British Pregnancy Advisory Service

BPAS - Stratford upon Avon

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

British Pregnancy Advisory Service (BPAS) Stratford Upon Avon is operated by British Pregnancy Advisory Service and was inspected as part of CQC's comprehensive inspection programme. BPAS Stratford Upon Avon has not been inspected since it was registered in June 2019. BPAS Stratford Upon Avon has two satellite services in Coventry and Nuneaton and is called the 'Stratford Upon Avon hub'. The BPAS Stratford Upon Avon hub provide termination of pregnancy services for women in Stratford Upon Avon, Coventry and Nuneaton and the surrounding areas.

From 1 April 2021 to 31 March 2022, the Stratford Upon Avon hub completed a total of 1896 early medical abortions (less than nine weeks six days pregnant). Of this total 799 were completed at the Stratford Unit Avon, 688 at Coventry and 409 at Nuneaton.

Prior to the inspection, inspectors reviewed monitoring and ongoing information about the service.

We rated this location it as requires improvement because:

- Women did not have timely appointments and had to wait longer than national guidance and there could be a delay in women receiving treatment.
- Requirements of the duty of candour were not fully met.
- Not all medicines were stored appropriately.
- Timely statutory notifications were not always made to The Care Quality Commission

However:

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records.
- Staff provided good care and treatment and there were appropriate arrangements to ensure women had appropriate pain relief. 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. Key services were available seven days a week.
- 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, families and carers.
- The service made it easy for people to give feedback.
- Leaders ran services using 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. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Requires Improvement 	We rated the service as requires improvement For a summary of our findings please see the overall summary at the beginning of this report.

Summary of findings

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Summary of this inspection

Background to BPAS - Stratford upon Avon

The BPAS Stratford Upon Avon hub (Stratford Upon Avon, Coventry and Nuneaton services) offer consultation, medical assessment, early medical abortion up to nine weeks and six days and service specific counselling and treatment. As part of the care pathway, women are offered sexual health screening and contraception.

The service is registered to provide the following regulated activities:

- Termination of Pregnancy.
- Family Planning Service.
- Treatment of Disease, Disorder or Injury.
- Diagnostic Imaging Services.
- Surgical procedures.

Under these activities the service provided:

- Pregnancy Testing.
- Unplanned Pregnancy Counselling.
- Early Medical Abortion.
- Abortion Aftercare.
- Sexually Transmitted Infection (STI) testing and treatment.
- Contraceptive advice and supply.

BPAS Stratford Upon Avon is registered to provide surgical termination of pregnancy but this activity has been suspended by the provider since the beginning of the Covid 19 pandemic. There are no current plans to recommence this registered activity. Women who are over nine weeks and six days or require a surgical termination of pregnancy are offered appointments at another BPAS termination of pregnancy service.

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

Pregnant women (and girls) would be able to take the two medicines used, Mifepristone and Misoprostol for early medical abortion, up to nine week and six days gestation, should they meet the eligibility criteria, in their own homes without the need to first attend a hospital or clinic.

It is possible for a medical practitioner to provide a remote consultation and or prescribe medicines for an early medical abortion from their own home. rather than travelling into a clinic or hospital to work.

This service has had three registered managers since its registration in June 2019. The current registered manager had been registered since October 2021 and is also the registered manager of another BPAS registered location.

Summary of this inspection

How we carried out this inspection

We carried out a scheduled comprehensive inspection at this service on 27 April 2022. The inspection was unannounced which means the service did not know we were coming. The inspection was undertaken by one CQC Inspector and a specialist advisor in termination of pregnancy with support from an Inspection Manager. BPAS Stratford Upon Avon's two satellite locations in Nuneaton, Coventry were not inspected.

During this inspection we checked the environment, observed client consultations, looked at ten sets of client notes, the storage and management of medicines and spoke with six members of staff.

To get to the heart of women's' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Action the service MUST take to improve:

- The service must ensure that all requirements of the duty of candour are met (Regulation 20).
- The service must ensure women are offered an initial consultation within seven calendar days of contacting the service (Reg 17(2)(a).
- The service must ensure the appropriate storage of medicines Reg12(2)(g).
- The service must ensure timely statutory notifications are made to The Care Quality Commission Regulation 18(1)(2)

Action the service SHOULD take to improve:

- The service should ensure clarity around staff understanding of the duty of candour process.

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

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.

All staff received and kept up to date with their mandatory training which was comprehensive and met the needs of women and staff. Staff had access to mandatory training by a mixture of e-learning modules and face-to-face sessions.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew 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.

All staff received level three adult and children's safeguarding training which met national safeguarding training guidance for this service. Staff kept up to date with their safeguarding training and had both training and ongoing discussion about safeguarding scenarios. There was a system to alert managers and staff when they needed to update or refresh their training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. As part of all client's assessment staff asked questions to determine potential safeguarding risks. Staff completed a separate 'young person 'safeguarding risk assessment for girls under 18 years to identify potential safeguarding risks. Staff were trained and supported to recognise cases of domestic violence, child sexual exploitation and female genital mutilation (FGM).

Girls under 16 years had an initial video consultation and then attended a unit for an ultrasound scan. At the scan appointment they were seen on their own to assess any risk of coercion.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding adult at risk policy and a safeguarding children and young people policy. Both of which were in date and reflected national guidance. Staff were supported by the senior management team and safeguarding level 4 leads to raise issues and report safeguarding concerns. BPAS electronic client records included a system which enabled staff to request safeguarding advice and receive a timely response.

Staff made appropriate safeguarding referrals to the local authority and knew which safeguarding concerns to report direct to the regulator.

Staff understood the importance of maintaining the confidentiality of information about women's identity and their care and treatment. Staff ensured women's identity was protected, used their first or their preferred name only. Information was not shared with others including the woman's general practitioner without their consent unless there was an identified risk such as safeguarding concerns and women were made aware of this.

There were appropriate recruitment, selection and employment procedures in place to ensure women receive safe and appropriate care by staff who had appropriate checks undertaken.

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.

The premises were clean and had suitable furnishings which were visibly clean and well-maintained. There was a service level agreement in place for cleaning.

Cleaning records were mostly completed appropriately although there were some gaps for one week in April 2022 with the wrong dates recorded. The service did regular audits on cleanliness which showed satisfactory levels of cleanliness. If cleanliness failed to meet the required standard an action plan would be developed and monthly audits would be undertaken until improvement was demonstrated. Staff cleaned equipment after client contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff received training on infection prevention and control. Staff were seen to wash and sanitise their hands appropriately and wore personal protective equipment. Staff hand hygiene audits and use of personal protective equipment were undertaken monthly as part of the 'essential' steps audits and identified full compliance. Clinical staff had arms bare below the elbows to aid effective handwashing.

The service had commenced a new monthly programme of infection prevention and control audits. The last audit in April 2022 identified 100% compliance. The audit in January 2022 identified improvement was required with identified actions which had subsequently been undertaken.

The service had guidance on infection prevention and control in the context of COVID-19. Staff did twice weekly lateral flow tests. Women were asked if they of someone they had close contact with had symptoms of COVID-19 before they attended their appointment. Women attending the service also had their temperature checked on arrival.

Environment and equipment

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

Call buzzers were available in consultation rooms, the toilets and the waiting areas so either the woman or staff could alert staff if urgent attention was required.

The design of the environment followed national guidance. The service was situated at the back of a large health centre and had a separate entrance with a waiting room and reception area.

There were fire exit signs and fire extinguishers throughout the department. All fire exits, and doors were kept clear and free from obstructions. Fire alarms and emergency lighting were tested on a weekly basis.

Staff carried out daily safety checks of specialist equipment. The resuscitation trolley and was checked daily when the service was open and was not tamper proof at the time of the inspection. Equipment was regularly serviced and maintained. Faulty equipment was reported to facilities and was quickly repaired. Storage rooms were well stocked and kept tidy.

Staff disposed of clinical waste safely in appropriate waste bins. Bins were clearly labelled with what could be put in them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

Staff knew about national gestation guidelines for each type of termination. The service ensured appropriate assessments were conducted to minimise the risk of women receiving treatment that did not meet the eligibility for termination of pregnancy. Depending on answers to the risk assessment, for example the woman experiencing bleeding or pain, women may require a scan to accurately determine gestation. When gestation was assured staff were able to ensure women were on the right treatment pathway or when required referred to NHS care.

Staff completed risk assessments for each woman for example checks to ensure women were not alone overnight after they had received their treatment.

Staff were all trained in life support to enable them to respond to emergency situations.

Staff were aware of sepsis and clinical staff received training in sepsis identification and management.

Staff made women aware of they would need to contact their doctor should they not attend an appointment or confirm a negative pregnancy. If staff were unable to contact the women on several occasions a letter would be sent to their doctor to identify a potential ongoing pregnancy.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Counselling was arranged for women presenting with mental health difficulties. Support was arranged for women who decided to continue with their pregnancy.

Staff shared key information to keep women safe when handing over their care to others. The service had guidelines and policies in place for staff to follow in the event a woman needed to be transferred to an NHS Hospital.

Requires Improvement

Termination of pregnancy

Staffing

The service had 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 regularly reviewed and adjusted staffing levels and skill mix.

The service had enough clinical and support staff to provide the right care and treatment for women within current appointments. All staff received training specific to termination of pregnancy. Staff worked between services within the BPAS Stratford Upon Avon hub.

The service had enough medical staff with the right qualifications, skills, training and experience to provide the women with the right care and treatment. Medical staff were employed centrally by BPAS or worked under practising privileges. Agreement to medical staff employment and ongoing employment which included competence, experience, training and appraisals was part of the role of the BPAS medical director. Doctors worked virtually to support clinical staff and ensure women received timely safe care and treatment

Managers accurately calculated and reviewed the number and grade clinical and non-clinical staff. Managers could adjust staffing levels daily according to the needs of women who were booked for consultation or treatment. Discussions were in place to consider increasing the times services were open which would require additional staff.

The service had no staff vacancies. The manager and lead midwife were both fully trained clinicians and could step in to cover staff sickness when required. Continuity midwives also provided additional clinical support when required for example to support staff who had not completed all required training. Other local BPAS locations also worked together to cover staff absence. The service did not use bank or agency staff.

Records

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.

Women's care records were electronic, and staff could access them easily. Women's care and treatment records included a health assessment, risk assessments, prescription and the HSA1 forms (legal forms which must be signed by two doctors who agreed a woman was suitable to undergo a termination of pregnancy as per The Abortion Act, 1967). The HSA1 forms were appropriately completed by two doctors. Staff confirmed only when the HSA1 had been signed by two doctors could a prescription be generated.

Records were stored securely. Only authorised staff had access to records which were password protected. Display screens were locked when staff were not present. As part of their mandatory training, staff completed information governance sessions. The service carried out an information governance audits to ensure staff followed BPAS policies and were kept women's records securely.

When women transferred to a different BPAS service, there were no delays in staff accessing their records. The use of electronic care records meant if women required treatment or review at another BPAS treatment centre, staff were able to access their records. If staff needed to refer a woman to NHS care a summary of their care and treatment was printed off and for them to take with them.

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Requires Improvement

Termination of pregnancy

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Not all medicines were safety and appropriately stored.

Staff managed and stored most medicines safely. The temperature of rooms and fridges where medicines were stored was recorded and met manufacturers guidance. The medicines fridge temperature whilst within national guidance was seen to fluctuate and was very noisy. Misoprostol stored in this fridge had expired at the end of March 2022. There was no date of opening for syntometrine to provide assurance of the medicine's safety and efficacy. We were informed informed after our inspection this drug had not been used for some time since the service no longer provided surgical treatment and had been removed from the unit. Influenza vaccines were being stored unboxed and without information leaflets which identify side effects or contraindications. Following the inspection the provider informed us these medications were old stock from previous vaccinations and have been removed. The provider also confirmed all medicines in this fridge had been disposed of.

Emergency medicines on the medicine trolley were not secured or tamper proof. Staff did daily checks on medicines on the trolley but there remained a risk medicines including intravenous fluids could be tampered with. Managers told us a new tamper proof trolley had been ordered. Since our inspection managers have confirmed tags to secure the trolley were available.

Medicines management was audited and monitored. When action was required a record of actions undertaken was recorded. However, we found omissions found in relation to medicines stored in the medicine's fridge had not been identified as part of the most recent medication audit.

Staff followed systems and processes to prescribe and administer medicines safely. The service used abortifacient medicines to induce medical abortion. These were prescribed by one of the doctors who had completed the HSA1 form (a legal form which must be signed by two doctors for an abortion to take place). Nurses and midwives administered these medicines as directed. Nurses and midwives were trained in a range of specific patient group directions (PGDs) which enabled them to give very specific medicines to women without needing an individual prescription. For example, antibiotics, anti-sickness medicines and contraception.

The service had no controlled drugs (CDs) since surgery had stopped. CDs are medicines usually strong pain relief which require additional security.

Medicine allergies were clearly identified on women's records. The service had an in-date antibiotic policy which provided advice and effective use of antibiotics.

Staff reviewed women's medicines regularly and provided information about their medicines. Staff ensured women's medicines were identified and was recorded on their electronic patient record. There were weekly checks in place to ensure they had enough abortifacient medicines available for women who were booked for the following week. Women received specific instructions as to how and when to take the medicines they had been prescribed. This was both verbal and in written format.

Staff completed medicines records accurately and kept them up to date, recording the time and date medicines were administered.

Staff learned from safety alerts and incidents to improve practice. The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. The service had an electronic system in place to record what actions were taken and when they were completed.

Incidents

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 but all requirements of the duty of candour were not met. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were able to report incidents using the online system.

Staff raised concerns and reported incidents and near misses in line with the BPAS policy. Staff had reported a total of 271 incidents across the BPAS Stratford Upon Avon Hub of which one was identified as major (long term harm) and 10 were moderate (short term harm, other incidents were no harm or low harm).

The service reported no never events. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. They have the potential to cause serious patient harm or death.

Managers shared learning with their staff about serious incidents that happened elsewhere. Staff received feedback from investigation of incidents, both internal and external to the service.

Managers investigated incidents. Staff followed a clear process for reporting and investigating incidents. Managers attended monthly meetings, during which they discussed recent incidents both within their service and other clinics and then shared this information with their staff. Managers also cascaded information to their team about patient safety alerts.

The duty of candour is a requirement that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service must notify the relevant person an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Information about duty of candour was included within the Incidents, near misses and serious incidents policy. The policy identified a requirement to commence the duty of candour pathway when a notifiable incident occurred. Notifiable incidents identified were:

- Major complications
- Extreme and high risk rated clinical incidents
- Any other exceptional incident or complication that the head of client safety and risk or

1. medical director determines should fall within the BPAS definition of a notifiable incident.

Staff understood the basic principle of duty of candour as a need to be open and transparent and provide women a full explanation and an apology when things went wrong. There was a lack of clarity for staff when an incident was notifiable but may not require duty of candour.

The policy identified the duty of candour process would be commenced by either the registered manager or the quality and risk team when an incident was identified. The service reported eleven incidents which met the legal threshold for the duty of candour to be followed. We requested the report of one incident which we had been informed of prior to the

inspection which was identified as major harm and confirmation of duty of candour. An investigation report was available which identified errors. The duty of candour letter provided did not fully satisfy the requirements of the duty of candour. The letter identified a wish for the registered manager to discuss the incident with the women as they had been unable to contact them by phone. Whilst the letter did identify an error in treatment had occurred it did not fully include all the failures identified. The letter did however refer to a need to fulfil the duty of candour and be open and honest about what happened and how they had learnt from the woman's experience. Following our inspection BPAS have acknowledged the letter did not provide adequate information and there has been organisational learning as a result of this incident.

Following our inspection, we requested additional information about the 11 incidents of moderate or major harm and confirmation of the duty of candour process related to these incidents. The service provided information about the review of 10 of these incidents. The information identified six incidents were downgraded and did not require duty of candour. One incident identified partial completion of duty of candour, one incident identified incomplete information provided and no requirement for duty and there was no information about duty of candour recorded for two incidents. Information provided identified as some incidents occurred 12 months ago it would not be of benefit to the woman to engage them within the duty of candour process. However, the duty of candour was a legal requirement at that time. Information provided did not provide assurance of a robust duty of candour system in place. We had not previously been notified of nine of the incidents. Since our inspection BPAS have confirmed improvement which they have made to the duty of candour process.

An audit of duty of candour identified across BPAS Stratford Upon Avon hub between April 2021 to date identified there was no evidence of duty of candour for seven of the eleven incidents of the incidents reviewed,

Are Termination of pregnancy effective?

Good

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 followed policies to plan and deliver care according to best practice and national guidance. There were some challenges around sufficiency of appointments which meant national guidance for timely consultation was not always met, for more information please see within responsive access and flow section of this report.

All policies except for one policy were up to date. The operational policy / procedure guidance for resuscitation and anaphylaxis management was identified for review January 2022 but there was no updated policy. A manager told us this policy was currently with the medical director for final sign off.

Policies were developed and reviewed centrally facilitated by BPAS's senior leadership team and head office. Policies were in line with Department of Health Required Standard Operating Procedures (RSOP) guidelines and professional guidance from the Royal College of Obstetricians and Gynaecology (RCOG), Royal College of Anaesthetists for the treatment of women for termination of pregnancy. Staff had access to electronic versions of policies and were able to navigate the electronic system without difficulty.

Requires Improvement

Termination of pregnancy

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Staff had received training in the Mental Health Act and described the process to follow if they had concerns which we observed during the inspection.

Nutrition and hydration

The service provided fluids for women but food was not available as women's stay within the service was usually short.

Pain relief

Staff provided women with information about pain relief and ensured pain relief was provided for them to take at home.

Staff prescribed and recorded pain relief accurately. Staff discussed pain levels and pain relief in clinic consultations. Pain relief was also included as part of the early medical abortion packs. Staff gave women advice and information on how to manage their pain at home. Staff also made women aware if they were concerned about the degree of pain, they were experiencing they could contact the 24-hour care line for advice and support.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements for women.

The service completed and returned patient analysis data for each termination of pregnancy to the Department of Health (HSA4 report).

Managers and staff monitored the effectiveness of treatment and used the results to improve women's outcomes. Outcomes included both national, regional and location complication and failure rates. Complications varied and included continuing pregnancy, bleeding, excessive pain and ectopic pregnancy. An electronic incident record was completed, and the woman's records updated to reflect information and actions taken. The data was measured against the provider national average to provide evidence of any trends, themes or increases in complications in specific areas. Information provided showed complication rates were low.

Managers and staff carried out a programme of repeated audits to check to improve care and treatment. The audits for the service were compared against all the services in the BPAS area and learning taken to make improvements across the organisation These benchmark reviews prompted managers to look at issues and address any shortfalls when required. Managers shared and made sure staff understood information from the audits. When required improvement was checked and monitored. The manager confirmed audits identified satisfactory patient outcomes (such as complication and failure rates) against other services.

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 identified staff training needs and gave them the time and opportunity to develop their skills and knowledge. Staff undertook a training programme in which they developed skills in all areas of pregnancy termination such as consultation around treatment options, ultrasound, surgery and contraception. Managers told us this allowed staff to work in all areas of the service when required.

Requires Improvement

Termination of pregnancy

Managers gave all new staff a full induction tailored to their role before they started work. New clinical staff worked on a supernumerary basis alongside an experienced member of staff for a minimum of 12 weeks. The induction included a corporate induction, mandatory training and completion of a competency pack tailored to their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had had a recent appraisal.

The clinical leads supported the learning and development needs of staff. Competency was signed off by an experienced member of staff. Additional skills were available as extended training, for example sonography. Sonography is an externally accredited course for both first and second trimester. Sonography trainees are supervised by accredited staff until they successfully passed their theory and practical assessments.

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

Managers identified poor staff performance promptly and supported staff to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for women. Staff worked well as a team within the clinic and with outside agencies for example early pregnancy units, accident and emergency, mental health services and the local authority safeguarding. There were clear lines of accountability and staff we spoke with knew what and who they were responsible for.

Seven-day services

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

The clinic was open Mondays, Wednesdays and Thursdays. When the clinic was closed women could contact BPAS post treatment via the aftercare 24 hours a day telephone line which specialised in post abortion advice. The telephone line provided triage and arrangements could be made for women to be seen for a post treatment check at a BPAS unit, or if necessary, they were told to attend accident and emergency at their local NHS Hospital.

Health Promotion

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

The service displayed information promoting healthy lifestyles. Information available included contraception, sexually transmitted diseases and awareness of domestic violence and help available. Women received contraception advice. Early medical abortion packs had contraception advice booklets and contraception in each pack.

Women were offered testing for chlamydia and were signposted for sexually transmitted diseases screening.

Requires Improvement

Termination of pregnancy

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.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Staff discussed treatment options available with women to ensure they consented to treatment based on the information available. Staff recorded consent in women's' records. Care records contained signed consent from women. Possible side effects and complications were recorded, and records showed that these had been discussed with women to demonstrate informed consent. Staff ensured women and girls were seen alone to minimise the risk of coercion by a third party.

The service had a policy outlining the principles of consenting women and of capacity to consent. The service audited their consent forms and found consent was gained in line with required BPAS policies and procedures.

Staff understood Gillick Competence and Fraser Guidelines and supported girls under 16 years who wished to make treatment decisions and ensured they understood the decision. Staff had access to advice and support if they had any concerns regarding consent.

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 caring and took time to interact with women and were compassionate and respectful.

Staff understood and respected women's individual needs and showed understanding and a non-judgmental attitude when caring for them. Staff throughout the women journey within the clinic from the receptionist to clinicians were approachable and kind. Staff explained clearly and carefully the procedures and the options available to the woman.

Staff followed policy to keep women's care and treatment confidential. Women confirmed their attendance and then were booked in a separate room. Consultations were held in private rooms and women were assured of confidentiality of the service. At Stratford Upon Avon the reception area was part of waiting room, staff were aware to ensure no personal information was discussed in this area. Patient survey information identified the percentage of women who felt their personal information was treated confidentially was:

Stratford Upon Avon 80% (2.8% disagreed and 17 % did not record a response)

Coventry 92%

Nuneaton 93%.

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

Requires Improvement

Termination of pregnancy

Emotional support

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

Staff supported women who were anxious or became distressed. Staff understood the emotional impact having a termination of pregnancy could potentially have on a woman and tried to minimise any distress. Staff were empathic, non-judgemental, kind and compassionate.

Staff understood the emotional and social impact that a women's care, treatment or condition had on their wellbeing and on those close to them. Staff gave emotional support to women at various points in their termination pathway. Women could contact BPAS via a dedicated telephone number, detailed in the 'My BPAS Guide' booklet, to make an appointment for post-abortion counselling. Staff had placed a radio in the waiting room as a distraction for women who may be anxious. Patient survey information for all services within the BPS Stratford Upon Avon hub for the last 12 months, identified 100% of women felt staff were supportive and understanding.

Understanding and involvement of women and those close to them

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

Staff made sure women and those close to them understood their care and treatment and made them aware about information provided on the main BPAS website around help and support.

Staff talked with women in a way they could understand. Staff explained treatment and ongoing care to women clearly and always asked whether they understood or had any questions. Family and friends were not used as translators to ensure women's decisions were their own. Patient survey information for all services within the BPS Stratford Upon Avon hub for the last 12 months, identified 100% of women felt staff involved them in their treatment decisions.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women were able to give feedback on the service in person and electronically. Online surveys from 1 April 2021 and 31 March 2022 showed women gave positive feedback about the service. More than 96% of women said they would recommend the BPAS Stratford Upon Avon hub to friends and family: Coventry 94%, Nuneaton 95.8% and Stratford Upon Avon 98.1%.

Are Termination of pregnancy responsive?

Requires Improvement

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people in a timely way.

Women booked their appointments either by telephoning the BPAS Booking and Information Centre (BIC) which is open seven days a week, or by booking on-line which is accessible 24 hours a day. Women could refer themselves or be referred by a GP or other healthcare professional. Women were asked about their health, current and previous pregnancies, and risk assessments then completed to determine the best route for an appointment. An appointment was then made for the woman to have either a telephone/video call or an appointment at the clinic. Information detailed with the Access and Flow section shows women did not all have timely consultation.

The service provided both face to face and telephone consultations. Following consultation, medical assessment and agreement by two doctors (who would complete the form HSA1), early medical abortion was the default method of abortion up to and including 10 weeks. Early medical abortion medications could either be sent by post or women may attend the clinic to collect the medication to take home. The clinic would then make a follow up call after their early medical abortion to ensure the wellbeing of the woman and ensure the treatment had been effective.

Women who were 10 weeks or more pregnant were referred for treatment (either medical abortion or surgical abortion) to another BPAS service.

Facilities and premises were appropriate for the services being delivered. BPAS Stratford Upon Avon was situated within the grounds of a health centre which provided a range of primary care services. The service had a separate discreet entrance towards the back of the building. BPAS Stratford Upon Avon was based in a suite of rooms on the ground floor and could be easily accessed for people with mobility difficulties. Consultation rooms were private. Surgical facilities were available within a dedicated treatment room, recovery/ ward area and waiting room with changing facilities. Please note they had not been used for two years and there were no plans to use this facility at the time of the inspection. There were accessible toilets for those with limited mobility. Car parking spaces including blue badge accessible spaces was available.

The service had systems to help care for women in need of additional support or specialist intervention. BPAS provided a client guidance booklet called 'My BPAS Guide' which outlined the expected recovery for women. Abnormal symptoms were listed within the book, and it contained advice for women.

Managers monitored missed appointments. Information showed 646 women had not attended their planned consultations which included 210 women who did not attend their planned treatment and 164 who did not attend a post treatment checks appointment. Staff confirmed there were robust arrangements in place to follow up women who did not attend their appointment. The women were contacted and the reason for non-attendance was recorded on their electronic record along with assurance of their wellbeing. The manager said rate of nonattendance was high following contact with the aftercare service but they information provided gave assurance and their concern had been resolved. The manager said when possible they contacted women before their post treatment appointment and frequently this meant they no longer required the appointment and the appointment was then available for another woman.

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.

The service could support women with additional needs. Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Staff were able to identify where they could seek assistance for women with additional communication needs.

The premises enabled wheelchair access.

Staff were able to access interpreters or signers when needed and were able to use a translation service for women for whom, English was not their first language. As part of the initial website contact, women could 'select language' at the top of the BPAS website which then provided treatment information in their selected language.

Requires Improvement

Termination of pregnancy

BPAS had a central team which ensured when needed, women who were unsuitable for BPAS treatment were referred to a specialist centre within the NHS as soon as possible. This included women with a later gestation who could not be treated by BPAS.

Access and flow

Access to the service was not timely and women did not always receive appointments within agreed timeframes and national targets.

Women telephoned the BPAS Booking and Information Centre (BIC) to book telephone or face to face appointments. On average women waited longer than the national guidelines for both their initial consultation and their treatment.

National guidelines say women should wait no longer than seven calendar days from contacting the service to first consultation, but between 1 April 2021 and 31 March 2022 women waited more than 7.5 days across the Stratford Upon Avon hub (women attending Stratford Upon Avon and Coventry waited 7.5 days and women attending Nuneaton waited 8.3 days).

Following first consultation, women receive treatment within seven calendar days. Between 1 April 2021 and 31 March 2022, the Stratford Upon Avon hub met this. Staff training was ongoing to ensure staff had required competencies which would ensure additional appointments were available to reduce waiting times.

The registered manager and senior managers monitored waiting times and whenever possible maximised the availability of appointments within the services opening hours. The manager acknowledged there had been changes to the clinic appointments following the organisation restructure towards regional telephone hub services. However, the need for clinic appointments for women requiring either a scan or who had other complex problems meant less appointments were available and had delayed women accessing services and receiving treatment within agreed timeframes and national targets. Following our inspection BPAS informed us service provision was being consistently monitored and a permanent increase in appointments was being considered.

Managers and staff worked to make sure women did not stay longer than they needed to. Staff told women their clinic appointment would last between two and three hours. Staff explained to women their appointment included a consultation about treatment options and explanation of care needs and actions if they had any concerns, various tests including a scan and then a short wait for a doctor to confirm treatment and issue a prescription, Staff said they usually received confirmation from the doctor (HSA1) and prescription within 15 minutes. Managers monitored the flow of women through the clinic and would step in and support staff if women were waiting for prolonged periods of time for their treatment or discharge.

Staff made sure women could access emergency services when needed. Staff supported women when they were referred or transferred between services. Staff contacted services on behalf of the women, such as an early pregnancy unit and would ensure they were aware they would be attending and the reason for attendance.

The service had not cancelled any clinics or appointments. The registered manage and lead midwife both had clinical backgrounds and were additional to clinical staff and were able to step in to cover clinics for staff sickness which meant appointments were not cancelled.

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.

Requires Improvement

Termination of pregnancy

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

Staff understood the policy on complaints and knew how to handle them. If concerns were raised, staff would try to address them in the first instance and would then report the complaint and outcome on the electronic recording system. The manager would be informed, and a further investigation would be implemented at local level if required.

Managers investigated complaints and identified themes. There was a process to investigate complaints regardless of whether they were raised locally or centrally. If a complaint was made locally, it was investigated by the manager and overseen by the quality matron. BPAS Stratford Upon Avon had three complaints in the last 12 months. Complaints received included concerns about treatment and staff attitude. The service also collected information about possible improvements to the service and actions taken. Patient survey feedback identified waiting times for appointment and treatment was a concern. Complaints were shared at the monthly treatment unit manager meetings and themes discussed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Women received feedback from managers after the investigation into their complaint.

Are Termination of pregnancy well-led?

Requires Improvement

Leadership

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

There was a clear management structure for the provider both locally and nationally with lines of responsibility and accountability. Regional management teams had recently been strengthened to support clinics with additional clinical oversight.

The registered manager at the time of the inspection was also the registered manager for another BPAS service. The registered manager had been covering the service whilst the substantive manager had another interim role for 12 months. Staff said the registered manager would normally spend at least one day a week at BPAS Stratford Upon Avon and was accessible at other times by phone or email. The registered manager was supported by the lead midwife who had a supernumerary role supporting clinics with the Stratford Upon Avon hub.

Staff mainly worked in clinics with managers working remotely. Staff said they were supported and were able to raise any concerns they had with the management team. The registered manager and the matron were both away from work at the time of the inspection. Staff were clear which managers were covering the service in their absence.

Managers were aware of the issues facing the service such as ensuring staff who were trained in all key skills, continuity of the service and actions to reduce waiting lists when possible which was dependent on staff availability.

Managers completed BPAS manager training which was devised to ensure they had all required information and clinics were run to the same standard.

Requires Improvement

Termination of pregnancy

The clinic's certificate of approval to carry out termination of pregnancy was prominently displayed in accordance with Department of Health requirements.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services within the wider health economy.

The vision and strategy for BPAS was a future where every woman can exercise reproductive autonomy and is empowered to make her own decisions about pregnancy. Their purpose was to remove barriers to reproductive choice and to advocate for and deliver high quality, woman-centred reproductive health care. Staff spoke clearly about enabling women to access services and treat women with compassion and respect.

BPAS is a charity which provides evidence based and not for profit care. The BPAS strategy included providing effective services, meeting contract requirements and financial stability. Managers monitored the service provided to ensure stakeholder contracts and financial viability were met. The local strategy based around the provider strategy for the BPAS Stratford Upon Avon hub was the increased availability of appointments whilst ensuring financial viability. At the time of the inspection there was a pilot in place (for four weeks) to open BPAS Nuneaton for an additional day a week and to include assessment whether appointments were filled. The registered manager said they hoped there would be an opportunity to increase current opening times for BPAS Stratford Upon Avon on a phased approach initially increasing opening one of the clinic days until 5pm (current opening times are 2.30 and 3pm).

Culture

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

Staff were proud of the organisation as a place to work and said they were treated with respect. Staff spoke positively about working for BPAS at BPAS Stratford Upon Avon. Staff felt supported to raise concerns and said they felt listened to. The manager spoke positively about their team and their commitment to the service.

Many training opportunities were available to support staff develop their careers.

There was a positive approach to complaints about the service and looked at how women's experience could be improved. The service had a whistle blowing policy and staff knew how to raise concerns with managers.

Governance

Governance systems were not always effective. Staff at all levels were had regular opportunities to meet, discuss and learn from the performance of the service.

BPAS had processes and systems of accountability to support the delivery of the service. BPAS had a structure with several committees, each with a defined responsibility to ensure information was discussed regularly at the relevant group by relevant staff. Committees fed information into a board of trustees. There was a clinical governance committee; finance, audit & risk committee; and a strategic leadership team. These met four times a year, except for the leadership team which met every two weeks. The clinical governance committee comprised of a clinical advisory group, drugs & therapeutics committee, infection control committee, quality & risk committee, and a research and ethics committee. The operational quality manager/treatment unit manager met between eight and 12 weeks to review the quality of the service. BPAS medical director ensured the organisation met current national guidance.

The registered manager cascaded information to their teams both within team meetings and face to face and updated them with latest issues, developments. Learning from incidents, complaints and changes in policies and procedures were also shared.

Audits and dashboards were used to monitor the quality of the service provided and these were reviewed as part of the governance process. Information gathered was used to identify areas for change and learning. There were shortfalls in the governance arrangements for medicines audits. Governance systems did not robustly identify or ensure timely follow up of duty of candour. However, as identified elsewhere in this report, following our inspection BPAS has made improvements to their duty of candour process and procedures. Changes were needed to ensure women received timely access to appointments. It was positive the manager was considering strategies to achieve this to increase the availability of appointments

Learning from incidents and complaints were used to identify areas for improvement. All incidents had a dedicated person responsible for investigation and completion of an action plan. Senior managers had oversight of actions which were reviewed monthly. A report was completed which identified the timeframe actions were still outstanding. Complaints, incidents and any lessons learned were regularly reviewed during staff monthly meetings.

The service delivered care and treatment in accordance with the Abortion Act 1967. The certificate of approval was displayed and processes to ensure that the certificate of opinion (HSA1) and abortion notification (HSA4) were completed in line with legislation. The 10 sets of notes reviewed confirmed this had been completed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

BPAS managers monitored the delivery of clinical treatment and care and identified risks and improvements to safety and quality across the business. The service worked with the local commissioning group to monitor the service.

Performance dashboards were used to discuss, benchmark and monitor performance at monthly senior management team meetings and were accessible to treatment unit managers to review and compare their performance against other treatment centres.

BPAS Stratford Upon Avon had access to a corporate and a local risk register. Risks were rated red, amber and green depending on the level of risk, to identify the highest risks. Measure and controls to manage the risks were recorded and review dates were noted to ensure risks were monitored. Each risk was identified as being reviewed or approved and was rated as green or amber. Highest risks included staffing and the competency of staff particularly sonography to provide timely access to the service. The registered manager discussed staffing and how they had mitigated against staff sickness particularly during the second and third stages of the pandemic.

Information Management

The service collected 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 not consistently submitted to external organisations as required.

Most of the information required by staff was available electronically this included policies and procedures.

Clinical records were recorded and stored electronically and stored securely. The provider group worked from an integrated electronic record system which enabled details of care requirements to be shared with other clinics in the wider corporate group, the notes were immediately available.

BPAS collected data on the quality of the service from a variety of sources and used this to improve performance and identify and escalate risks. Regular audit processes checked to ensure performance met the required standards. The service made improvements and shared learning when the results of audits showed findings not up to the expected standards. Information was shared with staff to enable them to be part of any problem solving to improve performance when required.

Data or notifications were submitted to external organisations as required. It was the responsibility of the treatment unit manager to submit data or notifications to external organisations. We found statutory notifications had always been undertaken (seven of ten clinical incidents shared). We did not receive timely notification of the absence of the registered manager.

In order to meet the requirements of the Abortion Act 1967, following a termination, the registered medical practitioner must complete a HSA4 form and send this to the Department of Health within 14 days and include patient demographic data. BPAS had an on-line submission process for HSA4 forms, where the BPAS 'Booking Information System' had direct access to the Department of Health database. There was an effective system to ensure there were no delays in submission.

Engagement

Leaders and staff actively engaged with women and staff to plan and manage services.

Paper patient feedback surveys were removed in 2020 due to COVID-19 infection control limitations and were switched to an online feedback form. Reports summarising women's comments was available. National themes were reviewed and monitored by the client engagement manager and the quality and risk committee. Managers reviewed women's feedback and looked for any trends to improve service delivery.

Staff told us they had regular team meetings. Information was shared with staff in a variety of ways, such as face-to-face, email, and noticeboards.

Learning, continuous improvement and innovation

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

The COVID-19 pandemic had required considerable change which included staff providing less face to face treatment to working virtually to support women and provide advice about safe home use of abortion medicines.

Staffing arrangements had changed to meet new ways of working. Staff had an enhanced role and more staff received sonography training to enable them to provide more of the care women required.

BPAS senior leadership had supported research developments to enable initiatives such home use of abortion medicines and 'pills by post' to provide improved access for women to abortion services.