BPAS - Tottenham

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

BPAS Tottenham is part of the provider group British Pregnancy Advisory Service (BPAS). The service at BPAS Tottenham is located within NHS premises in a sexual health clinic in a GP surgery leased by BPAS on a sessional basis, and is provided under contract with local clinical commissioning groups for NHS patients. BPAS Tottenham also accepts private patients. Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy by surgical or medical methods.

The service was registered in February 2012 as a single specialty termination of pregnancy service providing a range of services for early medical abortion (EMA) up to a gestation of 10+0 weeks. This includes: pregnancy testing, unplanned pregnancy counselling/consultation, early medical abortion, abortion aftercare, sexually transmitted infection testing, and contraceptive advice and contraception supply.

We carried out this announced comprehensive inspection on 4 May 2016, as part of the first wave of inspection of termination of pregnancy services. The inspection was conducted using the Care Quality Commission's new methodology.

We have not provided ratings for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy services; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

The inspection team included an inspection manager and three inspectors, two of whom who were also specialist professional advisers in midwifery and nursing.

Our key findings were as follows:

Is the service safe?

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not carried out or documented in line with national or local guidelines.
- Incidents, including those with a potential to cause harm to patients or staff, were not always reported.
- Staff did not receive prompt feedback to reduce the risk of recurrence of incidents.
- The approach to anticipating managing day-to-day risks to people who used the service was reactive rather than pro-active, and tended to be led at a regional or corporate level. This meant that opportunities to prevent or minimise harm could be missed.
- National specifications for infection prevention and control were not adhered to. In particular, requirements for cleaning schedules, and checklists; and clear separation of clean and dirty activities and equipment.
- There were reliable systems, processes and practices in place to keep people safeguarded from abuse.
- There was a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Medicines were safely ordered, supplied, and stored in accordance with manufacturers' instructions, and administered only when they had been prescribed for a named client.
- Records were securely stored, well maintained and completed with clear dates, times and designation of the person documenting.
- Safety and maintenance checks were generally carried out on equipment in accordance with local and national requirements.
- There were sufficient numbers of suitably trained staff available to care for patients.
- Arrangements were in place to manage emergencies and transfer patients to another health care provider where needed and were known to all staff. There were no emergency transfers between January 2015 and May 2016.

Summary of findings

Is the service effective?

- Care took account of national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However; a structured governance system had been followed to introduce this treatment option.
- The complication rates for retained products of conception are 5 in 100 if medicines are taken at the same time (simultaneous administration), compared to 3 in 100 if taken 24-72 hours apart.
- Policies were accessible for all staff and were up to date and kept under review.
- Patients were offered pain relief, preventative antibiotic treatments and post-abortion contraceptives.
- Staff had an annual appraisal. Counselling staff participated in group counselling supervision.
- The BPAS aftercare line telephone service was accessible to patients 24 hours a day and seven days a week.

Is the service caring?

- Staff were caring and compassionate and treated patients with dignity, understanding, and respect.
- Patients gave consistently positive feedback and described the staff as 'kind, warm, and professional'.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients considering termination of pregnancy had access to pre and post termination counselling, with no time limits attached, but were not obliged to use the counselling service.

Is the service responsive?

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location and time they attended.
- Patients were able to attend other local BPAS clinics for treatment if Tottenham was closed.
- The clinic did not offer surgical treatment. Patients who chose this option would be referred for treatment at another BPAS unit in London offering surgical termination of pregnancy.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- Patients were provided with information to help them to make decisions.

Is the services well led?

- There were effective corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, local risks were not always identified or acted upon by people with the authority to do so.
- Staff felt supported by their treatment unit manager and regional operations director.
- The culture within the service was caring, non-judgmental and supportive to patients. Staff spoke positively about the need for, and the value of the service provided to patients.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for BPAS.

There were areas of practice where the provider needs to make improvements.

The provider must ensure:

- The supply and administration of medicines under patient group directions (PGDs) is managed in accordance with legislation, provider policy and up to date national guidelines

Summary of findings

- Incidents of all kinds, including those with a potential to cause harm to patients or staff, even when no harm occurred are reported and that local staff receive prompt feedback to reduce the risk of recurrence of incidents.
- Implement processes to ensure greater ownership of assessing, reporting and acting upon local risks.
- National specifications for infection prevention and control are adhered to. In particular, the requirements for cleaning, cleaning schedules, and checklists in 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', and separation of clean and dirty activities and equipment, in the department of health 'Health Building Note 00-09: infection control in the built environment, 2013'.
- All equipment is maintained and serviced to ensure it is reliable and ready for use.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Is the service safe?

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not carried out or documented in line with national or local guidelines.
- Incidents, including those with a potential to cause harm to patients or staff, were not always reported.
- Staff did not receive prompt feedback from incidents to reduce the risk of recurrence.
- The approach to anticipating managing day-to-day risks to people who used the service was reactive rather than pro-active, and tended to be led at a regional or corporate level. This meant that opportunities to prevent or minimise harm could be missed.
- National specifications for infection prevention and control were not adhered to. In particular, requirements for cleaning schedules, and checklists; and clear separation of clean and dirty activities and equipment.
- There were reliable systems, processes and practices in place to keep people safeguarded from abuse.
- There was a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Medicines were safely ordered, supplied, and stored in accordance with manufacturers' instructions, and administered only when they had been prescribed for a named client.
- Records were securely stored, well maintained and completed with clear dates, times and designation of the person documenting.
- Safety and maintenance checks were generally carried out on equipment in accordance with local and national requirements.
- There were sufficient numbers of suitably trained staff available to care for patients.
- Arrangements were in place to manage emergencies and transfer patients to another health care provider where needed and were known to all staff.

Is the service effective?

- Care took account of national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However; we saw that a structured governance system was in place and had been followed to introduce this treatment option.
- The complication rate for simultaneous administration was approximately double that for medical abortion treatment when medicines were administered separately.
- Policies were accessible for all staff and were kept up to date.
- Patients were offered pain relief, preventative antibiotic treatments and post-abortion contraceptives.
- Staff had an annual appraisal.

Summary of findings

- Counselling staff participated in group counselling supervision.
- The BPAS Aftercare Line, a telephone service, was accessible to patients 24 hours a day and for seven days a week.

Is the service caring?

- Staff were caring and compassionate and treated patients with dignity, understanding, and respect.
- Patients gave consistently positive feedback and described the staff as 'kind, warm, and professional'.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients considering termination of pregnancy had access to pre and post termination counselling, with no time limits attached, but were not obliged to use the counselling service.

Is the service responsive?

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location and time they attended.
- Patients were able to attend other local BPAS clinics for treatment if Tottenham was closed.
- BPAS Tottenham did not offer surgical treatment. Patients who chose this option would be referred to treatment at one of two BPAS treatment units in London.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English.
- Patients were provided with information to help them to make decisions.

Is the service well-led ?

- There were effective governance arrangements to manage risk and quality. However, local risks were not always identified or acted upon by people with the authority to do so.
- Staff felt supported by the treatment unit and regional managers, and considered the leadership and visibility of senior managers was good.
- The culture within the service was caring, non-judgemental and supportive to patients.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for BPAS.

Summary of findings

Contents

BPAS Tottenham

Services we looked at:
Termination of pregnancy.

Summary of this inspection

Background to BPAS - Tottenham

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy (abortion) by surgical or medical methods. British Pregnancy Advisory Service (BPAS) Tottenham is part of the provider group BPAS. The service at BPAS Tottenham is located within a sexual health clinic in a GP surgery leased by BPAS on a sessional basis, and is provided under a contract with local clinical commissioning groups (CCGs) for NHS patients mainly from Haringey, Enfield, Barnet and Walthamstow, and also accepts private patients.

BPAS Tottenham provides a range of termination of pregnancy services. They include: pregnancy testing, unplanned pregnancy counselling/consultation, EMA up to 10 weeks of pregnancy, abortion aftercare, sexually transmitted infection testing, and contraceptive advice and contraception supply. The services are provided under contract with local clinical commissioning groups for NHS patients and also accept private patients.

Our inspection team

The inspection team included an inspection manager, three inspectors: two of whom were also specialist professional advisors in midwifery and nursing.

Why we carried out this inspection

We carried out this announced comprehensive inspection on 4 May 2016, as part of the first wave of inspection of termination of pregnancy services. The inspection was conducted using the Care Quality Commission's new methodology.

We have not provided ratings for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy services; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the service, such as local clinical commissioning groups (CCG). Patients were invited to contact CQC with their feedback.

We carried out this announced comprehensive inspection on 4 May 2016, as part of the first wave of inspection of services providing a termination of pregnancy service. The inspection was conducted using the Care Quality Commission's new methodology.

Summary of this inspection

We spoke with four members of staff, including a nurse, client care coordinator, and the treatment unit and regional managers. We reviewed ten treatment records of patients, including two of patients under the age of 18 years. We also spoke with three patients using the service.

Information about BPAS - Tottenham

The British Pregnancy Advisory Service was established as a registered charity (Registered Charity Number 289145) in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. The mission statement for BPAS is that it supports reproductive choice and health by advocating and providing high quality, affordable services to prevent pregnancies with contraception or end them by abortion.

The treatment unit holds a license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with the Abortion Act 1967.

BPAS Tottenham was registered with CQC in February 2012. The service is easily accessible by public transport.

The service is managed by a registered manager who is responsible for three BPAS treatment units in North London and is supported by a team of nurses, midwives and clinical care coordinators/administrators. Doctors provide remote services that include assessment, confirmation that the lawful grounds for abortion are fulfilled, and prescribing of abortifacient medicines, from a BPAS premises licensed by DoH to carry out termination of pregnancy.

Detailed findings from this inspection

Notes

We did not provide ratings for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy services; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

BPAS Tottenham is contracted by Clinical Commissioning Groups (CCGs) in the Haringey area to provide a termination of pregnancy service for NHS patients predominantly from the Haringey, Enfield, Barnet and Walthamstow areas. The service is also available for self-funded patients. BPAS Tottenham shares accommodation with, but does not operate at the same time as the sexual health clinic of a GP surgery, and consists of:

- two private consulting rooms.
- two treatment rooms.
- waiting area.
- administration and office areas.

The treatment unit is open on Wednesdays between 9am and 4.30pm, and Fridays between 9am and 3pm.

The following services are provided:

- pregnancy testing.
- unplanned pregnancy counselling/consultation.
- medical abortion up to 10 weeks of pregnancy.
- abortion aftercare.
- miscarriage management.
- sexually transmitted infection testing and treatment.
- contraceptive advice and contraception supply.

BPAS Tottenham undertook 386 early medical abortions (EMA) between January 2015 and December 2015 (the reporting period).

Summary of findings

Is the service safe?

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not carried out or documented in line with national or local guidelines.
- Incidents, including those with a potential to cause harm to patients or staff, were not always reported.
- Staff did not receive prompt feedback from incidents to reduce the risk of recurrence.
- The approach to anticipating managing day-to-day risks to people who used the service was reactive rather than pro-active, and tended to be led at a regional or corporate level. This meant that opportunities to prevent or minimise harm could be missed.
- National specifications for infection prevention and control were not adhered to. In particular, requirements for cleaning schedules, and checklists; and clear separation of clean and dirty activities and equipment.
- There were reliable systems, processes and practices in place to keep people safeguarded from abuse.
- There was a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Medicines were safely ordered, supplied, and stored in accordance with manufacturers' instructions, and administered only when they had been prescribed for a named client.
- Records were securely stored, well maintained and completed with clear dates, times and designation of the person documenting.

Termination of pregnancy

- Safety and maintenance checks were generally carried out on equipment in accordance with local and national requirements.
- There were sufficient numbers of suitably trained staff available to care for patients.
- Arrangements were in place to manage emergencies and transfer patients to another health care provider where needed and were known to all staff.

Is the service effective?

- Care took account of national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However; we saw that a structured governance system was in place and had been followed to introduce this treatment option.
- The complication rates for retained products of conception are 5 in 100 if medicines are taken at the same time (simultaneous administration), compared to 3 in 100 if taken 24-72 hours apart.
- Policies were accessible for all staff and were kept up to date.
- Patients were offered pain relief, preventative antibiotic treatments and post-abortion contraceptives.
- Staff had an annual appraisal.
- Counselling staff participated in group counselling supervision.
- The BPAS Aftercare Line, a telephone service, was accessible to patients 24 hours a day and for seven days a week.

Is the service caring?

- Staff were caring and compassionate and treated patients with dignity, understanding, and respect.
- Patients gave consistently positive feedback and described the staff as 'kind, warm, and professional'.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients considering termination of pregnancy had access to pre and post termination counselling, with no time limits attached, but were not obliged to use the counselling service.

Is the service responsive?

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location and time they attended.
- Patients were able to attend other local BPAS clinics for treatment if Tottenham was closed.
- BPAS Tottenham did not offer surgical treatment. Patients who chose this option would be referred for treatment at another BPAS unit in London.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English.
- Patients were provided with information to help them to make decisions.

Is the service well-led ?

- There were effective governance arrangements to manage risk and quality. However, local risks were not always identified or acted upon by people with the authority to do so.
- Staff felt supported by the treatment unit and regional managers, and considered the leadership and visibility of senior managers was good.
- The culture within the service was caring, non-judgemental and supportive to patients.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for BPAS.

Termination of pregnancy

Are termination of pregnancy services safe?

By safe we mean people are protected from abuse and avoidable harm.

Our main findings for safety were:

- Serious incidents were reported and investigated. These were reviewed centrally and at clinic level. The cascade of learning and actions required as a result of incidents was not always timely.
- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not carried out or documented in line with national or local guidelines.
- Cleaning services were provided by the NHS premises host and although appropriate signage and instructions from BPAS were in place, checks on the quality of the cleaning by BPAS were not sufficient. National specifications for infection prevention and control were not always adhered to. In particular, the requirements for cleaning, cleaning schedules, and checklists set out in 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' and requirements for separation of clean and dirty activities and equipment, in the department of health 'health Building Note 00-09: infection control in the built environment, 2013'. This meant there was a risk of cross contamination.
- Safety and maintenance checks had not been carried out on all equipment used for the diagnosis and management of client treatment and care. For example, equipment used to monitor blood pressure, thermometers, and weighing scales. This meant there was a risk that equipment may not have been functioning to the required level or may not have been safe to use, which could lead to misdiagnosis or ineffective treatment.
- There were reliable systems, processes and practices in place to keep people safeguarded from abuse. Staff demonstrated a correct understanding of safeguarding of adults and children and accurately described actions to be taken in cases of suspected abuse. All patient records we looked at showed that the initial assessment included a 'safe at home' trigger, which was in line with NICE guidelines '[PH50] domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively'.
- There was a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Medicines prescribed by a registered medical practitioner were safely ordered, supplied, and stored in accordance with manufacturers' instructions and administered only when the doctor had prescribed them for named individuals.
- Records were securely stored, well maintained and completed with clear dates, times and designation of the person documenting.

Incidents

- The BPAS organisation had a 'client safety incidents policy and procedure' which set out the processes for reporting and reviewing incidents. Staff were required to report incidents of all kinds, including those with a potential to cause harm to patients or staff, even when no harm had occurred.
- All staff we spoke with were familiar on how to report incidents, and referred to a list of examples of incidents that should be reported. This included treatment complications, medicines errors and failed treatment.
- The system for reporting clinical and non-clinical incidents was paper based using an incident reporting book, that was updated and held by the treatment unit manager. Incidents were then escalated to the corporate risk and safety team who would record them on a central electronic register. We asked to see the summary of the incidents reported between January 2015 and December 2015 but this was not available.
- We looked at paper records of the safety incidents between January 2015 and December 2015. We saw low levels of reported incidents (12), none of which had resulted in patient harm. No incidents were reported between December 2015 and April 2016. Staff and managers we spoke with acknowledged there was underreporting.
- Themes of safety incidents related to incomplete medical abortions and problems with postal delivery of samples.

- There were no never events reported at BPAS Tottenham between January 2015 and December 2015. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
- Serious incidents were discussed at quarterly BPAS clinical governance meetings. There were no serious incidents (SIs) at BPAS Tottenham between January 2015 and December 2015. Where serious incidents had occurred across the organisation, investigations and analysis of the root causes were carried out by the national risk management and safety lead and the clinical director. Regional and treatment unit managers then disseminated lessons learned to staff. However, the cascade of learning and actions required as a result of incidents was not always timely.
- Eight serious incidents had occurred in other BPAS treatment units in the reporting period. Notes from the most recent London and South East regional management meeting held on 2 March 2016 confirmed learning about complaints and SIs had been discussed, and action points agreed. Safety issues we identified relating to the lack of cleaning schedules and checklists were discussed by the regional managers, however; there was no evidence that any local or regional action was agreed or implemented.
- An internal safety bulletin known as the 'red top alert' was issued to inform all staff of any safety issues. We saw examples of bulletins that included learning points arising from safety incidents at other BPAS treatment units, for example, issues related to information governance and medicines management.
- The Duty of Candour is a legal duty on health care providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers. We spoke with staff about the duty of candour in relation to patient safety incidents. Staff described situations when the duty of candour would have been applicable. For example, staff apologised to patients who required follow up treatment at BPAS Tottenham on days when the Finsbury Park treatment unit was closed.

Cleanliness, infection control and hygiene

- The premises appeared visibly clean and uncluttered.
- Cleaning schedules did not detail the required standard and arrangements for cleaning at the point of use and cleaning checklists required by 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.
- Cleaning was carried out daily by a contracted cleaning company, when the treatment unit was closed to patients. This meant staff had little opportunity to monitor the cleaning service, and relied on verbal feedback about specific concerns. Cleaning schedules did not detail the required standard and arrangements for cleaning at the point of use, and cleaning checklists required by the code were not in place. This meant that staff could not confirm the specific cleaning that took place. Staff undertook any cleaning required during clinic hours.
- Spillage kits for the safe disposal of body fluids were provided and were within the expiry date. Staff knew where to locate them, and correctly described their use.
- Health Building Note 00-09 'Infection control in the built environment, 2013' requires: 'clear demarcation between clean/ unused equipment and soiled/ dirty equipment, and that clean and dirty areas should be kept separate'. We saw this was not fully implemented as a clean suction machine and patient records were stored in the dirty utility room. We brought this to the attention of the treatment unit manager who told us corrective action would be taken.
- Antimicrobial –impregnated privacy curtains were in the treatment room, and were clearly labelled with the date when they were last changed.
- The BPAS infection control essential steps audit tool facilitated audit of hand hygiene, personal protective equipment, aseptic technique and sharps management. BPAS Tottenham was 100% compliant with the monthly audits for 2015 that were reported in December 2015.
- Protective personal equipment (PPE) used to prevent and control infection, such as disposable gloves and aprons was readily available, correctly stored, and worn by staff.
- Handwashing sinks, soap, and alcohol hand rubs were in good supply and we saw instructions for their use clearly displayed. We observed staff used them in accordance with local policy.
- Staff adhered to the management of clinical waste policies and disposal of sharp objects.

- There were no reported health acquired infections or Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Diff) from January 2015 to December 2015.

Environment and equipment

- The service was provided in a purpose built NHS facility, which was described by one client as 'spacious, private and safe'.
- Staff told us they had all the equipment required to deliver a safe and effective service, and were satisfied with the arrangements for maintenance and replacement of equipment.
- An environmental audit was performed annually as part of BPAS ongoing quality assurance programme. This was last undertaken in May 2015 which concluded that were no significant risks or further action required.
- One blood pressure monitor, and a set of weighing scales did not have recent maintenance or calibration checks. This could lead to faults remaining undetected, and an associated risk of misdiagnosis or ineffective treatment. We brought this to the immediate attention of the registered manager who told us corrective action would be taken.
- All electrical appliances on the premises had been inspected and tested for electrical safety to the requirements of the electricity at work regulations, and had a valid certificate until February 2017.
- 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 to use. Single-use items were sealed and in date, and emergency equipment had been serviced.
- Emergency call bells to summon assistance were in place and were regularly tested.

Medicines

- 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. However, not all references listed in the policy were the most up to date version of such guidance, despite a recent review. For example, out of date references to NMC midwives rules and standards, and the safer management of controlled drugs publications.
- Medicines were either prescribed remotely by doctors using a secure electronic prescribing system or they 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.
- We saw examples of two medicines that were supplied and administered under a PGD on six occasions between 22 February 2016 and 19 April 2016. These were: anti-D immunoglobulin for patients who had the blood group rhesus negative and Misoprostol which was used for treatment of retained products of pregnancy following a medical or surgical termination of pregnancy.
- Legislation prevents abortifacient medicines being supplied and/or administered under a PGD for the purpose of inducing an abortion. The BPAS PGD for misoprostol (an abortifacient medicine) is clear in its indications for use – retained products of conception – and that it must not be used for the purpose of inducing an abortion.
- Misoprostol does not have a UK licence to induce termination of pregnancy, so its use in this way is described as 'off-label'. The use of 'off label medicines' must be fully explained to patients before they take them. We saw that this was explained to patients a part of the consent process.
- Legal requirements for using PGDs are that they 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 Tottenham 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. This signature was not evident for Misoprostol, but was completed for anti-D. We brought this to the attention of the registered manager who told us corrective action would be taken.
- The BPAS medicines management policy, 2015, required that 'only nurses and midwives who have attended the relevant training for a PGD can supply or administer

according to that PGD. Records must be kept locally by the unit manager of those nurses or midwives who have attended the training and been signed off to use a particular PGD'.

- The BPAS policy also required nurses and midwives who have attended the relevant training for a PGD can supply or administer according to that PGD. Records must be kept locally by the unit manager of those nurses or midwives who have attended the training and been signed off to use a particular PGD. Training records and signatures of the nurse and midwife using PGDs confirmed staff had received the required training and were signed off to use a particular PGD.
- The BPAS policy was that the practices surrounding PGDs would be audited every six months. Due to the recency of the introduction of PGDs the practices had not all been formally audited. Where they were audited, all standards were met.
- 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. Supplies were sent direct to each treatment unit. There were no controlled drugs (medicines subject to additional security measure), stored or administered at this location.
- An external pharmacist provided advice and attended relevant committees on a consultancy basis. Staff were unclear about who to contact for pharmaceutical advice and could not recall a situation when they had needed to do so. We saw evidence of recently completed PGD training (November 2015) by all nurses and midwives who supplied and administered medicines under PGDs. However, we did not see evidence of other medicines management training.
- Managers told us there was no recent review of the pharmacy service or medicines management audit. This meant that any non-compliance with medicines management policies may be undetected. However; staff could not recall that any safety incidents or risks had been identified.
- National medicines safety alerts were sent to all treatment units by BPAS central office, and acted upon. Staff knew how to locate these and described the system for sharing information. However; staff told us there had not been any safety alerts that were specific to the termination of pregnancy services in the reporting period, or in 2016.
- Medicines were all 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 were monitored and recorded to ensure that medicines were kept at the required temperature. We saw fridges used for this purpose were locked, were clean and tidy and found no surplus or expired stock.
- There were systems in place to check for expired medicines. All the medicines we looked at were in date and correctly stored in line with manufacturers' instructions.
- Patients were asked if they had any known allergies. We reviewed ten records and saw that all ten had a record of whether or not the client was allergic to anything.

Records

- Client information and records were mainly paper based, stored securely, and only accessed by relevant staff.
- All of the records we looked at were well maintained and completed with clear dates, times and designation of the person documenting.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for termination and sign a form to indicate their agreement (HSA1 Form). All records we looked at met these requirements.
- The department of health requires every provider undertaking termination of pregnancy to submit demographical data following every termination (HSA4 form). This information had been correctly gathered and reported on.

Safeguarding

- There were no safeguarding concerns at the time of our visit.
- BPAS had a range of policies to ensure safeguarding of children and vulnerable adults. Staff knew how to access the safeguarding policies and demonstrated a good understanding of the processes involved for raising a safeguarding alert.
- 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 and escalating to the BPAS national safeguarding leads as necessary, and liaising with other agencies.

- The registered manager ensured that eligible staff were adequately trained on issues related to safeguarding through completion of mandatory two yearly BPAS 'Safeguarding vulnerable groups' training. Records we saw confirmed that 100% of staff were trained to safeguarding level 3 for adults and children.
- All staff we spoke with correctly identified the safeguarding lead, described what may constitute a safeguarding concern and understood the process for reporting concerns.
- Staff told us they routinely took the opportunity to ask patients about domestic abuse in line with NICE guidelines '[PH50] 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 that the client was 'safe at home'.
- Patients had access to information about local organisations to support them in case of domestic abuse.
- It was the organisational policy that if a girl under 18 years of age used the service, a comprehensive safeguarding risk assessment would be carried out. We saw that for those aged under 18, a safeguarding risk assessment was carried out and a decision made on the outcome of the assessment.
- We saw that the assessment included questions around consent and coercion to sexual activity and lifestyle to identify coercion, overt aggression, suspicion of sexual exploitation or grooming, sexual abuse and power imbalances.
- The BPAS safeguarding policies and processes reflected 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.
- BPAS Tottenham did not treat any young person under the age of 13. Between January 2015 and December 2015 the treatment unit had not treated any children between the ages of 13 and 15, or under 13 years old.

Mandatory training

- BPAS mandatory training covered a range of topics: life support, fire safety, health and safety, safeguarding, moving and handling, infection control and information governance. We were told that there were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- A fire evacuation exercise was completed in March 2015 and learning points shared.
- BPAS Tottenham had met the organisational target for completing mandatory training (100%).
- There was a 12 week competency based training programme for newly employed staff which included all the mandatory training topics, along with client support skills training, and topics including sexually transmitted infection training, ultrasound scanning and HIV training.

Assessing and responding to patient risk

- The 'BPAS Suitability for Treatment Guideline' set out which medical conditions would exclude patients for accessing treatment, and those medical conditions which, although not an automatic exclusion required careful risk assessment by a doctor, usually a regional clinical lead or the BPAS medical director. BPAS has a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Records we looked at confirmed that before treatment, all patients were assessed for their general fitness to proceed. The assessment included obtaining a full medical and obstetric history, measurement of vital signs, including blood pressure, pulse and temperature. An ultrasound scan confirming pregnancy dates, viability and multiple gestations was carried out in all cases. Relevant laboratory testing was undertaken as appropriate: for example haemoglobin level.
- All the patients undergoing abortion should have venous thromboembolism (VTE) risk assessment to determine the degree of risk they were at from blood clots forming. Out of ten records we looked at only six were completed.

- All client records showed that blood was tested at the time of the initial assessment to determine Rhesus factor, and Anti-D immunoglobulin was administered to patients who were found to be rhesus negative. Testing for sexually transmitted infections was available and carried out with the client's consent.
- 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 summons emergency assistance**.** In the case of a medical emergency BPAS transferred patients to the neighbouring NHS Trust hospital. There had been no such transfers in the reporting period.

Nursing staffing

- The service employed two nurses and one midwife (0.56 whole time equivalent). There were no vacancies at the time of our inspection. patients
- Nursing staff were supported by one client care coordinator, who offered counselling when required and carried out administrative duties, and receptionists (0.75 WTE).
- When patients attended the treatment unit there would be at least one registered nurse or midwife on duty and a client care coordinator.
- Staff rotas were managed regionally which meant that the service needs were met without having to use agency or locum staff.

Medical staffing

- For patients having medical abortions, doctors employed by the BPAS organisation provided an assessment and prescription service by working remotely from the licensed premises. A secure login and password from the department of health was used, preventing any unauthorised access.

Major incident awareness and training

- BPAS major incident and business continuity plans were updated in 2015 and 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, however; no formal training or simulation exercises had taken place.

Are termination of pregnancy services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our main findings for effective were:

- Care was generally provided in line with national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a robust governance system was in place and had been followed to introduce this treatment option.
- The complication rates for retained products of conception are 5 in 100 if medicines are taken at the same time (simultaneous administration), compared to 3 in 100 if taken 24-72 hours apart.
- Policies were accessible for staff.
- Patients were offered pain relief, prophylactic antibiotic treatments and post-abortion contraceptives.
- Staff had an annual appraisal.
- Counselling staff participated in group counselling supervision.

The BPAS Aftercare Line, a telephone service, was accessible to patients over 24 hours a day and for seven days a week

Evidence-based care and treatment

- Policies were accessible for staff and were developed in line with department of health required standard operating procedures (RSOP) and professional guidance. However; some polices did not follow national guidance.
- BPAS introduced simultaneous administration of mifepristone and misoprostol (medicines used to bring about abortion) in March 2015. This is not in line with RCOG guidance which recommends that mifepristone is administered first followed by the administration of misoprostol 24 – 48 hours later. BPAS had conducted which underpinned the policy and pathway for simultaneous administration of mifepristone and misoprostol. Outcomes were kept under regular review.

Termination of pregnancy

- The different pathways for EMA were discussed with women at the initial consultation appointment. Women then signed a consent form before proceeding with treatment.
- The treatment unit adhered to RCOG guidelines for the treatment of patients with specific conditions, such as ectopic pregnancy.
- All patients underwent an ultrasound scan to determine gestation of the pregnancy in accordance with the BPAS clinical guideline for all abortions.
- Blood was tested at the initial consultation to determine Rhesus factor. Anti-D immunoglobulin was administered to patients who were rhesus negative.
- RCOG guidance and RSOP 13: 'contraception and sexually transmitted infection (STI) screening states that information about the prevention of sexually transmitted infections (STI) should be made available, and all methods of contraception discussed with patients at the initial assessment with an agreed plan for contraception after the abortion.
- All patients were tested for chlamydia (a sexually transmitted bacterial infection) prior to any treatment. Patients with positive test results were referred to sexual health services. Patients were also referred to sexual health services for screening for other STIs and any required treatment.
- Contraceptive options were discussed with patients at the initial consultation and a plan agreed for contraception after the abortion. Patients were provided with contraceptive devices at the treatment unit. These included long- acting reversible contraceptives (LARC) which are considered to be most effective as suggested by the National Collaborating Treatment unit for Women's and Children's Health.
- Audit showed that the treatment unit was 100% compliant in following discussion around contraceptive advice.

Pain relief

- Pre and post procedural pain relief was prescribed, and recorded on the medicines administration 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 were clear about which medicines would be offered. For example for a medical abortion procedure, NSAIDs would be offered.
- Patients were advised to purchase over the counter medicines for use following discharge and given information about when and how to take them.

Patient outcomes

- Between January 2015 and December 2015, BPAS Tottenham carried out 386 EMAs.
- Patients undergoing medical abortion were asked to complete a pregnancy test two weeks after treatment to ensure that the treatment had been successful. Patients could contact the BPAS aftercare telephone service and were invited back to the clinic if there were any concerns.
- In order to monitor outcomes staff also relied on colleagues reporting back to them or patients reporting to the BPAS Aftercare line. If staff were informed that there had been a complication a form would be completed and it would be documented in client's notes. This was monitored by the quality leads and cascaded through meetings.
- Abortifacient medicines were administered using two options. They could 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 client's choice was always taken into account, although simultaneous administration was encouraged.
- The method of simultaneous administration of medicines was recently introduced by BPAS at all its treatment units for EMA treatment up to nine weeks of gestation, and is outside of national guidance contained in RCOG guidance: 'the care of patients requesting induced abortion' (November 2011).
- The introduction of simultaneous administration followed a national BPAS pilot study involving almost 2000 patients between March 2014 and January 2015. This pilot study demonstrated that simultaneous administration was associated with an increased need for surgical treatment in comparison to a dosing interval of 6 – 72 hours (7% compared to 3.3%). It also found acceptability and differences were almost the same between simultaneous administration and a dosing interval of 6 – 72 hours (89% compared to 90%).
- Minutes of a clinical governance committee meeting held in March 2015 reported the results of the pilot study

and acknowledged this process was outside of the national guidance. They also stated: 'An additional benefit of simultaneous administration is that fewer resources are needed at BPAS and for the woman if a routine second visit is not needed'.

- The service monitored the outcomes of this new method which were reported to the clinical governance committee. Minutes of the clinical governance committee meeting held in June stated that there had been an increase in complications since the introduction of simultaneous administration of mifepristone and misoprostol for EMA but that these were within what was quoted in the BPAS guide.
- Between September 2015 and December 2015 there were 22 complications of treatments carried out before nine weeks of pregnancy, 13 complications at nine weeks and two complication over nine weeks.
- The treatment unit kept a record of all patients that were referred to NHS hospitals with suspected ectopic pregnancy. Staff actively followed up the outcomes for these patients by direct communication with the early pregnancy assessment unit (EPAU) or with the client.

Audit

- A dashboard was in place to monitor and report on ten standards. These were: medicines management, safe staffing levels, clinical supervision, record keeping audits, safeguarding, treatment audits, complaints, lab sampling/labelling errors and sickness absence. The treatment unit manager reported on these monthly. BPAS Tottenham achieved compliance with all standards between April 2015 and November 2015.
- BPAS had a planned programme of audit that included those recommended by RCOG: consent 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).
- In December 2015 BPAS Tottenham demonstrated compliance rates between 63% and 100% for reception of patients consent for treatment, discussions related to different options of abortion, contraception discussion, confirmation of gestation and medical assessments audits. Reception of patients was 63% compliant because the client's date of birth was not asked for in reception as it was a public area.
- Action plans were developed and implemented to address the areas where improvements were identified, and responsibility was allocated and completion dates set.
- There was 100% compliance with testing for sexually transmitted infections at point of care testing.
- The BPAS infection control essential steps audit tool facilitated audit of hand hygiene, personal protective equipment, aseptic technique and sharps management. BPAS Tottenham was 100% compliant with the monthly audits that were reported in December 2015.

Competent staff

- All staff were supported through an induction process and competence based training relevant to their role. One member of staff told us the 12 week induction programme was 'good and equipped me to do the job'. The induction included safeguarding, STIs, scanning, and patient group directions (PGDs).
- Managers carried out checks to confirm professional registration, qualifications, insurance, disclosure and barring and revalidation.
- Staff had regular annual appraisals. Information provided by BPAS Tottenham showed that 100% of nursing, midwifery and administrative staff had completed an appraisal between January 2015 and December 2015. Staff were further supported through 'job chats' which took place at least once a year.
- Staff undertook training and assessment of competence in ultrasound scanning. For accreditation of first trimester scanning (to 12 weeks of pregnancy), staff were required to undertake a minimum of 50 transabdominal and 50 transvaginal scans, as well as 120 hours of clinical practice of which 50 are mentored. For second trimester scan accreditation (13 to 24 weeks), an additional 50 head circumference scans are required, and 5 should demonstrate placental location. Formal practical assessments and written work were undertaken as part of the competency framework.
- The RSOP 14: Counselling sets out that all the staff involved in pre assessment counselling should be trained to diploma level in counselling. Staff told us that the client care coordinators were trained to a diploma level in pregnancy counselling. Staff referred to as 'client care coordinators', who provided the pre and post-termination of pregnancy counselling service, had completed the 'BPAS Patient Support Skills and Counselling and Self Awareness' course and had

completed the client care coordinator competencies framework. Group supervision for staff providing counselling was also available and was provided three times a year. We saw evidence that staff had attended the groups.
- A module entitled client support skills was available for all unit staff and enabled staff to practise communication and support skills, listening skills and to recognise empathy.
- Initial contact with BPAS services was made through the national contact treatment centre run by BPAS staff that had completed a competency based training specific to the role.

Multidisciplinary working (related to this core service)

- Nursing staff, client care coordinators and other administrative staff worked well together as a team. There were clear lines of accountability set out in job descriptions that contributed to the effective planning and delivery of client care.
- Staff told us the most common reason for seeking clinical support and advice was a client's suitability for treatment. One member of staff told us 'I would go to our suitability policy, if that's not helpful I would go to the electronic client assessment system where you can have a discussion (around EMA). If I need advice about a client's treatment I would call the doctor on call or the clinical lead'.
- The treatment unit had close working relationships with the sexual health service which operated within the same premises.
- There were also close links with other agencies and services such as the local safeguarding team and the EPAU at the local hospital.

Seven-day services

- The RSOP guidance number 3 on 'post procedure' recommends that patients should have access to a 24-hour advice line which specialises in post abortion support and care. BPAS aftercare telephone service was available 24 hours a day and seven days a week.
- Callers to the BPAS aftercare telephone service could speak to a registered nurse or midwife who performed triage and gave advice. The 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 a face to face appointment.

Access to information

- The RSOP guidance number 3 on 'post procedure' recommends that wherever possible the client'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. Patients' decisions were recorded and their wishes were respected.
- Staff ensured that patient care records were transferred in a timely and accessible way and in line with BPAS protocols, if the client was referred to a different BPAS treatment unit or another provider for further treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated clear and concise explanations of the options for terminating pregnancy and for ongoing contraception and how these were discussed when obtaining consent for treatment.
- Records we reviewed contained signed consent forms from patients in all cases. Staff told us that the consent forms and 'my BPAS guide' were produced in different languages, for example Spanish, Arabic, Chinese, Hungarian, and Turkish and were given to patients as needed. It was also available in Braille.
- Staff could not recall a situation at BPAS Tottenham where they had cared for a client who lacked the mental capacity to give consent to treatment, however they demonstrated an understanding of the principles of the mental capacity act as this was an area that had been included in the BPAS mandatory safeguarding training.
- Staff described a situation where they were not sure a young person understood the process because, when asked to do so, she could not repeat what the nurse said. The member of staff explained to her that it was not a test but that she needed to know that the client understood what was said. Following further explanation the nurse was satisfied that the client demonstrated that she understood.
- A trained pregnancy counsellor offered patients the opportunity to discuss their options and choices in line with department of health RSOP 14: 'counselling' as part of the consent process.
- All patients under 18 years discussed their options with a counsellor prior to being asked for their consent.
- Staff assessed patients aged less than 16 years by using Gillick competence and Fraser guidelines. Gillick

competence is used to assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. Fraser guidelines look specifically at whether doctors should be able to give contraceptive advice or treatment to under-16-year olds without parental consent. Where necessary an adult could sign the consent form if present.
- Nurses and midwives completed a checklist to assess whether a child under 16 was competent to give consent.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs). Staff we spoke with discussed the need to ensure that patients had capacity to make an informed decision.

Are termination of pregnancy services caring?

By caring we mean that staff involved and treated people with compassion, kindness, dignity and respect.

Our main findings for caring were:

- Patients felt safe and well cared for and consistently reported about the non-judgmental approach of staff.
- Patients' choices were respected. Their preferences for sharing information with their partner or a supporter were established and reviewed throughout their treatment.
- Patients' emotional and social needs were valued by staff and embedded in their care and treatment.
- Privacy and dignity were upheld throughout the client's contact with the service.

Compassionate care

- Patients commented positively about the non-judgmental approach shown by staff they interacted with.
- Written comments from patients included: 'I was treated with dignity and understanding. Staff were very informative and helpful' and 'all staff I spoke to were extremely kind and warm, yet also professional. Thank you'.
- We observed patients and those close to them being treated with compassion, dignity and respect. All consultations took place in a private room and privacy was respected at all times in all areas at the treatment unit.
- We observed positive interactions between patients and staff. Patients were introduced to all healthcare professionals involved in their care, and were made aware of the roles and responsibilities of the members of the healthcare team.
- Patients' preferences for sharing information with a supporter were established, respected and reviewed throughout their care.

Understanding and involvement of patients and those close to them

- During the initial assessment, staff explained to patients 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.
- Patients were given leaflets and 'my BPAS Guide' which had information regarding different methods and options available for abortion and how pregnancy remains would be disposed of. If patients needed time to make a decision, this was supported by the staff, and patients were offered an alternative date for further consultation.
- All of the records we reviewed showed that post discharge support available for patients at home had been considered and recorded. Patients were given written information about accessing the 24 hour BPAS Aftercare Line: the telephone service for support following abortion procedures.
- Patients were involved in their care, and were given the option to administer their own vaginal tablets and given instructions on how to do this.

Emotional support

- Patients considering termination of pregnancy should have access to pre-termination counselling. All the patients who attended the treatment unit were provided with pre-termination counselling. This was undertaken by experienced client care co-ordinators who had completed the BPAS Patient Support Skills and Counselling and Self-Awareness courses and were required to be fully competent with the client care coordinator competencies framework.

- Patients had 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.
- We observed that patients, and those close to them, who were anxious or unsure about their decision were provided with extra support.

Are termination of pregnancy services responsive?

By responsive, we mean that services are organised so that they meet people's needs.

Our main findings for responsive were:

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- Due to limited opening times, patients may be required to attend other local clinics for treatment for medical abortion.
- The clinic did not offer surgical treatment and patients who chose this option were treated at another London based BPAS clinic that offered surgical termination of pregnancy.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- Patients were provided with information to help them to make decisions.

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.
- Patients could book their appointments through the BPAS telephone booking service, which was available 24 hours a day throughout the year. The electronic triage booking system offered patients 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.
- Treatment was offered at other BPAS treatment units within the region for patients who required surgical treatments, preferred a different location, or where a convenient appointment time was not available at the Tottenham location. If patients chose the treatment option of taking the medicines 24 – 48 hours apart, they were required to attend another local BPAS clinic if Tottenham was closed when the second medicine was due.

Access and flow

- Patients told us it was easy to access the service. One client, who had called into the treatment unit without an appointment, told us 'I didn't have an appointment, they didn't send me away'.
- Patients were referred from a variety of sources such as GPs and health centres, and also through self-referral.
- 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 days. Between July 2015 and September 2015, 69% of patients had their consultation within seven working days of referral.
- BPAS measured the number of patients who waited longer than 10 days from their first appointment to their treatment. 20 patients had waited longer than 10 days from their first appointment to treatment within the reporting period. Sometimes this was due to the patient's preference; however BPAS did not break down the figures for how many women waited by patient preference.

Meeting people's individual needs

- Patients were given leaflets and the 'My BPAS' guide which had information regarding different methods and options available for termination of pregnancy and the associated potential risks. This included the 24 hour telephone number of where patients could seek advice if they were worried. A manager told us this booklet was also available in braille for patients with sight loss.

- The 'my BPAS guide' also provided relevant information about disposal of pregnancy remains. Staff told us that they would discuss patients' expectations and choice about sensitive disposal of pregnancy remains on an individual basis. Leaflets were given to patients to inform them what to expect after treatment.
- If patients needed time to make a decision, this was supported by the staff, and patients were offered an alternative date for further consultation.
- BPAS treated fit and healthy patients without an unstable medical condition. For patients who did not meet these criteria a referral form was completed and managed by a specialist referral placement team. This was a seven day service. Patients were referred to the most appropriate NHS provider to ensure that they received the treatment they required in a timely and safe way.
- The treatment unit was accessible to wheelchair users and accessible toilets were available.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English. We saw where a nurse used the telephone interpreter service to ensure a client, whose first language was not English, had understood and weighed up the decision to continue the treatment.
- Midwives and nurses undertaking assessments had a range of information leaflets that they could give to patients as required. This included advice on contraception, sexually transmitted infections, miscarriage and services to support patients who were victims of domestic abuse and how to access sexual health clinics.
- We saw a folder containing information about local and national support organisations. For example, the contact details for Victim Support, NSPCC, Frank, MIND, Samaritans, Domestic Violence assistance including a local organisation called Hearthstone, Haringey Women's Aid, Respect not Fear (a relationship website for young people), Broken Rainbow (a support service for the lesbian, gay, bi-sexual, transgender community) and The Hideout (domestic abuse support for children and young people). Information was also displayed in treatment rooms, noticeboards and in the client toilet areas.
- 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. Staff we spoke with confirmed they had undertaken such training.

Learning from complaints and concerns

- There was a local complaints register. Staff told us that the registered manager was the first point of call for complaints so that issues could be addressed with the client within the treatment unit. All unresolved complaints would be managed centrally by the BPAS client engagement manager. A full investigation of a complaint would be carried out and feedback given to staff.
- Between January 2015 and December 2015, BPAS Tottenham received no formal written complaints. Two verbal complaints were received in July 2015 and had both been resolved. The first complaint related to a client being unable to have treatment on the same day as her consultation appointment was too close to the treatment unit's closing time. The client was offered an apology and booked for the next day treatment at a different clinic. The second complaint related to waiting times. The staff apologised and explained the process.
- 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 client feedback. The midwife or nurse asked patients to complete this form before leaving the treatment unit. Staff told us that patients usually wanted to leave immediately after the treatment and the majority left without completing the form.
- We were told by staff that BPAS complaints procedures were discussed as part of the corporate induction days and saw the programme which confirmed this.

Are termination of pregnancy services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Termination of pregnancy

Our main findings for well-led were:

- There were effective corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, local risks were not always identified or acted upon by people with the authority to do so.
- The culture within the service was caring, non-judgemental and supportive to patients.
- Staff spoke positively about the need for, and value of the service to patients.
- Staff felt supported by their treatment unit manager and regional operations director

Vision and strategy

- The organisation's aim was: 'to provide high quality, affordable sexual and reproductive health service'. The organisation had clearly defined corporate objectives to support its aim.
- 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 supported to promote the values through training and ongoing support. BPAS policies and procedures reflected the client'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 organisational structure chart supplied by the provider showed clear lines of accountability to the chief executive officer and the board of trustees.
- 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 of the forum reviewed complaints, incidents, serious incidents, audit results, complications, patient satisfaction and quality assurance for point of care testing and declined treatments. We saw forum records that detailed information was shared with a focus on shared learning. This forum reported to the organisation's clinical governance committee.
- Minutes from RQuAIF were also shared at the regional management meetings, which were attended by regional operations director and the treatment unit managers. Managers attending the meetings were expected to hold meetings within their treatment unit to ensure that learning was shared to a wider audience.
- Notes from the most recent London and South East Regional Management meeting held on 2 March 2016 that confirmed learning about complaints and serious incidents requiring investigation (SIRI) had been discussed, and action points agreed. We also saw in the notes that the safety issues we have reported on relating to the need to improve cleaning schedules and checklists had been discussed, however; there was no evidence that any action was agreed or implemented.
- Regional and treatment unit managers disseminated lessons learned to staff at treatment unit meetings, and action plans were developed to reduce the risk of a similar incident reoccurring. This was generally managed regionally and learning was shared across all treatment units in the region.
- Key policies were launched via a conference call which was accessible to all staff. These were also recorded and available for a month to enable staff to access them. A recent example of issues discussed in this was the duty of candour.
- BPAS had a central risk register which listed various areas of generic risks across all treatment units. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. However, we asked to see the local risk register and none was available. Managers confirmed that a local risk register was not in place.
- 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.
- Legislation requires that for an abortion to be legal, two doctors must agree, in good faith, that at least one and the same grounds under the abortion act is met. They must indicate their agreement by signing the HSA1 form. BPAS had remote doctors working on registered premises who reviewed the patient's records and signed the HSA1 forms.
- BPAS treatment units completed monthly audits of completion of HSA1 forms to ensure and evidence

compliance with the BPAS policy. BPAS Tottenham demonstrated 100% compliance with accurate completion of HSA1 forms in accordance with legal requirements.

- The department of health (DH) requires providers undertaking termination of pregnancy to notify them by the completion of HSA4 forms. The HSA4 notifications were completed and uploaded to the DH electronic reporting system. Doctors working under practising privileges at BPAS treatment units across the UK completed HSA4 notifications for those patients for whom they had prescribed medication. A record was made on the client's notes that the HSA4 form was completed and submitted. An automatic reminder was sent out by the DH after two weeks if an HSA4 form had not been received.
- Information from regional managers meetings, including risks and safety incidents was not shared in a timely fashion with staff, as there was no system for actual time reporting, and this sometimes happened up to three months later. Staff told us this was frustrating on occasions and that they would prefer more immediate feedback in order to improve the service.

Leadership of service

- The service was led by the Registered Manager supported by the regional operations director.
- Staff told us the senior management team were visible and had a regular presence at the treatment unit. Managers were supportive and, for clinical staff, the associate director of nursing was accessible and available for advice and support for clinical or professional issues.
- There was a newly appointed regional operation's director, who completed a structured handover and induction programme. This included a BPAS short course on leadership and managing people.
- 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 bi-annual national managers day for all managers. Bi-annual 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; conscious sedation (a combination of medicines to help patients to relax (a sedative) and to block pain (a pain killer) during the procedure, nurses' revalidation and scanning.

Culture within the service

- 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.
- Staff spoke positively about the care and services they provided for patients and were proud to work for BPAS. They described BPAS as a good place to work, and felt they could approach managers if they felt the need to seek advice and support.
- One member of staff told us "I love and enjoy BPAS. The best move for me. We have a good team and everybody is friendly". Another said, "I enjoy this work and the fact that I can be helpful to women, I am happy to be able to help women and as a team we do the max for everyone".
- 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 that details of the service were accessible through the staff intranet.

Public and staff engagement

- Patients using the service were given a survey to complete entitled 'Your opinion counts'. Staff told us that due to the sensitivity of the treatment and the emotional experience for the patients, it was sometimes a challenge to engage with patients and get a response.
- The response rate. The analysis of feedback from the client satisfaction survey for January 2015 to April 2015 showed an overall satisfaction with care of 9.3 out of ten. 100% of patients surveyed would recommend the service.
- Staff surveys were completed to gain staff opinion of working at the treatment unit. The staff survey results for the BPAS organisation 2015 were generally positive: 92% of staff across the organisation stated they were proud to work at BPAS and 86% of staff stated they would recommend BPAS as an organisation to work for.

Innovation, improvement and sustainability

- The use of 24 hour telephone appointment service and web chat service for patients was innovative.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The provider must ensure:

- The supply and administration of medicines under patient group directions (PGDs) is managed in accordance with legislation, provider policy and up to date national guidelines.
- Incidents of all kinds, including those with a potential to cause harm to patients or staff, even when no harm occurred are reported and that local staff receive prompt feedback to reduce the risk of recurrence of incidents.
- Implement processes to ensure greater ownership of assessing, reporting and acting upon local risks.
- National specifications for infection prevention and control are adhered to. In particular, the requirements for cleaning, cleaning schedules, and checklists in 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', and separation of clean and dirty activities and equipment, in the department of health 'Health Building Note 00-09: infection control in the built environment, 2013'.
- All equipment is maintained and serviced to ensure it is reliable and ready for use.