

BPAS - Finsbury Park







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive?		Good	
Are services well-led?		Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

BPAS - Finsbury Park is operated by British Pregnancy Advisory Service. The service has no inpatient facilities.

BPAS Finsbury Park provides consultation and early medical abortion (EMA) and medical abortion treatments up to a gestation of 10 weeks and surgical procedures under local anaesthetic and conscious sedation up to 14 weeks gestation. EMA treatment is offered to patients at the time of their initial consultation from Monday to Friday and surgical procedures on Saturdays. Pre- and post-treatment counselling is available Monday to Friday.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection visit to the service on 8 November 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this service was termination or pregnancy.

Services we rate

This is the first time we rated this service and we rated it as **Good** overall.

We found good practice in relation to termination of pregnancy:

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment.
- The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff monitored the effectiveness of care and treatment.
- Managers appraised staff's work performance and provided support and development.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs.
- It was easy for people to give feedback and raise concerns about care received.
- Patients could access the service when they needed it and received the right care promptly.
- Leaders had the skills and abilities to run the service. Leaders and staff actively and openly engaged with patients and staff to plan and manage services.
- Staff were focused on the needs of patients receiving care.
- Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions and improvements.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Termination of pregnancy

Rating

Good



Summary of each main service

BPAS Finsbury Park is operated by British Pregnancy Advisory Service (BPAS). It comprises one main location in Finsbury Park, London.

The service provides termination of pregnancy as a single speciality service.

We rated this service as good overall as it was good for safe, effective, caring, responsive and well led.

Summary of findings

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Good 

Location name here

Services we looked at

Termination of pregnancy;

Summary of this inspection

Background to BPAS - Finsbury Park

BPAS Finsbury Park provides support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. The main activity is termination of pregnancy. The service is registered for the following regulated activities:

- Diagnostic and screening procedures
- Family planning services
- Treatment of disease
- Disorder and/or injury
- Termination of pregnancy
- Surgical procedures

The service provided the following services:

- Pregnancy testing
- Unplanned pregnancy counselling/consultation
- Medical termination of pregnancy

- Surgical termination of pregnancy under local Anaesthetic or conscious sedation
- Termination of pregnancy aftercare
- Miscarriage management
- Sexually transmitted infection testing and treatment
- Contraceptive advice and supply

BPAS - Finsbury Park is operated by British Pregnancy Advisory Service. The service has been registered with CQC since 2010. The service primarily serves the communities of North London. It also accepts patient from outside this area. There are no satellite units attached to this location.

The service had a registered manager in post since 2013.

Our previous inspection of this service was carried out in April 2016. We did not rate this type of services at the time.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors with expertise in sexual and reproductive health, maternity, obstetrics and gynaecology. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about BPAS - Finsbury Park

The service has three screening rooms and one consulting room.

During the inspection we spoke with six staff including registered nurses, health care assistants, reception staff, and senior managers. We spoke with six patients and relatives. During our inspection, we reviewed 12 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been

inspected three times, and the most recent inspection took place in April 2016, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity undertaken by the provider from August 2018 to July 2019.

- The service carried out 1,670 early medical abortions including 620 early medical abortions where home use of Misoprostol was provided.
- The service provided 328 surgical termination of pregnancies; all under local anaesthesia.
- The service did not carry out any termination of pregnancy after 14 weeks gestation.

Summary of this inspection

- The service treated eight children aged between 13 and 15 years old.

The service employed nine registered nurses and midwives, 11 care assistants and administrative staff.

Track record on safety:

- No never events
- No serious injuries
- Four notifications of complication post termination of pregnancy

- One patient who was transferred from the service to another health care provider

No incidences of service acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of service acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of service acquired Clostridium difficile (C.diff)

No incidences of service acquired E-Coli

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated it as **Good** because:

We found the following areas of good practice:

- The service managed patient safety incidents well. Staff reported incidents and lessons learnt were shared.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment.
- The service followed best practice when prescribing, administering, recording and storing medicines.

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

- The guidance related to decontamination of flexible endoscopes was not followed as traceability records were not kept.

Good



Are services effective?

We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Key services were available seven days a week to support timely patient care.

Good



Are services caring?

We rated it as **Good** because:

Good



Summary of this inspection

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

Are services responsive?

We rated it as **Good** because:

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.
- People could access the service when they needed it and received the right care promptly. The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences.

Good



Are services well-led?

We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They used systems and processes to manage performance effectively.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- Staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff at all levels were clear about their roles and accountabilities.
- Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions and improvements.

Good








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	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Termination of pregnancy

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
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 staff and made sure everyone completed it.

The service had clearly set training requirements which defined individual staffing groups' needs and training frequency. There was a system to ensure leaders knew if staff had completed their training. Mandatory training matrix showed the staff overall compliance and listed the training staff were expected to complete.

Mandatory training included basic life support, infection control, fire safety, health and safety training, and information governance training amongst others. We noted that staff achieved good level of compliance with mandatory training (90% or above).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report adults abuse, however, they were not provided with children specific safeguarding training.

The manager was the designated member of staff responsible for acting upon adult or child safeguarding concerns locally and for coordinating any response action

within the unit. They were also tasked with escalating any concerns to the lead nurse for safeguarding or the provider's safeguarding lead group as necessary and liaising with other agencies.

Staff we spoke with had a good knowledge of safeguarding protocols and awareness of issues they should be concerned about when treating adults, children and young adults. They gave us appropriate examples where safeguarding protocols were initiated by members of staff. They were also aware of who to contact, should they need advice in relation to safeguarding.

The service had policies and procedures on safeguarding and management of patients aged under 18. These also included protection of vulnerable adults as well as incidents related to domestic abuse.

Staff undertook 'safeguarding vulnerable groups' training every two years, and an introduction to safeguarding was included in the induction training, which all staff attended.

The provider reported that 95% of staff who were involved in the care of patients aged under 18 were trained to safeguarding level 3 and that all have completed level 2 training. This was a bespoke package designed and delivered by the provider's designated safeguarding nurse and included: an overview of legislation factors and identifying risk, types of abuse, sexual exploitation, consent, gang activity, the Mental Capacity Act 2005, managing a disclosure, information sharing, making a referral, record keeping and case studies.

The safeguarding training included information on female genitals mutilation (FGM). It was mandatory for staff to report FGM to the police for all service users under 18 years old.

Termination of pregnancy

The service treated eight children aged between 13 and 15 years old (August 2018 to July 2019). The provider's policy required all pregnancies recorded for children under 14 years old to be reported to the provider's safeguarding leads. Staff were to undertake a safeguarding assessment for all under 18-year-olds and inform the local social work team.

The provider requested references from previous employers and told us that any breaks in employment were investigated. For professionals such as nurses and midwives, their professional registration was confirmed with the appropriate regulatory body. All staff underwent a Disclosure and Barring (DBS) checks.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

There were housekeeping staff responsible for cleaning all areas and we found all areas were maintained to a good standard of cleanliness. Patients and relatives told us they were satisfied with the level of cleanliness in the service. Areas we visited were tidy and uncluttered.

Monthly audits of infection control measures were undertaken. These looked at four areas: hand hygiene, use of personal protective equipment such as gloves or aprons, aseptic technique and use and disposal of sharps. They showed the service consistently performed well in all four areas.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had sufficient supplies of soap and paper towels. Personal protective equipment such as disposable gloves and aprons were readily available to staff. Staff followed the provider's infection prevention and control policy, they were bare below the elbow and we saw staff adhering to a good hand hygiene policy.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

National guidance recommends an audit trail of decontamination, for each patient, of transvaginal probes. The service had decontamination guidelines in place, that detailed a three step decontamination process, and protective sheaths were used over the transvaginal probe for every patient. An 'I am clean' sticker was then attached to the probe and staff ticked a box in individual patient's notes to indicate the process had taken place. However, this did not provide clear traceability records should a look-back investigation be required following a decontamination failure or suspected infection transmission. We raised these concerns with the provider at the time of inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Overall the areas we visited were in a good state of repair.

Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us they felt the equipment used by them was modern and well maintained.

Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The service had systems to ensure it was checked regularly, fully stocked, and ready for use.

There were security cameras at the front of the building and surrounding environment and visitors gained entry by using an intercom and buzzer system.

Assessing and responding to patient risk

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

All patients had a consultation and medical assessment before treatment, to make sure termination of pregnancy was legal and safe.

All patients who underwent surgical termination of pregnancy had venous thromboembolism (VTE) risk assessment completed to reduce the risk of occurrence.

The provider used a surgical safety checklist, modelled on the World Health Organisation (WHO) and five steps to safer

Termination of pregnancy

surgery checklist recommended version. It was adjusted to accommodate the specialist care environment. Specific instructions for staff on how to use the modified WHO checklist was included within the perioperative care policy. Compliance with the checklist was audited regularly within surgical units (peer audit) and by the clinical audit and effectiveness manager on a rotational basis. The manager was required to audit effective use of the surgical safety checklist and report their findings centrally as part of the clinical audit process.

The track and trigger system used by the provider to monitor deteriorating patients derived from the national early warning score and has been adjusted to reflect specific patients' needs in the termination of pregnancy service settings. It was used only by patients undergoing surgical procedure. Patients had blood pressure, pulse, respiratory rate, temperature and oxygen saturation recorded prior the conscious sedation procedure. The measurements were then repeated every 30 minutes or more frequent depending on the modified early warning score (MEWS) score. The escalation protocol considered response to potential sepsis infection and instructed staff how to act to prevent deterioration and provide medical support.

The booklet that provided information about post treatment care, recovery, and details on what to expect following treatment was given to every patient. Abnormal symptoms following treatment were listed, with information on what patients should do if they experienced these, including details of the provider's aftercare line which was accessible 24 hours, 7 days a week.

For conscious sedation procedures, a registered nurse who had completed conscious sedation training was present during the treatment in addition to the surgeon and two health care assistants.

All staff were required to complete a basic life support training annually. In addition, the lead midwife and staff present during surgical abortion completed immediate life support training at the same frequency.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep

patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed staffing levels and skill mix to ensure it responded to service and patients' needs.

The hospital developed a minimum clinical staffing levels policy and procedure which determined the required staffing levels for the service. The service employed nine registered nurses, and 11 care assistants and administrative staff. Staff told us they felt there were sufficient number of staff to provide the required care and treatment to patients. However, the staff survey undertaken in 2018 indicated over 30% of staff at the provider level did not feel there was always enough staff to allow them to do their job well.

Rotas were completed locally which meant managers had the oversight and authority to match skills sets to service users' needs.

The service had access to bank staff employed within the organisation if they required, they did not use temporary 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

Medical staff were employed on both a substantive basis and under practising privileges. Their recruitment was managed centrally by the provider. 'Practising privileges' is a term that is used in legislation and defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as: 'the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital'. Records of medical staff practicing privileges were held at the head office and the medical director had overall responsibility for the management of medical staff.

Medical staff also worked remotely to review patients' case notes and medical histories prior to signing the HSA1 forms and prescribing medications. A HSA1 form is used by practitioners to certify their opinion and grounds for termination of pregnancy.

Records

Termination of pregnancy

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

The service carried out a regular case note and record keeping audit which showed overall good compliance with the provider's standard.

Records were stored securely and were easily available to all staff providing care. Paper records were kept for three years. Following this period, they were archived for ten years in line with the records retention and disposal policy.

Clinical staff told us they had access to current medical records and test results to support them to care safely for patients.

The HSA1 form was completed before the termination of pregnancy, as required by the 1967 Abortion Act (amended 1990). The form provides an evidence that the termination of pregnancy is being performed legally, because the two doctors are of the opinion, in good faith, that the patient meets one of the grounds stipulated in the Act. The service completed monthly audit to ensure and evidence compliance with the requirement and to ensure an accurate completion.

The HSA4 form is the termination of pregnancy notification form, which needs to be submitted after the procedure to the Department of Health (DoH) within 14 days of the termination. Timely submission of these forms was one of the standards reviewed on the performance indicating dashboard for the service.

Information confirming that the service employs only 'fit and proper' staff in relation to each such person employed by the service was not accessible locally. It was held within a centralised provider's records management system and not readily available to the registered manager at the time of the inspection. We were able to verify these records as they were provided by the manager after the inspection.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time

We observed good medicines management. We found no expired stock during our checks and noted medicines were well organised. The service had system for monitoring medicine administration errors and used it effectively to identify learning and prevent potential future occurrences.

The provider used misoprostol as a 'to take out' (TTO) medicine for inducing an early medical abortion. It was prescribed on a patient specific direction (prescription) by a doctor and supplied by a registered nurse or midwife to the patient, according to the prescription. TTO packs of misoprostol were supplied by an external pharmacy service and the packaging was labelled with a relevant patient information leaflet. Patients were prescribed mifepristone and misoprostol. Mifepristone was taken at the clinic. Department of Health approved home use of misoprostol in England on 1 January 2019.

The manager of the service was responsible for controlled drugs (CD) at the location. The provider had a policy and procedures that defined the responsibilities of staff in relation to controlled drugs. CDs were stored and managed in line with the current practice.

The organisation had recently updated and amended their conscious sedation management policy (August 2019) to address problems identified at another location. The organisation removed permission of drawing up sedation medication in syringes in advance of use. Staff received communication and instructions related to the practice.

Patient group directives (PGD) were in place for a selection of drugs. PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. The service had designated staff who could prescribe and administer medicines using a PGD. PGD training was undertaken at the head office.

The resuscitation trolley was located at an easily accessible and well-ventilated area, away from radiators. The medicines contained within, consumables, and cylinders were in date.

Incidents

The service managed patient safety incidents well. Staff reported incidents and lessons learnt were shared with the whole team.

Termination of pregnancy

Patient safety incidents were monitored and reviewed by the clinical safety committee alongside patients' complaints and reported satisfaction level. Incident reporting culture was strong, and feedback was provided to staff that reported incidents. None of the staff we spoke with mentioned any concerns about patients' safety.

The process for reporting, investigating and learning from adverse events and near misses was covered in the 'client safety incidents policy'.

The service did not report any never events during the past 12 months prior to the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff we spoke with felt there was a learning culture and that they could raise issues without worrying about repercussions.

When things went wrong, staff apologised and gave patients information and suitable support. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the duty of candour process. Staff we spoke to, understood the duty of candour requirement and its implication to clinical practice.

In the 12 months prior to our inspection, the service reported there were no incidents which would lead to serious injuries. The service made four statutory notifications of complication post termination of pregnancy and of one patient who due to complications required a transfer from the service to another health care provider.

Safety thermometer

The service used monitoring results well to improve safety.

The service was not required to report under the NHS Safety Thermometer programme.

Staff completed a patient's venous thromboembolism (VTE) assessment for those patients who underwent termination of pregnancy under conscious sedation.

A local integrated governance dashboard was updated monthly. Collected information included data related to safety performance which could be shared with staff.

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. Managers checked to make sure staff followed guidance.

Care and treatment were delivered in line with the current legislation and nationally recognised evidence-based guidance. All policies were easily accessible for reference via the provider's intranet. Policies and guidelines were developed in line with professional bodies such as the Royal College of Obstetricians and Gynaecologists (RCOG), Department of Health Required Standard Operating Procedures (RSOP), Royal College of Anaesthetists, and the National Institute for Health and Care Excellence (NICE) guidelines.

Practice compliance with relevant clinical guidance was monitored through regular audits and reported through the provider's regional and national clinical governance structures. Audits were conducted by designated staff to assess the quality of care, compliance with policies and procedures, and monitor standards. This included clinical procedural audit, infection control audit, essential steps and monthly environmental audits. Audit outcomes and service reviews were reported to governance committees such as infection control and quality and risk committees (QRC). The manager attended meetings with their area manager where audit outcomes were discussed. The manager was required to complete action plans for areas of non-compliance which were reviewed by the provider's clinical department and QRC. Other audits that monitored various aspects of the service were: surgical safety checklist

Termination of pregnancy

audit, safeguarding audit monitoring adherence to policy, outcome audit of two different regimens for early medical abortion (EMA) treatment. Each termination of pregnancy conducted in the service was notified to the Department of Health (HSA4).

Several aspects of care and treatment were reported to external organisations such as the Health Protection Agency (HPA) (C. Diff and MRSA rates). These included: Serious Hazards of Transfusion (SHOT; where transfusion has occurred); Medicines and Healthcare products Regulatory Agency (MHRA; adverse drug events and equipment failures) amongst others.

The service developed a procedure and policy related to women's wishes regarding the disposal of pregnancy remains. It was guided by the Human Tissue Authority guidance on 'the disposal of pregnancy remains following pregnancy loss or termination'. The document also referenced Royal College of Nursing guidance and The Scottish Government guidance. Where a patient did not have specific wishes regarding the disposal, pregnancy remains were collected by an authorised carrier for incineration. An audit trail was maintained at the service.

The provider was involved in providing advice and guidance to the Human Tissue Authority on development of the guidance on the disposal of pregnancy remains following pregnancy loss or termination. They were also part of the team involved in updating the Royal College of Nursing's guidance document.

In line with the RCOG and RSOP guidance women were offered testing for sexually transmitted infections and various methods of contraception, including long acting reversible contraception (LARC).

All patients were offered counselling services throughout their treatment journey and this was in line with RSOP recommendations.

Pain relief

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

Staff assessed and monitored patients pain to ensure they were comfortable and not in pain. Women were routinely

offered pain relief during conscious sedation termination of pregnancy. Patients were also advised to purchase over the counter medicines for use at home and instructed when and how to take them.

Staff assessed patients pain using a standard pain assessment tool and by asking patients if they were in pain. The pain tool enabled staff to measure patient's pain level by a scoring system. Records we reviewed demonstrated pain relief was prescribed and administered correctly.

Patients were provided with information related to pain control as part of their discharge information pack.

Patient outcomes

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

The service carried out 1,670 early medical abortions (EMAs) including 620 early medical abortions where home use of misoprostol was provided. In addition, they carried out 328 surgical termination of pregnancies; all under local anaesthesia. The service did not carry out any termination of pregnancy after 14 weeks' gestation.

Patients undergoing an EMA were asked to ensure that a pregnancy test was completed post treatment (minimum of 2 weeks) to ensure that the treatment had been successful. Patients could contact the BPAS aftercare line and were invited back to the clinic if there were any concerns.

Any post procedure complications were recorded using the electronic incident reporting and management system. The reports were reviewed by the service manager and the area manager and discussed at their bimonthly meetings. The complication data was also reviewed at clinical governance committee.

The provider told us that that 13% of patients decided not to proceed with the termination of pregnancy procedure after making initial contact with the service.

There was approximately 10% of patients who opted for long acting reversible contraception post procedure. 43% of patients undertook test for sexually transmitted infections at their consultation.

The service carried out regular consultation audits which sought to confirm if gestation period had been confirmed

Termination of pregnancy

accurately, pregnancy options and contraception were discussed. The observational audit from April 2019 reported that in all cases staff adhered to the required principles in relation to the above. It also noted that full medical assessments were undertaken in all cases. The service achieved an overall score of 97% and where action was needed the service was asked to prepare an action plan.

The service had a clinical audit plan which included an early medical abortion audit and conscious sedation termination of pregnancy audit, both four times a year. The audit results were recorded on the dashboard which was submitted to the clinical department monthly they were reviewed by the national nursing manager.

Competent staff

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

Staff were supported to undertake continued professional development activities, to update their skills and knowledge as well as their professional registration. All clinical staff were expected to attend the provider's 'clinical forum' where expert speakers presented topics relevant to the clinical work.

The provider told us that 90% of registered nurses and 91% of administrative staff had undergone an annual appraisal in the 12 months prior the inspection.

Staff who provided counselling had completed the 'support skills training' and 'counselling and self-awareness' courses and were competent with the provider's competencies framework. They also accessed a specialist post termination of pregnancy counselling training.

The provider's induction programme consisted of 12 weeks of specialist training such as consent course, and health and safety. As part of the induction programme staff were sent to different BPAS locations. Managers signed off staff competencies throughout the 12-week programme to ensure staff were trained and could complete different aspects of their role.

Each practitioner undertaking ultrasound scans was audited every two years.

Multidisciplinary working

Nurses, midwives, doctors and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff at different grades worked together as a team. Nurses and other healthcare professionals such as the client coordinator or counsellors and administrative staff supported each other to provide good care.

All staff groups spoke highly of their colleagues and told us they had good working relationships with their colleagues.

The service involved patients' GP in patients care and communicated with them regarding the procedure if this was a preference of the patient.

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

Seven-day services

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

The provider operated Monday 9am to 5pm and Tuesday to Friday 8am to 6.30pm. They were also open on Saturday 8.30am to 6.30pm.

The provider's aftercare line was accessible 24 hours, 7 days a week.

The provider's appointment booking phone lines were open from 7am to 9pm every day.

Health promotion

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

The service had access to numerous health promoting leaflets which they offered to patients. It contained information related to health promotion, self-care, available procedures, and contraception amongst others. Patients also had access to educational resources available on the providers website.

Staff provided patients with information on contraceptive methods including long acting reversible contraception (LARC). Patients were offered sexually transmitted infections (STI) tests.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed

Termination of pregnancy

national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood importance of ensuring that patients had capacity to make an informed decision. Consent training was part of the induction programme and consisted of a one-day course and shadowing 20 consenting procedures.

Staff completed generic and role-specific training which included a workshop in 'welcoming diversity' to ensure they recognised different cultural needs and beliefs. This training was designed to equip staff with the knowledge and skills to support patients in making decision related to reproductive choices, whilst acknowledging and respecting their individual needs.

Staff explained the risks associated with, and implications of, the treatment and asked patients to confirm they fully understood procedures before gaining consent. Patients were given time to consider treatment options. Patients had time to read through information they were given whilst waiting for the two remote doctors to authorise the termination of pregnancy. This allowed time for women to consider their options before making an informed decision. Written consent was obtained on the day of the procedure. There were different consent forms for each type of treatment.

A trained pregnancy counsellor offered patients the opportunity to discuss their options and choices in line with the national guidelines and as part of the consent process.

Patients who could not give consent or patients who lacked capacity were referred to the relevant NHS organisation so that an independent mental capacity advocate could be appointed.

Staff understood their responsibility in supporting young adults with decision making. Gillick competence is concerned with determining a child's capacity to consent and Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. Staff we spoke with understood the principles of both and knew they should be applied when obtaining consent for patients under the age of 16 and used a specific Gillick competence and Fraser guidelines assessment form.

Staff were aware of principles of the Mental Capacity Act (MCA) and that all adults presumed to have capacity unless proven otherwise. They understood capacity may fluctuate and that 'unreasonable decisions' did not necessarily mean the person lacked capacity. Training related to the MCA was included in their safeguarding training.

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.

Patients and relatives we spoke with said they were happy with the support offered and found staff approachable and responsive.

Patients were given a survey/comment form to complete on the day of their procedure. These could be left in a survey box or posted directly to the provider's head office. The satisfaction survey reports were produced by the client engagement manager and used to compare outcomes against other locations and identify trends and patterns as well as any potential improvements in the service delivery. We observed that survey results were positive and provided detailed information that allowed monitoring patients experience. For example, patients survey undertaken in July 2018 to July 2019 achieved an overall satisfaction score ranging between 9.5 to 9.7 out of 10. Patients reported that their privacy and dignity was maintained and that they had confidence and trust in the staff who cared for them.

We observed patients and those close to them being treated with compassion, dignity and respect. Staff followed the service policy to keep patient's care and treatment confidential. All consultations took place in a private room and privacy was respected at all times in all areas at the treatment unit.

Termination of pregnancy

Staff were professional, friendly and polite when addressing patients or their relatives. They were willing to help and demonstrated commitment to a patient-centred approach.

Emotional support

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

Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional needs, which was understood as being crucial in the patient's care. They understood the impact the treatment could have on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals. We observed that staff spoke to patients compassionately and put them at ease to minimise their potential distress.

The provider's aftercare phone line was always operational. Callers who required clinical advice would speak to a registered nurse or a midwife. Patients could also contact the service via a dedicated telephone number to make an appointment for post-termination of pregnancy counselling.

The service introduced 'client care coordinators' that undertook post termination of pregnancy counselling. Counselling was free to access, the service could be accessed on the same day or weeks, months or years after the procedure.

Understanding and involvement of patients and those close to them

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

Patients told us, that staff answered all patients' questions patiently and in a considerate manner. We observed good rapport between staff and patients and staff displayed good listening skills. Evidence of patients' involvement in their care was seen in their notes.

Staff explained to patients all the available methods for termination of pregnancy that were appropriate and safe. The staff considered gestational age (measure of pregnancy in weeks) and other clinical needs whilst suggesting these options.

Staff provided patients with an aftercare booklet, which gave details of a telephone advice line and information on the treatment they had. It also included information on how personal data would be shared with the Department of Health.

Patients survey results for 2018/2019 indicated that patients felt involved in their care and were provided with information about their aftercare. They also said they were given a clear explanation about their treatment.

Are termination of pregnancy services responsive?

Good 

We rated it as **good**.

Service delivery to meet the needs of local people

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

The service was contracted by clinical commissioning groups in north central London to provide the service for the women in this region.

Appointments were booked via the provider's contact centre, which also acted as an information service. Patients could self-refer to the service or could be referred by any local sexual health service or their GP. Patients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment.

The facilities and premises were appropriate for the services being delivered. The clinics were easily accessible and local transport facilities were good.

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 and patients could access locations of their choice when preferred. They coordinated care with other services and providers when appropriate.

Termination of pregnancy

The service provided care and treatment to medically fit patients. Patients who did not meet these criteria were referred to the most appropriate NHS provider to ensure that they received the treatment they required in a timely and safe way.

Staff had completed 'welcoming diversity' training during their initial induction and this helped them understand and recognise different cultural needs and beliefs.

The treatment unit was accessible to wheelchair users and accessible toilets were available.

An interpreting service was available to patients to support communication if their first language was not English. Staff could use the telephone interpreter service to ensure a patient, whose first language was not English, understood and could inform the decision to undertake the treatment.

Staff were aware of local support services and other organisations that could provide support around social needs of a patient. It included victim support services, domestic abuse support, mental health support and advice, and gender identity support or substance abuse services amongst others.

Patients were given information related to the disposal of pregnancy remains and were invited to inform the service should they have any specific wishes related to this. The service facilitated, when possible, requests made by patients concerning management of the pregnancy remains. The service offered information about local funeral services to assist women who wished to arrange a cremation or burial. The discussion and plan for disposal were documented in the case notes.

Access and flow

People could access the service when they needed it and received the right care promptly.

Patients could self-refer or be referred by their GP. The service undertook all aspects of pre-assessment including counselling, dating scans to confirm pregnancy and determine gestational age, and other assessments of health and wellbeing.

Royal College of Obstetricians and Gynaecologists (RCOG) states that to minimise delay, service arrangements should be such that referral to a termination of pregnancy provider should be made within 2 working days. The service must offer assessment within 5 working days of referral or self-

referral and then the procedure within 5 working days of the decision to proceed. Women requiring abortion for urgent medical reasons should be seen as soon as possible. The provider told us that in the 12 months preceding our inspection 125 patients waited longer than 10 days from the decision to proceed up to the termination of pregnancy. It represented approximately 6.2% of all patients being treated at the service during the same period. The survey undertaken between April and July 2019 indicated that 93% of patients thought the waiting time for their treatment was acceptable while 7% said they would prefer an earlier appointment.

Patients were offered a choice of dates, times and locations to ensure they were able to access appointments within the shortest waiting time and at the nearest location. The capacity manager and associate director for remote services were responsible for overseeing appointments availability across the provider's locations, working with the service to amend appointments lists when necessary. Waiting times were discussed at the area and service managers' meetings and at the quality review committee meetings. The service prepared quarterly activity reports for its commissioners to inform them of the average number of days from contact to consultation, and from first point of contact to treatment. Patients did not always choose the first available appointment because it was not always convenient to them or they needed extra time to decide about whether to proceed with the termination of pregnancy or continue the pregnancy.

All patients were asked to complete 'client comments/feedback' forms which included a section on waiting times between contact and treatment and if they were seen within 30 minutes of their appointment time. The survey undertaken in April to July 2019 responded to by 334 patients indicated that 83% of patients were seen within 30 minutes from their booked appointment time.

A booklet 'my BPAS guide' was given to every patient and provided written information about their post treatment care. The guide had a section dedicated to recovery, which detailed what would normally be expected following the treatment. It mentioned possible complications, available support and guidance for any concerns. There was a 24-hour telephone number, patients could use if they needed support on any concerns they had.

Learning from complaints and concerns

Termination of pregnancy

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

The service displayed a poster and provided leaflets about how to make a complaint or provide feedback. Complaints and feedback were reviewed at the regional managers meetings. Exception reporting was monitored by the quality and risk committee then fed into the national clinical governance committee. Information on how to complain was also available from the provider's website, within the patient's feedback form, and the 'my BPAS guide', a copy of each of which was given to all patients.

The service received eight complaints in the 12 months prior our inspection. There were no clear trends or patterns. Some complaints related to staff attitude or a patient feeling rushed. Records indicated that in all cases the service offered an apology and explanation. In all cases the service provided prompt response in less than seven days. Trends and patterns were discussed at the area managers meetings and reported in the 'exception report' to the quality and risk committee as well as in the quarterly monitoring report presented to commissioners of the service.

If a patient raised concern whilst at the service, they could have a discussion with a member of staff, or the manager. If the issue was raised at a later stage, this could be discussed with the manager or the provider's client engagement manager.

The service used an electronic record system to log complaints and trace any actions taken in response. The client engagement manager was responsible for the oversight of the management of complaints in cooperation with the associate director of operations and/or an appropriate member of the executive leadership team. The service manager was the first point of call to resolve issues raised at the service level.

Staff were aware of the complaints procedure and how to manage and escalate these.

Are termination of pregnancy services well-led?

Good 

We rated it as **good**.

Leadership

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

The service was managed by the 'treatment unit manager' who was also the register manager for this location. There was a lead midwife, responsible for supervising nurses and midwives, and a lead client coordinator supporting other coordinators, clerical staff and healthcare assistants.

The provider employed associate director of operations and an area manager who were responsible for line managing the service manager and general oversight of the location and other BPAS sites located in the same region. They were supported by the director of nursing and the medical director responsible for clinical practice oversight and patients' engagement.

Vision and strategy

The service had a vision for what it wanted to achieve. The vision and strategy were focused on improvement of services and patients experience. Leaders and staff understood and knew how to apply them.

The provider's ethos was to treat all patients with dignity and respect, to provide a caring, confidential and non-judgemental service. Personal autonomy was 'at the heart of the care' provided by the service. Their ambition was "a future where every woman can exercise reproductive autonomy and is empowered to make her own decisions about pregnancy". The provider aimed to "remove all barriers to reproductive choice and to advocate for and deliver high quality, woman-centred reproductive health care".

Staff were supported to promote organisational values through training and ongoing support. The provider's

Termination of pregnancy

policies and procedures reflected the patient's right to influence and make decisions about their care, in accordance with the provider's quality standards of 'confidentiality, dignity, privacy and individual choice'.

Culture

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 without fear.

Staff were recruited in accordance with the provider's recruitment and selection policy and procedure, which allowed recruiting managers to explore if candidates supported organisational values. The provider did not employ or subcontract individuals who did not embrace 'organisational beliefs'.

Staff demonstrated a compassionate and caring attitude. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.

Staff spoke positively about the service and were proud to work for BPAS. They described the service as a good place to work and as having an open culture and felt they could approach managers if they felt the need to seek advice and support.

Staff had access to a free counselling/support telephone service which they could call in relation to any work related or personal problems.

Governance

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

Staff were encouraged to seek advice from the provider's head office staff in relation to any support/business functions. They had established forums and committees where decisions related to operational management were taken. It included operational activity committee and area managers meetings. The provider had an established board of trustees, clinical governance committee, research and ethics committee, infection control committee, information governance committee and quality and risk committee. The medical director was responsible for

monitoring national and international developments in care and service delivery and reporting to the clinical governance committee on developments that were recommended for implementation.

The provider had a clinical advisory group made of experts in the field of termination of pregnancy care to support evidence based clinical practice and identify regional areas of risk, needs and gaps in service provision. They reported these to the clinical governance committee as appropriate. The group members met three times a year.

The provider had a research and ethics committee which met twice a year to examine all proposals for research, audits or service evaluation involving patients which were to be carried out within BPAS units or with BPAS staff. The committees' responsibility was also to ensure that such activities conformed to generally accepted ethical principles. The committee also reported to the clinical governance committee.

The service had assurance visits from the North Central London Clinical Commissioning Group. The provider told us that the commissioners did not raise any concerns during their visits in August 2019 and were satisfied with the quality of the service delivered.

The HSA1 form was completed before the termination of pregnancy, as required by the 1967 Abortion Act (amended 1990). It was electronically 'signed' by two registered medical practitioners. The HSA1 form provides an evidence that the termination of pregnancy is being performed legally, because the two doctors are of the opinion, in good faith, that the patient meets one of the grounds stipulated in the Abortion Act 1967. The provider policy required staff, before any aspect of treatment was initiated, to check the HSA1 form and confirm there were signatures from two registered medical practitioners. The service completed monthly audit to ensure and evidence compliance with the requirement and to ensure an accurate completion. An audit carried out in June 2019 recorded 100% compliance with the requirement of accurate completion.

Managing risks, issues and performance

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

Termination of pregnancy

Day to day observation of safe care delivery was undertaken by the manager and the lead midwife. Feedback was provided to staff with a view to promote, develop skills, or address areas of poor practice.

Complaints and feedback were reviewed at the regional managers meetings. Exception reporting was monitored by the quality and risk committee then fed into the national clinical governance committee.

The service had a local risk register. Risks were noted along with the person responsible for monitoring them and ensuring mitigation actions were implemented. Two risks with the highest score (most severe) on the register related to redevelopment of the nearby site not managed by the provider, which could affect the location, and the controlled drugs delivery which were not always carried out in line with the safe protocol.

Managing information

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

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to record systems to allow them to perform their work effectively.

The provider had policies that addressed access to health records and personal information, and these were informed by the appropriate national guidelines and legislation. The provider had a named data protection officer and the Caldicott guardian, responsible for protecting patients interests regarding their identifiable information. The senior information officer ensured policies were implemented and record management systems were fit for purpose and monitored to prevent mismanagement of information.

We were not made aware of any data security breaches that occurred at the service within the 12 months prior the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights. Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily attributed to the person creating them.

The department used information available through performance reports and local audits to inform and improve service planning. This was readily available and easy to understand for staff involved in care and treatment delivery. The information was also timely and relevant and could be benchmarked against similar services managed by the provider.

When required, the service submitted reports and notifications promptly to support shared learning and to share information with external bodies such as CQC.

The HSA4 form is the termination of pregnancy notification form, which needs to be submitted after the procedure to the Department of Health (DoH) within 14 days of the termination. The provider used the DoH's secure HSA4 web form version which enabled practitioners to complete and send HSA4 forms to the chief medical officer online in accordance with the Abortion Act 1967. The provider's doctors obtained a secure login and password from the DoH to enable them to use this service. The form was 'signed' online by the doctor who terminated the pregnancy. Timely submission of these forms was one of the standards reviewed on the performance indicating dashboard for the service. In cases of medical termination of pregnancy, the doctor who prescribed the medicine was required to submit the HSA4 form.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff told us they felt engaged in the day to day operation of the service and could influence changes. They had regular staff meetings which they used to share information related to complaints or incidents, to learn and share examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

Staff surveys were completed to gain staff opinion of working at the treatment unit. The results for 2018

Termination of pregnancy

suggested slight improvement (1%), when comparing with 2017 provider's level results, in managers offering regular appraisals or support "when it was needed". Staff reported they had more opportunities to develop professionally or attend courses. However, they also reported decrease in managers' understanding of "how things really are" and staff receiving feedback from patient's complaints (5% decrease). Staff felt there was less staff "to do the job well" (7% decrease) and poor performance was not always dealt

with effectively (2% decrease). Overall staff working for the provider would recommend BPAS to their friends and family if they needed care or treatment (93%) and felt their work made difference to patients (91%).

The department engaged patients by encouraging them to take part in patient surveys. Results of the survey were discussed at staff meetings and informed planned improvements. We noted that 2018/2019 results were positive.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure effective traceability records for decontamination of transvaginal probes are kept, in line with national guidance.