

British Pregnancy Advisory Service

BPAS – Basingstoke

Inspection report

Crown Heights
Alencon Link
Basingstoke
RG21 7AN
Tel: 02380540396
www.bpas.org

Date of inspection visit: 19 May 2022
Date of publication: 25/07/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Good



Summary of findings

Overall summary

We rated this location as requires improvement because:

- The service did not manage emergency equipment safely.
- The service did not have a robust process for checking the emergency drug boxes to ensure they contained the necessary medicines and in line with resuscitation council requirement.
- The number of staff who had completed the intermediate life support training was low.
- Women at times waited for longer periods for access to interpreting services which the provider was trying to resolve.
- Women did not always receive care in a timely way to meet their needs.

However:

- Staff had a variety of training which included how to recognise and report abuse. The service-controlled infection risk well. Staff kept clear and up to date records of patient's care and treatment.
- Staff provided good care and treatment, gave women refreshments, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff completed safeguarding assessments and risk assessments for women thought to be at risk of self-harm or suicide and escalated them appropriately.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff now recognised and assessed a patient's possible lack of mental capacity to make decisions and documented this.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Termination of pregnancy

Requires Improvement



We rated this service as requires improvement because it is effective, caring and well led although safe and responsive requires improvement. We had not rated this service previously. The service saw 598 patients in total for early medical abortions (EMA). 516 patients had TOP EMA- Patients collected pills on site. 81 patients received TOP EMA- Pills by post. One patient had TOP EMA as tablet to take home The service held a current Department of Health licence to practice under the Abortion Act.

- Zero patients were transferred out to another hospital from March 2021 to April 2022.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin- susceptible Staphylococcus aureus (MSSA), Escherichia coli (E. coli) and Clostridioides difficile (C.Diff).

Summary of findings

Contents

Summary of this inspection

Background to BPAS - Basingstoke

Page

5

Information about BPAS - Basingstoke

5

Our findings from this inspection

Overview of ratings

7

Our findings by main service

8

Summary of this inspection

Background to BPAS - Basingstoke

BPAS Basingstoke is operated by British Pregnancy Advisory Service. 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 Basingstoke moved to their current premises in 2015.

The BPAS Basingstoke clinic undertakes early medical abortion up to ten weeks (EMA). The service was not providing surgical termination of pregnancy (SToP) at BPAS Basingstoke. Women requiring late surgical abortions were signposted to other BPAS clinics in the local area. The clinic also offered pills by post, contraception service and sexually transmitted infection testing, as part of the termination of pregnancy treatment.

BPAS Basingstoke clinic was last inspected in August 2015 and met the quality standards it was assessed against. The service was not rated as the Care Quality Commission (CQC) was not required to rate such services at the time.

The location is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Family planning
- Diagnostic and screening procedures
- Termination of pregnancies.

Under these regulated activities the service provided:

- Pregnancy Testing.
- Early Medical Abortion (EMA)
- Consultations
- Scans
- TTO Appointments
- Contraception service

The service has a registered manager in post.

How we carried out this inspection

We carried out an unannounced inspection on 19 May 2022 using our comprehensive methodology, we inspected all key lines of enquiry. The inspection team consisted of a CQC lead inspector and a specialist advisor with expertise in termination of pregnancy.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led.

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Summary of this inspection

During the inspection visit, the inspection team:

- Assessed all areas of the clinic including treatment areas and waiting rooms.
- We reviewed the emergency equipment and medicines management.
- Following the inspection, we contacted four people who had used the service to gain their feedback about their care.
- Spoke with the operation quality manager, treatment unit manager and two other staff including the clinical lead for the service.
- Reviewed patients' care and treatment records and risk assessments.
- Looked at a range of policies, procedures, data we had received from the service and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a provider **SHOULD** take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should consider updating the emergency trolley content list to accurately reflect their content.
- The service should consider ways of checking the identities of women receiving care.
- The service should develop systems to effectively meet the timeframe from contact, consultation and treatment.
- The service should develop systems to support women to access and receive care and treatment to meet their needs in a timely manner.
- The service should continue to review the access to interpreting services for women.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Termination of pregnancy	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Overall	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

Termination of pregnancy

Safe	Requires Improvement 
Effective	Good 
Caring	Good 
Responsive	Requires Improvement 
Well-led	Good 

Are Termination of pregnancy safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills to most staff and made sure everyone completed it.

The mandatory training was comprehensive to meet the needs of patients and staff. Staff were provided with training specific to their job role, this meant they received the required training relevant to their role. Compliance for basic and intermediate life support training (ILS) was 100%. The ILS update training which incorporated sepsis and recognition of deteriorating patients was 40%. The provider told us they were waiting for more update training sessions to be available. The service was not currently providing any surgical procedures.

Staff completed training on recognising and responding to patients with mental health needs, learning disabilities. This meant staff gained knowledge and skills to care for and meet the needs of all patient groups.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service recorded staff training attendance and staff were also reminded to complete any outstanding training during team meetings and offered staff some protected time to do so.

Safeguarding

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

Between May 2021 and April 2022, the service had made 38 safeguarding referrals. Staff were confident in identifying adults and children who may be at risk of significant harm and worked well with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had any concerns. The service had a safeguarding algorithm for staff to escalate concerns. There were relevant internal and external contacts displayed within the department. Staff we spoke with could describe how they would recognise potential abuse and actions they would take. All staff that we spoke to were able to confirm their safeguarding training levels and the name of the safeguarding lead.

Termination of pregnancy

Staff received training specific for their role on how to recognise and report abuse. Staff including senior managers were supported to undertake regular updates in safeguarding to maintain their skills and followed procedures for safeguarding children and adults. All staff had received level 3 safeguarding training and the operation quality manager had level 4 safeguarding training.

Staff completed safeguarding assessments and risk assessments for women thought to be at risk of self-harm or suicide and escalated concerns to the crisis team as required. The service had updated their safeguarding list and provided contact details for staff to refer women and children to the appropriate safeguarding teams. This included children safeguarding, NHS safeguarding midwives, domestic violence, vulnerable and sexual abuse supports.

Staff followed safe procedures and policy for children attending the clinic. All patients under 16 years had face to face consultations at the clinic. Patients under 18 years of age had video call consultations with checks that they were not being coerced and able to speak freely. However, staff told us there was no process for checking identities of women such as NHS number and other identification of women they were treating. A senior manager told us they would be discussing this with the contracting trust.

Cleanliness, infection control and hygiene

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

All areas seen were clean and had suitable furnishings which were clean and well-maintained.

There was clear information which was displayed to assess and reduce the risks of cross infection. Policies and procedures had been reviewed in line with department of health guidance during the pandemic. The service had developed a COVID-19 prompt sheet that staff used for screening patients prior to their appointment.

The service maintained a cleaning record to monitor cleanliness and reduce infection control risks. The records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact to reduce the risks of cross infection. The service carried out regular infection control audits and data provided by the service showed 100% compliance.

We found the disposable screen in one of the treatment rooms was last changed in December 2021. Staff member told us this should be changed every three months and had not been picked up during their internal audit. The provider has told us this had now been resolved.

Environment and equipment

The design, maintenance and use of facilities, premises mostly kept people safe. However, the emergency equipment were not always managed safely. Staff were trained to use them. Staff managed clinical waste well.

The emergency equipment and resuscitation trolley were not managed safely and effectively. The emergency trolley did not contain adult yanker sucker and tracheal suction catheters, as per the service emergency content list.

Termination of pregnancy

Although staff had signed to confirm they had completed the safety checks of specialist equipment, however this had not been picked up. We found some items were not available in the resuscitation trolley and others which had expired. The contents of the emergency trolley did not reflect BPAS Basingstoke emergency trolley content list.

We highlighted this to senior managers at the time of the inspection and in our post inspection feedback letter to the provider. Following the inspection, the treatment unit manager told us they had reviewed the emergency trolley and had acted upon the concerns raised during the inspection.

The design of the environment and facilities were suitable to meet the needs of women. The furnishing was in good order and clean. Consideration was given for people with limited mobility and wheelchair users with level access available to people.

Staff disposed of clinical waste and sharps safely, these were stored in a designated locked area prior to collection. The service had a service level agreement for the disposal of all clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff completed risk assessments for each patient using a recognised tool, and reviewed this regularly, including after any incident. They used the situation, background, assessment and recommendations (SBAR) tool for communicating deterioration in patients.

Staff used a nationally recognised tool to identify deteriorating patients such as modified early warning score (MEWS) and escalated them appropriately. This supported staff in the early detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

The service had developed a local procedure to deal with and protect urgent scans for women ensuring they received appointment within 48 hours for women with suspected ectopic, pain and haemorrhage.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff knew about and dealt with any specific risk issues. There were policies and procedures to recognise and respond to patients risks such as venous thromboembolism (VTE) a condition in which a blood clot forms in a vein and sepsis in line with national guidance.

The service had arrangement in place under a service level agreement for the transfer of patient to the early pregnancy unit at the local NHS trust.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Termination of pregnancy

BPAS Basingstoke is a midwife led service. Managers calculated and reviewed the number and grade of midwives, nurses, and administrative coordinators for each shift in accordance with national guidance. The provider had told us that there was no nursing staff vacancy at BPAS Basingstoke. The team consisted of a treatment unit manager with overall responsibility for the management of the service. This was supplemented with a lead midwife, two midwives and two nurse practitioners and three administrative assistants. Managers adjusted staffing levels daily and according to the needs of patients. They worked at the Solent hub which covered three services and staff worked across services to support safe care. The service had low vacancy and turnover rates.

The service had enough staff to keep women safe and in the event of absence, women were offered the next available appointment in clinic or at another BPAS location. Managers had introduced double clinics in January 2022 which allowed for two clinicians to be on site supporting each other and improving morale and confidence in delivering women's care.

Records

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

The service used an electronic record system. We reviewed five sets of patients' records. These contained detailed information of patients' assessments which followed patients' clinical pathway as appropriate.

Patient records were stored and maintained securely, and procedures were followed for restricted access to confidential records. Staff had access to up-to-date, accurate information on patients' care and treatment following assessments and consultations. Clinical staff had access to an electronic records system to complete assessments and deliver care to women.

Access to the electronic patient records was password protected and restricted to core staff teams and staff logged off computers when these were not in use.

Medicines

The service used systems and processes to safely prescribe, administer medicines. However, the emergency boxes were not managed safely and did not contain the drugs as listed on the emergency list.

Staff mostly followed systems and processes for the safe management of medicines. There had been concerns at other locations relating to the management of take out medicines (TTO). A senior manager confirmed that all TTOs were labelled at head office and staff did not label TTOs locally.

The emergency drug boxes at the service were not safely managed as they did not contain the drugs which were on the emergency drug list, and this could impact negatively as these drugs would not be available in an emergency. The boxes also contained medicines which were not on the service list and there were no instructions about their use and amount that may be given to women in an emergency. These related to Atropine minijets and Amiodarone which is a drug used in cardiac arrest situations and to treat fast and irregular heartbeats. Although staff had signed the checklist to show that the emergency equipment and drugs had been checked. The provider could not be assured that women would have access to and receive safe treatment in case of an emergency.

Termination of pregnancy

Following our inspection, the unit manager has confirmed that they had undertaken a review of the emergency medicines boxes at the service.

The service had developed and used Patient Group Directions (PGDs). These are written instructions which allows healthcare professionals to supply or administer certain medicines in the absence of a written prescription. The service maintained a list of PGD medicines which the staff used to prescribe medicines. Policies and procedures were in date and were available to support the staff's practices.

Staff reviewed patients' medicines and provided specific advice to patients about their medicines. Staff followed current national practice and guidance to check patients had the correct medicines.

Women were provided with a booklet with step-by-step instructions on pills at home for the early medical termination of pregnancy. This explained to patients what medicines they were taking, in what order to take the medicines and the side effects which could occur from the medicines. Women were provided with a 24-hour contact number for advice and if they were worried about their treatment.

The medicines booklet provided to women for early medical abortion (EMA) contained detailed information about the harm about giving prescribed medicines to others and ensuring they took them within the legal timeframe.

Staff confirmed to us, and the service currently did not have any controlled drugs since they had suspended all surgical procedures.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service used an electronic system to internally report and record incidents. Staff knew what incidents to report and were confident in using their internal reporting system.

Incidents were investigated by the local unit manager and Lead midwife as appropriate. Local managers oversaw any necessary local or immediate action and submitted reports and escalated to the risk and governance team who decided whether incidents were escalated as a Serious Incident Requiring Investigation (SIRI).

The service had reported one incident that met the serious incidents criteria in the last 12 months This related to a patient delay in taking medicine supplied for early medical abortion (EMA) and the pregnancy had progressed to third trimester. The service had reiterated to women about the importance of taking their medicines as prescribed.

Incidents were discussed at safety huddles and at team meetings and learning from incidents were shared across the three services.

Staff understood the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support.

Termination of pregnancy

Are Termination of pregnancy effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had developed clear patient pathways and documented consultations with women in an electronic patient record.

Staff followed the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Women were provided with information in line with NICE guidance including those women who were having a medical abortion at home, explaining how to be sure that the pregnancy has ended. Women were also informed on signs and symptoms that indicated they needed medical help after an abortion, and who to contact as required.

The Royal College of Obstetricians and Gynaecologists (RCOG) has produced guidance for gynaecological services during the COVID-19 pandemic. The service had developed their service for pills by post and early medical abortion in line with these guidelines.

The service measured wait times to minimise delays in women accessing services in line with national best practice guidance (NICE QS 199).

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff referred to the psychological and emotional needs of patients and this was documented in their records.

The service supported women undergoing medical termination of pregnancy and were offered a contraceptive pill or signposted to local services for other methods of contraception.

Staff gave information during consultation and information about procedures and medications were available in booklets and on-line.

Nutrition and hydration

Women had access to hot and cold drinks when attending the clinics.

Women attended the clinics as outpatients and were provided with hot and cold refreshments as needed. Women were supported to live healthier lives and advice was available on diet and managing weights.

Pain relief

Termination of pregnancy

Staff assessed and provided advice verbally and in leaflet or booklet to women to manage their pain. Women had access to 24 hour helpline for further advice.

Women received advice on pain relief during their consultations and received some pain relief medicines as part of their early medical abortion (EMA) following assessments. Women were advised to take over the counter medicines for pain such as ibuprofen or paracetamol for mild to moderate pain. The service also provided patients with a 24-hour help line for those who experienced pain or complications at home.

Patient outcomes

Managers monitored the effectiveness of care and treatment.

The service monitored its compliance to provide appointments, consultations and scans within the recommended timeframe and gestation. The service was working across the three Solent hub and referred women to these clinics to support women in receiving a scan appointment within the required timeframe. Women we spoke with said they had timely appointments and scans and they did not have to wait long.

The service had developed a flow chart that staff followed to monitor their do not attend rates and action was taken. The audit schedule included response times, safeguarding, infection control, hand hygiene, environment, medicines and records. Actions from audits included additional trained sonographers and developing clearer guidance and supply of medicines for early medical abortions via post.

Managers shared and made sure staff understood information from the audits through team meetings.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Managers gave new staff a full induction tailored to their role before they started work which included online learning and face to face.

Managers supported staff to develop through regular supervision and yearly appraisals of their work. Records we viewed showed that the service had achieved 100% compliance with their staff appraisals.

Managers held monthly staff meetings and records of these were maintained and shared across the Solent team hubs.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff were supported and received additional training for their role. This included first and second trimester scanning training. BPAS Basingstoke had five staff members who were first trimester accredited and one staff member who was second trimester accredited.

Termination of pregnancy

The service supported staff to undertake training to maintain their professional registration and revalidation requirement. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers. The service also checked staff had current registration to allow them to practice.

Multidisciplinary working

The midwives, nurses and other healthcare professionals worked together as a team to benefit women.

Patients' records and feedback from staff showed that there was effective multi-disciplinary working and women were receiving treatment to meet their needs.

The service worked with partner organisations such as the multi-agency safeguarding teams, sexual health clinics, early pregnancy unit and local NHS trusts to ensure women received safe and effective care. Women were supported to access a counselling service and the women we spoke with were aware of this. A copy of the treatment was shared with the women's GPs only if they gave their consent.

Seven-day services

BPAS Basingstoke did not provide a seven-day service.

The service operated on Monday, Wednesday and Friday, they did not provide any emergency care or treatment days. The provider had told us the Hampshire cluster was opened six days a week and women could speak to staff and were offered appointments at Portsmouth and Southampton.

Patients were provided with an emergency contact number to enable them to seek advice and support out of hours. This was available 24 hours a day and seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas and online. Staff completed a full assessment of women and provided support for women to live healthier lifestyle and sexual health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards.

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

The service had procedures that staff followed for gaining valid consents including mental capacity assessment. This was clearly evidenced in the records we reviewed. The service had developed a mental capacity flow chart for women over 16 years which staff used to guide them in their assessments. The service did not treat anyone under 16 years.

Termination of pregnancy

The electronic recording system had been included a section detailing mental capacity assessment, staff were unable to complete a patient's record without completing the assessment of mental capacity. All patient records reviewed documented the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005.

Staff supported women and ensured they had information available to make an informed decision about their care. Patient information leaflets were given to women which detailed the risks of procedures.

Staff received training in the Mental Capacity Act. Staff understood Gillick Competence and Fraser Guidelines and supported children to make decisions about their care and treatment and recorded these decisions.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act, staff told us they could escalate any queries regarding mental capacity to the central BPAS safeguarding team for advice and support.

Are Termination of pregnancy caring?

Good 

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed staff interacting with women in a respectful and considerate way during a telephone consultation. We contacted four women following the inspection as there was no one receiving care at the time. Women told us they were happy with the care and support they had received, and they were treated with care and compassion. The service carried out bi-monthly patient satisfaction surveys. We reviewed a sample of women survey undertaken between April 2021 to January 2022. The service scored 100% for staff being supportive, receiving clear information and women being fully involved in their care and treatment.

Staff followed policy to keep women's care and treatment confidential. We observed telemedicine consultation with the woman's consent. The consultation was carried out in private with doors marked as engaged to maintain women's privacy. Staff carried out women assessments in a caring and compassionate manner, giving them time to ask questions.

Staff had understanding and demonstrated a non-judgmental attitude when assessing women and supported women to other support and services as needed.

Women were offered counselling services through BPAS to support their decision to terminate a pregnancy. Women we spoke with confirmed that they were made aware of and offered this service which they had declined.

Emotional support

Staff provided emotional support to women to minimise their distress. They understood women's personal, cultural and religious needs.

Termination of pregnancy

Staff gave women emotional support and women told us they felt well supported during the consultations and again during their scans. Staff followed their process and women were given the choice of a chaperone to assist them if they wished.

Staff understood the emotional and social impact that a person's treatment had on their wellbeing and on those close to them. Staff demonstrated a caring and passionate attitude when discussing the needs of women during the inspection.

Understanding and involvement of women and those close to them.

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Women were involved and staff supported them to make informed decisions about their care. Appropriate treatment options according to the women gestation were discussed and their preferences considered when choosing a treatment option.

Women attending the service could have a chaperone in line with the service policy. Minutes of a recent staff team meeting showed chaperone was discussed and staff were reminded to offer this service, to document confirming this had happened and to ensure this was offered throughout the women's pathway.

The service made sure women and those close to them understood their care and treatment. Women received information booklet and leaflets which were relevant to their treatment. Women told us that had received leaflets and were also signposted to BPAS website.

Women and their families could give feedback on the service and their treatment, and they were positive and felt involved in their care. The patient satisfaction survey showed women were positive about their care and the service scored a 100% on involvement in their care and treatment.

Are Termination of pregnancy responsive?

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

In the reporting period of April 2021 to March 2022, the service had provided care and treatment to 598 patients.

Managers planned and organised services so that they met the needs of the local population and worked across three clinics as one cluster. All telemedicine consultations were carried out remotely.

The service offered appointments three days a week to ensure that women were able to access scans and early medical treatment within the set timeframe.

Termination of pregnancy

Managers ensured that women who did not attend appointments were contacted and there were clear processes that staff followed and actions they should take, and this was recorded.

There was a service level agreement with local NHS trusts where patients could be transferred in the event of an emergency.

Meeting people's individual needs

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

Staff used admission documentation that included detailed assessment of a patient's individual needs. We reviewed the service E- patients' records and found assessments and information which were clearly documented.

The environment was designed to meet the diverse needs of patients. Information was available about interpreting services and staff were confident in using this and ensured women could access the service. However, staff told us the interpreting service was not always responsive and women experienced long delays in receiving support. This included interpreters who were conscious objectors and refused to support women seeking an abortion. Following the inspection, the provider had told us staff could provide feedback of any concerns relating to the interpreting service. These were discussed at monthly meetings between BPAS and interpreting service managers.

Patients were able to choose their preferred treatment option and usually at a service which was closest to them, subject to their gestation and medical assessment. BPAS Basingstoke was providing a service on reduced days and patients attended alternative BPAS clinics in the area.

However, the service website did not contain up to date information about the clinic opening hours which could be to the detriment of women accessing care. The clinic had changed their clinic days and staff said it had been closed on Thursdays since January 2022, but the website had not been updated.

Women with a learning disability were supported and offered face to face consultations and support from the local authority teams to ensure they received appropriate care and treatment. Consultations were planned and included over the phone and face to face according to risks to meet women individual needs.

Access and flow

People mostly could access the service when they needed it and received the right care. Waiting times were monitored to ensure referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

The service had 598 attendances for early medical abortion (EMA) Between April 2021 and March 2022.

Staff planned each woman's attendance as early as possible and according to their needs. The service had a process to measure waiting times between contact to consultation and consultation to treatment. This was to ensure women could access services when needed and received treatment within agreed timeframes and national targets.

Termination of pregnancy

Between April 2021 and March 2022, there were notable variation of 7 to 85% between women contacting the service and consultation. During the same period the service achieved between 53 to 91% of women were seen within seven days of consultation to treatment. This meant that a considerable proportion of women did not receive care in a timely way. The service had been improving their targets which showed between January to March 2022, 73 to 74 % of women had received treatment within the timescale.

A senior manager told us they had difficulty following the pandemic in providing urgent appointment within 48 hours due to staffing and lack of trained sonographers. The service had taken actions and trained extra sonographers and were working to resolve this issue.

Women mostly could access the service as needed and were given flexible appointment times appropriate to their gestation. The service had a telephone consultation service which carried out an initial consultation and offered patients a choice of appointments suitable to their gestation.

The four women we spoke to following the inspection told us they had attended the clinic within 48 hours of having contacted BPAS.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service had received three complaints between March 2021 to April 2022. They had a complaint policy and procedure, and staff knew how to access this. Information on how to raise a concern or complaint was available to patients and their relatives. Women we spoke with told us they had no complaints and would be confident in raising any concerns about the service.

Managers followed their policy on complaints and knew how to handle and acknowledge them. Managers investigated complaints and identified themes and women received feedback from managers after the investigation into their complaint. The treatment unit manager was responsible to manage complaints locally and involved the lead midwife for any clinical concerns. Complaints were also escalated to the head office as appropriate.

Managers shared feedback from complaints with staff and learning was used to improve the service. Examples of learning following a recent complaint and action taken included staff to reiterate the need to rebook appointments when patients were more than 10 minutes late and could not be accommodated the same day.

Are Termination of pregnancy well-led?

Good 

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Termination of pregnancy

There was a clear leadership structure from service level to senior management level. The leadership team consisted of the chief executive officer and strategic teams whose functions were to ensure they met their responsibilities to provide a safe, high-quality and accessible service to women. The leadership team included the director of nursing and quality, infection control specialist nurse, pharmacy consultant medical director, director of finance. The senior leadership team met monthly and had a rotating focus for their meetings.

The treatment unit manager (TUM) was responsible for the day to day management of the service with oversight from an operational quality manager (OQM). The manager was experienced and was supported by the corporate leadership teams. They were in the process of applying to register with the commission. Staff confirmed that the TUM attended all three services within their hub and was supported by the clinical lead and (OQM).

The service had a certificate of approval as issued by the Department of Health to undertake termination of pregnancies. Local and senior managers were visible, available and approachable. The senior leadership teams had not been visible, and staff said this was a concern during the pandemic. Senior managers told us that they had listened to the staff and had set up more regular visits to the local areas to meet the staff.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service had a clear vision and strategy they wished to achieve including values and strategy to achieve. This was informed by best practice guidance and the needs of women nationally.

The service had used different means to collect information from its staff, external stakeholders and healthcare professionals as well as the public about the current and future directions of the business. The manager disseminated any updates through the team meetings. Staff had opportunities to discuss priorities and issues relating to the service.

BPAS national and local strategic plans changed in line with legislation and the needs of women. The service had tailored its provision of community services since the introduction of “Pills by Post” during the COVID-19 pandemic and kept up to date with changes in legislation, this had meant fewer women needed to attend the service for consultation or treatment. Learning had been taken from any incidents that occurred to ensure the delivery of early medical abortion (EMA) at home was as safe as possible.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted an open culture where patients, their families and staff could raise concerns without fear.

Staff worked together as a team with a common focus of delivering high-quality care to women attending. Staff felt the local management teams were approachable, visible and offered them support to carry on their roles.

Termination of pregnancy

The treatment unit manager and clinical lead met with staff regularly and staff were able to contact them for advice and guidance as required. Staff were proud of the service they provided for their local community and vulnerable women. The provider had developed clear guidance to support vulnerable women and those at risk of self-harm or suicide. The staff played a crucial role in health care by providing compassionate and inclusive care to all. They recognised they had a duty to be constantly aware of those who may be vulnerable, regardless of their demographic and the symptoms.

Staff were confident in reporting incidents and concerns internally and BPAS encouraged learning from all incidents and audits. Staff were encouraged to develop professionally and take part in additional training opportunities. The service had a freedom to speak up guardian in place for staff to escalate concerns.

Staff understood the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. They said it was important to be open and honest with women when things went wrong and were confident in initiating this. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support.

We gathered feedback from patients who had used the service following the inspection. Women were positive about the care and support and information they had received to make an informed choice about their care. They told us staff were caring and supportive and ‘non-judgmental’.

The service undertook quarterly service users’ surveys, we looked at the last three survey results between July 2021 to March 2022. This showed women expressed a high degree of satisfaction regarding their care and treatment. They said they were offered appointments within a suitable timeframe. They said they were given good information and explanation to make an informed decision about their care.

Governance

Leaders operated mostly effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a governance structure and processes to support the delivery of a quality service. The service managers reported directly to the senior leadership team with clear lines of escalation in place.

The governance structure was made up of various other groups and committees which included the Clinical Governance Committee, Clinical Advisory Group, Drug and therapeutics and Infection control. They all met quarterly and contributed to the overall governance of the service. The board of trustees was responsible for ensuring BPAS fulfilled its organisational/ charitable purpose through effective leadership.

The Research and Ethics Committee (REC) provided advice on ethical issues that affect BPAS and were referred for its consideration by the Clinical Governance Committee, the Clinical Advisory Group, the Finance, Audit and Risk Committee or the BPAS Board.

Termination of pregnancy

The treatment unit manager and the operation quality manager worked together and attended the local clinical governance committee and heads of department meetings. Minutes seen showed a standardised format was used which looked at incidents and audits undertaken and their outcomes. Minutes were descriptive and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was provided to staff during team meetings.

The service complied with and submitted documentation in line with its legal requirements. Midwives and registered nurses administering the second stage of medical termination or the surgeon completing the surgical procedure were responsible for submitting the HSA4 form on the system which was then sent to the Department of Health within 14 days of the termination taking place. The treatment unit manager (TUM) reviewed and checked form submissions to ensure compliance.

Management of risk, issues and performance

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

The provider had a business continuity plan with clearly defined responsibilities for key staff members in the event of an emergency and closure of the service. This included involving the local communications team, the lead for CCG / NHS England in the process to provide advice and support. Staff were advised that if this impacted on partner organisations, they should also be notified.

Managers at local level now had processes in place relevant to their location in the event of an emergency. There was an internal procedure in the event of emergency, including staff working within the cluster to meet the needs of women. Managers escalated local risks up to a quality and risk committee who discussed risks at a leadership level. Staff reported incidents using their internal process appropriately and according to BPAS policy.

The service worked collaboratively with the multi-agency safeguarding hub, early pregnancy unit and local NHS trusts to ensure women received a holistic approach to their care. Staff had regular meetings with the clinical commissioning group (CCG) sharing performance information, as part of their contract requirements.

The service maintained a local risk register. Risks identified were recorded on a standardised template which identified the impact, likelihood and risk scores. Actions were developed to mitigate risks. The risk register was reviewed regularly, and any actions taken to mitigate risks were recorded. We spoke to a senior staff member about risks within their service and confirmed the risk register was discussed as part of the service performance review meeting.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information governance board had a wide representation which included the senior information risk officer (SIRO), Caldicott guardian, data protection officer. They worked together to ensure management of information risk and information was used lawfully, securely, fairly and for its intended purposes.

Termination of pregnancy

The service had developed processes and audits to support them in collecting reliable data and analysing it and staff had access to this.

Staff conducted monthly audits and the findings were collated and compared monthly to enable improvement. Audits results were accessible and discussed to promote learning.

Staff could access patient electronic records appropriate to their needs and procedures being completed. Computers were password protected and locked when not in use. We saw that computers were not accessible to patients. Statutory notifications were submitted to external organisations as required by law.

Engagement

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

The service actively engaged staff and patients, so their views were reflected in the planning and delivery of services. The local managers and clinical lead worked closely with staff in the development of the service.

The latest staff survey which was completed in 2021 high levels of satisfaction in areas such as recognition and initiative, but lower levels of satisfaction reported in areas such as pay, training and employee benefit. The survey showed that 91% of staff would recommend BPAS to friends and family for treatment, 88% believed they had a worthwhile job and were very positive about the support from line managers.

Managers told us that the senior leadership teams were aware of the survey results and were actively working to improve the welfare and well-being of the staff.

Local teams held monthly team meetings and minutes of these were available. The meetings followed a structured format which included safeguarding, audits, complaints and feedback, risks and incidents. Staff were given an opportunity to raise any other business such as training needs or clarity on new policies. Staff received regular communication and updates to detail any issues and improvements in the service.

The service engaged actively with women using services. We looked at the last two quarterly patients' satisfaction reports completed between July and December 2021. Patients expressed a high degree of satisfaction about the care and treatment they had received. The service had scored 100% on clear information was provided and staff were supportive and given enough time for treatment and to ask questions. Areas for improvement were appointments timeframe and suitable locations which scored 85-95%.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Learning from incidents, safeguarding and daily practice was shared locally within the team. Staff described the formal processes for sharing learning and elements of good practice with the wider organisation through senior managers.

The information governance board assured the effective management of information risk in promoting a culture of good information governance. Key objectives of the group were to ensure that BPAS used information fairly, lawfully and for specified, explicit purposes and keeping information accurate and up to date.

Termination of pregnancy

The research and ethic committee maintained an overview of all research conducted at BPAS. It examined proposals for research, audit or service evaluation involving patients, or materials derived from patients. This was to ensure that they conform to generally accepted ethical principles and standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <ul style="list-style-type: none">• The provider must ensure that emergency trolley and emergency drugs are reviewed and available to meet the resuscitation council guidelines. Regulation 12.• The provider must ensure that the emergency first line drug boxes are reviewed in line with the policy practices. Regulation 12• The provider must ensure that all staff complete intermediate life support training in line with their roles. Regulation 12