BPAS - Doncaster

Quality Report

Danum Lodge Clinic,
123 Thorne Road,
Doncaster,
DN2 5BQ
Tel: 03457 30 40 30
Website: www.bpas.org

Date of inspection visit: 23 to 24 October 2019
Date of publication: 07/02/2020

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BPAS Doncaster is operated by British Pregnancy Advisory Service. The British Pregnancy Advisory Service was established as a registered charity in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. BPAS Doncaster opened in 1982 and provided a satellite site in York.

BPAS Doncaster provides medical and surgical termination of pregnancy services, feticide treatment, screening for sexually transmitted diseases, contraception advice, counselling and vasectomy procedures. Facilities included three screening rooms, seven consultation rooms, a treatment room and eight inpatient beds for overnight stays for patients undergoing late medical treatments.

York provided medical abortions under 10 weeks' gestation. There was a consulting room and a treatment room within a GP practice.

The BPAS Doncaster clinic undertook; early medical and late medical abortion and surgical abortion under local anaesthetic, with or without conscious sedation, and under general anaesthetic.

We inspected this service using our comprehensive inspection methodology. We conducted an unannounced inspection on 23 and 24 October 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.

Ann Ford
Deputy Chief Inspector of Hospitals (North)

Overall summary

We rated it as **Good** overall.

We found the following areas of good practice:

The service had suitable premises and equipment. There were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service provided mandatory training in key skills to all 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 kept detailed records of patients' care and treatment and followed BPAS processes when prescribing, giving, recording and storing medicines. Staff completed and updated risk assessments for patients undergoing surgical and late medical terminations of pregnancy. The service reported and managed patient safety incidents well.

The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff assessed and monitored patients regularly to see if they were in pain. Staff followed appropriate consent processes. Staff promoted sexual health in line with national guidance. There was an emergency transfer agreement with the nearest acute hospital.

Staff cared for patients with compassion and provided emotional support to patients. Staff involved patients' decisions about their care and treatment.

The service managed and investigated concerns and complaints appropriately.

Summary of findings

The service had a vision for what it wanted to achieve and workable plans to turn it into action. Managers promoted a positive culture that supported and valued staff. There was inclusive and effective leadership at all levels. Leaders demonstrated the experience, capacity and capability needed to deliver sustainable care.

Staff throughout the service were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities, were proud of the organisation as a place to work and spoke highly of the culture. Staff were actively encouraged to speak up and raise concerns.

However:

Some patients waited longer than two weeks from first contact to treatment which was outside of Required Standard Operating Procedures (RSOP) as specified by the Department of Health. Some national and local actions had been put into place to reduce this. However, audit results continued to show missed targets.

Although we observed good medicines management and practice throughout our inspection, audit results showed the service had failed to meet BPAS requirements for medicines management on six occasions.

Two trolley mattresses were found to be torn. It was not clear if one of these was the same trolley mattress identified in an internal infection control audit in December 2018. Therefore, it was not clear if the service acted upon identified infection control risks.

The service did not use a paediatric specific early warning score for young patients and, in the case of a young patient who developed sepsis, a modified early warning score (MEWS) was not used on admission.

Although staff told us they were committed to improving services continually, audit results did not show lasting improvements on dashboards although actions were identified and managed to ensure positive changes.

Following this inspection, we told the provider that it must make some improvements, because a regulation had been breached, and to help the service improve. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Good 	The British Pregnancy advisory Service (BPAS) Doncaster provided surgical termination of pregnancy up to 23 weeks and six days gestation, medical termination of pregnancy up to 23 weeks and six days gestation. The centre also had a satellite clinic in York providing medical termination up to 70 days (10 weeks) nine weeks and six days gestation. The service also provided contraception advice including the fitting of long acting reversible contraception (LARC) as well as vasectomy (male sterilisation treatment). We rated this service as requires improvement overall. Safe, effective and caring were all rated as good. Responsive and well led were rated as requires improvement.

Summary of findings

Contents

Good

BPAS - Doncaster

Services we looked at
Termination of pregnancy;

Summary of this inspection

Background to BPAS - Doncaster

BPAS Doncaster was part of the provider group British Pregnancy Advisory Service, established as a registered charity in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. BPAS Doncaster opened in 1982 and had a satellite clinic in York staffed by the Doncaster team: It was a private single specialty service in Doncaster, South Yorkshire.

BPAS Doncaster had a contract with Doncaster Clinical Commissioning Group to provide termination of pregnancy services and vasectomies. The York site had a contract with all four of the North Yorkshire Clinical Commissioning Groups to provide termination of pregnancy services. It also accepted patient referrals from outside these areas.

There had been a Home Office Controlled Drugs Officer meeting at BPAS Doncaster on 10 October 2018. The Officer had been very satisfied with all aspects of this inspection and the evidence provided.

There were no other external reviews or investigations at BPAS Doncaster between April 2018 and March 2019.

The centre had a registered manager in post since April 2011.

BPAS Doncaster is registered to provide the following activities:

- diagnostic and screening procedures
- family planning services
- treatment of disease, disorder or injury
- termination of pregnancy
- surgical procedures

Within the scope of these registered activities BPAS Doncaster offers the following services to patients:

- pregnancy testing
- unplanned pregnancy counselling/consultation
- medical abortion
- surgical termination of pregnancy under general anaesthetic
- surgical terminations of pregnancy under local anaesthetic/conscious sedation
- vasectomy
- abortion aftercare
- miscarriage management
- sexually transmitted infection testing and treatment
- contraceptive advice
- contraception supply

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an additional CQC inspector and a specialist advisor with expertise in sexual and reproductive health. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

How we carried out this inspection

We carried out the unannounced inspection of BPAS Doncaster. During the inspection, we visited the BPAS Doncaster clinic on 23 October 2019 and the early medical abortion unit (EMU) in York on 24 October 2019.

We spoke with 17 staff including; registered nurses and midwives, a health care assistant, reception and administration staff, medical staff, an operating department practitioner and managers. We spoke with six patients and two partners. During our inspection, we reviewed 12 sets of patient records.

Summary of this inspection

Information about BPAS - Doncaster

In the reporting period 1 April 2018 to 31 March 2019, the centre carried out 1310 surgical terminations of pregnancy (SToP) under local anaesthetic/conscious sedation and under general anaesthetic, and 2453 EMA and 224 late medical terminations of pregnancy were carried out after 20 weeks gestation. In the same period the centre also carried out 272 vasectomies.

Two surgeons were directly employed by BPAS. One surgeon and two anaesthetists who also worked at NHS trusts worked on a sessional basis at BPAS under practising privileges. BPAS employed 11 registered nurses and midwife practitioners, 22 administrators. The centre had used agency staff to cover a total of 112 registered nurse shifts in the twelve months prior to the inspection.

Track record on safety

- No never events and three serious incidents requiring investigation
- Eight patients were transferred out to another hospital
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Fifteen complaints were received within the reporting period.

The centre held a current Department of Health licence to practice under the Abortion Act and displayed copies of the licence at each of its registered locations

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?

Good

We rated it as **Good** because:

The service provided mandatory training in key skills to all staff and made sure everyone completed it. This included safeguarding training which was completed to the standard required by the intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2014).

Processes were in place to safeguard vulnerable adults, young people and children. Staff conducted thorough assessments following BPAS safeguarding policies.

The service controlled infection risk well.

The environment, facilities, and most equipment was suitable to keep patients safe. Staff were trained to use equipment necessary for their role.

Staff completed and updated risk assessments for patients undergoing surgical or late medical terminations of pregnancy and removed or minimised risks.

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

Patient records contained relevant information to keep patients safe. Staff appropriately shared information to other linked agencies as required. Staff completed all parts of patient records to a high standard.

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

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

The service monitored information to improve safety.

However, we also found;

Although we observed good medicines management practice throughout our inspection, audit results showed the service had failed to meet BPAS requirements for medicines management for several months. Action plans were developed following each audit. Managers discussed results with staff and prompted them to take actions.

Summary of this inspection

The service had recorded two medication errors in 2019. Managers had discussed each error with staff and requested they complete a reflective account.

Two trolley mattresses were found to be torn. It was not clear if one of these was the same trolley mattress identified in an internal infection control audit in December 2018.

The service did not use a paediatric specific early warning score for young patients and, in the case of a young patient who developed sepsis, MEWS was not used on admission. Actions following on from this incident included introduction of a baseline MEWS score on admission, case note audit and sepsis training for staff.

Are services effective?

Good

We rated it as **Good** because:

The service provided care and treatment based on national guidance and evidence-based practice for both termination of pregnancy and vasectomies. Staff were promptly updated on new legislation and changes and were able to quickly implement this safely as a result.

Staff gave patients enough food and drink to meet their needs and improve their health.

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

Staff monitored patient outcomes and the effectiveness of care and treatment with set actions for improvements where necessary.

The service made sure staff were competent for their roles and maintained their skills through professional development, monitored through the appraisal process.

Staff worked well as a team. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

There was suitable provision of services to ensure care and treatment. Staff ensured delivery and achievement of the best outcomes for patients.

Health promotion information was available.

Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005.

Are services caring?

Good

We rated it as **Good** because:

Summary of this inspection

Staff treated patients with kindness and respect. We observed that all staff displayed a non-judgemental approach and supported patients to make their own informed decisions.

Staff strove to maintain patients' dignity.

Staff, particularly client care co-ordinators, received specific training in counselling skills to provide emotional support as part of the consultation. This service was offered through patients' appointments should patients become distressed at any time.

Pre- and post-abortion counselling was available to all patients via the BPAS 24-hour phone line.

Patients were kept involved in their care and treatment at all times. Staff answered questions and offered transparent information including the risks and benefits of treatment options.

Where appropriate, patients' partners or other support were kept involved in information about treatment.

Patients were given the option to take pregnancy remains following surgical terminations of pregnancy. Where patients chose to do this, advice and guidance was provided.

Are services responsive?

Requires improvement

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

Audit showed 35.6% of patients waited longer than two weeks from first contact to treatment which was outside of Required Standard Operating Procedures (RSOP) as specified by the Department of Health.

However, we also found:

The service was inclusive and took account of patients' individual needs and preferences. Patients could access information in alternative formats and languages. It was easy for people to give feedback and raise concerns about care received.

With the aid of a lift for all patients, ramps for wheelchair users and staff consideration, the service was accessible to patients regardless of mobility.

The service offered telephone and face to face appointments for initial consultations. These were checked in full prior to issuing treatment at the next face to face appointment.

Are services well-led?

Good

We rated it as **Good** because:

Although the service had robust reporting systems including a quality and safety dashboard, there was little evidence of

Summary of this inspection

improvements to local performance. Action plans were developed following each audit and managers had discussed staff errors and requested they complete reflective accounts. However, medicines management was marked as unachieved for five months out of 12.

The service had a local risk register which was updated with actions but did not include all identified concerns such as waiting times and audit results or actions around medicines management.

Although the service worked to find solutions, waiting times for appointments exceeded the RCOG guidance stating all women should be provided with treatment within 10 working days of first contact.

However:

Local leaders were visible and supportive. Managers integrated with staff and shared information and updates regularly.

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.

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

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 it as **good.**

Mandatory training

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

All staff had received immediate or advanced life support training as relevant to their role.

There was a comprehensive programme training available staff to access updates when required. Nurse practitioners underwent a comprehensive 12-week, induction programme, which covered all elements of mandatory training they required.

The service provided a structured induction and mandatory training programme for staff. Staff completed online and face-to-face mandatory training modules. Modules were set by BPAS head office.

Managers used an electronic training dashboard to monitor and manage staff training. At the time of our inspection, compliance for modules was 100% for infection control, safeguarding adults and safeguarding children level three, and advanced life support and immediate life support. Compliance rates for other modules were general data protection regulation (GDPR) 71% and moving and handling 82% against the BPAS target of 90%.

Staff we spoke with were positive about the training they received and felt that they received the appropriate training to carry out their role.

Staff were required to complete a local induction the first time they worked at a satellite centre to familiarise themselves with the workings and the local health and safety policies and procedures at the centre.

Safeguarding

Processes were in place to safeguard vulnerable adults and young people. Staff we spoke with were all aware of their responsibilities and had access to safeguarding policies for adults and children.

The BPAS area manager was the safeguarding lead. We reviewed the service's safeguarding children and safeguarding adults policy which were in date and available to all staff on the service intranet.

All staff, including administrators, were trained to level three in both adult and child safeguarding. In addition, staff had access to a range of BPAS policies relating to protecting patients from abuse and harm. Staff were aware of how to discuss or act upon specific types of potential abuse such as domestic violence, child sexual exploitation, female genital mutilation and modern slavery.

We saw safeguarding risk assessments for patients in the records we viewed. These enabled identification of vulnerable adults and any safeguarding concerns for adults or children. Staff told us, and we saw, they made safeguarding referrals to the local authority.

The staff at Doncaster had good links with the local safeguarding board and could contact their national designated safeguarding leads when needed.

It was an organisational policy that if a girl under 13 years old used the service then a safeguarding referral would automatically be made. For those aged up to 18 years, a safeguarding risk assessment was completed, and a decision made on the outcome of the assessment, following discussion with the designated safeguarding lead.

Staff knew who the safeguarding lead for the service was and where to seek advice.

Staff we spoke with were aware of different levels of questioning about sexual partners, consent, and information sharing regarding young people.

The organisation had policies and procedures for staff to follow if cases of female genital mutilation or sexual exploitation were discovered and staff were clear what actions they needed to take in this situation.

All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment. Patients could be accompanied by a partner, relative or friend for the subsequent part of the consultation if they chose.

Cleanliness, infection control and hygiene

The service controlled infection risks. We found all areas to be clean, but two trolleys had torn mattresses.

We inspected consultation rooms, a waiting room, utility rooms and store rooms and found them all to be visibly clean. We saw green 'I am clean' stickers being used to identify equipment that had been cleaned and ready for use.

We found a good level of cleanliness of furniture and most equipment. However, although an internal infection audit in December 2018 showed compliance of 97.2% overall, a torn cushion had been identified on a recovery trolley and an action to replace this was noted. During our inspection we found two trolley mattresses were torn. It was not clear if one of these was the same trolley mattress or additional to the one found in the December 2018 audit.

We found toilets were tidy and visibly clean. The service used IPC compliant recliner chairs that could be wiped down and we observed staff wiping equipment with disinfectant wipes after use throughout the centre and at the EMU.

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

The service achieved hand hygiene and personal protective equipment (PPE) audit results of 100% compliance throughout the reporting period of April 2018 to March 2019.

Staff conducted monthly IPC compliance audits as part of the compliance monitoring programme. Any actions were shared at team meetings.

All clinical areas we visited were visibly clean and free of clutter. There were sufficient hand washing sinks in clinical areas.

Throughout our inspection all staff were observed to be 'bare below' the elbows. There was easy access to personal protective equipment (PPE), such as aprons and gloves of different sizes. We witnessed staff using PPE effectively. We saw staff decontaminated their hands immediately before and after every episode of direct contact or care. This complied with guidance from the National Institute for Health and Care Excellence (NICE) QS61: infection prevention and control.

During our last inspection in 2015, we found the theatre area was cluttered with pieces of equipment and we found dust, hairs and miscellaneous bits of equipment present on the floors. We saw that a light box was cracked and damaged which made it difficult to clean.

At this unannounced inspection there were no issues with cleanliness in theatre areas and cleaning schedules and checklists showed regular checks were carried out.

Results of all audits were submitted formally and IPC was reported formally on a dashboard as a performance indicator. The Doncaster unit had a rating of green, which meant that IPC compliance was above 90%.

Staff undertook regular infection control audits with a target of 90%. Where issues were found, the auditor provided actions to be completed. These were shared with staff at team meetings and submitted as part of the compliance dashboard to BPAS management. However, we were not assured all actions arising from infection prevention and control (IPC) audits were followed up.

We observed staff cleaning all equipment appropriately between patients.

Infection prevention and control (IPC) was part of mandatory training and records for the time period between April 2018 and March 2019 showed a compliance rate of 100% for all staff.

Staff wore scrubs and washable shoes that were appropriate for the treatment room, and a supply was readily available.

At the last inspection we found doors to the treatment room were left open prior to and after procedures. Staff had been observed opening sterile theatre packs whilst doors were open. At this inspection doors were closed after the patient was brought to theatre and sterile packs were opened appropriately.

Medical devices were a mixture of single use and reusable items. Reusable items were sent off site for decontamination and sterilisation. Contaminated instruments were collected by an external company which also delivered the sterilised instrument sets. There was a formal system in place to track instrument sets that had been sent for processing.

Waste management was handled appropriately, with different colour coding for general and clinical waste. All clinical bins were seen to be foot operated with lids and were not overfilled. Waste management and removal, including those for contaminated and hazardous waste, was in line with national standards. Clinical waste was stored securely outside in locked bins in a secure external area at the back of the building and collected by an external company once a week.

Pregnancy remains following surgical ToP were individually and appropriately collected and stored. There was appropriate segregation and storage of pregnancy remains to enable sensitive disposal or retention if requested by a patient or for criminal investigation purposes. A record log detailed when remains had been stored and collected.

Following a recent complaint, BPAS staff had reviewed the containers used to store pregnancy remains for those patients who wished to organise their own disposal. New biodegradable containers had been supplied and in use to store pregnancy remains ready for collection.

Environment and equipment

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

BPAS Doncaster clinic had facilities which included a reception with a separate waiting area, seven consultation rooms, a treatment room and a dayroom including the recovery room. There were three recliner chairs for patients' recovery following ToP or vasectomy. There were three ward areas with eight beds for patients who may stay overnight when undergoing a late medical ToP. There were also changing rooms for patients and staff. Facilities for patients were all three floors with a lift and stairs. The early medical unit satellite clinic was located within a medical centre with a consulting room and treatment room leased from the GP practice.

The entrance to the service had secure entry with CCTV and a buzzer to let people in which was controlled by reception staff. The reception area where patients registered was separate to the main waiting area. Emergency call buttons were located throughout the centre with a telephone system as a backup when assistance was required.

There were always two staff rostered to work at the satellite clinic to ensure no staff worked alone. The medical centre provided a receptionist.

BPAS Doncaster had a backup generator which meant that there would be uninterrupted power to the centre to ensure equipment still worked in the event of a power cut.

All premises had fire safety assessments, signage and fire extinguishers located appropriately.

Resuscitation equipment and medications were checked regularly. Trolleys and emergency rucksacks were checked daily when clinics were running, and sealed drawers and packs were opened and checked weekly. We saw completed checklists to show checks were carried out. We checked various consumables and found that they were sealed and in date. Emergency drugs were fully checked following use and each time drugs expired. There was sticker on the trolley to indicate next expiry date, which would trigger a full check and replacement of drugs when needed. We also saw that there was a weekly check log for fridges and emergency equipment at the early medical unit satellite clinics. Staff knew how to report if fridge temperatures went out of range and which products could be used or required disposal.

A clinical incident occurred during our inspection and all emergency drugs and equipment needed were available directly. We observed staff had immediately restocked supplies and all equipment used was reset and cleaned ready for the next use.

We checked the major haemorrhage box and found everything to be in order.

We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as blood pressure monitors and ultrasound scanning machines and found they had been safety tested. Safety testing stickers were on all equipment with servicing dates.

Oxygen cylinders were stored securely and were in date. Sharps bins were correctly labelled and not filled above the maximum fill line.

Store cupboards were locked and secure. Evidence of stock rotation was in place and all stock we checked was in date and stored in an appropriate manner.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, staff did not complete early warning score charts for patients undergoing medical ToP or specific charts for children and young people.

Patients who were identified at initial consultation as not suitable for treatment or who had complex needs were referred to the provider's centralised clinical team for onward referral as appropriate. This team also carried out the pre-assessment process to ensure patients unable to be treated by BPAS were not booked into consultation appointments at the clinics.

All records we reviewed contained venous thromboembolism (VTE) risk assessments which staff completed prior to treatment. Audit of VTE risk assessments showed 100% compliance.

We observed staff using the BPAS modified World Health Organisation (WHO) and five steps to safer surgery checklists in the treatment room. This was embedded in practice and we saw in records we reviewed that staff consistently used this. Records we reviewed showed the correct use of the BPAS modified WHO and five steps to safer surgery checklist.

At our last inspection we observed varying levels of compliance with BPAS surgical safety policy. At this inspection we saw all staff were engaged with the process and the checklist was completed appropriately at each stage. We observed compliance by all team members during patient treatment. Audits carried out between April 2018 and March 2019 showed 100% compliance for the checklist completion.

Anaesthetic risk was assessed during the medical consultation part of the patient's pathway and any identified medical risks were addressed prior to attending for their procedure.

The anaesthetist reviewed any patients with a medical risk prior to theatre.

Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of modified early warning scores (MEWS). MEWS is a service-specific modified early warning system which allowed early recognition of and reaction to a patient's physical deterioration. We checked MEWS charts in records we reviewed and found them to be correctly filled in.

However, the service did not use a paediatric specific MEWS system. In the case of a young patient who developed sepsis, the nursing team had identified MEWS was not completed on admission with baseline scores not recorded. This was noted as part of a serious incident investigation. During our inspection we observed a serious investigation meeting where the team discussed this case. The multidisciplinary team planned to introduce the use of MEWS for all young people and children for any TOP procedure. Staff had completed sepsis skills exercises and planned to redesign the sepsis screening tool.

Anaesthetists were supported by nurses and operating department practitioners (ODP) who were trained in anaesthetics and recovery and there was always a dedicated trained nurse or ODP who supported the anaesthetist in the treatment room.

We viewed the deteriorating patient policy which was in date and available on the service's intranet. A major haemorrhage protocol was followed if a patient bled excessively and staff we spoke with were able to describe actions they would carry out which matched the protocol.

During our inspection we observed staff care for a deteriorating patient following the escalation processes. Medical and nursing staff acted quickly and managers supported the team to enable an emergency transfer by ambulance to hospital.

The service had a service level agreement with a local NHS trust for emergency transfers.

Staff had completed training in identifying and managing sepsis in 2017 and 2018. However, the team were completing training updates following an incidence of sepsis earlier in 2019. At the time of the inspection 71.4% of staff were booked onto update courses. New staff were booked to attend training courses. Warning signs which included symptoms of sepsis were printed in the aftercare booklet "My BPAS Guide" which was given to patients to take home from their first appointment. Patients were told to call the provider's 24-hour aftercare telephone line if they were concerned about any symptoms they had.

We observed staff from the multidisciplinary team checking records and discussing each case before the woman arrived in the treatment room.

There was always a qualified member of staff in the recovery room. Nurses completed observations of patients prior to discharge and more often for patients they had concerns about.

Staff informed women of what signs would indicate complications and staff gave clinic contact numbers and advice regarding obtaining emergency care if they should experience a sudden, heavy blood loss.

Patients who were booked for a late medical or surgical ToP attended a pre-assessment clinic which included assessment of the patient's full medical history, an ultrasound scan to confirm gestation and sexually transmitted infection screening. Patients had a blood test to determine their rhesus status and blood group. Patients with a rhesus negative blood group received an anti-D injection (immunoglobulin) to protect against complications in future pregnancies. We saw evidence of anti-D injections being administered to patients in records we reviewed.

Patients were screened for sexually transmitted infections as part of their treatment. If there was a positive result, the service called the patient and referred them to sexual health and counselling services in the community. If a patient was not contactable, a notification was sent to their general practitioner (GP) (if the patient had consented to this) to ensure that the information was communicated and treated.

The service treated all ToP patients with prophylactic antibiotics to reduce the risk of uterine infection.

All patients were scanned during a surgical procedure to ensure no products of conception remained. We observed staff scanning a patient during a surgical procedure to check this.

Nurse staffing

The service had enough nursing and support 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 adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Staffing rotas showed that there was a registered nurse or midwife on duty at all times when patients attended appointments at the centre.

The provider used safe staffing guidance, which ensured that safe and appropriate patient to staff ratios were maintained at all points of the patient's treatment pathway. At the time of our inspection there were three nursing staff vacancies.

The use of agency (temporary) staff was kept to a minimum. Due to the need for a specialised skill set, it was not possible to use agency staff for consultations and treatments. However, the service did use agency nurses or operating department practitioners (OPD) in the treatment room. All were known to the service and had completed local inductions. In the last 12 months, 112 shifts for registered nurses were covered by agency staff.

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.

BPAS Doncaster employed two surgeons. In addition, one surgeon and two anaesthetists worked under practising privileges. This meant that they had permission from BPAS

to work privately for this location. We checked one practising privileges folder and saw that relevant checks had been completed and were updated as required; such as annual appraisals and five-year revalidation documentation. To obtain practice privileges doctors had to provide evidence of GMC registration, indemnity insurance, qualifications and evidence of their annual appraisal from their substantive NHS post and revalidation.

We saw there was a process in place for ensuring information was checked and updated every two years and disclosure and barring checks were repeated every three years. We confirmed that doctors had met the above requirements and saw records that showed managers made checks every two years to ensure that Doctors remained eligible to practice at BPAS.

Doctors also had to be up to date with relevant training such as advanced life support for anaesthetists. All doctors had disclosure and barring checks and child protection training to level 3.

The unit manager arranged cover for doctors' leave. We saw the anaesthetist stayed on the premises until all patients were fully recovered from their anaesthetic or conscious sedation.

Out of hours cover was provided by the on-call doctor, who was an anaesthetist. We observed an emergency transfer and staff contacted the obstetrics and gynaecology registrar at the local NHS acute hospital. This was documented in a transfer agreement. Managers told us the following day the process had worked well.

Other BPAS employed remote doctors as part of the BPAS client administration system (CAS). CAS doctors provided medical advice, reviewed patient assessments, agreed treatment and electronically signed the HSA1 forms (legal forms which must be signed by two doctors who agree that a patient is suitable to undergo a termination of pregnancy as per The Abortion Act, 1967).

No locum doctor shifts were required between 1 April 2018 and 31 March 2019.

Records

Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, the service had identified areas where record keeping could be improved.

Records were a mixture of paper and electronic. Records included initial and on-going consultation information, documentation of patient care during the operative phase and anaesthetic records for surgical ToPs. We reviewed 12 sets of patient records and we saw that HSA1 forms (legal forms which must be signed by two doctors who agree that a patient is suitable to undergo a termination of pregnancy as per The Abortion Act, 1967) were present for every patient; with two signatures from doctors.

Patient records included speciality pathways and risk assessments for venous thromboembolism (VTE), sexual health and malnutrition.

We reviewed 12 sets of records across various pathways and found them to be contemporaneous, complete and legible. Records indicated good risk assessments and follow up of any medical concerns or issues identified were well documented and reviewed following appropriate interventions.

BPAS checklists and risk assessments had been completed appropriately. These included completed World Health Organisation (WHO) and five steps to safer surgery checklists, MEWS charts for patients having a late medical or surgical ToP and venous thromboembolism (VTE) risk assessments which staff completed prior to treatment.

However, as already noted, at the time of our inspection MEWS charts were not routinely completed for patients on admission. Staff recognised that in the case of a 15-year-old who had developed sepsis, a baseline MEWS would have identified early signs that could have been quickly acted upon. Nursing staff had begun to identify other areas where a MEWS chart should be used in future to help recognise signs of a patient's deteriorating condition.

Record keeping and documentation audits were carried out and compliance was consistently met BPAS targets of over 90%.

At our previous inspection in 2015 there had been some minor issues in a small number of records regarding legibility of signature of medical staff and no printing of name following signature for nursing and midwifery staff. At this inspection all signatures were present and names of staff were written legibly.

We saw staff checked electronic and paper records used before, during and after patient treatments. They included patients' previous medical history and HSA1 completions. We observed medical staff checked these prior to surgical ToP being carried out.

We also saw that records documented allergies, safeguarding information and proformas for patients under the age of 18. Records also documented that there had been discussion around disposal of pregnancy remains.

All records, which included patient-identifiable information, were stored securely and kept strictly confidential within the establishment and electronically.

Patient records were stored securely in locked cupboards behind the reception area. Electronic records could only be accessed by authorised staff members and were password protected.

Staff showed us the method for safe transport of records to and from the York clinic. Secure storage was available at the clinic. Staff were able to access BPAS electronic records via the computer at the satellite clinic.

At our previous inspection in 2015 we found documentation of discussion regarding respectful disposal of pregnancy remains was not routinely documented. At this inspection we saw records were consistently completed to show a discussion with patients had taken place about this sensitive issue.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. However, audit results showed the service failed to meet BPAS requirements for medicines management. The service had recorded two medication errors in 2019 and we found no evidence of actions taken or lessons learned to prevent a recurrence of either event.

Internal audit of medicines management was undertaken monthly and for six out of the last 12 months the results had failed to achieve BPAS requirements of 90% compliance. However, during our inspection we observed safe and competent administration of medications in all areas. Audits provided did not show specific scores regarding compliance. Action plans were developed following each audit. Managers discussed results with staff and prompted them to take actions.

Two medication errors had been reported in April 2019. One involved a patient receiving two doses of Anti D vaccine after the patient told staff they had not received it. A second dose was given and staff found the first dose had been documented but not checked. The other incident was an incorrect CAS prescription for the wrong dose and route for Misoprostol. The nurse had administered the correct medicine but had not checked the prescription before administration. Both were categorised as low harm, but documentation provided to us during the inspection did not show actions taken or lessons learned to prevent a recurrence of either event. However, staff later provided action plans that were developed following these errors and they showed each member of staff was required to complete a reflective account.

Medical staff at the service used an electronic prescribing system to prescribe medicines on site or remotely if required. The unit provided prescriptions for analgesia, antibiotics and contraceptives. A doctor prescribed all abortifacient medicines and nurses provided some non-abortifacient medicines under Patient Group Directions (PGDs). PGDs also covered pain-controlling medication, treatment of chlamydia and prophylactic antibiotics to prevent post procedure infection. The discharging nurse or midwife provided antibiotics and contraceptive medications and checked the women understood what the medications were for and the importance of taking them as prescribed.

We saw that intravenous fluids were appropriately stored and in date.

Medicines were kept in locked cupboard in the treatment rooms and access was by a key which was held by the nurse in charge for the shift. Medicines cupboards in the early medical satellite units were locked and a key was kept by the nurse who conducted the consultation.

The BPAS pharmacist provided pharmacy support and advice to the Doncaster clinic.

The area manager was the controlled drugs officer and for auditing of medicines and reporting to the local intelligence network.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001)). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of

the contents of the CD cupboard was completed fully and correctly. Two members of qualified staff checked the CD stock levels; the doctor or anaesthetist and a registered nurse. CD stock levels were accurate and the medicines were in date. The keys for the CD cupboard were held by the nurse in charge for the shift. Two qualified staff always signed for controlled drugs.

There had been a Home Office controlled drugs officer meeting at BPAS Doncaster in October 2018. BPAS staff reported the officer had been very satisfied with all aspects of their inspection and the evidence provided.

Checks for expired medicines were completed as well as logs for the daily maximum and minimum fridge temperatures for fridges used to store medicines. The fridge temperature logs that we checked at the main centre and at the York satellite clinic were all within acceptable range and we saw that these fridges were locked. Staff told us after our inspection that temperature probes were reset after each reading so maximum and minimum temperatures were recorded when premises were closed, and staff could take action if fridges and the medicines inside had been outside of the safe range.

Emergency medicines were noted to be within their expiry date and stored in tamper evident packaging.

Medicines were couriered to the satellite clinic and staff signed for all deliveries. We visited the York satellite clinic and we saw emergency medicines including adrenaline were received and stocked appropriately. We saw checklists to show medicines were checked weekly.

Medication records were completed correctly and completely and also showed that allergies were clearly documented in prescribing documents.

PGDs were in line with national guidance. Accountable officers were clearly named and they had signed PGDs correctly. All PGDs were within review date and staff undertook training and signed the record sheet when training was complete and they felt competent to administer and or supply the prescribed medications.

Medicines for EMA and medical termination of pregnancy were always prescribed by a doctor after a face-to-face consultation had taken place with a nurse which included consenting and completion of the HSA1 form (grounds for carrying out an abortion) form signed by two doctors.

The medicine, Misoprostol, which is used to induce abortions is not officially licenced for this purpose. However, it is widely used for this purpose as supported by the Royal College of Obstetricians and Gynaecologists (RCOG) and this is explained on patient consent forms.

The government legalised and approved the home-use of misoprostol in England from 1January 2019 for women that had not exceeded nine weeks and six days' gestation at the time mifepristone was taken. BPAS Doncaster medical staff prescribed misoprostol and nurses supplied this for home use in line with this approval and patient choice. We observed nursing staff giving detailed instructions to patients on how to take this medicine. They also referred to the "My BPAS Guide" which provided information and diagrams for patients, and the clinic and BPAS telephone numbers for further advice and information should patients need it.

Prior to 2019, patients opting for EMA were given the choice (depending upon gestation) of simultaneous treatment whereby they had both medicines required at the same time, or patients could choose to take the first tablet at the clinic and return for the second medicine 24 to 48 hours later. Simultaneous administration is associated with a slightly elevated risk of complications and side effects are more likely to occur. Although patients were offered both options and had the risks explained; we saw, at that time, some women had chosen to take both medicines on the same day.

In 2018 the Department of Health had approved home use of Misoprostol for EMA, so patients were able to take the second tablet home with them; thus avoiding the raised complications of simultaneous administration and providing more dignity to patients.

Current practice reflected the introduction of take home Misoprostol for EMA treatment. BPAS no longer offered a choice of simultaneous EMA, unless the client could not provide a residential address in Britain for use of Misoprostol at home, for example women from Northern Ireland or another country. This was reflected in the EMA guideline.

We observed a midwife practitioner providing the second dose of tablets to a patient for home use, checking they had sufficient information explaining the process using the

patient booklet. The patient was advised to call BPAS Doncaster clinic during opening hours or the 24-hour Aftercare line at any time if they had any questions of concerns.

Local anaesthetic for men undergoing vasectomy was prescribed and administered by the doctor carrying out the procedure.

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.

Incidents were reported and investigated, staff we spoke to were aware of their responsibilities in relation to incident reporting. Staff were able to tell us of incidents that had happened at BPAS Doncaster and subsequent learning actions.

The BPAS incident reporting policy required managers to review and sign off all incidents. Incidents were investigated by managers and lessons learned were shared by email and at monthly team meetings.

There were no never events reported in this period. Never events are serious incidents that are entirely 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.

The service used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they were encouraged to report incidents and could also request individual feedback within the incident reporting form.

In the last 12 months, there were 256 clinical incidents reported by BPAS Doncaster. Of these 142 were categorised as low harm, and 44 were moderate harm. One incident was reported as major (long term harm).

There were three serious incidents reported internally and to CQC between April 2018 and March 2019. A 72- hour review was undertaken for each serious incident and immediate actions and learning was sent by email to all staff by the treatment unit manager. Lessons learned from incidents were shared with staff and we saw records to show the duty of candour was applied.

Staff told us they received feedback from incidents via the central BPAS office. Medical staff and nursing staff were aware of recent incidents. The registered manager was responsible for reviewing all incidents and noting any required actions.

Incidents were reported regionally and nationally through the Regional Quality Assurance and Improvement Forum (RQuAIF) and clinical governance meetings and learning was shared through a process, which included the Doncaster representative sharing information locally. An executive summary was produced and every member of staff was expected to read this and sign to say they had done so.

We observed a serious incident requiring investigation (SIRI) meeting during our inspection where serious incidents had been thoroughly investigated and initial findings were discussed with staff. The BPAS incident lead led the meeting and we saw the full multidisciplinary team were present and engaged. Staff were encouraged to raise concerns and suggestions for improvements. Several staff put forward ideas to prevent similar incidents in future and these were received positively by managers and the team. Managers checked that appropriate actions were taken to reduce the risk of future incidents.

An example of learning from incidents included; early recognition of sepsis with training updates provided for staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour fully.

A serious incident occurred during our inspection and we noted staff who had been directly involved in the incident

had taken part in a debriefing session straight after the incident had been dealt with. Staff continued to work as a team for the remainder of the list and supported each other at the end of the shift.

The BPAS corporate office received Medicines and Healthcare products Regulatory Agency (MHRA) Alerts and Safety Notices and emailed these to the treatment unit manager for the attention of all clinical and nursing staff.

Safety Thermometer (or equivalent)

The service monitored harm free care.

Every patient scheduled to undergo surgery had a venous thromboembolism (VTE) assessment conducted on initial assessment and also on admission for surgery. Patients did not stay overnight at the clinic following surgery therefore were not re-assessed in the clinic.

Where patients were identified as being at risk, prophylactic medicine was given, usually in recovery.

BPAS produced a national quality report for 2018/ 2019 which was accessible to patients on the BPAS website. This provided national findings including the number of patients who were assessed for a VTE (100%). In addition this report showed no cases of c.difficile infection had been reported nationally, and no pressure ulcers grade two or over had been acquired by patients whilst in the care of a BPAS clinic.

Are termination of pregnancy services effective?

Good

We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff had access to up-to-date policies and procedures through the BPAS intranet.

Managers checked to make sure staff followed guidance and all policies we reviewed were up to date and accessible by staff on the provider's intranet.

We saw that the service adhered to best practice guidelines as stated in RCOG and Required Standard Operating Procedures (RSOP) as specified via the Department of Health. For example, the service had available information in booklet form on all types of contraception, to enable patients to choose the most suitable option for them. We observed staff offering contraception options post termination. Where a patient chose no option or a non-barrier method; advice was given on the use of condoms to prevent sexually transmitted infections (STIs) as per RSOP 13. All patients were given condoms to take home; including vasectomy patients.

We reviewed 12 patient records and found that patient needs had been assessed and all patients were assessed and treated for venous thromboembolism (VTE) in accordance with National Institute for Health and Care Excellence (NICE) guidance.

There was a process in place to ensure patients received appropriate cervical preparation in line with best practice guidelines. At the consultation stage, patients were asked a series of questions and their age and gestational period were taken into account to determine whether cervical preparation was needed. Women requiring cervical preparation attended the clinic early and received this prior to their procedure.

We reviewed a sample of the provider's policies such as the management of the deteriorating or septic client policy, data protection and confidentiality policy and the safeguarding adults policy. We found these were all reviewed and in date. BPAS policies made appropriate reference to national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE), Association of Anaesthetists of Great Britain and Ireland (AAGBI), Royal College of Obstetricians and Gynaecologists (RCOG) and the Department of Health Required Standard Operating Procedures (RSOP).

The service conducted audits as part of a compliance monitoring programme. Audits included medicines management, infection control and EMA audit. Key indicators such as training compliance rates, audit results and complaints were monitored on a dashboard. This was in line with the Department of Health Required Standard

Operating procedures (RSOP) 16 which recommends that all providers should have in place clearly locally agreed standards against which performance can be audited, on specific outcomes and processes.

Staff followed a nationally developed process for counselling women prior to termination of pregnancy and best practice, following RSOPs and RCOG clinical guidelines for medical abortions.

Uptake of long acting contraception measures taken by women following abortion was measured. Contraceptive options were discussed at the initial assessment stage and also discussed during the consent process. The service audited the documentation of contraception advice on discharge and noted some instances where this had not been discussed. However, the auditors found staff had discussed contraception options with patients at earlier stages of their treatment pathway. Staff were reminded to document discussions at discharge to ensure patients had a clear plan for contraception following their procedure.

We observed the consultation and discharge processes of two patients and saw both patients were given a My BPAS Guide" which included information on preparation, each type of procedure and aftercare. Staff members explained possible complications and directed patients to a 24-hour telephone line if they had any concerns. Discharge letters were sent to patients' general practitioners (GP) if they consented to this.

BPAS Doncaster offered non-scalpel vasectomies. These are recommended as an effective method due to the reduced risk of bleeding and intraoperative pain as compared to vasectomies using a scalpel (Faculty of Sexual & Reproductive Healthcare Clinical Effectiveness Unit).

Patient outcomes for vasectomy were measured and reported. We reviewed 4 sets of records which showed staff had given information to men requesting vasectomy. A BPAS booklet also outlined to patients what to do in the event of complications arising; including excessive bleeding. All patients had access to a 24 hour phone line which was staffed with nurses and midwifes which they could contact if they had any questions.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

There were appropriate processes in place to assess patients' nutrition and hydration needs and ensure they were met.

Patients were informed at their pre-assessment about fasting and fluids prior to receiving anaesthetic. They were told not to eat for six hours before their appointment and to drink clear fluids up to two hours before their appointment which was in line with Royal College of Anaesthetists Guidance.

Should patients not adhere to this; their procedure was either moved to later in the day where possible, or rearranged. We saw a complaint where a patient's procedure had been rearranged for this reason. Staff explained the reasons behind this in their response and how this should be done prior to their procedure.

If a patient had specific requirements, such as being diabetic, staff told us they would book them first on the operating list.

We observed staff asking patients when they last drank or ate at different stages of the treatment process including prior to surgery. We also observed the surgeon checking with the patient prior to surgery.

Staff made drinks for patients and provided snacks, water and hot drinks after surgery.

Patients who stayed overnight were offered snacks and advised on the type of food they could bring should they feel hungry during their procedure.

We noted a patient's companion had complained there was nothing available for them to eat and staff had acted on this by ensuring patients were aware there were no catering facilities at the clinic for companions.

Pain relief

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

Staff used standardised assessment tools to measure pain which was in line with Royal College of Obstetricians and

Gynaecologists (RCOG) guidance. Records we reviewed showed that pain assessments had been completed and pain scores were documented following surgical procedures.

Medical staff prescribed pre and post-procedural pain relief. Records we reviewed showed that pain relief such as non-steroidal anti-inflammatory medication was prescribed which was recommended in RCOG guidance.

Patients undergoing conscious sedation were also given a local anaesthetic to the cervix to help manage pain. Vasectomy patients received a local anaesthetic prior to their procedure.

Following treatment, patients were provided with codeine to manage pain; and we observed nurses giving advice regarding other pain relief such as using over the counter paracetamol to ease symptoms.

We observed staff checking with patients about their pain. We also saw that patients were offered a warming pad to help ease pain.

Patient outcomes

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

We saw that the service monitored specific outcomes as per RCOG guidelines. National complication rates were discussed at area level and national management meetings.

The treatment unit manager monitored performance and communicated to the regional management team and staff at the service.

The unit dashboard included results on performance for medicines management, staffing levels, clinical supervision, infection prevention, case note audits, serious incidents, safeguarding and complaints. The most recent risk management and clinical governance minutes showed most results were within the BPAS expected levels. However, data showed medicines management had not achieved the BPAS threshold for performance in seven out of 12 months and submission of HSA 4 forms to Department of Health was not achieved in ten out of 12 months. Action plans were developed following each audit. Managers discussed results with staff and prompted them to take actions.

The area manager compared local audit results with those of other BPAS locations to learn from them and learning was discussed regularly at staff and managers' meetings. Clinical audits for BPAS Doncaster showed results were consistently good with several results for surgical and medical ToP practice and documentation of 100% with the lowest being 97%, and all met BPAS national targets.

Between April 2018 and March 2019 BPAS Doncaster performed 2453 medical terminations. In the same period, the centre performed 1310 surgical ToP and 272 vasectomies.

Complication rates such as retained products of conception, on-going pregnancy, post procedure infection and transfer to a local NHS trust were monitored. Data submitted showed that between April 2018 and March 2019 there were eight patients (0.02%) transferred to another healthcare provider for further treatment.

BPAS Doncaster complication rates were similar to the BPAS national rates. However, the BPAS Doncaster vasectomy complication rate was 1.8%, higher than the national rate for which quarterly data ranged from 0.21% to 0.91%. There were eight minor complications including wound infection and haematomas and one instance of failed vasectomy.

Staff provided all vasectomy patients with information on post-vasectomy testing and patients were followed up at the centre where semen samples were sent for testing and successful outcomes were confirmed to men.

Managers did not monitor numbers of patients who did not proceed with treatment. Staff explained part of their counselling process ensured patients were able to change their mind at any time about their decision. Patients were advised of where they could access care if they were continuing the pregnancy.

Competent staff

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

BPAS had revised the nurse/midwife training programme to enable staff to complete competencies more efficiently.

Staff had yearly appraisals and at the time of inspection 100% of staff had completed their appraisals. Staff also had

regular one-to-one meetings with their managers which included observation of their practice. Managers shared results of these observation which enabled a review of competence and BPAS standards, any training needs and opportunities for development.

Staff we spoke with told us they received a comprehensive induction and were supported by their team lead. Nursing and midwifery staff were assessed on clinical competencies during their first twelve weeks in post. Temporary (agency) staff had a local induction process which included orientation.

Nursing staff were trained to perform ultrasound scans for dating purposes. This was a university accredited course which involved a theory course, clinical training with written assessments and summative assessments. Staff were then observed, supported and assessed by trained colleagues on site.

We saw a programme of auditing patient care and quality of treatments was monitored through direct observations of procedures through supervision of staff. This meant any concerns regarding staff competence could be raised quickly and addressed. Data from the service showed that staff had 100% compliance to care and treatment standards when observed.

Registered nurses and midwives had been trained to insert LARC implants.

Client care co-ordinators underwent specific BPAS training in counselling skills in order to provide in depth emotional support to patients during initial consultations.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and was the process nurses and midwives must follow every three years to maintain their registration. Managers and team leaders supported staff to monitor NMC revalidation.

The treatment unit manager checked medical staff were registered with the General Medical Council and completed the revalidation training. Medical re-validation was introduced in 2012 to ensure all doctors were up to date and 'fit to practice'. Managers showed us evidence doctors had received yearly appraisals and had followed up submission of documentation for these.

Anaesthetists were supported by nurses, midwives and operating department practitioners (ODPs) who were trained in anaesthetics and recovery and there was always a dedicated trained nurse who supported the anaesthetists in the treatment room.

The regional clinical education lead was responsible for overseeing medical staff in terms of competence. They explained their role and how the team used learning opportunities to improve practice and performance.

When skills gaps were identified or when staff wanted to develop in their role, staff were encouraged to access additional training. We saw healthcare assistants (HCA) had developed their role to support staff in the recovery area.

Multidisciplinary working

Staff of different job roles worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

We saw evidence of good multidisciplinary team (MDT) working within BPAS Doncaster. We saw staff attended a morning huddle where patients on the surgical list that day were discussed. The meeting was attended by nurses, doctors and the anaesthetist conducting the surgical list.

We observed throughout our inspection staff contributed to inclusive discussions about the patients and we saw there was respect for each member of the multidisciplinary team and the contribution they made. Staff listened to concerns and comments from colleagues at all levels. There were holistic discussions about patients' needs and communication was clear and inclusive. Staff communicated effectively to ensure patients were seen in a timely manner and transitioned safely between areas.

We observed multidisciplinary approaches to care planning for patients. During our inspection we observed healthcare assistants and the ODP preparing prior to a procedure and the anaesthetist and surgeon discussing medical details. Doctors spent time working together with the nurses and midwives to coordinate patient care.

We observed all staff listened and took action when the BPAS modified WHO and five steps to safer surgical

checklist was read out prior to a surgical procedure. Staff worked together to document medications given, additional equipment used and the swab count following the procedure.

We saw evidence of good working relationships between nurses, midwives and medical staff. All staff we spoke with said they felt comfortable approaching doctors for support or advice. Nurses, midwives and doctors could also contact each other by telephone if they needed to discuss a patient in detail. Staff told us that the medical staff were easy to contact and responded to requests for advice quickly.

There was evidence of effective multidisciplinary partnership working with external agencies and professionals such as the local authority for safeguarding referrals. Communication with the patient's GP only happened with patient consent.

Managers and specialists were available at the end of the phone if staff needed help or support with other issues such as safeguarding or infection prevention and control. Staff told us they found it easy to access any help needed and specialists and managers were responsive and supportive.

BPAS Doncaster had service level agreements with a neighbouring NHS trust, which allowed them to transfer a patient to the hospital in case of medical or surgical emergency. We were told and we observed this worked well when required.

Seven-day services

There was suitable provision of services to ensure care and treatment delivery and supporting achievement of the best outcomes for patients.

The BPAS Doncaster clinic was open from Monday to Thursday and included two late afternoon and evening sessions. This had increased from one late session per week to meet increased demand since our last inspection. There were no appointments offered routinely for weekends.

The York clinic offered consultations and EMA treatments three days a week. This had recently increased to meet demand from two days a week.

If women needed to use services on other days, they could be signposted to alternative BPAS clinics. Women who wanted or needed weekend services could use the BPAS clinic at Liverpool.

BPAS provided a 24 hours per day and seven days a week advice line, which specialised in post-abortion support and care. This was in line with Required Standard Operating Procedures set by the Department of Health. Callers to the BPAS Primecare service could speak to registered nurses or midwives who would give advice.

Vasectomy appointments were held one day a week at the BPAS Doncaster clinic.

Health promotion

Health promotion information was available. Staff promoted methods to prevent future unwanted pregnancies and sexually transmitted illnesses.

We saw a range of health promotion information displayed such as leaflets giving information and posters on contraception, sexually transmitted infections and services to support women who were victims of domestic abuse.

We observed staff discussing future contraception with patients during consultations and providing patients with leaflets on different types of contraception. Screening for sexually transmitted infections was also discussed during consultations and staff offered eligible patients the option to be tested for Chlamydia. Staff provided all patients with condoms upon discharge and advised them to use them.

Consent and Mental Capacity Act

Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

BPAS provided standard consent forms to be signed by patients following an informed decision about treatment and aftercare. Hard copies of consent forms were available in several different languages to enable informed consent for patients whose first language was not English. Although BPAS consent policy specified consent must be signed and

written, scope was given to where patients would be unable to sign for example, due to a disability. In these instances, verbal consent would be acceptable and recorded in patient notes.

Consent forms were incorporated into each clinical pathway. We saw staff discussed risks and complications and gave patients the opportunity to ask questions before they asked the patient to sign their consent. After initial consultations, and admissions, we saw other staff followed up and rechecked consent forms to ensure the patient was still wanting to proceed.

We observed staff obtaining consent and procedures being explained to patients. All patient records we reviewed demonstrated that consent was sought and clearly recorded in patients' notes. We observed staff gaining verbal consent before treatment and we observed patients providing written consent prior to their treatment. We saw that patients were asked again prior to surgery if termination of the pregnancy was their final decision. For patients whose first language was not English, a telephone interpreter could be used.

Staff we spoke with were aware of the requirements of consent and information sharing to safeguard young people and vulnerable adults. They knew what to do if a patient lacked capacity. Patients with learning disabilities were assessed on a case by case basis and referred to an NHS provider if the centre felt that this was more suitable to the patient's needs.

All medical and nursing staff we spoke with understood the Fraser and Gillick competencies which helps assess whether a child has the maturity to make informed decisions about treatment without consent of a parent. Staff were aware of situations where these principles would be applied. Medical and nursing staff were aware of the MCA and the implications for young people below the age of 16.

For the first part of the initial consultation, staff saw all patients alone to ensure that the choice to terminate the pregnancy was voluntary.

Are termination of pregnancy services caring?

Good

We rated it as **good.**

Compassionate care

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

We spoke with four patients and two companions and observed consultations. We saw that staff were respectful and compassionate with patients. Patients and a relative we spoke with commented on the professionalism and non-judgemental manner of the staff "from the person who answered the phone and the receptionist onwards" were kind and supportive. One person commented that "everyone has been so kind and understanding. They did not judge me and made me feel comfortable". A mother told us "staff were very kind and caring". "My daughter is very young and staff explained everything clearly".

Staff told us how they could provide additional explanations and answer questions particularly if patients were very anxious. We observed staff checking patients' understanding of processes and how they could access additional support including counselling should they want it.

Patients told us their privacy and dignity was respected. We saw staff ensuring patients were covered with a blanket before and after procedures and before being taken to the recovery room. Consultation rooms had signs on the doors to indicate when they were in use.

We observed clinical and non-clinical staff talking sensitively to patients. We observed nurses, midwives and doctors introducing themselves to patients and taking the time to explain to patients what would happen next. Staff introduced themselves and made patients aware of what their role was to help the patient feel comfortable and involved.

Patients could request that clinic staff made anonymous contact calls on their behalf if sexually transmitted infection test results were positive.

Good

Termination of pregnancy

All patients were given an opportunity to feedback on the care they received whilst at BPAS Doncaster via 'my opinion counts' forms. We saw patients were handed these after treatment and encouraged to complete them.

Emotional support

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

Staff described how they would support patients emotionally at all stages of treatment. We saw nurses and healthcare assistants supporting and reassuring patients prior to surgical ToP.

We observed nurses checking on patients in the waiting room and we saw that nurses spent time speaking to patients who were anxious. We saw nurses spending time with patients who were upset or distressed.

We saw staff throughout the multidisciplinary team talking to a patient who had suffered a surgical complication their procedure. The whole team spoke kindly and gave the patient and their companion information on her condition and what would happen next. Staff monitored the patient and accompanied them to the next stage in their treatment.

BPAS offered pre- and post-abortion counselling to all patients which was easily accessible. This was in line with the Required Operating Standards (RSOP; 14) as directed by the Department of Health. Patients could self-refer using a dedicated phone line.

All patients were offered the opportunity to speak to a counsellor during their first consultation and received information and contact details for a 24-hour helpline and a post abortion counselling service provided by BPAS trained counsellors. We observed counselling being discussed with patients during our inspection.

Patient records we reviewed showed that discussion around counselling had been recorded.

Understanding and involvement of patients and those close to them

Staff supported and involved patients to make decisions about their care and treatment.

We observed staff involved the patient at every step of the process. Patients told us they felt their partner, friend or family member was able to be involved in understanding the treatment and the process for the patient.

Staff provided impartial information and allowed patients make an informed choice about treatment, including the option to look at alternatives to abortion. Staff made more appointments for patients who wished to go home and consider their options before arriving at a final decision.

We observed nurses communicating in a way the patient could understand and giving explanations when patients asked. Patients we spoke with and those close to them told us they felt comfortable asking nurses questions and that questions they had asked were answered and explained fully. Patients also told us they received enough information regarding aftercare and contraception choices.

Records we reviewed documented that the disposal of pregnancy remains had been discussed during the consultation. We observed consultations and found that staff were thorough and followed guidance for the treatment pathway. Staff ensured that patients understood the discussion and gave opportunities for the patients to ask questions.

Patients told us staff had given them "My BPAS Guide" booklet to read or keep giving information and advice regarding their procedure and aftercare. They could refer to it if they had any questions, forgot any details or instructions. They had been told about the 24-hour advice telephone line and knew how to find the number from the booklet. A separate booklet was available for patients undergoing vasectomies.

Are termination of pregnancy services responsive?

Requires improvement

We rated it 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. The service worked with others in the wider system and local organisations to plan care.

Good

Termination of pregnancy

BPAS Doncaster provided termination of pregnancy services and vasectomy to NHS patients from Doncaster, York and the surrounding areas as per their contract with the local Clinical Commissioning Groups (CCGs).

The main service at Doncaster was open four days and two evenings a week on Monday and Wednesday. Surgical lists took place on all these days. The York early medical unit satellite clinic was available three days a week between Monday and Friday.

Patients could access the service via their GP or local health professionals, or could self-refer by ringing the BPAS contact centre which was accessible 24 hours, seven days per week.

Patients could visit the clinic of their choice; even if this was out of area. The service accepted patients from Ireland, Northern Ireland and Wales.

The booking system allowed for the patient to choose an appropriate BPAS service location and the team informed the caller of different treatment options available for termination of pregnancy dependent on gestation.

BPAS Doncaster staff planned operational and clinical service provision in advance. These plans included the services available each day and week, skill mix of staff to ensure patients received the right service at the right time and staff received the right support to provide care.

The clinics we visited during the inspection were in suitable premises and had appropriate facilities for the purpose of termination of pregnancy.

BPAS Doncaster received information from head office regarding dates protestors may be present outside the service. Staff received messages regarding dates of official protests. Staff told us they could advise patients how to approach the clinic if they wished to avoid protestors.

There was a service level agreement in place with the local NHS trust where patients could be transferred to in an emergency. Staff could obtain advice from medical staff at the trust with an interest and experience of ToP.

Pregnancy remains were stored appropriately and disposed of sensitively and complied with the Human Tissue Authority (HTA) Code of Practice (April 2017). Staff told us, and we saw records to show most pregnancy remains were collected by an external company for appropriate disposal according to the Code of Practice.

When the service needed to keep pregnancy remains, for example for DNA testing or criminal investigation, the policy stated that staff must use new equipment and a separate storage container. This was in line with HTA guidelines. In all cases, no pregnancy remains were kept for longer than six months. Options for pregnancy remains were discussed in consultations and we saw evidence of these discussions in records that we reviewed.

Following a recent complaint a new type of container was supplied for patients wishing to take their pregnancy remains home or deliver to a funeral director for sensitive disposal. The new containers ensured safe and sensitive packaging and transportation of pregnancy remains.

Staff worked with a range of local clinical commissioning groups and were aware some criteria varied between commissioners. Managers knew where to look if in doubt about a patient's eligibility.

Service level agreements were in place with local laboratories for screening and blood testing if needed. Staff carried out point of care blood testing for haemoglobin (iron levels) and rhesus status during consultations.

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.

Patients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment. If patients needed to use services on days when the main centre was closed, they could use alternative BPAS clinics in Yorkshire or further afield. Patients who wanted or needed weekend services could use the BPAS Merseyside clinic. If treatments were in two parts, staff worked to provide appointments at the BPAS Doncaster or York clinics to provide patients with flexibility.

BPAS Doncaster could fund travel for patients under 18 or vulnerable adults. If they could not offer the treatment the patient had chosen, staff helped them to decide where, when and how they could access the treatment they required. Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs, who did not meet usual acceptance criteria.

Patients were allowed to have relatives or friends accompany them in consultations after the safeguarding stage of the consultation had been completed. BPAS staff told us it was routine practice to give clients the option of their escort accompanying them into the treatment room for local anaesthetic and conscious sedation procedures.

Relatives, friends and partners were not allowed in the recovery rooms to maintain the privacy of patients. However, staff told us that very occasionally patients with complex needs or particularly vulnerable groups such as very young patients had used the service. When this happened, a friend or relative could accompany the patient to help ensure the patient fully understood the treatment. Depending on the wishes of the patient, the friend or advocate could stay with the patient throughout treatment and examinations, following their private consultation. Only female companions could stay with a patient in the ward or recovery areas unless there were special circumstances and by special agreement. This was to preserve the safety and dignity of other patients.

We saw some leaflets were provided in languages other than English. Any BPAS documents or leaflets could be printed in large print for patients with visual impairments and a braille version of the "My BPAS Guide" could be provided. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The BPAS Doncaster service met legislation requirements with the use of alternative ways to communicate with patients.

BPAS guidelines in place regarding the use of interpreters. Staff could source telephone interpreters. No face to face interpreters were used. Women would have to wait longer for an appointment including interpreter services. However, a woman could choose to wait for a later appointment with an interpreter if they wished.

Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the abortion. Staff also discussed contraception with men undergoing vasectomy and gave information about effective methods to be used until post-procedure tests were clear.

Staff told us they rarely treated patients with learning disabilities but they would be assessed on a case by case basis. Any patient could be offered the opportunity to visit the centre before their procedure or appointment.

BPAS Doncaster was located in an old-style residential property but could provide access for wheelchair users. However, there was a lift for access to the second and third floors and staff considered access for all patients as individuals.

Posters in the waiting room, the BPAS Guide and staff informed patients that they could request a chaperone.

Access and flow

Although the service had some difficulty meeting demand, people could mostly access the service when they needed it and received the right care. However, there were some long waiting times for appointments and delays experienced by patients waiting within clinics. Actions to address these were not always effective.

Patients were able to choose their own dates and times of appointment to suit their lifestyle and staff aimed to see patients as quickly as possible.

Staff at the telephone booking service carried out an initial consultation and offered patients a choice of dates, times and locations. This ensured patients were able to attend the most suitable appointment for their needs, subject to their gestation and clinical assessment.

When a decision to proceed was made staff at the contact centre made an appointment for the patient at one of the clinics for further consultation, assessment and treatment. This was often on a separate day but BPAS Doncaster could offer treatment later in the same day subject to a full medical assessment, legal procedures being carried out and appointment availability.

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Department of Health (DoH) state that patients should not have to wait more than two weeks between first making contact and having treatment. The service had difficulty meeting demand and had missed the Department of Health 10-day target from referral to treatment for ten months out of the last 12.

Between April 2018 and March 2019, 1353 patients waited longer than 10 days from their decision to proceed to

having a termination which equated to 36% of patients treated. The service told us this was, in part, due to patient choice such as clients preferring to wait for a local appointment rather than travel further, and BPAS Doncaster being the only unit in the north of England providing late gestation surgical and medical termination of pregnancy.

Waiting times were monitored weekly by a central team. The service was able to adjust lists and add additional appointments to meet demand. The service also expedited patients who were nearing the legal limit or who were under the age of 18. Quarterly data showed the average wait from initial contact to consultation ranged between 7.7 days and 9.6 days. This exceeded the Department of Health RSOP 11: Access to Timely Abortion which states that patients should be offered an appointment within five working days of referral or two weeks from referral to treatment. Data for the same period showed the average wait from consultation to treatment ranged between 3.9 and 5.2 days. This was in line with the second part of the standard which states patients should be offered the termination of pregnancy treatment within five working days of the decision to proceed.

The service also received a weekly report corporately with the current waiting times and current number of patients awaiting appointments. Data provided to us showed that for the month of May 2019 the longest wait for the first available appointment for most treatments was sixteen days and the wait for a Surgical ToP with dilatation and evacuation after a telephone consultation only was 37 days. However, there were many different options available with shorter waiting times. Staff told us the BPAS telephone consultation team were aware if a patient could not be offered a treatment slot within seven days they would inform the treatment unit manager who would aim to accommodate them through a normal appointment. If this was unsuccessful the patient would be referred to the national Accelerated Booking Team to find an alternative appointment at another BPAS clinic. Staff said that, by following this process, it meant a patient would not have to wait 37 days for their appointment.

The report showed that the waiting time for an EMA at the York Clinic with Misoprostol tablets at take home was 29 days. Staff told us this was due to staff at the centre block booking these appointments for women from York as directed by their commissioner. The report was unable to demonstrate how long women in York waited for an appointment for an EMA. However, staff could offer a patient that treatment at the Doncaster clinic on the same day if they wished to go there instead.

The BPAS quality report stated this was an issue in 2017/18 and that “actions taken across BPAS had resulted in some improvement. However, much of this improvement has been counteracted by increased caseload and clients opting to wait longer than guidelines for a ‘consultation and same day treatment’ appointment”. The report also showed clients not seen within 30 minutes of their appointment time was 17% and this had remained consistent with previous years.

BPAS had introduced a Capacity manager role April 2017 to nationally address waiting times.

Staff told us of local actions being taken to reduce waiting times for termination of pregnancy which included additional sessions and surgical lists. Between April 18 and March 19 BPAS Doncaster offered an additional 63 conscious sedation appointments by running extended surgical lists and 72 additional general anaesthetic appointments plus 728 additional EMA appointments. Managers told us additional staff had been recruited to ensure consistent staffing levels.

adding additional clinic slots at the York location to undertake more consultations and EMA.

From April 2018 to March 2019; 338 patients did not attend for their appointment (2 for consultation and 336 for treatment) at the Doncaster clinic, and 112 patients did not attend in this time frame for York (108 for consultation and 4 for treatment).

Staff explained they could overbook clinics to help mitigate against breaching Department of Health recommendations. Staff said this worked in most cases because they did not attend (DNA) rate for treatments at the Doncaster clinic was quite high and unused slots could be filled. Patients were informed they may be able to have a stand-by appointment and to prepare as directed. The area manager told us they had only ever had to turn away one stand-by patient in all the time they had worked at the Doncaster clinic.

The percentage of women treated at less than 10 weeks gestation was also monitored; for the same reporting period of April 2018 and March 2019, 61.5% of women had been treated below 10 weeks at BPAS Doncaster and 99.8% at BPAS York. The total for both sites was 67%.

During our inspection we spoke with patients about waiting times for appointments. Generally, patients felt their wait time was acceptable.

Patients told us they were informed of waiting times in clinic and any delays on arrival at the centre. We observed staff sensitively informing patients in the waiting area there would be a delay.

Patients attended a consultation appointment following their initial telephone booking. Staff told us they allowed additional time for patients under the age of 18 years to ensure they understood all the information they were given and to carry out thorough safeguarding checks.

Appointments involved confirmation of pregnancy gestation by ultrasound scan, observations and point of care testing for rhesus status, sexually transmitted infection screening, discussion of treatment and consent, booking an appointment for treatment, administration of medication and discussion and, or administration of contraception.

We observed consultations which were not rushed and saw that staff were able to spend enough time with each patient to meet their individual needs.

Staff told us appointments were carefully scheduled for the York early medical unit satellite clinic when only one nurse would be working at a time.

Staff told us they referred patients to the early pregnancy assessment unit team at the local NHS hospital if clinicians suspected an ectopic pregnancy. BPAS also had a national accelerated booking team which received referrals from units where they needed assistance finding a treatment before the client reached the legal abortion limit. There was also a specialist placement team who placed clients in NHS appointments that have been deemed unsuitable for treatment at BPAS.

Staff told us the decision to proceed with a termination was entirely the choice of the patient. If nurses found that patients appeared to be uncertain about their decision, the patient was advised to take time to consider their options before rearranging an appointment.

Learning from complaints and concerns

It was easy for patients 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.

There was a complaints policy with clear responsibilities for all staff and managers. The treatment unit manager recorded and investigated all complaints arising from patients at their clinics and complaints were discussed at central governance committee meetings. Managers forwarded written complaints to the head of quality and customer services. Staff monitored progress through the complaints action plans on a monthly basis.

The BPAS website gave information on how to provide feedback or make a complaint.

There were posters in the waiting rooms and at the satellite clinic informing patients of how to make a complaint. Patients told us they felt comfortable speaking directly with staff if they wanted to complain and knew how to make a complaint. Nurses, midwives, the treatment unit manager and administrative staff told us they tried to address concerns as they arose.

From April 2018 to March 2019 the service received 15 complaints and all patients were offered an apology. All complaints received were responded to within timescales set by BPAS. All informal complaints had been resolved and the BPAS team had given patients advice on making a formal complaint. Most concerns were about operational issues such as appointment availability and delays in clinics, but three complaints were about the attitude of a doctor and lack of communication with the patient. The log provided to us at inspection showed there was no action taken following these three complaints. However, following our inspection, staff told us there were only two formal complaints during the reporting period. Staff said the treatment unit manager completed a report on all formal complaints. This report would include lessons learnt and actions taken. One action required the surgeon to introduce themselves to patients had been achieved. Staff said the second complaint did not require an action.

Feedback and learning from complaints were shared at team meetings. All complaints were investigated with outcomes and lessons learned documented. However, we saw only one example of actions taken in response to a complaint. This was from an external service regarding the

way foetal remains were packaged when a patient wished to make their own arrangements for sensitive disposal. Managers had organised for containers to be provided for this purpose.

Any trends and lessons learned from complaints throughout BPAS were discussed at team meetings and management meetings. We saw evidence of discussion of complaints within the minutes of these meetings.

Are termination of pregnancy services well-led?

Good

We rated it as **good.**

Leadership

Leaders understood 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 displayed the certificate of approval to undertake termination of pregnancies as issued by the Department of Health.

Leaders supported staff to develop their skills and take on more senior roles.

Two senior managers at BPAS Doncaster had been appointed to seconded posts in 2019.The previous treatment unit manager had been seconded to a new area manager post and the previous clinical lead was seconded to treatment unit manager. The area manager was overseen by the director of operations and associate director of operations.

The area manager understood issues, challenges and priorities in the service. However, at the time of our inspection the seconded treatment unit manager had not settled into their post or taken over fully all responsibilities and the area manager continued to provide support.

A nurse manager supported the treatment unit manager. They managed nurses and health care assistants, and an admin co-ordinator who oversaw administrative staff and client care co-ordinators.

Staff told us managers were approachable and available and integrated within the units. They worked directly with patients and supported with general duties as well as managerial work. On the day we inspected the York clinic an administrator was off work and the treatment unit manager had planned to work form the York site to provide consultations and to ensure the nurse had support.

The treatment unit manager and area manager took ownership of the service and told us staff at all levels were able to suggest changes and improvements for the service.

All staff saw quality of care and patient experience as the responsibility of all staff. Local staff and senior managers held the area manager in high regard. They reported the local leadership was supportive and the clinical lead and senior nurse were effective in their roles.

BPAS Doncaster was set up as a cluster with one satellite clinic. The area manager was the registered manager.

The assistant director of nursing acted as professional lead for nursing in addition to other roles, which included the safeguarding lead and director for infection prevention and control.

Staff at the early medical unit satellite clinic rotated from the main BPAS Doncaster clinic and were managed by the senior nurse who provided day-to-day supervision and support. Staff also had access to both the area manager and treatment unit manager for additional support. The area manager was supported by, and reported to the BPAS regional manager.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

Strategic plans were developed and implemented in line with BPAS national strategy. Staff hoped to see a reduction in the number of appointments required following introduction of simultaneous medical abortion treatment and more recently, home administration of misoprostol. There had been an expansion of the service provided at York but the clinics were still unable to fully meet demand for appointments.

Good

Termination of pregnancy

The mission statement for the service was to provide safe and effective care for termination of pregnancy and these values were made clear to all new staff through the induction process and training.

Values and behaviours of the organisation were displayed by all staff we met and spoke with. We saw staff enabled and supported patients to make informed decisions with no judgement. Patients were free to change their mind without repercussions. We saw all staff during the inspection strove to provide an excellent service based on best practice principles. I

BPAS as an organisation was involved in research and projects to develop the termination of pregnancy services. We saw this strategy was quickly integrated locally at this service to ensure patients received high quality and up to date care and treatment. This was also done in collaboration with relevant Clinical Commissioning Groups.

The area manager was knowledgeable about corporate strategy and understood how this affected local provision of services. There was a systematic approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Staff we spoke with were aware of future plans and changes to hopefully reduce waiting times for appointments.

It was important to the organisation and to local staff that all new staff could uphold the value of women's choice. Several staff were registered midwives and told us they enjoyed their work at BPAS because they could support women in their choices.

The area manager told us staff could influence and be involved in changes through team meetings. Staff confirmed they were made aware of any plans and changes to the service and were able to put forward suggestions for change.

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.

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were passionate about their work and spoke of good teamwork in a patient-centred environment.

Staff we spoke with at all levels were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.

There was strong team-working and a common focus on improving the quality and sustainability of care and patient experiences. We observed staff worked together to share responsibility and care for patients. This included managers who were happy to join in with the wider team to meet to needs of the patients.

The service provided opportunities for career development if staff wished to specialise or take on a lead role. The leadership development strategy with succession planning at a local level was evident and we saw staff were supported during development.

We observed good staff relationships at all levels. Medical staff were seen as members of the team and staff at all levels worked together and supported each other. We observed multidisciplinary teamworking and collaboration throughout the inspection. We attended the treatment room during our inspection and observed effective teamworking. We saw all staff showed respect for each member of the multidisciplinary team and the contribution they made.

Staff told us they felt able to raise concerns or ideas, felt listened to and discussed ideas for improvements with their managers and professional leads.

We found an open and honest culture and staff were knowledgeable about the duty of candour. Staff knew about the service's processes and procedures and could give examples of the learning that was shared from an incident.

All staff we spoke with, including administrative staff consistently told us they felt supported by their managers. Staff told us they were encouraged to develop and take part in additional training.

Governance

Good

Termination of pregnancy

Leaders operated effective governance processes throughout the service and with partner organisations. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, not all Department of Health and Royal college of obstetricians and gynaecologists regulations were met.

The Department of Health licence was displayed in the main centre and at the satellite sites.

The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 Form). We looked at eight patient records and found that all forms included two signatures and the reason for the termination. The BPAS client administration system (CAS) provided electronic HSA1 forms which, once reviewed and signed by remote BPAS CAS doctors, were printed out and held in paper patient records. Staff told us there were some rare occasions when the BPAS doctors on site would provide the signatures prior to treatment. No patients were treated without two signatures.

The service submitted HSA4 forms to the Chief Medical Officer electronically through the provider's patient record system as recommended by the Department of Health. Registered nurses administering the second stage of medical termination or the surgeon completing the surgical procedure were responsible for submitting the HSA4 form on the system which was then sent to the Department of Health within 14 days of the termination taking place. The TUM reviewed and checked form submissions on a weekly basis to ensure compliance. The audit of HSA4 form submission showed BPAS Doncaster had not achieved the 14 day submissions on ten out of 12 months during the reporting period. Following our inspection staff told us the treatment unit manager carried out actions each month to try and avoid an 'unachieved' result by constantly reminding surgeons of their responsibility to access the DoH system and authorise within 14 days. The unit had produced posters to put up in areas of the unit to use as reminders as well as emails to doctors to remind them mid-month.

There was a clear governance system for the organisation and senior staff explained to us how information was shared up to board level and trustees through the clinical governance committee, and down to staff at the centre. The clinical governance committee reviewed complications, and patient feedback. They reviewed and ratified policies and received annual reports such as the infection prevention and control annual report. The clinical advisory committee was led by the medical director. There were Regional Quality Assurance and Improvement Forum (RQuAIF) groups which monitored incidents and patient safety.

Managers and staff told us they felt involved in the wider governance of the organisation and that their input was valued.

The area manager reviewed all service level agreements with third parties. The area manager was aware of the need to submit statutory notifications for example changes in management and serious incidents.

Managing risks, issues and performance

Leaders and teams used systems to monitor performance and identified actions to reduce their impact. There were plans to cope with unexpected events. However, required standards had not been met for medicines management performance or submission of Department of Health HSA4 forms. Not all performance risks were recorded on the service risk register.

Local team meetings were held to share information. Staff from the York clinic also worked at BPAS Doncaster as their main role so were included in meetings. Minutes were taken for staff unable to attend. Managers discussed performance and risk within these meetings; for example, complication rates following treatment, themes identified within incidents and risks to individual services such as staff sickness.

The treatment unit manager was responsible for completing a monthly dashboard which monitored quality and safety on an ongoing basis. Measures included medicines management, safer staffing, clinical supervision, infection prevention, appraisal rates, record keeping audits, patient group direction (PGD) compliance, treatment audits and HSA4 completion audits.

We saw results of this dashboard for BPAS Doncaster from April 2018 to March 2019. We saw that overall, most measures were met. However, there were some areas where targets had not been achieved. For example, for five

out of 12 months BPAS Doncaster failed to meet the requirements for medicines management. However, the York clinic had achieved the medicines management audit for 11 months out of 12.

The dashboard showed BPAS Doncaster did not achieve the required standard for submitting HSA4 forms to the Department of Health for ten months out of 12. The target related to the submission of HSA4 forms within 14 days as per the legal requirement set by the Department of Health (DH). Doctors who performed the surgical termination of pregnancy or prescribed the medical abortion medicine were legally responsible for submitting this form via an online portal. On occasions, such as during annual leave or a period of sickness, this submission was delayed. Actions were taken to discuss this with the medical team. However, staff believed that in the most part submissions were provided on time and they believed most delays were due to submissions not being acknowledged by the DH system.

We viewed minutes of treatment unit managers' meetings and saw that topics that were discussed included incidents across BPAS clinics, informal and formal complaints, safeguarding cases and learning and action taken from these. Staff shared learning that had occurred from incidents and complaints at their location in order to share learning with other BPAS clinics.

The regional manager chaired area managers meetings which were attended by the senior managers and team leaders. Meetings included comprehensive discussion of incidents, safeguarding concerns, audits, risk register with action plans and names allocated to the actions with deadlines. The group monitored performance and local compliance against an integrated quality dashboard which was then monitored on a corporate level.

We viewed BPAS Doncaster's risk register which documented seven current risks. The register showed control measures, risk levels and review dates. We saw plans and actions the service had put in place to mitigate the current top risks and to cope with unexpected events. Risks included secondment of the new treatment unit manager and support arrangements for them. There was a shortage of trained perioperative practitioners. One vacancy had been advertised and a member of the team had begun training to move into this role. In the meantime, the service was using a member of agency staff who had previously covered several shifts via the agency at BPAS Doncaster in this role. They were fully oriented to the unit and members of the team.

There were no local risks identified regarding appointment waiting times and staff we spoke with were aware there was currently no capacity for these to be changed. However, waiting times were detailed on the national risk register which were managed with a national and area focus. Managers told us they organised additional sessions and surgical lists. Between April 18 and March 19 BPAS Doncaster had offered an additional 63 conscious sedation appointments by running extended surgical lists, an 72 additional general anaesthetic appointments, plus 728 additional EMA appointments.

Staff told us how they implemented ideas locally such as overbooking late medical ToP sessions with a standby patient. However, these were not formal measures and did not significantly reduce waiting times to meet Royal College of Obstetricians and Gynaecologists (RCOG) requirements.

Staff had not recorded missed performance targets for medicines management as a risk. It was not clear how staff or managers expected this to improve.

Clinical staff met every morning to discuss individual cases and identify potential risks.

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.

The service used paper and electronic patient records. Paper records were kept securely when not in use. When in use they were accompanied by a member of staff to ensure data protection. Electronic records were available to authorised staff via a secure, password protected system.

Staff had recently improved the process for transportation of patient records to the York clinic and had procured a lockable metal carrying box. We saw this in use during our inspection. No records were left at the York site before or after clinics.

Staff had access to information such as policies, procedures and updates both electronically and in paper form.

During our inspection we observed the surgeon and anaesthetist reviewed the reason for termination prior to signing HSA1 forms. We also saw that the reason for the termination of pregnancy was provided on all HSA1 forms. This was in line with the Department of Health Required Standing Operating Procedures (RSOP) which required the provider to ensure that the completion of legal paperwork (HSA1 and HSA4) met the requirements of the Abortion Act 1967. The service used an on line secure portal to submit DH forms.

General data protection regulation (GDPR) training compliance was 71%. Managers told us staff completed regular updates and courses were booked for staff to attend.

Staff had a good understanding of performance for BPAS Doncaster. Information was available to managers and staff on quality, operations and finances. This enabled managers to plan ahead.

Staff discussed quality and performance measures in managers' meetings. Staff told us they had access to information but it was not clear if staff could or would challenge or question information provided to them. We did not see any reference to sustainability of the service in local team meeting minutes.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations effectively.

BPAS produced a yearly quality report where clinics and satellite units were reported on and cited in the report. This was published on the BPAS website and was accessible to the general public. Information contained figures on patient satisfaction, complication rates, harm free care results, results from complaints, and overall changes made to the care and treatment given to patients based upon all of the above.

Patients' views and experiences were gathered and acted upon to shape and improve the service. Patients were encouraged to share their views on the quality of the service and their experience through paper 'my opinion counts' feedback forms. We reviewed some completed forms and found patients were very positive about the way staff engaged with them.

Overall satisfaction scores for BPAS Doncaster clinic ranged from 9.56 to 9.65 out of 10 and scores for the York clinic ranged from 9.83 to 9.87 out of 10.

Any feedback that required immediate attention would be investigated by the clinic managers and discussed at staff meetings and governance meetings. Although it was recognised it could be difficult for this type of service, staff did not engage with local patient groups or associations to gather views of local men and women who may use the service.

BPAS Doncaster had taken part in an electronic feedback pilot and were waiting to see if BPAS would use this method in future.

BPAS had a robust complaints policy and openly advertised to patients, through the website, patient booklets and notices in clinics, how they could make a complaint.

Staff told us they felt well informed and part of a team. Staff said they felt involved in the development of the centre as they had regular meetings where feedback and learning were shared.

The BPAS quality report showed the latest staff survey had identified some areas for improvement including communication within the organisation and staff wellbeing. As a result, BPAS had introduced more regular bulletins to staff including a 'Feel Good Friday' newsletter, unit visits from directors and regular question and answer sessions hosted by members of the executive leadership team. They had launched a package of improvements around mental health and wellbeing including training for line managers and mental health first aiders.

Staff told us they found team meetings useful and that they were a good opportunity to voice any concerns they had.

Good

Termination of pregnancy

Nursing and medical staff who worked at the York satellite clinic also worked for part of the week at the main BPAS Doncaster clinic so were part of the integrated team. Staff commented that communication between staff and management was good and managers engaged with them to create an inclusive atmosphere.

Staff at the York satellite clinic told us they could always pick up the phone to the managers at the Doncaster site if they needed any support or advice. However, all staff were integral to the main BPAS Doncaster team and staff told us they did not feel there was any lack of support when working at the York clinic.

The service worked with local agencies to support patients with specific needs. For example, staff attended safeguarding children boards to share relevant information regarding their patients. The service attended meetings with the relevant Clinical Commissioning Groups to discuss performance and how to develop the service.

Learning, continuous improvement and innovation

Managers were committed to continually learning and improving services and were involved with improving patient care and promoting more effective treatment and aftercare.

Managers told us they were openly encouraged to make suggestions for change. Individual and team skills and knowledge were used to drive learning from other organisations and to organise collaborative work with other BPAS clinics.

Managers encouraged staff to attend training or complete additional modules to help with personal and professional development. HCA's had completed additional training to enable them to support in the recovery areas.

We observed staff discussing a serious incident at a team meeting and all members of the team posed ideas to enable staff to recognise a deteriorating patient quickly, to improve the service and provide a better service for patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The service must continue to ensure waiting times for patients are reduced, in-line with Royal College of Obstetricians and Gynaecologists (RCOG) standards and Required Standard Operating Procedures (RSOP 11).

The service must monitor reasons for any delays from first consultation to treatment to ensure delays do not impact upon patient outcomes.

The service must ensure all equipment meets infection and prevention control requirements at all times.

The service must introduce a specific paediatric early warning score for use with appropriate children undergoing surgical terminations of pregnancy.

The service must ensure all risks to performance measures are recorded and acted upon.

The service must ensure all HSA4 forms are submitted to Department of Health within 14 days of a procedure, in-line with Required Standard Operating Procedures (RSOP).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Family planning services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for patients. There was ineffective management of waiting lists, which meant that patients were not always provided with treatment within 10 working days in accordance with RCOG guidance and Required Standard Operating Procedures (RSOP). Not all equipment met infection and prevention control requirements at all times. This meant that patients could be put at risk of infection when undergoing surgical termination of pregnancy. There was no specific paediatric early warning score for use with appropriate children undergoing surgical terminations of pregnancy. This meant patients as young as 13 received care appropriate for adults. Not all risks to performance measures were recorded and acted upon. Not all HSA4 forms were submitted to Department of Health within 14 days of a procedure, This did not meet Required Standard Operating Procedures (RSOP).