BPAS - Birmingham South

Quality Report

The Robert Clinic
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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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

BPAS Birmingham South provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was termination of pregnancy. The Robert clinic (as it was known) offered a service to women within the West Midlands conurbation via a national telephone appointment service. It provided medical and surgical terminations of pregnancy.

BPAS Birmingham South is part of the national charitable organisation British Pregnancy Advisory Service (BPAS).

BPAS provided care and treatment for more than 65,000 women each year in over 60 reproductive healthcare clinics nationwide. Most patients had their care paid for through the NHS.

We carried out this inspection under our Comprehensive Inspection programme. Prior to our visit we asked the provider organisation to send us information and data about the service and we visited the service on 26 May 2016. We did not inspect the vasectomy service.

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities it provides.

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 peoples' needs?
- Is it well-led?

Are services safe at this service

- There were systems in place to ensure all reported incidents were investigated. Staff were clear on the process for incident reporting and felt able to report appropriately.
- There were processes in place to assess and respond to patients' risk.
- The staff were up to date with mandatory training and staff had been trained to recognise and act upon suspicions of abuse.
- There was a protocol in place to transfer a patient to a local NHS Hospital if required including Birmingham Women's Hospital should their health deteriorate.
- Nursing and medical staffing numbers were sufficient and appropriate to meet the needs of patients in their care.
- The environment and equipment were clean and well maintained, and infection control procedures were followed.
- The provider had policy and procedure for safe management of medication in line with national guidance. Medicines were stored and prescribed safely.
- Controlled drugs were not routinely checked on a daily basis. This was not in keeping with nationally agreed safe practice.

Are services effective at this service:

Summary of findings

- Care and treatment was delivered using evidence based and national guidelines. Staff received training to equip them with the knowledge and skills to care for the patients receiving care in the centre.
- Outcomes of patients' care and service delivery were monitored in accordance with guidelines.
- Systems were in place to regularly audit clinical practice, including the patient helpline service, patient satisfaction and contraception uptake.
- The service did not participate in any relevant local or national audits, peer review or bench marking against other similar provider services. The provider told us it made use of any opportunities made available to bench mark from NHS services, in a competitive commissioning market it did as much as was reasonable to benchmark its service.
- Consent was sought from each patient before surgical and medical abortion procedures.
- It was not made clear on the consent form when simultaneous abortion medication was administered, that this method could increase the failure rate for a patient.
- There was not a clear capacity assessment protocol in practice for women with learning disabilities or signposting to an independent advocacy service.

Are services caring at this service

- Staff treated patients attending for consultation and termination of pregnancy with compassion, dignity and respect.
- There was a focus on the needs of patients.
- All patients considering termination of pregnancy had access to advice on abortion options and contraception.
- The provider offered on going counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Are services responsive at this service

- The clinic opened four days each week and was situated within walking distance of a train station.
- Patients could book appointments through a national telephone service that ran a flexible appointment system across clinics to offer as much choice as possible to patients.
- Patients could be offered consultation and treatment all in one day if required. Most patients had their procedure within 10 working days of first contact with the service.
- Translation services were available and there was a free on going counselling service for patients.
- The clinic encouraged patients to give feedback on the service.
- Complaints were responded to appropriately and within service agreed timescales.
- There were limited effective means to support patients with a learning disability to understand and give informed consent to procedures.
- The risks of failure of some procedures were not made clear enough to patients.

Are services well led at this service

- The organisation had a clear vision to provide safe and effective care for termination of pregnancy and staff shared this vision.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings.
- Staff received feedback from governance and quality committees so they could improve the service.
- There was strong local leadership of the service.

Summary of findings

- Staff felt supported by their managers and were confident they could raise any concerns and have them dealt with appropriately.
- The organisation had a proactive approach to staff and public engagement.
- The organisation sought ways to improve the service to patients and improve flexibility and choice.

We saw several areas of good practice including:

- The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the effectiveness of questions to identify young women who were isolated, at risk of abuse or exploitation.

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

  Importantly, the provider must:

- The provider must put into practice protocols for assessing consent and obtaining support for all patients who lack capacity to consent including those patients with a learning disability.

In addition the provider should:

- Put in place a system to cleanse or regularly replace light switch pull cords in toilets.
- Check controlled drugs each day the clinic is open.
- Consider participating in relevant local or national audit programmes or peer review to bench mark outcomes against other similar provider services.
- Ensure that where patient's consent to simultaneous administration of abortion medication for medical abortions, they are clearly informed this method could increase the risk of failure.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

Staff reported incidents and incidents were logged, investigated and learned from. The quality and safety of the services provided at the clinic were checked regularly by the manager who had to send this information to senior managers and the clinical team which is then reported to the Board that ran the organisation.

We found services at the clinic were effective. Patient's care and treatment was based on up to date good practice. Staff followed BPAS policies and procedures that supported legal requirements.

Managers regularly checked clinical practice to maintain good standards of patient care and continuously improve outcomes for patients. Doctors and nurses followed recognised safe surgical procedures. Staff employed at the clinic including doctors, nurses, administrators and receptionists were competent, well trained and experienced.

Staff gave patients good information on which to base their decisions and give informed consent. They spent time explaining options and procedures and giving advice on contraception. However, we also found it was not made clear enough to patients the increased risk of abortion failure posed by some methods. Also, there was not a clear mental capacity assessment protocol in practice for women with learning disabilities or help to access an independent advocacy service.

All staff treated patients and those close to them with kindness and respect and put them at ease. Nurses asked

Summary of findings

about and respected patients' wishes about sharing information with a partner or family members or carers and nurses checked along the way that patients were sure of their decision. A booklet called 'My BPAS Guide' was given to every BPAS patient and BPAS offered on going counselling support to all patients with patients under 18 years old counselled before treatment as a matter of policy.

The clinic opened four days each week and was near to a train station and local bus routes. Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients. Patients were generally offered an appointment within five days and treatment within ten working days of first contact with the service. The clinic had facilities on the ground floor and translation services were available. There was a free on going counselling service for patients. However support offered to patients with a learning disability to understand and give informed consent to procedures was limited.

The clinic was well run by a manager registered with the CQC and staff were committed to the BPAS vision of women being in control of their fertility. The service was patient centred and caring. There was an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings. However it was not made sufficiently clear to patients that consenting to the simultaneous administration of abortifacients could increase the risk of failure for the patient.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities it provides.

Summary of findings

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Birmingham South Clinic

Services we looked at: Termination of pregnancy

Summary of this inspection

Background to BPAS - Birmingham South

BPAS Birmingham South is part of the national charitable organisation British Pregnancy Advisory Service (BPAS). It is situated in a residential area near a train station. BPAS Birmingham South was a privately run termination of pregnancy clinic prior to BPAS ownership in 1992.

At the time of our inspection it provided consultation and medical abortion treatments up to 10 weeks gestation and surgical treatment under local anaesthetic and conscious sedation up to 14 weeks gestation. It also carried out vasectomy procedures.

BPAS Birmingham South provided support, information, treatment and aftercare for people seeking help with regulating their fertility and associated sexual health needs. Its main activity was termination of pregnancy. The Robert clinic, as it was known, offered a service to women within the West Midlands conurbation via a national telephone appointment service

The manager of the service was registered with the CQC and also managed a service in central Birmingham and in Brierley Hill.

Our inspection team

Our inspection team comprised two CQC Inspectors and access by telephone to a Consultant Obstetrician and Gynaecologist.

Why we carried out this inspection

We inspected this service as part of our Comprehensive Inspection programme of acute medical services. We inspected the termination of pregnancy services; we did not inspect the vasectomy service.

How we carried out this inspection

Prior to our visit we asked the provider organisation to send us information and data about the service covering the period for 2015. During our visit we looked at data for 2016 and we also asked for some additional information after our visit.

We made an announced visit to the service on Thursday 26 May 2016.

We spoke with four patients and followed their treatment pathway. We also spoke with three nurses, a doctor, a health care assistant, reception staff and the registered manager and regional manager. We observed treatment and care, looked at records and looked around the environment of the clinic.

Information about BPAS - Birmingham South

The Robert clinic was a period Edwardian detached house in a residential area of the Kings Norton suburb. The building was solely occupied by BPAS. It had two screening rooms, three consulting rooms, a procedures room (surgical theatre) and two waiting rooms. There were no overnight beds. The building did not have a functional lift but some consulting and screening rooms were on the ground floor.

Summary of this inspection

Between January and December 2015 the clinic carried out 373 medical terminations of pregnancy and 1532 surgical terminations of pregnancy. These included twenty girls aged between 13 and 15 years old.

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?

- There were systems in place to ensure all reported incidents were investigated. Staff were clear on the process for incident reporting and felt able to report appropriately.
- There were processes in place to assess and respond to patients' risk.
- The staff were up to date with mandatory training and staff had been trained to recognise and act upon suspicions of abuse.
- There was a protocol in place to transfer a patient to a local NHS Hospital if required including Birmingham Women's Hospital should their health deteriorate.
- Nursing and medical staffing numbers were sufficient and appropriate to meet the needs of patients in their care.
- The environment and equipment were clean and well maintained, and infection control procedures were followed.
- The provider had policy and procedure for safe management of medication in line with national guidance. Medicines were stored and prescribed safely.
- Controlled drugs were not routinely checked on a daily basis. This was not in keeping with nationally agreed safe practice.

Are services effective?

- Care and treatment was delivered using evidence based and national guidelines. Staff received training to equip them with the knowledge and skills to care for the patients receiving care in the centre.
- Outcomes of patients' care and service delivery were monitored in accordance with guidelines.
- Systems were in place to regularly audit clinical practice, including the patient helpline service, patient satisfaction and contraception uptake.
- The service did not participate in any relevant local or national audits, peer review or bench marking against other similar provider services. The provider told us it made use of any opportunities made available to bench mark from NHS services, that in a competitive commissioning market it did as much as was reasonable to benchmark its service.
- Consent was sought from each patient before surgical and medical abortion procedures.
- It was not made clear on the consent form when simultaneous abortion medication was administered, that this method could increase the failure rate for a patient.

Summary of this inspection

- There was not a clear capacity assessment protocol in practice for women with learning disabilities or signposting to an independent advocacy service.

Are services caring?

- Staff treated patients attending for consultation and termination of pregnancy with compassion, dignity and respect.
- There was a focus on the needs of patients.
- All patients considering termination of pregnancy had access to advice on abortion options and contraception.
- The provider offered on going counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Are services responsive?

- The clinic opened four days each week and was situated within walking distance of a train station.
- Patients could book appointments through a national telephone service that ran a flexible appointment system across clinics to offer as much choice as possible to patients.
- Patients could be offered consultation and treatment all in one day if required. Most patients had their procedure within 10 working days of first contact with the service.
- Translation services were available and there was a free on going counselling service for patients.
- The clinic encouraged patients to give feedback on the service.
- Complaints were responded to appropriately and within service agreed timescales.
- There were limited effective means to support patients with a learning disability to understand and give informed consent to procedures.
- The risks of failure of some procedures were not made clear enough to patients.

Are services well-led?

- The organisation had a clear vision to provide safe and effective care for termination of pregnancy and staff shared this vision.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings.

Summary of this inspection

- Staff received feedback from governance and quality committees so they could improve the service.
- There was strong local leadership of the service.
- Staff felt supported by their managers and were confident they could raise any concerns and have them dealt with appropriately.
- The organisation had a proactive approach to staff and public engagement.
- The organisation sought ways to improve the service to patients and improve flexibility and choice.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The clinic had; two screening rooms, three consulting rooms, a procedures room (surgical theatre), two waiting rooms and a reception within a large detached house in a Birmingham City suburb. It was staffed by a doctor, nurse specialists and reception and administration staff. Women could access the BPAS service through a national phone service for appointments.

It offered medical termination of pregnancy (up to 10 weeks gestation) and surgical termination of pregnancy (up to 14 weeks gestation) together with sexual health screening and contraception advice. The clinic could refer patients for late gestation termination of pregnancy and other 'complex' terminations to specialist NHS services.

In 2015 the clinic carried out 373 medical terminations of pregnancy and 1532 surgical terminations of pregnancy. These included 20 females aged between 13 and 15 years old.

Summary of findings

Staff reported incidents and incidents were logged, investigated and learned from. The quality and safety of the services provided at the clinic were checked regularly by the manager who had to send this information to senior managers and the clinical team which is then reported to the Board that ran the organisation.

We found services at the clinic were effective. Patient's care and treatment was based on up to date good practice. Staff followed BPAS policies and procedures that supported legal requirements.

Managers regularly checked clinical practice to maintain good standards of patient care and continuously improve outcomes for patients. Doctors and nurses followed recognised safe surgical procedures. Staff employed at the clinic including doctors, nurses, administrators and receptionists were competent, well trained and experienced.

Staff gave patients good information on which to base their decisions and give informed consent. They spent time explaining options and procedures and giving advice on contraception. However, we also found it was not made clear enough to patients the increased risk of abortion failure posed by some methods. Also, there was not a clear mental capacity assessment protocol in practice for women with learning disabilities or help to access an independent advocacy service.

All staff treated patients and those close to them with kindness and respect and put them at ease. Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers and nurses checked along the way that patients were sure of their decision. A booklet called 'My BPAS

Termination of pregnancy

Guide' was given to every BPAS patient and BPAS offered on going counselling support to all patients with patients under 18 years old counselled before treatment as a matter of policy.

The clinic opened four days each week and was near to a train station and local bus routes. Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients. Patients were generally offered an appointment within five days and treatment within ten working days of first contact with the service. The clinic had facilities on the ground floor and translation services were available. There was a free on going counselling service for patients. However support offered to patients with a learning disability to understand and give informed consent to procedures was limited.

The clinic was well run by a manager registered with the CQC and staff were committed to the BPAS vision of women being in control of their fertility. The service was patient centred and caring. There was an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings. However it was not made sufficiently clear to patients that consenting to the simultaneous administration of abortifacients could increase the risk of failure for the patient.

Are termination of pregnancy services safe?

- **Summary:**
- We saw the provider had a system in place for staff to report incidents and incidents were logged, investigated and learned from. A quality and safety dashboard completed by the clinic was in place and was submitted monthly through the provider's assurance system to the regional clinical lead.
- Staff followed procedures in place for good hygiene and control of infection, safe storage and administration of medication, safeguarding children and vulnerable adults, assessing and responding to clinical risk for patients and record keeping.
- Staff followed recognised safe surgical procedures including sedation and observation and monitoring of patients for deterioration in condition. The clinic had arrangements in place to transfer patients to local NHS hospitals in any emergency.
- There were sufficient nurses and doctors available to treat patients.

However we also found:

Controlled drugs were not routinely checked on days when the clinic was only open for consultations. This was not in keeping with nationally agreed safe practice.

Incidents

- We saw the provider had a system in place for staff to report incidents through their line manager. The registered manager for the service was responsible for ensuring reported incidents were investigated and learned from. The provider used a paper based incident reporting form. These paper forms were scanned and sent to the regional clinical lead for review.
- The provider reported no never events, never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the

potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

- The provider reported two serious incidents (SI) in the three months before our inspection; a drug error and retained swabs. Retained foreign object post-procedure is included as a Never Event in the NHS England 2015 list. The registered manager told us these were under investigation at the time of our visit but immediate steps had already been taken to prevent these incidents recurring.
- We tracked an incident and noted from a range of records that the incident was investigated; lessons were learned and discussed at the provider's regional clinical team and regional quality, assessment and improvement forum level and local team level.
- Action was identified and planned with timescales for achieving improved practice including reviewing the relevant guidelines and providing refresher training for clinicians or support staff. These actions were audited for effectiveness. Staff we spoke with confirmed they had received feedback and training and their practice had changed as a result.
- The manager told us the provider's serious incident investigation team may attend the clinic to investigate an incident. They would discuss learning individually with clinicians during the process.
- We saw a quality and safety dashboard was in place and completed by the manager and submitted monthly through the provider's assurance system to the regional clinical lead.
- The provider had put in place a 'red top' bulletin page. This brought to staff attention immediate changes that needed to take place after an incident or complaint within the organisation, with links to policies and procedures, while the full governance process went on.
- We saw copies of these available in the clinic for staff to read including one for the medication incident and drugs error incident at the Birmingham South clinic in 2016.
- Each member of staff was expected to read the red top alert and then the subsequent incident report and sign to confirm receiving the information. Staff we spoke with confirmed they did this. The signed sheet was then sent back to the head office to be logged centrally with the provider.
- Doctors confirmed they were sent three monthly reports indicating number of procedures undertaken, complaints and complications. Outliers were identified in this way and were reviewed by the medical director.
- All clinical staff members we spoke with were aware of their duty of candour responsibilities. **T**he provider confirmed managers had training in this area as they deal directly with compliments, feedback, complaints and incidents.'
- The registered manager described to us the system in place to respond to this regulation including sharing outcomes from the investigation with the patient and offering an apology.
- We noted the provider had decided to apply the Duty to the incident we tracked, although the investigation concluded no harm had been caused. It then became a complaint and was looked at again by the medical director under the provider's complaints procedure.

Cleanliness, infection control and hygiene

- The provider had hygiene and control of infection policy and procedures in place in line with the Health and Social Care Act (2008) code of practice on the prevention and control of infections and related guidance. We noted staff conformed to these.
- We noted the clinic was visibly clean, tidy, well organised with no clutter that would prevent effective cleaning. However the light switch pull cords in patient's toilets were very grubby from people's hands. We raised this with the manager who assured us it would be dealt with.
- We noted infection prevention was a safety and quality dashboard item audited each month by the registered manager.
- The manager undertook monthly safety audits. For example, infection control in the procedures room most recent audit of September 2015, which showed 94% compliance.

Termination of pregnancy

- The manager told us each month the clinical audit and effectiveness manager sent a specific audit for the clinic to carry out, for example in April 2016 it was hand decontamination and the clinic was found to be compliant.
- Also a BPAS infection control essential steps audit tool covered extra issues and the unit infection control lead observed five practitioners and/or five practices each month.
- The March 2016 audit found one area of non-compliance (a vomit bowl not cleared away) and we noted this was discussed at the staff meeting in April 2016.
- During our visit we observed four clinical procedures and noted staff used personal protective equipment appropriately. For example, all staff changed aprons and gloves between patients. In the procedures room all staff wore scrubs, had their hair tied back and arms were bare below the elbow.
- We observed staff hand washing and noted it was satisfactory. Posters with steps to correct method of hand washing washing were on display to prompt staff in consistent good technique.
- We noted the consulting, screening and procedure room floors, toilets and staff kitchen were not carpeted and could therefore be effectively cleaned. Other floors of the clinic such as waiting areas were carpeted. There was a cleaning schedule in place for cleansing the procedures room between patients and at the end of the list.
- Procedures were in place to safely manage waste. For example, we saw clinical waste was separated appropriately from other waste and bins were not overfilled.

Environment and equipment

- We noted current Department of Health licence and CQC registration documentation prominently displayed to demonstrate the premises were appropriately under regulation.
- Entry to the building was monitored and controlled and consultation rooms had call bells which staff could use in an emergency.
- Procedures and consulting rooms were appropriately equipped and furnished.
- Equipment was regularly checked, for example we saw the ultrasound machine and light were well within their portable appliance testing tolerance and fire extinguishers were regularly serviced.
- Emergency equipment was cleaned and checked and ready for use.

Medicines

- The provider had a policy and procedure for safe management of medication in line with national guidance. During our visit we observed medication administration to four patients and saw staff complied with these.
- For example, we saw patients' details were confirmed with the patient; allergies were checked with the patient and were indicated correctly on the prescription chart. All medications were prescribed correctly. Signed prescription charts were appropriate and completed as required by the Abortion Act 1967, following the signing of the HSA1 form. They were signed for with the doctor or nurses printed name and signature. We heard a clear explanation given to the patient about how to take the medication and the expected side effects.
- The provider had arrangements in place to monitor and audit medication management. For example, we noted the quality dashboard for April 2016 showed 'achieved' for medicines management at this clinic.
- The registered manager was responsible for controlled drugs at the clinic. We saw the storage of medication in the clinic, including controlled drugs was appropriate. We noted medicines fridge temperatures were checked and recorded daily.
- We noted the controlled drugs supplies were checked on days when the procedure room was in use and these checks were completed and up to date. However, controlled drugs were not routinely checked on other days when the clinic was only open for consultations. This was not in keeping with nationally agreed safe practice.

Records

- Patient records were held in paper and electronic format.

- The manager's monthly audit programme included records. In April 2016 an audit of case notes for a record of surgical safety showed no errors.
- We looked at three sets of patient notes and we found them to be contemporaneous, complete and legible. They were fit for purpose in detail and included a risk assessment involving medical and social history.
- We saw documentations for termination of pregnancy (HSA1 forms) were present in each set of patient notes and signed prescription charts where appropriate as required by standard operating procedure 1 (RSOP) from the Department of Health.
- The provider had a secure electronic system in place for patient records including termination of pregnancy certification. This meant a second registered medical practitioner at a remote location (another clinic, Approved Place, run by the provider) could view patient history and other notes, make an independent decision in good faith and sign the HSA 1 form. We saw this system working effectively during our visit.

Safeguarding

- The provider had policies and procedures in place for safeguarding children and vulnerable adults and staff understood these in practice**.**
- Patients identified as at safeguarding risk, for example less than 18 years of age, underwent a safeguarding risk assessment. We noted the questions asked aimed to identify individuals who were isolated, at risk of abuse or exploitation.
- Girls of 14 years or younger were treated after assessment with the involvement of the provider's safeguarding lead who assessed whether to involve social services or the police. Staff told us the local police attended whenever BPAS reported an underage pregnancy.
- The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment.
- We noted a poster displayed in the staff area to prompt awareness of female genital mutilation (FGM) and the pathway they would follow if they came across a patient with FGM.
- All staff were trained to level 3 safeguarding children and all staff were trained in safeguarding adults.
- All staff were aware of their responsibility under the Fraser guidelines in relation to gaining consent from underage patients.

Mandatory training

- All staff we spoke with including administrative and support staff confirmed they had completed mandatory training. They said the clinic closed once every two years for staff to receive mandatory training. We noted with the exception of a new starter this was confirmed by the training matrix.

Assessing and responding to patient risk

- We saw nurses documented clinical observations of patients prior to administration of medication, including identification of allergies and for post procedure reviews.
- The provider reported during 2015, 1532 patients underwent surgical termination of pregnancy that were risk assessed for Venous Thrombo Embolism (VTE).
- The provider told us it had recently introduced (but gave no date) a modified early warning system (MEWS) at the clinic, a tool for recovery staff to use. It used a points system to indicate when a patient's condition required escalation for senior clinical advice.
- We observed surgical procedures and noted staff used a white board on the wall in full view of all the team to complete a safety checklist and patient information for each procedure including the WHO five steps to safer surgery checklist. A swab count and all instruments were checked at the end of each procedure.
- We noted through the three surgical procedures we observed that staff took observations at appropriate intervals including during recovery.
- The clinic had formal transfer agreements in place with local NHS hospitals should a patient require transfer post-operatively in an emergency.
- We noted the transfer policy displayed on the wall in the procedure room with contact names, job roles and telephone numbers.
- One patient had been transferred from the clinic to another health care provider in 2015.

- Following surgical treatment, patients were assessed for fitness for discharge by a registered nurse/midwife.
- The clinic was practising conscious sedation for surgical procedures and therefore did not have an anaesthetist doctor present during procedures. We noted from records all clinical staff held immediate life support training competence and health care assistants held basic life support training competence.
- A training matrix showed all clinic staff had updated basic life support training in April 2016. The lead nurse and one nurse practitioner also had up to date immediate life support training. The Resuscitation Council (UK) training guidelines advise that anaphylaxis training is part of this course.

Nursing staffing

- We observed the clinic had sufficient nurses on duty to meet the needs of patients.
- The clinic employed 2.8full time equivalent registered nurses. On the day of our visit there was a full theatre list and some medical terminations of pregnancy appointments in the afternoon.
- We saw there were three nurses and two health care assistants (NVQ level 3) on duty. Nurses included the regional nurse and midwife
- The provider reported zero use of agency nursing staff during 2015 and a 100% rate of annual appraisal.

Medical staffing

- The clinic employed 0.6 full time equivalent registered medical practitioners.
- We saw one appropriate medical practitioner (doctor) undertaking surgical procedures and acting as operator-sedationist for conscious sedation of patients.
- The provider reported zero use of agency medical staff during 2015 and a 50% rate of annual appraisal.

Major incident awareness and training

We noted there was a protocol in place to transfer a patient to a local NHS Hospital. There was a written emergency contingency plan in place specific to the clinic and this covered failure of supply such as gas, water and electricity. There was no formal, local contingency plan for business continuity in the case of prolonged loss of premises due to major incident.

Are termination of pregnancy services effective?

Summary:

- Staff provided care in line with national best practice guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. The organisation was monitoring outcomes from this treatment
- Care and treatment was supported by policies and procedures which staff followed.
- There were systems in place to regularly audit clinical practice including surgical procedures and these worked to maintain good standards of patient care and continuously improve outcomes for patients.
- Staff employed at the clinic including doctors, nurses and administrators and receptionists were highly competent, well trained and experienced. They had access to good information systems and worked together, and with staff in local acute hospitals when necessary, for the benefit of patients.

However we also found:

- It was not made sufficiently clear to patients that consenting to the simultaneous administration of medication for medical termination of pregnancy method could increase the risk of failure.
- There was not a clear capacity assessment pathway in practice for women with learning disabilities or signposting to an independent advocacy service.

Evidence-based care and treatment

- The provider's policies were in line with the Royal College of Obstetrician and Gynaecologists guidelines with the exception of the use of simultaneous administration of abortifacient drugs for early medical

abortion (EMA), which is outside of current Royal College of Obstetrician and Gynaecologist (RCOG) guidance. However the organisation was monitoring outcomes from this treatment.

- We followed the patient pathway of four patients, three who underwent surgical and one who underwent medical termination of pregnancy. We noted staff provided care in line with national best practice guidelines and followed the provider's policies during the treatment they provided.
- Patient notes showed individualised care pathways; all of the notes we viewed were completed appropriately including consent and discussion regarding choices and information about continuing the pregnancy and future contraception.
- For example: all women were provided with an ultrasound examination prior to discussing of termination of pregnancy methods; medical risk assessments were incorporated into the patient pathway; complications were clearly explained and contraception was offered to all women.
- Staff carefully monitored patient's recovery from surgical treatment.
- Information on signs and symptoms to be aware of and which would be concerning was discussed with the patient at discharge including after medical termination and highlighted in the patient information booklet
- Since early 2015 the clinic had been using conscious sedation for surgical terminations of pregnancy up to 14 weeks gestation. We noted BPAS clinical guidelines for conscious sedation dated March 2015 and these referenced national guidance on safe sedation.
- We observed sedation was carried out in keeping with the national guidance. For example; the procedure room was staffed by the operator-sedationist who was the surgeon performing the evacuation procedure, a registered nurse responsible for patient monitoring and an assistant to procedure, who was a health care assistant.

Pain relief

- We observed appropriate pain relief was prescribed and administered during surgical procedures. Clinicians asked patients undergoing surgery with conscious sedation about pain levels during the procedure.
- We observed staff gave patients appropriate pain relief to go home with after taking medication of an early medical termination of pregnancy. Details on pain relief were also set out in the 'My BPAS guide' which staff gave to every patient.
- We heard advice given regarding eating and drinking following discharge and this was also in the patient information leaflet. Clinical staff prescribed anti-sickness drugs if required.
- During 2015 the provider had carried out a subjective evaluation of the method of conscious sedation during surgical procedures from a small sample of patients. Patients were asked to complete a questionnaire on their discharge from the clinic. This limited evaluation supported the sedation method to have been effective in pain control.

Patient outcomes

- The provider had put in place systems to regularly audit clinical practice. We were told BPAS had a planned programme of audit and monitoring including the patient helpline service, patient satisfaction and contraception uptake.
- Local managers reported audit outcomes and service reviews to governance committees such as infection control (IC) and the regional quality, assessment and improvement forum Registered managers were expected to complete action plans for areas of non-compliance which were then reviewed by the BPAS clinical department and the regional quality, assessment and improvement forum
- We saw the registered manager completed an outcomes audit each month and completed a clinical dashboard which was sent to the clinical team.
- The patient journey was audited monthly by the manager following through the experience of a sample of patients.
- We reviewed data collected by the provider from May 2015 to April 2016. This data looked at major and minor clinical complications including surgical termination of pregnancy and outcomes of failed medical terminations of pregnancy, comparing the two different regimens for this treatment.
- Some data was available for 2014/15 comparison but not all and this made comparison of the two medical regimens unreliable.

- There was one surgical major complication (0.72% of patients in January to April 2016) (uterus penetration) and two surgical minor complications (1.46% of patients).
- Data for medical termination was less clear but appeared to show for example, for the period May to August 2015 simultaneous administration of the medication had increased the number of minor complications from the same period in 2014 at 0-9 week's gestation.
- Continued pregnancy rose from 0.35% of patients in 2014 to 4.82% in 2015. 1.04% of abortions in 2014 were incomplete. From September to December 2015 0.91% of abortions were incomplete.
- We discussed this with the manager during our visit and they said the numbers for their service were too small to be significant.
- The provider's 2016 audit plan included medical treatments. The manager told us the service did not participate in any relevant national audit programme to bench mark its outcomes against other similar provider services.
  The provider informed us following the inspection that it did as much as was reasonably possible to do to benchmark its service and welcomed peer review with its NHS colleagues at every opportunity that was offered to it. 'However, it operated in what had been developed by commissioners as a competitive business environment. One of the results of this was an absence of data on which to base benchmarking or peer audit'
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- .
- The provider had been trialling conscious sedation at the clinic during 2015. It developed an evaluation tool to collect patient feedback specifically about their experience of the sedation service.
- Surveys were administered before discharge. From August to October 2015; 91 patients underwent a surgical procedure under conscious sedation and 28 (31%) of patients responded to the survey.
- Analysis by the provider concluded, 'operator-delivered conscious sedation has been delivered safely and satisfactorily at BPAS Birmingham South. Feedback was needed from a greater number of patients to determine if any changes need to be made to the care pathway, particularly with regard to pain management. Consideration would also be given to assessing pain intra-operatively and in the recovery area, rather than asking women to comment at discharge.'

Competent staff

- Nurses said they had adequate time for supervision and were being supported with the revalidation process.
- We noted from minutes of two recent staff meetings that discussion and information covered a range of clinical issues including for example, infection control and discussion of conscious sedation guidelines and practice over which some staff raised questions for the medical staff to take to clinical governance.
- All nurses had ultrasound competency. They told us this had been supported through an education programme and was overseen by the lead nurse for the clinic and the corporate ultrasound lead.
- Nurses had up to date appraisals but doctors did not. During 2015/16 only 50% of doctors had appraisals. Doctors we spoke with also worked for the NHS, they told us BPAS offered good on going training.
- The clinic employed nine reception/administration staff and we observed they were knowledgeable about the systems required to support compliance with regulations. They also had a high level of sensitive interpersonal skill in their dealings with patients.
- The manager told us all clinical staff had training in conscious sedation, a joint day of theory training and then different packages of training for nurses and for doctors. The training matrix we saw confirmed this. Clinical staff were then supervised for over 50 procedures or over a six month period.

Multidisciplinary working

- We observed effective multidisciplinary team working between the administration staff and the nurses. Nurses and doctors worked well together in the procedures room for the benefit of patients.

- There was a service level agreement with the local NHS hospital to accept patients in an emergency. The clinic had good contact arrangements with local early pregnancy assessment units in NHS acute services and clinicians referred patients as appropriate.
- We noted on discharge patients were given a letter providing sufficient information about the procedure to enable other practitioners to manage complications if required. Patient's consent was requested to send a copy of the letter to their GP and we noted the letter contained adequate information.

Seven-day services

- The provider had a centralised phone line appointment system and could offer patients appointments at a clinic and time that suited them.
- There was patient access to a 24 hour patient's helpline. If a patient accessed the helpline they were followed up by the clinic staff the next working day.
- The Birmingham South clinic ran on Tuesdays to Fridays (8.15am to 5pm) with occasional Saturday opening for vasectomy consultations. Emergency slots were factored into the appointments plan.

Access to information

- All BPAS guidelines and protocols were available online on their intranet site for staff to access.
- We noted patients notes were available electronically for two doctors including those not present in the clinic to assess their medical history and other information and to agree and certify in good faith that they fulfilled one of the legal criteria for termination of pregnancy.
- Patient prescriptions and HSA1 documentations were available to doctors to complete and sign online when a doctor was not present in the clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed informed consent was sought from each patient before surgical and the medical abortion procedure and this included giving information about possible complications and implications. The consent was checked by the nurse administering medication.
- The contraception method was indicated in patient's notes we looked at. Appropriate consent with the risk and benefits was discussed with the patient. Contraception and sexually transmitted infection information was discussed at discharge and was in the patient information booklet.
- Patients we spoke with in general told us all staff explained all risks associated with the different procedures. However, we noted it was not made clear on the consent form when simultaneous abortion medication was administered that this method of administration was new and the provider had been was part of a research trial the provider was participating in at the time of our inspection during 2015/16. The method could increase the early medical abortion failure rate for a patient. The provider since assured us that the practice of nurses verbally communicating this information to patients was reinforced immediately after our inspection visit
- The nurse initially saw all patients without the presence of whoever had accompanied them to the clinic. For patients less than 18 years of age a Gillick competency assessment was completed and Fraser guidelines followed for contraceptive advice.
- We discussed with the manager the clinic's practice around gaining consent. They told us the provider policies were available to staff on the intranet and described the clinics networks with safeguarding nurses employed by the local clinical commissioning groups and the team at the Birmingham Children's hospital. There was a single point of telephone contact for BPAS to use for advice. We noted a poster to this effect in the staff area.
- Operational/clinical policy and procedures for consent to examination and treatment were in place that addressed responsibilities under the Mental Capacity Act 2005. However, we found from discussion with staff and the registered manager there was not a clear capacity assessment protocol in practice, in keeping with required standard operating procedure (RSOP) 8 for women with learning disabilities. Nor was there signposting to an independent advocacy service. Staff were not clear about capacity assessment processes for patients with learning disabilities; their understanding was it was not necessary to trigger a capacity assessment if a patient had someone accompanying them such as a supportive parent or care worker. This put this particular patient group at risk because not

undertaking a mental capacity assessment and using an independent mental capacity assessor (IMCA) meant the provider could not assure themselves that the person was not being coerced into the decision.

Are termination of pregnancy services caring?

Summary:

- Staff in all roles treated patients and those close to them with kindness and respect and put them at ease.
- Nurses asked about and respected patients' wishes about sharing information with a partner or family members or carers.
- Nurses checked along the way that patients were sure of their decision. Patients were given opportunities to express their feelings. Additional information and counselling could be offered or the procedure postponed if they were unsure.
- BPAS offered on going counselling support to all patients and patients under 18 years old were counselled prior to treatment as a matter of policy.

Compassionate care

- All staff we observed with patients including administrative and reception staff were kind and considerate. They treated patients with respect and dignity and followed systems in place to maintain patient's privacy and confidentiality.
- Doctors we spoke with were committed to supporting women to manage their lives. They articulated an understanding of the difficulties women faced making decisions about their fertility.
- We spoke with three patients whose care pathway we followed. They confirmed they were satisfied with the treatment they received; they said staff were very kind and the service was easy to access.

Understanding and involvement of patients and those close to them

- The clinic provided counselling support and it was offered to all patients. Patient under 18 years were counselled prior to treatment as a matter of policy.
- We noted patients were given opportunities to express their feelings and to change their mind if they wished. For example, the nurse administering the early medical abortion medication asked question prompts to check if the patient had any anxieties and if they were sure of their decision, the nurse then indicated their response in the notes. Additional information and counselling could then be offered or the procedure postponed.
- Patients we spoke with whose treatment pathway we followed told us the procedure, the risks, after effects and all the medication was clearly explained to them. Also staff used the 'My BPAS guidebook' to reinforce this information and was available for patients to refer to.

Emotional support

- We noted counselling support from the client care co-ordinator was offered to all patients and we observed patients under 18 years old were counselled prior to treatment as a matter of policy.
- In the procedure room we observed the nurse held a patient's hand through the surgical procedure to offer emotional support.
- We observed nurses giving information about the providers 24 hour telephone counselling service during post treatment discussions in line with RSOP 3.

Are termination of pregnancy services responsive?

Summary:

- Patients could book appointments through a national telephone service that ran a flexible appointment system to offer as much choice as possible to patients.
- Patients were generally offered an appointment within seven calendar days of contact with the service. Patients could be offered consultation and treatment all in one day if required. Most patients had their procedure within working 10 days of making contact with the organisation.
- Translation services were available and there was a free ongoing counselling service for patients.
- The clinic encouraged patients to give feedback on the service including making a complaint and the provider used this to improve the service.

However we also found:

There were limited effective means in practice of supporting patients with a learning disability to understand

and weigh up the issues involved. Staff relied on the input of support workers or parents to facilitate the patients understanding of the procedures and the options and consent.

Service planning and delivery to meet the needs of local people

- Patients could self-refer to the services as well as through traditional referral routes. Patients were offered appointments to suit their needs, there were enough appointments available to suit the need for treatment and patients we spoke with confirmed this. The clinic opened Tuesdays to Fridays from 8.15am to 5pm and on Saturday on occasions for vasectomy procedures.
- Managers told us the provider's business development managers were responsible for overseeing capacity management and clinic managers amended their appointment templates, adding additional appointments when necessary to meet local needs.
- The provider had local commissioning arrangements in place to enable funding arrangements for patients where appropriate and contracts with local NHS acute services to refer patients with complex pregnancies.
- The clinical staff had the support of three part time administrators who were based and worked only in the Birmingham South clinic. This included a client care coordinator who was counselling trained and supported the service to meet national guidelines relating to the 'Care of Women Requesting Induced Abortion (2011)'.
- Patients could also contact BPAS via a dedicated telephone number in order to make an appointment for post-abortion counselling. Post abortion counselling was a free service to all BPAS patients, and could be accessed any time after their procedure, whether this was the same day or many years later.
- The provider had a policy and procedure in place in for safe and dignified disposal of pregnancy remains including patient consent. We spoke about this with a health care assistant. They were able to describe for example, the recognised good practice protocol in place for when patients wished to keep their pregnancy remains.

Access and flow

- A centralised electronic triage booking system offered patients a choice of dates, times and locations. This ensured women were able to access the most suitable appointment for their needs and access treatment as early as possible.
- Women were able to choose their preferred treatment option and location, subject to their gestation time and a medical assessment and patients we spoke with confirmed this.
- BPAS also provided a service for patients who were unable to be treated safely within the BPAS guidelines. These patients could be referred via the provider's specialist service to an NHS hospital for treatment. This could include patients who are late in gestation but mainly those with more complex medical requirements. The provider told us it was able to provide treatment for patients up to 24 weeks gestation within BPAS clinics across the organisation.
- We tracked the access pathway of one patient through the electronic booking system and consultation notes. We noted the BPAS doctor saw and referred the patient to a specialist NHS termination of complex pregnancy service.
- The system recorded what appointments were available within a 30 mile radius of the patient's home address at the point of booking. This enabled the provider to analyse waiting times and evidence patient choice.
- The provider had systems in place to ensure as far as possible the total time from first contact to procedure was not more than 10 working days in line with the RSOP 11.
- However, the provider's data showed during 2015, 338 (approx. 15%) of patients waited longer than 10 days from first appointment to termination of pregnancy.
- Across Birmingham (two BPAS services) for the period October – December 2015 the provider reported the proportion of women who had their consultation within seven days (CCG target seven calendar days) was 89%. The proportion of women who could have had their consultation within seven days was actually 97%.
- The figures, against a target of seven calendar days, as reported to the clinical commissioning groups (CCG's) across Birmingham and shared with us by the provider, reduced for the quarter January to April 2016.

Termination of pregnancy

- The proportion of women who had their consultation within seven days was between 70% and 77% and the proportion of women who could have had their consultation within seven days was actually around 94%.
- This data also showed the average numbers of days from 'first contact' to 'treatment' during that quarter across Birmingham was 12.5 to 13.5 for the mean average and 10 to 11 for the median average number of days (whether calendar or working day was not indicated).
- The provider told us so far in 2015/16, over 82%of patients at the clinic had been treated below 10 weeks gestation which, was above the national average.
- Patients could be offered consultation and treatment all in one day if required or telephone consultation. The service reserved appointment slots in the afternoon to ensure this one day service could be accessed if needed.

Meeting people's individual needs

- The service operated over a number of floors in an Edwardian period building. The lift was not safely functional and therefore no longer used. There were waiting, consultation and procedures and recovery rooms on the ground floor.
- Policies were in place to aid translation via language line telephone services. Staff had access to translation services over the 'phone or if necessary face to face. The provider had a contract with a translation service that patients could use to access the national contact centre to make an appointment at a clinic.
- We saw from records an example of BPAS providing extra financial help to a patient who had to travel to London and stay overnight to attend a late gestation termination of pregnancy services NHS clinic.
- We noted there were limited effective means in practice of supporting patients with a learning disability to understand and weigh up the issues involved, as is required by RSOP 8. The 'My BPAS guide' booklet had no easy read page or accompanying leaflet to signpost a patient through its contents.
- Staff relied on the input of support workers or parents to facilitate the patients understanding of the procedures and the options and consent.

Learning from complaints and concerns

- The provider had a system in place for patients to raise concerns, make a complaint or just provide feedback. They reported they had received three complaints about the service during 2015.
- All patients were given a client survey/comment form entitled 'Your Opinion Counts' and there were boxes available at the clinic for patients to leave their forms or post directly to the providers head office. We noted a poster and leaflets on display encouraging and guiding patients to make a complaint or give feedback.
- Managers told us completed forms left at the clinic were initially reviewed by the clinic manager and then sent to the head office for collation and reporting. This meant the manager could begin to immediately address any adverse comments.
- The provider's client engagement manager produced satisfaction survey reports which were collated by clinic. The provider's regional quality, assessment and improvement forum and clinical governance committee reviewed a report of all complaints and a summary of service user feedback (including return rates and scores). Survey results were shared with the clinic.
- The patient booklet 'My BPAS Guide' also included a section on how to give feedback and how to complain, as did the provider's website.
- The manager told us one incident we tracked was stepped down from a rating of 'serious incident' after investigation. The patient was dissatisfied and made a complaint and the matter was looked at again by the medical director and through the complaints procedure. The provider organisation was able to learn lessons regarding practice associated with the original incident and change some practices to improve the service.

Are termination of pregnancy services well-led?

Summary:

- Staff were all committed to the BPAS vision of women being in control of their fertility. The service was patient centred and caring.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings. Messages were communicated to staff through email and a team brief.

- Clinic performance was measured through audits and reported on a monthly dashboard to the regional operations director. Action plans were developed for areas that required improvement.
- The clinic was well run by a manager registered with the CQC and staff felt confident about speaking up, learning from incidents and trying out new ways to improve the service.
- Staff encouraged patients to give feedback about the service they received and contribute to improving the service in a range of ways including through social media.
- The clinic had successfully led within BPAS on trying a new method of sedation for surgical procedures.

Leadership / culture of service

- The clinic was overseen by a manager registered with the CQC. She told us she was available to staff everyday via telephone if not on site and that she planned her week to cover all three the clinics she managed and varied her time to ensure contact with all staff. Clinical and administrative staff we spoke with confirmed this.
- Staff we spoke with in all roles reported that the organisational culture was open and honest. They felt confident to approach the registered manager at any time with concerns or questions and said regional managers and national leaders were accessible to them.
- Staff we spoke with about learning from incidents told us they did not feel victimised when they made mistakes and they were encouraged to be involved in sharing learning from incidents.
- Medical staff confirmed they received three- monthly reporting on procedures, complaints and complications.

Vision and strategy for this this core service

- We saw the service displayed the provider's documentation of approval (issued by the Department of Health to carry out terminations of pregnancy) in a prominent position within the clinic.
- Staff we spoke with were clear on the BPAS vision of women being in control of their fertility and that the service was patient centred and caring.

Governance, risk management and quality measurement for this core service

- We noted the provider had put in place robust arrangements for risk management and quality assurance. These were followed by the registered manager and reported up through the organisation by good effective governance structures. For example, we saw that measures had been put in place in the clinic to mitigate the risk of three areas of practice that had generated serious reportable incidents during 2015/16.
- The provider had a system of governance in place at national and regional levels. It comprised of a board of trustees, a clinical governance committee, research and ethics committee, infection control committee, information governance committee and regional quality, assessment and improvement forums.
- In 2015 BPAS implemented the clinical dashboard to measure quality and safety, which was an improvement tool for measuring, checking, and analysing clinical standards. We noted the registered manager monitored clinic performance and submitted monthly data on the dashboard to the regional operations director. The dashboard included results on medicines management, staffing levels, clinical supervision, infection prevention, case note audits, serious incidents, safeguarding, complaints, laboratory sampling, labelling and staff sickness. Clinic performance was compared and monitored at the regional quality, assessment and improvement forum meetings.
- High risk incident logs were maintained for each clinic including Birmingham South. We noted incidents were assessed and given 'RAG' rating status that identified the level of risk and investigation by the provider. The registered manager and doctors told us the regional quality forums were embedded on a good and effective cycle.
- The provider showed us routinely collected data from each clinic on clinical complications and year on year comparisons. This included data comparison for simultaneous and 48 hour gap administration of abortifacient (drugs used to bring about a termination of pregnancy) medication for early termination of pregnancy as part of a clinical trial.
- Documentations for termination of pregnancy (HSA1 forms) were present in each set of patient notes we looked at and signed prescription charts where appropriate.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their

agreement (HSA1 form), in line with the requirement of the 1967 Abortion Act. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. A doctor on site at BPAS Birmingham South reviewed the completed documentation following the initial assessment by the nurse and either authorised the HSA1 as the first doctor or declined and requested further information. If a second doctor was available on site they would review the information and similarly authorise the HSA1 as the second doctor or decline and request further information. If a second doctor was not available onsite, BPAS used the electronic central authorisation system to ensure information and the HSA1 form was accessible and signed by doctors located at other BPAS units. Authorising doctors had access to information including the patients' medical history, blood test results, reason for seeking a termination and scan measurements, although the actual scan pictures were not available electronically. When the HSA1 form was fully completed the termination of pregnancy procedure could take place legally.

- The Department of Health required every provider undertaking termination of pregnancy to submit specific data following every termination of pregnancy procedure performed (HSA4 form). We observed staff recorded this data. There was an email reminder process to prompt doctors to submit the HSA4 information to the Department of Health. The HSA4 was signed online within 14 days of the completion of the abortion by the doctor who terminated the pregnancy. For medical abortions, where patients delivered pregnancy remains at home, the doctor who prescribed the medication was the doctor who submitted the HSA4 form.

Public and staff engagement

- Staff encouraged patients to give feedback about the service they received in a range of ways including through social media. The provider had consulted and involved young patients in the content of and questions in the safeguarding assessment form.
- The client engagement manager reviewed any comments left about the service on the NHS Choices website.
- Staff told us they felt part of the organisation and were proud of their skills and service.
- Results for the Friends and Family test showed 100% of patients (212 responded for the period January to March 2016) were either likely or extremely likely to recommend the clinic.

Innovation, improvement and sustainability

- BPAS actively looked for improvements to the way it delivered services. For example the clinic had trialled conscious sedation for surgical procedures during 2015. After eight months the service was evaluated and expanded to other BPAS clinics from November 2015 to replace a general anaesthetic list.
- The provider told us it has been involved in providing advice and guidance to the Human Tissue Authority (HTA) on production of its document, 'Guidance on the Disposal of Pregnancy Remains Following Pregnancy Loss or Termination', and was part of the team updating the Royal College of Nursing's guidance document, 'Sensitive Disposal of all Foetal Remains'.

Outstanding practice and areas for improvement

Outstanding practice

The provider organisation had consulted a sample of young people in designing the safeguarding risk assessment. This improved the effectiveness of questions to identify young women who were isolated, at risk of abuse or exploitation.

Areas for improvement

Action the provider MUST take to improve

Action the clinic MUST take to improve

- The provider must put into practice protocols for assessing consent and obtaining support for all patients who lack capacity to consent including those patients with a learning disability.

Action the provider SHOULD take to improve

Action the clinic SHOULD take to improve

- The provider should ensure that controlled drugs are checked each day the clinic is open.
- The provider should consider participating in relevant local or national audit programmes or peer review to bench mark outcomes against other similar provider services.
- The provider should ensure that where patient's consent to simultaneous administration of abortion medication for medical abortions they are clearly informed this method could increase the risk of failure.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **11 Need for consent** (1) Care and treatment of service users must only be provided with the consent of the relevant person. (2) Paragraph (1) is subject to paragraphs (3) and (4). (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act. (4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act. (5) Nothing in this regulation affects the operation of section 5 of the 2005 Act, as read with section 6 of that Act (acts in connection with care or treatment). The provider was not meeting this regulation because: • The provider did not have effective protocols in practice for patients who may lack capacity to consent.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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