

BPAS - Nottingham West

Quality Report

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Date of inspection visit: 06 August 2019

Date of publication: 06/11/2019

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



Overall summary

British Pregnancy Advisory Service (BPAS) Nottingham West is operated by the British Pregnancy Advisory Service. BPAS is a not for profit, charitable organisation with 70 locations in England. BPAS Nottingham West main clinic is in Stapleford a town on the outskirts of Nottingham City. BPAS Nottingham West also has three satellite clinics; BPAS Newark, BPAS Mansfield and BPAS Nottingham City. The service provides the following:

pregnancy testing, unplanned pregnancy counselling/consultation, medical and surgical abortion, abortion aftercare, miscarriage management, sexually transmitted infection testing and treatment, contraceptive advice and contraception supply. Surgical abortion is performed under local anaesthetic. The service sees women and children from the age of 12 years. The satellite clinics only provide early medical abortion.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 06 August 2019, along with a visit to the BPAS Newark satellite clinic on 09 August 2019.

To get to the heart of patients' 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.

The main service provided by this BPAS Nottingham West was termination of pregnancy.

Services we rate

We rated this service as **Good**.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and access to light refreshments and gave patients pain relief when they needed it. Managers monitored the

effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, 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 patients 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 patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service easily however, the service was not meeting the Department of Health's standards for access to timely abortion services.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and staff were committed to improving services continually.

Name of signatory

Heidi Smoult Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service

**Termination
of pregnancy**

Rating

Good



Summary of each main service

The service was safe, effective, caring, responsive and well led.

Summary of findings

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Good



BPAS Nottingham West

Services we looked at

Termination of pregnancy;

Summary of this inspection

Background to BPAS - Nottingham West

British Pregnancy Advisory Service (BPAS) Nottingham West is operated by British Pregnancy Advisory Service. The service opened in 2015. The British Pregnancy Advisory Service is a British charity whose stated purpose is to support reproductive choice by advocating and providing high quality, affordable services to prevent or end unwanted pregnancies with contraception or by termination of pregnancy. BPAS Nottingham West main clinic is in Stapleford, a town on the outskirts of Nottingham City, and has three satellite clinics in Newark, Mansfield and Nottingham City. The service primarily serves the community of Nottinghamshire. It also accepts patient referrals from outside this area.

The service provides consultation and early medical abortion treatment up to 63 days gestation and surgical vacuum abortion up to 13 weeks' and six days gestation under local anaesthetic. The service did not treat patients longer than 14 weeks and six days gestation. All patients had an ultrasound scan to confirm the gestation period. The service did not carry out emergency termination of pregnancy, termination of pregnancy because of a foetal abnormality or feticide (causing the death of a foetus prior to termination of pregnancy).

The service has had a registered manager in post since April 2015.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in community sexual and reproductive health. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about BPAS - Nottingham West

The main clinic is in Stapleford on the outskirts of Nottingham with three satellite clinics in Mansfield, Newark and Nottingham City and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family Planning
- Surgical Procedures
- Termination of Pregnancy
- Treatment of disease, disorder or injury.

During the inspection, we visited BPAS Nottingham West, Stapleford and BPAS Newark. We spoke with seven staff including registered nurses and midwives, client care co coordinators, and senior managers. During our inspection, we reviewed five sets of patient records and five staff files.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in April 2016 but was not rated.

Activity (April 2018 to March 2019)

In the reporting period April 2018 to March 2019, 1953 medical abortions and 40 surgical abortions were carried out, all of these were NHS-funded.

- There were no children under the age of 13 years treated in the reporting period.
- 17 children aged between 13 and 15 years of age were treated in the reporting period.
- The service employed six registered nurses and five administrative staff.
- The service did not use agency or bank staff

Summary of this inspection

Track record on safety

- No never events
- No serious incidents
- No incidents of hospital acquired
- Five complaints

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **Good** because:

Good



- The service provided mandatory training in key skills to staff and made sure everyone completed it.
- Staff understood how to protect patients 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and staffing levels and skill mix.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However, we also found the following issues that the service provider needs to improve:

Summary of this inspection

- We found two items of cleaning products not stored in line with the Control of Substances Hazardous to Health regulations.

Are services effective?

We rated effective as **good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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 worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Some services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Good



Are services caring?

We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However, we also found the following issue that the service provider needs to improve:

- Staff did not always inform patients about how the service used their personal information.

Good



Summary of this inspection

Are services responsive?

We rated responsive as **Requires improvement** because:

- The service was not meeting the Department of Health's standards for access to timely abortion services.

However, we also found the following areas of good practice:

- The service planned and provided care in a way that met the needs of local people and the community served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- 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. The service included patients in the investigation of their complaint.

Requires improvement



Are services well-led?

We rated well-led as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

Good



Summary of this inspection

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Termination of pregnancy

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

Are termination of pregnancy services safe?

Good 

We rated safe as **good**.

Mandatory training

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

Staff received and kept up to date with their mandatory training. We saw the mandatory training records for all staff which showed 100% compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training topics included, life support, first aid, infection control, information governance, fire safety, manual handling, health and safety and safeguarding.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This training was included in the mandatory safeguarding training.

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

Staff were trained to an appropriate level in safeguarding in line with the intercollegiate document, Safeguarding Children and Young People: Roles and competencies for Health Care Staff March 2014.

There was a policy in place that described the management of the deteriorating or septic patient. Staff we spoke with understood the policy and had received training in sepsis management.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. 100% of staff had attended level three safeguarding children and adults training which was refreshed every two years.

Staff had up to date Disclosure and Barring Service (DBS) checks. The DBS enables organisations in the public, private and voluntary sectors to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involving children or vulnerable adults.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had attended equality and diversity training during their induction period.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described to us behaviours and situations that may cause concern. For example, the repeated attendance of a person escorting other individuals whose first language was not English and adults who were reluctant to leave a child alone with a member of staff.

Termination of pregnancy

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A designated member of staff was responsible for managing safeguarding concerns. Safeguarding concerns and issues could be escalated to the organisations lead nurse for safeguarding, the safeguarding lead group or the relevant local safeguarding team depending on the nature and urgency of the concern. Collaborative work took place between local safeguarding services and the registered manager.

A range of policies were in place to support staff in managing safeguarding issues including local child protection procedures, domestic abuse and protection of vulnerable adults. Policies include the action staff should take for female genital mutilation and awareness of child sexual exploitation. The safeguarding lead was responsible for the review of local safeguarding procedures, ensuring they were in line with corporate British Pregnancy Advisory Service (BPAS) policies and procedures.

A specific safeguarding policy was in place for safeguarding children and young adults under the age 18 years. The policy gave specific guidance for children of various ages and those who were under the age of 13 years. This included additional safeguarding risk assessments, Gillick competency assessment and applying the Fraser guidelines. The Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe.

The safeguarding risk assessment was completed for all patients under the age of 18 years and we saw these completed in the patient records we reviewed. Staff made sure that all patients had a private moment with them to disclose any worries or concerns, we observed family member being asked to leave the consultation room for this to happen.

There was a clear written procedure for receiving patients at the reception desk which reminded staff that all conversations with patients and other staff should be conducted in a discrete manner preserving patient confidentiality. Patients were also asked what name they would like staff to use.

Posters and information leaflets about domestic abuse were displayed clearly in the waiting area with contact details of local domestic abuse services that patients could take away with them.

Cleanliness, infection control and hygiene

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

A range of policies and procedures were in place covering infection prevention and control. We also reviewed the infection control annual plan 2018 which was mapped to the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections.

The reception, waiting area, treatment and consulting rooms at both sites we visited were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning equipment was colour coded in line with National Patient Safety Agency recommendations.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore bare below the elbow and washed their hands after patient contact and between patients. Hand sanitising gel was visible for the use of patients and the public.

During surgical procedures staff wore scrubs, scrubs are the clothing worn by surgeons, nurses, physicians and other workers during surgical procedures.

Staff cleaned equipment with anti-bacterial wipes after patient contact and labelled equipment to show when it was last cleaned. The treatment room was deep cleaned at the end of the day and all other areas deep cleaned once a week.

Surgical equipment and other consumables were single use and disposed of safely. The ultra sound machine was cleaned thoroughly after each patient in line with the European Society of Radiology Ultrasound guidelines. We found a box of sterile vaginal probes in the dirty utility room. We informed the clinic manager who moved them for correct storage in the clean utility room.

Environment and equipment

The maintenance of facilities, premises and equipment kept people safe. Staff were trained to use

Termination of pregnancy

them. Staff managed clinical waste well. However, the design of the waiting area meant staff could not always ensure patient confidentiality and cleaning products were not always safely stored.

The main treatment clinic and satellite clinic were both housed in modern buildings. There were plenty of seats in the waiting areas, consultation and treatment rooms were well equipped.

The service had suitable facilities to meet the needs of patients' families. Both the clinics we visited were easily accessible and had facilities for people with a disability.

Staff carried out daily safety checks of specialist equipment. Resuscitation and emergency equipment was checked at the beginning of each clinic session and we saw the daily checklists confirming this.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they had plenty of equipment to carry out care and treatment and the equipment was well maintained and serviced according to the manufacturer's guidelines. We saw service schedules for the ultrasound machines and checked the labels on six pieces of electrical equipment which showed they had been serviced recently.

The service did not always store cleaning products in line with the Control of Substances Hazardous to Health regulations found two cleaning products in the dirty utility room. We informed the clinic manager who removed them straight away and stored them correctly.

Staff disposed of clinical waste safely. Waste was segregated correctly, there were colour coded bins for the disposal of sharps and waste medications, all the bins were signed and dated. Clinical waste was disposed of in clearly marked clinical waste bins. Swabs taken to detect sexually transmitted infections were labelled and sealed in plastic envelopes then sent individually by post to the pathology laboratory.

A policy described the management and disposal of pregnancy remains this included what to do if patients wished to take the remains away and dispose of them privately. Pregnancy remains were stored separately from other clinical waste before being sent for incineration the day after surgery.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient during the pre-assessment consultation and throughout their care and treatment, updated them when necessary and used recognised tools. Comprehensive risk assessments were completed for each person requesting treatment. This included a medical assessment, venous thrombo embolism (VTE) assessment, ultrasound scan and blood test to check for rhesus negative blood. In the patient records we reviewed we saw that all risk assessments, observations and investigations had been completed.

Treatment guidelines were in place to support staff in determining which treatments and types of anaesthesia were suitable for patients with a medical or other condition as well as when hospital-based care was recommended. Patients suitable for treatment within BPAS clinics fell into categories I and II of the American Society of Anaesthesiologists (ASA) Physical Classification System meaning that they were fit and healthy or had a mild Medical illness.

Staff knew about and dealt with any specific risk issues. Any concerns raised during the pre-assessment consultation were raised with the registered medical practitioner reviewing the patient's medical history and assessment information. Staff were aware of the procedure to follow in the event of a patient needing emergency transfer to an NHS service supported by clinical guideline on the management of major haemorrhage. No one was transferred to an acute hospital in the reporting period.

The service had access to mental health liaison and support if they were concerned about a patient's mental health. The medical questionnaire completed by all patients asked for information about mental health problems including post-natal depression. Staff told us if they were concerned about a patient's mental health they would liaise with their community psychiatric nurse or GP.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The perioperative care policy and procedure included the

Termination of pregnancy

BPAS modified early warning system. Surgical abortion documentation included an observation chart, early warning score triggers and details of escalation (what to do if the early warning score increased).

The service complied with the World Health Organisation surgical safety checklist. The BPAS surgical safety checklist was completed for all surgical patients. We saw that the checklists had been completed correctly in the patient records we reviewed. The process involves several safety checks before, during and after surgery to avoid errors.

The surgical procedure operation record included a record of the number of swabs, instruments, sutures and needles used during the procedure. In the notes we reviewed we saw these had been counted and recorded twice.

A haemorrhage trolley was available in the treatment room for use in the event of major or significant blood loss. We checked the trolley and saw that it was suitably equipped.

There were systems in place for the early recognition of sepsis. The operation record contained a sepsis screening and recognition tool in line with the UK Sepsis Trust. Staff described to us the action they would take if a patient was assessed as having sepsis. Depending on the severity of the patient's condition this could be refer the patient to their GP, refer the patient to the nearest emergency department or call a 999 ambulance.

The pre-assessment included questions about the patient's home circumstances and whether they were appropriate for a medical abortion. During the consultations we observed staff explained thoroughly what the patient needed to do and what they could expect. This information was repeated in the My BPAS booklet given to all patients.

Patients were given a discharge letter documenting the care and treatment given. If patients agreed a copy of the letter was also sent to the patients GP. Patient were told that in the unlikely event of any serious complications following the procedure to share the information in the letter with other health care professionals.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and staffing levels and skill mix.

The service was delivered by a team comprising registered nurses and midwives, client care co coordinators, receptionists and health care assistants. The team worked across all four clinics in BPAS Nottingham West. The service did not use bank or agency staff.

The staff rota was planned well in advance and indicated where each member of staff was working. The manager told us that sickness and turnover rates were low and at the time of our inspection, there were no vacancies. On the day of our inspection the number of staff on duty matched the planned numbers.

The service had enough staff of the relevant skill levels to keep patients safe. Nursing and midwifery staff had all completed training relevant to the gestation and method of termination of pregnancy (TOP) being carried out.

Managers accurately calculated and reviewed the number of nurses, client care co coordinators and healthcare assistants needed for each shift in accordance with national guidance. Additional clinic sessions could be arranged to meet peaks in demand if needed.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The organisation employed a team of registered medical practitioners (RMP) who worked remotely to complete the certificate of opinion which must be completed and signed by two RMP's before commencement of the treatment for the termination of pregnancy. Staff told us there was always two RMP's available to sign the certificate.

BPAS Nottingham West employed one consultant surgeon under practising privileges who worked one day per week to carry out surgical abortions. Cover was available from other BPAS clinics for when the surgeon was on leave. The service did not use locum medical staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to staff providing care.

Termination of pregnancy

Patient notes were comprehensive, and staff could access them easily. Electronic and paper records were completed for each patient. Paper records were scanned and uploaded into the electronic record.

We reviewed the records of five patients. All were fully completed signed and dated and contained the pre-assessment information, details of treatment and completed certificates of opinion.

Records were stored securely. Electronic patient records were password protected and paper records were stored in a locked file. Paper records were kept for three years. Following this period, they were archived for ten years in line with the records retention and disposal policy.

When patients transferred to a new team, there were no delays in staff accessing their records. Patient records could be accessed from the BPAS information system wherever they presented for their treatment.

Patients were given a discharge letter providing enough information about the procedure to allow another practitioner elsewhere to manage complications. We observed patients being asked if they would like a copy of the discharge letter to be sent to their GP.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The medicines management policy and procedure clearly described the supply, transport, storage and disposal of unwanted medicines. The roles and responsibilities of all staff in relation to the prescribing and administration of medicines was detailed including the use of patient group directives. The policy considered relevant legislation and referred to professional guidance from organisations such as the Nursing and Midwifery Council, the General Medical Council and the National Institute for Care Excellence (NICE).

Staff reviewed patients' medicines and provided specific advice to patients and carers about their medicines. Information about patients' current medications was taken during the pre-assessment consultation. Detailed information about the medicines used for early medical abortion was given during the consultation and supported

by information in the My BPAS guide. During the consultations we observed staff describing how and when the medicines should be taken and checking the patients understanding.

Staff stored and managed medicines, including medical gases such as oxygen, and prescribing documents in line with the provider's policy. During our inspection we saw that medicines were stored correctly, and stock control systems meant that adequate medicines supplies were maintained. Medicines were obtained for the central BPAS pharmacy store. We observed staff administering and prescribing medicines in line with the organisations policy. The nurse in charge was responsible for the medicine cupboard keys.

Staff followed current national practice to check patients had the correct medicines. In the five sets of patient records we reviewed the prescription section was pre-populated with a selection of medicines and staff scored through any medicines not being used. This meant that medicines information could be read easily. The date, time and dose of the medicines being administered was fully completed. And staff had signed to say they had given the medicine. We observed patients being asked about allergies and saw these being recorded in their records.

Patient group directives (PGD's) were in place for a selection of drugs including those to treat sexually transmitted infections, contraception and nausea. PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Staff had received appropriate training in the PGD's and we saw an up to date signed list of staff who could prescribe and administer medicines using a PGD.

The organisation had a small antibiotic formulary in place to cover post termination prophylaxis, the treatment of sexually transmitted infections and antibiotics to be administered for sepsis. The formulary had been written in line with NICE recommendation and was regularly reviewed by the chief pharmacist and medical director. It included the indication, drug of choice and dose, this meant that antibiotics were prescribed responsibly.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines

Termination of pregnancy

safely. The organisation had a pharmacy support team who regularly reviewed information about relevant medicines and communicated changes to staff through the clinic managers.

Staff were aware of the yellow card system which is in place to report adverse drug reactions and side effects to the medicines and healthcare products regulatory agency.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients were asked if they used recreational drugs or ever injected drugs into their veins. Staff told us if they had any concerns they would contact the patients GP, with the patient's permission, or raise it with the BPAS Clinical Lead for advice.

The service did not use controlled drugs. Controlled drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments).

Incidents

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

An incident, near miss and serious incident policy and procedure supported staff in the management of incidents. It included guidance from the department of health on serious incidents and the national patient safety agency on never events. It also included information about duty of candour.

Following a serious incident, a debriefing meeting took place to identify any learning and create an action plan. Compliance and timeliness of the action plan was monitored through the organisation's quality assurance visits.

Staff knew what incidents to report and how to report them they reported all the incidents that they should report in line with the organisations policy. Staff described to us the

system they used for reporting incidents and the types of incident they reported. For example, incidents of retained products of conception were always reported as an incident.

The policy also described the organisations responsibility to report serious incidents and never events to external organisations such as the National Reporting and Learning System, Care Quality Commission and the Medicines and Healthcare products Regulatory Agency (MHRA).

During the reporting period there were no serious incidents or never events reported. 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 healthcare providers. They have the potential to cause serious patient harm or death.

We saw evidence that learning from serious incidents and never events was shared at the organisations clinical governance committee and cascaded to staff through the clinic managers team briefings and the quarterly BPAS staff bulletin.

Staff described a recent near miss incident involving a medicine. Although learning was mainly for one individual, all staff had been reminded about their responsibilities around medicines management and the importance of checking allergy information.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. There had been no incidents during the reporting requiring the duty of candour process.

Health alerts from the MHRA were received centrally and relevant information cascaded to staff by clinic managers at team briefings.

Safety Thermometer (or equivalent)

The service did not collect NHS Safety Thermometer information.

Termination of pregnancy

Are termination of pregnancy services effective?

Good 

We rated effective as **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 protected the rights of patients' subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures we reviewed referred to guidance recommended by professional bodies. For example, the perioperative care policy and procedure was developed in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and The Royal College of Obstetricians and Gynaecologists (RCOG) guidance.

Policies relating to termination of pregnancy were developed in line with the Department of Health, Required Standard Operating Procedures (RSOP's).

Care and treatment was delivered in line with the department of health, required standard operating procedures (RSOP's). During the consultations we observed staff discussed the methods available to the patient depending on length of gestation.

Evidence-based advice was given on sexually transmitted infections, family planning and contraception. Contraception was discussed at pre-assessment, including long acting reversible contraception, and condoms were offered.

The service offered routine testing for chlamydia to all patients, chlamydia is a common sexually transmitted infection which can be treated with antibiotics.

Termination was performed as soon as possible after the patients consent, same day treatments were available for early medical abortions and we observed these taking place on the day of our inspection.

The service offered surgical termination of pregnancy using vacuum aspiration which uses gentle suction to remove the pregnancy, this procedure was carried out under local anaesthetic.

A policy was in place to support staff managing the deteriorating or septic patient which included the use of a modifies early warning system, communication using the situation, background, assessment and recommendations (SBAR) method and clear escalation guidance. The UK Sepsis Trust, sepsis screening and action tool was also included in the surgical procedure documentation.

We observed staff giving comprehensive advice on discharge which was reinforced in a booklet, My BPAS Guide. A discharge plan was also completed for each patient including a checklist of key information to be confirmed with the patient prior to discharge.

Nutrition and hydration

Patients did not need to fast before treatments. Hot and cold drinks were provided, and light snacks were available from a café in the same building.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Anticipatory pain relief was advised before both medical and surgical terminations. Patients were advised to take a non-steroidal anti-inflammatory drug an hour before their appointment.

A pain assessment tool was used for both medical and surgical patients. Pain was scored from zero to three, zero being no pain and three being severe pain. Pain was assessed prior to discharge; patients were only discharged if the pain score was no more than one.

Staff prescribed, administered and recorded pain relief accurately. We saw prescription sheets completed accurately in the patient records we reviewed and observed staff administering medicines correctly. Patients were given codeine phosphate to take home, codeine is effective for moderate to severe pain.

Discharge planning included advice on pain relief and this was complemented by information in the My BPAS booklet.

Patient outcomes

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Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers carried out a comprehensive audit programme. A planned programme of audit was in place which included regular audits such as infection control and record keeping and ad hoc audits such as the British Pregnancy Advisory Service (BPAS) surgical safety checklist and early medical abortion treatments. Audit outcomes were shared at relevant meetings and clinic managers created local action plans for non-compliance.

There was regular monthly audit of a set of standards reported for each clinic on a dashboard. Each standard was marked as green for achieved and red for not achieved. The dashboard was then given an overall rating. We saw completed audits for June 2019 for BPAS Nottingham West which was rated green.

If there was an overall rating of red, more than one standard not achieved, the area manager worked with the clinic manager to develop action plans to achieve a green rating. Information from the dashboard could be benchmarked against other clinics within the organisation.

Improvement was checked and monitored through completion of the monthly dashboard. Managers shared and made sure staff understood information from the audits.

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 patients. Managers made sure staff received specialist training for their role. All new members of staff attended the BPAS induction course and we saw evidence of this in the staff records we reviewed. The induction policy and procedure described the induction programme and relevant legislation and law covered by the programme.

All clinical staff attended the BPAS 12-week clinical training programme. The programme included specialist training to equip clinical staff with the skills and knowledge to carry

out the work. The programme included topics such as ultrasound scanning, contraception and sexually transmitted diseases delivered in a classroom environment and used a competency-based framework.

Staff performing ultrasound scans were audited once a year by the BPAS lead sonographer. The lead sonographer quality assured a random selection of ultrasounds and discussed the findings with the staff member. Any adjustments needed in practice were identified which meant that the quality of ultrasound scans carried out by the service was maintained.

During our inspection we observed a new member of staff working under supervision of an experienced member of staff who was supernumerary. The new member of staff demonstrated competencies which were then signed off by the supervisor in the competency booklet. The new member of staff told us they felt the training was excellent with no pressure to perform any task unless they were completely confident to do so.

Managers supported staff to develop through yearly, constructive appraisals of their work. In the five staff records we reviewed all staff had a documented appraisal within the last 12 months. Staff had the opportunity to discuss training needs during the appraisal meeting and were supported to develop their skills and knowledge.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were supported to undertake Continued Professional Development activities, in order to update their skills and knowledge. For example, all clinical staff were expected to attend the BPAS Clinical Forum where expert speakers presented topics relevant to the work. Staff told us they had requested to attend additional counselling courses which had been agreed by line managers. Learning and development courses were delivered by a range of providers and internal BPAS specialists.

The consultant also worked for a local NHS hospital. He had a named responsible officer. Responsible officers are individuals who have overall responsibility for evaluating the fitness to practice of doctors and making a recommendation to the GMC regarding revalidation.

Staff had the appropriate level of life support training, client care co coordinators had basic life support training,

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clinical staff had immediate life support training and the consultant had advanced life support training. We saw evidence of this in staff records we reviewed and the mandatory training record for all staff.

The 24-hour aftercare help line was manned by registered nurses or midwives who had received specialist training in termination of pregnancy.

BPAS staff who provide counselling had received bespoke training in counselling and self-awareness and specific training for post termination counselling.

Processes were in place to manage poor performance. Managers told us that poor performance would be discussed in one to one meetings and staff appraisals. Informal disciplinary procedures would be followed in the first instance involving a description of the shortcomings, what needs to be done to improve and timescales for improvement. The disciplinary policy and procedure described the next stage in the event of no improvement.

We did not see evidence of a formal process to share information with other healthcare providers when a staff member was suspended from duty, but managers told us that the central human resource department would manage this.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Staff had good working relationships with other health care professionals when required to care for patients. Staff told us they liaised regularly with local maternity services, safeguarding services and patients GP's. During our inspection we observed a member of staff contacting an early pregnancy assessment clinic (EPAU) to discuss a concern about a patient and make a referral. Clear explanations were given to the patient and a referral letter for the EPAU detailing the concern.

During our inspection all staff demonstrated effective team working. They understood each other's roles, communicated well and sought second opinions from colleagues when required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. They also liaised with community psychiatric nurses and the patient GP.

Arrangements were in place for patients who required ongoing procedural care. Following discharge, patients who had undergone a surgical abortion were provided with the clinic contact details and the 24 hour helpline number, they were also offered a post op check at the clinic one week later. Patients were given a comprehensive discharge pack which included written information, condoms and a pregnancy test.

A 24-hour aftercare line was available for all patients to answer any queries or concerns in line with best practice for patients undergoing day case procedures. The My BPAS information booklet gave comprehensive information about what to expect post termination and contact numbers for the aftercare line and the clinic.

Patients were advised to call the aftercare line if they had certain specific symptoms including fever. Staff manning the aftercare line used the sepsis screening and action tool and escalated patients to urgent or emergency health services as appropriate.

Seven-day services

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

The service operated from Monday to Friday, surgical abortions took place weekly at the main clinic.

Most tests and investigations could be carried out at the time of the consultation with instant reporting, for example blood test for rhesus negative blood group and ultrasound scan.

Swabs taken to detect sexually transmitted infection were posted on the same day to a pathology laboratory and patients informed of the results within a week if treatment was required.

There was 24-hour access seven days a week to the aftercare helpline and patients could make an appointment for counselling services at any time before or after the treatment.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. In both the clinics we inspected we saw racks of patient information leaflets on pregnancy related matters, sexually transmitted infections and contraception. This information was also displayed on notice boards.

During the consultations we observed staff discussed contraception in detail, provided initial contraception medicines and informed patients where to get further supplies. Information on contraception and sexually transmitted diseases was also included in the My BPAS booklet given to every patient.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported by the consent to examination and treatment policy and knew where to find this on the BPAS intranet if needed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and recorded consent in the patients' record. There were detailed consent forms for surgical abortion, medical abortion and evacuation of retained products of conception.

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

Staff understood the law around the age of consent and when to use the Gillick test to assess if a child under the age of 16 could consent to treatment i.e. Gillick competent. The Gillick test determines if children under the age of 16 have enough understanding and intelligence to understand the treatment, its purpose, likely effects and risks and other options to make an informed consent.

The Fraser guidelines specifically relate only to contraception and sexual health. They are named after one of the Lords responsible for the Gillick judgement but who went on to address the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.

Staff made sure patients consented to treatment based on all the information available. We observed staff completing consent forms in the consultations we attended and discussing in detail the following: risks and complications of the procedure, alternative treatments, Gillick competency test and Fraser guidelines (if appropriate) and use of abortifacient medicines. We were confident that patients were able to make a fully informed consent.

Where interpreters were involved with the consent process they were required to sign the consent documentation to confirm they had interpreted the information to the client to the best of their ability and in a way they believed could be understood.

The consent process was audited monthly as part of the records audit and the results were included in the clinic dashboard information.

Are termination of pregnancy services caring?

Good 

We rated caring as **good**.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff always asked patients if they wanted to know if they had a twin pregnancy or if they wanted to see the scan before the scan was performed.

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We observed staff interacting with patients in a caring, non-judgemental way while maintaining a professional manner. Staff were very kind towards patients and checked throughout the consultation and treatment that they were comfortable.

Staff followed policy to keep patient care and treatment confidential. There was specific guidance in place for how patients should be greeted at reception and the option for patients to choose what name to be used for them in the clinic environment. We observed that window blinds were closed and curtains around couches drawn to respect privacy. All consultations were conducted in private.

During the consultation patients were asked if they could be contacted by phone, letter or e mail. Staff also asked if answerphone messages could be left on telephones.

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

Staff responded in a compassionate and timely way when people experienced pain. Staff explained the trans vaginal scan could be mildly uncomfortable. Patients were advised to give anticipatory pain relief before medical and surgical abortions.

Staff were very supportive before and after treatments, consultations were carried out in an unhurried manner and patients were always given time to reflect on decisions they needed to make.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. They described to patients the range of emotional responses to the treatment they might experience and the action they could take if they needed assistance.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us that there was always a room

available for the use of distressed patients but if patients became distressed or upset during the consultation they would stop the consultation and talk to them about their feelings.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service offered a free counselling service which was available to patients at any time before, during or after treatment and remained available years after the procedure had taken place. The dedicated phone number to access counselling services was advertised on the BPAS web site and in the My BPAS booklet given to all patients.

Patients completed a medical questionnaire prior to their pre-assessment consultation. The questionnaire asked about the patient's mental health and whether the patient had a history of mental ill health. Staff asked more detailed questions about mental health issues during the consultation and if they were concerned referred the patient back to their GP or discussed it with the clinic manager.

During the consultation specific questions were asked to identify those who may need additional emotional support. For example, sexual violence, poor social support and coercion. Patients were asked if they felt safe at home and if they felt safe with the person they had sex with who made them pregnant. Patients under the age of 18 were asked further questions such as have you ever been made to do something sexual you didn't want to.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Staff sometimes did not inform patients about how the service used their personal information.

Staff made sure patients and those close to them understood their care and treatment. Partners were encouraged to be present during the consultation and

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were able to ask questions or raise concerns. Patients who attended on their own were asked if they had support at home or if someone could stay with them whilst they were having or recovering from treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used simple terms and explained any medical terms to patients. Staff checked patients understanding throughout the consultation.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Each patient was given a feedback form to complete following consultation and treatment. Feedback from patients was overwhelmingly positive about how they were treated by staff.

Patients were given comprehensive information about all aspects of the treatment and recovery and information leaflets which endorsed the verbal information. This included how to take the medication in the case of medical abortion and what to do if they changed their mind.

Staff did not always inform patients about how the service used their personal information. During the consultations we observed staff did not tell patients about the information shared with the Department of Health and Social Care for statistical purposes on the HSA4 form.

Discussions about cost rarely took place as most patients were treated through NHS funding. However, the manager told us that costs were clearly advertised on the BPAS website.

All patients were asked if they wanted a copy of the discharge letter to go to their GP and these were only sent with the patient's permission.

Are termination of pregnancy services responsive?

Requires improvement 

We rated responsive as **requires improvement**.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. If there was a peak in demand managers were able to arrange additional clinic sessions.

Facilities and premises were appropriate for the services being delivered. The clinics we visited were in town centres, easily accessible and had ample local parking.

Patients could book appointments through a variety of ways, using the central booking system given on the British pregnancy advisory service (BPAS) website, contact the clinic directly or a referral from the patient's GP. Patients could choose which treatment clinic they attended and a date and time suitable to them. However, the service did not operate at weekends and surgical abortions only took place at the main clinic one day per week.

Confirmation of the appointment was sent by text, e mail or post, whichever the patient had chosen, and reminder texts were sent to minimise missed appointments.

BPAS sex and relationships education lessons were also available to local schools and colleges and could be arranged through the central education team.

If patients did not attend for their appointment it was documented in their records and the client care co coordinators would contact them to see if they wanted to re book. This included new patients and patients who were booked for a post treatment check.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. All clinics in the Nottingham West region had disabled access which was described on the BPAS website.

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The service had information leaflets available in languages spoken by patients and the local community. The central booking system allocated longer appointments for patients who required an interpreter. The consent form was available in 16 different languages. The service used a recognised language interpretation service by telephone or face to face if necessary.

Information was also available in Braille. Braille is a tactile writing system used by people who are visually impaired. It is traditionally written with embossed paper. A hearing loop system was also available at the main clinic. A hearing loop (sometimes called an audio induction loop) is a special type of sound system for use by people with hearing aids.

Patients could request a chaperone, notices containing this information were clearly displayed in waiting areas.

The suitability for treatment guidance included what to do if a person was not suitable for treatment due to a pre-existing medical condition. For example, patients would be referred to their GP with a letter giving an explanation as to why the BPAS service was not appropriate. The information was shared with the patients GP only with the patient's permission.

There was a special placement team who could direct patient to the right place to receive the right care.

The booklet My BPAS guide given to every patient described how the pregnancy remains were disposed of and invited patients to make any special requests in relation to disposal of pregnancy remains. A specific information sheet was available to women who wished to dispose of the pregnancy remains privately. Information was also available about local funeral services for women who wished the remains to be cremated or buried.

The disposal of pregnancy remains was discussed during the pre-assessment consultation. A BPAS policy was also in place to support staff and was based on the human tissue authority, Royal College of Nursing and Scottish government guidance.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Managers monitored waiting times and made sure patients could access services when needed although they did not always meet the standards set by the Department of

Health, however, waiting times did meet the commissioners target of 14 days. The BPAS capacity manager had an overview of appointment availability and worked with clinic managers to increase or decrease appointment and staffing levels when necessary.

In the reporting period the waiting times were an average of seven days from referral to consultation, appointments should be available within five working days from the initial referral. Patients should be offered an abortion within five days of the decision to proceed with the procedure. In the reporting period for this service the average time between the decision to proceed and the abortion was 14 days. This meant that patients were waiting longer than they should for the initial consultation and the procedure. Managers told us the organisation was actively working to reduce waiting times.

The manager told us that some women chose to delay treatment as they needed extra time to consider their options and that this affected the consultation to treatment performance standards. However the organisation did not collect information on delayed appointments and procedures so we could not be assured that all the delays were due to patient choice.

Appointments could be made easily. Appointments could be booked through the BPAS contact centre which was a 24-hour telephone booking and information service. The service took self-referrals or referrals from GP's. Women could choose the date, time and location for their appointment.

Appointments were rarely cancelled, in the event of an appointment being cancelled an alternative was offered within seven days taking into account the gestation of the patient and any effect this may have on treatment. During our inspection we observed that most appointments ran on time. One consultation was complex and the patient required referral to hospital so creating a delay for the next patient. The delayed patient was kept informed and an apology given for the delay.

Staff supported patients when they were referred or transferred between services. We observed staff supporting a patient who was referred to a local acute hospital. They checked she knew where to go and if there were any problems getting to the hospital.

Learning from complaints and concerns

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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. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. At the clinics we inspected we saw notices displayed and leaflets available describing how to give feedback or make a complaint. The information included details of other services who could support the complainant such as citizens advice, Healthwatch and the parliamentary and health service ombudsman. The information was also available on the BPAS website and in the My BPAS booklet.

Staff understood the policy on complaints and knew how to handle them. Staff described to us how they would manage a complaint and referred to the BPAS complaints and client feedback policy and procedure.

Managers investigated complaints and identified themes. There had been five complaints in the reporting period. We reviewed all five complaints and saw they had been investigated in line with the BPAS policy and within the timescales.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Local complaints were usually resolved at the time, for example, someone might complain about the room temperature, these were still documented to identify trends.

Patients wishing to make a formal complaint were referred to the client engagement manager and acknowledged within three days. A full response was made within 20 working days and during this time the client engagement manager maintained contact with the complainant.

Managers shared feedback from complaints with staff and learning was used to improve the service. In the complaint reports we reviewed we saw learning had been identified and action had been taken to share learning with relevant staff.

A summary of complaints was presented at the monthly clinical governance committee. Annual trend analysis identified any themes for sharing across the organisation.

Are termination of pregnancy services well-led?

Good 

We rated well-led as **good**.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and expertise.

The registered manager had been in post since April 2015 and managed all the clinics in the Nottingham West region. They were based mainly at the main centre in Stapleford but visited the satellite clinics at least once a month.

The organisation supported leaders to attend a leadership development programme as well as twice yearly managers conferences and modular management training courses.

The certificate of approval issued by DH was displayed prominently and the service maintained a register of patients undergoing termination of pregnancy (TOP) which was retained for three years. The service recorded the number of TOP's undertaken; 1993 TOP's were performed in the reporting period.

The perioperative care policy and procedure incorporated the local safety standards for invasive procedures which meant staff had a good understanding of good safety practice.

Vision and strategy

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

The vision of the service was to: Provide inclusive, reproductive health care services that are responsive to the needs of everyone who wishes to use them. Promote the

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development of services that are accessible, effective, safe and confidential. Safeguard individual freedom and moral autonomy in making reproductive choices. Staff had contributed to the vision statement through a series of consultation events. Staff we spoke with were aware of the vision and the fundamental elements within it.

The British Pregnancy Advisory Service had an overall corporate strategy and business plan which were accessible to all staff. Progress towards the strategy was communicated to staff through team briefings. Staff we spoke with described the content of the team briefings and told us they were able to submit comments and suggestions.

The strategy incorporated the vision principles. The registered manager and regional manager were knowledgeable about the corporate strategy and understood how this affected the local provision of services.

The service made sure that staff provide TOP care in line with the the Royal College of Obstetricians and Gynaecologists (RCOG) and other professional bodies. Best practice was incorporated in policies and procedures we reviewed and demonstrated in the way staff delivered care and treatment.

Culture

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

Staff we spoke with told us they felt valued and respected and spoke highly about local managers.

The organisation also incorporated the 6C's in their procedures and practice. The 6Cs are care, compassion, competence, communication, courage and commitment and were launched in December 2012 by NHS England. We observed staff demonstrating the 6C's in the care and treatments they delivered to patients.

Staff understood the duty of candour. The complaints policy and incident management policies both incorporated guidance on duty of candour. Duty of candour awareness training was disseminated to staff by the clinic

manager and included in incident reporting training. Duty of candour events were reported routinely to the quality and risk committee. The clinic manager had additional training on duty of candour supported by a duty of candour flowchart.

The service ensured the safety and wellbeing of staff. The induction programme covered health and safety topics relevant to the service such as, display screen equipment regulations 1992, health and safety (First Aid) regulations 1981 and health and safety at work act 1974. Staff had access to occupational health services. We saw in personal files that pre-employment occupational health checks had been completed for all staff.

A policy on equality of opportunity at work meant recruitment decisions were based on the candidate's ability to do the job and eliminated discrimination on any grounds. Recruitment packs included an equal opportunity monitoring form.

During our inspection we found all staff to be open and friendly, staff cooperated well with each other and demonstrated supportive and appreciative relationships towards one another.

British Pregnancy Advisory Service (BPAS) is a not for profit organisation, 97% of patients had their treatment paid for by the NHS. Prices for fee paying patients were clearly advertised on the BPAS website. The manager at BPAS Nottingham West said it was rare for them to see fee paying patients.

Governance

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

A transparent governance structure was in place. Committees were in place for key areas such as information governance, quality and risk, infection control and research and ethics. Information was shared across committees and with staff through a series of manager and staff meetings.

The organisation had a clinical advisory group comprised of internal and external clinical experts to review and

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advise on clinical policies. This group was represented at the clinical governance committee so information could flow both ways to ensure the service was up to date in clinical matters.

There were named organisational leads for key areas such as safeguarding, medicines, ultrasound and infection prevention and control. Staff could describe the clinical governance structure and knew the named leads and who to go to for specialist advice.

We reviewed around 30 policies and procedures. Policies and procedures were in place for every aspect of the service, current and based on evidence-based guidance.

The clinic had been approved by the Secretary of State to provide treatment for termination of pregnancy and held a valid licence.

The manager was aware of the requirement to notify Care Quality Commission (CQC) and Department of Health in writing about the death of a woman within 12 months of using the service and of other statutory notifications to the CQC.

There was a robust electronic system in place for registered medical practitioners (RMP) to remotely review the patient's assessment records and sign the HSA1 forms. Form HSA1 must be completed, signed and dated by two registered medical practitioners before a termination of pregnancy is performed under Section 1 (1) of the Abortion Act 1967.

After the first RMP had signed the form the records were sent electronically to the second RMP to sign and also prescribe any medication needed. On completion the records were then sent electronically back to the clinic for staff to check they had been completed correctly.

Staff told us that the RMP's would only sign the HSA1 forms if they were satisfied with the information in the patient record, also nursing staff would only proceed with treatment if the forms had been completed correctly. In the patient records we reviewed we saw that the HSA1 forms and prescriptions sheets had been completed correctly.

The HSA1 forms were stored in the patients record and kept for a minimum of three years. Five HSA1 forms were audited each month as part of the records audit and results included in the unit's monthly dashboard.

Recruitment of staff followed the BPAS recruitment and selection policy and procedure. In the five staff files we reviewed all the relevant documentation was in place to give assurance that recruitment processes were robust and certificates and proof of identification had been verified.

In the consultants personal file we saw completed documentation granting practising privileges and a certificate of indemnity insurance in accordance with the Health care and Associated Professions (Indemnity Arrangement) Order 2014. The BPAS medical director was responsible for managing practising privileges.

The BPAS recruitment process included questions for candidates on pro-choice, the organisation did not employ or subcontract individuals with a conscientious objection to termination of pregnancy. People who are pro-choice believe that women have the basic human right to decide when and whether to have children, based on their own moral and religious beliefs, even though they themselves may not choose termination of pregnancy as an option for an unplanned pregnancy.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Comprehensive risk assessments were in place for operational, clinical and environmental risks. Emergency contingency and business continuity plans were in place with specific information relevant to each location. The plans considered risks to the service and mitigating actions. For example, failure in information technology systems, under established staffing levels and issues affecting the supply of equipment.

We reviewed the risk register for BPAS Nottingham West. Risks identified represented those voiced by staff including the risk that patient sensitive information may be overheard by other patients and escorts in the waiting area.

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The organisation could monitor performance across all its clinics using a quality dashboard. A set of key performance indicators were audited monthly and rated red, amber or green to indicate where performance was below the expected level.

A tested emergency generator was in place at the Stapleford clinic which meant that treatments requiring electrical equipment could continue in the event of a power failure.

In the event of patients requiring a higher level of care or emergency care, protocols were in place for transferring patients to local acute NHS hospitals.

An infection control annual plan was in place which was in line with the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance. This described the risk assessments that should take place to promote infection prevention and control.

Fluctuations in demand could be managed by arranging extra clinics. The manager told us that bad weather had not disrupted services but, if staff could not travel to work staff more local to the clinic would be asked to work and patients would be contacted if clinics needed to be changed.

The organisation had completed a risk assessment against the possible outcomes of Brexit negotiations which was reviewed and updated regularly and the quality and risk committee, we saw a copy of the most recent risk assessment. A strategic review of procurement processes was taking place which included potential impact of a no deal Brexit.

Managing information

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

Information was managed in line with the Data Protection Act. Patients were informed how their information would

be used in the My BPAS guide and posters displayed in waiting areas. Staff were aware of their responsibilities around patient confidentiality and electronic systems were password protected.

The service submitted information to external bodies as required including the DH, CQC and commissioners.

Information collated included the views of people, quality, operations and finance. We saw in the minutes we reviewed that information was shared at relevant meetings within the organisation and escalated to the board of trustees if necessary.

There was a system in place to ensure HSA4 forms were submitted to the DH in accordance with Abortion Regulations 1991. The forms were completed online within 14 days of the termination of pregnancy and submitted directly to the DH electronic system.

We saw evidence that lessons were learnt when there was a breach of confidential information. The incident was reported and investigated with the patient's involvement and individual learning was identified for a member of staff.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

When patients had completed their treatment they were given a feedback form to complete. The forms were first reviewed by the clinic manager to respond to any immediate feedback concerns. The forms were then submitted to the client engagement manager for collation and trend analysis. Survey reports were produced and submitted to commissioners, the quality and risk committee and the clinical governance committee.

We saw in the quality accounts that trends had been identified from patient feedback and actions identified to make improvements. Locally staff had changed the way they prepared their own meals at meal breaks due to feedback about food smells in the clinical areas.

A staff survey was carried out every year. We saw the survey results for 2018. The survey asked 40 questions about working for BPAS. The results had been shared with staff during Spring 2019 and staff were invited to comment and

Termination of pregnancy

make suggestions about improvement areas. Action plans were still being developed but some themes had been identified such as lack of visibility of the executive leadership team (ELT). This had resulted in a rolling programme of unit visits by the ELT.

The local manager proactively collaborated with local health providers and partner organisations. Meetings had taken place with the early pregnancy assessment unit at a local acute hospital to improve communications and patient pathways. The manager had also visited staff at a local charity supporting sex workers to improve understanding of the service they each provided.

The service engaged with commissioners in a transparent way and submitted regular reports on performance.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The organisation participated in research and had a research and ethics committee. We saw the research project register which described two projects that had taken place in the reporting period. This showed the organisation was striving to expand its knowledge and understanding of the service with a view to identifying improvements.

The medical director attended and contributed to national and international termination of pregnancy events to keep the organisation informed of new guidance or developments. Events attended included the National Institute for Care Excellence, termination of pregnancy guideline development group, the National Abortion Federation and the RCOG world congress.

The service used a standardised improvement tool in the form of the monthly unit dashboard which reported on compliance against 12 standards and rated each unit red amber or green. The latest unit dashboard for BPAS Nottingham West was rated green which meant it was compliant with all 12 standards.

Staff were encouraged to make suggestions about service improvements. The service held a staff meeting every three months to discuss the clinics performance and identify areas for improvement.

The manager arranged social events for the staff twice a year. Staff told us the best reward they received was the positive feedback from patients. Targeted reward schemes took place occasionally. For example, a reward for the member of staff who obtained the highest number of consents for chlamydia screening.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that patients are informed that information (HSA4) is shared with the Department of Health and Social Care.
- The provider should take action to improve DH standards for access to timely abortion services and record when this was due to a delay caused by patient choice.