# BPAS - Finsbury Park

## Quality Report

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

BPAS Finsbury Park is part of the provider group British Pregnancy Advisory Service (BPAS) The service at BPAS Finsbury Park is located within NHS premises in a suite of rooms leased by BPAS on a sessional basis, and is provided under contract with local clinical commissioning groups for NHS patients. BPAS Finsbury Park also accepts private patients. Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy by surgical or medical methods.

The service is registered as a single specialty termination of pregnancy service. BPAS Finsbury Park provides a range of termination of pregnancy services for early medical abortion (EMA) up to a gestation of 10+0 weeks. This includes: pregnancy testing, unplanned pregnancy counselling/consultation, early medical abortion, termination of pregnancy aftercare, sexually transmitted infection testing and contraceptive advice and contraception supply.

We carried out this announced comprehensive inspection on 18 April 2016, as part of the first wave of inspection of termination of pregnancy services. The inspection was conducted using the Care Quality Commission's (CQC) new methodology.

We have not provided 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; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

The inspection team included an inspection manager and three inspectors, two of whom who were also specialist professional advisors in midwifery and nursing.

Our key findings were as follows:

**Is the service safe?**

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not always carried out or documented in line with national or local guidelines.
- National specifications for infection prevention and control were not always adhered to. Checklists to monitor cleaning standards were not in place, and colour coding of cleaning equipment was not followed.
- Patient toilet areas were not clean and ready for use.
- Safety and maintenance checks were not carried out on all equipment used for the diagnosis and management of patient treatment and care.
- There was limited use of systems to record and report safety incidents between January 2015 and December 2015. However, we saw improvements had been made since then, and that some learning and actions required from incidents was shared with the staff and with other BPAS treatment units.
- The approach to anticipating managing day-to-day risks to people who used the service was reactive rather than pro-active, and tended to be led at a regional or corporate level rather than locally managed. Opportunities to prevent or minimise harm were missed.
- Patient records were stored securely, were legible and complete.
- All the patients undergoing a ToP underwent a venous thromboembolism (VTE) risk assessment to determine their individual risk of developing blood clots.
- There were sufficient numbers of suitably trained staff available to care for patients.
- Arrangements were in place to manage emergencies and transfer patients to another health care provider where needed and were known to all staff. There were no emergency transfers between January 2015 and May 2016.

**Is the service effective?**

- Care took account of national best practice guidelines.

# Summary of findings

- The exception was the use of simultaneous administration of abortifacient drugs for EMA, which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a robust governance system was in place and had been followed to introduce this treatment option.
- The complication rates for retained products of conception are 5 in 100 if medicines are taken at the same time ( simultaneous administration), compared to 3 in 100 if taken 24-72 hours apart.
- Policies were accessible for staff.
- Patients were offered appropriate pain relief, preventative antibiotic treatments and post-abortion contraceptives.
- Staff annual appraisal rates did not meet the organisational target of 100%.
- Counselling staff participated in group counselling supervision in line with best practice guidance.
- The BPAS Aftercare Line, a telephone service, was accessible to patients 24 hours a day and for seven days a week.

**Is the service caring?**

- Staff were caring and compassionate and treated patients with dignity and respect.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients considering termination of pregnancy had access to pre and post termination counselling, with no time limits attached, but were not obliged to use the counselling service.

**Is the service responsive?**

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- Patients were able to attend other local BPAS clinics for treatment if Finsbury Park was closed.
- The clinic did not offer surgical treatment. Patients who chose this option would be referred to treatment at another London based BPAS treatment unit offering surgical termination of pregnancy.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- Patients were provided with information to help them to make decisions.

**Is the services well led?**

- There were effective corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. Local risks were not always identified or acted upon by people with the authority to do so. The culture within the service was caring, non-judgemental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Staff felt supported by their local manager and regional operations director.

**However, there were areas where the provider needs to make improvements.**

**Importantly the provider must ensure:**

- The supply and administration of medicines under PGDs is managed in accordance with legislation, provider policy and up to date national guidelines.
- Incidents of all kinds including those with a potential to cause harm to patients or staff, even when no harm occurred, are reported and that staff receive prompt feedback to reduce the risk of recurrence.
- Implement processes to ensure greater ownership of assessing, reporting and acting upon local risks.
- Ensure staff appraisal and mandatory training are meeting the organisational target of 100%.
- Ensure that processes for signing the HSA1 forms are managed in a timely manner.
- All equipment is maintained and serviced to ensure it is reliable and ready for use.
- All areas in which BPAS treat patients are cleaned and that cleaning schedules and checklists are maintained to demonstrate this.

# Summary of findings

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

## Overall summary

### Is the service safe?

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not always carried out or documented in line with national or local guidelines.
- Cleaning schedules and checklists to monitor cleaning standards were not in place, and the national colour coding of cleaning equipment was not followed.
- Safety and maintenance checks were not carried out on all equipment used for the diagnosis and management of patient treatment and care.
- There was limited use of systems to record and report safety incidents between January 2015 and December 2015. However, we saw improvements had been made since the reporting period, and that the learning and actions required from incidents was shared with the staff and with other BPAS treatment units.
- The approach to anticipating managing day-to-day risks to people who used the service was reactive rather than pro-active, and tended to be led at a regional or corporate level rather than locally managed. Opportunities to prevent or minimise harm were missed.
- Patient records were stored securely, were legible and complete.
- All the patients undergoing termination of pregnancy were assessed for venous thromboembolism (VTE) to determine their individual risk of developing blood clots.
- There were sufficient numbers of suitably trained staff available to care for patients.
- Arrangements were in place to manage emergencies and transfer patients to another health care provider where needed and were known to all staff.

### Is the service effective?

- Care took account of national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical EMA, which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a robust governance system was in place and had been followed to introduce this treatment option.
- The complication rate for simultaneous administration was approximately double that for medical EMA treatment when medicines were administered separately.
- Policies were accessible for staff.
- Patients were offered pain relief, prophylactic antibiotic treatments and post-termination of pregnancy contraceptives.
- Staff annual appraisal rates did not meet the organisational target of 100%.
- Counselling staff participated in group counselling supervision.
- The BPAS Aftercare Line, a telephone service, was accessible to patients 24 hours a day and for seven days a week.

### Is the service caring?

- Staff were caring and compassionate and treated patients with dignity and respect.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients considering termination of pregnancy had access to pre and post termination counselling, with no time limits attached, but were not obliged to use the counselling service.

### Is the service responsive?

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- Patients were able to attend other local BPAS clinics for treatment if Finsbury Park was closed.

# Summary of findings

- The clinic did not offer surgical treatment and patients who chose this option were referred for treatment at another BPAS unit in London.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English.
- Patients were provided with information to help them to make decisions.

**Is the services well led?**

- There were effective corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, local risks were not always identified or acted upon by people with the authority to do so.
- The culture within the service was caring, non-judgemental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Staff felt supported by their treatment unit manager and regional operations director.

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# BPAS - Finsbury Park

**Services we looked at:**
Termination of pregnancy.

# Summary of this inspection

## Background to BPAS - Finsbury Park

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy by surgical or medical methods (abortion). British Pregnancy Advisory Service (BPAS) Finsbury Park is part of the provider group BPAS. The service at BPAS Finsbury Park is located within NHS premises in a suite of rooms leased by BPAS on a sessional basis, and is provided under contract with local clinical commissioning groups for NHS patients. BPAS Finsbury Park also accepts private patients.

BPAS Finsbury Park provides a range of termination of pregnancy services. They include: pregnancy testing, unplanned pregnancy counselling/consultation, EMA up to 10 weeks of pregnancy, abortion aftercare, sexually transmitted infection testing, and contraceptive advice and contraception supply. The services are provided under contract with local clinical commissioning groups for NHS patients and also accept private patients.

## Our inspection team

The inspection team included an inspection manager, three inspectors, two who were also specialist professional advisors in midwifery and nursing.

## Why we carried out this inspection

We carried out this announced comprehensive inspection on 18 April 2016, as part of the first wave of inspection of termination of pregnancy services. The inspection was conducted using the Care Quality Commission's (CQC) new methodology.

We have not provided 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; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

## 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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the service, such as local clinical commissioning groups (CCG). Patients were invited to contact CQC with their feedback.

We carried out this announced comprehensive inspection on 18 April 2016, as part of the first wave of inspection of services providing a termination of pregnancy service. The inspection was conducted using the Care Quality Commission's new methodology.

We spoke with five members of staff in the treatment unit, including a midwife, client care coordinators,

# Summary of this inspection

administrative and clerical staff, and the treatment unit manager and regional operations director. We reviewed 10 treatment records of patients, including four of patients under the age of 18 years.

During our inspection we spoke with one patient and one supporter of a patient and observed how staff interacted with them both.

## Information about BPAS - Finsbury Park

The British Pregnancy Advisory Service was established as a registered charity (Registered Charity Number 289145) in 1968 to provide a safe, legal termination of pregnancy 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 termination of pregnancy.

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

BPAS Finsbury Park was registered with CQC in July 2011. The service is easily accessible by public transport. It is registered as a single specialty service for termination of pregnancy services to NHS and self-funded patients predominantly from the North London area.

The service was managed by a registered manager who is responsible for three BPAS treatment units in North London, and who is supported by doctors, nurses, midwives and clinical care coordinators/administrators.

# Termination of pregnancy

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Information about the service

BPAS Finsbury Park is contracted by CCGs in the North London to provide a termination of pregnancy service for the patients of this area. The service is provided in a suite of consulting rooms which are leased by BPAS on a sessional basis.

The treatment unit is open on Monday 09:00 to 17:30 and Tuesday 16:30 to 21:00 to include a late afternoon and evening session and Thursday 09:00 to 13:00 and Saturday 09:00 to 14:00. These opening times have been adjusted in order to meet local demand. Treatment can also be offered at the time of consultation during certain sessions in response to patient feedback.

BPAS Finsbury Park works closely with other local sexual health services including Sexual Health On Call (SHOC).

The following services are provided at BPAS Finsbury Park:

- pregnancy testing
- unplanned pregnancy counselling/consultation
- EMA up to 10 weeks of pregnancy
- termination of pregnancy aftercare
- sexually transmitted infection testing
- contraceptive advice and contraception supply.

BPAS Finsbury Park shares accommodation with, but does not operate at the same time as, Sexual Health On Call (SHOC). The treatment unit consists of:

- reception area with secure access
- one private consulting room
- two treatment rooms
- waiting area
- administration and office areas.

BPAS Finsbury Park undertook 220 EMAs between January 2015 and December 2015

## Summary of findings

**Is the service safe?**

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not always carried out or documented in line with national or local guidelines.
- Cleaning schedules and checklists to monitor cleaning standards were not in place, and the national colour coding of cleaning equipment was not followed.
- Safety and maintenance checks were not carried out on all equipment used for the diagnosis and management of patient treatment and care.
- There was limited use of systems to record and report safety incidents between January 2015 and December 2015. However, we saw improvements had been made since the reporting period, and that the learning and actions required from incidents was shared with the staff and with other BPAS treatment units.
- The approach to anticipating managing day-to-day risks to people who used the service was reactive rather than pro-active, and tended to be led at a regional or corporate level rather than locally managed. Opportunities to prevent or minimise harm were missed.
- Patient records were stored securely, were legible and complete.
- All the patients undergoing termination of pregnancy were assessed for venous thromboembolism (VTE) to determine their individual risk of developing blood clots.
- There were sufficient numbers of suitably trained staff available to care for patients.

# Termination of pregnancy

- Arrangements were in place to manage emergencies and transfer patients to another health care provider where needed and were known to all staff.

**Is the service effective?**

- Care took account of national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical EMA, which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a robust governance system was in place and had been followed to introduce this treatment option.
- The complication rates for retained products of conception are 5 in 100 if medicines are taken at the same time (simultaneous administration), compared to 3 in 100 if taken 24-72 hours apart.
- Policies were accessible for staff.
- Patients were offered pain relief, prophylactic antibiotic treatments and post-termination of pregnancy contraceptives.
- Staff annual appraisal rates did not meet the organisational target of 100%.
- Counselling staff participated in group counselling supervision.
- The BPAS Aftercare Line, a telephone service, was accessible to patients 24 hours a day and for seven days a week.

**Is the service caring?**

- Staff were caring and compassionate and treated patients with dignity and respect.
- During the initial assessment, nurses and midwives explained to patients all the available methods for termination of pregnancy that were appropriate and safe. Staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients considering termination of pregnancy had access to pre and post termination counselling, with no time limits attached, but were not obliged to use the counselling service.

**Is the service responsive?**

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- Patients were able to attend other local BPAS clinics for treatment if Finsbury Park was closed.
- The clinic did not offer surgical treatment and patients who chose this option were treated at another BPAS treatment unit in London.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English.
- Patients were provided with information to help them to make decisions.

**Is the services well led?**

- There were effective corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, local risks were not always identified or acted upon by people with the authority to do so.
- The culture within the service was caring, non-judgemental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Staff felt supported by their treatment unit manager and regional operations director.

# Termination of pregnancy

## Are termination of pregnancy services safe?

**By safe we mean people are protected from abuse and avoidable harm.**

Our main findings for safe were:

- Authorisation for the supply and administration of medicines under patient group directions (PGDs) was not carried out or documented in line with national or local guidelines.
- Cleaning services were provided by the NHS premises host and although appropriate signage and instructions from BPAS were in place, checks on the quality of the cleaning by BPAS were not sufficient. National specifications for infection prevention and control and cleanliness were not always adhered to. In particular, the requirements for cleaning, cleaning schedules, and checklists set out in the Health and Social Care Act 2008: code of practice for health and adult social care on the prevention and control of infections and associated guidance 2015, were not applied which meant that staff could not provide evidence of what cleaning had taken place. Colour coding for cleaning materials and equipment was not correctly adopted in accordance with local guidance.
- Safety and maintenance checks had not been carried out on all equipment used for the diagnosis and management of patient treatment and care. For example, equipment used to monitor blood pressure, thermometers, and weighing scales. This meant there was a risk that equipment may not have been functioning to the required level or may not have been safe to use, which could lead to misdiagnosis or ineffective treatment.
- Serious incidents were reported and investigated. These were reviewed centrally and at clinic level. The cascade of learning and actions required as a result of incidents was not always timely.

We also found good practice:

- There were reliable systems, processes and practices in place to keep people safe from abuse. Staff demonstrated a correct understanding of safeguarding of adults and children and accurately described actions to be taken in cases of suspected abuse. All patient records we looked at showed that the initial assessment included a 'safe at home' trigger question, which were in line with NICE guidelines [PH50] Domestic violence and abuse. There was a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.
- Medicines prescribed by a registered medical practitioner were safely ordered, supplied, and stored in accordance with manufacturers' instructions and administered only when the doctor had prescribed them for named individual.
- Records we looked at were securely stored, well maintained and completed with clear dates, times and designation of the person documenting.

### Incidents

- The BPAS organisation had a 'Client Safety Incidents Policy and Procedure' which set out the procedures for reporting and reviewing incidents. All staff we spoke with were familiar on how to report incidents, and some gave examples of incidents that had been reported.
- The system for reporting clinical and non-clinical incidents was paper based using an incident reporting book, that was held by the treatment unit manager. Incidents were then escalated to the corporate risk and safety team who would record them on a central electronic register. We asked to see the summary of the incidents reported between January 2015 and December 2015 but this was not available.
- We looked at paper records held at the treatment unit of the safety incidents reported between January 2015 and December 2015. There were 13 incidents reported and discussed at the regional managers meeting.
- Three copies of the incident report were made, one remained in the patient notes, one remained in the book and one was sent to head office. We saw that two incident reports had not been filed in the patient's notes.
- We noticed improvements to incident reporting had taken place since January 2016. The regional operations director attributed this to the treatment unit manager encouraging staff to be more proactive.
- There were no never events reported at BPAS Finsbury Park between January 2015 and December 2015. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.
- Serious incidents were discussed at quarterly BPAS clinical governance meetings. There were no serious

incidents (SIs) at BPAS Finsbury Park between January 2015 and December 2015. Where serious incidents had occurred across the organisation, investigations and analysis of the root causes were carried out by the national risk management and safety lead and the clinical director. Regional and treatment unit managers then disseminated lessons learned to staff.

- Eight serious incidents had occurred in other BPAS treatment units in the reporting period. Notes from the most recent London and South East regional management meeting held on 2 March 2016 confirmed learning about complaints and SIs had been discussed, and action points agreed. We also saw in the notes that the safety issues we have reported on relating to audit of PGDs and the need to improve cleaning schedules and checklists had been discussed by the regional operations directors, however; there was no evidence that any local or regional action was agreed or implemented.
- An internal safety bulletin known as the 'red top alert' was issued to inform all staff of any safety issues. We saw examples of bulletins that included learning points arising from safety incidents at other BPAS treatment units, for example, issues related to information governance and medicines management.
- The Duty of Candour is a legal duty on health care providers to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers. We spoke with staff about the duty of candour in relation to patient safety incidents. Staff described situations when the duty of candour would have been applicable. For example, staff apologised to patients who required follow up treatment at BPAS Tottenham on days when the Finsbury Park treatment unit was closed.

**Cleanliness, infection control and hygiene**

- The premises were visibly clean and uncluttered, with the exception of a patient toilet area, which we brought to the attention of the manager.
- Cleaning was carried out daily by a contracted cleaning company, when the treatment unit was closed to patients. This meant staff had little opportunity to monitor the cleaning service, and relied on verbal feedback about specific concerns. Staff undertook any cleaning required during clinic hours.
- Spillage kits for the safe disposal of body fluids were provided. Staff knew where to locate them, and correctly described the procedure for managing this situation in accordance with the local policy.
- Infection control audits were carried out by internal reviewers every six months to manage and monitor the prevention and control of infection. The most recent infection control audit showed 97% compliance with cleaning standards. However; cleaning standards did not comply with national specification the Health and Social Care Act 2008: code of practice for health and adult social care on the prevention and control of infections and associated guidance, 2015. Cleaning schedules did not detail the required standard and arrangements for cleaning at the point of use and cleaning checklists required by the code were not in place. This meant that staff could not confirm the cleaning had taken place.
- The National Patient Safety Agency Safer practice notice 15 'Colour coding of hospital cleaning materials and equipment, 2007' was not correctly followed. We saw a green mop designed for cleaning kitchen areas stored in a blue bucket designed for cleaning general areas, and a blue mop designed for cleaning general areas stored in a green bucket designed for cleaning kitchen areas. The mop heads were dry to touch and the buckets were dusty which did not give the impression that they had been used recently. The manager was unable to confirm when they were last used.
- Protective personal equipment (PPE) such as disposable gloves and aprons was readily available, correctly stored, and worn by staff.
- We saw all staff adhered to the BPAS handwashing and bare below the elbow policies to enable good hand washing and reduce the risk of infection.
- Handwashing sinks, soap, and alcohol hand rubs were in good supply and we saw instructions for their use clearly displayed.
- Staff adhered to the management of clinical waste policies and disposal of sharp objects.
- There were no reported health acquired infections or Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Diff) from January 2015 to December 2015.
- Disposable curtains with an antibacterial covering were used in the treatment room and were clearly labelled with a date to show when they were last changed.

- There was appropriate segregation of clean and dirty waste, and safe disposal of clinical waste including sharp instruments and objects. Staff adhered to the management of clinical waste policies and disposal of sharp objects.

**Environment and equipment**

- The service was provided in a purpose built NHS facility, which was spacious and provided privacy and dignity and access for people with a disability.
- An environmental audit was performed annually as part of BPAS ongoing quality assurance programme. This was last undertaken in May 2015, which concluded that were no significant risks or further action required.
- Two blood pressure monitors, one thermometer, and one weighing scale that we saw did not have evidence of up to date calibration. Staff were unaware of the requirements for calibration. This could lead to faults remaining undetected, and an associated risk of misdiagnosis or ineffective treatment. We brought this to the immediate attention of the registered manager who told us corrective action would be taken.
- All electrical appliances on the premises had been inspected and tested for electrical safety to the requirements of the electricity at work regulations, and had a valid certificate until February 2017.
- Oxygen cylinders and emergency suction equipment were available for use in an emergency, and were stored correctly. Emergency equipment for resuscitation was also available in a portable bag that included medicines and airway tubing in accordance with national guidance. First aid equipment was available in secure boxes. All emergency equipment was checked on the days the treatment unit was open to ensure it was available and fit to use. Single-use items were sealed and in date, and emergency equipment had been serviced.

**Medicines**

- Staff involved in the supply and administration of medicines were required to comply with the BPAS medicines management policy, 2015, which set out systems and staff responsibilities in line with national standards and guidance. However, not all references listed in the policy were the most up to date version of such guidance, despite a recent review. For example, out of date references to NMC midwives rules and standards, and the safer management of controlled drugs publications.
- Medicines were either prescribed remotely by doctors using a secure electronic prescribing system or they were supplied and administered under Patient Group Directions (PGDs). PGDs are written instructions for the supply and administration of medicines to groups of patients who may not be individually identified before presentation for treatment.
- We saw examples of two medicines that were supplied and administered under a PGD on five occasions between 22 February 2016 and 19 April 2016. These were: anti-D immunoglobulin for patients who had the blood group rhesus negative and Misoprostol which was used for treatment of retained products of pregnancy following a medical or surgical termination of pregnancy.
- Legislation prevents abortifacient medicines being supplied and/or administered under a PGD for the purpose of inducing an abortion. The BPAS PGD for misoprostol (an abortifacient medicine) is clear in its indications for use – retained products of conception – and that it must not be used for the purpose of inducing an abortion.
- Misoprostol does not have a UK licence to induce termination of pregnancy, so its use in this way is described as 'off-label'. The use of 'off label medicines' must be fully explained to patients before they take them. We saw that this was explained to patients a part of the consent process.
- Legal requirements for using PGDs are that they need to be signed by each individual member of the multidisciplinary group (doctor and pharmacist), the clinical governance lead on behalf of the NHS organisation authorising the PGD, and the individual health professionals working under the direction. All PGDs at BPAS Finsbury Park were authorised by the director of nursing and operations, BPAS consultant pharmacist, the medical director, clinical governance committee and BPAS chief executive officer. In addition each PGD required the signature of the treatment unit manager to authorise the local use of the PGD in each

specific location. This signature was not evidentfor Misoprostol, but was completed for anti-D. We brought this to the attention of the registered manager who told us corrective action would be taken.

- The BPAS medicines management policy, 2015, required that 'only nurses and midwives who have attended the relevant training for a PGD can supply or administer according to that PGD. Records must be kept locally by the unit manager of those nurses or midwives who have attended the training and been signed off to use a particular PGD'.
- Training records and signatures of the nurse and midwife using PGDs at BPAS Finsbury Park were incomplete. On three of five occasions the practitioner(s) had retrospectively signed a statement to say they had completed the training and that they read and understood the content of the PGD, sometimes as long as two months after the medicine was given. On one occasion there was no signature. This meant that the healthcare professionals were not properly authorised to supply and administer medicines using the PGD. We brought this to the attention of the registered manager who acknowledged this had been an oversight.
- The BPAS policy was that the practices surrounding PGDs would be audited every six months. Due to the recency of the introduction of PGDs at Finsbury Park,the practices had not been formally audited. We saw no evidence of any medicines management audits and the manager confirmed this was the case. This meant that any non-compliance with medicines management policies may be undetected.
- BPAS had a centrally managed contract for the purchasing of medicines. Medicines were supplied by an approved pharmacy supplier. Orders for medicines were placed electronically and checked by an authorised person. Supplies were sent direct to each centre. There were no controlled drugs (medicines subject to additional security measures), stored or administered at this location.
- An external pharmacist provides advice and attends relevant committees on a consultancy basis. Staff were unclear about who to contact for pharmaceutical advice and could not recall a situation when they had needed to do so. We saw evidence of recently completed PGD training (November 2015) byall nurses and midwives who supplied and administered medicines under PGDs. However, we did not see evidence of other medicines management training.
- Managers told us there was no recent review of the pharmacy service or medicines management audit, however they could not recall that any safety incidents or risks had been identified.
- National medicines safety alerts were sent to all treatment units by BPAS central office, and acted upon. However there had not been any that were specific to the termination of pregnancy services in the reporting period, or in 2016.
- Medicines were all stored in a locked cupboard, or, where they needed to be kept cool, in a designated refrigerator for this purpose. The minimum and maximum temperature of fridges used to store medicines were monitored and recorded to ensure that medicines were kept at the required temperature. We saw fridges used for this purpose were locked, were clean and tidy and found no surplus or expired stock.
- There were systems in place to check for expired medicines. All the medicines we looked at were in date and correctly stored in line with manufacturers' instructions.
- Patients were asked if they had any known allergies. We reviewed ten records and saw that nine had a record of whether or not the patient was allergic to anything.

**Records**

- Patient records were mainly paper based and only accessed by relevant staff.
- Patient information and records were held securely in locked cupboards.
- Monthly audits of consultation notes had been carried out. Information provided by the organisation showed that the most recent report was dated April 2016, and there was above 90% compliance with record keeping standards.
- All of the records we looked at were well maintained and completed with clear dates, times and designation of the person documenting.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for termination and sign a form to indicate their agreement. All of the records we looked at met these requirements.

- The Department of Health requires every provider undertaking termination of pregnancy to submit demographical data following every termination. This information had been correctly gathered and reported on.

**Safeguarding**

- There were no safeguarding concerns at the time of our visit.
- Staff knew how to access the safeguarding policies and demonstrated a good understanding of the processes involved for raising a safeguarding alert.
- The registered manager was the designated member of staff (safeguarding lead) responsible for acting upon adult or child safeguarding concerns locally, co-ordinating action within the treatment unit and escalating to the BPAS national safeguarding leads as necessary, and liaising with other agencies. All staff we spoke with correctly identified the safeguarding lead, described what may constitute a safeguarding concern and understood the process for reporting concerns.
- The registered manager ensured that staff were adequately trained on issues related to safeguarding through completion of the BPAS 'safeguarding vulnerable groups' training. Records we saw confirmed that 100% of staff were trained to safeguarding level 3 for adults and children, which was the required level for their area of responsibility.
- Staff told us they routinely took the opportunity to ask patients about domestic abuse in line with NICE guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. This guidance is for everyone working in health and social care whose work brings them into contact with people who experience or perpetrate domestic violence and abuse. All patients were seen in a one to one consultation with a nurse or midwife. All the records we looked at showed that a routine question was asked to confirm that the patient was 'safe at home'.
- Patients had access to information about local organisations to support them in case of domestic abuse.
- All patients under the age of 18 had a safeguarding assessment at initial consultation. Staff discussed the assessment of patients under the age of 14 with the safeguarding lead. Any patients aged under 13 were routinely referred to the local safeguarding authority. Staff were aware of the process but could not recall a recent example of when this happened.
- We saw that the assessment included questions around consent and coercion to sexual activity and lifestyle to identify coercion, overt aggression, suspicion of sexual exploitation or grooming, sexual abuse and power imbalances.
- The BPAS policies and processes reflected up to date national guidance on sexual exploitation of children and young people, and female genital mutilation. Staff we spoke with recalled these principles being included in their most recent safeguarding training.

**Mandatory training**

- BPAS mandatory training covered a range of topics: life support, fire safety, health and safety, safeguarding, moving and handling, infection control and information governance. We were told that there were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- The organisational target for completing mandatory training was 100%. Staff told us they had all completed mandatory training. Records supplied by the provider did not support this view. We noted the following gaps: advanced or basic life support (undifferentiated between levels of training) had been completed by 80% of staff, fire safety 90%, health and safety 90%, infection prevention and control 80% of staff. 100% compliance had been achieved in safeguarding of adults and children, and information governance.
- BPAS had introduced a 12 week competency based training programme for new staff which included all the mandatory training topics, along with patient support skills training, and topics including sexually transmitted infection training, ultrasound scanning and HIV training.

**Assessing and responding to patient risk**

- The 'BPAS Suitability for Treatment Guideline' set out which medical conditions would exclude patients for accessing treatment, and those medical conditions which, although not an automatic exclusion required careful risk assessment by a doctor, usually a regional clinical lead or the BPAS medical director. BPAS has a specialist placement team to source appointments within the NHS for patients who were not suitable for treatment at BPAS on medical grounds.

- Records we looked at confirmed that before treatment, all patients were assessed for their general fitness to proceed. The assessment included obtaining a full medical and obstetric history, measurement of vital signs, including blood pressure, pulse and temperature. An ultrasound scan confirming pregnancy dates, viability and multiple gestations was carried out in all cases. Relevant laboratory testing was undertaken as appropriate: for example haemoglobin level.
- All patient records showed that blood was tested at the time of the initial assessment to determine Rhesus factor and Anti-D immunoglobulin was administered to patients who were found to be rhesus negative. Testing for sexually transmitted infections was available and carried out with the woman's consent.
- Clinical and non-clinical staff we spoke with were able to describe the actions required in the event of a medical emergency and how to summons emergency assistance**.** In the case of medical emergency BPAS transferred patients to the neighbouring NHS Trust hospital. Staff could not recollect a time when they had transferred a patient under these circumstances.
- First aiders had been trained and appointed and accurately described their role and responsibilities.

**Nursing staffing**

- The service employed one nurse and one midwife (0.4 full time equivalent (WTE)). There were no vacancies at the time of our inspection. When patients attended the treatment unit there would be at least one registered nurse or midwife on duty.
- Nursing staff were supported by one (1.4 WTE) client care coordinators, who offered counselling when required and carried out administrative duties, and receptionists.
- Staff rotas were managed regionally which meant that the service needs were met without having to use agency or locum staff.

**Medical staffing**

- For patients having medical EMA, one doctor was available three Saturdays per month doctors to provided face to face consultations, complete the HSA1 form and write prescriptions. At other times doctors working remotely provided a telephone service and completed the HSA1 form and wrote prescriptions from the licensed premises.
- Doctors were employed by BPAS or worked under practising privileges, which is the authority given to a doctor at a location other than their usual place of work, to provide patient care. Practising privileges are limited by the individual's professional registration, experience and competence. Managers carried out checks to confirm professional registration, qualifications, insurance, disclosure and barring and revalidation.

**Major incident awareness and training**

- BPAS major incident and business continuity plans provided guidance on actions to be taken in the event of a major incident or emergency. Staff we spoke with were aware of the procedure for managing major incidents.

## Are termination of pregnancy services effective?

**By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.**

Our main findings for effective were:

- Care took account of national best practice guidelines.
- The exception was the use of simultaneous administration of abortifacient drugs for early medical termination of pregnancy, which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. We saw that a robust governance system was in place and had been followed to introduce this treatment option.
- The complication rates for retained products of conception are 5 in 100 if medicines are taken at the same time (simultaneous administration), compared to 3 in 100 if taken 24-72 hours apart.
- Policies were accessible for staff.
- Patients were offered pain relief, prophylactic antibiotic treatments and post-termination of pregnancy contraceptives.
- There was an annual appraisal provided for staff however not all staff had completed this.
- Counselling staff participated in group counselling supervision.
- The BPAS Aftercare Line, a telephone service, was accessible to patients over 24 hours a day and for seven days a week.

# Termination of pregnancy

**Evidence-based care and treatment**

- Policies were accessible for staff and were developed in line with Department of Health
- Required Standard Operating Procedures (RSOP) and professional guidance. Some polices did not follow national guidance.
- BPAS introduced simultaneous administration of mifepristone and misoprostol (medicines used to bring about termination of pregnancy) in March 2015. This is not in line with RCOG guidance which recommends that mifepristone is administered followed by misoprostol 24 – 48 hours later. BPAS had conducted which underpinned the policy and pathway for simultaneous administration of mifepristone and misoprostol. Outcomes were kept under regular review.
- The different pathways for EMA were discussed with women at the initial consultation appointment. Women then signed a consent form before proceeding with treatment.
- The treatment unit adhered to RCOG guidelines for the treatment of patients with specific conditions, such as ectopic pregnancy.
- All patients underwent an ultrasound scan at the treatment unit to determine gestation of the pregnancy in line with the BPAS clinical guideline for termination of pregnancy.
- We saw that blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to patients who were found to be rhesus negative.
- RCOG guidance and RSOP 13: Contraception and Sexually Transmitted Infection (STI) Screening suggest that information about the prevention of sexually transmitted infections (STI) should be made available and that all methods of contraception should be discussed with patients at the initial assessment and a plan should be agreed for contraception after the termination of pregnancy.
- All the patients attending the BPAS Finsbury Park treatment unit were tested for Chlamydia infection (Chlamydia is a sexually transmitted bacterial infection) prior to any treatment. Patients with positive test results were referred to sexual health services. Patients were also referred to sexual health services for further screening for other STI and treatment.
- Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the termination of pregnancy. The patients were provided with contraceptive option and devices at the treatment unit. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Treatment unit for Women's and Children's Health.
- The audits of records showed that the treatment unit was 100% compliant in following the discussion around contraceptive advice.

**Pain relief**

- Pre and post procedural pain relief was prescribed on medication records. Best practice was followed as non-steroidal anti-inflammatory drugs (NSAIDs) were usually prescribed. These are recognised as being effective for the pain experienced during the termination of pregnancy.
- Staff we spoke with were clear about which medication would be offered and in which order. For example for an EMA pregnancy procedure NSAIDs would be administered.
- Patients were advised to purchase over the counter medicines for use at home and were advised about when and how to take them.

**Patient outcomes**

- Between January 2015 and December 2015, BPAS Finsbury Park carried out 220 EMAs.
- Patients undergoing EMA were asked to ensure that a pregnancy test was completed after two weeks post treatment to ensure that the treatment had been successful. Patients could contact the BPAS Aftercare Line and were invited back to the clinic if there were any concerns.
- Staff told us that in order to monitor outcomes they relied on other staff reporting back to them or patients contacting BPAS by using BPAS Aftercare Line. If the clinic was informed that there had been a complication a form would be completed and it would be documented in patient's notes to ensure that the information was captured. This was monitored by the quality leads and cascaded through meetings.
- Abortifacient medicines were administered using two options. They could either be administered over a two day period, returning to a BPAS treatment unit the

following day, or both the medicines could be administered simultaneously in one visit. The patient's choice was always taken into account, although simultaneous administration was encouraged.

- The method of simultaneous administration of medicines was recently introduced by BPAS at all its treatment units for EMA treatment up to nine weeks of gestation, and is outside of national guidance contained in, 'The Care of Patients Requesting Induced Abortion' (November 2011, RCOG). There is evidence that a simultaneous regime works, some showing no difference in outcome, some suggesting a trend towards a higher failure rate and some showing worse outcomes. For example, rates of surgical evacuation for reasons other than ongoing pregnancy range from 1.8% to 4.2% and the risk of medical abortion failure is higher where the specified interval between mifepristone and misoprostol was less than 24 h. However, two studies showed simultaneous administration to be just as good and one should a 6 hour interval is all that is required.
- The introduction of simultaneous administration followed a national BPAS pilot study involving almost 2000 patients between March 2014 and January 2015. This pilot study demonstrated that simultaneous administration was associated with an increased need for surgical treatment in comparison to a dosing interval of 6 – 72 hours (7% compared to 3.3%). It also found that acceptability and differences were almost the same between simultaneous administration and a dosing interval of 6 – 72 hours (89% compared to 90%).
- Minutes of a Clinical Governance Committee meeting held in March 2015 stated that the complication rate was significantly higher and acknowledged this process is outside the national guidance. They also state that, 'An additional benefit of simultaneous administration is that fewer resources are needed at BPAS and for the woman if a routine second visit is not needed'.
- Complication rates were reported in December 2015 according to the treatment administered. Between September 2015 and December 2015 there were 22 complications of treatments carried out before nine weeks of pregnancy, 13 complications at nine weeks and two complication over nine weeks.
- The service monitored the outcomes of this new method which were reported to the clinical governance committee. We saw minutes of the Clinical Governance Committee meeting held in June 2015 that there had been an increase in complications since the introduction of simultaneous administration of mifepristone and misoprostol for EMA but that these were within what was quoted in the BPAS guide.
- The treatment unit kept a log of patients that were referred to NHS hospitals with suspected ectopic pregnancy. We saw that staff actively followed up the outcomes for these patients by direct communication with the early pregnancy assessment unit (EPAU) or with the patient.

**Audit**

- BPAS Finsbury Park had a dash board that measured ten standards. These were: medicines management, safe staffing levels, clinical supervision, record keeping audits, safeguarding, treatment audits, complaints, lab sampling/labelling errors and sickness absence. We saw that between April and December 2015 the treatment unit achieved compliance with all standards apart from April and May. The data did not specify which measures felt short of the required standards.
- BPAS had a planned programme of audit that included audits recommended by RCOG: consenting for treatment, discussions related to different options of termination of pregnancy, contraception discussion, confirmation of gestation and medical assessments audits. Audit outcomes and service reviews were reported to governance committees such as infection control and regional quality, assessment and improvement forums (RQuAIF).
- BPAS Finsbury Park demonstrated compliance rates between 93% to 100% (May 2015) with reception of patients, consent for treatment, discussions related to different options of termination of pregnancy, contraception discussion, confirmation of gestation and medical assessments audits. Action plans were developed and implemented to address the areas where improvements were identified, responsibility allocated and completion dates set.
- We saw that there was 100% compliance with testing for sexually transmitted infections at point of care testing.
- The BPAS Infection Control Essential Steps Audit tool facilitated audit of hand hygiene, personal protective equipment, aseptic technique and sharps management. BPAS Finchley Park was 100% compliant with the audits conducted in October, November and December 2015.

**Competent staff**

- Records showed that all staff were supported through an induction process and competence based training relevant to their role. A member of staff who had recently completed the induction programme described it as good and thorough.
- Managers carried out checks to confirm professional registration, qualifications, insurance, disclosure and barring and revalidation.
- Staff we spoke with told us they had regular annual appraisals. Information provided by BPAS Finsbury Park showed that 50% of nursing and midwifery staff and 67% of administrative had completed an appraisal compared to the target of 100% between January 2015 and December 2015. Appointments were in place to undertake outstanding appraisals. Staff were further supported through 'job chats' which records showed took place at least once a year.
- Staff undertook training and assessment of competence in ultrasound scanning. For accreditation of first trimester scans (up to 12 weeks of pregnancy), staff were required to undertake 50 abdominal, 20 vaginal and five gynaecology scans. For second trimester accreditation (from 13 to 27 weeks of pregnancy), they were required to undertake 50 scans of the baby's head and five scans of the placental site.
- The RSOP 14: Counselling sets out that all the staff involved in pre assessment counselling should be trained to diploma level in counselling. Staff told us that the patient care coordinators were trained to a diploma level in pregnancy counselling. Staff referred to as 'clinical care coordinators', who provided the pre and post-termination of pregnancy counselling service had completed the 'BPAS Patient Support Skills and Counselling and Self Awareness' course and had completed the patient care co-ordinator competencies framework. Group supervision for staff providing counselling was also available and was provided three times a year. We saw evidence that staff had attended the groups.
- Initial contact for any of the services provided by BPAS was made through a national contact treatment unit. The treatment unit was run by dedicated BPAS staff who had completed a competence based training specific to the role.

**Multidisciplinary working (related to this core service)**

- Medical staff, nursing staff, clinical care coordinators and other administrative staff worked well together as a team. There were clear lines of accountability set out in job descriptions that contributed to the effective planning and delivery of patient care.
- The treatment unit had close working relationships with SHOC, a sexual health service for sex workers, which operated within the same premises. One day a week, appointments were available at the BPAS clinic after the sexual health clinic so that patients could receive same day treatment if required.
- Staff told us that they had close links with other agencies and services such as the local safeguarding team and the Early Pregnancy Assessment Unit (EPAU) at the local hospital.

**Seven-day services**

- BPAS Aftercare Line was available 24 hours per day and seven days a week. Callers to the BPAS Aftercare Line could speak to a registered nurse or midwife who performed triage and gave advice. The dedicated team of nurses and midwives had received training for the role from BPAS. Patients were followed up by staff at the treatment unit they had attended, either by a phone call or by appointment at the clinic.

**Access to information**

- RSOP 3: Post Procedure recommends that wherever possible the woman's GP should be informed about treatment. Patients were asked if they wanted their GP to be informed by letter about the care and treatment they received. Patients' decisions were recorded and their wishes were respected.
- Staff at the treatment unit ensured that patient care records were transferred in a timely and accessible way and in line with BPAS protocols, if the woman was referred to a different BPAS treatment unit or provider for further treatment.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We asked about the consent process. Staff demonstrated clear and concise explanations of the options for terminating pregnancy and for ongoing contraception.
- The care records we reviewed contained signed consent from patients in all cases. Staff told us that the consent

form and 'My BPAS' guide were produced in different languages, for example Spanish, Arabic, Chinese, Hungarian, and Turkish when needed they could print them for patients.
- Staff could not recall a situation at BPAS Finsbury Park where they had cared for a patient who lacked the mental capacity to give consent to treatment, however they demonstrated an understanding of the principles of the mental capacity act as this was an area that had been included in the BPAS mandatory safeguarding training.
- A trained pregnancy counsellor offered patients the opportunity to discuss their options and choices in line with Department of Health RSOP 14 Counselling discussion as part of the consent process.
- Staff assessed patients aged less than 16 years by using Gillick competence and Fraser guidelines. Gillick competence is used to assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. Fraser guidelines look specifically at whether doctors should be able to give contraceptive advice or treatment to under-16-year olds without parental consent. Where necessary an adult could sign the consent form if present.
- Nurses and midwives completed a checklist to assess whether a child under 16 was competent to give consent.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLs). Staff we spoke with discussed the need to ensure that patients had capacity to make an informed decision

## Are termination of pregnancy services caring?

**By caring we mean that staff involved and treated people with compassion, kindness, dignity and respect.**

Our main findings for caring were:

- Patients felt safe and well cared for and consistently reported about the non-judgmental approach of staff.
- Patients' choices were respected. Their preferences for sharing information with their partner or a supporter were established and reviewed throughout their treatment.
- Patients' emotional and social needs were valued by staff and embedded in their care and treatment.
- Privacy and dignity were upheld throughout the patient's contact with the service.

### Compassionate care

- Patients were positive about the way they had been treated by staff. Comments from patients included: 'A very supportive caring service. All staff were positive and non-judgemental which made such a difficult situation easier to cope with. Thank you all'; and 'Excellent service. Good advice. Everything explained well explained. Thank you'.
- Patients commented positively about the non-judgmental approach shown by staff they interacted with.
- We observed patients and those close to them being treated with compassion, dignity and respect. All consultations took place in a private room and privacy was respected at all times in all areas at the treatment unit.
- Patients' preferences for sharing information with a supporter were established, respected and reviewed throughout their care.

### Understanding and involvement of patients and those close to them

- We saw that during the initial assessment, staff explained to patients all the available methods for termination of pregnancy that were appropriate and safe. The staff considered gestational age (measure of pregnancy in weeks) and other clinical needs whilst suggesting these options.
- Patients were involved in their care, and were given the option to administer their own vaginal tablets and given instructions on how to do this.

### Emotional support

- Patients considering termination of pregnancy should have access to pre-termination counselling. All the patients who attended the treatment unit were provided with pre-termination counselling. This was undertaken by experienced client care coordinators who had completed the BPAS Patient Support Skills and Counselling and Self-Awareness courses and were required to be fully competent with the client care coordinator competencies framework.

- Patients had access to advice and counselling before and after their procedures, either face to face or by telephone. The BPAS Aftercare Line, a telephone service operated by registered nurses and midwives, was available 24 hours 7 days a week.
- We observed that patients, and those close to them, who were anxious or unsure about their decision were provided with extra support

## Are termination of pregnancy services responsive?

**By responsive, we mean that services are organised so that they meet people's needs.**

Our main findings for responsive were:

- Patients could book appointments through the BPAS telephone booking service which was open 24 hours a day throughout the year. This also enabled patients to choose the location they attended.
- Due to limited opening times, patients were required to attend other local clinics for follow up treatment for EMA.
- The clinic did not offer surgical treatment and patients who chose this option were treated at another London based BPAS clinic that offered surgical termination of pregnancy.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- Patients were provided with information to help them to make decisions

### Service planning and delivery to meet the needs of local people

- The senior management team was involved in developing the facilities and the planning of the service along with commissioners.
- Patients could book their appointments through the BPAS telephone booking service, which was available 24 hours a day throughout the year. The electronic triage booking system offered patients a choice of appointment to help ensure patients were able to access the most suitable appointment for their needs as early as possible.
- BPAS offered a web chat service, via their internet page, for patients who wanted to know more about the services provided.
- A fast track appointment system was available for patients with higher gestational age or those with any complex needs.
- BPAS was able to offer treatment at other BPAS treatment units within the region for patients who preferred a different location, or where a convenient appointment was not available at Finsbury Park. Surgical treatments were offered at two London based locations.
- If patients chose the treatment option of medicines administration 24 – 48 hours apart, they were required to attend another local BPAS clinic if Finsbury Park was closed when the second medicine was due. We observed that one woman was discontent with this at the time of our visit.

### Access and flow

- Patients were referred from a variety of sources such as GPs, and also through self-referral. The treatment unit undertook all aspects of pre-assessment including counselling, dating scans to confirm pregnancy and determine gestational age, and other assessments of health and wellbeing.
- RSOP 11: Access to Timely Abortion Services state that patients should be offered an appointment within five working days of referral and they should be offered the termination of pregnancy treatment within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by the Department of Health. BPAS measured the number of patients who had their consultation within seven days. Between July 2015 and September 2015, 74% of patients had their consultation within seven working days of referral. The actual number that could have been seen at the treatment unit was 99%. Staff told us that the discrepancy was due to patients being treated at another treatment unit, or because they needed more time to consider their decision.
- BPAS measured the number of patients who waited longer than 10 days from first appointment to treatment. We saw documentary evidence that 19 patients had waited longer than 10 days from first their appointment to treatment in the reporting period. Sometimes this was due to the patient's preference; however BPAS did not break down the figures for how many women waited by patient preference.

### Meeting people's individual needs

- Patients were given leaflets and the 'My BPAS' guide which had information regarding different methods and options available for termination of pregnancy and the associated potential risks. This included the 24 hour telephone number of where patients could seek advice if they were worried. A manager told us this booklet was also available in braille for patients with sight loss.
- The 'my BPAS guide' also provided relevant information about disposal of pregnancy remains. Staff told us that they would discuss patients' expectations and choice about sensitive disposal of pregnancy remains on an individual basis. Leaflets were given to patients to inform them what to expect after treatment.
- If patients needed time to make a decision, this was supported by the staff, and patients were offered an alternative date for further consultation.
- There was a clearly defined referral process for patients who required a specialist service. BPAS treated fit and healthy patients without any unstable medical condition. For patients who did not meet these criteria a referral form was completed and managed by a specialist referral placement team. This was a seven day service. Patients were referred to the most appropriate NHS provider to ensure that they received the treatment they required in a timely and safe way. We saw two examples of where this had happened this in two records we looked at.
- The treatment unit was accessible to wheelchair users and accessible toilets were available.
- A professional interpreter service was available to enable staff to communicate with patients whose first language was not English. We saw where a nurse used the telephone interpreter service to ensure a client, whose first language was not English, had understood and weighed up the decision to continue the treatment.
- Midwives and nurses undertaking assessments had a range of information leaflets that they could give to patients as required. This included advice on contraception, sexually transmitted infections, miscarriage and services to support patients who were victims of domestic abuse and how to access sexual health clinics.
- We saw a folder containing information about local and national support organisations. For example, the contact details for Victim Support, NSPCC, Frank, MIND, Samaritans, Domestic Violence assistance including a local organisation called Hearthstone, Haringey Women's Aid, Respect not Fear (a relationship website for young people), Broken Rainbow (a support service for the lesbian, gay, bi-sexual, transgender community ) and The Hideout (domestic abuse support for children and young people). Information was also displayed in treatment rooms, noticeboards and in the client toilet areas.
- Staff who worked at the treatment unit were required to be pro-choice, and were supported by the organisation to promote the values through training and ongoing support such as 'Welcoming Diversity' training to ensure they recognised different cultural needs and beliefs. Training records showed this had taken place. Staff we spoke with confirmed they had undertaken such training.

**Learning from complaints and concerns**

- Staff told us that the registered manager was the first point of call for complaints so that the issues could be addressed with the patient at treatment unit level. All unresolved complaints would be managed centrally by the BPAS patient engagement manager. A full investigation of a complaint would be carried out and feedback was given to the staff.
- Literature and posters were displayed advising patients and their supporters how they could raise a concern or complain formally or informally. Information on how to make a complaint was also included in the 'My BPAS' guide.
- A separate form entitled 'Your opinion counts' was available inviting patient feedback. The treatment midwife or nurse asked patients to complete this form before leaving the treatment unit. Staff told us that patients usually wanted to leave immediately after the treatment and the majority left without completing the form.
- We were told by staff that BPAS complaints procedures were discussed as part of the corporate induction days and saw the programme which confirmed this.
- Staff told us that the registered manager was the first point of call for complaints so that the issues could be addressed with the patient at treatment unit level. All unresolved complaints would be managed centrally by the BPAS patient engagement manager. A full investigation of a complaint would be carried out and feedback was given to the staff.

- Between January 2015 and December 2015, BPAS Finsbury Park received three formal complaints. These were: inappropriate information being given at initial consultation, inappropriate greeting on arrival at the clinic, and a delay in waiting times.
- We reviewed the three formal complaints and saw that a complaint report had been completed and that a letter had been sent to each patient explaining the outcome of the investigation, actions taken and lessons learned. This meant that duty of candour had been applied.

## Are termination of pregnancy services well-led?

Our main findings for well-led were:

- There were effective corporate governance arrangements to manage risk and quality. This included an audit programme and an established system to cascade learning. However, local risks were not always identified or acted upon by people with the authority to do so.
- The culture within the service was caring, non-judgemental and supportive to patients. Staff spoke positively about the need for and value of the service to patients.
- Staff felt supported by their treatment unit manager and regional operations director.

### Vision and strategy

- The organisation's aim was: 'to provide high quality, affordable sexual and reproductive health service'. The organisation had clearly defined corporate objectives to support its aim.
- The organisation's ethos was to treat all patients with dignity and respect, and to provide a caring, confidential and non-judgemental service. Staff were supported to promote the values through training and ongoing support. BPAS policies and procedures reflected the patient's right to influence and make decisions about their care, in accordance with BPAS quality standards of confidentiality, dignity, privacy, and individual choice.

### Governance, risk management and quality measurement

- The organisational structure chart supplied by the provider showed clear lines of accountability to the Chief Executive Officer and the Board of Trustees.
- The BPAS regional quality assessment and improvement forum (RQuAIF) met three times a year and maintained oversight of all services in the region. The forum consisted of a lead nurse, a patient care manager, doctor, nurse, clinical lead and associate director of nursing. At each meeting members of the forum reviewed complaints, incidents, serious incidents, audit results, complications, patient satisfaction and quality assurance for point of care testing and declined treatments. We saw forum records that evidenced information was shared with a focus on shared learning. This forum reported to the organisation's clinical governance committee.
- Minutes from RQuAIF were also shared at the regional management meetings, which were attended by regional operations director and the treatment unit managers. Managers attending the meetings were expected to hold meetings within their treatment unit to ensure that learning was shared to a wider audience.
- Notes from the most recent London and South East Regional Management meeting held on 2 March 2016 confirmed learning about complaints and SIs had been discussed, and action points agreed. We also saw in the notes that the safety issues we have reported on relating to audit of patient group directions and the need to improve cleaning schedules and checklists had been discussed, however; there was no evidence that any action was agreed or implemented.
- Regional and treatment unit managers disseminated lessons learned to staff at treatment unit meetings, and action plans were developed to reduce the risk of a similar incident reoccurring. This was generally managed regionally and learning was shared across all treatment units in the region.
- Key policies were launched via a conference call which was accessible to all staff. These were also recorded and available for a month to enable staff to access them. A recent example of issues discussed in this was the duty of candour.
- BPAS had a central risk register which listed various areas of generic risks across all treatment units. These risks were documented and a record of the action being taken to reduce the level of risk was maintained. However, we asked to see the local risk register and none was available. Managers confirmed that a local risk register was not in place.

# Termination of pregnancy

- A director of infection prevention and control (DIPC), based at BPAS head office was responsible for leading the organisation's infection prevention team. The DIPC was part of the organisation's clinical governance and patient safety teams and structures.
- Legislation requires that for an abortion to be legal, two doctors must agree, in good faith, that at least one and the same grounds under the abortion act is met. They must indicate their agreement by signing the HSA1 form. BPAS had remote doctors working on registered premises who reviewed the patient's records and signed the HSA1 forms. BPAS had remote doctors working on registered premises who reviewed the patient's records and signed the HSA1 forms.
- BPAS treatment units completed monthly audits of completion of HSA1 forms to ensure and evidence compliance with the BPAS policy. BPAS Finsbury Park demonstrated 100% compliance with accurate completion of HSA1 forms in accordance with legal requirements.
- The Department of Health (DH) requires providers undertaking termination of pregnancy to notify them by the completion of HSA4 forms. The HSA4 notifications were completed and uploaded to the DH electronic reporting system. Doctors working under practising privileges at BPAS treatment units across the UK completed HSA4 notifications for those patients for whom they had prescribed medication. A record was made on the patient's notes that the HSA4 form was completed and submitted. An automatic reminder was sent out by the DH after two weeks if an HSA4 form had not been received.

**Leadership of service**

- The service was led by the Registered Manager supported by the regional operations director.
- Staff told us the senior management team were visible and had a regular presence at the treatment unit. Managers were supportive and, for clinical staff, the associate director of nursing was accessible and available for advice and support for clinical or professional issues.
- A clinical member of staff had made suggestions to improve the service which was introduced in collaboration with the treatment unit manager. For example, documents needed for consultation and information for patients was organised for easy access and a discharge pack was made up for patients.
- A director's brief was issued quarterly which was also discussed at regional team meetings. Treatment unit managers then held local quarterly team meetings to cascade information to the unit staff. These meetings were structured, had an agenda and were recorded.
- BPAS held a bi-annual national managers day for all managers. Bi-annual clinical forums were held for all staff and treatment units closed to facilitate attendance. The recent clinical forum had discussed the future direction of the company; conscious sedation (a combination of medicines to help patients to relax (a sedative) and to block pain (a pain killer) during the procedure, nurses' revalidation and scanning.
- Staff told us that if meetings were held on their days off, they did not attend. However, managers were unaware of this and confirmed that time would be for attendance at all meetings.

**Culture within the service**

- Staff displayed a compassionate and caring manner. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for BPAS. They described BPAS as a good place to work and as having an open culture, and felt they could approach managers if they felt the need to seek advice and support.
- Staff had access to a free counselling/support telephone service which they could call in relation to any work related or personal problems. We saw details of the service were accessible through the staff intranet.

**Public and staff engagement**

- Patients using the service were given a survey to complete entitled 'Your opinion counts'. Staff told us that due to the sensitivity of the treatment and the emotional experience for the patients, it was sometimes a challenge to engage with patients and get a response.
- The analysis of feedback from the patient satisfaction survey for January 2015 to April 2015 showed an overall satisfaction with care of 9.3 out of ten. 100% of patients surveyed would recommend the service.

# Termination of pregnancy

- Staff surveys were completed to gain staff opinion of working at the treatment unit. The staff survey results for the BPAS organisation 2015 were generally positive: 92% of staff across the organisation stated they were proud to work at BPAS and 86% of staff stated they would recommend BPAS as an organisation to work for.

**Innovation, improvement and sustainability**

- The use of 24 hour telephone appointment service and web chat service for patients was innovative.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The supply and administration of medicines under PGDs is managed in accordance with legislation, provider policy and up to date national guidelines.
- Incidents of all kinds including those with a potential to cause harm to patients or staff, even when no harm occurred, are reported and that staff receive prompt feedback to reduce the risk of recurrence.
- Implement processes to ensure greater ownership of assessing, reporting and acting upon local risks.
- Ensure staff appraisal and mandatory training are meeting the organisational target of 100%.
- All equipment is maintained and serviced to ensure it is reliable and ready for use.
- All areas in which BPAS treat patients are cleaned and that cleaning schedules and checklists are maintained to demonstrate this.