity

Termination of pregnancies
Surgical procedures
Treatment of disease, disorder or injury
Family planning services
Diagnostic and screening procedures

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- The service did not ensure that medicines issued to clients by staff, known as TTO (to take out) packs, meet legal requirements for labelling. (Regulation 12 (1) (2) (g))

Regulated activity

Termination of pregnancies
Surgical procedures

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Family planning services

Diagnostic and screening procedures

Treatment of disease, disorder or injury

- The service did not implement a safe system and process reflecting the observation of children under the age of 18 years using the modified early warning score (MEWS) to ensure early recognition and safe timely escalation of a deteriorating patient. (Regulation 12 (1) (2) (a) (b))