British Pregnancy Advisory Service

BPAS - Birmingham South

Inspection report

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Date of inspection visit: 12 July 2022
Date of publication: 20/09/2022

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

BPAS Birmingham South is operated by the national charity British Pregnancy Advisory Service (BPAS). BPAS Birmingham South is also known as the Robert Clinic.

We inspected BPAS Birmingham South in response to information we had received about the service. We used our focussed inspection methodology and we did not inspect all aspects of the care provided. We only inspected the safe and well led key questions during this inspection. BPAS Birmingham South had a comprehensive inspection in September 2019 where it was rated good overall.

From June 2021 to May 2022, the service completed 1142 medical abortions and 1525 surgical abortions.

We rated it as requires improvement because:

- Not all notifiable events were reported in line with mandatory legal reporting regulations.
- The service was not using a specific paediatric early warning score tool for use with children under the age of 16 years undergoing surgical terminations of pregnancy.
- Governance arrangements were not sufficiently robust or effective to always identify concerns and risks.
- Pregnancy remains were not always stored following the provider's policy or best practice.
- Not all staff had completed their mandatory training.
- Emergency equipment and intravenous medicines were not stored securely.

However

- The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff kept good care records. The service learned lessons from incidents.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued and strong teamworking was evident. All staff were clear about their roles and accountabilities. The service engaged well with women to plan and manage services and all staff were committed to improving services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Requires Improvement 	See overall summary of this service.

Summary of findings

Contents

Summary of this inspection

Background to BPAS - Birmingham South

BPAS Birmingham South are known as the Robert Clinic and provide support, information, treatment and aftercare for patients seeking help with regulating their fertility and associated sexual health needs. Its main activity is termination of pregnancy.

Services are booked at the clinic for patients within the West Midlands region via a national telephone appointment service.

The service provides early medical abortion up to nine weeks and six days gestation and surgical abortion under local anaesthetic up to 13 weeks and six days gestation. Surgical abortion under conscious sedation can be provided up to 17 weeks and six days. Surgical abortions under general anaesthetic are not conducted at the clinic, but they can be arranged for women at other BPAS clinics when necessary.

BPAS provide service specific counselling and treatment, sexual health screening and contraception and carry out vasectomies.

The service is registered to provide the following regulated activities:

- Termination of Pregnancy.
- Family Planning Service.
- Treatment of Disease, Disorder or Injury.
- Diagnostic Imaging Services.
- Surgical procedures.

Under these activities the service provided:

- Pregnancy Testing.
- Unplanned Pregnancy Counselling.
- Early Medical Abortion.
- Surgical termination of pregnancy (SToP).
- Abortion Aftercare.
- Sexually Transmitted Infection (STI) testing and treatment.
- Contraceptive advice and supply.
- Vasectomies.

The registered manager had been registered since May 2021 and is also the registered manager of another local BPAS registered location.

The government approved the use of misoprostol for medical abortions at home in England on 1 January 2019. On 30 March 2020, the Secretary of State for Health and Social Care made two temporary measures that superseded the previous approval. The temporary arrangements were aimed at minimising the risk of transmission of coronavirus (COVID-19) and ensuring continued access to early medical abortion services during the COVID-19 pandemic. To date, the amendments made are still in place.

Summary of this inspection

The new arrangement meant that pregnant women (and girls) who met an eligibility criteria would be able to take two medicines, Mifepristone and Misoprostol, for an early medical abortion up to nine weeks and six days gestation, in their own homes and without the need to first attend a hospital or clinic. The arrangement also meant medical practitioners could provide remote consultations and prescribe medicines for early medical abortions for women to take in their own home without the need to first attend a hospital or clinic.

How we carried out this inspection

We carried out an unannounced focused inspection (the service did not know we were coming) on 12 July 2022. During the inspection we observed patient consultations, attended the treatment room and the pre-operative and post-operative recovery areas. The inspection was undertaken by one CQC inspector and a specialist advisor with expertise in termination of pregnancy with support from an offsite inspection manager.

During this inspection we observed client interactions, looked at 10 sets of client notes, observed two surgical abortions and spoke to three patients and six members of staff.

As part of this focused inspection, to get to the heart of women's' experiences of care and treatment, we asked the following questions of this service: are they safe and well-led. As we have a legal duty to rate this service type, we rated the services' performance against each the safe and well-led 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 service was termination of pregnancy. You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

- The service must use a specific paediatric early warning score tool for use with children under the age of 16 years undergoing surgical terminations of pregnancy. (Regulation 12 (2) (a) (b).
- The service must ensure governance systems are effective. (Regulation 17).
- The service must ensure all statutory notifications are made to the Care Quality Commission and in a timely way in line with the statutory regulations. (Regulation 18(1) (2) the Care Quality Commission (Registration) Regulations 2009).

Action the service SHOULD take to improve:

- All staff should ensure they complete mandatory training in line with the BPAS policy.
- The service should ensure the emergency buzzer in theatre is fit for purpose.
- The service should ensure emergency equipment, emergency medicines and intravenous fluids are stored securely at all times.
- The service should ensure that all risks have been identified and assessed, and all actions taken to mitigate those risks are recorded.
- The service should ensure all staff follow the safe and secure storage and disposal arrangements for pregnancy remains which meet the provider's policy.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Termination of pregnancy	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Termination of pregnancy

Safe	Requires Improvement
Well-led	Requires Improvement

Are Termination of pregnancy safe?

Requires Improvement

We rated safe as requires improvement. (Down one rating).

Mandatory training

The service provided mandatory training in key skills to all staff. Not all staff were up-to-date with their mandatory training.

Staff received mandatory training, although not all staff had completed their mandatory training in line with the BPAS policy. The compliance rate for mandatory training was set at 90%. Clinical staff had achieved less than 90% compliance for six out of the nine modules. Mental capacity training and health and safety essentials training were 75% compliant, data protection was 83% compliant.

Patient safety training was a new topic for clinical staff, this was 22% compliant however, there was a plan to achieve full compliance with this training by 1 September 2022.

The registered manager told us all other training would be updated by the end of August 2022. They stated delays in updating training had been due to staff shortages during the Covid-19 pandemic.

In addition to mandatory training, staff completed additional competency training related to the requirements of their role. For example, conscious sedation training was necessary for all staff working in theatres. All staff competed life support training appropriate to their role. Clinical staff completed immediate life support training which was 100% compliant as was airway management training and conscious sedation training.

The mandatory training was comprehensive and met the needs of women and staff. Mandatory training was easy to access using a mixture of e-learning modules and face-to-face sessions.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they were reminded when they needed to renew their training, however due to staff shortages during the pandemic, they were not always able to update their training in a timely way.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff understood the importance of maintaining the confidentiality of information about women's identity and their care and treatment.

Termination of pregnancy

Clinical staff received level three adult and children's safeguarding training which met national safeguarding training guidance. Most clinical staff were up to date with their safeguarding training as 92% had completed this. Senior managers were suitably trained to safeguarding level four. Staff kept up to date with their safeguarding training and were reminded by managers when renewals were required.

Staff received training and support to recognise cases of child sexual exploitation and female genital mutilation (FGM) and were aware of the requirement to report women under 18 who may have undergone FGM.

The electronic patient records system enabled staff to record safeguarding information and risk assessments and to request safeguarding advice in a timely way. The system included an ability to make safeguarding referrals to the local authority and other partner organisations.

Senior staff highlighted women who had safeguarding concerns and were having surgery to staff during the morning safety huddle.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff completed a separate 'young person' 'safeguarding risk assessment for girls under 18 years to identify potential safeguarding risks. All women under 18 years of age were required to attend the clinic, or video appointment with an adult over 18 years of age.

Girls under 16 years had an initial video consultation if requested, or a face-to-face appointment, and then attended the clinic for an ultrasound scan. At the scan appointment girls under 16 were seen on their own to identify any coercion risks. Staff completed and updated safeguarding risk at every interaction with girls under 16 years old.

The service had a safeguarding adults at risk policy and a safeguarding children and young people policy which reflected national guidance. Staff were supported by the senior management team and safeguarding level 4 leads to raise issues and report safeguarding concerns. Staff made appropriate safeguarding referrals to the local authority.

Staff understood the importance of maintaining the confidentiality of information about women's identity and their care and treatment. Staff ensured women's identity was protected. The reception booking in desk was in a private area and staff used women's first or their preferred name only. Information was not shared with others including the women's doctor without their consent.

Recruitment, selection and employment procedures ensured staff had appropriate checks to safeguard women using the service.

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.

The premises were clean and had suitable furnishings which were visibly clean and well-maintained. An external company was responsible for cleaning the premises. Cleaning was done every morning before the clinic opened. The cleaning company carried out frequent cleaning audits which were shared with the registered manager and evidenced cleaning had been carried out satisfactorily. Staff also carried out their own cleaning audits and the registered manager did a full cleaning audit every six months.

Staff cleaned equipment and couches after every patient contact. Some equipment was labelled to record when it was last cleaned. Theatre equipment was cleaned appropriately, and treatment couches and recovery areas were fully wiped down after each woman's discharge.

Staff received training on infection prevention and control and had received specific training on donning and doffing specialist personal protective equipment (PPE) during the COVID-19 pandemic.

Staff wore appropriate PPE and washed and sanitised their hands between each patient. Clinical staff were bare below the elbow for effective handwashing. Hand hygiene and the use of PPE was regularly audited and showed good compliance.

Monthly infection prevention and control audits were carried out and showed good compliance every month. Compliance for June 2022 was 100%. Where compliance was not achieved, action plans were put in place to improve performance.

Reusable surgical instruments were sent to an appropriate facility for decontamination in line with national guidance.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. Emergency equipment was not stored securely, and the theatre emergency buzzer was not clearly identifiable in all areas of the clinic. Some clinical waste was not stored safely or in line with the providers policy.

The two resuscitation trolleys containing intravenous therapy fluids and emergency medicines were not locked. One of the resuscitation trolleys was in an open area between two clinical areas. This posed a risk to women attending the clinic as they may be accessed by unauthorised visitors. Senior staff were aware that the emergency trolleys were unlocked and told us there had been an issue obtaining appropriate tamper proof security seals for the trolleys. The seals that were supplied with the trolley required scissors to remove them and had therefore been removed. Following our inspection, the registered manager told us appropriate security tabs had been tested and approved and that the clinic would be ordering these. It was envisaged that the security ties would be in place within the following week.

The decision to keep the two trolleys unlocked was taken by the BPAS head office and was on the service risk register. Senior staff completed a risk assessment and had introduced daily checks to reduce the risks associated with the unlocked trolleys. However, this did not mitigate the risk of medicines being tampered with, or of items being removed from the trolley between checks.

The second unlocked resuscitation trolley was stored in a room with a keypad lock on the door. There was a risk of delays in accessing this emergency equipment if staff forgot or mistyped the access keycode in an emergency. Senior staff told us they had struggled to find a suitable location for this trolley due to the restricted space. This risk was not monitored or mitigated on the service risk register.

Staff carried out daily safety checks of specialist equipment. The emergency buzzer in theatre was demonstrated to staff at the start of each surgical list. However, this buzzer was not fully identifiable as the emergency buzzer, on the first and second floors. In a theatre emergency, there may have been delays in staff responding quickly. Local managers became aware of this in May 2022, and a replacement system was being sought. This risk was not on the service risk register. Following our inspection, the provider told us mitigations were in place, including ensuring all staff were able to recognise the sound of the alarm from all floors and that regular tests and demonstrations were done for new and agency staff.

Resuscitation trolleys and the major haemorrhage trolley were checked every day. Equipment was regularly serviced and maintained. General storage rooms were kept tidy.

The service operated out of a multi-story terraced house which was not designed originally for clinical use. However, the clinical rooms, and the theatre had been modified appropriately and although small met the needs of the service most of the time. Staff told us there was not enough storage space.

Hand hygiene sinks were located throughout the clinical areas. The theatre room was bright and spacious with appropriate flooring and cleanable surfaces. There were carpets in the non-clinical rooms and on the staircase between clinical areas. Although these appeared visibly clean during our inspection, carpets are not recommended for healthcare facilities due to their inability to be effectively cleaned following spillages.

Fire exits were marked and kept clear of obstruction. Fire extinguishers were up-to-date with their service checks and readily available throughout the building.

Staff disposed of clinical waste safely in appropriate waste bins. Bins were clearly labelled for each waste type.

Pregnancy remains were collected into a shared vessel. Collecting several pregnancy remains in one receptacle separate from clinical waste was the default position. However, there were safeguards in place to ensure that women were informed of their choices surrounding this and were given the option of having of having their pregnancy remains collected separately prior to their procedure.

Pregnancy remains were stored in appropriate sealed containers and a record log of the disposal was kept for three years post collection. Remains were collected weekly by external contractors and taken for appropriate disposal.

Not all staff were aware of and followed the BPAS policy guidance for the safe storage and collection for this type of waste. On the morning of our inspection, two large boxes containing pregnancy remains, dated for two consecutive dates in June 2022, were in an unlocked utility room at room temperature, awaiting collection the following day. By the end of our inspection, there were three containers awaiting collection.

During our inspection, staff told us the containers had been removed from the freezer the day before ready for a collection in two days' time. Some staff were unable to say why the waste might have been stored outside of the freezer.

The local guidelines for BPAS Birmingham South waste products of conception, required the waste to be stored in the freezer until collection, unless the freezer was full. The freezer was not full during the inspection. Additionally, the BPAS provider policy required pregnancy remains be stored in a secure freezer and in a secure storeroom. The storeroom was not locked during our inspection.

Staff said the waste contractor collected the pregnancy remains when clinical staff were off site and that administrative staff provided access. All staff that were trained in infection prevention and control were allowed to handle clinical waste.

There was a separate process for individual storage of pregnancy remains if patients requested this for private burial or cremation, and in the case of criminal investigations, which staff were aware of.

Visitors gained access to the service using an intercom and buzzer, and security cameras were in operation at the entrance and throughout public waiting areas. The reception staff was positioned away from women who had already been booked in to enable privacy for other women when booking in on arrival. There was a separate waiting room for women waiting to be seen.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and acted upon risks to patients at risk of deterioration. Paediatric early warning scores were not used.

Individual risk assessments were carried out for women at the clinic and those receiving telephone consultations. Recognised risk assessment tools were used. Some specific risks for women were updated and assessed every time women they had contact with staff, for example, safeguarding risk assessments. Individual risk assessments were reviewed regularly, including after incidents.

BPAS did not use paediatric early warning scores (PEWS) for girls under 16 having a surgical termination of pregnancy. PEWS scores are specific for children and consider a child's different physiology giving escalation of risks at different points than adult early warning scores. Staff in the clinic said they were aware of the ongoing discussions around the use of MEWS and PEWS. We were told most under 16-year olds attended with their mother and were able to recognise signs quickly when their child appeared unwell.

BPAS told us they were having ongoing engagement with other independent termination of pregnancy providers, with the CQC and with other stakeholders regarding the use of an appropriate tool for abortion care, which uses a scoring system which includes pregnant paediatric patients who may have different physiology to pregnant adults.

Modified early warning scores (MEWS) were used to identify women early who were at risk of deterioration. We looked at ten MEWS charts and each score had been calculated correctly and escalated appropriately.

Staff completed appropriate assessments to minimise the risk of women receiving treatment outside of the eligibility criteria for termination of pregnancy. Staff knew the national gestation guidelines for each type of termination.

Ultrasound scan appointments were arranged based on risk assessments. For example, if a woman was unsure of the date of their last menstrual period or had pain or bleeding. Ultrasound scans were always arranged for girls under 16 years of age and for those women having surgical terminations. This helped ensure women were on the right treatment pathway and those that were not suitable for treatment at BPAS were identified quickly and were referred to the NHS for their care.

Under 16-year olds were offered appointments at larger BPAS centres where they were given the additional option to have their termination under a general anaesthetic.

Staff confirmed medical staff did not leave the premises until they had made sure patients were fit for discharge.

Key information was shared with other healthcare providers when handing over their care to others. The service had guidelines and policies for staff to follow in the event a woman needed to be transferred to an NHS Hospital. Staff were aware of these arrangements and described instances where they had been followed.

Requires Improvement

Termination of pregnancy

The service followed an abortion related complications identification and management plan for transferring women to another hospital. This stipulated that a clinician must travel with the woman during the transfer. The requirement for a suitably skilled clinician to accompany the patient during transfer was also included in the 'agreed transfer of care' document. However, incidents reported showed staff did not always accompany women to hospital in line with the plan. We were told clinicians did go 'when required' and that the decision was made on the advice of ambulance staff attending the emergency.

Senior staff led a daily huddle at the start of each shift where staff were allocated a role in the event of an emergency, for example, transferring a woman to an NHS hospital, or cardiac arrest. Roles allocated included who was responsible for assisting with the woman's airway, calling an ambulance or getting the emergency resuscitation trolley. This helped ensure women were treated safely and quickly.

A modified surgical safety checklist was used for surgical terminations of pregnancy and was based on the World Health Organisation (WHO) five steps to safer surgery. The WHO checklist tool was designed to improve the safety of surgical procedures. Records showed staff completed the checklist at all stages throughout surgery. We observed two surgical procedures and saw that safety checks were all completed appropriately. Instruments and swabs were all counted during procedures to ensure nothing went missing.

Managers audited the use of the safer surgery checklist and results for June 2022 showed 96% compliance in completing surgical case notes.

BPAS used a risk assessment to assess the risk of deep vein thrombosis (DVT). The initial risk assessment identified whether the woman required a further assessment, with possible treatment, or if there was minimal risk, in which case a full venous thrombolysis assessment (VTE) was not applicable. All records we checked had a completed VTE assessment indicating a further full assessment was not required. Staff were aware of risks which required a full VTE assessment.

Risk assessments were used for sepsis and staff had received training in its identification and management. BPAS completed some blood testing; women had their rhesus status determined if they were over 10 weeks gestation and receiving a medical treatment or if they were having surgical treatment. Haemoglobin levels would also be checked subject to certain criteria. Blood loss following terminations was monitored and recorded to identify concerns early.

Psychosocial assessments and risk assessments for women at risk of self-harm or suicide were undertaken and counselling was arranged for women presenting with mental health concerns. Counselling sessions were online and unlimited, and women were able to self-refer to the service at any time. Support was arranged for women who decided to continue with their pregnancy.

Staffing

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

The service had enough clinical and support staff to keep women safe. All staff received training specific to termination of pregnancy. Some staff worked at several different clinics within the region. This ensured appropriately trained staff were always available for the type of services provided on a given day. For example, on days when surgical terminations

under conscious sedation were undertaken, the nurses on shift were trained in immediate life support and airway management. BPAS employed continuity midwives specifically to rotate to different clinics to provide additional clinical support in instances where there were staff shortages due to sickness or when there were skills gaps and staff working had not yet completed all their required training.

Managers accurately calculated and reviewed the number and grade of clinical and non-clinical staff. Managers could adjust staffing levels daily according to the needs of women who were booked for consultation or treatment.

The service had one whole time equivalent clinical role (either nurse or midwife) vacancy which was being recruited to. Low levels of agency staff were used. Agency staff were experienced and familiar with the service and received a full induction.

The service had enough medical staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Medical staff were either employed centrally by BPAS or worked under practising privileges. Practising privileges' staff were employed elsewhere but worked for BPAS in a limited, defined capacity. When doctors were employed under practising privileges their clinical background and competencies were checked and the type of terminations they were competent to carry out was agreed. The registered manager ensured doctors working in the service kept up to date with their training. The BPAS medical director oversaw the additional training needs, appraisals and the recruitment process for doctors employed under practising privileges.

Records

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

Women's notes were comprehensive for each of the ten records we looked at. Records were mostly electronic, and staff could access them easily. HSA1 forms (legal forms which must be signed by two doctors who agreed a woman was suitable to undergo a termination of pregnancy as per The Abortion Act, 1967) were present and appropriately completed.

Records were stored securely. Only authorised staff had access to records which were password protected. During surgery, only one set of patient records were open in theatre to avoid incorrect data entries.

If staff needed to refer a woman to NHS care a summary of their care and treatment was printed off and for them to take with them.

Display screens were locked when staff were not present. As part of their mandatory training, staff completed information governance training.

Notes audits were carried out monthly to ensure staff followed BPAS' policies. Results indicated most records were fully completed.

Medicines

The service used systems and processes to safely prescribe, administer and record medicine. Not all medicines were stored appropriately.

Requires Improvement

Termination of pregnancy

Staff followed systems and processes to prescribe and administer medicines safely. The service used medicines to induce medical abortion. These were prescribed by one of the doctors completing the HSA1 form (legal forms which must be signed by two doctors who agreed a woman was suitable to undergo a termination of pregnancy as per The Abortion Act, 1967). Nurses and midwives supplied and administered these medicines as directed by the prescriber.

Nurses and midwives were trained in a range of specific patient group directions (PGDs) which enabled them to supply and administer very specific medicines to women without needing an individual prescription. For example, antibiotics, anti-sickness medicines and contraception.

Emergency medicines and fluids stored on the resuscitation trolley were not secured with tamper proof devices. See equipment section above for further information regarding the unlocked trolley.

Intravenous (IV) fluids were not stored securely. The IV store did not have a lock on the door. The clinic was open for cleaning and waste collection when there were no clinical staff present. There was a risk IV fluids could be tampered with. The registered manager had ordered a keypad lock for the IV store and was waiting for this to be fitted at the time of our inspection. Following our inspection, the provider told us they had found a key and the cupboard was locked, and that they were awaiting a keypad to be fitted.

Most medicines were managed safely. The temperature of medicine fridges was recorded and met manufacturers guidance. There were appropriate checks on controlled drugs, medicine allergies were recorded on women's records and the service antibiotic policy provided advice on the effective use of antibiotics.

Staff reviewed women's medicines regularly and provided information about their medicines. Medicine administration was recorded on women's patient records.

Women who were sent medicines through the post were given specific instructions on how and when to take the medicines they had been prescribed. This was both verbal and in written format. Pain relief for women having terminations of pregnancy was regularly reviewed and adjusted as per individual requirements.

Staff completed medicines' charts accurately and recorded dates and times of administration. Medicines were all signed for. Medicines' management was audited and monitored and compliance in June 2022 was 96%. When action was required a record of actions undertaken was recorded.

Staff discussed safety alerts and incidents during morning huddles and in team meetings. Medicine safety alerts were shared with staff and incidents were discussed.

Incidents

The service did not always manage patient safety incidents in line with guidance. Not all staff recognised and reported incidents and near misses in a timely way. Not all serious incidents were notified in line with the Care Quality Commission registration regulations. However, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Requires Improvement

Termination of pregnancy

Staff reported incidents on the internal incident reporting system. Staff raised concerns and reported incidents and near misses in line with the BPAS' policy. However, not all serious incidents were investigated in a timely way or reported to the Care Quality Commission in line with the statutory requirements of the CQC registration regulations for notifiable incidents. For example, not all incidents where women required transfer to an acute hospital were investigated as a serious incident.

From July 2021 to July 2022 there had been one never event in the service. Never events have the potential to cause serious patient harm or death. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event occurred in April 2022 and was not recognised as a never event or reported to CQC until after our inspection. Following our, inspection the never event was investigated and reported appropriately.

Managers shared learning with their staff about serious incidents that happened elsewhere and recent incidents that had occurred at this clinic at regular team meetings. Staff received feedback from the investigation of incidents, both internal and external to the service. Managers involved women in investigations about their care. Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation and an apology when things went wrong. The duty of candour is a duty that requires a health service body to notify patients, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred. They must notify the relevant person an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

Are Termination of pregnancy well-led?

Requires Improvement

We rated it as requires improvement.(Down one rating)

Leadership

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

There was a clear management structure within the service locally and nationally within BPAS. Leaders were aware of their responsibilities and accountabilities. Local services fed into BPAS's regional and national management teams ensuring senior leaders had clinical oversight.

BPAS Birmingham South was led by a registered manager who was supported by the area operational and quality manager and quality matron. There was also a lead midwife at the unit. Managers were aware of the issues facing the service including meeting accessibility targets and ensuring the service had safe staffing levels with skilled clinicians.

The registered manager had undertaken bespoke BPAS management training which provided them with appropriate skills and knowledge in order to run the service and keep women safe. The training ensured BPAS clinics were all operated to the same high standard. There was a clinical leadership development course for senior clinical staff which was mainly self-directed learning via a workbook, but also included interactive sessions and some face-to-face teaching.

Termination of pregnancy

The register manager at BPAS Birmingham South was also the registered manager for one other BPAS location and spent their time between both sites. Following some restructure in the area, the third registered location and satellite previously managed by this registered manager was removed from their remit. This has improved oversight of the remaining two units.

The registered manager worked remotely on some days and was accessible by video call. A senior midwife oversaw the clinical care of patients on a day-to-day basis and worked closely with the registered manager. All staff reported the senior team were visible.

The certificate of approval to carry out termination of pregnancy was displayed in accordance with Department of Health requirements.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The vision and strategy for BPAS was a future where every woman can exercise reproductive autonomy and is empowered to make her own decisions about pregnancy. Their purpose was to remove barriers to reproductive choice and to advocate for and deliver high quality, woman-centred reproductive health care. Staff spoke clearly about enabling women to access services and treat women with compassion and respect. BPAS is a charity which provides evidence based and not for profit care. The BPAS strategy included providing effective services, meeting contract requirements and financial stability. Managers monitored the service provided to ensure stakeholder contracts and financial viability were met.

Culture

Staff were respected, supported and valued and worked well as a team. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff were proud of the organisation they worked for and said they were treated with respect and felt appreciated and valued for the work they did. Staff spoke positively about their role working for BPAS. Everyone we spoke with told us they all worked together as a team. Leaders were proud of their staff and worked hard to make them feel valued.

Staff knew how to raise concerns and felt supported and listened to. The service had a whistle blowing policy and staff knew how to raise concerns with managers.

There had been a recent staff survey in 2021, however, the local responses were not shared with CQC. The BPAS senior leadership team (SLT) took a decision to only share organisation-wide headlines with external bodies due to the small numbers of respondents in some areas and to share further detail would risk confidentiality. The regional breakdown of staff feedback was distributed to area operational quality mangers who discussed the results locally with their teams. We were told the top three actions from each area were fed back to HR and the senior leadership team.

Complaints were dealt with positively and involved the service looking at how women's experiences could be improved. Most complaints were regrading waiting times. Complaints were discussed at quality meetings and an action log was help by local teams.

Requires Improvement

Termination of pregnancy

Governance

Governance processes were in place, although these were not always effective. Most staff were clear about their roles and accountabilities and had regular opportunities to meet. There were missed opportunities to discuss and learn from the performance of the service.

BPAS had processes and systems of accountability to support their delivery of services. This included several governance committees with defined responsibilities to ensure information was shared and discussed by relevant staff in the organisation. Most committees met quarterly including the governance committee, audit and risk committee, and finance committee. Reports from committee meetings were fed to the board report for trustees. The leadership team met every two weeks. The BPAS medical director was responsible for ensuring the organisation met current national guidance.

An operational quality manager worked alongside the registered manager to review the quality of the service. Information was shared up to the senior team and back down to junior staff.

However, the governance systems in place were not always effective at identifying issues early. Several concerns had not been picked up before our inspection. For example, although staff reported incidents using the providers reporting system, these were not always investigated or addressed in a timely way. Staff told us incidents were reviewed by a dedicated person and investigations were undertaken according to the level of harm identified. However, not all serious incidents had been investigated appropriately, and the provider's governance system had failed to identify this.

There were missed opportunities for learning due to the incorrect categorisation of some incidents. For example, following a never event earlier in the year, a second similar event was reported several weeks later. Although this event was correctly identified as a near miss, no actions had been taken following the first never event which may have prevented the second event.

Some BPAS' guidelines and processes were not always followed, and the governance systems had not addressed this. For example, BPAS policy for the transfer of patients to another healthcare facility. Although there was a service level agreement for women needing transfer to an NHS hospital in an emergency or for further treatment, the full policy was not always followed. For example, BPAS staff did not always accompany women going to hospital as per the policy. Where BPAS staff did not accompany women, this was not always documented which meant managers could not identify if the decision to not accompany the woman was appropriate.

Updates from the senior leadership team were shared during regular team meetings. This included current issues and changes to services or new national guidance, as well as learning from incidents, complaints and changes in policies and procedures.

Audits and dashboards were used to monitor the quality of the service and were reviewed as part of the governance process. Information gathered was used to identify areas for improvement and learning. Audit results over time showed evidence of improvements.

The service delivered care and treatment in accordance with the Abortion Act 1967. The certificate of approval was displayed and processes to ensure that the certificate of opinion (HAS1) and abortion notification (HSA4) were completed in line with legislation.

Requires Improvement

Termination of pregnancy

Management of risk, issues and performance

Leaders and teams used systems to manage performance. Not all risks were identified or had actions to reduce their impact. They had plans to cope with unexpected events.

There was a corporate risk register held centrally and a local risk register which included risks for BPAS Birmingham South and another local BPAS service. Risks were rated red, amber, yellow and green depending on the level of risk. Red risks represented the most serious risks. However, not all risk register entries had a risk level calculated.

The local risk register had several high risks listed, including safe staffing to enable ultrasound scanning when required, and the resuscitation trolley which was not tamper proof. This was on the corporate and local risk register as it was applicable across several locations.

Although all risks had some controls to manage the risks, not all risks were sufficiently mitigated. The control measure for the unlocked trolley was to ensure it was checked every day. However, this action did not mitigate the risk of items being removed or tampered with.

The risk associated with the emergency buzzer in theatres was not recorded as a risk and there was no written assessment for this. Following our inspection, buzzer sounders were sourced and were due to be fitted within two weeks. Meanwhile, further staff training had been implemented on the buzzer system to ensure everyone was aware of the procedure to follow.

BPAS told us they had recognised the need for further training and support for managers to embed risk management into everyday work. They had recently appointed a risk manager to support this work and a new risk policy was due for presentation to BPAS at end of July 2022. Additionally, risk register e-learning training had been launched in July 2022 for all managers.

Managers monitored performance both in terms of access to services and quality performance such as infection control and safeguarding audits. Performance dashboards were used to discuss, benchmark and monitor performance at monthly senior management team meetings and were accessible to all managers to review and compare their performance against other BPAS clinics.

Service managers told us they had regular meetings with the local commissioning group to monitor the service provision and patient satisfaction surveys were undertaken regularly.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were not always submitted to external organisations as required by legislation.

Most of the information required by staff was available electronically including policies and procedures.

Clinical records were recorded and stored electronically, except for surgical records which were recorded on paper and stored securely. All BPAS clinics used the same integrated electronic records system which enabled women's details of to be shared with other BPAS clinics if required. If a woman chose a different location to have her treatment their notes were immediately accessible.

BPAS collected performance information and recorded it electronically which enabled timely information sharing.

Requires Improvement

Termination of pregnancy

The registered manager submitted some notifications to external organisations electronically, including those required to fulfil the requirements of the Abortion Act 1967. The BPAS booking system allowed direct access to the Department of Health database which ensured there were no delays in reporting. Staff used an online secure portal to send and receive HSA1 and HSA4 forms (legal forms which must be signed by two doctors who agreed a woman was suitable to undergo a termination of pregnancy as per The Abortion Act, 1967) securely. However, notifications required by the Care Quality Commission (Registration) Regulations 2009 were not always completed.

Engagement

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

Feedback from patients was obtained using an online response form which managers monitored. National themes were reviewed with a focus on an improvement to women's experiences of using the service. Results from the satisfaction surveys from January 2022 to March 2022 were mostly very positive in all aspects of feedback provided.

Managers engaged with patients following complaints and provided feedback on any changes which had been implemented as a result of their concerns.

Staff told us they had regular team meetings. Information was shared with staff in a variety of ways, such as face-to-face, email, and noticeboards.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The COVID-19 pandemic had required considerable change which included staff providing less face-to-face treatment to working virtually to support women and provide advice about safe home use of abortion medicines. As COVID-19 cases started to decline, more face-to-face appointments have been made available. Staff said they were keen to offer face-to-face consultations where women preferred these.

Clinical skills had been extended to improve services and this included ensuring more midwives and nurses received sonography training. This enabled the service to offer timelier scans to women and at a time and location most convenient to them.

The service had introduced a new appointment reminder system in an attempt to reduce the number of women who failed to turn up for their appointment. This helped the service offer more appointments to women needing their services.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not use a specific paediatric early warning score tool for use with children under the age of 16 years undergoing surgical terminations of pregnancy.

Regulated activity	Regulation
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Governance systems were not effective and failed to pick up risks and issues sufficiently early in order to possible harm.

Regulated activity	Regulation
Termination of pregnancies	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents • Statutory notifications were not made to the Care Quality Commission and in a timely way in line with the statutory regulations.