CareQuality Commission

British Pregnancy Advisory Service

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this announced focused inspection on 18 October 2016 to review corporate issues and governance at a provider level. We did not review "caring" as part of this inspection as care is not provided at this location. Termination of pregnancy (TOP) refers to abortion by surgical or medical methods.We did not provide ratings for this service.

CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy services.

The British Pregnancy Advisory Service (BPAS) is an independent healthcare charity which was established in 1968. The charity's stated purpose is advocating and caring for women and couples who decide to end a pregnancy. Most of the patients have their care paid for by the NHS although patients can pay for their own treatment. Patients can self-refer to the service. Vasectomy services are also offered through the service locations. The service is provided to more than 65,000 women each year in over 60 reproductive healthcare clinics nationwide.

We saw several areas of outstanding practice including:

- Development of services which meets the needs of patients using the service through research and campaigning. These include the practice of simultaneous administration of medication to effect a termination of pregnancy and the accreditation of the scanning programme.

However, there were also areas of practice where the provider needs to make improvements at a local level which are described in individual location reports.Importantly, the provider should:

- Introduce and comply with a formal policy and procedure to ensure that the requirements of the fit and proper person's regulation are met. Take steps to assure themselves that members of the senior team meet the requirements of the fit and proper person's regulation.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to British Pregnancy Advisory Service

The British Pregnancy Advisory Service (BPAS) is an independent healthcare charity which was established in 1968. The charity's stated purpose is advocating and caring for women and couples who decide to end a pregnancy. Most of the women have their care paid for by the NHS. The service is provided to more than 65,000 women each year in over 60 reproductive healthcare clinics nationwide.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included the head of hospital inspection and one CQC inspector manager.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

We carried out this announced focused inspection 18 October 2016 to review corporate issues and governance at a provider level. We did not review "caring" as part of this inspection as care is not provided at this location.

We spoke with 12 members of staff in the head office including: administrative and clerical staff, the treatment chief executive officer, and the director of nursing and operations for BPAS and the associate director of nursing, the medical director and the human resources director. We looked at governance records, policies and had a demonstration of the electronic patient records system.

Facts and data about this trust

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

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

The following services are provided at BPAS:

- pregnancy testing
- unplanned pregnancy counselling/consultation
- early medical abortion up to 10 weeks of pregnancy
- surgical abortion up to 24 weeks of pregnancy
- abortion aftercare
- sexually transmitted infection testing
- vasectomy
- Contraceptive advice and contraception supply.

The service has 44 registered locations throughout England registered with the Care Quality

Summary of findings

Our judgements about each of our five key questions

	Rating

Are services at this trust safe?

We found that:

- The provider has a duty of candour policy which is known to staff. Sufficient support is available in order that the provider maintains an open and honest relationship with patients.
- The management of incidents is appropriate and lessons learnt are disseminated to all staff.
- Serious incidents are investigated by staff trained in root cause analysis. Staff at a local level are involved in the action planning following an incident occurring.
- Safeguarding training is provided to level 3 for all staff. This is regularly updated and training is focused on the needs of the service.
- Patients are managed in line with national guidance and are protected when their condition deteriorates, through a service level agreement and focus on early transfer to NHS hospitals.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 places a statutory duty of candour requirement on all providers of health and social care. This regulation requires the provider to notify the relevant person that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology.
- The provider had a policy to assist staff in the duty of candour process. This was available on the local intranet.
- All managers of centres received training in this regulation before its introduction in April 2015. The risk management and client safety lead ensured that the duty of candour process is fulfilled. This person and the client engagement manager, had responsibility for complaints management, assist staff in the implementation of the policy.
- A duty of candour flow chart was available to staff guide them through the corporate process. This is easy to follow and informs staff of who needs to be alerted to the need to speak with patients.
- The client engagement manager authorises letters to patients following discussion with the local team and the patient.
- **Safeguarding**

Summary of findings

- The provider has a number of policies which cover safeguarding. These include: Safeguarding and Management of Clients Aged Under 18 Policy and Procedure dated November 2014 and Policy and Procedure for the protection of vulnerable adults (POVA) dated December 2013. These are available to staff via the internal intranet. Policies were updated on a three yearly cycle or when required through changes in legislation or guidance.
- The provider ensures that all staff undertake safeguarding training at face to face sessions throughout their employment. These begin at induction where training to level 3 safeguarding is delivered. Training is refreshed every two years of employment.
- All staff are trained to level 3 safeguarding training. This training is adapted to meet the needs of the service and utilises examples which have occurred throughout the service as case studies.
- Safeguarding training comprises training in the care of vulnerable people, female genital mutilation and child sexual exploitation. The training is focused on the care of people and the exploration of difficult issues with patients who may be at risk.
- All patients under the age of 18 years of age have a risk assessment undertaken to ensure that safeguarding issues are highlighted. Any concerns can be discussed with senior staff who are trained to level 4 safeguarding practices. However, referral to a local safeguarding board is made at a local level to encourage active working with local authorities.
- The service has a system so that if a patient returns to the service it is already noted that they are vulnerable.
- Local services have tailored safeguarding processes which are designed in conjunction with their local safeguarding board.
- The policy for safeguarding and management of clients under 18 policy describes how the staff manage patients under the age of 14. All potential referrals or advice would be sought from the designated safeguarding officer. There is mandatory referral in place for patients under the age of 13.
- The provider undertakes an annual audit of referrals and produces an annual safeguarding report. The service undertakes an annual section 11 audit against safeguarding policies and practices. We saw the audit from 2015 in which all areas were risk rated as green. There were no further actions taken in respect of the audit.
- All staff sign confirmation that they have read the safeguarding policy on an annual basis.
- **Incidents**

Summary of findings

- Incidents are recorded on a paper-based system. The provider plans to implement an electronic system in February 2017.
- Incident reports are created at a local level and if the incident is thought to potentially be serious these are referred to the medical director, director of nursing and operations or her associate, and the risk management and client safety lead.
- Low risk incidents are managed at a location level. However a record of these is made which feeds up to the regional and national teams. These are reviewed by the risk manager.
- The identification of themes of incidents is currently undertaken manually. However the implementation of an electronic system will allow for this to be done more effectively.
- Serious incidents are reported through to the serious incident review group for further investigation and dissemination of provider wide learning.
- There is a process in place which staff can utilise to obtain advice and support when managing incidents. Debriefs to staff occur after a serious incident.
- Staff are involved in investigation and action planning to ensure that learning occurs and that ownership of the incident occurs at a local level.
- Reporting of serious incidents follows the national framework for incident management. All staff investigating serious incidents are trained in root cause analysis.
- **Management of the deteriorating patient**
- Whilst there is no overarching policy, the management of deteriorating patients is referenced in peri-operative policies, the management of major haemorrhage policy and the rapid transfer policy.
- Post anaesthetic patients are held in the post anaesthetic room for approximately 30 minutes. They have one to one observation by a registered nursing practitioner. Physical observations are recorded within the patient's notes and assessed using a modified early warning score. Any concerns are to be addressed by the surgeon or the anaesthetist.
- The decision to discharge patients from this recovery area is the responsibility of the anaesthetist. However this may be delegated to a registered practitioner. A check list is in place to ensure that the patient meets the criteria for discharge from the recovery area.
- Once discharge from the first stage recovery area a second stage recovery takes place. The policy is clear about the care provided in this area and ensures the safety of the patient.
- The provider has agreements in place with local NHS trusts to ensure that urgent care is provided to those patients requiring treatment.

Summary of findings

- The doctor can only leave the premises when all patients are out of the first stage of recovery. They undertake a round to ensure that all patients are safe and well. There is a written agreement that the doctor should remain contactable post procedure. However the focus remains on the needs of the patient and early transfer to an NHS facility if this is required. The medical director informed us that whilst transfer was rare the service would rather transfer a patient early for further care than put their safety at risk. Nursing staff have the authority to request and organise a transfer to the local NHS provider if they are concerned about a patient's welfare.
- Doctors and nurses employed by BPAS have an intermediate life support qualification which is maintained with support by the provider. Anaesthetic staff are qualified to advanced life support.
- Doctors are available for advice over the telephone if emergency fluids are required however the focus remains on transfer of unwell patients.
- The provider introduced an adapted modified early warning score for use in its locations in late April 2016. This modified early warning score was adapted with experts in the field to meet the needs of the service. A roll out of training occurred for staff. However inspections at individual locations demonstrated that at the time inspections EWS was not always embedded. Some of our inspections occurred around April 2016 which was the implementation of this system. The provider is currently reviewing the implementation to ensure consistency of practice across all locations.
- **Cleanliness, infection control and hygiene**
- The provider has an infection control manual containing subsidiary policies to underpin the working practices of the organisation. The policies are in line with the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance, which came into force on 1st October 2010. The infection control arrangements policy outlines the responsibilities of each level within the organisation and the governance arrangements for the implementation and adherence to the policy.
- The provider also uses an Infection prevention and control annual plan to identify the systems and processes in place to ensure that the environment is clean and reduces the risks of infection to patients using the service.

Summary of findings

- There is an infection prevention and control committee meeting three times per year which reviews the themes and trends from all locations. This committee is a sub-committee of the clinical governance committee.
- Infection prevention and control link practitioners are in each location or cluster. These staff received a one day training course to equip them for their role. They undertake monthly audits as well as training staff within the location or cluster. There is an annual update provided for link practitioners. Link practitioners audit infection control practices, including hand hygiene, using the Department of Health Essential Steps document, and the infection prevention societies environmental audit tool each month, and this forms part of the quality dashboard.
- Every year the associate director of nursing or the clinical audit and effectiveness manager undertakes a full infection control audit at every location which encompasses all 12 sections of the environmental audit tool produced by the infection prevention society.. Following this audit an action plan is designed for the location.
- The associate director of nursing is the nominated director of prevention and control for the organisation. The director of nursing had undertaken a specialist university course in the management of an infection control service.
- Within the theatre environment there are two levels of expectations around the management of cleanliness within the theatre. For those locations undertaking procedures under general anaesthetic full theatre standards apply. However when undertaking conscious sedation or local anaesthetic procedures these standards are modified to reduce unnecessary stress on the patient whilst still reducing the risk of infection. Within a list of patients having conscious sedation or a local anaesthetic the surgeon and assistant would be expected to wear theatre attire and undertake scrub procedures. However, other staff would wear their own uniforms in line with the uniform policy. The surgeon would be expected to undertake a full scrub procedure prior to commencement of the list and to disinfect their hands and change protective equipment between procedures.
- We discussed the collection of the products of conception and were informed that this depended on the type of equipment used at the centre. All equipment used on individual patients is disposable however some collection equipment could be used for multiple procedures.

Summary of findings

- From our inspection at location level we identified shortfalls in the corporate policy on decontamination. We raised this with the provider who took steps to address this.
- **Medicines**
- We raised the issue of the management of medicines with the provider as a small number of locations had told us that they had concerns regarding the transportation of medicines between sites. The provider told us that that staff were occasionally required to transport medicines between sites as the second site was not open when medicines were delivered.
- The provider told us that there is a policy in respect of how medicines should be transported which included the use of a secure box. The locked box was used to transport medicines is signed out of one location and into the secondary site. Locked boxes were available from the equipment department for local sites to order.
- Having recognised that this was not best practice the provider told us that they had revised the agreements with local pharmaceutical suppliers to ensure delivery at individual sites wherever possible.

Are services at this trust effective?

We found that:

- Care is based on national guidance unless BPAS has sufficient evidence to offer alternatives.
- The provider has researched alternative treatments to ensure that patients are provided with the information they need to make an informed decision.
- Occurrence of risk is discussed with the patient and information provided to support this.
- Complication rates are reviewed to ensure the effectiveness of the services to patients.
- Staff competency is regularly assessed and training provided which is accredited.
- Consent is taken and checked when treatment is not given on the same day.
- Staff are trained to ensure that patients of all ages and abilities understand what they are consenting to.

Evidence based care and treatment

- Independent places carrying out termination of pregnancy must by law hold approval given by the Secretary of State for Health. This is in addition to being registered with CQC. The Secretary of State will consider the approval if providers comply with:

- The Abortion Act 1967 and regulations made under that Act – currently the Abortion Regulations 1991
- The requirements set out in regulations made under the Health and Social Care Act 20083; and
- The Required Standard Operating Procedures ("the RSOPs")

The RSOPs set out minimum legal and professional standards that if followed help ensure that care and treatment is provided in a safe, effective, responsive and well led manner.

- RSOP standards require that policies and procedures are in place to ensure that termination of pregnancy is in line with legislation and national guidance. The provider was able to demonstrate that these policies were in place.
- RSOP standard nine requires that services are carried out in line with the Statement of Purpose which is provided to CQC in order to set out in detail the types of care and treatment that will be provided at locations Through our inspection of the locations we found that services provided at each location were in line with those described in the provider's Statement of Purpose.
- Whilst most services offered by the provider were in line with current RCOG guidance, the practice of simultaneous administration was not in line with current RCOG guidance. BPAS currently offered treatment for early medical abortions either by way of the simultaneous administration of the medicines necessary to effect a termination of pregnancy (only for pregnancy under 9 weeks) or initial dose followed at some point within a 72 hour window with a second medication. The provider no longer offers an interval of 6-8 hours between administrations of the medications because the outcomes with this interval were not found to be significantly better than with simultaneous administration.

Patient outcomes

- The provider undertook an evaluation of the effectiveness and feasibility of simultaneous administration in 2015. It included 891 patients who chose to take both medications (mifepristone and misoprostol) simultaneously and 1,194 patients who chose to take the medications with a 6 to 72 hour window. This evaluation found that there was a 2.7% risk of the patient retaining a non-viable pregnancy or gestational sac if they took both medications at the same time and a 0.7% risk if they took these with a 6 hour or more delay. The risk of continued pregnancy was 2.5% in simultaneous administration and less than 1.2% with a gap in administration.

Summary of findings

- The evaluation also included the risk of further treatment and any extra procedures necessary. The provider informs patients of the risks through information available on their website and at initial consultation. However the provider has found that many patients prefer to take the medications simultaneously as it negates the need for return to the centre.
- The provider is currently reviewing data from all medical abortions undertaken in respect of complications seen at clinics. However the medical director informed us that there is little difference in geographical terms but more difference in optimisation in terms of length of pregnancy.
- Patients who opted for a medical abortion at 22 weeks and over were given medication to prevent the delivery of a living foetus. Whilst there is limited evidence for the use of feticide medication in surgical abortions BPAS do undertake this for patients who are 23 weeks pregnant and above to avoid the possibility of a live birth should labour ensue following use of cervical preparatory agents.
- Complication rates by procedure type, across BPAS and by unit and surgeon (as applicable), are regularly reviewed by the regional quality assurance groups and by the BPAS Clinical Governance Committee, and reported to the Board.
- Quality dashboards with ten key performance indicators to improve quality measurements had been introduced corporately in 2015 .The objectives of the clinical dashboard were to provide a real-time, or near real-time, measure of quality and safety. These were in line with the RSOP 16 standards.

Competent staff

- There are clinical guidelines in place for ultrasound scanning, entitled Ultrasound, and dated March 2015. Staff undertaking scanning are doctors, registered nurses or midwives.
- Staff initially undertake a two day scanning course and are required to ensure that they are updated as to the female pelvic anatomy. The purpose of the training is to confirm an intrauterine pregnancy and gestational age and to alert the patient to any potential physical abnormality with the uterus or adnexa. Any abnormalities noted are referred to the patients GP or the local NHS services, with the patients consent. An image is taken of the suspected abnormality to aid diagnosis from an expert practitioner.
- The two day course is accredited by the College of Radiographers and delivered in conjunction with Bournemouth University. Staff undergo a period of supervision following attendance at the training for a period of between three and six

months. They complete a log book of a specified number of procedures and produce an assignment on the theory and practical application. The sign off of competency is only undertaken when candidates have successfully completed these elements.

- An audit of individuals' practice is undertaken every two years. A report relating to scanning training, incidents arising and numbers of competent staff is reviewed at the provider governance meeting.
- Equipment to enhance the training is currently being purchased. This will enable students to scan a simulated pregnancy and it is anticipated that this will enhance learning.
- Counselling staff are available in the locations where services are provided. All Counsellors undertake training in order to fulfil their role. Staff are supervised and there is a competency frame work to which they must be assessed as competent prior to practicing unsupervised. Whole time equivalents of 19% of the staff providing services have a diploma in counselling.
- Medical practitioners are either employed solely by BPAS or had practicing privileges with BPAS. All anaesthetists are Consultants and have a broad-based hospital practice. The medical director and team monitor the competency of doctors through review of their complication rates, complaints and incident rates. Reports are generated for doctors on a six monthly basis and reviewed by the medical director on a four monthly basis.
- The provider has a policy on managing doctors with clinical or conduct concerns. This policy clearly sets out the actions to be taken in respect of medical staff where they may be concerns. Where there are concerns about individual practitioners an investigation is undertaken. If remediation is necessary, the medical director works with the clinical leads and operations directors to design a programme of remedial learning. Where necessary serious concerns about a member of the medical staff are reported to the appropriate registered bodies.
- The provider ensures that nurses' registration is confirmed at nursing staff's annual one to one meetings with their line manager. The provider offers a revalidation portfolio which assists registered staff to demonstrate continuing competence as a registered nurse or midwife. Lead nurses within units are trained so that they can assist registered staff with revalidation. Part of the clinical conference contained a session on revalidation led by the registering body.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

Summary of findings

- There is a policy entitled 'Consent to examination and treatment' dated June 2016. The policy outlines what consent is and when written consent should be sought. Consent forms can be produced in different languages in order that patients whose first language is not English can give informed consent. The policy is explicit about capacity to consent and advises staff on the taking of consent from young people and those under the age of 16 years. The policy follows national guidance on these issues.
- Patients received the booklet 'My BPAS Guide' which provided written information about their post treatment care. The guide had a section dedicated to recovery, which detailed what would normally be expected following treatment. Abnormal symptoms following treatment were also listed, with information on what clients' should do if they experienced these, including details of the BPAS Aftercare Line which was accessible for 24 hours, 7 days a week.
- Consent is taken at the time of the initial consultation by a doctor, registered nurse or midwife. The risks and complications are written within the My BPAS Guide and also on the consent form. During the consent process the requirement is for staff to refer to the information within the guide and ensure that patients are aware of the risks to individual procedures. If treatment is not provided on the same day staff check that consent is still given prior to treatment.
- Staff received face to face training in gaining consent from patients. This covered the law in terms of consent, vulnerable patients, Gillick competency and Fraser guidelines for younger patients and talking to patients about issues such as female genital mutilation and child sexual exploitation. Staff are assessed against a competency framework prior to being signed off as competent to undertake consent processes.

Are services at this trust caring?

We did not assess the service in terms of caring. However all staff we spoke with talked about issues sensitively and with respect. Staff at the provider location talked frequently about the effect of services on patients and how they strove to ensure that services met all the needs of patients using the service.

Are services at this trust responsive?

We found that:

- Services were planned to meet individuals' needs.
- Staff were trained to hold sensitive or difficult discussions with patients.

Summary of findings

- Staff trained to recognised alternative methods of communicating with patients who may be vulnerable or have learning disabilities.
- Information was available to patients to take away to ensure that they had access to information to make an informed decision.

Service planning and delivery to meet the needs of local people

- All patients' first contact with the service was via the call centre. Staff at the centre directed patients to the nearest or preferred service. The provider has 44 registered locations where surgical and medical terminations of pregnancy are carried out. These are described in the provider's statement of purpose which is available on their website.
- The provider told us that patients could normally access services within a week of calling the contact centre. However, whilst the suspension of services at another provider was in force patients had experienced waits of slightly longer due to increased demand. This had not affected their treatment options.
- Services were planned and contracts from commissioners of service sought to enable ease of access to services. However, where contracts were not in place patients were referred to other providers or travelled to other clinics for treatment.

Meeting people's individual needs

- RSOP standard three requires that there are protocols in place to support women following an abortion. This includes the provision of sufficient information, counselling and support services and consent to share information with their GP and the Department of Health. Counselling was provided at locations and through a telephone consultation service. Receptionists at the service offered patients counselling services. These were offered to patients throughout and post treatment.
- Young people under the age of 16 were seen by appropriately trained counsellors. Counsellors were trained and received supervision in order to talk to patients under the age of 16 years.
- All staff were trained to care for people with a learning disability or other potentially vulnerable patients. This was undertaken through face to face training and used case studies relevant to the services offered in order that staff felt confident in caring for patients.

Summary of findings

- Some locations were adapted for those with a physical disability.
- The provider had written information available at locations for clients and partners explaining what to expect during and after the abortion, including potential side effects, complications and any clinical implications. This information was also available on their website.
- The provider ensured that locations had a range of information that they could give to clients as required. This included advice on contraception, sexually transmitted infections, miscarriage and services to support clients who were victims of domestic abuse and how to access sexual health clinics. This information could be requested in different languages if required

- Translation services were available to patients for whom English was not their first language.
- Staff at locations were trained to discuss sensitive information with patients including the disposal of pregnancy remains.

Learning from complaints and concerns

- There were a total of 27 formal complaints received in 1 January – 30 April 2016. The complaint rate has seen a decline over the previous quarters from 0.16% in the same period in 2015 to 0.13% in 2016.
- The provider demonstrated that complaints were investigated and monitored for trends. A report on complaints was provided to the Clinical Governance Committee three times a year and an overarching summary of complaints and lessons learned annually.
- Following one complaint the provider introduced a new pregnancy testing kit which was trialled against the current method to ensure that it was more effective.
- Complaints regarding the attitude of staff were addressed at the individual locations.
- Complaints are triangulated with current practices and procedures and where issues of non-compliance are identified these are addressed through additional training and supervision.
- The provider has introduced a local complaints register at each location in order to monitor complaints at a local level. Local complaints are those raised at the time of the client's visit and which are resolved on the spot without needing escalation.
- The provider also monitors commendations and these are used to identify areas of good practice at the locations.

Summary of findings

Are services at this trust well-led?

We found that:

- There is a clear vision and strategy for the organisation which is shared by the senior team.
- Governance arrangements are effective and appropriate challenge is made by members of the senior team.
- Governance meetings are held at a number of levels within the organisation and the feedback from these reported upwards to the senior team.
- Risks to the organisation are identified and managed appropriately at the time of this inspection.
- The senior leaders of the organisation had the experience, skills and knowledge to ensure good leadership of the organisation.
- There is a positive culture where the patient is put at the centre of care and learning and development are key to providing an excellent service to patients.
- Patients and staff are key to new developments within the services offered. Patient feedback is sought and changes identified to ensure that the service they receive is in line with expectations.

However:

- The fit and proper person regulation is not currently being fully met by the provider as checks were not currently undertaken in line with the guidance.

Vision and strategy

- The provider had a vision and strategy for the service. This was well known to the senior team we spoke to. The vision was as follows 'We support pregnancy choices and trust women to decide for themselves. We treat all clients with respect and provide confidential, non-judgmental and safe services'.
- The senior team were very patient focused and their vision and strategy put the patient at the centre of care.

Governance, risk management and quality measurement

- There was a clear governance structure in place. Committees for infection prevention and control, regional quality assessment and improvement, infection prevention, and research and ethics reported into the clinical governance committee. This committee then reported operational matters into the board of trustees. Committees met frequently and minutes we saw reflected discussion and appropriate challenges made by individuals sitting on the committees.

Summary of findings

- The clinical governance committee had a clear role in reviewing all complications and patient feedback. It also ratified policies and received annual reports such as the infection prevention and control annual report.
- The subgroups of the clinical governance committee were a clinical advisory group convened by the Medical Director three times a year and more often if needed, to provide clinical advice and review clinical policies and procedures. The CAG includes a drugs and therapeutics committee function. There was also an infection prevention and control committee and three 'Regional Quality, Assessment and Improvement Forums' (RQuAIF).
- The RQuAIF reviewed local treatment complication rates to ensure they were at or below accepted, published rates. We saw from minutes of meetings that incidents, complaints and patient experience were also monitored through these forums.
- The provider had in place a governance system that ensured that it met the requirements of the RSOP standards.
- There was a relatively new system in place in that risk registers were held locally within a unit or cluster. The location reports may not reflect the position as at October 2016. The manager of these units or clusters had training on risk identification and management. The registers were reviewed by operations managers on a fortnightly basis. The risk manager had oversight of all risk registers. Risk registers were spreadsheet based and could be used to identify themes and trends.
- The regional directors reviewed the risk registers for the locations for which they had responsibility. They held local governance meetings where these were discussed. The national clinical governance meeting decided if a risk was significant enough to be placed on the provider risk register.
- Top risks were reviewed centrally every four months as a minimum by the central team. Risk registers we saw contained the risks we had identified during inspection.
- The BPAS Client Engagement Manager produced patient satisfaction reports, disaggregated to each unit for contract performance reports to each CCG. A report of all complaints and a summary of patient feedback, including return rates and scores, was reviewed by the Regional Quality Assurance and Improvement Forums (RQuAIF) and Clinical Governance Committee. BPAS shared the survey results with unit managers and discussed at regional managers meetings, with staff and commissioners.

- There were accountability frameworks for the unit manager and lead nurse to refer to when faced with financial decisions or human resource issues, such as managing sickness and absence.
- The BPAS clinical dashboard was used nationally to record measures of quality and safety. Managers used this as an improvement tool for monitoring, checking, and analysing clinical standards. Unit managers measured performance through a programme of audits and communicated to the regional management team and staff at the service. This complied with RSOP 16 standards.
- The dashboard included results on medicines management, staffing levels, clinical supervision, infection prevention, case note audits, serious incidents, safeguarding, complaints, laboratory sampling and labelling and staff sickness. This enabled all BPAS units to benchmark against each other and provided a real- time indicator of quality and safety in each unit.
- HSA 1 and 4 forms were completed in line with legislation. The IT system was being adapted to ensure that the HSA4 forms were submitted in a timely manner. The IT system ensured that staff could not progress to the next screen without the HSA1 forms being correctly completed. This ensured that treatment was given in line with legislation.

Leadership of the trust

- The senior leaders of the organisation had the experience, skills and knowledge to ensure good leadership of the organisation. This was evident in the appointment of key individuals who had been approached because of identified skills gaps within the organisation. This led to appropriate challenge within the organisation and the desire to continually improve services as well as exploring new opportunities.
- The nursing and medical leadership were visible within the organisation and staff at location level felt that they were able to contact the senior leaders should they require support. The senior clinical leaders were also experienced in dealing with poor performance of clinical staff within the organisation should this be necessary.
- The medical director is the responsible officer and appraisal lead for the organisation. The medical director ensured that appraisals were completed for those doctors employed by BPAS. Doctors with practising privileges arranged appraisals outside of the organisation.

Culture within the trust

Summary of findings

- Staff within the units and clusters generally found that the senior staff were approachable and supportive.
- There was a strong emphasis on equipping staff to provide care which was patent focused and non-judgemental.
- We also spoke to senior staff who displayed ambition to provide the very best in services to meet the needs of individual patients and who took into account in the provision of services the impact to individuals.
- We spoke with staff who were driving a learning culture within the organisation. When things went wrong the focus of senior team was on how they prevented this from reoccurring and how they ensured that everyone learnt from the incident. An example of this was the way in which safeguarding issues which arose at a local level were incorporated into the national safeguarding training programme.
- We also spoke with a number of animated senior staff who told us of new initiatives or developments where they were either improving services or championing the rights of women in England.

Fit and Proper Persons

- Regulation 5 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014 requires providers to ensure that all those with director level responsibility are fit and proper to carry out their role.
- The provider had a recruitment and selection policy which outlined the processes and steps of recruitment. However this did not explicitly relate to the fit and proper person requirement for directors.
- There was no evidence at the announced inspection that directors had been checked to ensure that they met the fit and proper persons test. However we received assurances following our inspection that this was being carried out and that a policy was going to board for approval in November 2016 which outlined the responsibilities for the organisation.

Public and staff engagement

- The provider undertakes patient feedback at the individual locations in order to assess the level of service at individual sites.
- We saw evidence of how patient complaints had been discussed at the governance committees and had led to a change of supplier of products.

Summary of findings

- The provider undertook a pilot of a new service to be offered and gained patients feedback from those patients involved as to the responsiveness of the service to their needs.
- Staff were involved in initiating new ideas and services through the staff forums, conferences and training events.

Innovation, improvement and sustainability

- The chief executive and other members of the senior team were able to discuss business ideas and strategies to improve and sustain services.
- The medical director was key in developing services to meet the needs of patients using the service through research and development.
- The senior team were championing services for patients with national bodies to affect change in guidance and legislation.

Outstanding practice and areas for improvement

Outstanding practice

Development of services which meets the needs of patients using the service through research and campaigning. These include the practice of simultaneous administration of medication and the accreditation of the scanning programme.