British Pregnancy Advisory Service

BPAS - Richmond

Quality Report

Rosslyn Clinic
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Date of inspection visit: 21-22 July 2015.
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Termination of pregnancy	

Summary of findings

Letter from the Chief Inspector of Hospitals

British Pregnancy Advisory Service (BPAS) provides a termination of pregnancy service in Richmond, Surrey. The service is provided from a building owned by the service and there is a satellite clinic giving advice on pregnancy options, in Willesden, North London.

BPAS Richmond offers advice to women and teenagers and the full range of abortion procedures from early medical abortion procedures up to a gestation period of ten weeks and surgical abortion procedures up to a gestation period of 24 weeks (the legal limit for most cases). Contraception for women is also offered.

Our key findings were as follows:

Safe

- Some aspects of safety required improvement. Serious incidents were reported and investigated. BPAS reviewed these centrally, rather than at clinic level. The cascade of learning and actions required as a result of incidents was not always timely. In more serious incidents when women had to be transferred to hospital, the clinic had not always involved hospital staff at an early enough stage, which was a potential risk to women.
- Lower level incidents, broken equipment, misleading signage, the use of supernumerary staff to cover staff shortage were not routinely reported.
- Although medicines were appropriately stored, we had concerns about the BPAS policy of using the content of a single ampoule of propofol for more than one patient, which was outside the licence for that drug.
- Staff were aware of safeguarding procedures and had received training in safeguarding adults and children. However, safeguarding policies did not reflect all up to date national guidance on sexual exploitation of children and young people and risks of female genital mutilation.
- The environment and equipment were generally clean and well maintained, and infection control procedures were mostly followed, but there was room for improvement here.
- The clinic was adequately staffed with doctors, nurses and healthcare assistants. Nursing staff shortfalls on shifts were covered by supernumerary senior nurses or by temporary bank and agency nurses.

Effective

- Women were cared for by a team of sufficiently trained doctors, nurses and administrative staff to provide care to women that protected them from abuse and avoidable harm, which was in line with Department of Health's Required Standard Operating Procedures.
- There was a programme of auditing determined by senior managers based at the provider's head office. However, sampling for audits was not proportionate to the size of the clinic.

Caring

- Women received compassionate care,and were treated with dignity.
- All women considering termination of pregnancy had access to advice on abortion options and contraception.
- Clinic staff were sensitive to the different stages of decision-making that individual women had reached. Assistance was tailored to their age, comprehension and social circumstances.

Responsive

- Bookings could be made through a central BPAS booking line at any time of day or night.
- An independent telephone interpreting service was available to enable staff to communicate with women who did not speak English.
- Staff monitored the performance of the clinic against the waiting time guidelines set by the Department of Health and it was performing satisfactorily.

Summary of findings

- Feedback was sought from women, and surveys and complaints were used to identify areas for improvement.
- Women at later gestation periods were able to decide on disposal arrangements for the pregnancy remains, and their wishes and beliefs were respected, however the issue was not raised by clinic staff for women at earlier gestations. All women should have this opportunity. A 24-hour advice line was available for women if they had concerns following an abortion.

Well-led

- Staff at the clinic were well supported by managers based at the provider's head office and by regional managers. However, the leadership on site was an area for improvement. Medical, nursing and administrative staff worked in separate hierarchies and information flows were not always good, and there was no overall staff leadership.
- BPAS had not provided training for the registered manager in the legal responsibilities of the role. Staff understanding of legal obligations was weak; for example the Department of Health license was not displayed prominently within the clinic to assure women of the appropriate registration of the service.
- The culture within the service was caring, non-judgemental and supportive to women, but we saw evidence that staff did not always work well together among themselves. A clique of staff who had worked together for a long time were not always supportive to new staff.
- Staff spoke positively about the need for and value of the service offered to women.

There were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure all staff understand and follow protocols for transfer to NHS hospitals in the event of serious incidents.
- Comply with the practice recommended by the product manufacturer, NHS England and the Royal College of Anaesthetists and discontinue multi-dosing from single patient use propofol ampoules.

In addition, the provider should:

- Display the certificate of approval (issued by the Department of Health) in a prominent position within the clinic to help women and clinicians better understand the licensing system.
- Review safeguarding policies regularly to ensure they reflect all up-to-date guidance, including on the sexual exploitation of children and young people and risks of female genital mutilation.
- Review the policy on disposal of pregnancy remains following pregnancy loss or termination in the light of the Human Tissue Authority's 'Guidance on the disposal of pregnancy remains following pregnancy loss or termination' March 2015.
- Ensure incidents of all kinds, including those with a potential to cause harm to women or staff, even when no harm occurred, are reported and that local staff receive prompt feedback to reduce the risk of recurrence of incidents.
- Encourage greater local ownership among staff of practices and procedures at the clinic, including carrying out audits that are proportionate to the size of the clinic, assessing local risks and encouraging staff to take responsibility for maintaining standards.
- Ensure there is a clear referral pathway for appropriate women to trained counsellors with appropriate expertise if such staff are not available at the clinic.
- Monitor waiting times systematically for women attending the clinic to help identify ways of improving the experience for women.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Termination of pregnancy		The termination of pregnancy service at BPAS Richmond clinic followed statutory guidance. However, some aspects of safety required improvement. For example, the multi dosing from single use propofol ampoules, and staff understanding and following protocols for transfer to NHS hospitals in the event of serious incidents. The environment and equipment was generally clean, well maintained and infection control procedures were followed, although improvements could be made here. Resuscitation equipment was available, however, the training record for the clinic did not show when staff with advanced life support training had last received training. Staff were aware of safeguarding procedures and had received training in safeguarding adults and children, although training materials were not fully up to date. Medicines were appropriately stored but we had concerns about the use of an anaesthetic drug, propofol for more than one patient. This drug was prepared in single patient infusion ampoules. Women were cared for by a team of sufficiently trained doctors, nurses and administrative staff, in a process that ran efficiently and followed procedures recommended by the Royal College of Obstetricians and Gynaecologists to provide care to women that protected them from abuse and avoidable harm in line with Department of Health Required Standard Operating Procedures (RSOP). There was a programme of auditing determined by senior managers based at the head office.However, the recommended sample sizes used for audit purposes were small for quality assurance in a clinic the size of Richmond. Women received compassionate care. All women considering termination of pregnancy had access to advice on abortion options and contraception. Clinic staff were sensitive to the different stages of decision making that individual women had reached. Their help was tailored to age, comprehension and social circumstances. Women were able to decide on disposal arrangements for the pregnancy remains, although

Summary of findings

clinic staff did not normally discuss this except with women at late gestations. A 24-hour advice line was available for women if they had concerns following an abortion.

The clinic was responsive to women's needs. Bookings could be made through a central booking line at any time of day or night. An independent telephone interpreting service was available to enable staff to communicate with women who did not speak English. BPAS monitored its performance against the waiting time guidelines set by the Department of Health and was performing satisfactorily. Feedback was sought from women and surveys and complaints were used to identify areas for improvement.

Staff at the clinic felt supported by the head office and by regional management. Staff felt the clinic offered a good service to women and spoke positively about the need for and value of the service they offered to patients. The culture within the service was caring, non-judgemental and supportive to women, but we saw that staff did not always work well with each other. The local leadership was an area for improvement. Medical, nursing and administrative staff worked in separate hierarchies and information flows were not always good. Some staff did not consider the clinic to be well-managed.

BPAS - Richmond

Detailed findings

Services we looked at
Termination of pregnancys

Detailed findings

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Background to BPAS - Richmond

British Pregnancy Advisory Service (BPAS) provides a termination of pregnancy service at Richmond. The service at BPAS Richmond is provided from a building owned by the service and there is a satellite clinic based at Willesden, North London that is only open one day a week.

The clinic offers advice to women and the full range of abortion procedures from early medical abortion procedures up to a gestation period of ten weeks and surgical abortion procedures up to a gestation period of 24 weeks (the legal limit in most cases). Contraception for women, abortion counselling and post treatment check ups are also offered.

The clinic is open five days a week from Tuesday to Saturday. The full range of services is offered at Richmond on all these days. The satellite clinic at Willesden is open one day a week for advice from client care coordinators only.

Between 1 July 2014 and 30 June 2015, 5492 surgical terminations and 1973 medical terminations were carried out. Richmond clinic carried out 323 terminations at were 21 weeks and over. Almost all terminations, other than those for women from outside England, are paid for by the NHS.

The registered manager (RM) for the Richmond clinic had been away for some time. Her role has been covered by an RM from elsewhere in the organisation and BPAS have applied to CQC for this person to become RM for Richmond on a permanent basis.

We carried out this comprehensive inspection as part of the first wave of inspection of services providing a termination of pregnancy service. The inspection was conducted using the Care Quality Commission's new methodology of inspecting services. We did not provide ratings for this service.

Our inspection team

Our inspection team was led by:

Inspection Manager : Roger James, Care Quality Commission

The inspection team included two inspectors, an inspection assistant, a pharmacist and a specialist advisor who was an associate director and head of midwifery.

Detailed findings

How we carried out this inspection

To get to the heart of women' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place on 21 and 22 July 2015 with an unannounced visit on 25 July 2015. Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the service. These included the clinical commissioning groups (CCG) and the hospital with which the service has a transfer agreement. Women were invited to contact CQC with their feedback.

We spoke with a range of staff in the clinic, including nurses, client support workers, administrative and clerical staff, doctors and anaesthetists, and the dDirector of oOperations for London and the South East and the Associate Director of Nursing from BPAS Head Office.

Facts and data about BPAS - Richmond

BPAS Richmond is a stand-alone clinic which is owned by BPAS. The unit consists of a consultation centre with five screening rooms and four consultation rooms and an operating theatre clinic for treatment. There are 11 day beds for women after their procedure.

BPAS Richmond has been operated by BPAS since 1996. The clinic is located in a predominantly residential area.

The clinic caters for the needs of women from across England, Wales and Scotland who travel to be seen here. Some women come from overseas.

The Richmond clinic has one satellite branch, BPAS Willesden. This has two waiting areas and four consulting rooms. This clinic is currently open on Tuesdays for advice and referral to treatment at other clinics.

Notes

We did not rate this clinic during this inspection.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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The clinic is open five days a week from Tuesday to Saturday. The full range of services is offered on all these days. The satellite clinic at Willesden is open one day a week.

Between 1 July 2014 and 30 June 2015, 5492 surgical terminations and 1973 medical terminations were carried out. The Richmond clinic carried out 323 terminations at 21 weeks and over. 96% of terminations were paid for by the NHS.

We carried out this comprehensive inspection as part of the first wave of inspection of services providing a termination of pregnancy service. The inspection was conducted using the Care Quality Commission's new methodology of inspecting services. We did not provide ratings for this service.

Summary of findings

The termination of pregnancy service at BPAS Richmond clinic followed statutory guidance. However, some aspects of safety required improvement. For example, the multi dosing from single use propofol ampoules, and staff understanding and following protocols for transfer to NHS hospitals in the event of serious incidents.

The environment and equipment was generally clean, well maintained and infection control procedures were followed, although improvements could be made here.

Resuscitation equipment was available, however, the training record for the clinic did not show when staff with advanced life support training had last received training.

Staff were aware of safeguarding procedures and had received training in safeguarding adults and children, although training materials were not fully up to date.

Medicines were appropriately stored but we had concerns about the use of an anaesthetic drug, propofol for more than one patient. This drug was prepared in single patient infusion ampoules.

Women were cared for by a team of sufficiently trained doctors, nurses and administrative staff, in a process that ran efficiently and followed procedures recommended by the Royal College of Obstetricians and Gynaecologists to provide care to women that protected them from abuse and avoidable harm in line with Department of Health Required Standard Operating Procedures (RSOP). There was a programme of auditing

determined by senior managers based at the head office.However, the recommended sample sizes used for audit purposes were small for quality assurance in a clinic the size of Richmond.

Women received compassionate care. All women considering termination of pregnancy had access to advice on abortion options and contraception. Clinic staff were sensitive to the different stages of decision making that individual women had reached. Their help was tailored to age, comprehension and social circumstances. Women were able to decide on disposal arrangements for the pregnancy remains, although clinic staff did not normally discuss this except with women at late gestations. A 24-hour advice line was available for women if they had concerns following an abortion.

The clinic was responsive to women's needs. Bookings could be made through a central booking line at any time of day or night. An independent telephone interpreting service was available to enable staff to communicate with women who did not speak English. BPAS monitored its performance against the waiting time guidelines set by the Department of Health and was performing satisfactorily. Feedback was sought from women and surveys and complaints were used to identify areas for improvement.

Staff at the clinic felt supported by the head office and by regional management. Staff felt the clinic offered a good service to women and spoke positively about the need for and value of the service they offered to patients. The culture within the service was caring, non-judgemental and supportive to women, but we saw that staff did not always work well with each other. The local leadership was an area for improvement. Medical, nursing and administrative staff worked in separate hierarchies and information flows were not always good. Some staff did not consider the clinic to be well-managed.

Are termination of pregnancy services safe?

Some aspects of safety required improvement. Staff said they were encouraged to report incidents that caused harm to women or staff. Serious incidents were investigated and reviewed centrally. Learning and actions required as a result of incidents were cascaded to staff, but this process was not always timely. When investigations involved a hospital transfer, hospital staff reported that they were not always involved at an early enough stage. We were not assured that staff routinely reported all minor and non-clinical incidents, some of which could nonetheless potentially cause harm.

The clinical areas were generally clean and staff mostly followed infection control practices. Equipment was serviced and checked regularly to ensure it was safe to use. The clinic had resuscitation equipment in case anyone collapsed in the clinic. However, the training record for Richmond clinic did not show when staff with advanced life support training had last received training so it was not clear that their training was up to date.

Medicines were appropriately stored, but we had concerns about using the contents of a single ampoule of propofol, designed for single patient use, for more than one woman because this introduced a risk of infection. Nurses administered analgesics and antibiotics under Patient Group Directions. Drugs to induce abortion were prescribed by a doctor as required by law after HSA1 forms had been signed. (HSA 1 forms are used to set out the legal grounds for an abortion to be carried out and must be kept with the patient notes for three years from the date of the termination).

Women's records were completed appropriately and most were stored securely. However we saw some records stored in a general staff area which were not locked so there was a risk of disclosure of confidential information.There were sufficient suitably trained staff available to care for women and staff were up to date with mandatory training.

Staff were aware of safeguarding procedures and had received training in safeguarding adults and children. During surgical procedures, staff used a modified version of the World Health Organisation surgical safety checklist (The BPAS Surgical Safety Checklist), which was designed to prevent avoidable harm.

The clinic had a business continuity plan in the event of in the event of emergencies such as power cuts or IT failures.

Incidents

- Clinical and non clinical incidents were reported by hand on clinical incident paper forms, in triplicate. The incident reporting book was held by the clinical nurse manager who encouraged staff to report incidents. All staff we spoke with were familiar with how to report incidents. A copy of an incident relating to a woman's care was added to their case notes. There was insufficient evidence that all incidents, particularly all non clinical incidents were reported through this system. For example, transfers to a tertiary hospital, of which there had been six between July 2014 and July 2015, were only recorded as incidents when there were other complications that would necessitate further investigation. We were told subsequently that transfers were recorded separately as part of the unit transfer log, and that a transfer alert was sent centrally to a designated receivership when a transfer occurred.
- BPAS' 'Client Safety Incidents Policy and Procedure' set out the procedure for reviewing serious incidents, and involved head office staff. Complications and clinical incidents were reviewed at regional level. Serious clinical incidents at Richmond clinic were reviewed by a BPAS doctor who had not been involved in the case.
- We reviewed three serious clinical incidents (SIs) during our inspection and saw evidence of investigations and root cause analyses leading to changes to practice to reduce the risk of recurrence. For example, as a result of an incident involving transfer of a woman to hospital, changes had been made to the transfer protocol. However, guidelines and protocols were only effective if implementation was rigorous. In a recent serious incident that we reviewed we noted that BPAS staff had not followed agreed protocols for transfer to hospital.
- Where an incident involving hospital transfer required detailed investigation, both the hospital and BPAS carried out separate investigations including root cause analysis. The regional manager told us that meetings with the hospital were infrequent and there had been no joint meeting yet to discuss a serious incident that had led to a hospital transfer two months previously, in May 2015.
- The clinic recorded information on clinical incidents and near misses. A near miss is a sub-category of clinical incident, and is an event or circumstance that could have resulted in unnecessary harm but did not. There had been eight high risk and seven moderate risk incidents recorded from January 2015 - June 2015. The clinic had also recorded 19 minor complications from surgical abortions in that period (mainly retained products of conception) and 21 complications from medical abortion (mainly retained products of conception in early pregnancy).
- Although staff told us that staffing was sometimes short, staff shortage was never recorded as an incident. Nor was closure of the satellite clinic because of staff sickness. The satellite clinic at Willesden had been closed for that reason during our inspection. The main focus of reporting appeared to be on clinical incidents.
- Sessional doctors said they received a bi-annual report of all their cases from BPAS, but did not receive learning points, nor were they invited to staff meetings to discuss incidents other than SIs.

Cleanliness, infection control and hygiene

- Most areas we visited were visibly clean and cleaning schedules were displayed. We noted the edges of the stair covering were not easy to keep clean and the theatre area was rather cluttered.
- A theatre cleaning schedule was available and theatre cleaning was carried out by the domestic staff at the end of each day. . We also saw records of the six-monthly deep cleaning schedule, which was carried out by internally employed staff. Nurses cleaned up any bodily fluids during their shift.
- Staff told us infection control audits were completed by the manager. The results of the infection control audits for the month of December 2014 showed Richmond scored an average of 94% against various outcomes; the same overall score as the previous audit. Staff could not provide us with a more recent audit.
- In most areas, we observed staff complying with good practice in infection prevention and control measures. Nurses were 'bare below the elbow' to enable good hand washing and wash basins were available in almost every room. Staff had access to personal protective equipment, including gloves and aprons. However in the recovery area, we observed poor hand hygiene practice on two separate occasions; a member of staff did not wash their hands between clients and another did not wash their hands between cleaning a trolley and tending to the next client. This contravened NICE Quality Standard 61.

- The clinic had reported no incidence of methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile (C diff) in the reporting period January 2014 to December 2014.
- Laundry was carried out on site for this clinic and for one other BPAS clinic. Clinical staff were not expected to launder their uniform, wear it outside the clinic nor take it home. All uniforms were kept at the clinic.

Environment and equipment

- The clinic was based in a converted residential house over four floors. Some corridors were too narrow for a patient trolley and the lift was also narrow. Theatre trolleys did not fit in the lift, but we were told trolleys used by the ambulance service could just fit. Staff told us the lift sometimes broke down, in which case women had to use the stairs.
- There were two resuscitation trolleys (one in theatre, the other on the second floor) with emergency medicines, oxygen, suction and defibrillators. Records showed that the resuscitation trolley on the second floor was checked by a nurse five days a week. Although equipment on this trolley had not been used since 2005, all items were in date, indicating that items were checked and replaced as necessary.
- The theatre area was visibly clean although somewhat cluttered.
- We saw an up to date fire risk assessment with a fire plan for each floor of the building that had been approved by the Fire Service in May 2015. There was a designated fire marshal for each floor. Fire information was kept on laminated sheets in a folder by the rear door, and there was a copy in reception. A record was kept of everyone coming into the building so it would be clear who was in the building in the event of fire. There were two assembly points at the rear of the building. The fire alarms were tested weekly by the maintenance man; however we noticed gaps in the record when this person was absent. Alternative arrangements were needed to cover this duty.
- Asbestos was recorded on an asbestos register. There was an ongoing requirement that asbestos in the building was not disturbed. Specific authorisation and a method statement was required if work needed to be done. We saw evidence that the clinic used companies that had method statements in place.
- We saw up to date records of servicing of air conditioning, electrical installations and clinical equipment. Water had been tested for legionella, which had led to the closure of rarely used showers and regular flushing of the remaining showers.
- Staff told us a visual health and safety check was done every morning but the finding were not recorded. We noticed a broken window restrictor, and that one of the cleaning cupboards was unlocked during the day. A number of signs on doors were misleading. For example, several were labelled 'shower' although the shower had been removed, and the office labelled 'admissions' was used for discharge.
- The Willesden premises were not owned by BPAS but were part of an NHS health centre. BPAS had sole use of the area on a Tuesday. There was no receptionist but there was security within the complex. There were two waiting areas and four consulting rooms.

Medicines

- Clinicians had appropriate arrangements for obtaining medicines; a doctor signed the order and a contracted pharmacy delivered stocks to the clinic. Adequate supplies were available to enable women to have their medicines when they needed them.
- Medication was stored securely in a locked medicines cupboard. Medicines and blood requiring cool storage were stored appropriately and records showed they were kept at the correct temperature and so would be fit for use.
- Controlled drugs were stored and managed in line with national guidance. However, in the controlled drug register for alfentanyl, the dose administered to women had not been recorded correctly, i.e. the number of ampoules had been recorded rather than the actual doses.
- Surgical termination was carried out under general anaesthetic (sedation). The service used propofol as their standard anaesthetic drug. The drug was given by injection and a laryngeal mask airway was not used during the procedure. This was appropriate for a short period of sedation Conscious sedation was not used at the clinic. The BPAS medicines management policy stated that it was acceptable to multi-dose from single propofol ampoules. However, the data sheet for the drug clearly stated each ampoule was for single patient use only. We saw instructions for theatre staff to draw up

5 and 10ml syringes of propofol in preparation for the theatre list. We were told these were the capped off in preparation for use by the anaesthetists. When we observed the practice, we were concerned that a syringe could potentially be used for more than one woman.

- The clinic had a range of patient group directions (PGDs). These were up to date with a record of staff that had received training to use them, and were deemed competent to do so. This enabled nurses to ensure the safe and timely administration of analgesics and antibiotics. All PGDs were reviewed every two years in line with national guidance on patient group directions. They were ratified by the BPAS' clinical governance committee and approved by the chief executive officer (CEO).
- Prophylactic antibiotics against chlamydia trachomatis and anaerobes infections were prescribed to all women having abortions to reduce the risk of infection. Local microbiology protocols for the administration of antibiotics were used.
- Drugs that induced abortion were only prescribed by doctors. The doctor would sign the prescription after the woman had had a consultation with a nurse, and after the HSA1 form had been signed by two medical practitioners. We were told it was rare that either of the two certifying doctors had seen the women. To do so would have been good practice and is recommended in the Required Standard Operating Procedures, although not a legal requirement. Doctors relied on the nurse's summary of the facts of the woman's case, and the grounds on which she was seeking an abortion. There were always two doctors on site at this clinic. We were told that when the Willesden clinic began to offer Early Medical Terminations, the HSA1 forms would be signed remotely and electronically.
- Any medicine errors were recorded on clinical safety incident forms. We saw an example of how practice had changed following the incorrect administration of an anti-D immunoglobulin injection to a woman.
- The clinic had procedures for checking that medicines were correctly labelled with the woman's name, date and instructions on how to take them when medicines were given out on discharge.
- Medicines were safely disposed of by placing them in a dedicated disposal bin that could be tracked to the place of origin.

Records

- Women's records (called case notes by BPAS staff) were completed by hand on pre-printed templates. They were stored in lockable cabinets in the staff room, which was also used by non-clinical staff. However, these cabinets were sometimes left unlocked during the day which was a confidentiality risk.
- We reviewed 25 sets of notes. They were generally well completed with legible dates, times and designation of the person making the documentation. However, sometimes information was very brief; for example the record of discussion on the reason for abortion and we found a few handwritten notes that were hard to read.
- Some of the nurses were not accredited sonographers so the results of scans were checked by the clinical nurse manager. We were told the quality of scans of every practitioner were audited by a BPAS lead sonographer every two years.
- Although we had been told that no records were kept at the Willesden clinic, we found some records there in a locked drawer. The two sets of notes related to women referred externally to hospitals for medical issues and there appeared to have been a delay in forwarding these. We were told women usually carried their own notes to their appointment at another BPAS clinic, although we were told notes were occasionally sent by post.

Safeguarding

- A nurse was the designated safeguarding lead at the clinic. If she had concerns about the welfare of a woman, she could escalate the case to the national clinical lead. Staff at the clinic knew who the safeguarding lead was and when to seek advice. The policy stated staff were required to be trained to level 3 in child safeguarding although staff themselves were uncertain of the level of their training. Eighty-one per cent of staff were trained to level 3 in safeguarding children.
- Staff had easy access to the policy "Safeguarding and Management of Clients Aged under 18 Policy and Procedure". This policy had been updated in 2014 so it did not take account of the revision to 'Working Together to Safeguard Children March 2015', which reflected some government decisions relating to child sexual exploitation. That government document was not referred to in the policy nor was there a copy in the staff room folder on safeguarding.

- Staff told us correctly, they would not necessarily report Female Genital Mutilation (FGM) in an adult as a safeguarding concern. They recorded client numbers of women with FGM in an anonymous register. However, staff were not aware that if a woman with FGM had children who might be a risk of FGM, it was a Department of Health requirement (Female Genital Mutilation Risk and Safeguarding: Guidance for professionals. DH March 2015) to report them. This was not covered in the safeguarding policy.
- Young women aged under 16 years were assessed by using Gillick competence and Fraser guidelines to assess whether the individual had the maturity to make their own decisions and to understand the implications of those decisions. Those under 16 years old were recommended to involve their parent or another adult to provide support. A safeguarding risk assessment was carried out and a decision made on the outcome of the assessment, following discussion with the designated safeguarding lead at the clinic.
- We reviewed five records of young people under 16 years which showed staff followed appropriate procedures, that risk assessments were carried out and a safeguarding referral was made to the local authority where the young woman lived when appropriate. Between January 2014 to June 2015 the Richmond clinic had not treated anyone under 13 years. Staff knew that it was a BPAS policy that if a 12 year girl used the clinic, a safeguarding referral would automatically be made.
- Safeguarding risk assessments on adults were carried out appropriately. When there was a suspected case of abuse a safeguarding referral was made to the safeguarding team where the woman lived.

Mandatory training

- Mandatory training covered topics such as fire safety, health and safety, manual handling, infection control, information governance and level 3 child safeguarding. Most training was face to face but information governance training involved watching a DVD. The interim unit manager maintained the training records.
- Data provided by the clinic showed staff were 100% up to date with mandatory training as of April 2015. There were reminder systems for staff to prompt them when they were overdue for their mandatory training.

Assessing and responding to the risk to women

- All women were asked about their medical history, including whether they had any known allergies. On the basis of this, staff assessed the suitability of women for treatment referring to the BPAS suitability for treatment guidelines. Contra-indications might be high BMI, epilepsy or anaphylaxis. Women not suitable for treatment at a standalone clinic such as Richmond were referred to the NHS. In February 2015, six women and in March 2015, three women were referred to specialist hospitals because of other medical problems.
- All women seeking abortion were assessed on the day of their procedure for the risk of venous thromboembolism (VTE) in line with BPAS policy. Risk of bleeding was not routinely assessed. The risk was documented in the woman's record and included actions to mitigate any risk identified. Audits showed that VTE assessments were routinely completed on the day of treatment on all women having an abortion.
- All women also had a blood test to identify whether their blood was Rhesus negative, in which case they would have an anti-D immunoglobulin injection to protect them against complications in any future pregnancy. This was in line with national guidelines.
- The clinic declined treatment on women who were unwell on the day of their procedure or had not fasted. Seven women had been declined treatment either by the doctor or the anaesthetist between 1 January and 30 June 2015. All were re-booked and treated.
- During surgical procedures, staff used a modified version of the World Health Organisation checklist', which was designed to prevent avoidable harm. The operation department practitioner (ODP) read out the checklist while the woman was in the anaesthetic room. Sign out was carried out by the scrub healthcare assistant (HCA) contrary to the recommendations of the Association for Perioperative Practice (APP), which states that sign out should be done by a registered person. We also observed that a swab count was undertaken at the end of procedure but not at the beginning when the swab bag was opened. APP recommends that the same two people should count items (one person a nurse or ODP registrant) before and after a procedure.
- The clinic audited the surgical safety checklist using a BPAS checklist audit tool. Only three cases were looked at each month which was a very small proportion for a

clinic of this size. The June 2015 audit showed that the compliance of the Richmond clinic was 100%. In May 2015, the score had been 93% because introductions had not been done at the start of the list.

- Women who wished to leave the clinic following oral administration of misoprostol tablets were allowed to complete the abortion at home. We saw that women were offered support and robust follow-up arrangements if they chose this course.
- Nurses had access to medical support in the event a woman's condition deteriorated. The anaesthetist was expected to remain on site until the last woman had left the recovery unit. The doctor had to be contactable until the clinic closed. We reviewed one serious incident where this policy had not been followed.
- When a woman was transferred to NHS services for emergency assessment/admission, they were accompanied by a nurse or doctor and a photocopy of their notes was given to the hospital. Women with a suspected ectopic pregnancy or other pregnancy concern would be referred to an Early Pregnancy Unit, an out-of-hours service or an accident and emergency department. Six women had been transferred to hospital between July 2014 and June 2015. This was a small number in proportion to 7464 procedures undertaken at the clinic.
- A staff member, without training and who was not the health and safety officer, carried out a health and safety risk assessment every six months, using a generic BPAS form. The assessment included clinical areas for which the form was not well suited because it did not include clinical safety standards. This method was in itself a risk.

Nursing staffing

- There were five full time registered nurses working at the clinic. A further five nurses were employed for set weekly contracted hours of between 16.25 and 36 hours a week. Five Health Care Assistants (HCAs) also worked several different hourly patterns.
- There were 20 working time equivalent nurses. The vacancy rate for registered nurses was 22%. In addition, there were two HCA vacancies and an ODP vacancy. The ward manager ensured all nurses were on the Nursing and Midwifery Council Register. New staff did not always stay long at the clinic.
- The clinic had a bank of nurses to cover absences, but also used agency staff. Several different agencies were used, but in each case there was a service level agreement that nurses must have relevant training. We saw a standard induction checklist for agency staff.
- Three HCAs worked in the theatre and an Operating Department Practitioner (ODP) supported the anaesthetist.
- The clinical nurse lead and the theatre manager at the clinic were both generally supernumerary so could fill gaps if staffing fell short.
- There was currently no nurse at the Willesden clinic.

Medical staffing

- A doctor and an anaesthetist worked in the operating theatre every day. The Regional Clinical Director for BPAS's London and South East Region was a full time employee of BPAS and he carried out abortions on two days a week at the Richmond clinic.
- Anaesthetists and some other doctors worked under practising privileges. Staff at the head office were responsible for checks on doctors' qualifications, insurance, registration, disclosure and barring service checks (DBS) and revalidation reports as well as granting practising privileges.
- The training record for Richmond clinic did not show when staff with advanced life support training had last received training.

Other staffing

- Most of the 40 administrative staff were part time; some as few as six hours a week, and had worked there many years. The role of reception staff was to greet clients, answer the telephone, ensure notes were ready for theatre lists, prepare letters for discharge and collect fees from women not funded by the NHS.
- Client care coordinators were responsible for initial conversations with women about their options. Only one worked full time, others were part time, some working only six or nine hours a week.
- The clinic also employed domestic assistants, a catering assistant, a maintenance man and a driver.
- The role of client care coordinator at Willesden clinic was covered by a person from another BPAS clinic,not from Richmond clinic. There were no other staff working at that clinic.

Termination of pregnancy

Security

- There were usually anti-abortion protestors outside the Richmond clinic. Staff called the police if there were problems or interference with staff and women accessing the clinic by the protestors.
- We had some concern that the coordinator at the Willesden clinic worked alone on the one day a week that clinic was open. Some women would come for appointments with a partner and people could be quite assertive. We were told that the plan was for Willesden clinic to become a treatment clinic and there would then be a nurse present in addition to the client care coordinator.

Major incident awareness and training

- The clinic had a business continuity plan and staff we spoke with were aware of the procedure for managing incidents such as fire or power cuts. Staff understood evacuation procedures but had not rehearsed these or transfer to hospital scenarios.

Are termination of pregnancy services effective?

Care was provided in line with national and statutory guidelines. Nurses offered women appropriate pain relief, prophylactic antibiotics and post-abortion contraceptives. The clinic performed audits recommended by Royal College of Obstetricians and Gynaecology (RCOG) such as infection control, consent to treatment, discussions about options for abortion and contraception. Pregnancy and gestation was confirmed by ultrasound.

Staff referred to as 'client care coordinators, who provided the pre and post abortion counselling service had undergone BPAS training. They were all experienced in counselling in this field, but told us they were able to refer women to other counselling services, if a woman's needs warranted more in depth counselling

Not all staff had had an annual appraisal.

Medical staff, nursing staff, client support workers and other non-clinical staff each had clearly defined roles but some staff felt that teams did not always work cohesively..

A telephone advice line for women was available 24 hours a day. Nurses rather than doctors obtained consent from women.

Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLs). Staff understood the need to ensure that women had capacity to make an informed decision. They also identified the need to act in the person's best interest, seeking advice and making joint decisions with others when there were concerns about a person's capacity to understand.

Evidence-based care and treatment

- The clinic adhered to the guidelines of the Royal College of Obstetricians and Gynaecology (RCOG) for the treatment of women for termination of pregnancy for foetal anomaly and ectopic pregnancy.
- BPAS policies were centrally developed at the organisation's head office in line with Department of Health Required Standard Operating Procedures (RSOP) guidelines and professional guidance. We did not see any local written policies.
- A range of contraception methods were available, including long acting reversible contraception (LARC) methods which was considered to be most effective and was recommended by the National Collaborating Clinic for Women's and Children's Health. The audits of records showed that the clinic was 100% compliant in discussions about contraceptive advice.
- All women had an ultrasound scan to determine the gestation of the pregnancy in line with the BPAS clinical guidelines. Women were asked in advance if they wished to see the images.
- All women were tested for chlamydia infection (chlamydia is a sexually transmitted bacterial infection) before treatment. Staff risk assessed women for other sexually transmitted infections (STIs). Some clinical commissioning groups (CCGs) required women from their area to have specific tests. Women with positive test results were referred to sexual health services. This met RCOG guidelines.
- Senior management at BPAS head office asked its clinics to carry out audits recommended by RCOG such as on consent for treatment, discussion of different options of abortion, contraception discussion, confirmation of gestation and medical assessments. Auditors used standard tick box checklists, completed by hand. Clinic staff collated local results and reported them to to the regional office for further consideration. The regional manager believed this system provided robust independent scrutiny of results which fed into BPAS'

clinical governance. A monthly dashboard of the main audits highlighted potential risks but did not show trends. We considered the sample size used for the standard audits to be small in relation the size of the Richmond clinic.

- Senior management at the BPAS head office had developed an infection control annual audit plan to monitor and control infection and to maintain a clean environment. An annual cycle of audits focused on one topic a month; for example in May it was medicines and theatre processes was done in June. The Richmond clinic's scores were 100% for infection control, although we had observed that hand washing was below expectations. We were not aware of any spot checks on safety being undertaken by the clinic. BPAS head office expected all its clinics to score over 90%.
- BPAS policy was for clinics to carry out monthly HSA1 audits to ensure compliance. However, staff at this clinic had carried out no audits between November 2014 and March 2015. The results of the June and July audits demonstrated 99% and 97% respectively, compliance with the legal requirements in relation to HAS1 forms. There was no evidence of the pre-signing of HSA1 forms. This audit did not apply to Willesden, where no terminations were currently carried out.
- Operating theatre staff were unsure if NICE guidelines were used in theatre. We did not see evidence of spot checks as recommended in NICE quality standard QS49.
- We were told that record keeping audits and pre-operative assessment record audits were undertaken monthly. However, the most recent case note audit for Richmond was for March 2015. Richmond's score was 92% (March 2015). The comparable figure for Willesden was 97%. The manager selected a random sample of five records for review. For a clinic as busy as Richmond this was a small percentage of records. Actions to address improvements were recorded as brief manuscript notes and there did not seem to be a formal process to ensure maintenance of standards.
- In line with the Department of Health RSOPs the clinic gave women a choice of abortion method appropriate to their gestation. The operating theatre had access to ultrasound as recommended in RSOP guidelines, although it was not routinely required.

Pain relief

- Pain relief medication was administered by nurses according to BPAS protocols.
- Women choosing medical abortion and returning home were given advice on the use of painkillers at the first sign of pain, the appropriate dosage, and a hierarchy of painkillers if non steroid anti-inflammatory drugs (NSAIDs) proved not sufficient. The booklet provided to women included space to record when their pain relief was next due, to ensure women knew the correct time intervals for taking pain relief.

Outcomes for women

- The clinic reported statistics to commissioners on spend, activity levels, ages of patients and treatments by age and type. A senior manager told us that they reported known cases of continued pregnancy and other complications but such information often relied on women contacting BPAS by using the telephone advice line and the clinic had no way of whether women presented at A&E departments post abortion. When the clinic was informed of a complication, staff completed a form that was added to a woman's notes. Feedback on outcomes was monitored by the quality leads and information was cascaded to clinics through meetings.
- Women undergoing medical abortion were asked to ensure they carried out a pregnancy test two weeks after their procedure to ensure it had been successful. Women could return to the clinic if they had any concerns.
- BPAS carried out the audits recommended by RCOG such as consenting for treatment, discussions related to different options of abortion, contraception discussion and confirmation of gestation
- Women who had undergone treatment were offered a follow up appointment but nursing staff told us that fewer than 3% of women attending the Richmond clinic took up this offer .

Competent staff

- New staff were supported through an induction programme and competence-based training appropriate to their role. For example, a client care coordinator would attend the 'BPAS Client Support Skills and Counselling and Self-Awareness' course and be assessed against the client care co-ordinator competency framework. At Richmond, the staff advising women pre-abortion had provided counselling service for many years.

- Nurses had completed a two day scanning course, although some were not accredited to undertake transvaginal ultrasound scans. Their scans were reviewed by the clinical nurse manager who was fully accredited.
- Staff had access to specific training to ensure they were able to meet the needs of the women they delivered care to. For example, staff had attended training in 'Welcoming Diversity' to ensure they recognised different cultural needs and beliefs. Women were asked about their faith.
- Most staff told us they had regular annual appraisals. Information provided by BPAS showed that 100% of medical staff, 93% of nurses and 70% of other clinical staff had completed an appraisal in the time period between January 2014 to December 2014. Staff told us they were supposed to have 'job chats' three times a year but not all staff had these chats within the last year. Some staff said they did not receive and constructive feedback, and this was borne out by the staff survey.
- Sessional staff, such as anaesthetists, were kept informed of changes of policy by email and were required to confirm in writing that they had read the document. We were told these doctors received a twice yearly report of their own cases but were not involved in shared learning.

Multidisciplinary working

- Doctors, nurses, care coordinators and other non-clinical staff worked together as a team.
- Staff had links with other agencies and services such as local safeguarding teams and early pregnancy units at local hospitals.
- BPAS Richmond had a service level agreement with neighbouring NHS Trust which allowed them to transfer women to the hospital in case of medical or surgical emergency.

Seven-day services

- The clinic was open five days a week and carried out procedures every day between Tuesday and Saturday. The clinic was closed on Sunday and Monday.
- A 24-hour advice line specialising in post abortion support and care was provided in line with the Department of Health's RSOP standards. Staff at the clinic could follow up a woman treated a Richmond clinic with a phone call or by offering a further appointment at the clinic.

Access to information

- All policies were available on the intranet and some printed policies were kept in folders in the staff room.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed four consultations where appropriate discussions and referral pathways were discussed.
- We observed, during the consultation that nurses asked women for consent and explained the risks appropriately and correctly. Consent was re-confirmed when the woman saw the second nurse. The care records we reviewed contained signed consent from women. Possible side effects and complications were recorded and the records showed that these had been mentioned to women.
- When women expressed any doubts, staff carefully discussed their concerns. Women were offered a second consultation if they were not entirely sure about their decision to terminate the pregnancy, so there was no pressure on women to decide to have an abortion.
- A nurse discussed contraceptive options with women at the initial assessment and agreed appropriate contraception after the abortion. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards and understood the need to ensure that women had capacity to make an informed decision. They also identified the need to act in the person's best interest, seeking advice and making joint decisions with others when there were concerns about a person's capacity to understand.

Are termination of pregnancy services caring?

Staff treated women with compassion and respect. Consultations were held in private rooms. All women had a chance to speak with a nurse on their own to establish that the woman was not being pressurised to make a decision. Aside from this, women could be accompanied by a friend or family member.

Women's choices were respected. Their preferences for sharing information with their partner or family members were established and reviewed throughout their care. The staff explained the different methods and options available for abortion. If women needed time to make a decision,

this was supported by the staff. Post-abortion counselling was offered, although take up was very low. Sensitive support was given to women who underwent termination of pregnancy due to foetal anomaly. Women who wanted to dispose of foetal remains in line with their beliefs and faith were provided with the relevant information.

Compassionate care

- Throughout our inspection, we observed staff treating women with compassion and respect. Consultations took place in private rooms and women's privacy was respected when scans were carried out. In the recovery areas, curtains were drawn so women could not see others in the room, although conversations could be overheard.
- We observed positive interactions between women and nurses, and women and client care coordinators. Staff introduced themselves and explained their role to women attending the clinic. However, during one procedure, we observed staff did not introduce themselves to the woman in the anaesthetic room.
- Staff asked women about their preferences for sharing information with their partner or family members. Staff treated women with respect and reviewed their care throughout their time at the clinic. Children under the age of 16 were encouraged to involve their parents or a family member and their wishes were respected.
- Women were encouraged to offer feedback through a satisfaction survey, "Your opinion counts". The surveys demonstrated high satisfaction with care. The response rate for feedback was 40% in the period from January 2015 to April 2015.

Understanding and involvement of women and those close to them

- During the initial assessment, staff explained the available methods for termination of pregnancy that were appropriate and safe to the woman at her gestation period. A woman's height and weight were measured. If women needed time to make a decision, this was supported by the staff and women were offered an alternative date for further consultation.
- Women could ask for a chaperone to be present during consultations and examinations.
- Women were involved in their care. They did their own swabs for STI testing and if having a medical abortion, were given the option to insert their own pessaries (a pessary is medication that is inserted directly into the vagina or cervix). Clinical staff explained to the women how to do this.
- Records reviewed showed that there were occasions when women changed their minds about terminating their pregnancy. Staff told us that in these circumstances the women were referred for scans and antenatal care.
- Women were asked if they agreed to BPAS informing their GP about the procedure they had undergone. Women's decisions were recorded and their wishes were respected. Women's confidentiality was further protected by the clinic arranging necessary maintenance on Mondays, when the clinic was not open to women. This met the requirements of NICE Quality Standard 15, Statement 13.

Emotional support

- All women had discussions with an experienced client care coordinator about their situation and needs. We observed that women who were upset, anxious or unsure about their decision, were given extra time and support.
- Staff gave women sensitive support if they were having a termination of pregnancy due to foetal anomaly. Staff told us they encouraged the person attending with the woman to be involved in their care as much as possible. For example, they could accompany their partner into the anaesthetic room. The treatment and appointments of such women were prioritised.
- Staff told us they would initiate discussions with women having terminations at late gestations about the disposal arrangements for pregnancy remains, but for early terminations staff were led by the woman so as not to cause undue distress. The document that all women received, "My BPAS guide" referred briefly to the options for disposal of pregnancy remains. Women's wishes were respected if they wanted to see the pregnancy remains or take them away for burial or cremation. Staff provided local information about this.
- The clinic offered post-abortion counselling sessions if required and could also refer women to specialist organisations for further support.

Termination of pregnancy

Are termination of pregnancy services responsive?

Women booked their appointments through a central BPAS telephone booking line which was open 24 hours a day throughout the year. A fast track appointment system was available for women with higher gestation period. Women could refer themselves and about a third were referred by a GP.

The clinic monitored its performance against the waiting time guidelines set by the Department of Health. The clinic saw 87.8% of women within the target of seven days from 'booking' to 'consultation'. Staff treated 76% of women within the seven-day target from 'decision to proceed' to 'treatment'. Delays were in some cases related to the woman's choice. BPAS reported the figures to commissioners quarterly. We heard several women or their partners complain about waiting times once at the clinic and noted that staff were aware that this was a concern although they did not record informal complaints of this kind. Staff told us that all women would have been warned by call centre staff that they might have to spend all day at the clinic.

An independent telephone interpreting service was available to enable staff to communicate with women who did not speak English. There was a clearly defined specialist referral process for women who had additional medical needs making them unsuitable for treatment at the clinic.

Formal complaints were managed centrally by the complaints manager and the patient engagement manager. Clinic staff carried out a full investigation of complaints which they forwarded to the head office. Feedback was given to the staff and complainant. There had been four formal complaints between January and June 2015. Examples of changes in practice as a result of complaint were that the clinic now limited the number of staff entering the anaesthetic room, and staff had been instructed not to discuss clinic or personal matters in front of women.

Service planning and delivery to meet the needs of local people

- The regional office planned the service in discussion with clinical commissioning groups (CCGs). Local staff at the clinic were not involved with the CCGs.
- Women booked their appointments through a central 24 hour telephone booking line. Women could specify an appointment at Richmond, but would also be told of possible dates at BPAS clinics within a 30 mile radius so they could attend the most suitable appointment for their needs and as early as possible. Some women chose to book appointments at some distance from their homes to increase their anonymity.
- A fast track appointment system was available for women with a higher gestation period or those with complex needs.
- Every abortion provider is legally required to notify the Chief Medical Officer of every abortion performed in England using form HSA4. These contribute to a national report on the termination of pregnancy. We saw this was mentioned to women in the initial consultation, and women were reassured that data supplied by the clinic was anonymised.

Access and flow

- Most women referred themselves and about a third of women were referred by their GP. Richmond clinic offered all aspects of pre-assessment care, discussions about pregnancy options , date checking of scans to confirm pregnancy and gestation period and medical assessments. Female sterilisation was not offered at this clinic.
- Between 1 July 2014 and 30 June 2015, Richmond clinic carried out 5,492 surgical terminations. There were 1,973 medical terminations in that period. Three hundred and twenty three terminations were carried out at gestation periods of 21 weeks and over.
- The clinic monitored its performance against the waiting time guidelines set by the Department of Health. In the first quarter of 2015, staff saw 87.8% of women within the target of five working days from 'booking' to 'consultation'. The clinic treated 76% of women within the five working day target from 'decision to proceed' to 'treatment'. Delays were in some cases related to the woman's choice of timing and clinic, or the need for further investigations prior to treatment. BPAS reported the figures to CCGs quarterly. During the previous year, (2014), 5% of women (370) waited over 10 working days from their consultation appointment to their treatment appointment.

Termination of pregnancy

- Staff reported that women complained that the waiting time when they were at the clinic were too long; they could spend all day at clinic, and had to wait again for follow up. We saw women complaining to reception staff. Staff told us women were all informed about waiting times at the time of booking. The clinic did not routinely monitor on site waiting times. Plans were in hand to streamline the process for women and reduce the number of different staff women saw during their visit. Currently, women started their pathway on the lower ground floor. They saw an advisor first , then a nurse. Women then went to the ground floor waiting room to be seen by the receptionist and another nurse before treatment.
- Women attending the Willesden clinic were only able to have a 15 minute pregnancy options discussion and then had to be referred to a nurse at another clinic for further assessment and treatment.
- Same day treatment for early medical abortion was available for both medical and surgical abortion. Although women liked the convenience of a single clinic visit, this increased waiting times. A woman might have their pregnancy options discussion and scan in the morning but not be treated until the afternoon.
- About 12% of woman did not attend pre-booked appointments. Some women were known to visit more than one abortion provider and choose the one they preferred. We saw an example of this on our visit, from a woman who had chosen Richmond over another clinic.

Meeting people's individual needs

- An independent telephone interpreting service was available to enable staff to communicate effectively with women who did not speak English. Consent forms were available in different languages on the website for such women.
- The clinic provided a pathway for women seeking to end a pregnancy because of a foetal abnormality. These women were given an information booklet and received sensitive treatment from staff. There was a separate waiting area for these women and their partners could accompany them to the anaesthetic room. Women could take away ultrasound pictures or footprints as a memento. Additional testing could also be carried out by the hospital where the woman had had her antenatal care, if she had been referred by the hospital. Additional testing was an option for women who referred themselves, but there would be a charge for this.
- The clinic followed BPAS's policy on advising and treating women with a learning disability. The number of such women seen had been very small; two or three in the year to date.
- The clinic treated fit and healthy women who were medically stable. Staff completed a referral form for women who did not meet the suitability criteria. Referrals were managed by a specialist referral placement team. This was a seven day service. Women were referred to the most appropriate NHS provider to ensure that they received the specialist treatment they required in a timely and safe way.
- The regional manager maintained that BPAS internal research had shown that most women did not want to make decisions about disposal of foetal remains but that staff would support women who had specific wishes; for example in Islamic teaching, all remains must be buried. We witnessed an instance of a woman making a decision about taking the remains for burial. BPAS did not offer cremation or burial.
- The 'My BPAS' guide provided brief information about disposal of pregnancy remains. When women did not have specific wishes with regard to disposal of the pregnancy remains, they were collected in individual containers, in the case of later terminations, and stored separately from other clinical waste. They were kept in a freezer until an external contractor collected them.BPAS will assist any client in the arrangements with regard to burial or cremation and will liaise with funeral directors and other agencies to facilitate this to the client's satisfaction. BPAS would assist women in arrangements for burial or cremation and would liaise with funeral directors and other agencies to facilitate this to the women's satisfaction. The woman would pay for the costs of burial or cremation.
- Terminations were not offered to women if their pregnancy did not show on a scan. Staff said the booking service sometimes referred women to a clinic too early in their pregnancy which meant those women had to return for a second appointment.
- Abortion protesters were outside the clinic almost every day. Women were warned about this when booking appointments, and BPAS offered a feedback form specifically for women to comment on the protestors if they wished. Police had been called on occasions to support the women and their partners.

- The clinic was not easily accessible to wheelchairs users and we were told that the booking line would generally refer women using wheelchairs to a more accessible clinic.
- All women attending a BPAS clinic received a copy of 'My BPAS Guide', which contained information about options for termination of pregnancy and potential risks. A suite of the key sections of the My BPAS Guide in a variety of other languages was accessible for staff to print from the BPAS Intranet which was an effective and cost-effective way to approach translation needs. The website could be viewed in some other languages such as French and Somali.
- BPAS had its own booklet about contraception and some commercially produced leaflets were also on display as well as posters about sexual health services. In addition, leaflets were given to women to inform them of what to expect after the procedure. This included a 24 hour telephone number, through which women could seek advice if they were worried.
- The certificate of approval for carrying out termination of pregnancy (issued by the Department of Health) and CQC registration were not displayed prominently. They were in corridors rather than waiting areas so many women would not see these.

Learning from complaints and concerns

- Surveys of women showed that 90% thought waiting times to treatment were acceptable. Satisfaction with the appointment itself was high. Around 98% to 100% of women were aware of how information about their abortion was used, for example in reporting anonymised data to the Department of Health. 100% of those who responded believed their personal information was confidential and that their GP did not have to be told. Women were less satisfied about information available to their escort; only 70% reported that information sharing with their escort was good. Some people posted feedback on NHS choices and the head office responded to these.
- Women were given information about how to raise a concern or make a complaint through leaflets on display: Complaints and Feedback Policy. This included information what happened when a complainant was not satisfied with the response to their complaint . Information on how to make a complaint was also included in the 'my BPAS Guide'
- The clinic kept a log of informal complaints. We reviewed the six recorded since January 2015. The interim site manager spoke to women who raised concerns informally to try to resolve them. However, the clinic did not record complaints about waiting time that we heard being made to the receptionist during our inspection, so there may be some under-reporting of complaints.
- Formal complaints were reviewed regionally by a complaints manager and patient engagement manager. A full investigation of a complaint was carried out and feedback was given to the complainant. We saw four formal complaints raised between January and June 2015.
- Staff said complaints management was discussed as part of the corporate induction days.

Are termination of pregnancy services well-led?

Local leadership at the clinic requires improvement. We were concerned about the leadership and management arrangements. There was no on-site manager at Richmond who was responsible for the overall leadership of the clinic and some staff did not think they were kept well informed about changes.

Regional managers told us about the organisation's value of treating all women with dignity and respect and to provide confidential, non-judgmental services. Local staff at the clinic were less sure about the values of BPAS and they did not recognise the written values.

There was a clear governance structure centrally and regionally to manage risk and quality, including an audit programme that met the audit and quality recommendations of RCOG, even though the samples were small. There was an established process for shared learning. However, at clinic level, these activities were seen as processes to be carried out, often on very small sample, rather than part of staff's own local responsibility of managing the clinic. Staff felt supported by regional managers.

The culture of the clinic was caring and supportive to women. Staff believed they offered high quality care.

Termination of pregnancy

Vision and strategy

- BPAS's mission was 'To be the leading UK provider of reproductive health services and champion of reproductive choice raising and advocating standards for health care in the UK'. Its strategic goals included providing high quality, affordable sexual and reproductive health services and performing in line with budget'.
- Staff at the clinic were passionate about providing a service that women needed and they wanted to give really good care, but few were closely engaged with the corporate objectives. Staff were keen to make the pathways more efficient and smoother for women by reducing the number of different assessments. However, it was clear that the changes would have implications for the jobs of some long-serving staff and this was creating some uncertainty.
- The Willesden satellite clinic provided a very limited service. It provided a clinic in the area because the CCG wanted one. The longer term intention was to provide early medical abortion there.

Governance, risk management and quality measurement

- Governance took place at national and regional levels. There was a Clinical Governance Committee, Research and Ethics Committee, Infection Control Committee, Information Governance Committee and Regional Quality, Assessment and Improvement Forums (RQAIF). The national medical director took a lead role in ensuring the organisation was working in line with current national guidance. The London and South East RQAIF met three times a year and maintained oversight of all services in the region which included the Richmond and Willesden clinics. This forum reported to the organisation's clinical governance committee. The forum included a lead nurse, a client care manager, doctor, nurse, clinical lead and associate director of nursing. At each meeting they reviewed complaints, incidents, serious incidents, audit results, complications, patient satisfaction and quality assurance for point of care testing and declined treatments. We saw from forum records that minutes were shared with staff. Minutes from RQAIF were also shared at the regional managers meetings who were expected to ensure that learning was shared with staff. Staff at Richmond were aware of this process.
- A BPAS team brief was circulated to managers quarterly and included generic, financial, marketing and clinical elements. New policies were launched via a conference call which was recorded and available for a month to enable staff to listen to it. This was a further mechanism for decisions from the centre to reach clinics.
- Even though Richmond was a large clinic by BPAS standards, staff said that board members did not visit the clinic. Some staff considered there were limited opportunities to feed information upwards to the regional or national office.
- Local clinic staff were not involved in identifying and managing risks specific to the Richmond clinic. They viewed risk as a regional office concern. We were shown a clinic risk register for Richmond clinic which was high level and generic with the people named as responsible being mainly in the head office. It appeared to have been drawn up by head office. It did not include local risks that were specific to Richmond clinic over which local staff could have some control. For example, the relationship with the specific transferring hospital and the importance of adherence to protocols, the specific local issues of protestors and relationship with residents in Rosslyn Avenue, the occasional breakdown of the lift especially as the operating theatre was not on the ground floor, nor the occasional overcrowding in the car park which meant the ambulance bay was not clear at all times. None of these issues, which staff recognised as risks when we spoke with them, were documented on the risk register for Richmond clinic or owned by clinic staff to ensure that the risks were mitigated in practice. For the Willesden clinic we would have expected to see lone working on the local risk register, but we did not see a local risk register for that clinic at all.
- The clinic complied with legal requirements. The assessment process for termination of pregnancy legally requires that two doctors agree on at least one and the same ground for the termination and sign a form to indicate their agreement (HSA1 Form). We looked at 25 sets of notes and found that all forms correctly included two signatures and a stamp with the doctors' names, and the reason for the termination as entered on the form by the nurse or client care coordinator. However, in none of the cases we reviewed, had either doctor signing seen the woman prior to the termination. There was no detailed evidence of consideration of where the

threshold of risk to the physical or mental health of the woman lay. Doctors had limited time between procedures to read and sign case notes and sign prescriptions.

- Every registered medical practitioner is legally required, under the Abortion Act 186, to notify the Chief Medical Officer (CMO) of every abortion performed in England and Wales, whether carried out in the NHS or an approved independent sector place and whether or not the woman is a UK resident. The notification form is HSA4. These forms provided data for a national report on the termination of pregnancy. Doctors confirmed they signed HSA4 forms online within 14 days of completing abortions. Administrative staff completed the forms based on the doctors' operating notes.
- The clinic maintained a register of women undergoing a termination of pregnancy, in line with the requirement of regulation 20 of the Care Quality Commission (Registration) Regulations 2009. This was completed in respect of each person at the time the termination was undertaken and was retained for a period of three years beginning on the date of the last entry.
- Woman from outside England and Wales paid fees to cover the cost of the service. BPAS did not aim to make a profit. Fees were published on the website. There was a lower fee for women from Ireland in specified circumstances.
- Some staff we spoke with had limited understanding of the duty of candour and said they had not received training in this.
- The learning and actions from incidents were cascaded to clinical staff at local meetings. We were told that team meetings were held and minutes were shared with staff who were not able to attend. We saw some meeting notes. However, some staff said that communications within the clinic were often informal and information sharing was not very robust so some staff felt they were not well informed on issues.

Leadership of service

- Some staff working at the Richmond clinic felt well supported by their clinic manager and regional manager and told us they could raise concerns with them. They also said the associate director of nursing was approachable and helpful.
- BPAS had applied to CQC to register another manager of a cluster of BPAS clinics who could act as RM for this site. This manager would not be expected to be at the clinic more than a day a week. We had concerns that this level of attendance would not provide sufficient leadership and that it could be a heavy responsibility to take on Richmond clinic in addition to the other clinics the person already managed . The registered manager has a legal responsibility for managing the carrying out of the regulated activity of termination of pregnancy, and that it met the regulatory and other legislative requirements, as well as ensuring that the service met national standards of quality and safety. Managers and staff at the clinic showed a limited understanding of the new care regulations, called the fundamental standards, against which CQC assessed performance and the provider had not provided training for managers on the legal responsibilities of registration with CQC. The application was still pending at the time the report was written.
- The interim manager was responsible for administrative staff, a doctor was responsible for medical staff and a clinical nurse manager for nurses. There was no onsite manager with responsibility for the overall leadership of this large clinic.
- It was recognised that the mutual relationship with the transfer hospital had room for improvement, because agreed protocols had not always been followed and some transfers had been of women with quite serious complications and at a late stage. Steps had been taken to improve partnership working.

Culture within the service

- Staff displayed a compassionate and caring approach to women.
- Senior staff told us they could openly approach regional or national managers if they felt the need to seek advice and support. However, staff within the clinic said some of the onsite managers were less approachable.
- Some of the staff we spoke with were happy working at the clinic, others felt the leadership and culture of the organisation was regimented and that some managers did treat all staff equally. Some staff observed that a significant proportion of staff had worked at the clinic a long time and some were not open to change and were not always supportive of newer staff. This may have contributed to staff turnover among newer recruits.
- The absence of a Registered Manager for some months had led to some planned changes being put on hold. This added to the uncertainty among some staff about

the impact of planned organisational changes, such as the future role of advisers. Following out inspection, we were told in September that the registered manager was returning to work on a phased basis.

Public and staff engagement

- Women attending the clinic were given feedback forms which asked for their opinion of the service. Staff however, told us that due to the sensitivity of the procedure and the emotional experience for the women, it was sometimes a challenge to engage with women and obtain a high enough response rate to questions. However, the analysis of feedback from surveys showed overall satisfaction with care.
- Staff surveys were run annual to gain staff opinion of working at the clinic. We noted that some staff did not feel valued or able to speak up, which corroborated what we found in speaking with staff.

Innovation, improvement and sustainability

- Staff were proud of the pathway the clinic offered for women having terminations on grounds of foetal abnormalities (TOPFA). They considered the arrangements sensitive as well as offering a choice of method not generally available in the NHS.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure all staff understand and follow protocols for transfer to NHS hospitals in the event of serious incidents.
- Comply with the practice recommended by the product manufacturer, NHS England and the Royal College of Anaesthetists and discontinue multi-dosing from single patient use propofol ampoules.

Action the hospital SHOULD take to improve

- Display the certificate of approval (issued by the Department of Health) in a prominent position within the clinic to help women and clinicians better understand the licensing system.
- Review safeguarding policies regularly to ensure they reflect up-to-date guidance, including on the sexual exploitation of children and young people and risks of female genital mutilation.
- Review the policy on disposal of pregnancy remains following pregnancy loss or termination in the light of theHuman Tissue Authority's 'Guidance on the disposal of pregnancy remains following pregnancy loss or termination' March 2015.
- Ensureincidents of all kinds,including those with a potential to cause harm to women or staff, even when no harm occurred, are reported and that local staff receive prompt feedback to reduce the risk of recurrence of incidents.
- Encourage greater local ownership among staff of practices and procedures at the clinic, including carrying out audits that are proportionate to the size of the clinic, assessing local risks and encouraging staff to take responsibility for maintaining standards.
- Ensure there is a clear referral pathway for appropriate women to trained counsellors with appropriate expertise if such staff are not available at the clinic.
- Monitor waiting times systematically for women attending the clinic to help identify ways of improving the experience for women.

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
Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment All staff did not understand and follow the protocols for transfer to NHS hospitals in the event of serious incidents. Regulation 12 (2) (i)

Regulated activity	Regulation
Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not follow the manufacturer's, NHS England and Royal College of Anaesthetists guidance on the single use of propofol ampoules. Regulation 12 (2) (g)