Marie Stopes International Central London Centre

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Termination of pregnancy (TOP) refers to the abortion of pregnancy by surgical or medical methods. Marie Stopes UK International (MSI) Central London is part of the provider group Marie Stopes International, a not for profit organisation that was founded in 1976, to provide a safe, legal abortion service following the 1967 Abortion Act.

Marie Stopes International Central London was registered with the CQC in March 2012. It provides medical and surgical termination of pregnancy, consultations, ultrasound scans, and counselling and support for people who use the service. The provider offers vasectomy, performed under local aesthetic, long acting reversible contraception, well woman screening, well man screening and sexually transmitted infection testing and screening.

Two early medical units (EMUs), known as satellite locations, are situated at Watford and Hemel Hempstead in Hertfordshire. They provide medical termination and consultations in the early stages of pregnancy. All three locations hold a license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967. Services are provided to both NHS and privately funded patients. Patients of all ages, including those aged less than 18 years are treated at all three locations.

Between January 2015 and December 2015 MSI Central London carried out 1057 surgical termination of pregnancy, and1090 early medical termination of pregnancy. In the same period MSI Hemel Hempstead carried out 504 early medical termination of pregnancy, and MSI Watford carried out 372 early medical termination of pregnancy.

We carried out this announced comprehensive inspection on 5-7 April 2016, 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. We have not provided ratings for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy services; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

The inspection team included an inspection manager, and three inspectors, two of whom who were also specialist advisers in midwifery and nursing, and a specialist advisor who was a consultant obstetrician and gynaecologist.

Our key findings were as follows: We highlighted areas for improvement in safety, effectiveness, caring, and well-led domains. We found the service to be responsive.

Are services safe at this hospital?

Safety was not always a sufficient priority because:

- There was inconsistent reporting of safety concerns. None of the staff we spoke with, other than managers, could recall a time when they reported a safety incident and some staff were not clear about the procedures to follow.
- A number of items of equipment used for the diagnosis and management of patient treatment and care was not subjected to safety or maintenance checks, particularly at the two EMUs.
- There were omissions in safety checks for patients undergoing surgical procedures at the Central London centre and audit processes to monitor whether the surgical safety checklist was being used were not sufficiently robust.
- National guidelines for infection prevention and control and cleanliness were not always adhered to. Requirements for cleaning, cleaning schedules, and checklists at all three locations were not met.
- Not all staff completed mandatory training in safeguarding, moving and handling and life support. However, staff demonstrated a correct understanding of safeguarding of adults and children and could describe actions to be taken in cases of suspected abuse.

Summary of findings

Is the service effective?

- Treatment was not always compliant with RSOP10: Professional Guidelines, which requires providers to have regard to relevant and professional guidance. For example, MSI did not adhere to the Royal College of Obstetricians and Gynaecology (RCOG) guidelines for the management of medical termination of pregnancy up to 9 weeks and 4 days gestation, which recommends 24 – 48 hours between the administration of the medicines used to bring about termination of pregnancy.
- Training specific for individual roles was provided to staff to ensure they were able to meet the needs of the patients they delivered care to. However, not all staff completed this training in a timely manner.
- Policies were accessible to staff and were generally developed in line with Department of Health standard operating procedures and professional guidance.
- Patients were offered appropriate pain relief, precautionary antibiotic treatments and post-termination of pregnancy contraceptives.

Is the service caring?

- Privacy was not always achieved in the waiting area and recovery lounge at the Central London location.
- Patients felt safe and well cared for and consistently reported about the non-judgmental approach of staff. Patients' choices were respected.
- All patients had a chance to speak with a nurse privately to make sure that all questions were answered and they received appropriate support to make a decision. Women could be accompanied by someone who was close to them.
- Patients' emotional and social needs were valued by staff and embedded in their care and treatment.

Is the service responsive?

- Patients were involved in decisions related to their treatment and had choice, flexibility and continuity of care. There was no evidence of any long waiting times, delays or cancelled appointments.

Is the service well-led?

- There was insufficient oversight of the service and its delivery. We were not assured by the leadership within the service. MSI provided the centre with an integrated governance framework in line with the NHS governance agenda. However; arrangements for performance management were fragmented and did not always operate effectively.
- Staff described and we observed the culture to be top down and directive. There were gaps between the governance at corporate and centre level. Managers were not included in policy development. For example, centre managers and staff were not fully aware of the rationale and evidence to support the introduction of simultaneous administration of medicines, and were not fully engaged in the process.
- Corrective actions to manage risks were not sufficiently prioritised or resolved in a timely way by people with the appropriate level of authority. Where issues remained unresolved mitigating actions were not always in place.
- Staff were not always clear of the audit processes and outcomes and the processes to identify, report and act on risks.
- The senior management team at the centre and at regional level was made up of relatively new members of staff following some interim appointments. Staff commented on the previously high frequency of changes in leadership which created some instability. Staff were feeling more settled and spoke positively about the new management team.

Summary of findings

- The centre managers were seen by staff to be supportive, visible and approachable at the Central London centre. However, staff were unsure about the arrangements for managers to visit EMUs and there was no evidence of planned, regular visits. Staff were, however, satisfied with the managerial telephone support they could access if necessary.

There were also areas of practice where the provider needs to make improvements. Importantly the provider must:

- Ensure policies are kept up to date and that relevant staff are involved in clinical policy development and review.
- Ensure there are systems in place to keep staff informed and trained in relevant legislation, regulations and guidance
- Improve local safety incident reporting and sharing of learning.
- Provide formal root cause analysis training for staff involved in incident investigations.
- Assess record and act upon risks for each location.
- Provide effective systems for safety and maintenance equipment checks and equipment replacement.
- Use the WHO safety checklists for all patients undergoing surgical procedures
- To ensure audit processes to monitor whether the surgical safety checklist is used and acted upon are formally introduced, carried out and acted upon.
- Enable effective management and governance to prevent and control infection and ensure medicines are managed correctly.
- To ensure all of the national standards, including environmental, and cleaning requirements are adhered to.
- Enable all staff to complete training that is necessary for them to fulfil their role(s), including safeguarding level three, delivering HIV testing results, and all mandatory training and relevant skills training.
- Staff should routinely ask women about domestic abuse in line with current guidelines.

Action the provider SHOULD take to improve

- Ensure environment provides privacy and dignity for patients using the service.
- Display up to date and visible information about how to raise complaints and concerns at all three locations.
- Ensure there is a formal agreement in place to support emergency transfers.

Due to the number of concerns arising from the inspection of this and other MSI locations, we inspected the governance systems at the MSI corporate (provider) level in late July and August 2016. We identified serious concerns and MSI undertook the immediate voluntary suspension of the following services as of 19 August 2016 across its locations, where applicable:

- Suspension of the termination of pregnancy for children and young people aged under 18 and those aged 18 and over who are vulnerable, to include those with a learning disability
- Suspension of all terminations using general anaesthesia or conscious sedation
- Suspension of all surgical terminations at the Norwich Centre

MSI responded to the most serious patient safety concerns we raised and was able to lift the restrictions on the provision of its termination of pregnancy services at this location on 7 October 2016.

Summary of findings

CQC has also undertaken enforcement action for breaches of the following regulations, which are relevant to this location:

- Regulation 12 Care and treatment must be provided in a safe way for service users
- Regulation 17 Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (Good governance)

CQC is actively monitoring compliance with the above warning notices in order to ensure that services are operated in a manner which protects patients from abuse and avoidable harm.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to Marie Stopes International Central London Centre

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy, by surgical or medical methods. Marie Stopes UK International (MSI) Central London is part of the provider group Marie Stopes International, a not for profit organisation that was founded in 1976, to provide a safe, legal termination of pregnancy service following the 1967 Abortion Act. MSI believes that everyone should have the right to choose whether and when to have children, no matter where they live. The organisation has expanded from one centre in London to a global network of more than 600 centres across 37 countries.

Our inspection team

Our inspection team of four included: the lead CQC inspector, two CQC inspectors who were also specialist professional advisors in midwifery and nursing, and a specialist advisor who was a consultant obstetrician and gynaecologist.

How we carried out this inspection

To get to the heart of clients' 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?

We have not published a rating for this service as the CQC does not currently have a legal duty to award ratings for services that provide solely or mainly termination of pregnancy.

Although we do not currently have the powers to rate these services, we report on whether they are safe, effective, caring, responsive to people's needs and well-led. We have highlight areas of good practice and areas for improvement.

During our inspection we visited three locations. We spoke with 18 staff members including: managers, doctors, registered nurses, health care support workers, a counsellor, communications manager, and administration staff. We looked at the care records of 40 patients: 15 undergoing surgical termination of pregnancy, 21 medical termination of pregnancy, and four aged under 16 years. We also looked at records of 37 men who had a vasectomy procedure. We observed interactions and communication with patients and their supporters; however this did not include male patients because there were no vasectomy consultations or procedures taking place during our inspection. We were unable to speak with patients at the London centre due to lack of suitable facilities to allow for privacy in the waiting and recovery areas. There were no patients at the Watford site when we visited. Patients at the Hemel Hempstead site did not wish to speak with us. We reviewed performance data submitted by the centre before and after our visit.

Summary of this inspection

Information about Marie Stopes International Central London Centre

Marie Stopes International Central London was registered with the CQC in March 2012. It provides medical and surgical termination of pregnancy, consultations, ultrasound scans, and counselling and support for people who use the service. The provider offers vasectomy, performed under local anaesthetic, long acting reversible contraception, well woman screening, well man screening and sexually transmitted infection testing and screening.

Two early medical units (EMUs), known as satellite locations, are situated at Watford and Hemel Hempstead in Hertfordshire. They provide medical termination and consultations in the early stages of pregnancy. All three locations hold a license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967. Services are provided to both NHS and privately funded patients.

Patients of all ages, including those aged less than 18 years are treated at all three locations. Between January 2015 and December 2015 MSI Central London carried out 1057 surgical termination of pregnancy, and 1090 early medical termination of pregnancy. In the same period MSI Hemel Hempstead carried out 504 early medical termination of pregnancy, and MSI Watford carried out 372 early medical termination of pregnancy. The vasectomy service operates on two days a month at the Central London centre. 351 non scalpel vasectomies were performed in the reporting period, with an average of 20 completed in one day. Counselling services are offered to all patients before and after their treatment and are provided face to face or by telephone.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

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

- There was inconsistent reporting of safety concerns. None of the staff, we spoke with, other than managers could recall a time when they reported a safety incident. Some staff told us they felt unclear of the correct procedures.
- The National Patient Safety Agency recommendation that the World Health Organisation (WHO) 'five steps to safer surgery' safety check is completed before, during, and after surgery for every patient undergoing a surgical procedure, was not consistently adhered to. There were some omissions in safety checks for patients undergoing surgical termination of pregnancy. The checklist was not used for any patients undergoing vasectomy. Observational audits to monitor the WHO checklist were not routinely completed or acted upon.
- National specifications for infection prevention and control were not adhered to. These included: requirements for flooring, furniture, and hand washing facilities. Staff could not confirm when cleaning took place at any of the locations, or how soft furnishings, such as chairs in the waiting areas and recovery lounge, were cleaned.
- Not all equipment used for the diagnosis and management of patient treatment and care was subjected to safety or maintenance checks. As a result there was a risk that equipment may not have been functioning to the required level or may not have been safe to use. This could lead to misdiagnosis or ineffective treatment.
- Staff demonstrated understanding of safeguarding of adults and children and could describe actions taken in cases of suspected abuse.
- Patient information was managed appropriately and stored securely in locked cupboards.
- Most records we looked at were well maintained and completed with dates, times and designation of the person documenting recorded on them.
- Following surgical procedures patients were monitored in the immediate post-operative period by a registered nurse in the recovery lounge until they were fit for discharge. Nurses assessed the patients'' vital signs and pain during this period.
- Staff rosters were managed centrally using an electronic rostering system. This meant that staffing levels met the service needs without having to use agency or locum staff.

Incidents

- Staff were required to submit incident reports on paper to the centre manager who would then assess and decide whether the incident needed to be recorded on the electronic reporting system. It was unclear to what extent incidents would be recorded in this way. None of the staff we spoke with could provide us with examples of when they reported a safety incident and told us incident reporting was not actively encouraged. Some staff told us they were not sure of the processes involved and could not recall any training on reporting, other than a brief introduction provided at the time when they started working for the provider. Staff were unable to describe the processes for sharing learning from incidents.
- We reviewed the electronic report of 64 safety incidents between January 2015 and December 2015. There was

no serious incidents or never events. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventive measures are implemented.

- Investigations of incidents and analysis of the root causes took place. Action plans were developed to reduce the risk of a similar incident reoccurring. However, managers involved in root cause analysis were not provided with any training to undertake the role. This meant that there may be inconsistencies in their approach.
- Clinical governance and regional management meetings were held on a quarterly basis and were attended by a range of managers. Staff received feedback on safety incidents through staff meetings and at training, but this was not always documented.
- Most staff were aware of the duty of candour and could describe the principles of open reporting. The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. We saw no evidence that any training on candour was provided for staff; however, there was information available on a staff noticeboard.

Cleanliness, infection control and hygiene

- An infection control advisor(ICA), based at Marie Stopes head office, was responsible for leading the organisation's infection prevention team. The ICA was part of the organisation's clinical governance and patient safety teams and structure. The ICA was supported by the regional manager, centre managers and a link nurse for infection prevention and control at the Central London location to ensure that local policies and practices were correctly implemented. However; at the time of our inspection the infection control team were very newly established due to staff changes, so we were unable to assess their impact.
- Infection control audits were carried out by internal reviewers every six months to manage and monitor the prevention and control of infection. There were some improvement in overall compliance rates between June 2015 (74%) and December 2015 (81%). Lower scores related to environmental issues, and highest scores to correct use of personal protective equipment (PPE), which is the specialised clothing worn by employees to protect against infection. The centre reported no incidence of hospital acquired infections or Meticillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Diff) in 2014.
- Infection control practices did not comply with national specifications such as Cleaning schedules and checklists required by the code were not in evidence, or where they were in evidence were not always completed, including in the operating theatre. This meant that staff could not confirm when cleaning took place, including how soft furnishings such as chairs in the waiting areas and recovery lounge were cleaned.
- Carpets were used in areas where body-fluid spillage was anticipated, including corridors and entrances. This did not meet not meet the requirements of the health building notice (HBN 00-09) related to infection control in the built environment and mean there is a high probability of body fluid contamination. There was no preventive maintenance or cleaning programme or specific risk assessment in evidence for carpeted areas as required by the national guidance on cleanliness and the prevention and control of infections and related guidance. We saw this identified as a risk on the risk register with an action noted to replace the flooring. However, this remained unresolved and staff were unaware of why this was not actioned.
- Chairs in the waiting area and the recovery area at the Central London centre were not easily cleanable and did not meet the requirements of the HBN 00-09. There were no systems to monitor the cleaning of the chairs and carpets in the waiting or recovery area and staff were unable to confirm when this happened.
- There was appropriate segregation of clean and dirty waste, and safe disposal of clinical waste including sharp instruments and objects.
- There were no spillage kits for the safe disposal of body fluids at the Watford or Hemel Hempstead EMUs which meant that there was a risk of cross contamination in the event of body fluids spilling on to surfaces. Staff we spoke with were unable to describe the correct procedure for managing this situation and seemed unaware of the required policy.

- Staff and managers acknowledged concerns about the standards of cleanliness and the lack of monitoring at the Central London and the Hemel Hempstead locations. We observed: rusty taps, smeared mirrors, dusty sanitary bins and skirting boards in toilets at Central London and Hemel Hempstead, and rusty taps and a dusty hand washing sink and dusty computer keyboard in the operating theatre at the Central London location.
- At each location cleaning was carried out by a contracted cleaning company at the time when the centres were closed to patients. This meant staff had little opportunity to monitor the cleaning taking place and relied on managers to provide feedback about specific concerns to the cleaners. At the London centre, this was largely through a communications book kept at the reception area. Staff we spoke with showed us a number of records in the communication book when cleaning was not carried out to the required standard, in accordance with the policies in place. We saw that a record of concerns from February 2015 was documented with no evidence of any response, agreed action, or resolution from the contracted cleaning company. The issues and lack of response were not reported as an incident, although they appeared on the risk register.
- The centre managers told us as they raised their concerns with the cleaning company and escalated the concerns to the regional manager. The regional manager had reviewed the appointment of a different company which was to provide the service from May 2016. There were less formal monitoring arrangements at Hemel Hempstead. Staff working there told us they reported some concerns verbally to the landlord they rented the facilities from but these were not recorded or acted upon. We raised our concerns about cleanliness with the centre and regional managers who told us corrective action would be taken.
- After surgical termination of pregnancy antibiotics to prevent chlamydia trachomatis and anaerobic infections were offered to all women, to reduce the risk of infection. Local microbiology protocols for the administration of antibiotics were used.
- Protective personal equipment (PPE) such as disposable gloves and aprons was readily available and worn by staff.
- All staff were observed to be adhering to the bare below the elbow policy to enable good hand washing and reduce the risk of infection.
- Staff adhered to the management of clinical waste policy, and disposal of sharp objects.

Environment and equipment

- There was inconsistent monitoring of maintenance and calibration checks of equipment. At the London centre, staff were unable to provide us with evidence that the required checks had been carried out on: ultrasound scanners, blood pressure monitors, weighing scales, equipment used to measure blood glucose levels, an operating theatre couch, and defibrillation equipment to be used in the event of a cardiac emergency. They could not recall when the checks last happened. At Watford, we saw an ultrasound scanner labelled 'not to be used after April 2015' in use. This could lead to electrical faults, poor image resolution, damaged probes and other faults remaining undetected. This meant there was a risk of misdiagnosis or ineffective treatment.
- At all three locations resuscitation equipment, including oxygen and suction was accessible, was checked on the days the centres were open, and was ready for use in an emergency.
- First aid equipment was also available in case of an emergency and was checked on the days the centres were open to ensure it was available and fit to use. Staff received training in its use. Oxygen cylinders were stored correctly. Single-use items were sealed and in date. However, there were some emergency medicines missing from the Watford site, which the manager was aware of and told us it was ordered and was treated as a priority.

Medicines

- Staff we spoke with were unclear about how to obtain pharmaceutical advice and could not recall a situation when they needed to do so.
- We saw two recent examples of insufficient medicine stocks at Watford: where the service ran out of antibiotics, and emergency medicines used in the management of anaphylaxis. Staff said as they were part of the GP premises they would be able to access medicines in the case of an emergency. However; we

saw no evidence of a formal arrangement in place. They attributed stock issues to a lack of formal systems for monitoring stock. Supplies relied on the vigilant monitoring of individual staff members. Managers acknowledged this had not always happened.

- We saw medicines safety alerts were sent to all centres by MSI central office, and were received and acted upon.
- Medicines were all stored in a locked cupboard, or, where they needed to be stored below a certain temperature, in a drugs refrigerator. There were no controlled drugs (medicines subject to additional security measure) stored or administered at any of the three centres.
- We looked at a random sample of medicines in all three centres. All the medicines we looked at were in date and correctly stored in line with manufacturers' instructions. The minimum and maximum temperature of fridges used to store medicines were monitored and recorded to ensure that medicines were kept at the required temperature and were all within the correct range. Fridges used for this purpose were clean and tidy and held no surplus or expired stock.
- All medicines were prescribed remotely by doctors using a secure electronic prescribing system and given as prescribed; however we did not see any evidence of a record of the number of medicines given against prescribed medicines other than in patients' individual records. Medicines used in the treatment of termination of pregnancy were only prescribed and administered once the legal requirements for obtaining the opinions of two doctors that the termination of pregnancy could go ahead were met.
- Although asking patients about their allergies was part of the MSI assessment process, and should have been recorded on the patient's notes, we saw two examples where allergies were not recorded which meant that there was a risk they would not be identified and acted upon.
- Health technical memorandum (HTM 07-01) relates to safe management of health care waste and requires that colour coded sharps bins are used to dispose of out of date or unused medicines. Expired or unused medicines were not correctly disposed of, as they were disposed of in sharps bins designed for clinical or highly infectious waste, not the bins designed specifically for disposal of medicines. There was no evidence of any auditing of compliance with the required practice. This meant that there was a risk that medicines might be accidentally diverted or intentionally misused.
- Mifepristone and misoprostol are the medicines used to bring about termination of pregnancy. Misoprostol does not have a UK licence to induce termination of pregnancy, so its use in this way is described as 'off-label'. The use of 'off label medicines' must be fully explained to patients before they take them. We saw that patients were provided with information about this and that they consented to taking the medicine.
- Patients were offered simultaneous administration of medicines for medical termination of pregnancy, where stage one and stage two medicines and antibiotics, were given within a 30 minute appointment. Simultaneous methods of inducting termination of pregnancy were not in line with RCOG recommendation for medical termination of pregnancy at or below 63 days gestation. The guideline recommends 24 – 48 hours between the administration of the medicines used to bring about termination of pregnancy. The provider informed us they stopped supporting simultaneous administration on 15 April 2016 after reviewing data regarding the simultaneous dose regime, including evacuation of retained products of conception rate (ERPC) at clinical leads meeting. The decision was also driven by feedback from clinical teams meetings and "manner and timings of implementation".

Records

- Patient records were mainly electronic and instantly accessed by all relevant staff. There were also some paper records such as consent forms and surgical safety checklists.
- Patient information and records were maintained securely, electronically, as access was password protected. Where paper copies existed, records were all stored in locked cupboards.
- All of the records we looked at were well maintained and completed with clear dates, times and designation of the person documenting.

Termination of pregnancy

- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for termination and sign a form to indicate their agreement. All of the records we looked at met these requirements.
- The Department of Health requires every provider undertaking termination of pregnancy to submit demographical data and certify every termination. Records we looked at showed it was correctly gathered and reported on.

Safeguarding

- There were no safeguarding concerns at the time of our inspection.
- Staff at all three locations were supported by a corporate safeguarding advisor and two safeguarding leads based at the Central London centre. The leads were trained to safeguarding level three and four, which is the required level for their area of responsibility.
- All clinical staff were required to be trained at safeguarding level two and non-clinical staff were trained to level one which was not in line with national guidance which required staff to be trained to level three. Three out of eight eligible members of staff completed refresher training at safeguarding level 2. However; all staff we spoke with correctly described what may constitute a safeguarding concern and the process for reporting concerns.
- All patients were seen in a one to one consultation with a nurse. Staff told us they did not routinely take the opportunity to ask women about domestic abuse in line with NICE guidelines. This guidance is for everyone working in health and social care whose work brings them into contact with women who experience domestic abuse and abuse.
- Staff knew how to access the safeguarding policies and demonstrated a good understanding of the processes involved for raising a safeguarding alert. However, the MSI policies and processes did not reflect up to date national guidance on sexual exploitation of children and young people, or female genital mutilation. Staff we spoke with could not recall these principles being included in their most recent safeguarding training, which pre-dated the changes.
- The centres did not treat any young person under the age of 13 in line with their organisational policy. Children under the age of 13 would be referred to the safeguarding board and the NHS. Between January 2015 and December 2015 the centre treated ten young people who were aged between 13 and 15 years old. Staff told us it was the organisational policy that if a girl under 18 years of age used the service then a safeguarding referral would automatically be made in line with national guidance. We saw that for those aged 13 to 16 years, a safeguarding risk assessment would be completed and a decision made on the outcome of the assessment.

Mandatory training

- MSI required that all staff completed mandatory training, this covered a range of topics including fire safety, health and safety, basic or immediate life support, safeguarding, moving and handling, infection control and information governance. There were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- A spread sheet supplied by the provider was used to extrapolate training completion rates for staff at the centre. Whilst all eligible staff attended refresher training in health and safety, infection prevention and control, and information governance only six out of eight eligible staff completed the safeguarding training at level 2. It did not meet the requirements of the national guidance which required staff to be trained to level three
- Immediate or basic life support (undifferentiated between levels of training) was completed by eight out of nine eligible staff. Eight out of eleven eligible staff attended the required moving and handling training.
- Managers told us only anaesthetists working at the centre were trained in advanced life support (ALS); however, we were unable to see any record of this as these were not maintained at the centre.

Assessing and responding to patient risk

- All patients underwent an initial risk assessment to determine their suitability for treatment at the centres. If risk factors were detected patients were referred to the NHS for on-going care and management. All patients had been risk assessed for venous thromboembolism (VTE) in the last 12 months.

Termination of pregnancy

- It was recommended by the National Patient Safety Agency in 2010 that The World Health Organisation (WHO) 'safer surgery' checklist should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery. MSI had no policy which would specify where it was suitable to use WHO checklist. Centre managers told us regular monitoring meant that incomplete surgical safety checklists were a rare occurrence. We saw that this happened with surgical termination of pregnancy.
- We looked at 15 WHO checklists of women who had surgical termination of pregnancy two of these were not fully completed.
- We looked at 37 records of male patients who had undergone vasectomy. None of the 37 records had a surgical safety checklist attached to them. Staff and managers confirmed they did not complete the WHO checklist for vasectomy patients as required by the national guidance. Staff told us that the impact of this was seen to be minor as the centre only undertook a single procedure for male patients, no swabs were placed within the wound and no antibiotics were indicated. However, there was no formal risk assessment and this meant that other risk factors such as diabetes, risk of hypoglycaemia and any known allergies might be overlooked during the patient's treatment as this also formed part of the checklist.
- Prior to termination of pregnancy all women should have a blood test to identify their blood group. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the woman have future pregnancies. The records that we reviewed demonstrated that all the women underwent a blood test prior to the termination of pregnancy and those who had a rhesus negative blood group received an anti-D injection.
- Following surgical procedures patients were monitored in the immediate post-operative period by a registered nurse in the recovery area until they were fit for discharge. Nurses assessed the patient's vital signs and pain during this period and documented all assessment and intervention.
- Clinical and non-clinical staff we spoke with were able to describe the actions required in the event of a medical emergency.
- Staff understood that in an emergency MSI would transfer patients to the neighbouring NHS Trust hospital. There was no formal agreement in place to support this arrangement. We saw two examples of where patients were transferred in a medical emergency between January 2015 and December 2015.
- Fire wardens and first aiders were trained and appointed and accurately described their role and responsibilities.

Nursing staffing

- The service employed seven registered nurses (3.52 whole time equivalents) including one theatre nurse. There were no vacancies at the time of our inspection. When patients attended the main centre and EMU satellite locations, there would be at least one registered nurse on duty.
- Staff rotas were managed centrally using an electronic rostering system. This meant that the service needs were met without having to use agency or locum staff.
- Nurses who worked at the EMUs also worked at the Central London centre on a regular basis to allow them to keep up to date with other aspects of the service and share learning. They told us they liked working across the three sites, and spoke positively about the variety.

Medical staffing

- For patients having medical abortions, doctors either provided a face to face consultation or worked remotely providing consultations and prescriptions from other MSI licensed premises.
- There were two (0.61 whole time equivalent) doctors working at the centre to provide surgical treatment under practising privileges granted by another provider.
- Anaesthetists also provided a service under practising privileges.
- Practising privileges is the term given to the authority to a doctor, to provide a service at another location than

their regular place of work. Suitable checks were carried out to enable medical staff to practise at the centre: professional registration, qualifications, insurance, disclosure and barring and revalidation.

Major incident awareness and training

- The centre's major incident and business continuity plans provided guidance on actions to be taken in the event of a major incident or emergency. Emergency plans and evacuation procedures were in place. Staff we spoke with were aware of how to respond to major incidents and emergencies; however they could not recall any specific training in this area.

Are termination of pregnancy services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Implementation of evidence based guidance was variable. MSI did not adhere to the Royal College of Obstetricians and Gynaecology (RCOG) guidelines for the management of medical termination of pregnancy up to 9 weeks gestation, which recommends 24 – 48 hours between the administration of the medicines used to bring about termination of pregnancy.
- Competence based training, specific for individual staff roles, was provided to ensure they were able to meet the needs of the patients they delivered care to. However; not all staff completed this training in a timely manner which meant they were unable to fulfil their role.
- The centre adhered to the RCOG guidelines for the treatment of patients with specific conditions, such as ectopic pregnancy.
- Policies were accessible to staff and were generally developed in line with Department of Health standard operating procedures and professional guidance.
- Patients were offered appropriate pain relief, precautionary antibiotic treatments and post-termination of pregnancy contraceptives.

Evidence-based care and treatment

- Policies were accessible to staff and care and treatment took account of Department of Health procedures for the approval of independent sector places for the termination of pregnancy services, Required Standard Operating Procedures (RSOP), and professional guidance, 2014.
- MSI offered surgical termination of pregnancy up to 14 weeks gestation of pregnancy and medical termination of pregnancy up to 10 weeks gestation of pregnancy. All patients underwent an ultrasound scan at the treatment centre to determine gestation of the pregnancy. This was in line with The Abortion Act and MSI guidelines for termination of pregnancy.
- Choice was offered in line with RCOG evidence-based clinical guideline (Number 7: The Care of Clients Requesting Induced Abortion). Patients could choose to have early medical abortion (EMA), late medical abortion, or surgical treatment under local or general anaesthetic.
- Patients were offered three options for medical termination of pregnancy, based on gestation: simultaneous administration of medicines – where stage one and stage two medicines and antibiotics, were given within a 30 minute appointment; six hour interval - where the patients had a six hour gap period between administration of the stage one and stage two medicines; and where there was a 24 to 48 hour period between administration of the two medicines used. Simultaneous and six hour methods of inducting termination of pregnancy are and not consistent with RCOG recommendation for medical termination of pregnancy at or below 63 days gestation. The guideline recommends 24 – 48 hours between the administration of the medicines used to bring about termination of pregnancy. This treatment offered at MSI was not consistent with professional guidelines issued by Department of Health (RSOP10), which requires providers to have regard to relevant and professional guidance.
- Staff we spoke with did not participate in the development and implementation of this new treatment. Some staff expressed concern that the treatment was not evidence–based. Managers were unable to provide us with an explanation or evidence of the decision making process behind the introduction of

the new treatment. There was no a risk assessment or action plans for the evaluation of this treatment, or any evidence of outcome monitoring since the practice was changed.

- Ultrasound was used in surgical procedures to reduce the risk of surgical complications, such as perforation of the uterus, in accordance with RCOG guidance.
- The centre met the RCOG guideline which recommends that screening for sexually transmitted infections (STI) should be made available. All patients, who gave consent, were tested for sexually transmitted infections, including chlamydia, HIV, gonorrhoea and syphilis. Which tests were offered was dependent upon the agreement with the clinical commissioning group and the contract the provider had with them. Positive results were communicated by telephoning the patient directly. Patients with positive test results were treated or referred to other sexual health services. Hepatitis B or C tests and vaccinations for Hepatitis A were provided where contracted for by the commissioning groups.
- Staff expressed concern they were not trained to deliver a negative HIV test result. NICE guidance on strategy, policy and commissioning on HIV testing and prevention (2014) recommends that providers offering HIV testing should ensure practitioners directly involved with testing for HIV, and other sexually transmitted infections, are trained to routinely offer and recommend an HIV test. They should be able to conduct post-test discussions, including giving positive test results and delivering post-test and general health promotion interventions.
- Patients undergoing medical termination of pregnancy were asked to complete a pregnancy test after four weeks to ensure that the procedure was successful. Patients were advised that they could telephone the 'One Call' call centre and were invited to go back to the centre if they had any concerns.
- All patients were treated with prophylactic antibiotics to prevent infection in accordance with national and local guidelines.

Pain relief

- Pre and post procedural pain relief was prescribed by registered medical practitioners and its administration was recorded in patients' records. Patients undergoing medical termination of pregnancy were given advice on use of painkillers and the appropriate dosage, should they require it during their stay and after leaving the centre. If the patient was nauseous further medication was provided to treat this.

Patient outcomes

- The service treated patients for termination of pregnancy only where pregnancy was confirmed, by ultrasound scan, to be 14 weeks gestation or under.
- Between January 2015 and December 2015 MSI Central London carried out 1057 surgical abortions, 1090 early medical abortions, and 351 non scalpel vasectomies. Two patients were transferred to another health care provider as they were at higher risks and required increased levels of medical intervention. MSI Hemel Hempstead carried out 504 early medical abortions, and MSI Watford carried out 372 early medical abortions. Ten patients aged between 13 and 15 attended for consultation and treatment.
- Patients offered surgical termination were offered a specific appointment to attend for the procedure. The procedure was carried out by the consultant.
- The organisation set key performance indicators (KPIs) for the centres and individual staff. These were monitored and reported upon as part of an on-going audit plan and performance review (appraisal) and any variance from the targets was addressed with individual staff members, where appropriate. Outcomes across all three centres within the reporting period, which were noted as good or better than expected included:100 % of correctly completed forms recording information about termination of pregnancy, 75% of patients were screened for sexually transmitted infection, 78% patients spent 66 minutes or less in the centre for their consultation and treatment, and waiting times were met.
- Outcomes that did not meet the key performance indicator targets were: lower than expected rates (38%) of people leaving the centre with long acting reversible contraception (LARC), and higher rates (30 occasions) where surgical lists for termination of pregnancy started later than the proposed time due to one member of staff arriving late. Mangers told us lateness was

addressed with the individual member of staff and led to improvement. However, there was no additional audits undertaken to understand why LARC uptake was lower than expected.

- Patients undergoing medical termination of pregnancy were asked to ensure that a pregnancy test was completed four weeks after they passed the products of conception to ensure that the procedure was successful. Follow up was undertaken through a method agreed with the patients. This was usually by telephone and women were invited back to the centre if there were any concerns.
- Patients undertaking a surgical procedure were offered a follow up appointment; however, nursing staff told us women did not tend to routinely take up this option.
- Centre managers told us in order to monitor outcomes they relied on other staff reporting back to them or patients contacting the 'One Call' telephone service. If the clinic was informed that there were any complications an incident form would be completed and it would be documented in the patients' notes to ensure that the information was captured. This was monitored by the quality and governance leads and cascaded through meetings. There were two reported cases in the last 12 months; there was no evidence of a trend that needed to be investigated further.
- Medicines that induced termination of pregnancy were only prescribed by doctors. The doctor would sign the prescription after the woman had a consultation with a nurse, and after the appropriate form was signed by two medical practitioners (record of grounds for carrying out a termination of pregnancy). We were told it was rare that either of the two certifying doctors saw the women. To do so would be a good practice as 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 a termination of pregnancy.

Competent staff

- All staff had a job description issued by the central office which set out their function, responsibilities and expected behaviours. However, none of the job descriptions were dated or had a date for review.
- Staff told us they were appraised. Records stated 100 % of medical staff, 85% of nursing staff and 100% of administrative staff completed an appraisal in the last 12 months. Reasons for not completing appraisal were maternity leave and sickness absence.
- Staff were supported through an induction process and competence based training relevant to their role and they felt it mostly met their training needs. However, three members of the team expressed frustration with the fact they were not able to complete training essential to their roles. For example, training records showed that two out of six eligible nurses did not complete training on consent, five out of eight eligible nursing staff were waiting for ultrasound scanning training, three out of six eligible staff were waiting for early medical abortion (EMA) training, four out of five were waiting for vasectomy training, and four out of six required contraception training. This was mainly affecting staff who were appointed to the organisation in recent months. This meant they could not fulfil the responsibilities set out in their job description and relied on staff from other centres working shifts alongside them in the meantime.
- We spoke with a counsellor who confirmed they completed appropriate training and the organisation's competence matrix and that they regularly received private counselling supervision. Records we looked at confirmed this.
- There were doctors who worked at the MSI centre under practising privileges, which is the authority given to a doctor by another provider, to offer patient care. Practising privileges are limited by the individual's professional registration, experience and competence. Managers carried out suitable checks to confirm professional registration, qualifications, insurance, disclosure and barring and revalidation of medical staff.

Multidisciplinary working (related to this core service)

- Medical staff, nursing staff, counsellors and other members of staff worked well together as a team. There were clear lines of responsibility that contributed to effective planning and provision of care.
- Staff gave examples of working with other agencies and services such as the local sexual health services, local safeguarding team and early pregnancy units at local hospitals.

Termination of pregnancy

Seven-day services

- The Central London centre was open five days a week and carried out surgical procedures two days a week. Vasectomy was offered twice a month. The Early Medical Units (EMUs) were open four days a week. All surgical procedures were carried out as day cases. If patients needed to access services at other times, they could be referred to alternative MSI UK centres in the central and south regions of England.
- The RSOP set by the Department of Health states patients should have access to a 24-hour advice line which specialises in post-termination of pregnancy support and care. 'One call' was the MSI telephone advice line providing 24 hours a day and seven days a week. Callers to the one call line could speak to registered nurses or midwives that performed triage to help to prioritise treatment, and who gave advice. They could also speak to counsellors.

Access to information

- MSI used an electronic central information management system that was accessible across the UK. Staff had access to specific systems relevant to their role. For example only the prescribing doctor could enter medicines on the prescription page. This system ensured that patient care records were instantly available if a woman was referred to a different MSI centre for further treatment.
- An information leaflet 'your treatment information' was available for patients attending any MSI centre. This leaflet contained information about different options available for termination of pregnancy including what to expect when undergoing a surgical termination. This also included any potential risks. However; neither this leaflet nor the MSI UK website, was updated to reflect the introduction of simultaneous administration of medicines method of EMA.
- A patients's consent was required for any communication with their general practitioner (GP), even if the GP made the initial referral. Patients were asked if they wanted their GP to be informed by letter about the care and treatment they received. Patients' decisions were recorded and their wishes were respected.
- An information leaflet was given to patients on discharge providing sufficient information to enable other practitioners to manage any complications in line with DH RSOP guidelines. The leaflet provided details of the MSI 24 hour telephone helpline arrangements; it was discreet and designed to fit into a purse to help protect privacy.

Consent and Mental Capacity Act

- MSI provided training on consent, however this had not always been provided in a timely way.
- Although we did not observe consent being obtained staff reassured us that consent was obtained in line with Department of Health RSOP guidelines. It was obtained at the initial assessment and confirmed on the day of treatment. Consent forms used within the centre were updated to reflect the introduction of simultaneous administration of medicines and listed potential risks and side effects of the procedure.
- Patients were seen alone in the first instance to ensure that they were voluntarily presenting for treatment. All care records we reviewed contained signed consent from patients. Possible side effects and complications were recorded and records showed these were fully explained.
- A trained pregnancy counsellor offered patients the opportunity to discuss their options and choices as part of the consent process.
- All patients under 16 years were required to discuss their options with a counsellor prior to giving their consent and there was an electronic flagging system in place which reminded staff of this requirement when they accessed individual records.
- Staff assessed patients aged less than 16 years by using nationally recognised tools for assessing a young person's capacity to consent to treatment ('Gillick competence' and 'Fraser guidelines') which look specifically at whether doctors should be able to give contraceptive advice or treatment to under-16-year olds without parental consent. Where necessary an adult could sign the consent form if present.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) (MCA). Staff we spoke with discussed the need to ensure that patients had capacity to make an informed decision. Staff also

identified the need to act in the person's best interest, seeking advice from the clinical and safeguarding leads based at the Central London centre and making joint decisions with others if there were concerns about a person's capacity to understand.

Are termination of pregnancy services caring?

By caring we mean that staff involved and treated people with compassion, kindness, dignity and respect.

- Patients felt safe and well cared for and consistently reported about the non-judgmental approach of staff.
- All patients had a chance to speak with a nurse on their own to make sure that the woman was not being pressurised to make a decision. Aside from this, women could be accompanied by someone close to them.
- Patients' choices were respected. Their preferences for sharing information with their partner or family members were established and reviewed throughout their care.
- Patients' emotional and social needs were valued by staff and embedded in their care and treatment
- All potential staff were screened during the recruitment process to ensure they were 'pro-choice' and non-judgmental.

Compassionate care

- Staff displayed a compassionate and caring manner to the care they delivered. They recognised that it was a difficult decision for women to seek and undergo a termination of pregnancy.
- Staff established and respected each person's preference for sharing information with their supporter, and respected and reviewed this throughout their care.
- Although we were unable to speak with patients due to lack of privacy and patients declining the opportunity to comment, the results of the 2015 patients satisfaction reports showed consistently high ratings for the overall service at all three locations. Patients stated they felt safe and well cared for and consistently reported about the non-judgmental approach of staff and the support they were shown, and how.
- The vasectomy service was provided on a separate day to the termination of pregnancy service, to ensure male and female patients did not meet during their treatments.

Understanding and involvement of patients and those close to them

- Nursing staff explained all the available methods for termination of pregnancy and recorded this in patient's notes. The staff considered gestational age (measure of pregnancy in weeks) and other clinical needs whilst explaining the options.
- There were arrangements to provide chaperone at the time of the consultation and procedure and notices displayed in treatment areas informed women of it.
- Staff told us patients were made aware of the statutory requirements for completing and sending off the termination of pregnancy notification form. This meant that data published was anonymised.
- The patient satisfaction survey for 2015 showed only 70% of respondents were satisfied with dignity and respect at the Central London centre compared to 100% at Watford and 95% at Hemel Hempstead. However, patients gave an overall positive rating of 97% for the service at Central London.

Emotional support

- Counselling was available for all patients accessing services, whether for termination of pregnancy or vasectomy. This could be provided face to face or by telephone.
- Patients under 16 were required to engage in counselling as part of their decision making and treatment, to ensure they were fully aware of and informed of their decisions.
- Patients using the service could be accompanied by a supporter during consultations and treatments; however they were unable to accompany them during surgical procedures to protect others privacy and dignity.

Termination of pregnancy

Are termination of pregnancy services responsive?

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

- Patients could book appointments through the MSI UK telephone booking service, 'One Call', which was open 24 hours a day throughout the year. This provided patients with prompt access to appointments. It also enabled patients to choose the location they wished to attend.
- There was a fast track appointment system for patients with a higher gestational age or complex needs.
- There was a clearly defined specialist referral process for patients and men who had additional medical needs making them unsuitable for treatment at the centre.
- The service monitored its performance against the waiting time guidelines set by the Department of Health (DH). Between January 2015 and December 2015, all patients received their treatment within seven working days from decision to proceed to termination of pregnancy, which is within the DH recommendations.
- A professional interpreter service was available to enable staff to communicate with patients for whom English was not their first language. There were also translation facilities on the MSI website where leaflets could be downloaded in 20 languages.
- Support was available for patients with a learning disability or other complex needs.
- Complaints were managed centrally in accordance with MSI policies. However; information about how to complain was not displayed.

Service planning and delivery to meet the needs of local people

- The business development team planned the service in discussion with clinical commissioning groups (CCGs). This was in accordance with DH guidelines which state that commissioners and providers of termination of pregnancy services should have local strategies in place for providing information for patients and healthcare professionals on routes of access including self -referral.
- The Central London centre was open five days a week. Surgical termination of pregnancy procedures were carried out twice a week and vasectomy procedures once every two weeks. On average there were between 25 and 30 procedures undertaken each day.
- The Watford and Hemel Hempstead centres were open two days a week. Patients were advised to telephone the 'One Call' out of hour's service at times when they were shut so they could discuss their options.
- Privacy was not always achieved at the Central London location, due to the occasionally overcrowded waiting area, and shared recovery area which could be used by four patients at a time. There was a privacy screen which could be used if needed. We noted that lack of privacy was the main theme in the seven complaints the centre received in the previous year.
- The centre was open to patients every Saturday for surgical procedures and medical abortions. Evening appointments were not available.
- A fast track appointment system was available for patients with a higher gestation period or those with complex needs.
- Service level agreements were in place with local laboratories for tests relating to sexually transmitted infections, and following vasectomy.

Access and flow

- Appointment times were designed to ensure short waiting times and access to the full range of services. There was flexibility to re-arrange appointments at very short notice to meet the needs of the patients.
- Initial contact for any of the services provided by MSI UK was made through 'One Call', the national contact centre, which was open 24 hours a day throughout the year. GPs and other services such as local genito-urinary clinics could refer patients directly to MSI.
- At the initial phone contact an individual patient assessment was undertaken to determine the most suitable location for treatment at an MSI UK centre. For example, patients requesting surgical treatment were directed to MSI Central London whilst those choosing medical treatment were advised that they could be treated at Central London, Hemel Hempstead, or Watford.

Termination of pregnancy

- Patients could specify their preference for an appointment at a particular centre, and would also be told of possible appointments at other MSI UK centres so they could attend the most suitable appointment for their needs and as early as possible.
- MSI UK monitored the average number of days patients waited from initial contact to consultation, from consultation to treatment and the whole pathway from contact to treatment.
- Department of Health guidelines state that patients should be offered an appointment within five working days of referral, and they should be offered the abortion procedure within five working days of the decision to proceed with termination of pregnancy. Records we looked at confirmed this always happened.
- Between January 2015 and December 2015 no patients waited longer than 10 days from the time of referral up to treatment being carried out.
- There was an electronic system to ensure two medical practitioners assessed that the legal grounds for termination of pregnancy were met and signed the suitable forms giving authorisation to carry out a termination of pregnancy and we saw this happened.
- MSI UK employed doctors who used an electronic approval system to assess patients' details remotely in order to provide signatures on required forms, and EMA prescriptions if needed.

Meeting people's individual needs

- All patients received a 15-minute private consultation without anyone else present. This allowed patients the opportunity to disclose any personal or private information; it allowed them to disclose any information regarding abuse or coercion. Following the initial private consultation, patients could choose whether they wanted a supporter to accompany them for the remainder of their consultation and examination and we saw this happened.
- A professional interpreter service was available to enable staff to communicate with patients for whom English was not their first language.
- To maintain confidentiality, patients were provided with a pin number for staff to use to confirm their identity. This pin number was also required for supporters seeking access to the centres.
- An information leaflet titled 'your treatment information' was available for patients attending any MSI centre. This leaflet contained information about different options available for termination of pregnancy including what to expect when undergoing a surgical termination. This also included any potential risks. However, neither this leaflet nor the MSI website, were updated to reflect the simultaneous administration of medicines method of early medical abortion (EMA).
- Consultations were delivered either face to face or by telephone to meet people's needs. There was no requirement for patients to attend the centre ahead of the procedures if they did not wish; however, the option was available to them.
- There was a clearly defined referral process for patients who required a specialist service. MSI centres treated clinically fit and healthy patients. Patients with unstable medical conditions who did not meet these criteria were referred to the most appropriate NHS provider to ensure that they received safe and timely treatment.
- In Central London, a waiting room was available for patients who were having medical termination of pregnancy. Another waiting room was provided for patients undergoing surgical procedures. At the Watford centre, the only available waiting area was shared with the GP practice. We noted there were babies in the waiting room as well as posters of babies which could upset patients waiting for consultations or treatments. At Hemel Hempstead there was a separate waiting area.
- The Central London centre was inaccessible to wheelchair users or people with limited mobility due to its age. The Hemel Hempstead and Watford centres were accessible to wheelchair users and people with limited mobility.
- Leaflets were given to patients to inform them what to expect after the procedure. This included a 24 hour telephone number patients could call to seek advice if they had any concerns.
- The centre followed guidance on the disposal of pregnancy remains issued by the Human Tissue

Authority. We were told that limited discussions took place with patients around making informed choice about pregnancy remains. Relevant information about pregnancy remains was not included in any patient information leaflets that we saw displayed at the centre. Staff we spoke with told us they discussed options on an individual basis if a woman raised this issue.

- Nurses undertaking pre-termination of pregnancy assessments had a range of information available to them that they could give to patients as required. This included advice on contraception, sexually transmitted infections, miscarriage and how to access sexual health clinics.
- Termination of pregnancy protesters were frequently outside the Central London centre. 'One call' staff informed patients of this prior to arrival at the centre so they were prepared. Staff told us the protestors were mostly peaceful but they would contact the police for assistance when necessary.

Learning from complaints and concerns

- We did not see any information displayed at the Central London or Watford centres to advise patients and their supporters how to raise a concern or complaint informally or formally. At the Hemel Hempstead site two different versions of a leaflet explaining their complaints procedure were available, the most recent was dated 2011. We brought this to the attention of the managers who told us corrective action would be taken.
- There were no complaints raised with the Care Quality Commission during the reporting period.
- Between January 2015 and December 2015, seven formal complaints were recorded; one complaint remained unresolved at the time of our visit. Formal complaints would be managed nationally by the Head of Customer and Quality Services. The centre manager told us that a full investigation of all complaints would be carried out and feedback would be provided to staff of any learning points and changes in policy. However; there was no record of learning shared from complaints within the reporting period.

Are termination of pregnancy services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- MSI provided the centre with an integrated governance framework in line with the NHS governance agenda. However; arrangements for performance management were fragmented and did not always operate effectively. There was insufficient oversight of the service and its delivery. We were not assured by the leadership within the service.
- There was limited evidence to support that the practice of simultaneous administration of medicines for early medical termination of pregnancy was discussed and approved formally prior to implementation .The early medical abortion (EMA) policy was not updated to reflect the introduction of simultaneous administration of medicines.
- The culture within the wider organisation was perceived by staff to be top-down and directive with service development led by the executive management team with minimal opportunities for staff engagement. This meant that the direction and leadership approach was not always clear.
- Managers in the centres were not included in policy development. For example, staff were not fully aware of the rationale behind the recent practice introducing simultaneous administration of medicines for early medical terminations.
- The regional manager and corporate (executive) management team were aware of the risks associated with ineffective servicing and maintenance of equipment and non-compliance with the infection prevention and control code that were on the risk register. However; they did not sufficiently prioritise the issues or resolved them in a timely way. The risk register was not reviewed regularly by people with the authority and experience to do so.

- Role specific training needs were not always prioritised or acted upon in a timely manner.
- Overall we found staff were aware of the vision and strategy for the centre. Organisational values and objectives were shared with staff and each had a general understanding of the overall strategy in place.
- From our observation and discussion with staff we saw a strong commitment to meeting the needs of patients and resilience and determination to do the best they could for patients.

Vision, strategy, innovation and sustainability and strategy for this core service

- The organisation had clearly defined corporate objectives to support its aim to deliver the highest quality care for patients. Senior managers had a clear vision and strategy for this service and staff were able to demonstrate common aims during individual interviews.
- Overall we found staff were aware of the vision and strategy for the centre. The values and objectives were shared with staff from the point of induction, and each had a general understanding of the overall strategy in place. .

Governance, risk management and quality measurement for this core service

- The option of simultaneous administration of medicines for EMA was introduced at the centre, and other MSI UK locations, in February 2016. Staff told us they were following the MSI UK EMA policy dated October 2015 for medical termination of pregnancy. We reviewed the policy and noted that it was not updated to reflect the introduction of simultaneous administration of medicines. The practice was not supported by evidence and it was not consulted with clinical staff and approved formally prior to implementation. The provider did not set a review date or method to ensure it was effective .
- The Central London centre risk register was held centrally (at head office) in electronic form. There were 25 risks recorded on the risk register in the reporting period. Each was categorised as: minor, moderate, significant or major impact. None of the identified risks were categorised as having a major impact.
- We saw no evidence of documented risks, or risk management action plans, for the Hemel Hempstead and Watford locations. Staff we spoke to at both sites spoke about identified risks, and explained how they were being mitigated. However, the risk register did not align with what we observed in practice.
- There was a section for action plans to be completed on the electronic risk register, however; this was only partially completed for one identified risk, which was to appoint and train safeguarding leads for the centre. There was no indication on the risk register of resolving other actions. For example, related to infection prevention and control, and lack of privacy.
- The provider used a self-assessment tool to monitor and ensure that location complied with regulations and requirements. Required actions to address non-compliance included: review of audit regime and the appointment of individuals to monitor standards in both infection prevention and control and regulatory compliance. Whilst the list was comprehensive, there was no time line or evidence to show when these actions would be completed and it was unclear what stage they reached or who was the responsible person.
- Legislation and regulations require that in non-NHS places, the place where termination of pregnancy is carried out must display a certificate of approval issued by the Department of Health. At the Central London and Hemel Hempstead locations we saw the certificate of approval displayed in a prominent position. It was not displayed at Watford. We brought this to the immediate attention of the manager who showed us the certificate at the Central London site and made arrangements to display it at Watford.
- The corporate integrated governance committee (IGC) met three times a year and reported directly to the MSI's board. Local IGCs met four times a year. On a quarterly basis MSI UK governance support team produced national clinical governance reports which they shared with the Central London Centre.
- The provider was in a process of introducing standardised integrated governance meeting templates and quality dashboards with key performance indicators to improve quality measurements. We saw that the measure related to incident and safeguarding reporting was achieved. Following audits managers developed

action plans which were monitored and followed through; for example, a recent outcome from a safeguarding audit resulted in Mental Capacity Act booklets being provided for all clinical staff.

- Staff described the culture within the organisation to be top down and directive from the executive management team.
- Managers investigated safety incidents and completed root cause analyses and action plans. We saw an example of a root cause analysis relating to one particular incident. However, staff did not receive training in root cause analysis and the provider did not plan for training related to it to take place.
- Legislation requires that for a termination of pregnancy to be legal, two doctors must agree in good faith, that the grounds for termination of pregnancy in the Abortion Act are met and documented in a certificate of opinion. Arrangements were in place to ensure that certificate(s) of opinion, known as HSA1 forms, were signed by two medical practitioners in line with the requirements.
- Risk management arrangements were in place to make sure that the certificate(s) of opinion (HSA1) were signed by two medical practitioners and the subsequent arrangements for submission of certification of termination of pregnancy forms (HSA4).

Leadership of service

- The senior management teams at the location and at regional level were made up of relatively new members of staff following some interim appointments. Staff commented on the high frequency of changes in leadership in the past which created some instability. However, staff and managers spoke positively about the improvements made since the new management team started, particularly improvements to staff retention and the environment.
- The centre managers at the Central London centre were seen by staff to be supportive, visible and approachable. They felt managers understood the challenges to good quality care and could identify the actions needed to address them although they did not always follow through in a timely manner. Staff were unsure about the arrangements for managers to visit EMUs and could not recall when visits took place but were satisfied with the telephone support they could access if necessary.
- Staff at the centre had clearly defined roles and responsibilities and told us they had a sufficient skill mix of staff working in other MSI centres to deliver the care needs of the patients. All of the staff we spoke with talked about their commitment to ensuring patients were looked after in a safe and caring manner.
- The regional manager were described as supportive of their staff. They were well aware of systems and procedures in place throughout the organisation that encouraged service development.

Culture within the service

- Clinical staff told us they were proud of the service provided at the centre, especially in support of vulnerable children and patients. However, the culture within the wider organisation was perceived by staff to be top-down and directive with service development led by the executive management team with minimal opportunities for staff engagement. This meant that the direction and leadership approach was not always clear.
- Staff told us they were comfortable reporting incidents and raising concerns. They also said they were encouraged to learn from incidents. However; they could not provide us with examples of when they last reported a safety incidents and local managers told us the service potentially under-reported incidents.
- Staff felt they could openly approach managers if they felt the need to seek advice and support.

Public and staff engagement

- Patients attending the centre were given feedback forms which asked for their opinion of the service. However, staff, told us due to the sensitivity of the procedure and the emotional experience for the women, response rates were low and it was sometimes a challenge to engage with patients in this way.
- There was a newly established national communications team who provided examples of engaging with the wider community around the Central London centre through various engagement activities. For example they met with and actively sought advice

and opinion of university students, homeless charities, and sex workers. They aimed to increase awareness of contraception/STIs and an understanding of the termination of pregnancy process.

- A regional conference held in December 2015 allowed staff to meet with colleagues from other MSI UK centres. They said they were given the opportunity to engage and feedback on practices used at different locations. Staff received updates from the director of commercial operations, which included actions being taken to address issues raised by staff, such as revision of the induction training program for new staff, and introduction of a new electronic system to produce rosters in a more timely manner.
- A quarterly staff magazine was issued which staff found useful for keeping in touch with corporate as well as local issues. This development was at the early stage with only one magazine being issued at the time of the inspection.

Innovation, improvement and sustainability

- Staff recognised the existing challenges and challenges for the future such as; insufficient clinic space, increasing patients demand, and a need for more flexible approach for EMUS in the local communities. The plan was for continuous improvement through the increased leadership support, and staff development to manage increasing demands for the services going forward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- To ensure policies are kept up to date and that relevant staff are involved in clinical policy development and review.
- Ensure there are systems in place to keep staff informed and trained in relevant legislation, regulations and guidance
- Improve local safety incident reporting and sharing of learning.
- Provide formal root cause analysis training for staff involved in incident investigations.
- Assess record and act upon risks for each location.
- Provide effective systems for safety and maintenance equipment checks and equipment replacement.
- Use the WHO safety checklists for all clients undergoing surgical procedures
- To ensure audit processes to monitor whether the surgical safety checklist is used and acted upon are formally introduced, carried out and acted upon.
- Enable effective management and governance to prevent and control infection and ensure medicines are managed correctly.
- To ensure all of the national standards, including environmental, and cleaning requirements are adhered to.
- Enable all staff to complete training that is necessary for them to fulfil their role(s), including safeguarding level three, delivering HIV testing results, and all mandatory training and relevant skills training.
- Staff should routinely ask women about domestic abuse in line with current guidelines

Action the provider SHOULD take to improve

- Ensure environment provides privacy and dignity for patients using the service
- Display up to date and visible information about how to raise complaints and concerns at all three locations.
- Ensure there is a formal agreement in place to support emergency transfers.