British Pregnancy Advisory Service

BPAS - Birmingham Central

Inspection report

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for clients and keep them safe. Staff had training in key skills, understood how to protect clients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to clients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of clients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated clients 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 clients, families and carers.
- The service planned care to meet the needs of local people, took account of clients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of clients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with clients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Good 	Our rating of this location stayed the same. We rated it as good because: • The service had enough staff to care for clients and keep them safe. Staff had training in key skills, understood how to protect clients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to clients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of clients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated clients 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 clients, families and carers. • The service planned care to meet the needs of local people, took account of clients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of clients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with clients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

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Summary of this inspection

Background to BPAS - Birmingham Central

BPAS Birmingham Central is operated by British Pregnancy Advisory Service (BPAS). The service provides a termination of pregnancy service in Birmingham.

The service is provided from a building leased by the service. The service provides termination of pregnancy as a single speciality service. BPAS Birmingham Central offers consultation, medical assessment/scanning, early medical abortion, medical termination of pregnancy and counselling through counsellors not on site. Treatment options are determined by the gestation of pregnancy and patient choice. As part of the care pathway, clients are offered sexual health screening and contraception. The service does not provide surgical termination of pregnancy and therefore we have not reported on this. However, if patients presented with later gestation, they were referred to another clinic that provided surgical termination of pregnancy.

The service also operates a TeleMedical Hub, which is a remote/digital early medical abortion services referred to as 'Pills by Post'. This service is available for clients of all ages and for medical termination of pregnancy up to nine weeks and six days. Young clients aged 16 and under were required to have a scan to access this service. For young clients aged between 17 years and 18 years the provider has a scan algorithm which establishes if the client is suitable for pills by post.

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

Under these activities the service provided:

- Pregnancy Testing
- Unplanned Pregnancy Counselling
- Early Medical Abortion (EMA) (up to 9 weeks and 6 days gestation)
- Medical termination of pregnancy (MToP)
- Abortion Aftercare
- Sexually Transmitted Infection (STI) testing and treatment
- Contraceptive advice and supply

Summary of this inspection

The government legalised / approved the home-use of Misoprostol in England from 1 January 2019. On 30 March 2020, the Secretary of State for Health and Social Care made two temporary measures that superseded this previous approval. These 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 global outbreak. The temporary arrangement meant that pregnant women would be able to take both Mifepristone and Misoprostol for early medical abortion, up to 9 week and 6 days gestation, in their own homes without the need to first attend a hospital or clinic.

It is possible for a medical practitioner to provide a remote consultation and or prescribe medication for an early medical abortion (EMA) to women in their own home rather than travelling into a clinic or hospital. On 30 March 2022, this arrangement was made permanent.

Activity

In the 12 months prior to our inspection from 1 July 2021 to 30 June 2022, the service completed 8,042 EMA abortions by telemedicine (remote consultation and supply of abortifacient medicines to take at home) and 1,444 EMA abortions at Birmingham Central. There were 139 EMA abortions for clients under 18 years of age.

The service was last inspected in July 2019.The inspection highlighted two areas where the provider needed to make improvements. These included ensuring client files contained completed VTE risk assessments and consolidating records to either paper-based or electronic. NICE guidance says all surgical patients and medical patients with severely reduced mobility should be assessed for their risk of developing VTE. During this inspection we found the service was no longer providing surgical abortion or vasectomies so VTE assessments are not routinely required. Records have been consolidated and electronic records were used.

How we carried out this inspection

We carried out an unannounced inspection on 21 July 2022. The inspection team included a lead inspector. The inspection was overseen by an Inspection Manager who was available for off-site support.

During the onsite visit, we spoke with three members of staff and one client and looked at five client records. We looked at documentation and client outcome data before, during and following the inspection. After the inspection, we held telephone interviews with key people we were not able to speak with during the unannounced inspection.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

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 SHOULD take to improve:

- The service should ensure that records of medicines are updated at the time medicines are removed from stock.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Termination of pregnancy

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

Are Termination of pregnancy safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff completed a range of mandatory training topics which included immediate life support, emergency first aider, infection control and medicines management. Records showed most staff had completed their mandatory training. For example, 100% of staff had completed basic life support training. Infection prevention and control training had been completed by 89% of clinical staff, this statistic was affected by one member of staff who had not completed the training. The member of staff had been given time to do the training and a date when the training had to be completed by.

The mandatory training was comprehensive and met the needs of clients and staff. Simulation exercises were used to provide further training in several topics such as sepsis, safeguarding, major haemorrhage and anaphylaxis. Feedback was used to learn from these exercises to improve practice.

Staff also received role specific training: for example, some staff were trained as fire marshals or for using medical gas. Clinical training included using patient group directives (PGDs), sexually transmitted infections (STIs) and assessing a client for suitability of treatment.

Medical staff received and kept up-to-date with their mandatory training. Medical staff working under practicing privileges (a license agreed between the individual medical professional and a private healthcare provider) received their training in the NHS trust where they held substantive contracts. Mandatory training compliance was reviewed as part of annual reviews of practising privileges agreements.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff received emails when their mandatory refresher training was due to be completed.

Good

Termination of pregnancy

Safeguarding

Staff understood how to protect clients 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 received training specific for their role on how to recognise and report abuse. All nursing and administrative staff received both adult and child safeguarding training at level three. Records showed 100% of clinical staff had completed this. The treatment clinic manager was the safeguarding lead in the unit and had access to a manager with safeguarding level four training. The provider had safeguarding specialists within the organisation and the treatment clinic manager attended two safeguarding supervisions each year.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff were aware of the provider's safeguarding policies, which included guidance for staff around female genital mutilation (FGM) and child sexual exploitation (CSE). All BPAS staff undertook 'Safeguarding Vulnerable Groups' training every two years, staff also received an introduction to safeguarding which was a part of induction. Staff could discuss safeguarding during supervision. Safety was promoted in recruitment practice and included safety checks such as 'Disclosure and Barring Service' checks.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding policy. In addition, the electronic client record system allowed staff to highlight if there was a safeguarding concern and to document actions taken when concerns were escalated. The provider's electronic records system meant as questions were asked and answered the system opened further questions. Staff could request a safeguarding referral or safeguarding support through the system. At all consultation and early medical abortion appointments, staff ensured anyone accompanying a client stayed in the waiting room in order that the client not feel pressured to answer questions a specific way. Staff asked clients about their home environments and ensured clients were safe.

Staff followed safe procedures for children visiting the service. All clients under the age of 18 years could attend for a scan on their own, but a responsible adult was required to attend with them for the medicines. Staff confirmed the identity of the responsible adults before any treatment was given.

Everyone aged under 18 had a safeguarding assessment completed. Any adult identified as vulnerable also had a safeguarding assessment. If anyone aged under 13 attended staff automatically made a safeguarding referral and requested advice from safeguarding leads. In the 12 months prior to inspection, no clients aged under 13 years had attended the clinic. However, all staff we spoke with knew their responsibility to report to all appropriate authorities including the police, as children under 13 years are considered in law to be unable to consent to having sexual intercourse as detailed in Section 5 of the Sexual Offences Act 2003.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect clients, themselves and others from infection. They kept equipment and the premises visibly clean.

BPAS Birmingham Central rented the premises under contract from a private individual. The landlord was responsible for cleaning the communal areas in the building such as stairs and communal hallways. The service had a contract with a cleaning company who cleaned the clinic rooms. Staff cleaned their own desks, trolleys, couches, equipment and changed curtains.

Clinic rooms were clean and had suitable furnishings which were clean and well-maintained. Staff completed a cleaning checklist in the morning before the clinic opened to check the clinic was visibly clean. Staff knew to contact the landlord if they had any issues or concerns regarding the cleanliness of the communal environment.

The service performed well for cleanliness. The treatment clinic manager undertook monthly audits. Audits for infection control, which included handwashing audits, showed the service achieved 94%. The clinic had reported zero healthcare acquired infections in the 12 months prior to the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff used aseptic techniques in the treatment rooms and had access to appropriate PPE for the tasks they were carrying out. Staff were bare below the elbows and did not wear jewellery other than a wedding band. Staff wore masks and tested themselves twice weekly for COVID-19.

Staff cleaned equipment after client contact. Cleaning supplies and hand sanitising gel was available in all the offices.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The facilities and equipment were safe for clients to receive treatment although the building was not designed to be used as a termination of pregnancy clinic. The building had been suitably adapted. The clinic was located within a commercial area of the city and was situated within a multi-occupancy building. There was restricted /controlled access to the building and to clinical areas to prevent unauthorised persons from entering. There was CCTV monitoring of outside areas to deter people who did not have a reason to be on the premises.

There was discreet signage within the building to the clinic, however a concierge was situated by the front door and could direct anyone who missed the signs.

There was a small client reception area and clients went through to a waiting area. Clients were then called to a consultation room with a midwife. Consultation rooms had a desk, chairs and a couch with a privacy screen. All furnishings were wipeable.

Staff carried out daily safety checks of specialist equipment. The resuscitation trolley was not secured to the wall at the time of our inspection; however, the trolley was stored in a staff office and was not easily accessible to anyone other than staff. The lead nurse told us they had a new trolley on order and were awaiting its delivery. Minutes of meetings confirmed this. Records showed staff checked emergency equipment daily when the facilities were used. The equipment was security tagged so it would be seen if anything had been tampered with and medicines on the trolley were in date. The temperature of the room where the emergency equipment was stored was monitored.

The service had enough suitable equipment and consumables to help them to safely care for clients. Records showed all equipment was regularly serviced and maintained to ensure it was safe to use. The provider centralised orders of PPE throughout COVID-19 to ensure no-one ran out, staff conducted weekly checks of stock, so they knew how much they needed. The lead nurse told us there were no problems ordering what they needed.

Fire safety was assessed, and staff received training, including scenario training in evacuation of clients twice yearly. There were processes to test fire alarms and equipment was checked annually by an external company. Weekly fire alarm tests were carried out.

Staff disposed of clinical waste safely. Clients who received the abortion pill (up to 9 weeks and 6 days) and had treatment at home were made aware of the options available to them for disposing of pregnancy remains. Staff explained this included flushing the remains down the toilet or wrapping and disposing of remains in the household waste. From 10 weeks onward the pregnancy was terminated by surgical means, so clients attended other clinics for this. If preferred, the client could arrange a private service, burial or cremation. Clients could bring the pregnancy remains back to the clinic if they wished for staff to dispose of. Staff disposed of pregnancy remains in clinical waste. Information about the options were described on the provider's website.

Waste was separated into clinical waste and general wate and disposed of safely. There were sharps bins which were labelled and closed when they were not in use, in line with national guidance. There was a service level agreement with an external provider for the collection of clinical waste.

Assessing and responding to client risk

Staff completed and updated risk assessments for each client and removed or minimised risks. Staff identified and quickly acted upon clients at risk of deterioration

Staff completed risk assessments for each client on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Clients completed a medical questionnaire to assess their suitability for treatment, which gathered information about their medical history. This included information about any allergies, menstrual history, pregnancy history and information about the current pregnancy (bleeding, nausea, pain) and surgical history (for example any reaction to anaesthetic). The questionnaire also asked about medical conditions such as asthma, heart conditions, anaemia and liver conditions and gathered information about the client's social history, such as if the client smoked or took illegal drugs, and if so if they injected into veins. The questionnaire also asked for information about the client's contraception history.

In an early medical abortion appointment, staff explained the importance of the timeframe the client had in which to take the second tablet. Staff also explained what to do if the client experienced vomiting within an hour of taking the tablet.

We saw staff asked clients about their medical histories including known allergies. Staff monitored the client's blood pressure, pulse and temperature before performing an ultrasound to determine the gestation of the pregnancy. Staff used this information to assess whether the client was suitable for treatment at the clinic, as the clinic only conducted medical abortions before 10 weeks, in line with BPAS's suitability criteria. If the client was not suitable for treatment at the clinic, they were referred to the BPAS specialist placement team who arranged treatment at either another BPAS clinic that was an appropriate environment, or an NHS hospital.

Where a client presented who was showing to be at a higher gestation, staff knew to refer then to the fast-tracking system. In these cases, the area medical surgeon and midwife manager conducted all appointments with clients where they were 22 weeks gestation or over, this was due to the complications associated with abortion at a later gestation.

At the early medical abortion appointment, staff gave clients a pregnancy test and advised them to take the test three weeks after the abortion. This was to ensure the abortion had successfully passed all pregnancy remains as retention could result in an infection. Staff explained what to do if there was a faint line on the test or if the client was unsure of the result to contact the team.

Good

Termination of pregnancy

The electronic system for records helped staff with decision making. For example, if a client had anaphylaxis staff were prompted to assess if they could treat the client safely or if they should be referred to the NHS. Staff also completed formal risk assessments for vulnerable clients and those aged under 18 or who had been subjected to female genital mutilation (FGM), or those at risk of child sexual exploitation (CSE).

At our previous inspection in May 2019 we found two out of five of the patient files we reviewed did not contain a competed VTE risk assessment and clients had a mix of paper and electronic records. At this inspection we found VTE assessments were completed as part of the pathway through the electronic record and staff were prompted to complete all areas of the record. Staff followed an escalation process when risk was detected during the medical and social assessment and made relevant referrals for support from other agencies to mitigate risk.

Staff knew about and dealt with any specific risk issues. BPAS Birmingham Central had an agreed transfer of care procedure between themselves and Birmingham Women's and Children's NHS Foundation Trust. Staff called the consultant if they had any concerns and clients were taken directly to the hospital, without going through A&E. Staff completed observations charts which included a sepsis tool, blood pressure, pulse, respiration, oxygen levels, level of consciousness, temperature, pain and Per vaginal (PV) bleeding. Staff also made referrals to Early Pregnancy Assessment Units (EPAU) for reviews and follow ups where required. Staff received resuscitation training at a level appropriate to their role. Staff had access to emergency equipment including resuscitation trolley, anaphylaxis kits and oxygen. Rotas showed there were always medical staff on site when the service was open.

Staff shared key information to keep clients safe when handing over their care to others. There was specific guidance and documentation for clients who needed to be transferred and staff knew how to access this. BPAS did not inform anyone else about the treatment offered unless the woman gave explicit permission or BPAS were required to do so in order to comply with a legal obligation or had a medical or safety reason to do so. Staff discussed this with the woman in advance.

Staff were aware of specific national guidance and legislation relating to the termination of pregnancy according to the gestation (the time from conception based on menstrual cycle). Individual risk assessments were completed for all clients who attended the clinic or through telephone consultations. There were specific eligibility criteria to assess if clients were safe to receive a medical abortion in their own home or if they needed to attend the clinic.

If the gestation was over 10 weeks and 0 days the clients only had the option of surgical termination. If under this gestation then they had a choice of either medical or surgical treatment.

All young clients, under the age of 16, had their gestation established through ultrasound scanning, had their assessment at the clinic, which included a full safeguarding risk assessment. If further safeguarding advice was needed staff would liaise with the safeguarding team. Young clients between the age of 16 and 18 were assessed by video rather than telephone call. If there was not a supportive adult on the call, who could verify they were over 18, the clients needed to attend the clinic for assessment.

Staff shared information about counselling services and referred clients to BPAS counselling, pre and post treatment counselling was available. When clients were discharged, staff ensured they knew they could access counselling at any point in the future if they had any concerns or issues relating to the termination of their pregnancy.

Good

Termination of pregnancy

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep clients 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 nursing and support staff to keep clients safe. At the time of inspection, permanent staff included one treatment unit manager, four midwife practitioners, four nurse practitioners and one lead nurse. There were also four administrative staff were employed at BPAS Birmingham Central. In the 12 months prior to inspection, no bank or agency staff had worked at the clinic, however we saw full induction processes in the event bank or agency staff were required. The clinic had a zero-vacancy rate at the time of inspection. The treatment clinic manager used a BPAS tool to calculate the number of staff required on duty each day; this depended on shift start times and alternate week shift patterns.

Managers accurately calculated and reviewed the number and grade of midwives, nurses, and other staff needed for each shift. BPAS had a national policy and guidance around minimum numbers of staff required and the process to escalate any staff shortages. To calculate the number of staff needed, waiting times from contact to consultation or ultrasound scan, and consultation to treatment were reviewed and monitored. If the wait times increased, then additional appointments could be added through overtime or additional cover. If the need for overtime and extra cover became consistent, staffing could be increased accordingly. BPAS Birmingham Central had a contracted third-party provider for the provision of ultrasound scans to enable prompt access to scan appointments.

TeleMed Birmingham was based on the premises. They used a tool that combined the teams' availability and the number of different consultations they needed to provide. This ensured that appointment choice across days and times was as even as possible. Any staff absence was deducted from the week's planned activity. Should staff absences ever reach a level that impacted ring fenced appointments (for clients with no choice of provider), then other hubs would be able to provide support until staff issues were resolved. The business development team reviewed the ring-fenced appointment numbers regularly, making amendments as required and communicated these to the hubs. This information and corresponding waiting times was provided to commissioners in quarterly reports.

The clinic had access to doctors who worked remotely, both for clinical support and remote signing of HSA1's and prescriptions. They had a separate rota that was organised by a central support department. The doctors were employed under practising privileges. '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 of medical staff practicing privileges were held at the BPAS head office.

Staff were recruited through a central BPAS recruitment system in accordance with the 'Recruitment and Selection' Policy and Procedure, which checked that candidates were pro-choice. BPAS did not employ or subcontract individuals with a conscientious objection to abortion, or those who did not embrace the organisations values. Candidates were assessed on their skills, knowledge and experience. Formal references were obtained from previous employers and any breaks in employment were investigated. Nurses and midwives had their professional registration confirmed with the appropriate regulatory body, prior to a position being offered. All employees were subject to a Disclosure and Barring Service check, a check to show whether candidates were suitable to work with certain groups, for example children or vulnerable adults.

Good

Termination of pregnancy

Records

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

Client notes were comprehensive, and all staff could access them easily. Client records were kept electronically. BPAS used a centralised electronic system, therefore, if a client was sent to another clinic, their records were readily available and could be accessed by staff. When clients were transferred to the surgical team, there were no delays in staff accessing their records.

When clients transferred to a new team, staff completed specific client documentation to ensure staff at the NHS hospital had the information they needed.

Records were stored securely, and computers were password protected to prevent unauthorised people from accessing records they did not need to. Records were easily available to all staff providing care.

The service completed documentation audits to ensure client records were completed as they were intended. Audits of HSA1 forms were also undertaken, these confirmed the forms were fully completed by two doctors and submitted in line with requirements.

Staff audited client records monthly, the result for the month prior to inspection was 100%. We checked five client records and found them to be clearly written, signed and dated. They contained detailed assessments of any risks, the client's medical history, social history including any safeguarding concerns and history of mental health and any other specific needs. There was also a clear rationale for a termination of pregnancy in line with National Institute for Health and Care Excellence guidelines. The only paper records were scans done on the day, early medical abortion (EMA) paperwork and the client's discharge letter.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Home use of abortion medication in England was legalised by the government from 1 January 2019. Under the approval, women had the choice of whether they wished to take the dose in safe and familiar surroundings of their own home or at licensed premises where they underwent treatment.

The clinic had access to doctors who worked remotely and had prescribing responsibility. These doctors prescribed the medicine that induced a miscarriage. Prior to administration, prescriptions were checked by nursing staff. Nursing staff then supplied pre-labelled medicines to take home to the client, according to the prescription. We saw the clinic nurse explain what medicine they were going to give to the client, what each tablet did and its side effects.

Staff did not always complete medicines records accurately or keep them up to date. The lead nurse had responsibility for ordering medicines for the clinic. The medicine order forms included the date the medicine was ordered, the date it was received, the name and title of the person who placed the order, the quantity ordered and received, and total amounts of each medication stored on clinic. We saw the monthly on-clinic medicine checklist. Every medicine in stock was counted and the amount logged, and expiration date signed for. We checked the medication cabinet and found medicines in stock did not match the log. This was logged as an incident and the treatment clinic manager arranged for

an audit to be conducted. After the inspection, the treatment clinic manager sent us a copy of the incident form which showed that after reviewing all of the treatments that had been provided including repeat medicines, there was no discrepancy as the total treatments provided during the period matched the stock level in the unit. This had been an error of staff not recording details at the time of making packs up.

Staff monitored the ambient temperature of the medicine room and medicines fridge and recorded these to ensure the efficacy of medicines. All temperatures were within an acceptable range. All staff we spoke with knew how to respond if the ambient temperature went outside of range. There were no controlled drugs stored or administered at the clinic.

Medicines as TTO (to take out) packs were issued by nursing staff either against Patient Group Directions (PGD's) or against a prescription from a prescriber. PGDs were written instructions which allowed specified healthcare professionals to supply or administer certain medicines in the absence of a written prescription. PGDs were appropriately authorised and in date.

Nursing staff provided advice to clients about their medicines. Clients were informed what medicines they were taking, in what order to take the medicines and what side effects could occur from the medicines. Where clients were supplied with medicines to take at home, a 24-hour contact number was available for advice.

The clinic had a service level agreement for the disposal of medicines with a professional company. Staff disposed of medicines in a dedicated disposal bin. The process of medical waste leaving the clinic to be destroyed was trackable.

Incidents

The service managed client safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support. Managers ensured that actions from client safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.Staff reported serious incidents clearly and in line with trust policy. There had been one serious incident at the clinic between July 2021 and June 2022. This had been a missed ectopic pregnancy. An ectopic pregnancy is when a fertilised egg implants itself outside of the womb, usually in one of the fallopian tubes. Managers debriefed and supported staff after any serious incident and staff also had additional training.

There was an electronic incident reporting system in place. Incidents were classed as either a clinical incident or a complication. A clinical incident was defined as an event that resulted in harm such as a medication error. A complication was defined as an unintended outcome such as haemorrhage or infection following treatment.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. There was an electronic process that staff followed to record that they had read and understood the feedback.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. Duty of candour incidents were recorded on the electronic incident reporting system, this ensured there was a process to follow up any duty of candour incidents. The missed ectopic pregnancy had been followed up under the duty of candour process.

Good

Termination of pregnancy

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from other BPAS units was shared during safety briefings to improve delivery of client care.

Any business continuity incidents were monitored through a new system, which meant the situation, background, assessment and recommendation were monitored. This meant any trends could be identified and shared with staff and other services. Quarterly meetings also identified trends and the treatment clinic manager told us the new system and the quarterly meetings usually mirrored each other identifying trends. Action was taken to minimise disruption; for example, equipment was maintained on service level agreements to prevent the likelihood of equipment failure.

There were no recorded accidents for BPAS Birmingham Central between June 2021 and June 2022.

Are Termination of pregnancy effective?

Good

Our rating for effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

BPAS had a clinical advisory group who had oversight of policies and ensured they were in line with professional bodies and up to date clinical practice. The BPAS medical director monitored national and international developments in care and service delivery.

All policies were easily accessible for staff to reference via the online system. All staff were aware of how to access these on the service's intranet. We checked 12 policies including medicines management and safeguarding policies and saw that all were in date, had been signed off by staff to say that they understood the policy and would comply with its contents. There was also a date for review and update of the policy.

Staff compliance with policies was regularly audited and reviewed. We saw that policies referenced appropriate medical bodies such as the Royal College of Obstetricians and Gynaecology, Department of Health Required Standard Operating Procedures and National Institute for Health and Care Excellence.

Staff completed three-point client identification checks to ensure they were treating the right client. Staff explained to clients' what symptoms they might experience during the medical abortion at home, which symptoms were normal, and which meant that the client should attend the Accident and Emergency department. This information was also available to clients on the service's website in case the client could not remember what was discussed during the appointment.

Staff followed national guidance. We observed staff advising clients of how to dispose of pregnancy remains following medical terminations that was in line with the Human Tissue Authority guidance.

Staff routinely referred to the psychological and emotional needs of clients, their relatives and carers. Information was flagged up and shared as required both on client records and in the morning staff briefing.

Good

Termination of pregnancy

Nutrition and hydration

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

Due to the nature of the service, food and drink was not routinely offered to clients. However, drinking water from water machines and biscuits were available.

Pain relief

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

Staff prescribed, administered and recorded pain relief accurately. Nurses gave pain killers from a list of agreed Client Group Directions or against a prescription from a prescriber. CGDs are written instructions which allow specified healthcare professionals to supply or administer certain medicines in the absence of a written prescription. Staff advised clients what to do if they experienced unmanageable pain.

Patient outcomes

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

Auditing of patient outcomes was in line with Department of Health 'Procedures for the Approval of Independent Sector Places for Termination of Pregnancy' and showed client outcomes at BPAS Birmingham Central for use of Misoprostol was in line with national standards.

BPAS completed national reports on the quality of its service and client outcomes. The clinic completed and returned client analysis data for each termination of pregnancy to the Department of Health (HSA4 report). The clinic also reported standards to the Health Protection Agency regarding Clostridium difficile and Methicillin-resistant Staphylococcus aureus rates and the Medicines and Healthcare Products Regulatory Agency regarding any adverse drug events and equipment failures as well as point of care testing errors.

The service kept clients informed of the most current outcome information when deciding about the type of medical abortion to have. At this inspection we saw up to date outcome data for all types of abortion was detailed on the service's website.

The service monitored outcomes of treatment in line with national guidance. The service monitored pathways of care, information provided, client's choices, pre-abortion assessment, abortion procedures and after abortion care. Outcomes for clients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve clients' outcomes. There were processes to use client outcome audits to improve services. For example, the pathway for pre-abortion assessment had been reviewed to ensure as far as possible that the eligibility criteria for early medical abortions in clients' own homes were assessed safe.

The BPAS national clinical governance committee monitored and reviewed client safety and treatment complication rates to ensure they were below national rates. We saw BPAS had a national planned auditing programme which was completed at local level. Audits included; infection control, the environment, case notes and record keeping and safeguarding adherence to policy and documentation. All audits at BPAS Birmingham Central met or exceeded standards.

The service held required licenses from the Secretary of State for Health and social Care to legally carry out termination of pregnancies. The service also held required liability insurance.

Good

Termination of pregnancy

Competent staff

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

BPAS had competency frameworks to support staff training and development. These varied depending on the job role and were developed to ensure staff across clinics were working to the same standard. Induction programmes were also developed by head office.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of clients. There was a competence framework that was designed to demonstrate staff had the required skills and knowledge to provide safe care and treatment. Leaders reviewed competency completions and nursing rotas were designed to ensure staff with the correct skills and knowledge were rostered to work.

Managers gave all new staff a full induction tailored to their role before they started work. New staff received a corporate induction and then completed a six-week local induction on clinic where they shadowed staff. Clinical staff completed a 12-week induction and completed a logbook. Telemedical clinical staff were supernumerary for eight weeks during induction. In-unit clinical staff were supernumerary during their 12-week induction. Staff had a three-month review and six-month probation.

Staff were given protected time to complete the revalidation process and used appraisal as an opportunity to discuss their competencies, learning and development, in preparation for revalidation. Staff could access information at home.

Staff advised us they were supported by the clinic manager to complete their revalidation. Revalidation is the process by which the Nursing Midwifery Council confirms the continuation of health care professionals to practice medicine in the UK. Staff maintained a log which was discussed during their annual appraisal. The appraisal completion rate for all staff at BPAS Birmingham Central was 100%.

All clinical staff were expected to attend the BPAS Clinical Forum, where expert speakers presented topics relevant to BPAS. Clinical staff also attended objective structured clinical examination (OSCE) scenarios training; this is used to evaluate health care professionals in a clinical setting. It assesses competency, based on objective testing through direct observation. The training involved actors playing clients in various situations and staff reviewed the investigations and scenarios. It is designed to test clinical skill performance and competence in skills such as communication and clinical examination.

There was a pool of trained BPAS counsellors who provided this service and staff were aware of how to refer clients when this was needed.

Managers supported staff to develop through twice-yearly, constructive appraisals of their work. During these appraisals staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff told us they received clinical supervision three times a year regularly and found this was useful.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Agendas had standard headings as well as a time for free discussion. Staff who did not attend meetings were asked to read them online; the treatment clinic manager had oversight of this.

Good

Termination of pregnancy

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit clients. They supported each other to provide good care.

Staff worked well as a team within the clinic and with outside agencies. There were clear lines of accountability and all staff we spoke with knew what and who they were responsible for.

Staff worked across health care disciplines and with other agencies when required to care for clients. Staff advised us they had close ties with other outside agencies such as safeguarding teams, transfer hospitals, EPAU, social workers, local police and support organisations such as women's refuges. The service also worked well with the integrated commissioning board.

When clients were discharged, they were given a discharge letter containing relevant information about their treatment that could be shared with other relevant healthcare professionals in the event of an emergency. Discharge letters were also shared with clients' GPs if the client consented to this.

Staff referred clients for mental health assessments when they showed signs of mental ill health, depression. Clients were asked about their mental health and clients were screened for risk of self-harm or suicide.

Seven-day services

Key services were available seven days a week to support timely client care.

All clients had access to a 24-hour after care service they could call for advice and support if they needed it following medical or surgical terminations of pregnancy.

The service was open Tuesdays, Wednesdays and Fridays between 9am and 3pm, Thursdays between 10am and 4pm, and on Saturdays between 8.30am and 1pm.

Health promotion

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

During the consultations, staff asked whether the client had been actively using contraception at the time of pregnancy. If the client replied no, then staff discussed the importance of contraception and which methods the client might prefer. If the client stated yes, staff asked which type they were currently using in order that the client could review other methods that may be more effective.

All clients were signposted to the provider's website for details of the many types of contraception available. Clients were then asked to consider which method they would like to use and discussed it during the early medical abortion appointment.

We saw staff discuss contraception at the early medical abortion appointment. All clients on leaving the clinic were provided with a pack of condoms to cover the period until an alternative long-term contraceptive was available. Staff advised us "Sexual health awareness and using contraception is a really important part of our job".

The service had relevant information promoting healthy lifestyles. We saw there were leaflets available to clients to promote a healthy lifestyle.

Good

Termination of pregnancy

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood their role and responsibilities regarding Fraser and Gillick guidelines. Gillick competence is the principle we use to judge capacity in children to consent to medical treatment. Fraser guidelines are used specifically for children requesting contraceptive or sexual health advice and treatment. Staff used specific BPAS consent forms for clients aged 16 and under. The consent forms included details of the Gillick and Fraser guidelines.

We saw client consent was asked for and recorded in the client record at every appointment. Staff ensured clients understood any medical terminology and got an opportunity to ask questions before giving consent. Staff asked clients whether there was someone they could call in the event of an emergency, whether that person knew the client was pregnant and having an abortion and if they did not know, were staff allowed to inform them.

During the early medical abortion appointment, staff gained consent for the procedure but also whether a referral letter could be sent to the clients GP. If a client expressed doubts or was unsure of their decision, staff supported them and discussed alternative options, including returning later, before requesting the client consent to any treatment. Staff advised clients they could have a second consultation appointment if they were not confident in their decision to terminate the pregnancy in accordance with national guidelines. Staff recorded on the consent form if consent was obtained in another language or with an interpreter.

Staff understood their roles and responsibilities regarding the Mental Capacity Act (2005). We were advised clients who lacked capacity rarely attended the clinic because it was important the woman understood the treatment and risks, however, all staff we spoke with stated they had completed both Mental Capacity Act and Consent training in the 12 months prior to inspection. BPAS employed a national capacity lead who ensured the provider was working with the most up to date guidance and legislation as well as providing training and support to staff on the clinics.

Staff understood how and when to assess whether a client had the capacity to make decisions about their care. Staff received training in how to assess clients' mental capacity and assessments were integrated into the assessments of all clients who contacted the services for a medical or surgical termination of pregnancy. Staff completed the risk assessment and clinicians used the information to establish if the woman could give consent or not. Staff told us "We don't deny treatment if in the woman's best interest but there's a process."

Staff gained consent from clients for their care and treatment in line with legislation and guidance. Consent was obtained from clients and re-confirmed and signed before treatment to ensure clients had not changed their mind. Staff ensured that the client gave her full consent and wasn't being coerced into terminating a pregnancy.

Staff made sure clients consented to treatment based on all the information available and clearly recorded consent in the clients' records. We observed staff provide clear information about the termination of pregnancy procedure and any risks involved. This included opportunities for clients to ask questions.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. All clients under the age of 18 years of age were required to attend the clinic with a responsible adult.

Good

Termination of pregnancy

Staff received and kept up to date with training in the Mental Capacity Act as part of their mandatory training.

The provider's website had a privacy notice which explained to clients how their personal information would be used on the provider's website under the BPAS Privacy Notice. This part of the website gave information about how the provider might share information with partner organisations, which help them provide or pay for clients' care. It also gave information on the legal responsibility of the provider to submit an electronic form (HSA4) to notify the Chief Medical Officer with anonymised information of every abortion treatment, including; date of birth, postcode, ethnicity, marital status, parity, treatment details, gestation and the legal grounds for the abortion.

Are Termination of pregnancy caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. There was a privacy, dignity and respect policy which provided guidance on the promotion of standards of care to enable the utmost privacy, dignity and respect for people who used the service. Clients were greeted warmly by the receptionist and made to feel welcome.

Staff treated clients well and with kindness. We observed several patient and staff interactions and saw that all staff spoke respectfully and kindly to clients. Clients said they were provided with necessary information prior to attending the clinic and were able to ask questions before and after the procedure.

During the COVID-19 pandemic, restrictions had been introduced which meant clients could not always have their partner, relative or friend with them when they were waiting for treatment. This was to reduce the risk to both staff and clients. At the time of the inspection, the service was fully open, and clients were able to bring one person with them.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave clients help, emotional support and advice when they needed it. Staff interacted well with clients and provided appropriate support.

We saw that staff were trained to provide a positive, compassionate and supportive care. During the initial consultations we saw staff took the time to ask clients about any specific cultural or social needs they may have had.

Good

Termination of pregnancy

Understanding and involvement of clients and those close to them

Staff supported clients to understand the procedure they were having and make decisions about their care and treatment.

Staff made sure clients understood their care and treatment. Clients were provided with information both in writing and from staff directly relating to their appointment and care and treatment.

Staff talked to clients in a way they could understand. Clients could give feedback on the service and their treatment and staff supported them to do this.

Clients gave positive feedback about the service. The provider monitored patient feedback, and this was shared with staff. Comments included, "I was overwhelmed with how lovely everyone was who dealt with me at BPAS" and "BPAS is an exceptional service that made me feel safe and supported"

All clients were spoken with on their own to check the decision was their own and they were not being coerced. Reasonable adjustments were made for all clients who needed additional support to make informed decisions about treatment. This included face to face consultation rather than telemedicine, extra time given for an appointment and access to support with speech, language, communication, physical or mobility needs.

Are Termination of pregnancy responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

At the time of inspection, BPAS Birmingham Central was contracted by Birmingham and Solihull Integrated Care Board to provide a termination of pregnancy service. BPAS Birmingham Central was in a commercial area in the city centre close to Birmingham New Street train station and had designated consultation rooms, with a reception and waiting area.

Managers planned and organised services, so they met the needs of the local population. The provider had a business development team which collected information about local demographics, so information was available to understand the needs of clients in the area. The provider also worked with commissioners with links to public health so had a good understanding of the local population.

Facilities and premises were appropriate for the services being delivered. Appointments were booked via the provider's contact centre, which also acted as an information service. Clients could self-refer to the service or could be referred by a sexual health service or GP. Clients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment.

Managers ensured that clients who did not attend appointments were contacted. The provider had a policy to manage missed appointments.

Staff could access emergency mental health support for clients with mental health problems, during their office hours.

Meeting people's individual needs

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

All clients were offered counselling at the time of the termination of pregnancy and at any time in the future if this was required related to the treatment.

The service provided support for clients who were homeless, lived in women's refuges and clients who moved between friends and had arrangements with other services to safeguard them. Clients often had a consultation before they attended the clinic, so staff were aware of any mobility needs and could book clients into another clinic if necessary.

Support was available for clients living with a mental health illness or other complex needs. Staff advised us they followed policy when advising and treating clients with a learning disability and had received training on how to support clients with extra needs. For example, the appointment period was extended to give extra time to explain procedures and ensure client understanding.

Staff completed equality and diversity training as part of their mandatory training, to ensure they recognised different cultural needs and beliefs and the impact these may have on a client. Staff had access to a telephone translation service that provided translation services to clients where English was not their first language. Clients with a hearing loss could get help from a sign language expert, staff told us the same sign language expert would be booked for consistency, each time the client needed to discuss anything. Clients had access to a 24-hour telephone support and a web-chat service for however long clients required.

The information on the provider's website was comprehensive and included an introduction to BPAS, what would happen at consultation, the different treatment options, what would happen at treatment, pain relief, recovery and pricing information if clients weren't NHS funded. Clients were given choices of how to dispose of pregnancy remains.

The service was inclusive of clients' individual needs. The treatment clinic manager explained they had supported transgender clients. The provider's website had information for trans, non-binary and intersex people and they were developing a range of client materials suitable for people who did not identify with the gender they were born with.

The location was not suitable for people who used wheelchairs. This was because the service was one flight of stairs above ground level. The building had a lift, but the service did not have any hoists should people require assistance getting onto a couch.

The clinic tracked clients having repeat abortions. Information gathered included the client's pregnancy history details and information about any terminations or caesarean sections. Staff explored contraception with the client and followed through to check the client wasn't being exploited. Staff liaised with other agencies, for example if the client needed support with housing. Staff respected the woman's decision.

The provider had policies and procedures to support people with complex needs and these included the Chaperone Policy, Consent to Examination and Treatment Policy and the Mental Capacity Assessment Flowchart.

Clients attending a BPAS clinic had the opportunity for being tested for sexually transmitted infections (STI). If clients had the abortion pill and were under 10 weeks, they may have had the option to receive an STI test in your treatment pack.

Access and flow

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

The Royal College of Obstetricians and Gynaecologists (RCOG) states that to minimise delay, service arrangements should be such that referral to a termination of pregnancy provider should be made within 2 working days. The service must offer assessment within 5 working days of referral or self-referral and then the procedure within 5 working days of the decision to proceed. Clients requiring abortion for urgent medical reasons should be seen as soon as possible.

As clients were able to book appointments seven days a week, the service monitored waiting times from booking to consultation with a seven calendar day window, not the five working day Monday to Friday quoted by RCOG. Records showed the number of consultations within this seven-day window did not meet national standards in November 2021, December 2021 and January 2022. In January 2022 only 23% of clients received a consultation within seven days. Since then, the service had improved and from March 2022 onwards, over 85% of clients received a consultation within seven days.

The service also monitored the time between consultation and treatment, again using a seven-day window. From July 2021 the service achieved over 90% for nine months, and over 85% for three months.

BPAS Birmingham Central provided 2,463 ultrasounds for 2,422 clients between 1-Jul-2021 and 30-Jun-2022. Between July 2021 and June 2022 there had been nine instances when appointments for scans were not available within 48 hours. In the same timeframe, there had been four occasions when treatments were excessively delayed or cancelled. The treatment clinic manager told us they checked they were working at capacity to keep waiting times to a minimum and had access to data to monitor this. An accelerated booking process was available if necessary, such as if a pregnancy was around 23-weeks. In order to ensure clients were treated within the 24-week gestation window, the booking team took details of the clients last known menstrual cycle. If a client was unsure of the date, the booking team arranged an emergency appointment.

The booking process began with screening clients to see if they required an ultrasound scan. Clients were either screened during their telephone consultation or by completing an appointment request form online. Most clients had a telephone consultation appointment initially. The triage tool used identified if a scan was required and whether it needed to be completed within 48-hours. Discussions were held about pregnancy options, such as continuing the pregnancy to either becoming a parent, adoption or ending the pregnancy.

Where indicated, an ultrasound scan was used to date the pregnancy and confirm the planned treatment was suitable. For example, if the pregnancy was under ten weeks, with the client being sure of their dates and 16 years of age or over a scan was not always necessary. The scan was performed sensitively, with the midwife using ‘pregnancy’ and not using terms such as foetus or baby. The client was not able to see the screen while the scan was in progress but could request to see it at the end.

Good

Termination of pregnancy

A midwife told us, “The booking system is very clever. We put BMI and gestation in so the system will only show treatments the client can have. It’s a safety net, because it won't show treatments they can't have, for example if their BMI is high”. At every stage, staff checked the information discussed and confirmed the client’s consent to treatment. Clients were booked for a counselling conversation the day after the scan.

The BPAS capacity manager and associate director for remote services had overview of appointment availability across all clinics. Waiting times were discussed at area and treatment clinic manager meetings as well as quality review committee meetings. Quarterly activity reports provided information on the average number of days from ‘decision to proceed’ to treatment and from first point of contact to treatment. Waiting times were reviewed at clinical commissioning group meetings. Staff asked for client feedback on whether waiting times were acceptable. One client we spoke with advised us they had not had any issues getting an appointment and they chose the specific date.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included clients in the investigation of their complaint.

Clients, relatives and carers knew how to complain or raise concerns. Information was available on the service’s website and in the clinic about how to make a complaint or raise a concern. When a formal complaint was received, the provider sent an acknowledgement letter within three days. Investigations were started and if they weren’t completed within 20 days, the provider sent a letter explaining the delay. If the complainant was happy with the response, the complaint was closed. If the complainant wasn’t happy with the response, the complaint was reviewed by BPAS Director and a new response sent. The provider’s website had information who to refer complaints to if the complainant wasn’t happy with the BPAS response.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The client services manager dealt with formal complaints. Local complaints were dealt with locally. If a client left the premises and later wanted to complain, their identity was checked before a discussion took place. In the month July 2021 to April 2022 the service received four complaints in total. Three of these were formal complaints and one was a local complaint. Themes of complaints were around the waiting times of surgical appointments which clients were referred elsewhere for or waiting times for appointments in clinic.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff received feedback during meetings and also accessed minutes of meetings on their intranet.

Are Termination of pregnancy well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Good

Termination of pregnancy

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for clients and staff. They supported staff to develop their skills and take on more senior roles.

There were clear lines of responsibility and communication. The treatment unit manager had overall responsibility for the clinic. They were accountable to the Operational Quality Manager and the Associate Director of Operations. The Associate Director was accountable to a Director of Operations, then the chief executive and the board of trustees.

Leaders had the skills, knowledge, experience and integrity to run the service. Treatment clinic managers received training for their role, such as modular management training courses and regular conference calls to discuss new or amended guidelines or policies. Managers completed the BPAS leadership programme and First Line Management courses done in partnership with ACAS, which was centrally organised to ensure all managers ran their clinics to the same standard.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. Staff told us leaders were visible and approachable.

Staff told us they had been supported to complete further training, such as completing a university course.

Vision and Strategy

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

BPAS's mission was, "To remove all barriers to reproductive choice while advocating for and delivering high quality, woman-centred reproductive health care" on their website. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners.

Staff in the clinic knew and understood what the vision, values and strategy were, and their role in achieving them. Staff told us BPAS values were about helping clients to make reproductive choices, being free at the point of contact and giving clients control. Staff said they achieved this by providing a safe and caring service. All staff we spoke with had 'bought in' to the vision and strategy for the provider and stated that it was the basis for the care they provided. Staff were proud of the service BPAS provided and told us, "BPAS is really good at understanding what is changing". The provider had a press team who monitored locally and nationally so the organisation could develop.

Staff at BPAS Birmingham Central had been involved in the campaign for pills by post. The service worked with other providers to provide a safety-net to help clients navigate their way around services, with equitable access for clients who did not speak English. When BPAS held a 'vision day', the lead nurse attended and brought the local perspective into the organisation views.

Culture

Staff felt respected, supported and valued. They were focused on the needs of clients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where clients, their families and staff could raise concerns without fear.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked well together, shared responsibility and resolved conflicts quickly and constructively. Staff told us there was great teamwork and they had good support from colleagues and senior staff when they needed it. Staff told us they were respected, valued and were positive and proud to work in the organisation. All staff we spoke with said the working environment within the clinic was supportive, that the team worked well together and if staff had an opinion, a method of improving the service, or an issue or concern they would be listened to, supported and given credit where credit was due.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and was action taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff in the BPAS clinic knew who the freedom-to-speak up guardian was and said they could raise concerns to leaders within the clinic. Staff told us the culture was diverse and inclusive and the team worked well together. The team was made up of staff from several cultures and backgrounds in all roles and managerial positions.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. There was a strong emphasis on the safety and well-being of staff. Equality and diversity were promoted within and beyond the organisation. The provider had an extensive employee assistance programme which was available to employees, their partners and children for a range of benefits which included counselling.

Governance

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

The Medical Director had responsibility for ensuring clinics were kept up to date with relevant clinical policies and guidelines. The Medical Director presented any changes to policy or practice to the Clinical Governance Committee for ratification, before it was implemented. There was also an infection control committee, a quality risk committee and a research and ethics committee. These four groups fed into the clinical governance committee whose findings were then presented to the board. The quality risk committee included clinical leads and management who reviewed complaints, incidents, serious incidents, audit results and client satisfaction. Treatment clinic managers received the minutes from these meetings and any learning was shared with the clinic staff. Once a quarter, BPAS head office produced a team brief detailing all clinical updates, media attention and finances which was shared with all clinics. Staff completed audits and the results were recorded on the provider's intranet, so staff could see how their service performed against other services.

Locally, the treatment clinic manager reviewed the clinic's safety standards for the previous month. These included; medicines management, clinical supervision, infection control, records audits, incidents, complaints, staffing issues. In the 12 months prior to the inspection, BPAS Birmingham Central had met all standards throughout the year.

In order to meet the requirements of the Abortion Act 1967 and 1990, staff must complete a HSA1 form before a termination. BPAS Birmingham Central was compliant with completing the HSA1 in ensuring there were two registered medical practitioners' signatures on the HSA1 form before administering the medicine that would induce a miscarriage. The HSA1 form provides a defence for the doctor terminating the pregnancy that the abortion is being performed legally because the two doctors are of the opinion, in good faith, that the woman meets one of the grounds stipulated in the Abortion Act 1967 (5). These grounds are translated into categories A-E, and the relevant grounds must be completed on the HSA1 form. The BPAS Birmingham Central records system did not allow the creation of a HSA4 form if two doctor

signatures were missing from the HSA1 form. We saw the system listed the clients name in one column, another column showed a red exclamation mark if the HSA1 form did not have two signatures. When two signatures were showing on the record the exclamation mark turned green. Therefore, staff on the clinic could instantly see the status of each client and contact a doctor if a signature was required.

There were effective structures, processes and systems of accountability to support good quality, sustainable services. These were regularly reviewed and improved. The provider had a schedule of audits all clinics were expected to follow. Results from audits were monitored by senior managers, who met with treatment clinic managers to drive improvement.

All levels of governance and management functioned effectively and interacted with each other. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

We saw a copy of the clinic's certificate of approval to carry out termination of pregnancy in accordance with Department of Health requirements.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Treatment clinic managers, Clinical Leads and Quality Matrons completed audits and service reviews were reported to the specified governance committee, for example infection control. Where a clinic was non-compliant, the treatment clinic manager completed an action plan which was reviewed by the BPAS clinical department as well as the quality risk committee.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. The register of in-clinic local risks as well as risks to BPAS as a provider were kept on the online staff system. The BPAS system meant risks were scored and all teams monitored risks using the same standards. This meant staff could easily see which risks had the most impact and needed urgent review. BPAS had appointed a risk manager whose job was to have oversight of all local risk registers and review any recurring issues or patterns which may need a provider wide solution.

Local risks were reviewed monthly within the local managerial team which included the treatment clinic manager and Operational and Quality Manager.The treatment clinic manager explained the three main risks for the service included non-collection of clinical waste, this was because there were problems using parking areas as loading bays. Other risks included staffing, especially when COVID-19 levels were high, and loss of power. The treatment clinic manager had business continuity plans in place and staff were aware of these. Staff completed risk assessment training as part of their mandatory training to understand the general risks in the building and the way they work.

The local register was up to date, provided details of the risk, when it was added to the register, the date it was last reviewed, the name of the person responsible for mitigating the risk, control measures to manage the risk and risk rating. We could see all items listed on the register had been reviewed and updated at the local managerial team meeting.

Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored. BPAS level managers attended quarterly risk meeting to review all risk registers and ensure effective monitoring and progression.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Information Management

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

There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care. In order to meet the requirements of the Abortion Act 1967 and 1990, a HSA4 must be sent to the Department of Health within 14 days of all terminations and include client demographic data. The HSA4 form was completed by staff on the clinic and submitted by the prescribing doctor to the Department of Health within 14 days post treatment. BPAS had an on-line submission process for HSA4 forms, where the BPAS 'Booking Information System' had direct access to the Department of Health database. Doctors received a secure login and password directly from the Department of Health in order to use this system.

We saw staff explained the process of completing the HSA1 forms. Staff explained that legally, two doctors were required to review the clients notes and agree or disagree to prescribing the medication that would induce a miscarriage, resulting in an abortion. This was clearly recorded in the client records.

Information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings at all levels. BPAS clinics completed monthly audits to ensure timely and accurate completion and compliance with legal standards of the HSA1 and HSA4 forms. In the month prior to inspection, the clinic audit result was 100% for both forms.

The service was registered with the Information Governance Office. There had not been any data breaches within the service.

There were arrangements to ensure data or notifications were submitted to external bodies as required. The service had sent notifications to the Care Quality Commission in line with regulatory requirements. Any incidents were investigated to ensure learning and service improvement opportunities were identified and shared.

Engagement

Leaders and staff actively and openly engaged with clients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for clients.

The provider used to give all clients attending the clinic 'Your Opinion Counts' booklets where clients could answer tick box questions about the service as well as leave comments regarding any good practice or areas for improvement. However, the nature of the service meant that clients who had previously used services sometimes did not want to engage further with the organisation. The provider had reviewed how to engage with clients and trialled contacting clients by email, phone or text message to gather feedback about the specific service the client had used. The treatment clinic manager told us this resulted in better feedback because it was a more specific response.

Staff met monthly for team meetings, they used these as an opportunity to discuss feedback forms, complaints, upcoming training and incidents. Nurses also had nurse specific meetings, for example the nurses' meeting in May 2022 told nurses the patient group directives (PGDs) had been updated and reviewed, and staff were to check the PGD folder and sign all the appropriate PGDs. Meetings were arranged around staff shifts and the clinic opening hours to ensure all staff could attend.

BPAS completed staff surveys where all staff could be actively engaged, including staff with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture. The results from the 2021 survey showed 91% of all staff would recommend BPAS to friends and family for treatment and 88% believed they had a worthwhile job. The survey showed staff gave very positive feedback for line managers. The treatment clinic manager ensured staff received thank-you and congratulation emails and rewarded staff with treats and evenings out. Lowlights of the survey were that only 40% believed BPAS took positive action on staff health and wellbeing, 54% reported feeling unwell due to work related stress and 42% were thinking about leaving or were actively looking for alternative employment.

Staff were motivated and felt involved in the development of the organisation because the chief officer, head of nursing and other senior staff had visited and spoken with staff. The treatment clinic manager provided feedback about staff views and ideas at meetings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in appropriate research projects and recognised accreditation schemes.. BPAS as an organisation was involved in several research projects, including "Enhancing Practice Around Reproductive Coercion within Reproductive Health Services", "Ultrasound in Abortion Care" and "Family planning during the 2020 COVID-19 pandemic survey", which aimed to understand how pandemics impacted pregnancy choices, allowing better preparation and meeting the needs of people in similar situations in the future.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation. There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work. The treatment clinic manager told us, "We are encouraged to innovate."