BPAS - Andover

Quality Report

Andover Health Centre
Charlton Road
Andover
SP10 3LD
Tel:0345 304030
Website:www.bpas.org.uk

Date of inspection visit: 8 June 2016
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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 Andover is part of the national charitable organisation British Pregnancy Advisory Service. BPAS Andover is located in a health centre which also provides sexual health services as part of an integrated sexual health services contract. BPAS Andover began operating in 2012 and provides consultations and medical abortions up to 10 weeks gestation including simultaneous (two medications are given within 15 minutes) early medical abortions up to nine weeks gestation. The unit does not provide a vasectomy service. There is no linked satellite service.

The unit manager has been in post since 2012 and was the registered manager for the service.

We carried out a comprehensive announced inspection visit at BPAS Andover on 8 June 2016. We inspected this service as part of our independent healthcare inspection programme. We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

The inspection team comprised one inspector and a specialist advisor. The advisor was a midwife and a director of midwifery services at an NHS trust hospital.

Our key findings were as follows:

Are services safe?

- Staff followed procedures to report, investigate and monitor incidents. Learning from incidents was shared across the organisation.
- Staff we spoke with understood the principles of being open and were supported to implement duty of candour requirements by the BPAS engagement manager and we saw two examples of this.
- The clinic environment and equipment were visibly clean and suitable for use; standards were monitored through audits and risk assessments.
- Medicines including abortifacient medicines were stored securely and records maintained. Regular medicines management audits were undertaken to monitor practice.
- Sufficient staff and skill mix were on duty to meet patients' needs. All staff were trained in safeguarding vulnerable adults and children to level 3. Staff obtained advice from the unit safeguarding lead or national BPAS safeguarding leads when needed.
- Arrangements were in place to transfer patients to the local NHS hospital if the need arose, accompanied by a member of BPAS staff.

Are services effective?

- Staff provided care and treatment that took account of national guidance, for example, Royal College of Obstetricians and Gynaecology (RCOG) guidance and the Required Standard Operating Procedures (RSOP) guidance from the Department of Health. The clinic also provided simultaneous early medical abortion for patients less than nine weeks gestation. The evidence to support the effectiveness of this treatment method was based on a BPAS trial carried out in 2014/2015.
- A programme of policy review was undertaken by BPAS corporately and all policies were approved by the national BPAS clinical governance committee. Staff had ready access to policies on the BPAS intranet.
- All staff at BPAS Andover were up to date with core training requirements and had access to additional training to develop their roles. Professional staff were supported to undergo revalidation.

Summary of findings

- Records showed that staff sought and recorded patients' consent to ensure patients made independent, informed choices about their treatment. We observed staff informed patients of the increased rate of complications with regards to simultaneous early medical abortion during the consultation process.

Are services caring?

- Staff provided care with compassion and sensitivity and were non-judgemental in their approach. BPAS Andover response rate for their satisfaction survey was 91% and results were consistently positive.
- Patients said they felt listened to, were given clear explanations by staff and had been involved in decisions about their care.
- All patients were offered a pregnancy options discussion with a client care coordinator (CCC) as part of their consultation. The CCC was not trained to diploma level in counselling, as recommended in the RSOP 14. However, they had undergone a BPAS training programme which included theory and competency based assessments.Staff checked patients understood their treatment options, and involved partners in their care when appropriate.
- The service provided patients with contact details of the BPAS after care advice line, available 24 hours seven days a week. A post abortion specialist counselling was also available if needed.

Are services responsive?

- The service was planned and delivered to meet the needs of the local population.
- Clear suitability for treatment guidelines were followed. In cases where patients had complex medical needs, suitable alternative placements were identified to respond to their needs.
- Staff had access to a telephone interpreting service and patient information was available in a range of languages.
- Patients were able to access services in a timely manner. Between January and March 2016, women in Hampshire had to wait an average of 4.8 days for their first consultation. The percentage of consultation appointments available within seven calendar days was 90.1%. Patients waited on average 4.4 days from consultation to treatment.
- The service recorded and responded to informal and formal complaints. The service had received one formal complaint between January and December 2015 which had been investigated and lessons learnt where appropriate.

Are services well led?

- A unit manager had been in post since 2012 and was the registered manager for the service.
- Staff we spoke with demonstrated they understood the BPAS values and aims and the strategic direction of the organisation. For example, the trend towards providing more same day consultation and treatment appointments.
- A clear and effective governance framework was used to ensure service quality and performance was monitored and actions taken when needed. Four monthly national clinical governance meetings and regional quality and managers meetings took place. These forums were used to discuss quality and risk issues and monitor the service was adhering to legal requirements such as completion and submission of legal documentation (HSA1 and HSA4 forms).
- A monthly audit of the abortion authorisation forms (HSA1s) was undertaken to ensure legal requirements were met and this showed consistent compliance. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful.

Summary of findings

- The unit manager used a risk register to collate the risks across the three units they managed. We saw control measures were in place to mitigate the risks.
- All staff we spoke with were kept informed of issues through emails and team meetings. Staff engagement also took place at a biannual clinical forum and annual staff survey. Staff described local and head office managers as approachable and accessible.
- BPAS actively looked for improvements to the way it delivered services.

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

The provider should:

- Ensure observational infection control audits are conducted appropriately to monitor adherence with infection control policies and procedures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

BPAS Andover provided a compassionate, caring and non-judgemental service in line with BPAS values as an organisation. Sufficient staff were available with the skills and training to provide care. BPAS produced policies that took account of best practice policies and evidence based guidelines. For example, in line with Royal College of Obstetricians and Gynaecology (RCOG) guidance and the Required Standard Operating Procedures (RSOP) guidance from the Department of Health. BPAS also carried out its own research before the implementation of simultaneous early medical abortion up to nine weeks. Risk assessments and audits including how the service was adhering to legal requirements regarding completion and submission of HSA1 and HSA4 forms were undertaken. This information was reported monthly to head office as part of the organisation's quality assurance processes. Incidents and complaints were reported, investigated and actions taken to reduce the recurrence. The unit manager recorded risks across the three units they managed in one risk register, which included control measures and review dates. The service had received one formal complaint in 2015 which had been investigated and improvements implemented.

All staff were trained in safeguarding vulnerable adults and children (level 3) and obtained advice from the unit safeguarding lead or national safeguarding leads as needed.

Clear suitability for treatment guidelines were followed. In cases where patients had complex medical needs, suitable alternative placements were identified to respond to their needs. All patients were offered a pregnancy options discussion with a client care coordinator as part of their consultation. The service signposted patients to the 24 hours seven days a week after care advice line and post abortion specialist counselling if the need arose. Patients were able to access services in a timely manner. Women in Hampshire had to wait an average of 4.8 days for their first consultation. The percentage of consultation appointments available within seven calendar days was 90.1%. Patients waited on average 4.4 days from consultation to treatment.

However, although infection control policies and procedures were monitored through audit, which consistently showed over 95% compliance since January 2015, the observational infection control audits had not been conducted as intended which potentially invalidated the results.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

BPAS - Andover

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to BPAS - Andover

The Andover clinic consisted of one screening room and three consulting rooms.

Activity

- Between January 2015 and December 2015 the service carried out 168 medical abortions.

Safety

- No 'never events' (January 2015 to December 2015)
- One serious incident requiring investigation between January and December 2015
- All staff who were involved in the care of patients aged under 18 were trained to level three in safeguarding children and young people.
- There were no nursing staff vacancies as of December 2015.

Effective

- Information provided by BPAS showed that 100% of staff had completed an appraisal as of December 2015.
- Between April 2015 and March 2016 over 90% of patients were screened for chlamydia

Caring

- The BPAS Andover survey showed 100% of patients using termination services during April 2015 to December 2015 would recommend the service to someone who needed similar care

Responsive

- Between January and March 2016, Hampshire had to wait an average of 4.8 days for their first consultation. The percentage of consultation appointments available within seven calendar days was 90.1%. Patients waited on average 4.4 days from consultation to treatment.
- There had been one formal complaint between January and December 2015.

Well Led

- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful and this is recorded on a HSA1 form. BPAS units completed monthly HSA1 audits to monitor legal requirements. The compliance of BPAS Andover with this audit was above 95% (April 2015 to March 2016).
- The response rate for patient feedback forms was 91%.

Our inspection team

Our inspection team was led by:

Inspection Lead: Lisa Cook, Care Quality Commission Inspection Manager

The team included one CQC inspector and a director of midwifery services with experience in 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?

Summary of this inspection

- Is it well-led?

Before visiting we reviewed a range of information we had received from the service and information from other stakeholders.

We carried out an announced inspection of BPAS Andover on 8 June 2016. We spoke with two patients and five members of staff including the regional director of operations, the treatment unit manager, service managers, nursing staff and support staff. We observed how staff cared for patients and reviewed nine patient's clinical records.

We would like to thank all staff, patients and other stakeholders for sharing their views and experiences of the quality of care and treatment at the BPAS Andover.

Information about BPAS - Andover

BPAS Andover is part of the national charitable organisation, British Pregnancy Advisory Service.

The clinic is located in a health centre in the centre of Andover. BPAS Andover is contracted by a local community NHS Trust, on behalf of the local clinical commissioning groups to provide a termination of pregnancy service for women and young people in Hampshire. BPAS Andover is part of an NHS trust integrated sexual health service located in a health centre.

The BPAS Andover clinic provides consultations and medical abortions (up to 10 weeks gestation) and simultaneous early medical abortions (up to nine weeks). The clinic operates weekly, Monday and Wednesday between 8.30am and 1.30pm. There was no linked satellite service.

Other services include pregnancy testing, unplanned pregnancy counselling, abortion aftercare, sexually transmitted infection testing, contraceptive advice and contraception supply. Between January 2015 and December 2015 the service carried out 168 medical abortions. At the time of inspection, there was a unit manager who had been in post since 2012 and was the registered manager for the service.

The CQC previously inspected the service in February 2014 and found the provider was meeting all the standards inspected.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

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Are termination of pregnancy services safe?

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

- Systems were in place to ensure staff reported incidents. These were investigated and learning shared across the organisation.
- The clinic and equipment were clean and checklists completed to ensure standards were maintained.
- Equipment including resuscitation equipment and drugs were available and regularly checked to ensure they were fit for use. Medicines were stored securely and administered safely.
- Sufficient staff were on duty with the appropriate skills and training to meet patients' needs.
- We reviewed nine patients' records. Pathway documents and clinical risk assessments were completed fully and legibly.

However,

- Although infection control policies and procedures were monitored through audit, which consistently showed over 95% compliance since January 2015, the observational infection control audits had not been conducted as intended which potentially invalidated the results.

Incidents

- There had not been any reported 'never events' at the unit. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
- Six complications and two clinical incidents were reported between April 2015 and August 2015. One of the clinical incidents was categorised as a serious incident. This resulted in a reminder to staff to stress to patients that they must attend the local early pregnancy unit or A&E department the same day, if tests indicated a high risk of ectopic pregnancy. All the reported complications were either continuing pregnancy or retained products of conception.

- Incidents were reported and investigated, staff we spoke with were aware of their responsibilities in relation to incident reporting. BPAS made a distinction between categorising incidents as clinical incidents and complications. For example, a clinical incident was defined as an event that resulted in harm such as a medication error. A complication was defined as an unintended outcome attributed to an intervention which resulted in harm such as haemorrhage or infection following treatment.
- Staff recorded incidents in a unit incident book. However, the incident copies that were meant to remain in the book as reference had been removed. At the time of the inspection the unit manager was not certain where the incident form copies were located. Following the inspection the regional operations director confirmed the copies had been removed to share the information with the regional clinical lead who was based at another location. Inspectors reviewed the incident reports of BPAS Andover at another unit, which was also managed by the same unit manager, the following day. The regional clinical lead determined whether incidents required investigation and submitted the reports to head office. BPAS had plans in place to replace the paper based incident reporting process with and an electronic system.
- Incidents were reported centrally and reviewed regionally through the Regional Quality Assurance and Improvement Forum (RQuAIF) and nationally through the clinical governance meetings. Learning was shared through meetings, emails and team brief. Significant learning points were communicated through information bulletins known as 'Red Top Alerts'. These included a staff signature sheet to confirm staff had read the updates. For example, the incident described above resulted in a red top alert on 'Management of potential ectopic pregnancies' in January 2016.
- The incident reporting procedure included information on how staff should respond to duty of candour requirements. 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 patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff understood the principles of 'being open', the unit manager was supported by the BPAS client engagement manager to ensure actions were taken when required. We were shown two examples of when duty of candour had been triggered and the patient had been notified of an incident that had or could have resulted in harm.
- The unit manager received the medicines and healthcare products regulatory agency (MHRA) alerts and safety notices. They informed staff, followed up and actioned if needed. However, the information rarely applied to this unit.

Cleanliness, infection control and hygiene

- All areas of the clinic we saw were visibly clean and tidy. The NHS trust premises in which the clinic was located had its own cleaning schedule and checklist, we saw BPAS staff carried out their own cleaning checks at the start of their clinic sessions.
- Facilities for hand hygiene included hand sanitisers and hand wash basins were provided and in good working order. We observed staff were bare below the elbows and observed appropriate infection control practices, such as washing hands and wearing gloves.
- Washable privacy curtains were in place in patient areas. The curtains were clean and intact. The cleaning schedule showed the curtains had been last cleaned in January 2016 and the next clean was planned for six months later in July 2016.
- The Andover unit followed the BPAS infection prevention and control (IPC) audit plan. The link nurse for IPC undertook one audit each month. However, these audits had been conducted as question and answer sessions and the auditor had not observed staff in practice as required. These audits covered aspects of clinical practice such as hand hygiene and aseptic technique as well as one aspect of the environment such as sharps disposal. Results of all audits were submitted to head office and IPC was reported formally on a dashboard as a performance indicator. The Andover unit had a rating of green, which meant that IPC compliance was above 90%. Between April 2015 and December 2015 all infection control audits showed above 90% compliance. However, as the audits had not been conducted as observational, this potentially invalidated the results.
- The infection control lead nurse undertook cleaning audits every three months. The audits we reviewed showed compliance was consistently over the standard of 90%.

- There was a policy in place regarding safe disposal of clinical waste. We saw waste was appropriately segregated and disposed of.

Environment and equipment

- We observed there was controlled entry into clinic. Arrangements were in place to maintain the equipment and premises that BPAS Andover operated from as part of the service level agreement with the local NHS trust.
- The BPAS health and safety advisor carried out biennial risk assessments including, fire, health and safety and waste management. These were last conducted in March 2016. One action was identified as part of the health and safety risk assessment, regarding the lack of electrical safety testing since January 2014. The unit manager was addressing this issue.
- Records showed the scanner and blood testing device had been serviced in the previous 12 months.
- Equipment was provided as part of the contract with the NHS trust. Staff ensured equipment which was solely for BPAS staff use was securely stored when they were not operating on site.
- We saw that resuscitation equipment, including the defibrillator was checked daily when the clinic was operating.

Medicines

- The lead nurse was responsible for medicines management in the unit. Medicines were supplied by the local NHS trust. Staff followed the BPAS medicines management policy. Monthly medicines management audits were carried out to ensure medicines were stored safely and records maintained. The unit dashboard showed compliance with the required medicines management standards between April 2015 and January 2016.
- The unit dispensed prescriptions for analgesia, antibiotics and contraceptives.
- We observed medicines storage cupboards were clean, tidy and well organised. Records showed drugs were checked regularly and stored safely.
- Resuscitation medications were available on the resuscitation trolleys, we saw these were in date and ready for use.
- Staff recorded fridge temperatures in line with medicines management guidelines. Readings were within accepted range and staff were aware of what action to take if readings were out of range.
- A doctor prescribed all abortifacient medicines and nurses provided some non-abortifacient medicines under Patient Group Directions (PGDs). PGDs are written instructions for the supply and administration of medicines to groups of patients who may not be individually identified before presentation for treatment. BPAS PGDs were in line with national guidance. Accountable officers were clearly named and they had signed PGDs correctly. All PGDs we reviewed were within their review date. Staff undertook training in the use of the PGD and signed the record sheet when training was complete and they felt competent to administer and or supply the prescribed medications.
- PGDs also covered pain-controlling medication, treatment of chlamydia and prophylactic antibiotics to prevent post procedure infection.
- The discharging nurse or midwife provided antibiotics and contraceptive medications and checked the patient understood what the medications were for and the importance of taking them as prescribed.
- 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 medical signatories. We saw the electronic information system enabled doctors to view the patient information and consultation details remotely, authorise the terminations by signing the HSA1 forms and sign electronic prescriptions. The system was designed to only generate the prescription after two signatures had been recorded on the HSA1 form.

Records

- The clinic had limited records storage facilities and was unable to retain patients' records for longer than two months. After this period notes were stored at a neighbouring BPAS location where they were held for a further month before being archived. Notes were transported in locked cases to the unit when needed.
- Patients' records included speciality pathways and risk assessments for example for sexual health.

Termination of pregnancy

- We looked at nine sets of patients' records who had undergone consultations and early medical abortions. We found them to be contemporaneous, complete and legible. Records indicated risk assessments and follow up of any medical concerns or issues identified were well documented and reviewed prior to the treatment.

Safeguarding

- BPAS had adult safeguarding and child protection policies that we saw were available to all staff via the location's intranet. The policies were up to date with regard to current legislation and national guidance.
- Effective systems were in place to safeguard vulnerable adults and young people. All staff we spoke with were aware of their responsibilities and had access to appropriate safeguarding pathways. The unit manager was the safeguarding lead and a safeguarding lead nurse was also in post.
- Safeguarding risk assessments were carried out when there was any suspicion of abuse and safeguarding referrals were made to the local safeguarding team. BPAS had recently increased the age (from 16 years to 18 years) for undertaking a detailed safeguarding risk assessment. The outcome of the risk assessment was discussed with the local or national safeguarding lead if needed and acted on appropriately. Between January 2015 and December 2015 no child under the age of 15 years had been treated at BPAS Andover.
- Our review of records identified three patients who were under the age of 18 years, of which one was under 16 years. Safeguarding risk assessments and Gillick competency (assessment of 16 years and under to give informed consent)and Fraser guidelines documentation were fully completed for this child.
- The staff training matrix maintained by the unit manager showed all staff had received adult and children's safeguarding training to level 3 in line with mandatory training requirements. This training also covered information relating to child sexual exploitation.
- Patients under the age of 18 years who had attended for consultation but did not attend for their appointment were followed up by phone call and if the patient decided to continue with the pregnancy the young person's GP was informed in writing.
- 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.
- Staff had received training related to female genital mutilation (FGM) and they were aware of the Department of Health requirements in the guidance, Female Genital Mutilation Risk and Safeguarding: Guidance for professionals. DH March 2015. Staff were clear what actions they needed to take if FGM was identified or patients were at risk of.
- BPAS produced an annual safeguarding report and audit to monitor compliance with section 11 of the Children Act 2004. We reviewed the February 2016 report which showed 100% compliance with the Act.

Mandatory training

- BPAS core mandatory training for all staff included health and safety, infection control and fire safety. All staff had received basic, immediate or advanced life support training, dependent on their role. For example, the lead nurse was trained to immediate life support, other staff were trained to basic. Additional role specific training was specified such as counselling skills for client care coordinators. BPAS specified which training was updated annually, such as basic and immediate life support.
- A training log was maintained by the unit manager which showed 100% staff were up to date with training. Staff were sent an email reminder before their training was due and managers were also alerted to remind staff.
- Training was delivered by e-learning or face to face workshops.
- Staff told us registered nurses and midwives underwent a comprehensive 12 week induction programme, which covered all elements of mandatory training they required including for example, scanning competencies. Their scanning practice was audited every two years.

Assessing and responding to patient risk

- Staff followed the BPAS suitability for treatment guidelines when determining if patients were appropriate for treatment at BPAS Andover.
- Risk assessments, medical follow up, interventions and postoperative reviews were evident in our observation of patients' journey and in the records we reviewed.

- Blood tests were performed on all patients to establish their rhesus status. Patients who were rhesus negative were provided an injection of anti-D to protect against complications should the patient have future pregnancies. Positive identity checks were made prior to commencing treatment. We reviewed the register and found it had two signatures to check results before treatment was administered.
- Staff were able to identify signs, which could identify a deteriorating patient and knew how to escalate when needed. Staff told us they had effective relationships with the local NHS hospital's obstetrics and gynaecology team and could access medical advice or instigate an emergency transfer in line with the emergency transfer protocol.
- Staff provided patients with a referral letter, copies of which were kept in their record, and called the local A&E department or early pregnancy unit if patients were directed to attend there following assessment.
- Staff gave patients written discharge information, copies kept in their record, and advice 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 consultation and/or termination of pregnancy.

Nursing staffing

- The clinic used a skill mix of registered midwives and nurses. There were no vacancies in the clinic.
- The performance dashboard for Andover had been green since April 2015 indicating no breaches of the minimum staffing level in this period.
- No agency nursing staff were employed at this unit.
- Staff we spoke with said there was always enough staff available to ensure patients had sufficient time and never felt rushed during appointments.

Medical staffing

- Unit staff told us they had access to medical staff via the electronic system and advice from the regional clinical lead and medical director when needed.

Major incident awareness and training

- There was a corporate business continuity plan and local arrangements centred on individual incident plans such as fire or loss of utilities and staff were aware of how to respond.
- In the event the BPAS rooms could not be occupied, arrangements were in place with the local trust to relocate the BPAS service to alternative rooms within the health centre or alternative location to provide continuity of the service.

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.

- Staff provided care and treatment that took account of best practice policies and evidence based guidelines. The service had clear standards agreed with commissioners and key performance indicators to monitor performance and service delivery.
- BPAS also carried out its own research before the implementation of simultaneous early medical abortion for patients up to nine weeks gestation. Since May 2015 approximately 85% of early medical abortions (up to nine weeks gestation) at BPAS Andover were provided using the simultaneous treatment method.
- Patient outcomes were monitored through an annual audit programme and achievement of key performance indicators. The service monitored waiting times and referrals to specialist pathways in line with the Required Standard Operating Procedure (RSOP) 16.
- Staff received clinical supervision, appraisals and had opportunities for development training.
- Staff audited records to check patients received effective care and treatment. At Andover all records audits between November 2015 and April 2016 showed 100% compliance.
- Staff understood how to seek consent from patients, including children under 16 years of age. They checked that patients made independent, informed choices about their treatment.

Termination of pregnancy

Evidence-based care and treatment

- Staff followed BPAS suitability for treatment guidelines which included clear exclusion criteria. Where staff had concerns about whether a patient was suitable for treatment they always sought clinical advice from the regional clinical lead or BPAS medical director.
- Staff had access to up-to-date policies and procedures through the BPAS intranet.
- Policies relating to termination of pregnancy and professional guidance were developed in line with, where appropriate, the Royal College of Obstetricians and Gynaecology (RCOG) guidelines and Department of Health Required Standard Operating Procedures (RSOP).In addition, BPAS Andover also offered patients a new way of receiving drugs to initiate an early medical abortion (EMA) up to nine weeks gestation, which meant patients were able to receive medicines at the same time. The provider had reviewed clinical research and carried out a national pilot to monitor outcomes of the options in 2014/2015. The updated My BPAS Guide (April 2016) for patients included details of options available, including the relative risks associated with the two methods of EMA. Patients under nine weeks gestation were offered early medical abortion (EMA) on the same day but if over nine weeks EMA was offered over two days to increase the effectiveness.
- BPAS Andover was partnered with the local sexual health service in Hampshire. This joint working enabled the service to provide chlamydia testing for all patients. Between April 2015 to March 2016 the unit exceeded the target of 90% of patients who were screened for chlamydia. All patients were offered screening for sexually transmitted infections. If a positive result was returned, processes were in place to track partners and offer treatment.
- Staff offered to discuss contraceptive options with patients during the initial consultation and assessment. They also discussed a plan for contraception after the abortion. Options included the long acting reversible contraceptive (LARC) methods, which are considered to be most effective as suggested by the National Collaborating Centre for Women's and Children's Health. BPAS Andover provided contraceptives or referred to another BPAS unit in accordance with patients' choice and in line with RCOG guidance. Data showed 35% of patients who had an abortion in the five Solent BPAS units, including Andover chose to receive the LARC (October 2015 to December 2015).

Pain relief

- Staff provided patients a 'My BPAS Guide' which contained information on pain control and suitable medicines to take after the procedure.
- All patients undergoing medical abortion were offered a small supply of codeine phosphate tablets to take home and appropriate advice on pain relief during the recovery process.

Patient outcomes

- In 2015 no patients were transferred to another healthcare provider for further treatment.
- BPAS had a planned annual programme of clinical audit and monitoring. The majority of subjects listed in RSOP 16 were covered through monitoring reports or regular audits. Unit results were reported regionally and discussed at quality forums.
- Complication rates such as retained products of conception, on-going pregnancy and post procedure infection were monitored and compared with other BPAS clinics. All results were within the expected range as outlined in the My BPAS Guide. For example, between May 2015 to December 2015 the reported unit complication rate for continuing pregnancy for patients undergoing simultaneous EMA under 9 weeks was 2.6%. This was above the expected rate of 2% (referred to in the My BPAS Guide) but based on a relatively small number (78) of simultaneous EMAs.
- Staff provided patients apregnancy test after the EMA procedure. Patients were advised to perform the test and to recontact the clinic or aftercare line if the test was positive or they had any concerns.
- Our review of records showed that when patients had contacted the aftercare line the record of contact was saved in the patient record and actions taken in response. For example, the patient was asked to reattend the clinic for a scan.

Competent staff

- The unit manager maintained a log of staff details, including disclosure and barring service checks and occupational health checks for staff.
- Registered nurses and midwives had undertaken a 12 week course of extended training and were able to scan patients, obtain consent for procedures and administer or supply contraception. Senior staff told us staff who undertook scanning had completed an ultrasound course had their practice audited every two years by the BPAS lead sonographer.
- At BPAS Andover the client care coordinators (CCC) were also the clinic reception staff. CCCs were trained in undertaking discussions with patients on pregnancy options. CCCs participated in two days of client support skills/ counselling training. This was followed by completion of a competency matrix which involved observing at least 15 consultations followed by being observed for at least 10 consultations prior to providing lone consultation. Senior staff said it normally took three to six months for individual staff to complete all the required competencies. Ongoing training and support was provided through supervision and access to experienced CCCs. Although CCCs were not trained to diploma level as stated in RSOP 14, BPAS CCCs were trained pregnancy counsellors. If patients required additional counselling support, for example, in cases of alcohol abuse,staff referred patients to specialist trained counsellors. The unit manager was also trained in offering supportive discussions post-abortion.
- BPAS supported nursing staff to prepare for revalidation through raising awareness of the requirements and supporting staff to produce evidence for their portfolio. The midwife practitioner had access to the hospital supervisor of midwives for supervision and support.
- In 2015 all BPAS Andover staff had participated in an appraisal in the previous year. Staff said their appraisal was a meaningful process and identified training needs. For example, the unit manager had received additional training in finance to develop their skills.
- Nursing staff had three monthly clinical supervision meetings with the regional clinical lead.
- All staff we spoke with were very positive about the training and development opportunities they had access to.
- All clinical staff were expected to participate in the biannual clinical forum.The last forum was held in April 2016 and covered key updates for staff, such as information on professional revalidation.
- Nursing staff had three monthly clinical supervision with the regional clinical lead or another trained clinical supervisor.
- The unit manager completed a 'clinical passport' for staff which recorded their staff training and competencies. This was used to ensure staff who worked in different BPAS units possessed an easily accessible record to provide assurance of their up to date training and competencies.
- 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.
- All staff we spoke with were very positive about the training and development opportunities they had access to.

Multidisciplinary working

- There were clear lines of accountability between different roles, for example, client care coordinators and nursing staff which contributed to the effective planning and delivery of care.
- Staff told us that they had close links with other agencies and services such as the local safeguarding team, contraceptive and sexual health services, counselling service and early pregnancy unit. This facilitated referral and signposting of patients to meet their needs.
- BPAS Andover had service level agreements with a neighbouring NHS trust, which allowed them to transfer a patient to the hospital in case of medical emergency. We were told this was rarely enacted.

Seven-day services

- The BPAS Andover clinic was open weekly, Monday and Wednesday, 8.30am to 1.30pm. If patients needed to use services on other days, they were signposted to alternative BPAS clinics by the BPAS contact centre or client care coordinators.

- < > 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 after care service could speak to registered nurses or midwives who were able to offer advice and feedback to the clinic for follow up, if needed.
  Patient records were primarily paper based. However, specific information was also stored on the electronic records system to allow doctors remote access to the patient details in order to complete the HSA1 form.
- The clinic did not have notes storage facility and patient records were securely transported to a neighbouring BPAS unit. Notes were accessible and retrieved when needed.
- Staff had access to relevant guidelines, policies and procedures in relation to termination of pregnancy.
- Staff were able to access diagnostic tests/blood results in a timely manner.
- Reports of contact with the aftercare service were emailed to the unit staff and saved on the patient's electronic record. Unit staff would also print the report and save a copy in the patient's record for ease of access.
- Patients were referred to the emergency contact numbers accessible 24 hours a day in the My BPAS Guide.
- Staff offered patients a copy of their consent form, if declined the copy remained in the notes and it was recorded as consent form copy 'not accepted'. Discharge information was sent to the patient's GP if the patient had consented for their information to be shared.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nurse and midwife practitioners checked patients understood the termination process and sought their consent to treatment appropriately. We observed three consultations and in all cases staff had taken time to ensure the patient was aware of the consent and risks involved in the procedure. We observed staff explained the reduced effectiveness and risks involved with using the simultaneous method during the consent process to ensure patients were able to make an informed decision.
- All the care records we reviewed contained signed consent from patients if the patient had decided to proceed with treatment. The forms documented that staff had discussed risks, possible side effects and complications. The unit used different consent forms designed for different procedures. These included consent for surgical or medical abortions, evacuation of retained products of conception and the medical management of a miscarriage.
- Staff used a specific form to document in the patient care record how they assessed competence of children under the age of 16 years using Gillick competence principles. Specific documentation was also used to record the assessment using Fraser guidelines in relation to contraception and sexual health advice and treatment.
- Staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Records from December 2015 showed 100% staff compliance with this training. Staff told us patients who lacked capacity to give their consent, for example, patients with complex needs and / or a learning disability, would be referred to the specialist placement team to ensure their needs were met appropriately. For example, by referral to an appropriate NHS facility. Staff explained if a situation arose where patients needed more time to obtain consent they would book additional time or repeated appointments to facilitate the process.

Are termination of pregnancy services caring?

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

- We observed staff provided care with compassion and sensitivity and offered patients the time they needed to make a decision. Staff behaved in a non-judgemental way and provided person-centred care.

- Staff checked patients understood their treatment options, and involved partners in their care when appropriate. Those who had responded to patient surveys said they had been given privacy and dignity and had been treated in a confidential manner.
- Patients gave positive feedback about the caring aspect of the service. They consistently said they had felt listened to, were given clear explanations by staff and had been involved in decisions about their care.
- Feedback from patients who we spoke with and through comments cards was all positive. Patients felt they were well informed and treated in a friendly manner.

Compassionate care

- We observed staff were respectful, kind and sensitive to patients attending the clinic. This was confirmed by the patients we spoke with.
- We observed staff respected patients' privacy and dignity. For example, staff only used patient's first names and provided care behind closed doors and used privacy curtains.
- Andover clinic collected feedback from patients using the BPAS 'your opinion counts' survey. Staff encouraged service users to complete the survey and the Andover response rate was 91%, significantly higher than the BPAS target of above 25% to ensure survey results were valid.
- Quarterly reports of the BPAS patient satisfaction survey showed that 100% of patients using termination services at BPAS Andover during April 2015 to December 2015 would recommend the service to someone who needed similar care. Patients reported high levels of satisfaction and the unit scored 100% on all the caring aspects of the survey.
- 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.
- We received seven completed comments cards. All the comments were positive. The most common description of the service was 'Friendly and helpful'.

Understanding and involvement of patients and those close to them

- Staff told us that patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care pathway. Younger patients were encouraged to involve their parents or family members and their wishes were respected.
- We observed two patient consultations and found that assessments were thorough and staff followed pathway guidance. Interactions were positive and staff gave information effectively. Staff took time to convey information in a way that was clear and concise with frequent reference to the 'My BPAS Guide'. We observed staff inform patients of their responsibility to follow their prescribed treatment and aftercare advice including perform a pregnancy test and contact the clinic immediately if the repeat test was positive.
- We observed staff provided information and checked patient's understanding before proceeding and referred to the My BPAS Guide throughout the pathway.
- Staff told us that patients were made aware of the statutory requirements of the HSA4 forms (a requirement to notify the Department of Health of an abortion) and were reassured that the data published by the DH for statistical purposes was anonymised. We observed this information was imparted in the consultations.
- Patients told us that staff had explained what was going to happen and they had enough information given to them. One comment card stated "Staff explained everything."

Emotional support

- All patients were offered a pregnancy options discussion at their first consultation and received information about the services they could contact after the abortion if they needed additional emotional support. Staff offered patients support in a non- judgemental way, which we observed during consultations.
- Client care coordinators and nursing staff within the clinic were experienced in identifying the signs of when a patient may require additional support or time before, during or after the procedure. For example, for patients suffering mental health, domestic violence or alcohol abuse.

Termination of pregnancy

Are termination of pregnancy services responsive?

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

- The service offered a 24 hour telephone referral service and a 24 hour advice line.
- Staff had access to an interpretation service and guidance materials in a range of languages. Patients with complex needs or who did not meet the clinic's suitability guidelines were referred to the specialist placement service.
- Women were able to access services in a timely manner. The service had improved access times. It had achieved the recommendation of ten days from contact to treatment. BPAS operated a fast-track appointment system for women with a higher gestation period or those with complex needs.
- Staff used an electronic system for doctors to sign the HSA1 forms remotely. This meant that staff could provide treatment promptly, particularly when patients opted for a simultaneous early medical abortion (EMA).
- Patients were given information on how to complain and raise concerns. The service responded to informal and local complaints and monitored the action taken and any trends.

Service planning and delivery to meet the needs of local people

- BPAS Andover was offered as part of an integrated sexual health services contract led by the local community NHS trust. The unit manager had regular meetings with the NHS trust to ensure the service was reviewed to meet patients' needs.
- Women in Hampshire had access to other BPAS clinics and were able to choose which clinic to attend depending on their preference.
- Between April to December 2015, the proportion of patients at BPAS Andover opting for simultaneous early medical abortion was approximately 85%. Since December 2015 the service had introduced same day consultation and simultaneous early medical abortion. Figures showed the take up of thishad steadily increased to an average of nine per month.

Access and flow

- Patients booked appointments for BPAS Andover via the national BPAS Contact Centre, a 24 hour, seven day telephone booking and information service.
- Women were able to choose their preferred treatment option and location, subject to their gestation and medical assessment. The electronic triage booking system offered patients a choice of dates, times and locations. Patients at later gestation were prioritised for appointments to ensure they were provided treatment within the legal time limit.
- The appointment schedules were organised on a monthly basis. The unit manager reviewed the availability of appointments on a daily basis and was able to make adjustments depending on demand. For example, if there was an increase in the demand for simultaneous EMAs, these were offered if slots were available.
- All patients were offered a consultation appointment either face to face or by telephone which covered the patient's contact details, medical history and reasons for termination. Where patients opted to proceed with treatment a second appointment in a suitable clinic was booked. Patients who had opted for a telephone consultation were booked for a longer treatment appointment to allow time to conduct the necessary tests and scan. Telephone consultations had recently been introduced and were under review. Telephone consultations were available for all patients regardless of age.
- Department of Health Required Standard Operating Procedure 11 (access to timely abortion service) states good practice is that women 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. Between January and March 2016 , women in Hampshire had to

wait an average of 4.8 days for their first consultation. The percentage of consultation appointments available within seven calendar days was 90.1%. Patients waited on average 4.4 days from consultation to treatment.

- The percentage of women treated under ten weeks gestation is a widely accepted measure of access into abortion services. Between January and March 2016 in Hampshire, 82.9% of women were treated below 10 weeks, which exceeded the national average of 80%.
- Aftercare advice was available 24 hours a day seven days a week, 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. This was accessible any time after the procedure and could be faceto face or by telephone, depending on the patient's preference.

Meeting people's individual needs

- The initial consultation with the client care coordinator also involved a discussion regarding pregnancy options. Patients who required further support were offered specialist counselling either through BPAS or the sexual health team.
- Following the 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 telephone interpreter service was available to enable staff to communicate with patients for whom English was not their first language.
- Staff told us they rarely treated patients with learning disabilities and if they needed to they would make reasonable adjustments such as ensuring the patient was accompanied by a carer or friend who could stay with them during their consultation and or treatment.
- Staff had access to a specialist placement team who would arrange referral to appropriate providers for patients with complex medical or special needs, who did not meet the usual acceptance criteria.
- There was 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 women who were victims of domestic abuse.
- Contraceptive options were discussed with patients at the initial assessments and a plan was agreed for contraception after the abortion.
- Staff gave all patients a My BPAS Guide which gave information about treatment options, what to expect, contact numbers and aftercare advice.
- Staff were able to print the My BPAS guides in different languages if needed.
- Patients preferred mode of contact was recorded to preserve confidentiality.

Learning from complaints and concerns

- There were posters and leaflets on display in the waiting areas 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 deposit 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.
- The clinic received very few concerns or formal complaints. Staff told us, where possible, they would resolve any concerns immediately. The unit had a log but no concerns had been recorded.
- The BPAS patient engagement manager was responsible for the oversight of the management of complaints. Any case needing escalation was 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 patient satisfaction survey results (both national and by unit)

was reviewed by each regional quality assessment and improvement forum and the clinical governance committee. Themes or trends were identified centrally and any actions, outcomes and lessons learned were shared across the BPAS organisation through a series of national and regional governance meetings and local team meetings.

- The patient booklet 'My BPAS Guide' also included a section on how to give feedback and how to complain, as does the BPAS website.
- In 2015 there had been one complaint received regarding BPAS Andover. This had been investigated and actions taken in response. For example, the waiting area had been relocated from the corridor to a designated waiting room which allowed a greater level of privacy and dignity for patients. We were told although complaints escalated to head office were discussed at RQuAIF, the learning from complaints resolved locally was not shared across the region/ organisation.
- The patient booklet 'My BPAS Guide' also includes a section on how to give feedback and how to complain, as does the BPAS website.

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.

- Staff we spoke with demonstrated they understood the values of the organisation and were committed to providing a high quality, non-judgemental service to improve women's lives.
- The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings. Messages were communicated to staff through email and a team brief.
- Unit performance was measured through audits and reported on a monthly dashboard to the regional operations director. Action plans were developed for areas that required improvement.
- BPAS conducted annual staff surveys and there was a staff forum. Staff reported they had easy access to directors in the organisation for support and advice.
- The unit manager was in the process of developing a risk register with the support of the BPAS national risk manager.
- There were systems in place to ensure the HSA1 forms were fully completed and that HSA4 forms were submitted in accordance with requirements.

Vision and strategy for this core service

- BPAS' ethos was to treat all patients with dignity and respect, and to provide a caring, confidential and non-judgemental service.
- Staff spoke of the values of the organisation and were aware of the direction the organisation was moving. For example, the provision of more same day treatments.
- Maintenance of the values was fostered through the proactive recruitment of staff who displayed the values and behaviours expected by the organisation.
- The unit manager was knowledgeable about the corporate strategy and understood how this affected local provision of services.
- Staff at BPAS Andover worked across the neighbouring BPAS units and were aware the integrated contract was in place until 31 March 2017.

Governance, risk management and quality measurement for this core service

- There was clear governance and reporting structure within the organisation. A national clinical governance committee was held every four months, chaired by a BPAS board member, to approve policies and procedures and address clinical risks. BPAS was structured in three regions and BPAS Andover was located in the South West and Central region. Each region held a regional quality assessment and improvement forum (RQuAIF), which was chaired by the regional director of operations and included representatives from all roles across the region. For example, medical, nursing and administrative staff. Staff attended the RQuAIF to discuss risks and clinical issues

including incidents and complaints in detail to ensure the appropriate learning and actions from issues were disseminated to staff across treatment units.A regional managers meeting (RMM) which included all treatment unit managers was scheduled shortly after RQuAIF to discuss issues raised by RQuAIF and operational issues.

- Our review of the last RQuAIF notes (2 February 2016) showed comparison of the complication rates for each unit in particular since the introduction of simultaneous early medical abortion which resulted in slightly higher rates of continuing pregnancy but within the expected range. BPAS Andover was not identified as an outlier.
- Our review of the notes of the RMM of 1 March 2016 showed that RQuAIF notes had been discussed. Recommendations from a complex complaint was highlighted. This had resulted in a change to the information provided to patients and the recommendation to facilitate a discussion with a BPAS doctor for patients who were an 'exception' to the normal pathway.
- In 2015 BPAS implemented the unit dashboard/ early warning scorecard policy. This required all unit managers to submit key performance and quality metrics to the regional director on a monthly basis and was monitored at RQuAIF. However, although incidents and complaints were reported the dashboard standards for reporting a serious incident requiring investigation and informal and formal complaints was set at zero. This potentially discouraged reporting.
- The dashboard included results on medicines management, staffing levels, clinical supervision, infection prevention, case notes audits, serious incidents, safeguarding, complaints, laboratory sampling, labelling and staff sickness. The most recent RQuAIF minutes (February 2016) showed that all results were within the BPAS expected levels.
- BPAS Andover was the smaller of three BPAS units in the Hampshire area; the unit manager and staff worked across all three units. The unit manager had a joint risk register to record and monitor risks across the three units. The register included the controls in place to manage the risks and regular reviews.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 form). We looked at nine patient records and found that all forms included two signatures and the reason for the termination. BPAS used the electronic client administration system to ensure information and the HSA1 form was accessible and signed by doctors located at other BPAS units. When the HSA1 form was fully completed the termination of pregnancy procedure could take place legally. Authorising doctors had access to information including the patients' medical history, blood test results, reason for seeking a termination and scan measurements, although the actual scan pictures were not available electronically. Staff carried out monthly audits of completion of HSA1 forms. BPAS Andover audits showed consistent compliance of above 95% between April 2015 and March 2016.
- The Department of Health 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. There was an email reminder process to prompt doctors to complete this task daily and all HSA4 forms were reported electronically to DH. The HSA4 was signed online within 14 days of the completion of the abortion by the doctor who terminated the pregnancy. For medical abortion, where patients deliver fetal products at home, the doctor who prescribed the medication was the doctor who submitted the HSA4 form.
- Record keeping and documentation audits were carried out monthly and compliance was consistently near 100%.
- BPAS Andover held staff meetings approximately every four months to discuss the team brief. The notes of the last team meeting were dated November 2015 where complaints and performance were discussed. Staff at BPAS Andover worked across neighbouring BPAS units and team meetings were held at another BPAS clinic.
- Communication was by email and key messages reinforced at face to face meetings. Updates to policies and red top alerts were printed and we saw staff were expected to sign to acknowledge they had read the updates.

Leadership / culture of service

- The certificate of approval (issued by the department of health) was displayed prominently opposite the reception desk when the clinic was operating.
- The service maintained a register of patients undergoing a termination of pregnancy, which is a requirement of Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. Staff completed the register at the time the termination was undertaken and BPAS kept an electronic copy for a period of not less than three years.
- Staff were recruited who subscribed to the values of the organisation. Staff spoke positively about their role in the clinic and about the impact they had on women's lives. Staff said they gained job satisfaction and felt they worked in an open and transparent culture.
- Staff said they received good support from their colleagues, managers and head office.
- Staff told us the medical and nursing directors were very accessible.
- We observed staff demonstrated mutual respect. There was effective team work and professionalism in the way the organisation was managed.

Public engagement and staff engagement

- All patients were given feedback forms and were encouraged to complete these. Units were expected to achieve a minimum response rate. The Andover response rate was 91%, significantly higher than the BPAS target of above 25% to ensure survey results were valid. The results for were consistently positive across all areas.
- BPAS carried out an annual staff survey, similar to the NHS staff survey, to elicit how staff felt they were valued and supported and if there were any issues or suggestions for improvements. The 2015 survey report was based on a response rate of 63%. Results were generally positive, for example over 90% said they would recommend BPAS to friends and family and had the knowledge skills and equipment to do a good job. The questions that scored the lowest at 59% was 'There are enough staff to enable me to do my job well' and 'How much influence do you have to improve things.' Results were not disaggregated to unit level, however regional themes were identified and action plan developed. One of the actions was to increase the frequency of BPAS director visits to the units and these had been scheduled for 2016.
- Updated policies or guidelines were cascaded to staff via email and staff were informed at face to face meetings with their manager. Staff were informed of new policies or updates by email and conference calls were led by head office staff with question and answer session.
- A process for cascading the national team briefs was in place and staff could feedback to managers and the executive team through this mechanism.

Innovation, improvement and sustainability

- BPAS actively looked for improvements to the way it delivered services. For example, in the previous year it implemented the provision of same day consultation and simultaneous early medical abortion. A telephone consultation service had been introduced and full data analysis of the service and evaluation was planned to be undertaken within six months.
- The introduction of the client administration system had improved the efficiency of the service by allowing doctors to authorise the HSA1 forms electronically. This enabled the service to reduce waiting times and offer same day treatment.
- BPAS Andover was due to extend sexual transmitted infections (STI) testing such as gonorrhoea and HIV testing to patients from July 2016.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve
The provider should

- Ensure observational infection control audits are conducted appropriately to monitor adherence with infection control policies and procedures.