BPAS - Southampton

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

Overall summary

BPAS Southampton is operated by British Pregnancy Advisory Service. British Pregnancy Advisory Service (BPAS) provides a termination of pregnancy service in Southampton, under contract with an NHS trust. The contract permits BPAS Southampton to use premises shared with the NHS sexual health service. We inspected the termination of pregnancy service using our comprehensive inspection methodology. We carried out an unannounced inspection of the service on 13 March 2020. On-clinic facilities included; three screening rooms, one for early medical abortion appointments, two clinical rooms and one room for the client care co-ordinator.

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

Summary of findings

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 of pregnancy.

Services we rate

We rated it as **Good** overall. However, there were areas of outstanding practice that included;

Staff reviewed ways they could change practice in order to improve the patient experience. Staff were reviewing training for providing implant contraceptives. The report on teenage pregnancy had resulted in the development of a parental support leaflet. Staff reviewed repeat patient's data and as a result were looking at how to reduce the number of appointments patients had to attend.

Areas of good practice included;

Staff understood their role in reporting safeguarding concerns. All staff we spoke with knew how to identify abuse, female genital mutilation, child sexual exploitation and the implementation of Gillick and Fraser guidelines.

Leaders supported staff with the emotional element of the job as well as their physical safety when protesters were located near the clinic. Governance processes ensured performance and risks were monitored and reviewed at board level.

The service was organised to support patients to be anonymous. The clinic was not signposted, patients were advised to only give a booking reference at reception, so no one knew why they were attending and staff uniforms were generic and did not contain a BPAS logo.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Good 	• BPAS Southampton is operated by British Pregnancy Advisory Service (BPAS). The service provides termination of pregnancy as a single speciality service. We rated the service as good overall. • The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. • Staff provided good care and treatment, managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. • There was a person-centred culture. Staff were highly motivated to offer care that was kind and promoted patient's dignity. Staff took patient's personal, cultural, social and religious needs into account. People's individual needs and preferences were central to the planning and delivery of services. The services were flexible, provided choice and ensured continuity of care. • There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these. Patients could access services in a way and at a time that suited them. There was active review of complaints and patients were involved in the review. • Leaders ran services well. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. The service engaged well with patients to plan and manage services and all staff were committed to improving services.

Summary of findings

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Good

BPAS Southampton

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to BPAS - Southampton

BPAS Southampton is operated by British Pregnancy Advisory Service. The service opened in 2012 and at the time of inspection provided consultation and early medical abortions. No surgical procedures were carried out at this clinic. The service was contracted as part of the Solent Integrated Sexual Health Contract in January 2012. In June 2013 the service was extended when the Southampton NHS termination of pregnancy service was decommissioned.

The clinic offers consultation, medical assessment, early medical abortion and medical abortion up to ten weeks gestation, counselling and treatment. As part of the care pathway, patients are offered sexual health screening and contraception.Treatment options are determined by the gestation of pregnancy and patient choice. Surgical termination of pregnancy is not provided at BPAS Southampton and therefore we have not reported on this. However, if patients presented with later gestation, they were referred to another clinic that provided surgical termination of pregnancy.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about BPAS - Southampton

The service is registered to provide the following regulated activities:

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

Under these activities the service provided:

- Pregnancy Testing
- Unplanned Pregnancy Counselling
- Medical Abortion
- Abortion Aftercare
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice and Supply

During the inspection, we visited all four consultation rooms, the waiting area and reception. We spoke with eight staff including administrative staff, the client care co-ordinator, nurses, the treatment clinic manager, the area manager and the lead midwife. We spoke with three patients and reviewed five 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 most recent inspection of the service took place in April 2016, CQC did not publish a rating for the service as at the time CQC was not able to legally award ratings for services that provide termination of pregnancy.

Activity in the 12 months prior to inspection:

- Number of administered and prescribed abortifacient medication for early-medical abortion 774
- Number of early medical abortions where home use of Misoprostol was provided 364

Track record on safety:

- No never events

Summary of this inspection

- No serious injuries
- No incidents of Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidents of Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidents of Clostridium difficile (C.diff)
- Five complaints

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Are services effective?

Good

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.
- The service made sure staff were competent for their roles. Staff worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.

Summary of this inspection

Are services caring?

Good

- Patients were respected and valued as individuals and empowered as partners in their care.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted the patient's dignity.
- Individual preferences and needs were always reflected in how care was delivered.
- Patient's emotional needs were highly valued by staff and embedded in their care and treatment.

Are services responsive?

Good

- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility, choice and continuity of care.
- Patient's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations was integral to how services were planned and ensured that services met patient's needs. There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality.
- Patients could access services in a way and at a time that suited them.
- There was active review of complaints and how they were managed and responded to, and improvements were made as a result across the services.

Are services well-led?

Good

- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply the vision, values and strategy and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients and staff could raise concerns without fear.
- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities.
- Leaders identified and escalated relevant risks and issues and had plans to cope with unexpected events.

Summary of this inspection

- Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

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

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 all staff and made sure everyone completed it.

Mandatory training was a combination of online training and face to face real life scenario training.

We saw the training matrix which included; health and safety, fire and equality and diversity training.

We saw one nurse was booked onto immediate life support training two weeks after the inspection. They were the only staff member outstanding for immediate life support. The training matrix showed for all other training, completion rates were 100%.

Safeguarding

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

The treatment clinic manager was the designated member of staff responsible for acting upon adult or child safeguarding concerns locally, co-ordinating action within the clinic, escalating to the lead nurse for safeguarding and the safeguarding lead group. They were trained to safeguarding level four for both adult and children's safeguarding in accordance with the intercollegiate document. The registered manager was responsible for sharing information with external agencies, reviewing local adult and child protection policies and procedures and ensuring they are in line with BPAS's safeguarding standards.

All BPAS Southampton staff undertook 'Safeguarding Vulnerable Groups' training every two years, staff also received an introduction to safeguarding which was a part of induction. Staff attended regular regional safeguarding meetings and safeguarding was included as a standardised topic during quarterly clinical supervision. This was in addition to staff receiving level three training for both adult and children's safeguarding.

Staff we spoke with knew the signs of abuse, who their safeguarding lead was, how to make a referral and how to access referral forms on the BPAS internal system. At all consultation and early medical abortion appointments we observed, staff ensured anyone accompanying a patient stayed in the waiting room in order that the patient not feel pressured to answer questions a specific way. Staff asked patients about their home environments and ensured patients were safe. One staff advised us they had recently completed a safeguarding referral when they noticed bruising on a patient's thighs.

All staff knew if a patient was under 18 then they must be accompanied by someone over 18 in line with Department of Health Procedures for the Approval of Independent Sector Places for Termination of Pregnancy. In the 12 months prior to inspection, no patients aged under 13 years had attended the clinic. However, all staff we spoke with knew their responsibility to report to all appropriate authorities including the police, as children under 13yrs are considered in law to be unable to consent to having sexual intercourse as detailed in Section 5 of the Sexual Offences

Act 2003. One patient aged between 13-15 had attended the clinic in the last 12 months, staff completed a BPAS safeguarding assessment form that was specifically designed for young people to find out if they were subject to any risks such as child sexual exploitation in accordance with Royal College of Physicians guidelines. Staff understood their role and responsibilities regarding Fraser and Gillick guidelines. Gillick competence is the principle we use to judge capacity in children to consent to medical treatment. Fraser guidelines are used specifically for children requesting contraceptive or sexual health advice and treatment.

Safeguarding training included understanding the signs and symptoms of female genital mutilation. Staff were able to tell us what indicators to look for and who to contact when they suspected female genital mutilation had occurred. One member of staff had completed a referral regarding female genital mutilation in the 12 months prior to inspection.

Cleanliness, infection control and hygiene

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

BPAS Southampton rented the premises under contract from the host NHS trust. The service level agreement stated that the host trust had responsibility for the cleanliness of the premises and BPAS Southampton had responsibility for cleaning equipment. We saw staff completed a cleaning checklist in the morning before the clinic opened to check the clinic was clean. Staff knew to contact the housekeeping department at the host trust if they had any issues or concerns regarding the cleanliness of the environment. The clinic had reported zero healthcare acquired infections in the 12 months prior to the inspection.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had sufficient supplies of soap and paper towels. We saw staff clean equipment between each use and wash their hands before and after patient contact. Staff washed their hands in accordance with World Health Organisations, five moments for hand hygiene. The most recent audits for cleanliness and hand hygiene on the clinic showed 100% compliance.

Personal protective equipment such as gloves and aprons were widely available in each room and we saw staff use it. The personal protective equipment came in various sizes in accordance health and safety executive guidelines. There was appropriate tracking and traceability of the cleaning of vaginal probes in accordance with national guidance. During all patient interactions we saw, staff used sterile covers on vaginal probes and cleaned both vaginal probes and ultrasound probes between patients in line with Department of Health 'Health Technical Memorandum 01-01'. Audits showed staff were cleaning probes in line with national guidance and best practice.

Environment and equipment

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

There was no signage within the hospital to the clinic. This was to protect patients and prevent protesters from knowing the location of the clinic within the hospital grounds. Patients were signposted to the sexual health clinic which shared a reception and waiting area with BPAS Southampton.

Equipment we saw in the four clinical rooms displayed a portable appliance testing sticker that was in date. We also checked the consumables cupboard in each clinical room, all consumables we reviewed were within their expiry date.

There was a service level agreement with the host trust to remove clinical waste from the clinic. We saw all clinical waste was securely stored on clinic until the end of the clinic when the host hospital collected the waste.

At the previous inspection in 2016, we observed a blood pressure machine and an ultrasound scanning machine did not have a label indicating their service or maintenance dates. Servicing records were held by the host hospital. Therefore, we were not assured whether this equipment was safe to use. At this inspection we saw the clinic now received a monthly copy of the host hospitals service sheet. Staff then logged the equipment servicing details onto the BPAS system. Managers attended quarterly contract meetings with the host hospital where they discussed upcoming servicing and ensured all equipment was in date.

Assessing and responding to patient risk

Good

Termination of pregnancy

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

Staff completed three-point patient identification checks to ensure they were treating the right patient. Staff explained to patients what symptoms they might experience during the medical abortion at home, which symptoms were normal, and which meant that the patient should attend the Accident and Emergency department. This information was also available to patients in the 'My BPAS Guide' in case the patient could not remember what was discussed during the appointment.

In an early medical abortion appointment, staff explained the importance of the timeframe the patient had in which to take the second tablet. Staff also explained what to do if the patient experienced vomiting within an hour of taking the tablet and that they should come back to the clinic.

We saw staff asked patients about their medical histories including known allergies. Staff monitored the patient's blood pressure, pulse and temperature before performing an ultrasound to determine the gestation of the pregnancy. Staff used this information to assess whether the patient was suitable for treatment at the clinic, as the clinic only conducted medical abortions before 10 weeks, in line with BPAS's suitability criteria. If the patient was not suitable for treatment at the clinic, they were referred to the BPAS specialist placement team who arranged treatment at either another BPAS clinic that was an appropriate environment, or an NHS hospital.

Where a patient presented who was showing to be at a higher gestation, staff knew to refer then to the fast-tracking system. In these cases, the area medical surgeon and midwife manager conducted all appointments with patients where they were 22 weeks gestation or over, this was due to the complications associated with abortion at a later gestation.

At the early medical abortion appointment, staff gave patients a pregnancy test and advised them to take the test two weeks after the abortion. This was to ensure the abortion had successfully passed all pregnancy remains as retention could result in an infection. Staff explained what to do if there was a faint line on the test or if the patient was unsure of the result to contact the team.

Staff had access to pathway information to support appropriate and prompt treatment. Pathways we saw included; a sepsis screening tool, basic and advanced life support protocols, anaphylaxis algorithms (anaphylaxis is a serious allergic reaction), pregnancy of unknown location algorithms (a patient has tested positive in a pregnancy test, but there are no signs of the pregnancy via ultrasound, therefore there is the possibility of ectopic pregnancy) and gestational sac only algorithms (where the ultrasound is unable to locate a pregnancy within the uterus).

All staff laptops had a green tab on the top right of the screen, all staff we spoke with knew to press this in the event of an emergency. The tab was linked to all the other laptops on the clinic and in sexual health and alerted staff of the location of the laptop within the clinic. Although the clinic was located at a host hospital, the hospital did not have an on site A&E. Any call from the clinic to 999 automatically informed hospital security who then signposted ambulance crew to the clinic. There was also an anaphylaxis kit on the clinic for use if a patient had an allergic reaction. We saw patient bloods were taken to determine whether a patient was rhesus negative. Patients were also given the option of having an HIV test with results given during the appointment.

At the previous inspection in 2016, the treatment clinic shared resuscitation equipment with the host hospitals sexual health services and although staff checked the trolley equipment each day, the trolley was located at the other end of the corridor from the BPAS consultation rooms. Safe access to the trolley had not been risk assessed. Since the last inspection this had been risk assessed and determined, in line with BPAS guidelines, that the clinic did not require its own defibrillator. However, following staff concern the manager informed us that one was on order.

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.

Staff were recruited through a central BPAS recruitment system in accordance with the 'Recruitment and Selection' Policy and Procedure, which checked that candidates were pro-choice. BPAS did not employ or subcontract individuals with a conscientious objection to abortion, or those who

did not embrace the organisations values. Candidates were assessed on their skills, knowledge and experience. Formal references were obtained from previous employers and any breaks in employment were investigated. Nurses and midwives had their professional registration confirmed with the appropriate regulatory body, for example the Nursing and Midwifery Council, prior to a position being offered. All employees were subject to a Disclosure and Barring Service check, a check to show whether candidates are suitable to work with certain groups, for example children or vulnerable adults.

At the time of inspection, four nurses and three administrative staff were employed at BPAS Southampton. In the 12 months prior to inspection, no bank or agency staff had worked at the clinic, however we saw full induction processes in the event bank or agency staff were required. The clinic had a zero-vacancy rate at the time of inspection. The clinic was twinned with BPAS Basingstoke, therefore staff working at the Southampton clinic also worked at Basingstoke.

The clinic had access to two on call doctors who had a separate rota that was organised by BPAS head office. The doctors were employed under practising privileges. '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 BPAS head office.

Records

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

Patient records were both electronic and hard copy. BPAS used a centralised electronic system, therefore, if a patient was sent to another clinic, their records were readily available and could be accessed by staff.

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.

Staff audited patient records monthly, the result for the month prior to inspection was 100%. We checked five patient records and found them to be clearly written, signed and dated. They contained detailed assessments of any risks, the patient's medical history, social history including any safeguarding concerns and history of mental health and any other specific needs. There was also a clear rationale for a termination of pregnancy in line with National Institute for Health and Care Excellence guidelines. Scan images were attached to the record face down out of respect for the patient and to ensure they could not see the image if they had requested not to.

Medicines

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

Home use of abortion medication in England was legalised by the government from 1 January 2019. Under the approval, women have the choice of whether they wish to take the dose in safe and familiar surroundings of their own home or at licensed premises where they are undergoing treatment.

The clinic had a daily rota of two on call doctors who worked remotely and had prescribing responsibility. These doctors prescribed the medicine that would induce a miscarriage and prior to administration prescriptions were checked by staff. The clinic nurse then dispensed the medicine to the client, according to the prescription. We saw the clinic nurse explain what medicine they were going to give to the patient, what each tablet did and its side effects. We saw staff place the medicine into the patient's hands and write the time frame for the second tablet to be taken on the medicine box. This was to prevent patients from losing a loose piece of paper with the information on. We saw staff completed pre-assessment medical forms with details of any patient allergies.

Management had responsibility for ordering medicines for the clinic. The medicine order forms included; the date the medicine was ordered, the date it was received, the name and title of the person who placed the order, the quantity ordered and received, and total amounts of each medication stored on clinic. We saw the monthly on-clinic medicine checklist. Every medicine in stock was counted and the amount logged, and expiration date signed for. We checked the medication cabinet and noted all medicines matched the log. Any medicines that had an expiration date within six months was highlighted in yellow. This was to signpost staff to use that medicine first. We also saw the

ambient temperature of the medicine room was monitored and recorded to ensure the efficacy of medicines. All staff we spoke with knew how to respond if the ambient temperature went outside of range. There were no controlled drugs stored or administered at the clinic. If a patient was found to be rhesus negative, they were referred to another clinic.

The clinic had a service level agreement for the disposal of medicines with the host hospital. Staff disposed of medicines in a dedicated disposal bin. The process of medical waste leaving the clinic to be destroyed was trackable.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There was an electronic incident reporting system in place. Staff confirmed they knew how and when to report incidents and there had been no serious incidents at the clinic for the last 12 months.

Incidents were classed as either a clinical incident or a complication. A clinical incident was defined as an event that resulted in harm such as a medication error. A complication was defined as an unintended outcome attributed to an intervention which resulted in harm such as haemorrhage or infection following treatment.

The process for reporting, investigating and learning from adverse events and near misses was detailed in the 'Client Safety Incidents' policy. Managers reviewed serious incidents during clinical governance meetings. Any learning or changes to policy or procedure was shared with the clinics either during team meetings or through email using a system called Red Top Alerts. This was a document noting any serious incidents across the organisation and was issued every other month. The document highlighted any updates to processes and procedures and shared learning. Staff provided examples of incidents that had resulted in change in process. These included new pathway for pts with high BMI to be referred to specialist locations.

Introduction of security key pads following a break in on one unit and a medicine related issue where medication was received without a batch code, therefore all clinics rechecked stock to ensure a code was included.

Staff advised us that the clinic and provider had a no-blame culture and they were encouraged to report incidents and near misses. One staff member said, "We are all human, we all make mistakes but that is how you learn".

All staff we spoke with knew their role and responsibilities under the duty of candour. 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 the recipients of care (or other relevant persons) of 'certain notifiable safety incidents' as soon as reasonably practical and provide reasonable support to that person.

Safety Thermometer

There was a BPAS dashboard used to monitor and compare; medicines management, safe staffing levels, clinical supervision, infection prevention, record keeping audits, patient group directions and treatment audits.

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.

BPAS had a responsible officer who reviewed policies and ensured they were in line with professional bodies and up to date clinical practice. The BPAS medical director monitored national and international developments in care and service delivery.

All policies were easily accessible for staff to reference via the online system. Staff compliance with policies was regularly audited and reviewed. We saw that policies

referenced appropriate medical bodies such as the Royal College of Obstetricians and Gynaecology, Department of Health Required Standard Operating Procedures and National Institute for Health and Care Excellence.

We checked 13 policies including; Consent to Examination and Treatment and Local Child Protection Procedures and saw that all were in date, had been signed off by staff to say that they understood the policy and would comply with its contents. There was also a date for review and update of the policy.

The BPAS national clinical governance committee monitored and reviewed client safety and treatment complication rates to ensure they were below national rates. We saw BPAS had a national planned auditing programme which was completed at local level. Audits included; infection control, the environment, case note and record keeping and safeguarding adherence to policy and documentation. All audits at BPAS Southampton met or exceeded standards.

Pain relief

Staff gave pain relief in a timely way.

The on-call doctors prescribed post procedural pain relief, which nursing staff dispensed to the patient to take home. We saw staff advising patients of use and dosage of pain relief, when to supplement it with at home remedies such as paracetamol and when to seek further medical support. The details of pain relief given to patients was clearly documented in the patient record.

Patient outcomes

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

Auditing of patient outcomes was in line with Department of Health 'Procedures for the Approval of Independent Sector Places for Termination of Pregnancy' and showed patient outcomes at BPAS Southampton for use of Misoprostol was in line with national standards.

BPAS completed national reports on the quality of its service and patient outcomes. The clinic completed and returned patient analysis data for each termination of pregnancy to the Department of Health (HSA4 report). The clinic also reported standards to the Health Protection Agency regarding Clostridium difficile and Methicillin-resistant Staphylococcus aureus rates, the Serious Hazards of Transfusion, where a patient had received a transfusion, the Medicines and Healthcare Products Regulatory Agency regarding any adverse drug events and equipment failures as well as point of care testing errors.

At the previous inspection in 2016, we stated the service should 'Keep patients informed of the most current outcome information when making a decision about the type of medical abortion to have'. At this inspection we saw up to date outcome data for all types of abortion was detailed within the 'My BPAS Guide' booklet.

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.

BPAS had competency frameworks to support staff training and development. These varied depending on the job role and were developed to ensure staff across clinics were working to the same standard.

Induction programmes were also developed by head office. New staff received a corporate induction and then completed a six-week local induction on clinic where they shadowed staff. Staff advised us they were supported by the clinic manager to complete their revalidation. Revalidation is the process by which the Nursing Midwifery Council confirms the continuation of health care professionals to practice medicine in the UK. Any individual feedback received from 'Your Opinion Counts' booklets was retained for use during revalidation. Staff were given protected time to complete the revalidation process and used appraisal as an opportunity to discuss their competencies, learning and development, in preparation for revalidation. The appraisal completion rate for all staff at BPAS Southampton was 100%.

All clinical staff were expected to attend the BPAS Clinical Forum, where expert speakers presented topics relevant to BPAS. Staff at BPAS Southampton were due to attend objective structured clinical examination (OSCE) scenarios training the week after the inspection. The training involved actors playing patients in various situations and staff reviewed the investigations and scenarios. Staff advised us they appreciated the training as they were able to express

their own personal opinions regarding situations patients found themselves in. "It's a really good opportunity to discuss real life scenarios. Our job is to support the patient, not to give personal opinion". OSCE is an examination used in health sciences. It is designed to test clinical skill performance and competence in skills such as communication and clinical examination. Skills and drills training included understanding of haemorrhage pathways. We saw staff also received contraceptive and ultrasound training which staff said was not standard in the NHS hospitals but BPAS supported staff to do this, not only for professional development, but so they could better support patients.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked well as a team within the clinic and with outside agencies. There were clear lines of accountability and all staff we spoke with knew what and who they were responsible for.

The clinic worked well with the neighbouring sexual health service and the two organisations planned services collaboratively, such as supply of contraception to patients following an abortion. Staff advised us they had close ties with other outside agencies such as the local outreach nurse who supported patients under 18 who had had an unplanned pregnancy, the local safeguarding team and the Police.

Seven-day services

The service was open Tuesdays between 8.30am and 7pm, Wednesdays between 8.30am and 1.30pm and Fridays between 8.30am and 1.30pm. The clinic opening times were organised to ensure patients always had access to a clinic in the near vicinity. Other nearby clinics included; BPAS Portsmouth, BPAS Andover and BPAS Basingstoke.

Health promotion

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

During the consultation appointment, staff asked whether the patient was actively using contraception. If the patient replied no, then staff discussed the importance of contraception and which methods the patient might prefer. If the patient stated yes, staff asked which type they were currently using in order that the patient could review other methods that may be more suitable.

All patients were given a 'My Guide to Contraception' booklet which detailed 20 different contraceptive methods and their effectiveness. Patients were then asked to consider which method they would like to use and discuss it during the early medical abortion appointment.

We saw staff discuss contraception at the early medical abortion appointment and book patients in for an implant with the on-site sexual health clinic. All patients on leaving the clinic were provided with a pack of condom contraceptives to cover the period until an alternative long term contraceptive was available. Staff advised us "Sexual health awareness and using contraception is a really important part of our job".

Consent and Mental Capacity Act

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

We saw patient consent was asked for and recorded in the patient record at every appointment. Staff ensured patients understood any medical terminology and got an opportunity to ask questions before giving consent. Staff asked patients whether there was someone they could call in the event of an emergency, whether or not that person knew the patient was pregnant and having an abortion and if they did not know, were staff allowed to inform them. During the early medical abortion appointment, we also saw staff gain consent for the procedure but also whether a referral letter could be sent to the patients GP.

If a patient expressed doubts or was unsure of their decision, staff supported them and discussed alternative options, including returning at a later date, before requesting the patient consent to any treatment. Staff advised patients they could have a second consultation appointment if they were not confident in their decision to terminate the pregnancy in accordance with national guidelines.

Good

Termination of pregnancy

Staff used specific BPAS consent forms for patients aged 16 and under. The consent forms included details of the Gillick and Fraser guidelines as described in the safeguarding section of the report under 'Safe'.

Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005). We were advised patients who lacked capacity rarely attended the clinic, however, all staff we spoke with stated they had completed both Mental Capacity Act and Consent training in the 12 months prior to inspection. Staff were able to tell us what they would do if they suspected a patient lacked capacity, for example promote the use of an advocate to support best interest decisions. BPAS employed a national capacity lead who ensured the provider was working against the most up to date guidance and legislation as well as providing training and support to staff on the clinics. Staff we spoke with said they appreciated having someone they could go to if they needed support or advice.

Are termination of pregnancy services caring?

Good

We rated it as **good.**

Compassionate care

The staff treated patients with compassion and kindness. All staff respected patient's privacy and dignity and took account of their individual needs.

Staff advised us "BPAS' ethos is to treat all clients with dignity and respect, and to provide a caring, confidential and non-judgemental service. Personal autonomy is at the heart of care." We saw staff interactions with patients were supportive and promoted positive relationships. All staff were very friendly and approachable and said that patients needed support and understanding and it was the staffs responsibility to make the process and experience the least traumatic possible. For example, staff received training on the use of language, they never said "baby" or "foetus", only "pregnancy" and the number of weeks.

Staff discussed with patients their situation at home, their relationship status and reasons for considering abortion in a kind, supportive and non-judgemental manner. Staff locked clinic room doors during consultation and curtains were pulled across during ultrasound scans to ensure privacy and dignity were maintained.

When patients had the ultrasound scan to determine the number of weeks gestation, they were asked whether they would like to see the images. If the patient stated they would, prior to seeing the images, staff advised them of what they were likely to see. Staff advised us "An image of a foetus at nine weeks is starting to look like a baby, which can be very emotional for someone thinking of having an abortion. Whereas at four weeks, the image is unrecognisable. We need to prepare patients if they want to see this".

All patients we spoke with were overwhelmingly positive in their comments. They advised us "All the staff I saw were extremely understanding and made me feel comfortable in my decision". "It is my first time going through something like this and I found the service very helpful and understanding. I feared being judged, which I was not". "All the staff were friendly and kind". "Staff were great". And "The staff were really kind and made me feel better about my decision".

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

All staff understood the emotional impact having an abortion could potentially have on a patient and tried to minimise any distress patients may have experienced.

Staff asked patients about their previous medical history including aspects of their mental health and well-being during the initial client care coordinator appointment. Early medical abortion appointments took place in a separate corridor to the consultation appointments, so patients did not have to revisit the same area. This was to support the mental health of patients and ensure they made an informed rather than emotional decision. Patient feedback stated being in the same environment made patients doubt their decision, therefore the layout of the clinic was adapted to support this.

Patients could contact BPAS via a dedicated telephone number, detailed in the 'My BPAS Guide' booklet, in order to make an appointment for post-abortion counselling. At BPAS Southampton, the lead client care co-ordinator

undertook those appointments. Post abortion counselling was a free service for all BPAS patients, who could access the service at any time after their procedure. Staff advised us patients commonly contacted counselling services on the anniversary of the abortion for many years post procedure. Staff advised us they were proud the provider offered this service for free. Staff who provided post abortion counselling, completed client support skills and counselling and self-awareness training. After this training was complete, staff attended annual post abortion counselling training.

Staff protected patients from being influenced by other people. For example, staff ensured anyone accompanying the patient to an appointment remained in the waiting room. This was to ensure patients did not feel pressured into making a specific decision. On booking the appointment, patients were given a booking number and asked to only give this when they booked in at the clinic reception. This was to prevent anyone in the waiting area for knowing the reason for the appointment as the reception and waiting area were shared with a sexual health clinic. Reception staff we spoke with knew to only ask for the booking reference. BPAS staff wore generic nurse's uniforms and called patients to their appointment by name only. Therefore, there was no method for identifying why a patient was attending.

Staff advised us, one patient had completed all the consent forms, seemed positive in their decision, however after taking the first tablet, they changed their mind. Staff supported them with this decision and helped to assist the patient to vomit. Before the patient left the clinic, staff discussed their concerns at the sudden change of decision and advised the patient to take a few days to consider their options. Staff arranged for the patient to see a counsellor stating, "All patients who change their mind mid process and then come back must see a counsellor".

Understanding and involvement of patients and those close to them

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

Staff were committed to ensuring patients were informed in order that they could make a decision that was best for them.

At the client care co-ordinator appointment, staff discussed patient communication preferences and ensured these were documented on the patient's notes. During these appointments we also saw staff discuss both surgical and medical abortions, listing the pros and cons of both. Patients were informed that if they wanted a surgical abortion, they would be referred to another BPAS clinic as only medical abortions were performed at the clinic.

Staff supported patients in understanding what they were likely to see whilst passing the pregnancy and also gave information regarding disposal of pregnancy remains to enable women to make an informed choice. An information sheet showing how remains should be managed if the patient wanted to do this privately was also provided as well as details of local funeral services who could arrange a cremation or burial. Staff signposted patients to the 'My BPAS Guide' that detailed how BPAS would support patients. All discussions were clearly documented in the patient's records including that patients were informed data would be shared with the Department of Health.

Staff clearly explained the process for taking the abortion medication. Staff advised patients that one tablet would be taken in the nurse's presence during the appointment and the patient would take the second tablet home. Staff discussed the time frame for taking the second tablet and advised the patient to make sure they had someone to support them whilst they were passing. Pain relief was also discussed, and the patient was given the opportunity to ask questions and check understanding after each item was discussed. Staff advised patients to involve family and friends where appropriate as staff recognised patients required support from people who knew them best.

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.

Good

Termination of pregnancy

At the time of inspection, BPAS Southampton was contracted by Hampshire clinical commissioning groups to provide a termination of pregnancy service. BPAS Southampton was located at a host hospital and had designated consultation rooms, with a reception and waiting area shared with the sexual health department within the hospital. The clinic was located on the ground floor and was accessible for wheelchair users, the hospital car park had a large number of disable parking spaces.

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 a sexual health service or GP. Patients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment.

Staff contacted patients prior to their appointment if they were attending on a date where there were going to be protesters outside the clinic. For example, protesters were outside the hospital premises for a Lent campaign for the 40 Days for Life. Hospital security and the on-clinic sexual health clinic were also informed of protesters presence.

Meeting people's individual needs

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

Staff at BPAS Southampton conducted a project to review whether patients were using contraception at the time of conceiving. The project found the majority of patients had used contraception. Therefore, staff were training to become competent in providing other long-term forms of contraception, for example, the implant, to support patients to find a method of contraception that worked for them.

The clinic tracked repeat abortions by completing a patient search of the national HSA4 system which stated the number of times a patient had an abortion. This information was also shown on the patient's medical records. As a result of information gathered regarding repeat patients, BPAS Southampton staff introduced a pilot scheme. The pilot noted that due to the nature of the service, patients wanted to attend the clinic as few times as possible. Patients were required to attend consultation and the early medical abortion appointment; however, they did not want to return to receive long term contraception. Therefore, to support this, staff were receiving training to provide contraceptive implants that they could give patients during the early medical abortion appointment. Staff were also looking at ways to reduce the number of appointments through use of telephone consultation, whilst also offering patients the support they needed. At the time of inspection there were three separate appointments in total, the consultation, the early medical abortion and contraceptive appointment.

Support was available for patients living with a learning disability, a mental health illness or other complex needs. Staff advised us they followed policy when advising and treating patients with a learning disability and had received training on how to support patients with extra needs. For example, the appointment period was extended to give extra time to explain procedures and ensure patient understanding. All staff attended a workshop in 'Welcoming Diversity' to ensure they recognised different cultural needs and beliefs and this impact these may have on a patient. Staff had access to a language line that provided translation services to patients where English was not their first language. Patients had access to a 24-hour telephone support and a web-chat service for however long patients required.

The 'My BPAS Guide' was given to all patients and included: an introduction to BPAS, what would happen at consultation, the different treatment options, what would happen at treatment, pain relief, recovery, medical information, feedback and complaints.

Access and flow

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

The BPAS capacity manager and associate director for remote services had overview of appointment availability across all clinics. Waiting times were discussed at area and treatment clinic manager meetings as well as quality review committee meetings. Quarterly activity reports provided information on the average number of days from 'decision to proceed' to treatment and from first point of contact to treatment. Waiting times were reviewed at clinical commissioning group meetings. Staff asked for patient feedback on whether waiting times were acceptable. The 'Your Opinion Counts' booklet asked

patients whether they would have preferred an earlier appointment, or the appointment date was chosen as it was convenient for the patient. All patients we spoke with advised us they had not had any issues getting an appointment and they chose the specific date.

The end to end process involved; the patient contacting the central booking team to make the initial appointment. Patients were given the opening hours for all clinics local to them, patients were then able to decide which clinic they wished to attend. On arrival at the initial appointment patients first met the client care co-ordinator who discussed the reason for the appointment, patient options, emergency contact details and whether the contact knew the situation, safeguarding and the patients at home situation. Patients were then seen for consultation, during which they were scanned to determine the pregnancy gestation. The length of gestation determined which options were available to the patient if they wished to proceed with the abortion. The patient was then booked in for their early medical abortion appointment. This appointment consisted of administering the first tablet and the patient taking the second tablet to be self-administered at home, discuss contraception and book in an implant if that was what the patient decided.

In order to ensure patients were treated within the 24-week gestation window, the booking team took details of the patients last known menstrual cycle. If a patient was unsure of the date, the booking team arranged an emergency appointment. Each clinic used an online standby list and also often kept first and last appointments aside for emergency referrals.

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 prior to inspection 119 out of 1138 patients (10%) were not seen within this timeframe.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

A summary of 'Complaints, Feedback and Client Satisfaction Survey' results (both national and by clinic) was reviewed at the Quality and Risk Committee and the Clinical Governance Committee. This summary was also available to the treatment clinic managers and area managers. Clinical Commissioning Groups who had contracts with BPAS received a summary of complaints and feedback at their quarterly meeting. Client satisfaction survey reports were produced by the BPAS client engagement manager and organised by clinic and commissioning contract.

Treatment clinic managers were the first point of call to resolve issues raised at clinic level. We saw a local complaints log was held at the clinic. All staff were aware of the complaints procedure and how to manage and resolve and escalate concerns. Complaints handling was included in the staff induction programme and reviewed annually at mandatory training. In the 12 months prior to inspection, BPAS Southampton had received five complaints. We saw details on how to complain were available in the waiting room, on the BPAS web clinic as well as the 'Your Opinion Counts' and 'My BPAS Guide' booklet. The treatment clinic manager advised us the last complaint they had received, regarding complications at home during passing, was reviewed by head office complaints team and it was concluded that the clinic team had done everything they could, and the complications could not have been foreseen.

At the previous inspection in 2016, we found the BPAS quality standard was set at zero formal complaints, which meant there was a risk that complaints might not be viewed as opportunities for learning and improvement. At this inspection, staff advised us all complaints logged on the online complaints reporting system, both formal and informal, were reviewed by the client engagement manager at the head office who assessed and responded to complaints. As the review was not done locally, and all types of complaints were reviewed.

Are termination of pregnancy services well-led?

Good

Termination of pregnancy

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.

The treatment clinic manager had overall responsibility for the clinic. They were accountable to the area manager and the clinical director. The clinical director was accountable to the chief executive and the board of trustees.

Registered managers received training in key policy areas of their role, such as modular management training courses and regular conference calls to discuss new or amended guidelines or policies. Managers completed the BPAS leadership development programme, which was centrally organised to ensure all managers ran their clinics to the same standard. The provider directors led the programme with each director heading up a learning and training day.

We saw a copy of the clinic's certificate of approval to carry out termination of pregnancy in accordance with Department of Health requirements.

Vision and strategy

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

BPAS values were; Compassionate - we listen to women and deliver services to meet their needs. We build relationships with those we care for based on empathy, dignity and respect. Courageous - we are the voice of the women we care for and are never afraid to advocate on their behalf, particularly when others are silent. We are at the forefront of innovation in clinical care and campaign tirelessly for the services women need. Credible - we act with integrity. Everything we do is evidence-based and ethical, informed by our knowledge and understanding of the needs of the women we serve. Committed to women's choice - we believe that women are best placed to make their own decisions in pregnancy, with access to evidence-based information to inform those choices, and the services they need to exercise them. All staff we spoke with advised us they adhered to the values and that the values were integrated into appraisal and supervision.

The vision and strategy for BPAS were; Ambition, a future where every woman can exercise reproductive autonomy and is empowered to make her own decisions about pregnancy. And to remove all barriers to reproductive choice and to advocate for and deliver high quality, woman-centred reproductive health care. All staff we spoke with had 'bought in' to the vision and strategy for the provider and stated that it was the basis for the care they provided.

BPAS Southampton had also created its own in-house charter in development with staff as to the specific standards of care they wanted patients attending the clinic to receive. We saw a poster showing the eight standards, these were; show understanding, be supportive, be polite, keep patients informed of delays, included support persons, introduce ourselves, apologise if things don't go as expected, communicate clearly.

Culture

Staff felt respected, supported and valued. The service promoted equality and diversity in daily work

All staff we spoke with said the working environment within the clinic was supportive, that the team worked well together and if staff had an opinion, a method of improving the service, or an issue or concern that they would be listened to, supported and given credit where credit was due.

Staff advised us that the culture was inclusive of diversity and that the team was made up of a number of different cultures and backgrounds in all roles and managerial positions and the team worked well together.

Staff advised us they felt supported by management and the BPAS head office team. For example, during protests, the public affairs and advocacy manager informed the treatment clinic manager and the area managers of the dates of the protest. The treatment clinic mangers then informed their teams and gave all staff emergency security contact numbers. This was in response to members of staff being harassed on their way to their cars after a shift. Managers advised us that staff safety was of upmost

importance and especially during winter, when it was dark, staff felt vulnerable. Therefore, BPAS Southampton had arranged a service level agreement with the host hospital to provide security and escorting arrangements for clinic staff.

Governance

Leaders operated effective governance processes, throughout the service. 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.

The medical director had responsibility for ensuring all clinics were compliant with legislation. They reported any changes to policy or practice to the clinical governance committee for review and implementation. The clinical advisory group was attended by all eight directors. There was also an infection control committee, a quality risk committee and a research and ethics committee. These four groups fed into the clinical governance committee whose findings were then presented to the board. The quality risk committee included clinical leads and management who reviewed complaints, incidents, serious incidents, audit results and patient satisfaction. Treatment clinic managers received the minutes from these meetings and any learning was shared with the clinic staff. Once a quarter, BPAS head office produced a team brief detailing all clinical updates, media attention and finances which was shared with all clinics.

Locally, the treatment clinic manager reviewed the clinics safety standards for the previous month. These included; medicines management, clinical supervision, infection control, records audits, incidents, complaints, staffing issues. In the 12 months prior to inspection, BPAS Southampton had met all standards throughout the year.

In order to meet the requirements of the Abortion Act 1967 and 1990, staff must complete a HSA1 form before a termination, a HSA2 must be completed after an emergency termination. BPAS was compliant with completing the HSA1 in ensuring there were two registered medical practitioners' signatures on the HSA1 form before administering the medicine that would induce a miscarriage. The HSA1 form provides a defence for the doctor terminating the pregnancy that the abortion is being performed legally because the two doctors are of the opinion, in good faith, that the woman meets one of the grounds stipulated in the Abortion Act 1967 (5). These grounds are translated into categories A-E, and the relevant grounds must be completed on the HSA1 form. The BPAS Southampton records system did not allow the creation of a HSA4 form if two doctor signatures were missing from the HSA1 form. We saw the system listed the patients name in one column, another column showed a red exclamation mark if the HSA1 form did not have two signatures. When two signatures were showing on the record the exclamation mark turned green. Therefore, staff on the clinic could instantly see the status of each patient and chase up the on-call doctor if a signature was required.

Doctors only prescribed medication after the patient had a risk assessment, history recorded, observations checked and a fully completed HSA1 form was signed by two doctors. It is a legal requirement that two doctors must have signed the HSA1 form, and both agreed in good faith to the rationale for the abortion, before they are able to prescribe the medicine used to induce the miscarriage.

Managing risks, issues and performance

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

Treatment clinic managers and area managers completed audit outcomes and service reviews were reported to the specified governance committee, for example infection control. Where a clinic was non-compliant, the treatment clinic manager completed an action plan which are reviewed by the BPAS clinical department as well as the quality risk committee.

The register of on-clinic local risks as well as risks to BPAS as a provider were kept on the online staff system. BPAS had appointed a risk manager whose job was to have oversight of all local risk registers and review any recurring issues or patterns which may need a provider wide solution.

BPAS level managers attended at quarterly risk meeting to review all risk registers and ensure effective monitoring and progression.

Local risks were reviewed monthly within the local managerial team which included the treatment clinic manager, area manager and lead midwife. The register was divided into three sections, the first detailed the different

categories that risks fell into, for example, strategic or operational. The second section detailed the scoring methodology which ensured all local teams were monitoring risk across the same standards. This gave specific examples of risks for each category as well as a rating to determine whether the risk was minor to catastrophic. A matrix then used the rating and likeliness of occurrence to score each risk. Risks rated one to four where colour coded green, risks rated five to eight were colour coded yellow, nine to twelve were orange and all risks rated above were coloured red. This meant staff could easily see which risks had the most impact and needed urgent review. The third section was the actual register, which at the time of inspection had no risk rated over five.

The local register was up to date, provided details of the risk, when it was added to the register, the date it was last reviewed, the name of the person responsible for mitigating the risk, control measures to manage the risk and risk rating. We could see all items listed on the register had been reviewed and updated at the local managerial team meeting.

At the previous inspection in 2016, we stated the provider had recently set up risk registers for each clinic. The principles of a local risk register were not fully embedded but was in the development stage. At this inspection we noted the treatment clinic manager and area manager reviewed local risks monthly, that the process of understanding risk was embedded with staff within the clinic. All staff we spoke with knew the contents of the clinics risk register and the plan for action in reducing the risk.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

In order to meet the requirements of the Abortion Act 1967 and 1990, a HSA4 must be sent to the Department of Health within 14 days of all terminations and include patient demographic data.

The HSA4 form was completed by staff on the clinic and submitted by the prescribing doctor to the Department of Health within 14 days post treatment. BPAS had an on-line submission process for HSA4 forms, where the BPAS 'Booking Information System' had direct access to the Department of Health database. Doctors received a secure login and password directly from the Department of Health in order to use this system.

We saw staff explained the process of completing the HSA forms. Staff explained that legally, two doctors were required to review the patients notes and agree or disagree to prescribing the medication that would induce a miscarriage, resulting in an abortion. This was clearly recorded in the patient records.

BPAS clinics completed monthly audits to ensure timely and accurate completion and compliance with legal standards of the HSA1 and HSA4 forms. In the month prior to inspection, the clinic audit result was 100% for both forms.

Engagement

Leaders and staff actively and openly engaged to help improve services for patients.

Staff gave all patients attending the clinic 'Your Opinion Counts' booklets where patients could answer tick box questions about the service as well as leave comments regarding any good practice or areas for improvement. However, the nature of the service meant that patients who had previously used services did not frequently want to engage further with the organisation.

Staff met monthly for team meetings, they used these as an opportunity to discuss feedback forms, complaints, upcoming training and incidents. Meetings were arranged around staff shifts and the clinic opening hours to ensure all staff could attend.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

In the UK, teenage pregnancy rates have fallen by 55% in the last decade to their lowest ever level. In order to better understand how to further support this demographic, BPAS conducted a report 'Social media, Sexual Relationship Education and Sensible Drinking: Understanding the dramatic decline in teenage pregnancy'. As a result of this study, BPAS developed a support leaflet for parents of teenagers who fall pregnant. The leaflet gave information

and advice for parents whose daughter was pregnant and parents whose son's girlfriend was pregnant. The leaflet was developed in conjunction with; a company that made an online decision-making tool to help clarify thoughts and opinions, and a sex, relationship and contraception advise service.

Outstanding practice and areas for improvement

Outstanding practice

Staff reviewed ways they could change practice in order to improve the patient experience. Staff were reviewing training for providing implant contraceptives. The report on teenage pregnancy had resulted in the development of a parental support leaflet. Staff reviewed repeat patient's data and as a result were looking at how to reduce the number of appointments patients had to attend.

Areas for improvement

Action the provider SHOULD take to improve

The provider should review ways in which to reduce the number of patients not seen within the 10-day timeframe set by Royal College of Obstetricians and Gynaecologists.