BPAS - Streatham

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Overall summary

BPAS Streatham is operated by British Pregnancy Advisory Service. BPAS Streatham provides medical and surgical termination of pregnancy services, feticide treatment, screening for sexually transmitted diseases, contraception advice, counselling and vasectomy procedures. The service provides surgical terminations up to 23 weeks plus six days gestation and medical abortions up to nine weeks plus six days gestation. Facilities include one treatment room, five consulting rooms a two stage recovery area, and a discharge area.

There was an early medical unit based within a health centre in Southwark. Early medical abortion treatment and consultations in the early stages of pregnancy were offered in a private room at this facility.

The service provides termination of pregnancy, sexual health screening and family planning services. We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 5,6,16,18 September 2019.

Summary of findings

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.

The main service provided by this hospital was termination of pregnancy services.

Services we rate

We rated it as **Requires improvement** overall.

We found areas of practice that require improvement:

- There was a corporate governance structure in place, however this was not effective at local level. Local governance arrangements did not ensure the identification, mitigation and monitoring of risks or the improvement of quality. There was a fractious relationship between some leaders and staff, and staff did not always feel valued or supported. We were not assured information fed into the monthly dashboard was accurate.
- The monitoring of staff mandatory training and competencies was not managed well. There was no formalised tracking until very recently, and this had yet to be embedded into the service. Not all staff had received an annual appraisal or regular performance reviews.
- There was not a strong culture for the reporting and sharing of feedback from incidents. We were not assured incidents of all levels were being reported.
- Waiting times from initial referral to treatment were not in line with Royal College of Obstetricians and Gynaecologists (RCoG) national guidance and Required Standard Operating Procedures (RSOP) 11: Access to timely abortion services. Patients could not always access the service when they wished. 54% of surgical termination of pregnancy patients above 14 weeks gestation, waited more than 10 days.
- Not all equipment was in good working order or had been calibrated.

However:

- Staff treated patients 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 patients, families and carers.
- The service had suitable premises and all areas of the clinic were visibly clean and clutter free. The clinic was wheelchair accessible with accessible toilets and a lift to all floors.
- Staff completed patient records accurately and stored them safely.
- The service treated concerns and complaints seriously and investigated them. The service included patients in the investigation of their complaint.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected BPAS Streatham. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	**Requires improvement** 	BPAS Streatham is operated by British Pregnancy Advisory Service (BPAS). It comprises one main location in South London and one satellite in Southwark. The service provides termination of pregnancy as a single speciality service. We rated this service requires improvement for safe, effective, responsive and well led and good for caring. Overall the service was rated requires improvement.

Summary of findings

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BPAS Streatham

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Termination of pregnancy

Summary of this inspection

Background to BPAS - Streatham

BPAS Streatham is operated by British Pregnancy Advisory Service. The British Pregnancy Advisory Service is a British charity whose stated purpose is to support reproductive choice by advocating and providing high quality, affordable services to prevent or end unwanted pregnancies with contraception or by termination of pregnancy. The service is registered as a single specialty service for termination of pregnancy and is registered for the following activities:

- Diagnostic and screening procedures
- Family Planning
- Surgical Procedures
- Termination of Pregnancy
- Treatment of disease, disorder or injury.

Services provided at the early medical unit included:

- Pregnancy testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing
- Contraceptive Advice and Treatment

The service has had a registered manager in post since October 2018

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and assistant inspector. The inspection was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about BPAS - Streatham

BPAS Streatham is open five days a week, Sunday to Thursday from 7.30am to 6pm. The Southwark early medical unit satellite clinic was available from Thursday and Friday from 9am to 4pm. The satellite clinic is located in a suite of consulting rooms, within a GP practice, which are leased by BPAS on a sessional basis.

BPAS Streatham has been opened for several decades and provides services for women of reproductive age and men from all areas of the UK, and sometimes overseas, although the majority of patients come from within London based clinical commissioning groups (CCG).

The clinic offers consultation, medical assessment, counselling and treatment. As part of the care pathway, patients are offered sexual health screening and contraception. Patients are able to choose the treatment that they have, based on their gestation, which includes, early medical abortion up to nine weeks and six days gestation, and surgical termination up to 23 weeks and six days gestation. Surgical termination of pregnancy (SToP), between seven and 14 weeks gestation, was offered using local anaesthesia, conscious sedation and no anaesthetic according to patients wishes. Surgical abortions up to a gestation 23 weeks and six days were offered under general anaesthetic. Medical feticide is provided before late gestation surgical abortions. Feticide is induced demise of the foetus.

During the inspection, we visited BPAS Streatham and BPAS Southwark satellite unit, we spoke with 16 members of staff including registered nurses and midwives, client care coordinators, and senior managers. We spoke with seven patients and reviewed 10 sets of patient records.

Summary of this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (April 2018 to March 2019)

- There were 5151 episodes of care recorded at the early medical unit (EMU) and BPAS Streatham.
- 2322 were medical terminations of pregnancy
- 2388 were surgical terminations of pregnancy
- 441 were surgical terminations of pregnancy after 24 weeks

Track record on safety

- There were no never events recorded for the period April 2018 to March 2019.
- There were two serious incidents recorded for the period April 2018 to March 2019.

From April 2018 to March 2019 the service received 15 formal complaints. All complaints received were responded to within 20 days which was in line with the provider's complaints policy.

Services provided at the location under service level agreement:

- Clinical and non-clinical waste removal
- Interpreting services
- Maintenance of equipment

Certain mandatory training modules

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

Requires improvement

We rated it as **Requires improvement** because:

- Not all staff had completed mandatory training core modules, and systems to track and monitor training were not fully embedded into the service.
- At the time of our inspection there was a lack of effective monitoring to ensure staff had received the appropriate safeguarding training.
- At the time of inspection not all equipment was in good working order or regularly calibrated. The scanner in the treatment room and the backup generator were both awaiting replacement, with orders placed but not yet received.
- Security to the treatment room was not sufficient. None of the doors which had locks were secure and we could easily gain access with no restrictions throughout our inspection.
- There was no formalised medicine management training or refresher training as stipulated in the medicine management policy, and this had been highlighted on the risk register. However the organisation was in the process of organising this.
- The service did not always manage patient safety incidents well. Staff did not always report incidents and lessons learnt were not always shared with the whole team.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to staff providing care.

Are services effective?

Are services effective?

Requires improvement

We rated it as **Requires improvement** because:

Summary of this inspection

- The service did not always make sure staff remained competent and up to date with their roles. We found one staff record identified competencies had not been signed off since they had started their employment over three years ago.
- There was a lack of effective processes to ensure agency staff had basic competencies to perform their role within the service. Recently the clinic had identified that agency staff had not received immediate life support (ILS) training and were only trained in level 2 safeguarding.
- Staff appraisals and supervision meetings were sporadic and inconsistent.

However:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff worked together as a team to benefit patients. They supported each other to provide care and communicated effectively with other agencies.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Are services caring?

Good

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Patients could access ongoing support should they need it.

Are services responsive?

Are services responsive?

Requires improvement

We rated it as **Requires improvement** because:

- People could not always access the service when they needed it. Waiting times for surgical treatments, did not meet RCoG national guidelines. This meant patients did not always receive care and treatment within the given timeframes set out by RSOP 11: Access to timely abortion.

Summary of this inspection

- The centre had experienced problems with the external translation company they used.
- The clinic had recently started to offer to patients the home use of misoprostol. However, we found women were not offered the choice of returning to the clinic to take the second tablet if they wanted to.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Are services well-led?

Inadequate

Are services well-led?

We rated it as **Inadequate** because:

- Local leaders did not always have the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They did not always support staff to develop their skills and expertise.
- Staff did not always feel respected, supported and valued.
- Some local leaders did not always operate effective governance processes, throughout the service. Staff did not always have opportunities to meet, discuss and learn from the performance of the service.
- Risks were not always fully identified, and actions taken to reduce their impact.
- Not all staff understood the vision or strategy of the service.

However:

- Leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services.
- There was evidence that some leaders and teams used systems to manage performance effectively.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Termination of pregnancy

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are termination of pregnancy services safe?

Requires improvement

We rated Safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to staff, however we were not assured they made sure everyone completed it.

- Staff completed mandatory training through e-learning modules and face to face training. Topics covered for mandatory training included, safeguarding level 3, health and safety, infection control, information governance, basic life support, immediate life support, fire awareness moving and handling and medical gases.
- There had been a lack of effective monitoring, management and oversight of mandatory training at a local level. This had been recognised and a new training record was in the process of being implemented at the time of inspection. The new system used a red, amber, green (RAG) rating to identify staff compliant (green), training booked (amber) and training overdue (red). This was yet to be fully embedded.
- Inconsistencies in evidencing staff training had occurred following a change to the central training system at BPAS head office. At the time of this inspection, the temporary treatment unit manager (TUM) was manually checking individual staff files to cross reference and update the new training record.
- We found one staff member had no evidence they had completed immediate life support training, since they had started at the centre. This staff member has since been booked on a course.
- Post inspection information at the end of September 2019 showed of the 12 mandatory training modules, two had a 100% completion rate. 60% of staff had completed basic life support training and 89% of staff had completed ILS training. We saw courses had been booked in October for staff to complete the training. It was estimated that all staff would have completed their mandatory training by the end of December 2019.
- At the time of our inspection there were no files updated or recorded centrally, to identify if staff had received sepsis training. Out of 24 members of staff, only nine staff had received sepsis training, which equated to 37% of staff. Staff members were booked for online training but, there was no 'sweep up' process for track and tracing. This was added to the risk register on 10 September 2019.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse.

- At the time of our inspection the monitoring that was in place in relation to safeguarding training compliance was not fully effective. We found two staff members had not completed safeguarding level 3 training, one staff member for over three years. The current mandatory

training safeguarding level 3 training was 64%. Whilst staff sickness had impacted full compliance, there was a lack of proactive oversight to address this in a timely manner.

- Those staff who had received training for Safeguarding level 3 knew how to recognise and report abuse and had received specific training in relation to child sexual exploitation (CSE), gang culture, domestic abuse a female genital mutilation (FGM).
- There was an up to date and accessible safeguarding policy which supported staff and gave clear guidelines on roles and responsibilities for reporting and escalating safeguarding. Staff we spoke with were clear on their roles and responsibilities for reporting and escalating safeguarding concerns.
- The registered manager was the designated member of staff responsible for acting upon adult and child safeguarding concerns locally and co-ordinated action within the clinic, escalating to the lead nurse for safeguarding at provider level. Staff were able to contact the lead nurse for safeguarding when the registered manager was not at the centre.
- The domestic abuse policy included information for staff to recognise and report on FGM. A risk assessment was completed, and concerns escalated to the police and social services. The clinic had identified three FGM cases from December 2018 to March 2019 and these had been escalated through the correct channels.
- Staff completed a risk assessment for all patients under the age of 18 years. The confidentiality of patients was key. Receptionists did not announce full names at reception and the information technological (IT) system flagged up those patients under the age of 18 years and any previous safeguarding referrals.
- Patient care co-ordinators saw all patients on their own for the initial consultation and the client care manager who had received counselling training could be called upon if concerns were identified. The client care manager oversaw all safeguarding for patients under 18 years of age.
- Staff we spoke with during the inspection were able to describe safeguarding incidents they had escalated and reported, and staff had a good understanding of how to identify safeguarding incidents.
- The service met the psychological needs of children and adults by offering both pre and post abortion counselling services. Observations of consultations and reviewing patient records showed staff offered these options for all patients. The 'My BPAS Guide', given to all patients who received treatment, contained information on how to access counselling services.
- There were posters and leaflets displayed throughout the clinic regarding different types of abuse such as domestic abuse and sexual exploitation. These provided advice and support service telephone lines and patients were able to take these leaflets home with them.
- Patients under the age of 13 were not treated at the clinic. There were clear guidelines for staff to follow and escalate and staff were able to tell us the actions they would take, for patients under 13 years. This included escalating to the safeguarding lead and contacting the local authorities safeguarding service, the police and referring the child to the NHS.

Cleanliness, infection control and hygiene

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

- Staff used control measures to prevent the spread of infection. There were in date and ratified policies and procedures to guide staff and staff completed infection prevention and control (IPC) mandatory training. Information received after our inspection showed 92% of staff had completed IPC training, which included seven members of staff who had completed the training during and after our inspection dates.
- Staff wore personal protective equipment (PPE) when treating patients and this included clean disposable gloves, uniform, aprons and masks dependant on the patient's treatment. There was a good selection and availability of PPE stock throughout the clinic.
- Staff washed their hands in accordance with the World Health Organisation (WHO) 'Five moments for hand hygiene' and 'bare below elbows' guidance. We observed staff following good hand hygiene practices throughout the inspection which included the use of hand gel.

- There was an IPC link practitioner who had received enhanced IPC training and they had an afternoon per week to complete IPC tasks such as audits.
- Monthly audits of infection control measures were undertaken using BPAS Infection Control Essential Steps Audit Tool. The tool looked at four areas, hand hygiene, use of PPE, aseptic technique and use and disposal of sharps. The set organisational target was 100%. Audits we viewed from February 2019 to July 2019 showed the clinic consistently scored 100% for hand hygiene, PPE and aseptic techniques.
- An infection prevention environmental audit was undertaken by the area nurse in July 2019. The audit included IPC checks in areas such as waste disposal, general environment, linen and care of equipment. The results were colour coded and the clinic scored green which meant the score was above 90%. The audit showed areas of concern, for example, non-compliance with sharps disposal management. Actions taken included an email sent to staff to reinforce the correct sharps disposal methods. During the inspection we found staff were correctly following sharps disposal.
- The risk register had a risk related to the daily checklists used for IPC. It was highlighted by the new TUM that the lists used were not in-depth enough and were not following BPAS infection control policy. At the time of our inspection, the checklists had been updated, circulated and included more detailed checks for staff to undertake.
- A deep clean of the treatment room occurred on a three-monthly basis. A house keeping service was in operation five days a week in the mornings and afternoons. We saw cleaning schedules were completed, dated and signed for the areas that had been cleaned.
- During the inspection we found staff disposed of clinical waste correctly. Clinical waste was locked in secure containers until collected by a specialist external waste company.
- Medical equipment and consumables were a mixture of single use and reusable items. Reusable items were sent to an external company for decontamination and sterilisation.We saw traceability stickers were placed in patient records, to identify pieces of equipment used during their treatment.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However, doors leading to the treatment room were unlocked and not all equipment had been calibrated.

- The design, maintenance and use of the premises and equipment were suitable for purpose. The organisation was in the process of planning to make adjustments to the building to improve the quality of services for patients. For example, updating the air conditioning unit and reassessing the layout of the building to ensure there was a better patient flow through the centre.
- All maintenance certificates were kept up to date locally and were logged onto a central electronic file. We saw that all equipment within the service had been serviced within agreed timescales. Maintenance contracts were managed by head office.
- We were told there had been recent problems with the backup generator. During the weekly test the generator sometimes did not start on the first turn and the service had had to call an engineer. We were told that so far, this had not impacted on the service and there had been no incidents reported due to the generator not working. We saw an e-mail to show the organisation had agreed the purchase of a new machine but did not see when this would be implemented.
- We checked 10 consumables items and found these were in date. Equipment we checked had been serviced and had stickers to indicate the item had passed the servicing checks. However, at the time of our inspection we found oximeters (a test used to measure the oxygen level of the blood) had no information to indicate if they had been electrically tested. The risk register identified that the calibration of blood pressure machines and weighing scales was not effective and that better checks and records of calibration were required. Actions taken showed new equipment had been purchased and calibrated but the 5kg weighing scales still needed replacing. This meant there was no way of knowing if they are working correctly and the potential risk being patients could be misdiagnosed. At the time of our inspection this was still an ongoing issue.
- Staff had reported that the scanner in the treatment room was not working properly. The image was sometimes distorted and at times switched off on its

own accord. This had been recently placed on the risk register, and the service had arranged for the scanner to be replaced and was due at the end of September 2019. The risk register stated that the machine was safe to use in the interim period but was not desirable. We were told no patient incidents had occurred or been reported due to the unreliable scanner. We were told there was another scanner that could potentially be used within the centre, but this had not been required.

- Lifesaving equipment such as a resuscitation trolley and a defibrillator were available, and staff completed checks to ensure the equipment was in good working order. We saw these checks had been made.
- We saw suitable arrangements for the disposal of clinical waste. Waste was segregated into appropriate bins with different colour coding. The disposal and storage of hazardous waste was in line with national standards and clinical waste was collected by an external specialist waste company. Waste disposal was checked as part of the monthly infection prevention control audit. The audit of February 2019 showed staff were compliant when following the correct procedures for the disposal of waste.
- Security cameras were in place at the front of the building and surrounding environment and visitors gained entry by using an intercom and buzzer system.
- During our inspection we found security to the treatment room was not sufficient. We could easily gain access with no restrictions, throughout our inspection.
- There was a major haemorrhage kit kept in the treatment room and we saw this had been regularly checked and signed to confirm the kit was ready for use.
- Medical gases were all in date and stored correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration.

- Staff completed full risk assessments prior to treatment during the pre-assessment stage. Further checks continued throughout the patient's treatment journey. The assessments included a venous thromboembolism (VTE) assessment, a blood test to check for rhesus negative blood and an ultrasound. Risk assessments included a discussion on the reasons why the patient was requesting a termination and the different options available to them, such as counselling services. Risk assessments had been completed in 10 records we viewed.
- Pre-operative assessments were completed before any surgical treatment. Surgeons and anaesthetists reviewed patients in order and to identify any risks. A safety huddle took place every morning where each patient was discussed, and any risks were considered. The huddle clarified roles of responsibility for the day and the huddle was well attended by all staff participating in treatments for that day.
- Patients eligibility for abortion assessments were routinely conducted. Patients who required further specialist care were referred to the BPAS suitability team for medical review.
- There was a formal transfer agreement in place with an NHS hospital for deteriorating patients. This had recently been updated in July 2019. There was a total of five patients transferred within the last 12 months. Regular meetings were held with the NHS trust where each individual patient case was discussed, and lessons learnt. A lead consultant from the NHS trust was currently working under a shared contract agreement between BPAS and the trust.
- Staff used a nationally recognised modified early warning score system (MEWS) tool to identify deteriorating patients. Staff had a good knowledge of escalation procedures and what to do in the event of a deteriorating patient. Staff described how they would use the MEWS tool and who they would escalate concerns to. The surgeon stayed onsite until the last patient was declared fit for discharge. The organisations perioperative care policy and procedure included the BPAS modified early warning system.
- The service had a policy for the management of the deteriorating or septic client. This clearly outlined how staff were to use MEWS and escalate to senior staff appropriately. Completion of MEWS was audited as part of the service's general anaesthetic and bi-yearly conscious sedation and local anaesthetic audits. We saw that for February 2019 the service achieved a 100% completion rate for MEWS.

- The service used the World Health Organisation (WHO) and five steps to safer surgery checklist and we found this was completed for all surgical patients. Checks included recording the number of swabs, sutures and needles during the procedure. Checklists we reviewed had been completed correctly. A WHO checklist was completed for patients who had vasectomy treatment. Audits we reviewed from the past year showed staff were consistently compliant with the WHO checklist with scores of 100%.
- The service had protocols in place to deal with haemorrhage.Staff had received scenario-based training and staff we spoke with were able to describe what they would do in the event of a haemorrhage situation. There was a haemorrhage kit within the clinic and the organisation had a haemorrhage policy in place. There was a dedicated blood fridge at the centre in the event of a major haemorrhage incident.
- For general anaesthetic treatments, the staffing levels included the surgeon, anaesthetist, one ODP, a perioperative nurse and two health care assistants. Two registered nurses trained in airway management and a health care assistant managed patients in the recovery stage. For conscious sedation procedures, a registered nurse who had completed conscious sedation training was present during treatment, with the surgeon and two heath care assistants. However, we could not be assured that staff had the appropriate skills, as the risk register highlighted that staff records showed not all staff had not completed ILS training. Information provided following inspection identified that there had been occasions where staff working in the treatment room had not received the appropriate skills and training (for example ILS training and conscious sedation recovery training). This had been entered onto the risk register on 2 September 2019 with identified actions to address the risk and improve oversight. We were assured that since the issue had been identified all staff who worked within the treatment and recovery area had the appropriate skills and training.
- Patients had a blood test to determine their rhesus status and blood group. Patients who had a rhesus negative blood group were given an anti-D injection to help prevent any complications in future pregnancies.
- Patients were given a discharge letter documenting the care and treatment given. If patients agreed a copy of the letter was also sent to the patients GP. Patients were told that in the unlikely event of any serious complications following the procedure to share the information in the letter with other health care professionals.
- The home use of misoprostol in England was approved by the government from 1 January 2019. Staff completed appropriate assessments with women who chose to self-administer the second stage of the medication (misoprostol) at home to ensure it was safe to do so. This option was only offered to women up to nine weeks and six days gestation. The first stage of the medication was taken at the clinic. Women were provided with a booklet which gave details on how to take the medication at home, and information on who to contact if they needed further support or guidance.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

- The organisations 'minimum clinical staffing levels' policy set out minimum clinical staffing levels at BPAS and gave guidance on the minimum staff required, for the different treatments offered. The treatment unit manager was responsible for setting clinical staffing levels at the clinic.
- At the time of inspection, there were three vacancies, one for deputy clinical nurse, one health care assistant and one operating department practitioner (ODP). The organisation was actively advertising for the posts.
- Fifteen registered nurses/midwives were employed at the time of our inspection. Regular bank and agency staff were used to cover vacant and unfilled positions, apart from the deputy clinical nurse position, which was viewed as an internal development opportunity.
- Rotas were completed locally which meant managers had the oversight and empowerment to match skills sets to the patient treatments planned.

- Staff from another clinic could be called upon if there were staff shortages and vice versa. This meant the clinic had the option of calling on experienced staff from within the organisation if they required.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Medical staff were employed on both a substantive basis and under practising privileges. Their recruitment was managed centrally by the provider. 'Practising privileges' is a term that is used in legislation and defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as: 'the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital.
- Records we viewed demonstrated those medical staff had up to date practicing privileges and general medical council certification for the surgeon. Records of medical staff practicing privileges were also held at head office and the medical director had overall responsibility for the management of medical staff.
- We reviewed the conscious sedation policy, and this was in date and ratified. The policy outlined clear protocols and processes for when conscious sedation could be administered without an anaesthetist present. There were nurse practitioner staff trained in conscious sedation. We saw those staff members had completed a conscious sedation course.
- Medical staff also worked remotely to review patients' case notes and medical histories prior to signing the HSA1 forms and prescribing medications. HSA1 forms are for practitioners to certify their opinion on the grounds for an abortion.
- At the time of our inspection there were no vacancies for medical staff.

Records

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

- Patient records were both electronic and paper based and contained detailed information on the patient's treatment journey. We reviewed 10 patients records from a variety of treatments and found they had been fully completed, signed and dated and contained information, such as consultation notes, pre-assessment medical history, patient allergies, completed HSA1 forms and signed patients consent.
- Electronic patient records were password protected and paper records were stored in a locked file. Paper records were kept for three years. Following this period, they were archived for ten years in line with the records retention and disposal policy.
- Patient information could be accessed through the BPAS information system, which meant patients could be seen at different clinics without delays in access to their information.
- During all consultations we observed patients were asked if information could be shared with their general practitioner (GP) and this was only done if consent was given.
- Five random patient records were audited monthly. The audits looked at the whole patient treatment plan and whether all risk assessments and relevant information had been recorded. From February 2019 to July 2019 the overall score was 100%. Any discrepancies within patient records were highlighted and actions suggested, which usually involved talking to the staff member and reminding them of the correct processes to follow.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. However, medicine management refresher training had not been effectively managed.

- Managers told us staff had to comply with the BPAS Medicines Management Policy and Procedure. The policy complied with the appropriate legislation and with standards laid down by the relevant professional bodies such as the Nursing and Midwifery Council (NMC).
- The organisation had recently updated and amended their conscious sedation management policy (August

2019) in light of practices identified at another location. The organisation had removed permission for the practice of drawing up sedation medication in syringes in advance of use. Staff we spoke with said they had received communication and instructions to stop this practice, and during our inspection we saw no pre-drawn medicine. Staff said this had happened in the past, but since the revised policy the practice had been stopped.

- Patient Group Directives (PGD) were in place for a selection of drugs. PGD's provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. At the time of inspection, we saw an up to date signed list of staff who could prescribe and administer medicines using a PGD. PGD training was undertaken at head office. However, the working party group meeting minutes of 21 August 2019, identified that the PGD folder contained two out of date PGD's and that six monthly audits were not consistently dated. Actions included updating the PGD audit tool and updating the PGD's. We found the PGD's were all up to date at the time of inspection.
- The service administered controlled drugs (CDs). We found CDs were stored in line with recommended legislation and all recordings we reviewed in the CD register had been signed by two registered nurses. The levels of stock entered, were completed fully and were correct.However, we saw there had been incidents in the past when the register had not been correctly completed, and this had been highlighted during the routine checks on the CD register by the organisation. The keys for CDs were held by the operating department practitioner. CDs were ordered by the area manager and deputy clinical matron.
- The Home Office Controlled Drugs Officer conducted a meeting at Streatham in July 2019 and reviewed the history of BPAS Streatham and the services provided. The officer discussed the CDs that were used and the pathway from requisition to delivery. This meeting included a review of local medicine management, the recording of drugs and audits as well as the BPAS unit dashboard. The review included a full building check, including the back garden and how secure the premises were. This included viewing CCTV footage and local policies and hard copies of the order forms and spot checks of drug numbers to register. The outcome of the review meant the clinic had their licence renewed.
- The clinic completed monthly medicine audits, where checks were made on correct practices for recording CDs, medicine and room fridge temperatures, and evidence that drugs received matched drugs ordered. The July audit showed there were discrepancies highlighted on 'times drugs given'. There were some missed fridge temperatures in the June audit, and the daily CD checks identified a discrepancy of total CD drugs at the end of the list. This had been reported as an incident and investigated appropriately. The August audit showed there were no discrepancies with CD's and the new TUM had shared the findings with staff.
- Staff had received training for the management of medical gases and at the time of inspection 100% of staff had completed their training. However, at the time of inspection, implementation of formalised medicine management training or refresher training was still in process and this had been entered onto the risk register on 8 September 2019. The revised Medicines Management Policy had launched on the 29th August 2019, with an accompanying email from the director of nursing that stated medicines management training would be available to access as an online module soon. The clinic was in the process of organising refresher training and this was due to be completed by end of October2019.
- Every month there was a full stock check of medicines. Staff had an index card where they signed out medicines with a number and this was added to the patient records and helped the centre track and trace daily use of medication such as misoprostol.
- The government legalised/approved the home-use of misoprostol in England from 1 January 2019 for women that had not exceeded nine weeks and six days gestation at the time mifepristone was taken. The clinic offered patients this option, having conducted research and studies of systematic reviews.
- The misoprostol (for home administration) was supplied against a prescription and labelled appropriately. The labelling included the patients name, date of dispensing, name of the medicine, directions for use,

precautions, and name and address of supplying pharmacy. In addition, women were given information on how to take the medication and patients records reflected that the medication had been supplied as a take home pack. The take home pack included contact details for patients in case they were worried or needed further support and guidance.

Incidents

The service did not always manage patient safety incidents well. Staff did not always report incidents and lessons learnt were not always shared with the whole team.

- Incidents were reported through the services electronic incident reporting system and followed the organisations client safety incidents policy and procedure. This described the monitoring and reporting process. Incidents were discussed at the quality and risk committee and this fed into the clinical governance committee.
- During the inspection, we were not assured incidents of all levels were routinely being reported, investigated and lessons learnt and shared with staff. The incident reporting and sharing of information culture within the clinic was variable and not strong. Many staff we spoke with said they did not always report incidents as they felt there was a blame culture within the clinic, and they did not always receive feedback of incidents reported. However, incidents were discussed in the morning huddle and feedback from incidents, when reported, were sent via e-mail or given face to face.
- Staff could describe incidents and knew the processes to follow when reporting.
- We reviewed two local team meeting minutes, and these showed no discussion had taken place on any incidents reported. Incidents was not a set agenda item during local team meetings. However, incidents were due to be discussed during the new working party group meetings, recently introduced by the new TUM, but, yet to be fully embedded into the service.
- The oversight of incidents at a senior level was a lot stronger, and we saw serious incidents, clinical incidents and common themes and trends were discussed during the bi-monthly area managers meetings and clinical governance meetings. Information and lessons learnt from these meetings were disseminated to clinics throughout the organisation, and the treatment unit managers of each clinic were responsible for sharing the information with staff.
- In the last 12 months there were no never events reported. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- During the reporting period there were two serious incidents reported. Serious incidents were investigated using a root cause analysis approach by the organisation's patient safety team.We were provided with information relating to the two incidents and found, although they had been thoroughly investigated, several agreed actions had not been updated or date of completion, added on the reports.
- A total of 76 clinical incidents were reported from April 2018 to April 2019.
- The duty of candour (DoC) 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. The DoC was applied for both serious incidents and for patients that were transferred to an NHS hospital. These patients were invited into the clinic for a meeting.

Safety Thermometer

The service used monitoring results well to improve safety.

- Staff completed a patient's venous thromboembolism (VTE) assessment on all records we viewed. In the past year the service had completed 2388 VTE assessments for those patients who underwent surgical termination of pregnancy.
- The number of patients who underwent an abortion after 20 weeks gestation who were risk assessed for VTE in the last 12 months totalled 441 patients.
- A local integrated governance dashboard was updated every month. Information collected included safety information which could be shared with staff.

Termination of pregnancy

- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (c.diff) or E-Coli in the previous 12 months.

Are termination of pregnancy services effective?

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

- Care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with professional bodies such as the Royal College of Obstetricians and Gynaecologists (RCOG), Department of Health Required Standard Operating Procedures (RSOP), Royal College of Anaesthetists, and the National Institute for Health and Care Excellence (NICE) guidelines. We reviewed policies such as the management of the deteriorating or septic client and found references had been made to: NICE CG50: Acutely ill adults in hospital: recognising and responding to deterioration July 2007 and NICE guideline NG51: Sepsis: recognition, diagnosis and early management. Effective processes were in place for policy ratification. Each clinical review and policy guidelines were reviewed by a responsible officer and validated by the clinical governance committee. Policies we reviewed were ratified and in date.
- At a local level, there was systems to monitor patient outcomes, such as failure rates, complaints, patient experience and prevention of infections and complications. This was in line with RSOP 16 'Performance standards and audit'.
- In accordance with RCOG and RSOP 13 'Contraception and sexually transmitted infection (STI) screening' patients were screened for sexually transmitted infections and offered contraceptive options during consultations and assessments for treatment. RSOP 13 states a woman should be offered testing for STI and all methods of contraception, including long acting reversible contraception (LARC) immediately after abortion. During our inspection we observed staff offer these options to patients throughout their treatment with the service.
- All patients were offered counselling services throughout their treatment journey and this was in line with RSOP 14: 'Counselling guidance'.
- The management of fetal tissue policy was in line with The Human Tissue Authority 2009 Code of practice 5: disposal of human tissue HTA London. We found patients were provided with information about disposal of pregnancy remains, so they could make a choice before treatment began.
- Discharge information was provided to patients in the form of a booklet. Information, such as possible complications and support and guidance for any concerns were supplied. There was a 24-hour telephone number, patients could use if they needed support on any concerns they had.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

- Patients received an information booklet 'My BPAS Guide' which provided information on fasting before treatment. Information on eating and drinking before treatment was available on the organisation's website. We saw staff checked the last time patients ate or drank during their admission appointment on the day of surgery.
- Patients were offered water, hot drinks and biscuits after they had received treatment. People who attended with patients had access to hot and cold drinks.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

- Staff assessed and monitored patients pain regularly to ensure they were comfortable and not in pain. Women were routinely offered pain relief such as non-steroidal anti-inflammatory drugs during surgical termination of pregnancy.

- Staff assessed patients pain using a standard pain assessment tool and by asking patients if they were in pain. The pain tool enabled staff to measure a patient's pain level by a scoring system. This was in line with Royal College of Obstetricians and Gynaecologists guidelines. Records we reviewed demonstrated pain relief was prescribed and administered correctly.
- Patients were given oral and written pain control information as part of their discharge information pack.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- RSOP16 states that outcomes of patients care, and treatment are routinely collected and that the service should have clear, locally agreed standards against which performance can be audited, with focus on outcomes. The organisation had a planned programme of audit and monitoring. Audit outcomes and service reviews were reported to governance committees such as infection control and quality risk committees. Managers attended meetings with their area managers where audit outcomes were discussed. Treatment unit managers completed action plans for areas of non-compliance which were reviewed by the organisations clinical department and quality risk committee.
- The organisation monitored performance outcomes monthly using a clinical dashboard. Complication rates were gathered alongside audited outcomes on waiting times for treatments, complaints and do not proceed rates.
- From April 2018 to March 2019 the clinic undertook 2388 medical terminations and 441 surgical termination of pregnancy procedures.
- Information provided from the organisation showed from April 2018 to March 2019 the do not proceed rate was 6%, which meant out of 4750 consultations, 285 patients did not proceed to treatment. From April 2018 to March 2019 the did not attend rate was 10.5% which meant from 4712 termination of pregnancy procedures, 493 patients did not attend for treatment.
- From April 2018 to February 2019, there were 11 clinical complications reported, such as continuing pregnancy after treatment and retained products of conception.
- The service monitored complication rates. Information we reviewed showed between April 2018 to March 2019, for major surgical complications, the rate was less than 1%. Complications included haemorrhage, and perforation of the uterus. For minor surgery, the rate was less than 2%. For medical abortion complications, the rate was less than 1%. Complications included incomplete abortion and two cases of continuing pregnancy.
- The service offered long acting reversible contraception (LARC) and had a steady uptake rate of 21.4 LARC is a method of birth control which provides effective contraception for an extended period without user actions. LARC was administered by the surgeon and nurses who had received and completed LARC training. The clinical commissioning groups who contracted the service expected a LARC uptake rate of 30%. Initiatives such as pre-consultation telephone calls to discuss LARC options with patients had started to help improve the uptake.
- Effectiveness of early medical abortion (EMA) was measured by patients taking a pregnancy test post treatment. When the pregnancy test was positive the patient would be asked to attend the clinic where further options would be discussed and agreed.
- We were not assured monitoring of audit information and checks were fully robust or accurate. At the time of our inspection the new TUM had introduced a more robust IPC daily checklists, which included more detailed areas for checks. This was in recognition that the old checklists were very basic and did not capture the full criteria required to ensure a full and thorough inspection of IPC practices had taken place at the start of the day. At the time of our inspection this had yet to be fully embedded into the service.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development, however this had been sporadic, and not consistent.

- Monitoring and oversight of staff records had not been fully effective. Staff records were not fully comprehensive, in terms of completed competencies and training. It had been recognised by the TUM that there were inconsistencies between evidence held in staff records and recorded on line. This was being looked into with the training department and individuals concerned.
- We found one staff record where certain competencies for the role they were employed for had not been signed off since they started the organisation over three years ago. This had been highlighted on the risk register.
- Two staff members had not completed the mandatory safeguarding training, one since 2015. Due to the lack of oversight and strong management of staff records, the organisation was taking steps to address the situation, and the staff had been placed on the necessary courses. This had been highlighted in the local risk register.
- Due to the temporary management arrangements and the lack of full-time substantive post of clinical nurse manager (CNM), most staff fed back they had not received regular one to one sessions and meaningful appraisals for the best part of two years. However, with the appointment of additional management staff there were plans to start completing appraisals for those staff that were outstanding. This was still in the process of being implemented at the time of our inspection. The current appraisal rate was 85%. The organisations medical director conducted appraisals of employed medical staff. We were told these were up to date and held centrally within the organisation, however we had not seen evidence to corroborate this.
- There was a BPAS induction programme for nursing staff consisting of 12 weeks of specialist training for their role such as consent course, and health and safety. As part of the induction programme staff were sent to different locations. Area managers or senior clinicians signed staff members competencies throughout the 12 week programme to ensure staff were trained and could complete different aspects of their role.
- Staff completed external training for ultrasound scanning. New staff completed a two-day face to face ultrasound scanning training external accredited course. Staff completed 50 ultrasound scans under the supervision of a mentor who was an experienced practitioner. Staff had to pass and be accredited for first trimester ultrasound scans before they could complete second trimester training. Staff had to complete three case studies as part of their course. Scans were audited every two years by the lead sonographer.
- The 24-hour support telephone line had skilled qualified medical practitioners available, should patients need the support and guidance.
- Oversight of processes to ensure agency staff had basic competencies to perform their role within the service was not fully effective. Recently the clinic had identified that agency staff had not received immediate life support (ILS) training and were only trained in level 2 safeguarding. As a result, the clinic had asked for all agency staff certificates before they were allowed to work at the clinic. This had been escalated to senior managers within the organisation, and they were now making checks on agency staff at a national level. At the time of our inspection certificates were being collected and only agency staff who had the correct set of competencies were allowed to work at the clinic.
- The risk register stated that staff had not completed refresher training for medicine management and were not following the medicine management policy. The policy stated that clinical staff and the TUM must undergo training every two years. The register also stated that nurses reported there was no formalised training, and nobody had received refresher training. It had been highlighted, through an audit of medical records, that the recording of information was inaccurate. It was believed the lack of organised training may have contributed to this. As a result, training had been organised and was due to be completed by the end of October.
- We saw staff who provided therapeutic support to patients, were appropriately trained and were experienced staff. Staff who provided post abortion counselling completed the BPAS Client Support Skills and counselling awareness course and were competent with the client care co-ordinator competencies framework.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide care and communicated effectively with other agencies.

- Staff worked well together to ensure patients received care. Staff conducted morning huddles where the patient list and clarification for job roles and responsibilities were discussed for that day. We observed the theatre huddle with the surgeon, anaesthetists and nursing staff and found the meetings allowed for open and frank discussions where every staff member could contribute.
- The clinic had a service level agreement with a local NHS trust for unplanned emergency transfers. The service met regularly with the trust to discuss the agreement and to go through each patient transfer for shared learning. The clinic was due to host a visit from a lead consultant from the trust for late procedures.
- Staff said they regularly communicated and worked together with local safeguarding services and patients GP's. We saw staff asked all patients if they could share relevant information with their GP. Where the patient gave permission, staff sent a copy of the discharge letter to the patient's GP.

Seven-day services

Key services were provided six days a week to support timely patient care.

- BPAS Streatham opened five days a week including one day at the weekend, with opening times starting at 07.30am and closing at 6pm.
- Patients could access advice and support throughout the year from a free telephone helpline which was available 24 hours a day, seven days a week.

Health promotion

Health promotion information was available.

- Patients were provided with oral and written information on contraceptive methods including long acting reversible contraception (LARC) when they visited the clinic. Patients were also offered the choice to be tested for sexually transmitted infections (STI) such as chlamydia and human immunodeficiency virus (HIV).
- A range of health promotional leaflets were available throughout the clinic, providing advice on choosing he best methods of contraception, and where to get further supplies.

Consent and Mental Capacity Act

Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).

- Staff understood the relevant consent and decision making requirements of legislation and guidance including the Mental Capacity Act (MCA) 2005 and the Children's Act 1989 and 2004. Staff were supported by the organisations consent to examination treatment policy when obtaining patient consent.
- During our observations, staff asked for patient consent at various stages throughout the patient's treatment. Written consent was obtained from the records we reviewed. There were different consent forms for each different type of treatment. Staff also explained the risks associated to treatment and asked patients to confirm they fully understood procedures before gaining consent.
- Patients were given time to reflect and consider each treatment option, even for those treatments that were completed on the same day. For example, for medical abortions patients had time to read through information they were given whilst waiting for the two remote doctors to legally authorise the termination of pregnancy. This allowed time for women to consider their options before making an informed decision.
- Patients were given time on their own with the nurse prior to treatment to ensure they were seeking abortion voluntarily.
- Patients who could not give consent or patients who lacked capacity were referred to the relevant NHS organisation so that an independent mental capacity advocate could be appointed.
- Staff fully understood Fraser and Gillick competencies. Gillick competence is concerned with determining a child's capacity to consent and Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. Staff we spoke with understood the principles and that they should be applied when obtaining consent for patients, under the age of 16 and used a specific Gillick competence and Fraser guidelines assessment form.

Termination of pregnancy

- The clinic conducted consent audits as part of the monthly consultation feedback audit, and information we reviewed showed staff consistently scored 100%. This information was fed into the monthly clinical dashboard.
- Consent training was part of the induction programme and consisted of a one-day course and shadowing experienced trained staff on 20 consenting procedures. Staff records we reviewed showed staff had completed this training.

Are termination of pregnancy services caring?

Good

We rated caring as **good.**

Compassionate care

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

- Staff treated patients with kindness, dignity and compassion. Staff took time to get to know patients and treated all patients as individuals. A patient we spoke with commented staff "Made me feel comfortable and were kind to me". Another patient said, "Staff were very warm and made me feel welcomed".
- Staff treated all patients in a respectful and professional manner and were non-judgmental.
- During intimate care and examinations, patient's privacy and dignity was respected. Consultations were conducted in private rooms and patients were provided with blankets when undergoing treatment to cover themselves with. Patients dignity was respected when they were transported from the treatment room to the recovery area.
- We reviewed the client satisfaction report from April 2019 to July 2019. The clinic scored 100%, for whether patients were treated with dignity and 100% and for whether they were given enough privacy. 100% of patients said they had been listened to and 100% of patients said they had confidence and trust in the staff who treated them.
- Patients had a private area for changing prior to surgical treatment.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff understood the impact a person's care and treatment could have on their wellbeing and provided emotional support to help reassure them. A client care co-ordinator was always available to speak with any patients who required additional emotional support during the pre-assessment stage.
- Staff checked with patients if they had someone to support then or accompany them home after treatment. We saw staff checked with patients that they had this support prior to any treatment.
- Staff offered pre and post counselling services to all patients. Patients were provided with information about to access a 24-hour helpline and we observed this was offered to all patients during our inspection. Patients were also signposted to specialist bereavement counselling services at local NHS trusts.

Understanding and involvement of patients and those close to them

Staff supported and involved patients to make decisions about their care and treatment.

- Staff communicated well with patients and made sure they understood their care and treatment. They gave patients the opportunity to ask questions about their care throughout the different stages of treatment. Staff explained procedures clearly and confirmed with patients that they understood what was happening. Patients we spoke with said they felt they had been informed of all risks and what the treatment involved. Patients said they had been given time to consider all their options.
- The client satisfaction survey from April 2019 to July 2019 showed that 98% of patients felt they had been given enough information about aftercare and 100% said they were involved in decisions about their treatment. All patients who provided feedback said they had been given clear explanations about their treatment. However, during the inspection several patients said staff could do better in explaining the

waiting times and one patient commented that the whole process had been very confusing, they had been told about the steps of the treatment but, not why it was happening. However, we did speak with several patients who commented they had been waiting for a while and this had made them upset and anxious.

- Women were given clear information on the supply of the second medication (misoprostol) to to take away and administer at home. We observed women given clear instructions on how to administer the medication. Staff asked patients if they needed to ask questions and asked if they understood all the instructions. Staff then provided all the information in a booklet and pinpointed information in the booklet which was relevant to their treatment.
- Staff made patients aware that information would be used for statistical purposes by the Department of Health, but the information would be anonymised.
- Discussions on costs were hardly discussed as most patients were NHS funded. However, information on costs were displayed on the organisation's website.
- During our observations staff disussed and gave options to patients on the disposal of pregnancy remains. Patients were made aware of what choices there were when following this pathway.
- Staff provided patients with an aftercare booklet, which gave details of a telephone advice line and information on the treatment they had.

Are termination of pregnancy services responsive?

Requires improvement

We rated responsive as **requires improvement.**

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.

- The service reflected the needs of the population served and managers were able to plan and organise services to meet the changing needs of the local population. If there was a peak in demand the service was able to adjust lists and opened on bank holidays.
- The facilities and premises were appropriate for the services being delivered. The clinics were easily accessible and local transport facilities were good.
- Patients were able to book appointments via BPAS contact clinic, available 24 hours a day. Patients were given a choice of appropriate location dependent on gestation and medical assessment.
- The service had recently introduced a vasectomy clinic, which was in the early stages at the time of inspection. The uptake had not been high, and the service was assessing the impact this had on the other services within the clinic, which had to be changed for vasectomy treatments. The service could not explain why there was such a low uptake of the service and were currently working with local CCG's to explore ways of improving the demand.
- The service attended regular meetings with the clinical commission groups (CCG) who contracted BPAS Streatham.
- Three members of staff were able to fit long acting reversible contraception (LARC) and the clinic was in the process of waiting for more dates of future courses for other staff to attend.
- Due to the introduction of patients being able to take the second stage of medical abortion at home, the service had made adjustments to the surgical list so those patients who wanted an intrauterine device (IUD)fitted could be seen.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, there were problems with the external translation service.

- Staff had completed 'welcoming diversity' training during their initial induction and this helped staff understand and recognise different cultural needs and beliefs.
- There was an interpreting service available for those patients for whom English was not their first language. However, we were told of a recent complaint received from a GP, where the patient who had used the service

during a consultation with BPAS, was given inappropriate information from the interpreter, in relation to their religious beliefs. Staff told us there had been occasions when interpreters were not purely focused on the service they should have been providing, for example they were washing up when translating or background noises of children crying could be heard. The organisation was aware of the issue and was in the process of engaging more closely with the service to rectify the problems. However, at the time of our inspection the clinic was still using the external service, but staff were asked to report any incidents to the treatment unit managers.

- Patients were given the choice of making an informed decision about the disposal of pregnancy remains. From records we reviewed and observations of consultations, staff provided this information to women in a sensitive manner.
- Due to the same day consultation and treatment options the organisation recognised this took away the 'thinking time' for women regarding LARC options. Therefore, the local CCG had commissioned the clinic to start pre-consultation telephone calls to discuss contraception options and give women more time to consider their options.
- The clinic had recently started to offer to patients the home use of misoprostol. However, we found women were not offered the choice of returning to the clinic to take the second tablet if they wanted to. For those patients who were not confident or needed reassurance the clinic did not offer this option, unless staff recognised patients who were not confident or comfortable.
- The clinic paid for hotel accommodation for those patients who needed to be seen by the service within a limited time frame and lived in another part of the country. This option was available for those patients who could not afford additional expenses.
- The service had information leaflets available in different languages and braille. The central booking system allowed one-hour slots for those patients who could not speak English. A hearing loop was available for use by people with hearing aids, and a sign language interpreter could be booked if patients required.
- Patients were able to request a chaperone and information was displayed throughout the clinic.
- Women seeking abortion for fetal abnormality were provided privacy in a separate room and their partner was able to stay with them throughout their treatment.
- The clinic had private rooms to accommodate those more vulnerable patients and patients under the age of 18 years of age.
- The clinic offered access for disabled and wheelchair users. There was a spacious lift to assist patients who needed treatment on the first floor.
- We inspected the satellite clinic in Southwark. The clinic was based within a healthcare clinic, and we found the room used by the organisation was based next door to a new born baby clinic. This meant that during consultations we could hear new born babies crying. This was not a suitable arrangement in terms of privacy and sensitivity for patients. Staff told us that they had raised this as an issue, but the health clinic could not provide an alternative room.
- Pregnancy remains following surgical termination were individually packaged, labelled and stored and collected for appropriate disposal in line with Human Tissue Authority guidelines. There was a process for individual storage of pregnancy remains when patients requested this to enable private burial, cremation or in the case of criminal investigations. in a freezer before collection. The service kept records and logs of those pregnancy remains.
- Staff made reasonable adjustments to help patients access the service and coordinated care with other services for those patients who required further support, for example, patients with pre-existing physical and mental health conditions.

Access and flow

People could not always access the service when they needed it. Waiting times for surgical treatments, meant patients did not always receive care and treatment promptly.

- Patients could access the service through GP referral, self-referral or family planning clinic. Contact could be made via telephone, e-mail or text. Whilst women

receiving medical abortion had timely access to initial assessments, test results, diagnosis and treatment, not all patients could access care and treatment for surgical termination in line with national guidance.

- The Department of Health Required Standard Operating Procedures (RSOP11) states that women should be offered an appointment within five working days of referral and they should be offered the termination of pregnancy within five working days of the decision to proceed.
- BPAS' capacity manager had an overview of appointment availability and worked with the treatment unit managers amending templates and adding appointments when necessary.
- Information we received from the organisation showed that from the period September 2018 to August 2019, the number of patients seen within 10 days from consultation (decision to proceed) to treatment was:
- 95% for early medical abortion patients: 2037 patients in total. 1918 patient were seen within 10 days which meant 5% were not seen within 10 days. The average wait was two days. 1223 patients chose same day consultation and treatment.
- 69% for surgical patients under 14 weeks gestation: 1506 patients in total, 1030 patients seen within 10 days, which meant 31% of patients were not seen within 10 days. (Average wait day was nine days).
- 46% for surgical patients above 14 weeks gestation: 963 patients seen. 440 patients seen within 10 days, which meant 54% of patients were not seen within 10 days. (Average wait day was 15 days)
- We reviewed the treatment service availability schedules for July and August 2019 and found for surgical termination procedures, some patients had been waiting for 20 days. The information provided did not include specific information as to the reasons for delay (such as treatment availability, patient choice, repeated cancellations or did not attends).
- The BPAS reporting systems had not kept up with the advances in appointment offerings, and therefore, the reporting systems were sometimes flawed. While the service could look into individual patient data and the reason behind the patient's waiting time (choice versus availability), where a specific note had been made, they were unable to pull the information together to form a report which would show this for all patients at clinic level. The organisation was also unable to record the reason for the delay. However, on our request, the organisation had looked into some of the individual records for BPAS Streatham, where longer delays had been noted, and reasons such as, patients cancelling the appointment, needing to arrange childcare, patient unsure of decision, arranging travel, wanting treatment at a clinic-often not in their home town and patient forgot to go to appointments were recorded.
- BPAS provided commissioners with quarterly activity reports for their particular commissioning groups which included waiting times.
- BPAS Streatham provided standby appointments, which enabled them to make the best use of any do not attend (DNA) appointments. The clinic had a large number of DNA and 'cancelled on the day by patients', and as a result had never had to decline treatment on the day to any patients on standby for a general anaesthetic appointment.
- At busy periods of the year the service adjusted lists by reducing conscious sedation treatments to incorporate additional general anaesthetic treatments, as other providers operated lists throughout the London region for conscious sedation.
- BPAS Streatham had opened on bank holidays to ensure capacity for late surgical terminations of pregnancy.
- Patients we spoke with during the inspection commented on the length of time they had waited on the day at the clinic. Some of the delays occurred while remote doctors completed the HSA1 forms. Patients were allowed out of the clinic, during the time of waiting for their treatment. We noted most of the complaints received at the clinic centred around waiting times.
- The client satisfaction report from April 2019 to July 2019 showed the lowest score for patient satisfaction was related to 'clients seen within 30 minutes of their appointment time'. Waiting times scored the most percentage of disagreement than any other questions asked in the survey.

Learning from complaints and concerns

Requires improvement

Termination of pregnancy

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.

- People were encouraged to raise concerns to the service. Information about how to give feedback was available throughout the service as well as posters about how to make a complaint or give feedback. The 'My BPAS guide' given to all patients who completed treatment contained information on how to make a complaint.
- The complaints and client feedback policy and procedure laid out specific timelines and formal processes in how a patient's complaint should be handled. The treatment unit manager at Streatham was the first point of call to resolve issues raised at the clinic and staff were encouraged to diffuse any complaints locally where possible. Patients wishing to make a formal complaint were referred to the client engagement manager and acknowledged within three days. The timeframe for a full response to be made was 20 working days.
- The clinic had received 13 formal complaints within the reporting time period of April 2018 to March 2019 and all were responded within the 20 day time frame. Complaints were logged onto the electronic incident reporting system and rated low or moderate. The complaints log we reviewed showed action had been taken against each complaint.
- Changes of practices at the clinic, as a result of a complaint around waiting times, now meant that patients were instructed to 'arrive' at a certain time rather than being told their 'appointment' was at a certain time. Patients were told that their arrival time did not necessarily mean they would be seen at that time.

Are termination of pregnancy services well-led?

Inadequate

We rated well led as **inadequate**

Leadership

Not all the leaders demonstrated the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They did not always support staff to develop their skills and expertise.

- Leadership at a local level did not always support the delivery of a quality sustainable service. There was a lack of effective oversight of staff competencies, local risks and robust auditing tools. Relationships between managers and staff was not unified.
- The structure of the leadership team at the centre, comprised of a treatment unit manager (TUM), who had overall management of the centre. They were supported by a clinical nurse manager who managed the clinical staff and a client care manager who managed patient care staff. There was an area nursing manager who visited the clinic and provided clinical support for nurses and clinical managers. An operations area manager managed the TUM and several other locations within a specific region. They were managed by the associate director of operations.
- At the time of our inspection the centre had been managed by a temporary (TUM) for the past 18 months. They worked a four-day week from Sunday to Wednesday at Streatham. In April 2019 the service had recruited a new TUM, and they were still in their probationary period at the time of our inspection.
- We found there were fractious working relationships within the local leadership management team and this impacted on effective leadership within the centre. There were different management styles, which meant actions required to manage risks, and quality improvements were inconsistent, lacked clarity and clear direction. This led to staff being confused as to how the service was being managed. Most staff said there was no balance in the style of management. Staff told us there was a heavy top down approach from certain managers within the organisation.
- However, staff told us the culture had started to change with the new TUM and clinical nurse manager. Staff found them supportive, accessible and approachable and willing to offer guidance and listen to them. They felt they understood priorities and issues the service faced and the development and training they required

to undertake their role. There was high praise from staff about the support the area midwife provided. Staff said the main directors who visited the service were accessible and took time to speak with staff.

- Managers could access a leadership and management programme and first line managers training, which covered managing staff absence and recruitment. The new CNM had recently attended training for managing absence and sickness.
- The service ensured a record was maintained of the total of termination of pregnancy procedures undertaken. The clinic displayed the certification of approval issued by the Department of Health in the reception area of the service.

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. However, staff did not fully understand it.

- Although the service had a vision and strategy, at a local level staff were unsure of what it was. Staff were more familiar with the values of the service; compassionate, courageous, credible and committed to women's choice. From observations, we saw staff incorporated the values in their everyday working role. Managers were more familiar with the corporate strategy and business plan. Information on the services strategy and vision were accessible to all staff on the services intranet.
- The service made sure that staff provided TOP care in line with the Royal College of Obstetricians and Gynaecologists (RCOG) and other professional bodies. Best practice was incorporated in policies and procedures we reviewed and demonstrated in the way staff delivered care and treatment.

Culture

Staff did not always feel respected, supported and valued. The service had an open culture for patients and families, so they could raise concerns without fear, but staff did not always feel they could.

- There was a negative culture and disconnect between some of the managers and staff within the centre. Most staff we spoke with, told us they felt the culture was reactive rather than proactive, with a culture of blame and harassment and this had created an unsupportive and demoralising environment at the centre. Staff told us they were unable to express themselves and challenge without fear of retribution. Staff believed some conversations they had would be used for 'self-gain' or 'self-importance' due to certain management styles. As one staff member said, 'If you raise concerns then you have to face the consequences. I have learnt to keep quiet'.
- Staff praised the new TUM and the CNM on their supportive, open and transparent style of management they had adopted in the short space of time since being in their respective roles. They felt the culture was more harmonious since they had started their roles, and they felt listened to. Staff fedback that the two managers often asked about their wellbeing, for example, they checked to ensure staff had taken their breaks, were more flexible in their approach and felt there was a more settled happier environment. The two staff members were in their probationary period as per BPAS policy.
- Most staff we spoke with enjoyed their role and working for BPAS as an organisation. Clinical staff worked well together and were supportive of each other as a team. Clinical and administrative staff had a good patient centred approach.
- The new TUM had created a working party group, a meeting to recognise good working practices, and recognise ways in which people could work together in a better way. Audit findings were shared at this meeting. However there had only been one meeting and so shared learning and staff participation in quality improvements had yet to be fully embedded into the service. Information provided after the inspection supported the working party group as a good way to engaging with staff and managing feedback. We were informed these meetings would continue.
- Clinical staff we spoke with said they had just recently received an appraisal, and this was with the new TUM and area nursing manager. They said the appraisal discussion had been good and career development opportunities and training had been discussed. Most staff said past appraisals had been sporadic and not entirely effective. Staff fed back they did not always feel valued and they did not feel they had been developed.

- British Pregnancy Advisory Service (BPAS) is a not for profit organisation, and approximately 97% of patients had their treatment paid for by the NHS. Prices for fee paying patients were clearly advertised on the BPAS website.

Governance

Local leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but did not always have opportunities to meet, discuss and learn from the performance of the service.

- The organisation had structures, processes and systems of accountability in place, that related to national BPAS structures and committees.
- The governance structures at local level fed into the corporate level structure, with the area managers holding bi-monthly meetings with the TUM to discuss capacity and waiting lists, audits, incidents, complaints, patient feedback, risk and other relevant items that needed dissemination or escalation. Outcomes from these meetings were fed into the operational activity committee and quality and risk committee meetings which were held every four months.
- However, local governance arrangements were not fully effective. The identification of risks and improvement of quality was not managed well. There had been a lack of monitoring of staff mandatory training and this meant information fed into the monthly dashboard was not entirely accurate. It had been identified that audit tools used for infection control checks and medicine management were not effective.
- The dashboard included headings such as, appraisals, medicines management, clinical supervision and providing a competent workforce. The dashboard was rag rated green, amber and red, with red highlighting areas of concern. We were not assured accurate information was reflected on the dashboard. For example, providing a competent workforce was consistently green rated for all the dashboards we reviewed. However, we highlighted staff who had not had competencies signed off and staff who had not completed mandatory training within a specified timeframe. Therefore, we were not assured that information used in reporting, performance management and delivering quality care was always accurate or reliable.
- We saw meeting minutes from the area managers meeting and the clinical committee group. Both meetings had standardised set agendas where incidents, patient complaints, clinical outcomes and operational issues were discussed. At a local level this standard was not applied. The clinic held team meetings, but there was no structure or set agenda to these meetings. We were told they were held approximately every six weeks. Minutes we reviewed showed no standardised topics were covered, such as incidents, complaints or lessons learnt. Information provided post inspection stated that a more formal team meeting agenda template would be implemented by the area manager for use in all the London area units.
- The new TUM had created a working party group, a team of clinical staff to identify new working practices to improve assurance checks and non-compliance identified, for example, in past infection control audits. Results included updating infection control tools for staff to use for their daily checks. We saw information on the outcome of working party group meeting was shared with staff throughout the clinic. The new updated infection control tools were in use during our inspection. There had only been one working party group meeting at the time of our inspection and this had taken place on 21 August 2019.
- The manager was aware of the requirement to notify the Care Quality Commission (CQC) and Department of Health in writing should a woman die within 12 months of using the service and of other statutory notifications to CQC.
- The service delivered care and treatment in accordance with the Abortion Act 1967. Patients were assessed for suitability for an abortion during the consultation stage, by a registered nurse and client care co-ordinator. The information was then sent electronically to two remote doctors for review. If the doctors were satisfied and happy to proceed, they would both electronically sign the form.

- The service audited the HSA1 forms by randomly selecting five patient records per month. We reviewed audits from February 2019 to July 2019 and found a consistent score of 100%.
- There were suitable arrangements in place to ensure those staff working under practicing privileges had appropriate indemnity insurance under The Health Care and Associated Professions (Indemnity arrangements) Order 2014.We reviewed all staff records for those working under practising privileges at the clinic and found indemnity insurance was in place.

Managing risks, issues and performance

Systems were not effectively used to monitor and manage performance effectively. Leaders and teams did not always use systems to manage identify and escalate risks.

- The organisation had arrangements for identifying, recording and managing risks, however these were not managed robustly at a local level.
- We reviewed the local risk register and found risks were outdated, did not have completion dates or actions taken against them. The new TUM had recently taken over managing the risk register and had added risks not previously recognised. The risk register was scored with a red, amber and green RAG rated system.
- We found a risk raised in 2017, in relation to ineffective tracking under 18 vulnerable adults resulting in lack of support or referral for those at risk, with a due for completion date 2017, had not been completed and no update on the register. One risk had no date raised and no actions or date to complete the actions.
- We found a risk dated 2018 regarding staff failure to complete mandatory training that had a due date of completion stated as May 2018. We found mandatory training was not fully monitored or managed well at the time of our inspection.
- New recent risks had been added to the register (19 August 2019) by the new treatment unit manager. These included, the unreliability of the scanning machine used in the treatment room. Surgeons had reported that the image was distorted and kept switching off during procedures. We were told this had been raised previously with the treatment unit manager, but no action had been taken. The new treatment unit manager had added the risk to the risk register and actions showed a new scanner had been purchased. At the time of our inspection the clinic was still awaiting the arrival of the machine. There had been no reported incidents where patient safety had been compromised. We were told another scanner in the clinic could be used if necessary.
- Another risk related to the scavenger system, which was not connected to the treatment room. A scavenger system collects and removes waste gases from the patient breathing circuit and the patient ventilation circuit. This had been identified by the new TUM and escalated. Actions included updating the daily checklist and organising a scavenger system to be delivered from another clinic. At the time of our inspection the clinic was still in the process of having this delivered.
- Managers had the ability to monitor performance through monthly dashboards, however, we were not assured that this had been undertaken in a robust manner. We found several concerns that were highlighted during the inspection, such as poor mandatory training monitoring, lack of incident sharing, lack of oversight of staff competencies that had only recently been recognised.
- At a corporate level, new director's in post had introduced a monthly risk steering group to discuss high level risks. There was a quality and risk committee who met on a quarterly basis and information was fed into the clinical governance committee meetings. We saw meeting minutes of June 2019 which showed risks and actions taken had been discussed.

Managing information

The service did not always collect reliable data and analysed it. Staff were not always provided with the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

- We were not assured there was a holistic understanding of performance which captured and integrated people's views with information on quality. Staff did not always receive consistent information on audit outcomes and this had only recently been addressed through the start of the working party group meetings.

- The quality of information to measure performance was not always accurate and therefore, not reliable. The organisation had systems for clinics to report performance and quality information, however this had not been managed well locally, which had meant oversight was not fully effective. Therefore, we were not certain valid, reliable and relevant information was always reported. The lack of identifying and acting upon risks meant issues were not always identified and acted upon to improve the quality of care.
- There was a system in place to make sure HSA4 forms were submitted to the Department of Health in accordance with the Abortions Regulations 1991. An HSA4 form is the official notification of abortion and must be submitted to the Chief Medical Officer within 14 days. There was an online completion and submission process in which the BPAS electronic system linked directly with the Department of health system. BPAS doctors obtained a secure login and password from the Department of Health to use the service. However, the service was not always sending the forms within the time frame. The monthly dashboard often showed the submission of HSA4 forms as red rated. This meant the deadline was not being met, and we were told this was due to doctors not always pressing the submission button. Management had reinforced the message to doctors, but this seemed to be a persistent problem.
- The service had system to make sure HSA4 forms were completed appropriately to indicate when treatment was provided at home in instances where the second medication (misoprostol) was supplied to the patient to take away and administer at home. The service's online submission system included a tick box for home use and staff would complete the HSA4 the following day from administration to ensure accuracy. However, we were not assured the forms were submitted within the 14 day period as this was reflected on the monthly dashboard.
- Information governance training was mandatory, and at the time of our inspection 79% of staff had completed training.

Engagement

Leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, locally more work was required to improve staff engagement.

- Patients were given a feedback form to complete after they had received treatment. The forms were submitted to the client engagement manager for collation. Patient satisfaction survey reports were reviewed at area managers meetings and the clinical governance committee.
- The overall patient satisfaction score was 9.4 out of 10 for the months of April 2019 to July 2019. 100% of patients surveyed said they would recommend BPAS to someone they knew for similar care.
- Managers attended regular engagement meetings with local NHS trust with whom they have transfer arrangements and local commissioners.
- The organisation conducted an annual staff survey; however, this was not specific to locations. We reviewed the staff survey of 2018 and found the most improved national highlights included 'there was a willingness to try new things', and 'would recommend BPAS to friends and family'. Bottom lowlights included 'poor performance and behaviour are dealt with effectively', and 'there are not enough staff for me to do my job well.'
- We were not assured that staff were actively engaged so their views were reflected in the planning and delivery of the service and in shaping the culture. However, the new treatment unit manager was making steps to include and engage nursing staff within the monitoring of performance and quality. However, this was in the early stages and was not fully embedded into the service.
- There was a star of the month award where staff nominated other members of staff and the organisation provided a free service for staff on advice for wellbeing and depression.
- The TUM told us the medical director asked for opinions from staff and a two-day BPAS forum had been recently held for staff to attend so they could provide their input into clinical issues.

Learning, continuous improvement and innovation

Requires improvement

Termination of pregnancy

Staff were not always committed to continually learning and improving services. They did not have a good understanding of quality improvement methods and the skills to use them.

- We did not see an embedded culture of learning, continuous improvement and innovation. In part this was due to negative relationships between senior leaders at the centre. We found there was unreliable data collection, a lack of effective oversight on staff training, and lack of feedback on reported incidents. This meant learning was not always shared to drive improvements. Although recent changes had been made to make improvements in these areas, this had yet to be embedded into the service. There was still more work to do.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are strong governance arrangements with strong leadership, to ensure that risks and quality performance are identified, mitigated and acted upon.
- The service must make sure there are effective systems for tracking and tracing staff mandatory training, including medicine management and sepsis training.
- The service must make sure all staff records are current and certifications on training and competencies are up to date.
- The service must make sure agency staff are immediate life support trained and trained to Safeguarding level 3.
- The service must make sure all equipment is calibrated and in good working order.
- The service must make sure the HSA4 forms are submitted on time.

Action the provider SHOULD take to improve

- The service should make sure there is an open and transparent culture where staff feel safe to raise concerns.
- The provider should make sure there is a more robust system for the reporting of incidents at all levels and staff receive feedback on learning.
- The service should make sure patients have the choice of whether the second medication of misoprostol is taken at home or at the clinic.
- The service should make sure there are robust arrangements in keeping PGD documentation up to date.
- The service should make sure formalised medicine management training and refresher training as stipulated in the medicine management policy is completed by staff.
- The service should make sure the waiting time for late stage surgical abortion is reduced in line with national guidance.
- The service should make sure patients do not wait too long on the day of their treatment.
- The provider should make sure they have assurance that the external interpreting services have non-biased non-judgmental staff.
- The service should make sure the vision and strategy of the organisation is embedded into the service locally.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance How the regulation was not being met. Local governance arrangements must support managers to assess, monitor and improve the quality and safety of services. They must support managers to mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17(1)(2)(a)(b)(c)