BPAS - Leeds

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 Leeds is part of the British Pregnancy Advisory Service. BPAS Leeds opened as a consultation centre in 1970. BPAS Leeds provided termination of pregnancy services, pre and post termination counselling as well as contraception advice and screening for sexually transmitted diseases. The clinic had provided surgical abortions under local anaesthetic until June 2015 when the consultant left the organisation and this part of the service was suspended. The organisation intends to resume this service when the vacant post has been filled. At the time of the inspection, the service was providing medical abortions up to 10 weeks gestation.

We made an announced inspected of the service on 12-13 April 2016 and an unannounced inspection on 27 April 2016 as part of our independent healthcare inspection programme.

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, which it provides.

Are services safe at this service?

There was a culture of reporting and learning from incidents across the organisation and within the local services. Staff we spoke with demonstrated an excellent understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse. All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment. All staff had completed training to level 3 in safeguarding for children and adults.

Staffing was sufficient and appropriate to meet the needs of patients in their care. Staff ensured medicines were stored and administered safely. Pathway documents and clinical risk assessments were completed fully and legibly. Staff completed and submitted all Department of Health documentation as required.

Are services effective at this service?

Care was provided 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. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment to build on their evidence base.

We observed that patient assessments were thorough and staff followed pathway guidance. Pain relieving medications were routinely prescribed for patients to take at home following their procedure or initiation of treatment.

Observation and assessment of staff competence was an integral part of pathway audit. Staff always made sure patients gave their consent in writing and adhered to Fraser guidelines in respect of children and young people. There were good links with local safeguarding teams, the local NHS hospital and other agencies.

Are services caring at this service?

Senior managers and staff involved and treated patients with compassion, kindness, dignity, and respect. The results of the BPAS 'Client Satisfaction' reports showed 100% of patients at BPAS Leeds were 'extremely likely' or 'likely' to recommend the service to others. Satisfaction reports showed high levels of patient satisfaction. Client Care Coordinators (CCCs) and nursing staff gave appropriate emotional support to patients. Staff provided all patients with a counselling service before and after termination of pregnancy if required or requested. There was access to specialist advice and support when needed. We saw examples where staff had gone out of their way to support patients in difficult situations.

Are services responsive at this service?

Summary of findings

Service planning monitored activity and staff scheduled sufficient clinics to meet demand. The service had access to a learning disability specialist who provided advice and support to staff caring for people with these needs. Staff made sure they had enough information and could get further advice when necessary. The service met waiting time guidelines and patients could choose a date or alternative venue for their procedure. The service shared learning from complaints across the organisation, nationally, regionally and locally and staff gave examples of this during the inspection.

Are services well led at this service?

The organisation had a clear mission to provide safe and effective care for termination of pregnancy. Senior managers had a clear vision and strategy for this service and there was strong local leadership of the service. Quality of care and patient experience was seen as the responsibility of all staff.

There were effective governance systems in place and staff received feedback from governance and quality committees. Staff felt supported by their managers and were confident they could raise concerns and have them dealt with appropriately. The organisation had a proactive approach to staff and public engagement.

The service met Department of Health requirements regarding compliance with the Abortion Act 1967 and the 'Required Standard Operating Procedures 2014'.

Our key findings were as follows:

- Staffing levels, medicines' management and record keeping were good.
- Staff followed policies and procedures.
- Care was provided 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. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment to further develop an evidence base.
- There was enough equipment to allow staff to carry out their duties. The service had processes for checking and maintaining equipment.
- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- There was evidence of a culture of learning and service improvement.
- There were systems for the effective management of staff which included an annual appraisal and support for revalidation
- The service had a rolling programme of local clinical audits. Managers monitored and benchmarked performance of all units across the organisation using a performance dashboard.
- Leaders were aware of their responsibilities to promote patient and staff safety and wellbeing.
- Leaders were supportive and the culture encouraged candour, openness, and honesty.

We saw several areas of good practice including:

- Staff went out of their way to provide a caring and holistic service to their patients. They did this by working well with local agencies to provide additional support and services where appropriate and by acting as an intermediary for patients who lacked confidence to make initial contact with other agencies.
- Regular, direct observation of staff practice was an integral part of the BPAS approach to ensuring staff maintained an expert level of competence in their individual roles.
- The provider ensured that all patients received a private initial consultation without anyone else present to protect patients against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.
- Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs, who did not meet usual acceptance criteria.

Summary of findings

- Staff knew their own role, remit for safeguarding children and vulnerable adults, and had a heightened awareness of the needs and vulnerabilities of children and young people using their service.
- Completion of records complied with prescribed practice and was consistently of a high standard.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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Background to BPAS - Leeds

The British Pregnancy Advisory Service was established as a registered charity in 1968 to provide a safe, legal abortion service following the 1967 Abortion Act. BPAS Leeds opened in 1970.

Leeds, Bradford, Wakefield, North Yorkshire and York, and Calderdale and North Kirklees clinical commissioning groups contract BPAS Leeds to provide a termination of pregnancy service for the patients of West Yorkshire and surrounding areas. The service also treats self-funded patients which accounts for around 2% of activity.

The service was registered as a single speciality service for termination of pregnancy and is registered for the following regulated activities:

- Diagnostic & Screening Procedures
- Family Planning Services
- Treatment of Disease, Disorder and/or Injury
- Termination of Pregnancy
- Surgical Procedures

The services provided under these activities were:

- Pregnancy Testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Surgical Abortion Local Anaesthetic/conscious Sedation (Although this was not being provided at the time of the inspection the service was planning to re-commence this service later in the year)
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice
- Contraception Supply

Our inspection team

Our inspection team was led by:

Inspection Lead: Berry Rose, Inspection Manager, Care Quality Commission.

The team included other CQC inspectors with additional training in the inspection of termination of pregnancy services.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out the announced inspection of BPAS Leeds on 12 and 13 April 2016 and an unannounced visit on 27 April 2016. We talked with patients and members of staff: including two receptionists, two client care coordinators (CCCs), four registered nurses / midwives (RNs / RMs) and a surgeon. We also spoke with the treatment unit manager one regional manager and the regional operations director. We looked at the care records of 23 patients (20 paper records and three electronic records). We observed social interactions and communication with patients and those close to them during our inspection.

As the service was not carrying out surgical abortions at the time of the inspection, but had done so in the previous 12 months and was planning to reinstate the service, we looked at retrospective surgical audits, data and records as well as the facilities available.

Prior to the inspection, we reviewed a range of information and data about the service.

Summary of this inspection

Information about BPAS - Leeds

The BPAS Leeds service provided termination of pregnancy services to both self-funded and NHS patients. The service provided termination of pregnancy services to children under sixteen and could provide counselling and treatment for girls as young as twelve. BPAS Leeds provided support, information, treatment, and aftercare for patients seeking termination of pregnancy.

From January to December 2015, the service carried out 1169 early medical abortions and 172 surgical abortions.

The service provided consulting and treatment rooms, ultrasound scanning and screening equipment, and nursing staff to support patients throughout the consultation and medical treatment. In the twelve months prior to the inspection, the service had carried out surgical abortions until July 2015 when the surgeon's post became vacant. BPAS Leeds was planning to reinstate this service in the Autumn of 2016. The clinic had a dedicated recovery area with three reclining chairs for surgical abortion patients. There were contracts in place for the provision of pathology and pharmacy services.

The Service held a licence from the Department of Health to undertake termination of pregnancy procedures. The licence was displayed in the main waiting area.

Medical abortions were carried out on patients of early gestations up to ten weeks. Surgical abortions were carried out on patients with gestations of less than 12 weeks.

The service employed a treatment unit manager, four (2.5 whole time equivalent (WTE) RNs / midwives, one was the lead nurse for the service, seven (3.6 WTE) CCCs and administrators. There was a vacant post for a surgical consultant (0.2 WTE)

The registered manager was responsible for the day-to-day running of the Leeds unit and was the named, local, safeguarding lead.. Medical services were provided by doctors working remotely. Remote medical services included clinical assessment, confirmation that the lawful grounds for abortion were met, and prescribing of abortifacient medicines.

A regional operations manager, regional operations director, and a number of corporate specialist advisors, nationally, such as; infection prevention and control and safeguarding leads supported the service.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

BPAS Leeds was contracted by clinical commissioning groups (CCGs) in the Leeds and West Yorkshire area to provide a Termination of Pregnancy service for patients from Leeds and the surrounding area. It was centrally situated in the city of Leeds and was easily accessible by public transport or car. The unit accepted NHS patients from any commissioning CCG and self-funding individuals from anywhere in the UK. Approximately 98% of treatments were NHS funded.

The service was open from 9am to 5pm on Monday to Thursday each week and 9am to 3pm each Friday. Patients could access termination of pregnancy services on other weekdays at alternative BPAS clinics in Yorkshire and the North of England. Patients who chose or needed weekend services could use the BPAS clinic at Liverpool.

BPAS Leeds treated patients of all ages, including those aged less than 18 years and could treat young people and children as young as 12. There had been a large number of clients under 16 seen at BPAS Leeds; the youngest patient treated was 13. Staff caring for patients less than 18 years of age followed strict safeguarding and management processes.

BPAS Leeds undertook; early medical and surgical abortion under local anaesthetic and pre and post termination counselling as well as contraception advice and screening for sexually transmitted diseases. However, the service had not offered surgical terminations since June 2015 due to the surgeon leaving post at this time. Staff referred any patients requiring surgical abortion or medical termination of pregnancy of later than 10 weeks gestation to alternative British Pregnancy Advisory Services (BPAS) such as Doncaster. The Leeds clinic management hoped to reinstate surgical terminations during 2016 when they recruited a new surgeon.

All staff we spoke with were dedicated to care for patients who needed termination of pregnancy services. Patients were involved in their care and encouraged to make an informed choice on the method of abortion, subject to their gestation and medical assessment.

A senior leadership team including a regional manager, a regional operations director and clinical experts supported the treatment unit manager and the Leeds service. The treatment unit manager was the registered manager and safeguarding lead for the service.

Medical services were provided by doctors working remotely. Remote medical services included clinical assessment, confirmation that the lawful grounds for abortion were met, and prescribing of abortifacient medicines.

Termination of pregnancy

Summary of findings

Termination of pregnancy services were safe, caring, effective, responsive and well led.

There was a culture of reporting and learning from incidents, across the organisation and within the Leeds service. Staff could demonstrate their understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse. All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment. Staffing levels, medicine management and record keeping were good.

Care was provided 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. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment to further develop an evidence base.

We observed that patient assessments were thorough and staff followed pathway guidance.

The service managers used a clinical dashboard, which measured and facilitated improvement in the quality and safety of clinical standards. Staff were competent and observation and assessment of staff competence was an integral part of pathway audit.

We observed interactions between patients and staff in the public areas of the service and during their consultation and treatment and saw that staff treated patients with compassion, dignity, and respect. They focused on the needs of each patient and responded quickly to their needs. Staff were very aware of the additional needs and risks associated with the care of young people and made every effort to ensure young people were supported through their treatment. The results of the BPAS 'Client Satisfaction' reports showed that 100% of patients at BPAS Leeds were 'extremely likely' or 'likely' to recommend the service to family and friends.

All patients had checks and tests before procedures. Waiting times were consistently within the guidelines set by the Department of Health, unless patients chose appointment times outside the recommended timescale. Information and advice were available from staff, leaflets and on-line to patients at all stages of their care. Interpreting and counselling services were available to all patients and staff made every effort to meet individual patients' needs. Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs. There were systems in place to ensure sensitive disposal of foetal remains, in accordance with national guidelines. The service was accessible for patients of all diversities including those with disabilities.

Senior managers had a clear vision and strategy for this service and there was strong local leadership of the service with quality care and patient experience seen as the responsibility of all staff. Staff felt supported by their managers and were confident they could raise concerns and have them dealt with appropriately. There were effective governance systems in place and staff received feedback from governance and quality committees. There were corporate and local risk registers and business continuity plans in place.

Department of Health requirements were met. The organisation had a proactive approach to staff and public engagement. Innovation, learning, and development were encouraged.

Termination of pregnancy

Are termination of pregnancy services safe?

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

- There was a culture of reporting and learning from incidents within this service and across the organisation.
- Staff we spoke with demonstrated an excellent understanding of safeguarding adults and children and knew what actions they needed to take in cases of suspected abuse.
- All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.
- All staff were trained to safeguarding adults and children level three.
- Staffing was sufficient and appropriate to meet the needs of patients in their care.
- Staff ensured medicines were stored and administered safely.
- Pathway documents and clinical risk assessments were completed fully and legibly.
- Staff completed and submitted all Department of Health documentation as required.

Incidents

- There were no serious incidents or never events at the service in the 12 months before the inspection.
- Information from serious incident investigations, elsewhere in the organisation, was cascaded out to all units on a monthly basis so all staff could learn from these. Staff told us they received this information through their local team meeting and via email. We saw records of these discussions at local team meetings.
- Incidents were reported and investigated, staff we spoke to were aware of their responsibilities in relation to incident reporting. Staff understood the principles of "being open" and had received information about the "Duty of Candour".
- We reviewed an example of when duty of candour had been applied. The unit manager had spoken to the patient, offered an apology and then written to her and offered a meeting to discuss what had happened.
- We saw from Clinical Governance Committee and Risk Management minutes that incidents were thoroughly investigated using a "root cause analysis" approach. We saw that appropriate actions were taken to reduce the risk of future incidents
- Staff told us and we saw that they used a "trigger list" to help them report incidents appropriately.
- Staff told us they received feedback from incidents via the central BPAS office. Medical staff and nursing staff were aware of recent incidents and staff who had been directly involved in the incidents had taken part in a debriefing, learning session.
- The registered manager was responsible for reviewing all incidents, initiating investigations and noting any required actions. The clinical lead reviewed the investigation reports and action plans for all clinical incidents to ensure the investigations were thorough and the action plan was complete.
- The health and safety manager reviewed those incidents and investigations relating to health and safety.
- Incidents were reported regionally and nationally through the Regional Quality Assurance and Improvement Forum (RQuAIF) and clinical governance meetings and learning was shared through a cascade of minutes to the unit manager. An executive summary was produced and every member of staff was expected to read this and sign to say they had done so.
- The patient safety policy contained information regarding duty of candour and staff were aware of the principles of this requirement.
- The regional clinical lead's role included investigating serious incidents within their own region, debriefing staff involved and sharing recommendations.
- Examples of learning from incidents included; the revision of clinical guidelines, following a small number of incidents, to reduce the risk of patients sustaining cervical tears during procedures; changes to the labelling system on laboratory request forms and the addition of the unit telephone number to the emergency patient transfer letter.
- The BPAS corporate office received Medicines and Healthcare products Regulatory Agency (MHRA) Alerts and Safety Notices and emailed these to the treatment unit manager for the attention of all clinical and nursing staff.
- BPAS Leeds reported incidents externally where required. Point of care testing errors were reported to

Serious Adverse Blood Reactions and events (SABRE) and adverse drug events and equipment failures were reported to the Medicines and Healthcare products Regulatory Agency (MHRA).
- To reduce point of care testing errors a second practitioner always checked results as per policy.
- We saw that staff received 'red top alerts' which indicated a need to take immediate action to prevent incidents occurring. One alert staff told us about was where two different drugs had similar packaging. Staff told us this heightened their awareness of this risk prior to changes to packaging being made.

Cleanliness, infection control and hygiene

- The consulting rooms, waiting areas and other clinical rooms were visibly clean and tidy.
- Cleaning schedules and standard operating procedures were available for each individual room or area. Staff referred to these schedules when undertaking cleaning outside of cleaning contractor hours.
- An external contractor provided cleaning services and the registered manager observed that standards were maintained informally as required and through quarterly audits. We saw from the audit results and meeting minutes that when there had been some issues identified regarding cleaning of blinds the registered manger had met with the contractors to make improvements.
- Facilities for hand hygiene were provided and soap dispensers we reviewed were in good working order. Staff had access to alcohol hand gel on an individual toggle attached to their uniform.
- We observed staff washing hands and using gel appropriately.
- Disposable curtains were in use in the clinical areas and were marked with the date of last change.
- Personal protective clothing was available in all areas we visited.
- The Leeds unit had a link practitioner for infection prevention and control who undertook monthly audits. There was a programme of IPC audits for the link nurse. Every month essential steps of hand hygiene was audited by observing a range of procedures. There was also an audit of one other aspect of infection control such as sharps disposal, waste management, or a clinical procedure. Hand hygiene audits consistently demonstrated 100% compliance and all other audits showed consistently high standards of infection control practice. Where issues or risks were identified, actions were taken immediately. For example, when the auditor identified that there was a risk of contamination of the clean trolley from splashing due to proximity to the sink, the equipment was rearranged to prevent this from happening.
- The director of infection prevention and control or the clinical effectiveness manager also undertook a comprehensive inspection of all areas, annually. Environmental and waste Inspections carried out in June 2015 showed good compliance with standards and that mitigations were in place for known risks.
- Results of all audits were submitted formally and IPC was reported formally on a dashboard as a performance indicator. The dashboard was not visible to members of the public.
- There was a policy in place regarding safe disposal of clinical waste and a service level agreement was in place with a waste contractor for removal. We saw waste was appropriately segregated and disposed of. Sharps bins were used correctly and a spillage kit was available if needed.
- We saw records that indicated water testing and temperature control checks were carried out in line with BPAS policy.
- All staff had received an annual infection control update.

Environment and equipment

- The service was provided from a sub-let suite of rooms. The premises appeared in a good state of repair and the suite of rooms had been adapted to meet the needs of the service.
- Staff told us and we saw that there were processes in place with the landlord to ensure any issues with the building maintenance and repairs were dealt with.
- Electrical safety testing of equipment was evident and we saw evidence of recent servicing of ventilation, sani-flow, emergency lighting, door entry system
- Evidence of stock rotation was in place and all stock we checked was in date and stored in an appropriate manner.
- We saw that resuscitation equipment and drugs were checked weekly and that trolley drawers were locked.

Medicines

- There was a designated person for the ordering of drugs online with the national purchasing department. A RN signed to accept delivery of drugs. There were local and national records of drug ordering and receipt and stocks were checked and rotated monthly.
- There was a comprehensive medicine management policy in place and staff had access to a pharmacist, employed by BPAS on a consultancy basis, if needed.
- The registered manager was responsible for auditing of medicines. The performance dashboard indicated that compliance with medicines management standards was consistently good (Green)
- The unit did not keep or administer any controlled drugs.
- The unit dispensed prescriptions for analgesia, antibiotics and contraceptives.
- We checked medication cabinets, which were clean, tidy and well organised. Drugs were checked regularly and stored safely and securely.
- Staff recorded fridge temperatures in line with good practice medication guidelines. Recordings were all within recommended range.
- A doctor prescribed all abortifacient medicines and nurses / midwives provided some non-abortifacient medicines under Patient Group Directions (PGDs). The PGDs were in line with national guidance, accountable officers were clearly named and they had signed the PGDs correctly.
- All PGDs were within review date and staff undertook training and signed the record sheet when training was complete and they were competent to administer and or supply the prescribed medications.
- Nurses / midwives told us they used PGDs with reducing frequency as the system now allowed for easier access to electronic prescribing.
- We saw that drugs that induced abortion were prescribed only for patients undergoing medical abortion following a face-to-face consultation with a member of the nursing team, written consent and completion of the HSA1 form signed by two doctors.
- PGDs also covered pain-controlling medication, treatment of chlamydia and prophylactic antibiotics to prevent post procedure infection.
- We observed discharging nurses / midwives providing antibiotics and contraceptive medications and checking that patients understood what the medications were for and the importance of taking them as prescribed.

Records

- Patient records were paper based. Patient information and records were stored safely and securely in lockable cabinets in line with the Data Protection Act. Medical records stayed on site for six months then were archived at the BPAS head office.
- Patient records included speciality pathways and risk assessments for venous thromboembolism (VTE), sexual health and safeguarding for patients under 18 years of age.
- We looked at 23 sets of records across various pathways and found them to be up to date, complete and legible. Records indicated risk assessments were completed and any medical concerns or issues identified were well documented and reviewed following appropriate interventions.
- Record keeping and documentation audits were carried out monthly and compliance was consistently good. Audits carried out January, February and March 2016 showed compliance of 97%, 100% and 94% respectively. We saw from audit reports that there were occasional issues with completeness of records. When issues were detected individual staff responsible were notified and reminders were sent by email to all staff regarding the omissions or errors detected.
- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same legal ground for the termination of pregnancy are met and sign a form to indicate their agreement (HSA1 Form). We looked at 23 patient records and found that all forms included two signatures and the reason for the termination. Documentation of the reasons for seeking termination was clearly documented in the paper record.
- Two doctors who worked remotely reviewed the completed documentation following the initial assessment by the nurse / midwife and if they agreed that one and the same ground was met signed the HSA1 form.
- We spoke to one of the doctors performing remote signing of HSA1 forms and were assured that clinical records usually contained sufficient information for doctors to be satisfied that the grounds for abortion were met. The doctor told us they would refuse a record with insufficient information and staff at the unit would need to take further information from the patient and resubmit the request for signature, with the additional

information. They gave us an example of when they had agreed that one of the grounds was met but this differed from the ground recorded by the other doctor. They had followed this up with their colleague and found that a recording error had been made. The first doctor had repeated his review of the record and amended the record to show that he did agree the same ground had been met.

- Nursing staff corroborated that on rare occasions doctors had asked for more information before agreeing to sign a HSA1.
- We saw that the full medical / nursing pathway records were scanned onto the electronic system so remote doctors had access to full information to make clinical assessments and legal judgements.
- We saw information recorded in paper notes and on the electronic system and the doctor we spoke with told us that this was sufficient for them to make clinical assessments and make a judgement in' good faith' whether grounds for abortion were met..
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit data following every termination of pregnancy procedure performed (HSA4 form). We observed staff recorded this data in the medical records.
- We saw that the doctor who terminated the pregnancy completed the HSA4 online within 14 days of the completion of the abortion. For medical abortion, where patients deliver foetal products at home, the doctor who prescribed the medication was the doctor who signed the HSA4 form.
- An administrator uploaded all HSA4 forms electronically to DH on a daily basis.

Safeguarding

- Good systems were in place to safeguard vulnerable adults and children and young people. Staff we spoke with were all aware of their responsibilities and demonstrated experience of using safeguarding pathways appropriately.
- Staff carried out safeguarding risk assessments for all patients under 18 years and when there was any suspicion of abuse of older adults. Staff made safeguarding referrals to the local authority when appropriate, following discussion with the BPAS safeguarding lead.
- Organisational policy was that if a 12-year-old girl used the service then staff would automatically make a safeguarding referral in line with the Sexual Offences Act 2003.
- Where young people were known to have a social worker, BPAS staff would contact the social worker if the young person consented to this. If a child was judged to be at risk staff would contact the social worker without consent if necessary.
- For those patients under 18 years, a safeguarding risk assessment was completed and a decision made on the outcome of the assessment, following discussion with the designated safeguarding lead. An audit of completion of this risk assessment was due to be added to the audit programme and clinical dashboard.
- The staff at Leeds had good links with the local safeguarding board and could contact their local designated Doctors and Nurse when needed.
- Staff told us that support from the unit manager and regional operations director was excellent when dealing with difficult safeguarding issues.
- All staff had received adult and children's safeguarding training and were up to date with mandatory training requirements.
- All staff had undertaken children's safeguarding training at level three.
- Staff would try to contact, by telephone, any patients under 18 who did not attend for their appointment to ensure all was well. One example was where staff had tried several avenues to contact a young person and been unable to do so. The staff had eventually needed to contact the patient's GP and school nurse who had made contact with the girl, to determine her whereabouts and safety.
- All patients received a private initial consultation without anyone else present to safeguard against possible coercion or abuse and to give them the opportunity to disclose such information in a safe environment.
- The Treatment Unit Manager was the local designated safeguarding lead. Staff knew they could seek advice and support from the regional operations director if the treatment unit manager was unavailable.
- Staff we spoke with were aware of different levels of questioning about sexual partners, consent, and information sharing regarding young people.

- The organisation had policies and procedures for staff to follow if cases of female genital mutilation or sexual exploitation were discovered and staff were clear what actions they needed to take in this situation.
- We saw that the unit held a file of local safeguarding policies and contact details for local safeguarding teams.

Mandatory training

- All staff received mandatory training, which included life support, infection prevention and control, safeguarding children and adults, information governance and other aspects of health and safety at work as part of their induction.
- There was a comprehensive programme training available staff to access updates when required.
- Training was provided face to face by external trainers.
- Nurses or midwives who were employed to be clinical practitioners underwent a comprehensive 12 week, training programme, which covered all elements of mandatory and the additional training they required.,
- All staff were up to date with their mandatory training requirements.
- Training was provided through a combination of online courses and updates and face to face from external trainers.
- All staff had received basic or intermediate life support training relevant to their role.
- Three members of staff were trained to deliver first aid in the workplace.

Assessing and responding to patient risk

- BPAS had developed its own Surgical Safety Checklist, modelled on the world health organisation (WHO) five steps to safer surgery. Compliance with the BPAS Surgical Safety Checklist was audited regularly by peer audit and by the Clinical Audit and Effectiveness Manager on a regular cycle. In March 2015, BPAS Leeds scored 100% in this audit. This was the latest audit data available, as the surgical procedures had not been undertaken since June 2015.
- We saw that staff used 'The BPAS Suitability for Treatment Guideline' which, clearly laid out the medical conditions that would exclude patients from accessing treatment, and those medical conditions which, require risk assessment by a doctor.
- For patients who were not suitable for treatment at BPAS Leeds on medical grounds, BPAS had a Specialist Placement team, which sourced appointments within the NHS. Staff gave us examples of when they had referred patients to the team for placement.
- We observed that before treatment, all patients were assessed for their general fitness to proceed. This assessment included obtaining a medical and obstetric history and measurement of vital signs, including blood pressure, pulse and temperature.
- We observed records and practice and saw that all patients received an ultrasound scan to confirm dating, viability and multiple gestations. Staff also checked the location of implantation to exclude the possibility of ectopic pregnancy. If staff suspected this, they made an immediate referral to the local early pregnancy unit. Staff from BPAS would ring the unit to discuss their findings with the doctor on-take.
- Blood tests were performed on all patients to establish those patients who had rhesus negative blood group. These patients received treatment with an injection of anti-D to protect against complications should the patient have future pregnancies. Other relevant laboratory testing was undertaken as appropriate and as agreed with the patient. These tests could include haemoglobin level, chlamydia and HIV testing. Staff offered all patients the screening tests for sexually transmitted diseases.
- We saw from patient records that after surgical treatment, each patient's vital signs, blood loss and pain level were monitored. We saw that the Leeds unit had a formal transfer agreement in place with a local NHS hospital, should a patient's condition require an emergency transfer. The unit was also able to refer patients with suspected retained products of conception following the procedure and patients who were suspected of having an ectopic pregnancy to the local NHS hospital.
- There was one emergency transfer from the Leeds unit in the 12 months before the inspection, when a post treatment patient had arrived at the unit with heavy bleeding. Staff had dialled 999 and the patient was transferred to the local gynaecology assessment unit. This was in line with the emergency transfer protocol and transfer agreement with the local NHS hospital.
- Risk assessments, medical follow up, interventions and preoperative reviews were evident in our observation of patient journeys and in the records we reviewed.

- All patients who underwent surgical abortion were risk assessed for venous thromboembolism (VTE).
- We observed that staff made positive identity checks before commencing a consultation or treatment.
- Staff gave patients advice and information regarding accessing emergency medical health services, should they suffer heavy blood loss following discharge. Aftercare and helpline numbers were included in the BPAS guide, given to all patients who had a termination of pregnancy.
- Discharge letters were offered to patients to keep for their information, regarding the treatment they had received. They could give this to other healthcare professionals if they needed to access emergency services.
- All patients who were suspected of having an ectopic pregnancy were referred to the local hospital and given a letter to give to the staff at the early pregnancy unit or A & E regarding tests already performed and scan results.

Nursing staffing

- BPAS Leeds employed; registered nurses or midwives as clinical practitioners, client care coordinators who undertook counselling / consultation with patients and reception/ administration staff. The registered nursing / midwifery staff undertook all clinical assessments, scanning, consent and, treatment. A regional lead nurse also supported the unit with training, clinical supervision and provided cover for clinics when needed.
- The clinic used the BPAS safe staffing policy, which outlined minimum staffing levels. The performance dashboard for Leeds had been green since April 2015 indicating no breaches of the minimum staffing level in this period.
- The clinic could access agency staff if they needed to cover shifts due to unplanned absence but this had not been necessary in the previous 12 months.
- The clinic used a skill mix of registered midwives (RM), nurses and CCCs. There was always at least one RN/ RM on duty.

Medical staffing

- Since June 2015, BPAS Leeds had not employed any medical staff. There was a part time vacancy for a surgeon, to work under practice privilege arrangements, to undertake surgical abortions. Surgical abortions could not be offered until this post was filled. To obtain practice privileges doctors had to provide evidence of GMC registration, indemnity insurance, qualifications and evidence of annual appraisal / revalidation.
- BPAS policy was that managers made checks every two years to ensure that doctors remained eligible to practice at BPAS.
- Policy indicated that all doctors had to have disclosure and barring checks prior to appointment and child protection training to level three was mandatory. We were unable to check this process in action, as there were no doctors in post at the time of the inspection.
- There was a process in place for ensuring information was checked and updated every two years and disclosure and barring checks were repeated every three years.
- Nursing and midwifery staff told us that if they needed any clinical advice regarding a patient they were able to ring the regional clinical lead or one of the doctors who were available for reviewing records and completing the HSA1 forms, if the clinical lead was unavailable.
- BPAS employed doctors at a corporate level, who worked remotely, to undertake screening of medical information and each patient's history. Staff used an electronic system to ensure two medical practitioners could make clinical assessments and make judgements in 'good faith' that one and the same ground for abortion had been met. The remote doctors signed the HSA1 forms giving authorisation to carry out an abortion. This included the facility for doctors to ask further questions of the nursing staff who could contact the patient if needed. We spoke to a surgeon by telephone who confirmed the process and that the information they received was sufficient to make their medical and legal decision.

Major incident awareness and training

- There were local contingency plans in place, such as fire or loss of utilities and staff underwent scenario-based training regarding these. Fire plans were visible in clinical areas.
- The main risk was IT failure that could prevent remote signing of HSA1 forms. Staff were aware of the need to escalate this immediately to ensure an alternative solution was put in place quickly.

- Staff told us they took part in emergency scenario exercises to ensure they knew what to do in case of different medical emergencies and how to initiate an emergency transfer of a patient to the acute hospital.

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.

- Care was provided 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. However, patients were given up to date information about the risks and benefits of this treatment before giving consent and the organisation was monitoring outcomes from this treatment to further develop an evidence base.
- The complication rate for simultaneous administration was higher than that for medical abortion treatment when medicines were administered with an interval of 24-72 hours.
- Patient assessments were thorough and staff followed pathway guidance.
- The service managers measured and facilitated improvement in the quality and safety of clinical standards.
- Pain relieving medications were routinely prescribed for patients to take at home following their procedures or initiation of treatment.
- Observation and assessment of staff competence was an integral part of pathway audit.
- Staff always made sure patients gave their consent in writing and adhered to Fraser guidelines in respect of children and young people.
- There were good links with local safeguarding teams, the local NHS hospital and other agencies.

Evidence-based care and treatment

- Staff had access to up to date policies and procedures through the BPAS intranet. We observed staff adhering to policies and procedures, for example, with regard to consultation and treatment and infection, prevention and control. Updated policies and guidelines were cascaded to staff via email and conference calls were held for staff to dial into. These were recorded for staff to access later if unable to dial in during the live presentations.
- Almost all of the policies were developed in line with Department of Health Required Standard Operating Procedures (RSOP) and professional guidance. However; BPAS introduced simultaneous administration of mifepristone and misoprostol (medicines used to bring about abortion) in March 2015. This is not in line with RCOG guidance, which recommends that mifepristone is administered first, followed by the administration of misoprostol 24 – 48 hours later. A structured approach had been taken when planning and implementing this pathway and it was kept under regular review.
- The introduction of simultaneous administration followed a national BPAS pilot study of 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, due to complications, in comparison to a dosing interval of 6 – 72 hours (7% compared to 3.3%). Acceptability to women was almost the same between simultaneous administration and a dosing interval of 6 – 72 hours (89% compared to 90%).
- The service monitored the outcomes of simultaneous treatments and reported outcomes to the clinical governance committee. Minutes of the clinical governance committee meeting in June 2015 stated 'there was 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 'my BPAs guide' stated " the risk of continuing pregnancy is two in 100 if the medicines are taken at the same time, and less than one in 100 if medicines are taken 24 – 72 hours apart. The risk of retained products of conception is five in 100 if the medicines are taken at the same time, and three in 100 if medicines are taken 24 – 72 hours apart. The risk of requiring surgical treatment for failed medical treatment is seven in 100 if the medicines are taken at the same time and three in 100 if medicines are taken 24 – 72 hours apart."
- We saw that there was ongoing monitoring of the outcomes of simultaneous treatments in comparison to interval treatments.

Termination of pregnancy

- We observed that staff discussed the relative risks of different treatment regimens including simultaneous treatment with the patients during their consultation and that the differences in failure rates were given verbally as well as pointed out in the BPAS guide. The BPAS guide was given to all women. Staff were aware of the most up to date information and told us they received regular updates regarding this through emails, bulletins, team briefs and from reading minutes of governance minutes. We saw that staff had signed record sheets to say they had read important bulletins and clinical updates.
- We observed that women choosing simultaneous treatment understood there was evidence that this was a less effective option that interval treatments.
- We observed from records and from observation of the patient pathway that doctors prescribing medication for medical terminations adhered to the Royal College of Obstetricians and Gynaecology (RCOG) guidelines and abortion legislation.
- Staff followed a national work instruction for the counselling of patients prior to termination of pregnancy and best practice, following RSOPs and RCOG clinical guidelines for medical abortions.
- There was a programme of clinical audit, which included audit of consultation and patient pathways and HSA4 (a requirement to notify the Department of Health of an abortion).
- Audits were conducted to assess the quality of care, compliance with policy & procedure and monitor standards. These included; HSA1 audit, clinical procedural audits, infection control audits and record keeping audit.
- The clinical audit and effectiveness manager, the unit manager and senior nurse were responsible for different elements of the audit programme.
- Immediate feedback was given to the unit manager or senior nurse / midwife on the day of the audit and this was shared with staff locally.
- Results were reported centrally for benchmarking and recommendations for action were made where necessary.

Pain relief

- All patients were prescribed pain relief to take home and this was recorded on the medicines administration records. We saw that non-steroidal anti-inflammatory drugs (NSAIDs) were prescribed, in line with best practice, unless there were contraindications for a particular patient.
- We saw that nurses / midwives gave patients good information and advice regarding what to expect post treatment and how to alleviate pain.

Nutrition and hydration

- Water and hot drinks were available for patients in the waiting areas.

Patient outcomes

- Patients undergoing medical abortion were asked to ensure that a pregnancy test was completed two weeks after their treatment to ensure that it had been successful. Patients were asked to contact the BPAS Leeds clinic or the 'Aftercare Line' and were invited back to the treatment unit if they had a positive pregnancy test.
- Staff told us that in order to monitor outcomes they relied on patients contacting BPAS by using BPAS Aftercare Line. If the treatment unit was informed that there had been a complication a form would be completed and it would be documented in patients'' notes to ensure that the information was captured.
- Monitoring of outcomes took place at corporate level and information was shared through the meeting structures to managers and to individual clinicians as appropriate.
- Locally, BPAS Leeds monitored and reported complication rates to relevant commissioning groups. We saw that patient information clearly gave the complication rates of each treatment and we observed staff discussing these with patients.
- National complication rates according to treatment regime (simultaneous treatment at nine weeks, interval treatment at 9 weeks and interval treatment at ten weeks) for September 2015 and December 2015 were reported at the clinical governance committee meeting in February 2016. Complications reported on were continuing pregnancy, incomplete abortion and retained non-viable pregnancy.
- Continuing pregnancy was the most common complication: 1.52% for simultaneous treatment at nine weeks and 3.23% for interval treatment at ten weeks. Incomplete abortion was more prevalent at nine weeks

regardless of the regime followed: 1.34% for simultaneous treatment and 1.33% for interval treatment. The non-viable pregnancy rate was similar for each treatment regime.

- BPAS recognised a higher rate of continuing pregnancy as pregnancy advanced and planned to undertake a comparative analysis of continuing pregnancy. Following this, patient information would be changed so that patients were aware of the risks and benefits of each treatment regime and could make an informed decision.
- We observed that staff gave patients current information about benefits and risks of all of the treatments available and that they showed women where they could find this information in the BPAS guide if they needed to look at again.
- The Leeds unit reported all clinical complications as incidents through the incident reporting system. Between January and December 2015, the unit reported 23 complications. Of these, 10 were ongoing pregnancy, and 10 were retained products of conception.
- Leeds complication rates for retained products of conception, on-going pregnancy and post procedure infection, when compared with other BPAS clinics, were within expected range for the period May 2015 – August 2015.
- We saw that Leeds clinic provided detailed information to clinical commissioning groups regarding complications.
- All patients were offered screening for sexually transmitted infections (STIs). If a positive result was returned, processes were in place to track partners and offer treatment.
- The treatment unit kept a record of all patients that were referred to NHS hospitals with suspected ectopic pregnancy. Staff actively followed up the outcomes for these patients by direct communication with the early pregnancy assessment unit (EPAU) or with the patient.
- We saw from commissioning reports that BPAS Leeds collected and reported data regarding; age of patients seeking treatment, uptake of sexually transmitted infection screening, patients who received contraception by type (including long acting reversible contraception), numbers of women who had a previous abortion, all complications and numbers of patients and reasons for not proceeding to treatment e.g. decision to continue pregnancy or gestation over legal limit. Information collected also included reasons why screening or contraception was declined

Competent staff

- Staff told us that all new staff worked as supernumerary until assessed as competent in their role.
- Registered nurses and midwives employed as clinical practitioners had undertaken a 12-week course of extended training and were able to scan patients using ultrasound, obtain consent for procedures and prescribe contraception. These staff needed to have 150 observed and supervised scan procedures before they were able to perform scans independently.
- We reviewed four sets of staff personnel records; these were well organised, well recorded and all staff had up to date training records and DBS checks carried out.
- All levels of training from induction to more advanced training were competency based and assessed before staff were signed off.
- Records evidenced completion of job specific induction programmes and extended training for registered staff and healthcare assistants and that competency assessments had been carried out.
- All nursing staff were aware of revalidation requirements and had been asked by the organisation to produce a portfolio. One to one meetings and appraisals had been restructured to include a section on revalidation and unit managers had a register of when staff revalidation was due.
- All clinical staff were expected to attend the BPAS Clinical Forum, where expert speakers gave presentations on relevant topics.
- The registered managers had received training in key areas of their role, such as management training courses and human resource workshops.
- Client care coordinators had mandatory annual clinical supervision sessions for counselling staff. These were peer reflective sessions and facilitated by a trained person. Staff told us they found these supervision sessions very valuable.
- Data from January – December 2015 showed that at the Leeds unit 100% of medical staff, 100% of nursing staff and 100% of administrative staff had received an appraisal.

- There was a defined set of behaviours expected of all staff working at BPAS, which managers used to aid recruitment and inform appraisal discussions.
- Staff told us they received an annual appraisal and had six-monthly job chats with their supervisor or unit manager.
- Senior nursing staff observed staff practice as part of pathway audits; this enabled a review of staff competence and identification of training needs. Observations and audit results were given to staff on a one to one basis to facilitate personal development and maintenance of a high level of skill.
- Regular, direct observation of staff practice was an integral part of the BPAS approach to ensuring staff maintained an expert level of competence in their individual roles.
- Staff we spoke with valued the direct observation of practice as a way in which to maintain their competence and prevent complacency.
- We saw competency records of observations and written communications between observer and practitioner that gave results and feedback on areas for improvement.
- There were national competency frameworks in place for registered nursing / midwifery staff and client care coordinators.
- The regional clinical lead was responsible for overseeing medical staff in terms of competence. There was a structured process with a template available for following up on concerns about a doctor's practice or performance. This included action planning to improve performance. We were unable to review this in practice as there were no doctors based at the Leeds unit.
- When skills gaps were identified or when staff wanted to develop in their role, staff were encouraged to access additional training. We saw that staff had received additional training with aspects of clinical practice such as counselling and contraception.
- Midwifery staff received supervision from a named supervisor of midwives at the local NHS trust.
- Clinical supervision was available for all nurses / midwives on a four monthly basis and was facilitated by a member of staff who had training in clinical supervision. Nursing staff found these sessions a positive experience.
- Staff received email notifications of training workshops inviting them to enrol.

Multidisciplinary working

- Medical staff, nursing and midwifery staff and other non-clinical staff worked well together as a team and respect for each other's roles was evident.
- There were clear lines of accountability that contributed to the effective planning and delivery of care.
- Staff told us that they could seek medical support and advice when needed. Staff could go to the electronic patient assessment system where they could have a discussion with a doctor regarding suitability for EMA. If they needed other advice about a patient's treatment they could contact the doctor on call or the clinical lead for the region.
- Staff told us that the medical staff were easy to contact through these systems and responded to requests for advice very quickly. We observed doctors responding to requests for prescriptions and assessment of additional clinical information regarding suitability for treatment.
- Managers and specialists were available at the end of the phone if staff needed help or support with other issues such as safeguarding or infection prevention and control. Staff told us they found it easy to access any help needed and specialists and managers were responsive and supportive.
- Staff told us that they had close links with other agencies and services such as the local safeguarding team. Staff gave examples of when they had referred patients to 'Women's Aid', local sexual health services, an under 19s' support agency and other agencies involved in supporting patients after sexual assault and suffering from domestic abuse.
- Staff went out of their way to provide a caring and holistic service to their patients. They did this by working well with local agencies to provide additional support and services where appropriate and by acting as an intermediary for patients who lacked confidence to make initial contact with other agencies.
- BPAS Leeds had service level agreements with a neighbouring NHS Trust, which allowed them to transfer a patient to the hospital in case of medical or surgical emergency. We were told about a recent transfer meeting between the Leeds unit and staff at the local early pregnancy unit. Discussion had led to the Leeds unit providing a letter for the patient to take to the hospital, which detailed the investigations undertaken, and findings to enable the patients suspected of having an ectopic pregnancy to be fast-tracked.

Termination of pregnancy

- Staff at BPAS Leeds would work with other termination of pregnancy providers when required, to ensure patients received the correct treatment at the right time.
- Midwifery staff had good links with the supervisors of midwifery at the NHS Trust, who provided advice and support when needed and clinical supervision for the registered midwives working in the unit.

Seven-day services

- The service was open from 9am to 5pm on Monday to Thursday each week and 9am to 3pm each Friday.
- If patients needed to use services on other days, they could be signposted to alternative BPAS clinics. Patients who wanted or needed weekend services could use the BPAS clinic at Liverpool.
- The clinic had run Saturday clinics during January 2016 to meet demand but this was not a regular occurrence.
- BPAS provided 24 hours per day and seven days a week advice line, which specialised in post-abortion support and care. This was in line with Required Standard Operating Procedures set by the Department of Health. Callers to the BPAS Primecare service could speak to RNs or midwives who would give advice.
- The Leeds clinic was to open a satellite clinic at Dewsbury, which would be open from the end of April 2016. The new clinic will offer services regarding consultation and EMA.

Access to information

- Patient notes were paper based and were kept onsite for six months following patient discharge. If any complications occurred this allowed easy access to notes within this time. Records were archived at a central store following this time but could be retrieved easily if needed.
- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy services.
- Staff were able to access diagnostic tests/blood results in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained by registered nursing or midwifery staff who had undertaken training regarding obtaining informed consent.
- All care records we reviewed contained signed consent from patients. Possible side effects and complications were recorded and the records showed that these had been fully explained.
- We saw that patient information clearly gave the complication or failure rates of each type of treatment and we observed staff discussing these with patients.
- Consent was checked again prior to any procedure, general or local anaesthetic taking place.
- Staff we spoke to were aware of Fraser guidelines to obtain consent from young people regarding contraception.
- Staff were able to provide examples of how they assessed competence of a young person using Gillick competence principles. Posters were also displayed in waiting areas about assessment of Gillick competence.
- Staff told us that they would always encourage patients under 16 years of age to tell their parents about their pregnancy and that they were seeking an abortion. However, they were aware of their duty to accede to their wishes if the child was Gillick competent and there were no safeguarding concerns.
- Staff told us that no child under16 years was treated without an accompanying adult, such as a friend or other relative if the child did not wish to involve their parents. Staff told us that they could liaise with a nearby 'women's aid' agency to arrange an independent advocate or chaperone if needed. Staff told us they had used this service in the past and would be happy to do so again.
- There was access to guidance and policies for staff to refer to concerning Mental Capacity Act (MCA).
- Staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records from June 2015 showed 100% staff compliance with this training.

Are termination of pregnancy services caring?

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

- Staff treated patients attending for consultation and procedures with compassion, dignity, and respect.
- Staff focused on the needs of each patient and responded quickly to their needs.

- Staff established and respected each person's preference for sharing information with their partner or family members, and reviewed this throughout their care.
- Staff explained the different methods and options for abortion. If patients needed time to make a decision, staff supported this.
- Patients gave very positive feedback in the BPAS 'Client Satisfaction' reports.
- The service provided counselling for all patients considering termination of pregnancy and post-termination counselling and support to partners and those people close to patients.
- We saw examples where staff had gone out of their way to support patients in difficult situations.

Compassionate care

- We observed consultations and staff interactions with medical termination patients and those close to them throughout our inspection and we saw how they involved and treated patients with compassion, kindness, dignity and respect. We observed professional, caring, and sensitive interactions between staff and patients in public areas, before, during and after consultations.
- Staff told us that patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care. Younger patients were encouraged to involve their parents or family members and their wishes were respected. However, every patient was seen alone for the first part of the consultation to ensure they felt at ease and were not under any pressure for any reason from a partner or the person attending with them.
- The results of the BPAS 'Client Satisfaction' reports showed that 100% of patients at BPAS Leeds were 'extremely likely' or 'likely' to recommend the service to family and friends.
- We saw examples of where staff had gone out of their way to support patients in difficult situations. One patient who had not qualified for NHS funding had attended for treatment but could not afford the full fee. BPAS worked with the patient to find a strategy that allowed her to have her treatment in a timely way.

Understanding and involvement of patients and those close to them

- Nursing staff told us and we observed that during the initial assessment with a patient they explained all the available methods for termination of pregnancy that were appropriate and safe to patients. The nurse / midwife would consider gestational age and other clinical needs whilst suggesting these options.
- We asked staff if there were occasions when patients changed their minds about a procedure. We were told that patients could attend for counselling only and that they may change their minds or use another service if they wanted a different procedure for example if a woman preferred a surgical termination or if they needed a later termination.
- Staff told us that patients were made aware of the statutory requirements of the HSA4 forms and were reassured that the data published by the Department of Health for statistical purposes was anonymised.

Emotional support

- All patients spoke to a CCC and a RN for counselling and assessment prior to their treatment. This service was also available post-procedure. Staff gave patients the service telephone number with details of when the centre was open as well as the main BPAS contact centre telephone number for other times of day or night.
- The records we reviewed recorded the post discharge support offered to patients and those close to them. Staff gave patients written information about accessing help from the staff at the clinic during service opening hours and the 24-hour telephone service following their procedure.
- Staff at BPAS Leeds signposted and referred patients to "Women's Health Matters" a neighbouring charitable organisation that could offer practical support such as help with travel fares, emotional support and even chaperoning should a patient need them.
- The BPAS ethos was to treat all patients with dignity and respect, and to provide a caring, confidential and non-judgemental service. The BPAS guide informed patients that personal autonomy for every patient was at the heart of BPAS care.
- BPAS policies, procedures and the care we observed during consultations 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.

- Staff provided patients' partners, and those supporting them, with information and support should they require it. Staff spoke to people face to face, provided a leaflet they could take away or signposted them to on line information. They also provided details on how to contact "Relate" for counselling should a partner express a different opinion about a termination from the woman seeking treatment. Staff explained to us that their priority was always the decision of the patient.

Are termination of pregnancy services responsive?

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

- Waiting times were consistently within the guidelines set by the Department of Health. Patients could be signposted to other clinics if they needed treatment on days the Leeds clinic was closed.
- The service was accessible for the booking of appointments and for advice and support 24 hours, seven days a week.
- Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex or additional medical needs, who did not meet usual acceptance criteria.
- The service had an effective complaints procedure and shared learning from complaints.
- Interpreting and counselling services were offered to all patients and the centre was accessible for those with disabilities.
- Staff tested patients for sexually transmitted infections prior to any treatment and referred those with positive test results to local sexual health services for further screening and treatment.
- There was an appropriate process should a woman wish for pregnancy remains to be disposed of sensitively.
- The service for surgical abortions was suspended at the time of inspection due to the surgeon's post being vacant.

Service planning and delivery to meet the needs of local people

- Treatment was carried out under NHS contracts with Leeds, Bradford, Wakefield, North Yorkshire and York and Calderdale and North Kirklees CCG to provide a termination of pregnancy service for the patients of West Yorkshire and surrounding areas. The clinic carried out self-funded procedures on request but these were very infrequent.
- The treatment unit manager was planning to extend the range of termination of pregnancy options offered at the Leeds clinic to include surgical termination.
- Service level agreements were in place with local laboratories for screening and blood testing if needed.
- The service was in the process of improving access to EMA by opening a satellite clinic at Dewsbury. The clinic was due to open at the end of April 2016.

Access and flow

- Patients could make appointments for BPAS Leeds via the BPAS Contact Centre, which was a 24 hours a day, seven days a week telephone booking and information service. Patients could self-refer into the service, as well as through traditional referral routes.
- The electronic triage booking system offered patients a choice of dates, times and locations. This ensured that patients were able to attend the most suitable appointment for their needs, subject to their gestation and medical assessment and patients could access treatment as early in their pregnancy as possible. Of the patients who responded to the BPAS patient satisfaction survey, 8% of patients said they would have preferred a shorter waiting time between initially contacting BPAS and their treatment and 13% chose to wait a little longer to suit their own needs. Most patients (90%) said that they waited less than 30 minutes to be seen after arriving at the centre.
- BPAS Leeds appointments were offered Monday to Friday each week.
- Patients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment. If patients needed to use services on other days, they could be signposted to alternative BPAS clinics. Patients who wanted or needed weekend services could use the BPAS clinic at Liverpool.
- Patients were able to attend the most suitable appointment for their needs and as early as possible. If treatments were in two parts, the clinic worked with the other BPAS clinics to provide patients with more flexibility.

Termination of pregnancy

- During times of peak demand, the service was able to provide additional or longer clinics. The service had provided Saturday clinics during January 2016 to meet demand.
- All patients completed a pre-consultation questionnaire sent by email. Consultations were face to face with nursing staff who discussed medical history and treatment options. When a decision to proceed was made, a second appointment was made for treatment. This was often on a separate day but BPAS Leeds could offer treatment later in the same day subject to full legal procedures being followed. Staff told us the time between appointments allowed for a cooling-off period of 2 to 3 hours so that the woman could confirm her decision or indeed change her mind about the treatment.
- The centre undertook all aspects of pre-assessment care including, counselling, date checking scans to confirm pregnancy and to determine gestational age and other assessments such as sexually transmitted infection (STI) tests.
- If patients were assessed as having a gestation of over 10 weeks, they were referred to another BPAS centre to suit their needs. If there was suspicion of an ectopic pregnancy, they were referred to a local NHS acute hospital for further assessment and or treatment.
- Department of Health Required Standard Operating Procedures state that patients should be offered an appointment within five working days of referral and the abortion procedure should be carried out 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. Of all patients who were seen and treated, 90% were within the time limits and appointments made outside of the guidelines were due to patient choice such as wishing to attend a different unit, or because they had attended too early to confirm their pregnancy.
- The clinic monitored the average number of days patients waited from initial contact to consultation, from consultation to treatment and the whole pathway from contact to treatment. Data was submitted to the BPAS corporate office and was monitored both locally and centrally. When demand peaked and waiting times were likely to exceed recommendations, the service could provide more appointments by adding the regional lead nurse to the rota or signposting patients to other clinics in the region.
- In the last 12 months, 190 patients waited longer than 10 days from first appointment to termination of pregnancy. The main reason for delay was given as patient choice to complete treatment locally rather than travel to a centre further away, with an available treatment slot within the ten-day target window.
- BPAS reported that the percentage of patients treated at less than 10 weeks gestation was a widely accepted measure of how accessible abortion services were. So far in 2015/16, over 84%of patients had been treated at less than 10 weeks, which was above the national average of 80%.
- Aftercare advice was available all day every day via a national helpline or patients could call the clinic directly during opening hours.
- 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. Patients could access the service at any time after their procedure, whether this was the same day or many years later.

Meeting people's individual needs

- The centre was situated on the third floor and accessible to wheelchairs users via a lift. A disabled toilet was provided.
- A copy of the BPAS Guide was available at reception in Braille for those blind or partially sighted patients who could read it.
- Following their initial private consultation, patients could choose whether they had their friend or partner accompany them for the remainder of their consultation and examination.
- A professional interpreting service was available to enable staff to communicate with patients for whom English was not their first language. Leaflets about consent were available in 16 different languages. We observed a care coordinator using the telephone interpreter service with a patient. This was conducted professionally and in a sensitive manner.
- Patients could request a chaperone to be present during consultations and examinations and there were signs clearly on display to inform patients that this was available.
- Staff told us that very occasionally patients with a learning disability or other complex needs had used their service. When this had happened, a friend had accompanied the patient and had helped ensure the

patient fully understood the treatment. Depending on the wishes of the patient, the friend or advocate could stay with the patient throughout treatment and examinations.

- Although staff had not received bespoke training or awareness regarding people with a learning disability they had undergone diversity training and further information was provided for staff in the Disability Discrimination Act policy.
- Patients were given a BPAS guide at the first consultation about different options available for termination of pregnancy including what to expect when undergoing a surgical or medical termination. These also included details of any potential risks, counselling services and sensitive disposal of pregnancy remains. The guide included information on what to expect following the procedure and the advice line number that patients could ring to seek any advice if they were worried. Staff gave patients the clinic number to ring for advice and guidance and encouraged patients to use this during opening hours.
- Counselling was provided to patients on any method of termination and if BPAS Leeds centre could not offer the treatment the woman had chosen, staff helped them to decide where, when and how they could access the treatment they required. We observed a care coordinator contacting another nearby centre to make initial contact and ask questions on behalf of a patient regarding the type of anaesthetic they should expect and whether or not they could drive or would need to be accompanied. The care coordinator went out of her way to request a suitable appointment, ask further questions and then left the room to wait until the patient had made contact with someone who could accompany her.
- Unit staff followed BPAS Policy and Procedure with patients regarding the foetus and the disposal of pregnancy remains. The 'My BPAS Guide', which was provided to every patient, described how pregnancy remains following a surgical abortion would be disposed of and invited the patient to inform the team if they had specific wishes. BPAS would facilitate, wherever possible and legal, any request made by a patient concerning management of the pregnancy remains. BPAS provided information to staff to enable them to meet those needs effectively and sensitively. Where a patient wished to dispose of the pregnancy remains privately, BPAS would provide them with a specific information sheet that set out how the remains should be managed. The treatment unit held up to date information about local funeral services to assist patients who wished to arrange a cremation or burial. The discussion and plan for disposal were fully documented in the care pathway within the case notes.
- Where patients did not have specific wishes with regard to disposal, foetal tissue from surgical abortions was collected by an authorised carrier and stored separately from other clinical waste before being sent for incineration. A full audit trail was maintained at the unit.
- Due to the very low gestational limits (up to 10 weeks) for medical termination procedures at this centre, staff explained that there should be little or no evidence of pregnancy remains and no patients to date had requested a disposal from the clinic.
- Nurses / midwives and medical staff undertaking pre-surgical and medical abortion assessments had a range of information to give to patients. There was also a range of leaflets and posters displaying information, easily accessible within the waiting area. This included advice on contraception, sexually transmitted infections and services to support patients who were victims of rape or domestic abuse.
- Patients could request that clinic staff made anonymous contact calls on their behalf if STI test results were positive.
- There was a Young People's resource file in the waiting area, which contained a wide range of information and signposting information to local young people's services including drop in services, counselling, stop smoking, genito-urinary medical services, contraceptive clinics, drug and alcohol services and other support services about abuse, sexuality and bullying. Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the abortion. Patients who had their treatment at the BPAS Leeds centre were provided with the contraception of their choice before leaving the centre. This included long acting reversible contraceptives (LARCs) such as injections and implants or Intrauterine devices or systems (IUD/IUS).

Learning from complaints and concerns

- The patient booklet 'My BPAS Guide' included a section on how to give feedback and how to complain, as did

the BPAS website. The Client Engagement Manager reviewed any comments left on NHS Choices website and shared feedback with the BPAS team with regard to lessons that could be learned.

- There were posters and leaflets on display in the waiting area advising patients how to raise concerns and give feedback. The information clearly stated how feedback could be given and how concerns would be dealt with. This included expectations about timescales and how to escalate complaints to the Parliamentary Health Service Ombudsman, if dissatisfied with their BPAS response.
- All BPAS patients were given a patient survey/comment form entitled 'Your Opinion Counts'. There were boxes at the unit for patients to submit their forms. The treatment unit manager initially reviewed locally submitted forms, prior to sending to the BPAS Head Office for collation and reporting. This meant that any adverse comments could be acted on immediately and learning shared with the team and other units.
- Staff told us that patients were given an opportunity to raise concerns with any staff member whilst at the clinic. Staff felt empowered to attempt to resolve situations if needed.
- The service had received three complaints in the 12 months prior to our inspection. One complaint was from a GP practice relating to information received about patients registered at another practice and was treated as an information governance breach. Two patients who had undergone EMA at BPAS Leeds had made complaints: one complaint had been made in person and the other had come to the centre via the patient satisfaction survey. Both patients felt offended by information or advice offered to them by staff at the centre and both patients had accepted an apology. Staff explained that they took patient complaints very seriously and dealt with them quickly, they checked records were complete and supported the member of staff the complaint was made against. In both cases, the team had met to discuss possible actions to be taken to improve service provision and reduce the risk of a similar issue arising again in the future.
- We reviewed all three complaints files and found that they had been investigated appropriately and actions had been taken where necessary. Managers told us an IG incident form had been completed and corrective actions were identified, however, this was not held in the file.
- The BPAS Client Engagement Manager was responsible for overseeing the management of complaints. Any case needing escalation would be brought to the attention of the Regional Director of Operations and the responsible member of the Executive Leadership Team.
- A summary of Complaints, Feedback and 'Client Satisfaction Survey' results (both national and by unit) was reviewed by each Regional Quality Assurance and Improvement Forum (RQuAIF) and the Clinical Governance Committee. Themes or trends were identified centrally and any actions, outcomes and lessons learned were shared across the BPAS organisation and with clinical staff through a series of national and regional governance meetings and local team meetings.
- An example of an action taken from national feedback in 2015 was in relation to what was playing on the TV. All units had been asked to ensure that TVs were set to news channels or programmes following a complaint about the content of TV chat shows.

Are termination of pregnancy services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Senior managers had a clear vision and strategy for this service and there was strong local leadership of the service.
- Managers were approachable, available, and supported staff within the service.
- There was good staff morale and they felt supported.
- There was a comprehensive committee and meeting structure to ensure effective governance, risk and quality management. The governance structure enabled oversight of the whole of BPAS and allowed for performance benchmarking between units.
- The organisation had a clear mission to provide for safe and effective care for termination of pregnancy.
- Quality of care and patient experience was seen as the responsibility of all staff.
- The organisation had a proactive approach to staff and public engagement.
- Staff completed and submitted Department of Health documentation correctly.

Termination of pregnancy

Vision and strategy for this core service

- The mission statement for the service was to provide safe and effective care for termination of pregnancy and these values were made clear to all new staff through the induction process and training.
- BPAS Leeds had a Department of Health Certificate of Approval that was displayed in the reception and patient waiting area.
- Values of the organisation were displayed by staff behaviours throughout our inspection.
- Maintenance of the values was fostered through the proactive recruitment of staff who displayed the values and behaviours expected by the organisation.
- It was important to the organisation and to local staff that all new staff could uphold the value of patients' choice.
- The registered manager was knowledgeable about corporate strategy and understood how this affected local provision of services.
- Staff were aware of strategic plans to; continue and monitor the effectiveness of simultaneous medical abortion treatment; to aim to reduce the numbers of surgical procedures; and to pilot and evaluate the use of conscious sedation for roll out across the organisation.
- Locally staff had been involved with the development of a satellite clinic at Dewsbury, which was to open at the end of April 2016.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure within the organisation, which included a clinical governance committee and a board of trustees. The organisation had systems and processes in place to ensure all board members and executive managers met fit and proper person requirements.
- The clinical governance committee had a clear role in reviewing all complications and patient feedback. It also ratified policies and received annual reports such as the infection prevention and control annual report.
- The governance groups monitored staffing levels at a regional and national level.
- The subgroups of the clinical governance committee were a clinical advisory committee which was an informal group convened by the Medical Director when needed, to provide clinical advice and review clinical policies and procedures. There was also an infection prevention and control committee and three regional RQuAIF groups.
- There was a corporate risk register, which was written by the financial director of BPAS. The risk register was reported and managed through the risk management committee to the board. Risks were categorised as economic, which included legal action, political and ethical. The registered manager had a good understanding of both corporate risks and how they applied to their own unit and local risks and mitigations.
- Risks were rated red, amber or green depending on their severity. The RQuAIF and the clinical governance committee reviewed the corporate clinical red and amber risks on a regular basis.
- Locally we saw that there had been a number of comprehensive risk assessments in relation to general risks, health and safety and waste management. There were mitigating actions in place and risks were reduced where possible.
- We saw that the unit manager had recently developed a local risk register that included risks to staff, patients and business continuity. The risk register outlined actions that were in place to mitigate risks, protect staff and patients and ensure patients could still receive consultations and treatment.
- There was a local contract with a registered waste carrier to correctly dispose of all categories of waste.
- We saw that a BPAS health and safety inspection in June 2015 had identified a small number of actions for the Leeds unit and that these had all been addressed.
- The assessment process for termination of pregnancy legally requires that two doctors agree that at least one and the same ground for a termination of pregnancy is met and sign a form to indicate their agreement (HSA1 Form). We looked at 23 patient records and found that all forms included two signatures and the reason for the termination.
- We observed that nurses / midwives checked the HSA1 forms were completed correctly before any aspect of treatment was initiated.
- A doctor in a BPAS licenced premise would review the completed documentation on the electronic system following the initial consultation and assessment by the nurse / midwife. At this point, if they agreed with the procedure being undertaken they would sign the HSA1 form. The information would be viewed by a second

doctor for them to review the information and sign the form if they agreed that at least one and the same ground was met. We spoke to a surgeon working from another BPAS licenced premise who told us that he checked all records carefully and would reject an application if the information was incomplete or if he disagreed with the first doctor's decision. The rejection would remain open until staff obtained sufficient information for the doctor to be certain of his approval.

- BPAS centres completed monthly HSA1 audits to ensure and evidence compliance with requirements. BPAS Leeds centre's audit carried out in 2014 and 2015 had consistently shown 100% compliance with HSA1 form requirements.
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit data following every termination of pregnancy procedure performed. These contribute to a national report on the termination of pregnancy (HSA4 forms).The HSA4 forms were uploaded electronically to DH within the required timescale. Administrative staff completed these forms on line for the prescribing doctors to sign electronically before upload to the DH. The BPAS doctor who had prescribed the medication signed the HSA4 forms online, through a secure individual log in, within 14 days of the abortion. Between April and December 2015 BPAS Leeds had a 100% compliance with this requirement.
- The BPAS Client Engagement Manager produced patient satisfaction reports, which were disaggregated to each unit for contract performance reports to each CCG. A report of all complaints and a summary of patient feedback, including return rates and scores, was reviewed by the Regional Quality Assurance and Improvement Forum (RQuAIF) and Clinical Governance Committee. BPAS shared the survey results with unit managers and discussed at regional managers meetings, with staff and commissioners.
- There were frameworks for the unit manager and lead nurse to refer to when faced with financial decisions or human resource issues, such as managing sickness and absence.
- The registered manager had a system in place to check nurses / midwives maintained their registration with the Nursing and Midwifery Council.
- The service used a BPAS clinical dashboard to record measures of quality and safety. Managers used this as an improvement tool for monitoring, checking, and analysing clinical standards. The treatment unit manager measured performance through a programme of audits and communicated to the regional management team and staff at the service.
- The dashboard included results on medicines management, staffing levels, clinical supervision, infection prevention, case note audits, serious incidents, safeguarding, complaints, laboratory sampling and labelling and staff sickness. This enabled all BPAS units to benchmark against each other and provided a real-time indicator of quality and safety in each unit. BPAS Leeds had good (green) compliance across all dashboard indicators for November and December 2015.
- Data was collected with regard to the DH RSOP 16 and the Leeds unit reported this information to commissioning bodies.
- BPAS was developing a new process that would require managers to submit evidence regarding actions taken where there were areas of non-compliance against the dashboard audits.
- BPAS Leeds undertook quality assurance checks for point of care testing and reported into the national quality schemes for HIV and Haemoglobin testing.

Leadership

- There was strong local leadership provided by the registered manager and the lead nurse for the unit. Nursing leadership was strengthened by a regional lead nurse who could provide clinical supervision, training and support to the unit when needed.
- The regional operations director provided management supervision for the registered manager and management and regional lead nurse. The associate director of nursing provided clinical supervision for the regional nurse.
- The staff at BPAS Leeds felt well supported by managers and told us they could raise concerns with them. Staff told us senior managers were easy to contact and had a regular presence in their centre, were approachable and helpful. The lead nurse or unit manager were available on a daily basis and staff felt able to approach them at any time if needed.
- Staff told us that regional and local managers and leaders were supportive of personal problems and teams rallied together to help each other in times of need, whether personal or professional.

- Staff gave examples of when managers had given advice and support with clinical, safeguarding and personal issues.
- The unit manager held monthly team meetings and staff told us they were able to express concerns and ideas for improving processes and services were listened to and adopted where feasible. A member of staff minuted these meetings by hand and any staff unable to attend read these. Staff needed to sign to say they had read the minutes.
- Learning from incidents, safeguarding and daily practice was shared locally with the team but staff were unaware how local learning and elements of good practice was shared with the wider organisation.
- Senior nurse meetings occurred three times a year across the BPAS organisation to share relevant information such as national and organisational policy, education and practice updates, for example, a nurse revalidation workshop.
- Unit managers met quarterly.
- The associate director of nursing acted as professional lead for nursing in addition to other roles, which included the safeguarding lead and director for infection prevention and control.
- Managers had access to a suite of training designed specifically for their role. Topics covered human resource subjects and leadership skills.

Culture within the service

- Staff displayed an enthusiastic but sensitive, compassionate and caring manner in the care they delivered. 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 Leeds. They described BPAS Leeds as a good place to work and as having an open culture.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents. Staff felt they could openly approach managers if they felt the need to seek advice and support.
- We met with senior managers who travelled to the centre for the inspection. They were supportive of their staff and discussed in detail systems and procedures in place throughout the organisation that encouraged an open and supportive culture.
- Nursing staff and managers we spoke with all liked working for BPAS and felt the organisation was very patient focussed, caring, compassionate and supportive of staff.
- There was an employee assistance programme and counselling provision for staff.
- Staff were encouraged to access training when they identified a skills gap through supervision or the appraisal process.

Public engagement

- Patients attending the clinic were able to provide feedback by commenting online at BPAS or on NHS choices websites.
- BPAS staff gave all patients a comment form entitled 'Your Opinion Counts'. There were boxes available at the unit for patients to submit their forms, or they could be posted directly to the BPAS Head Office. The Treatment Unit Manager viewed all forms prior to sending them to the BPAS Head Office for collation and reporting, so that any adverse comments could be acted on immediately. There was a poster and leaflets about how to make a complaint or give feedback.
- The clinic staff routinely asked patients to complete feedback cards and usually achieved over the 25% response rate, which was the corporate target for feedback. This target had been set to ensure representation of patient feedback. Analysis of the responses received showed that patients felt very satisfied with the care and treatment they had received. All categories measured for patient feedback achieved 100% positive results.
- The registered manager monitored all feedback for the units and implemented changes and took action where needed.
- The BPAS website had been upgraded to a mobile phone friendly application to make it more accessible to patients.

Staff engagement

- Staff took part in an annual staff survey and were able to engage with the wider organisation through an online staff forum.
- We were told that nationally the response rate to the staff survey was around 60% and that findings were fed back to all staff as it was not possible to disaggregate local results. Findings were discussed at local meetings to determine their relevance to the Leeds unit.

- There was a conference held for managers every two years.
- The BPAS doctor told us that the service were able to accommodate their needs in treating patients to the RCOG standards.
- BPAS held a one-day event for clinical and counselling staff every two years. Where feedback from the national forums was relevant locally, suggestions and issues were considered in team meetings and changes made as appropriate.
- Staff were able to engage with the wider organisation through an online staff forum.
- A process for cascading the national team briefs was in place and staff could feedback to managers and the executive team through this mechanism.
- Staff gave us examples of how processes had been changed because of their suggestions and how their feedback had led to improvements for patients.
- Staff told us they had used the employee assistance programme for practical issues outside of work and the support line for staff when upset by work related issues. Staff reported that they valued these systems and had found the support provided very helpful and easy to access.
- Client care coordinators also found the support provided by the annual reflective peer sessions very valuable.
- Staff received regular BPAS 'Connect' updates, which provided news, updates and training information, and team briefs, which included information about finance, marketing and clinical changes.

Innovation, improvement and sustainability

- Staff were involved in the development of a satellite service at Dewsbury to make their service more accessible to patients in the region.
- Although not directly involved in pilots regarding conscious sedation, staff were aware of what was going on elsewhere in the organisation and were expecting that when their unit recruited to the surgeon's post that they would receive training and development to be able to offer this as a treatment option.
- The unit was involved in the ongoing evaluation of simultaneous medical abortions as a sustainable treatment option.
- BPAS Leeds was actively recruiting a surgeon to enable them to reintroduce the provision of surgical abortions.
- The staff at Leeds were proactive regarding improving their service, pathways and experience for their patients.

Outstanding practice and areas for improvement

Outstanding practice

- Staff went out of their way to provide a caring and holistic service to their patients. They did this by working well with local agencies to provide additional support and services where appropriate and by acting as an intermediary for patients who lacked confidence to make initial contact with other agencies.
- Regular, direct observation of staff practice was an integral part of the BPAS approach to ensuring staff maintained an expert level of competence in their individual roles.