

# Marie Stopes International West 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

### Ratings

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

### Overall summary

Marie Stopes International West London Centre is operated by Marie Stopes International. Facilities at the centre include two treatment rooms, five consulting rooms, ultrasound facilities, a waiting room and three day rooms including a recovery room with reclining chairs.

The service provides surgical termination of pregnancy procedures up to 23 weeks and six days gestation as well as early medical abortion and medical termination of pregnancy up to nine weeks and six days gestation. Surgical termination of pregnancy is carried out under general anaesthetic, sedation, by vacuum aspiration or

# Summary of findings

dilatation and evacuation or no anaesthesia for up to 10 weeks according to the patient's choice or needs. The service also provides consultations, ultrasound scans, contraception advice including fitting of long acting reversible contraception (LARC) and screening services for sexually transmitted infections. There is also a vasectomy service (male sterilisation) provided at the centre. MSI West London Centre also manages five early medical unit (EMU) satellite clinics located in the community, where early medical abortion and consultations in the early stages of pregnancy are provided in a private consultation room.

We inspected this service using our comprehensive inspection methodology. We carried out unannounced inspections on 21 and 22 of May 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

At our previous inspection on 6 and 7 July 2017 we found a breach in regulation and we served a requirement notice in respect of:

Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment.

At this inspection we checked that action had been implemented to address this breach and we found that improvements had been made.

## Services we rate:

We rated this service as good overall. We found good practice in relation to:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

However:

- Hand hygiene compliance rates were low and we observed isolated occasions where staff did not wash their hands after touching computer keyboards when treating a patient.
- There was no record of stock levels for medicines such as mifepristone and misoprostol which meant the service was not following the provider's medicines management policy and it would not be possible to check if there were discrepancies in stock levels.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

## Nigel Acheson

Deputy Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Termination of pregnancy

### Rating

Good



### Summary of each main service

Marie Stopes International West London Centre provides surgical termination of pregnancy up to 23 weeks and six days gestation and medical termination of pregnancy up to nine weeks and six days gestation. The centre also has five satellite clinics in the community providing medical termination up to nine weeks and three days gestation. The service also provides contraception advice including the fitting of long acting reversible contraception (LARC) as well as vasectomy (male sterilisation services). We rated this service as good overall. Safe, effective, caring, responsive and well led were rated as good.

# Summary of findings

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### Summary of this inspection

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Good 

# Marie Stopes International West London Centre

**Services we looked at:**

Termination of pregnancy

# Summary of this inspection

## Background to Marie Stopes International West London Centre

Marie Stopes International (MSI) West London Centre is part of the provider group Marie Stopes International, a not for profit organisation that was founded in 1976.

MSI West London Centre is contracted by Ealing, Hounslow, Hillingdon, Hammersmith and Fulham, Brent and Harrow Clinical Commissioning Groups (CCGs) to provide a termination of pregnancy service for the patients of West London and surrounding areas. The centre also accepts patient referrals from around the UK and abroad. The service receives referrals from general practitioners (GPs), hospitals, family planning services and another independent provider. Patients are also able to self-refer. The service treats adults and young people aged 14 and above. Young people aged 14-16 forms 2% of the patients treated at the centre.

MSI West London Centre also manages five satellite early medical units (EMU) located in the community in Guildford, Hemel Hempstead, Hillingdon, Watford and Wembley, where medical termination and consultations in the early stages of pregnancy are provided in a private consultation room.

The service provides surgical termination of pregnancy procedures up to 23 weeks and six days gestation as well as early medical abortion and medical termination of pregnancy up to nine weeks and six days gestation. Surgical termination of pregnancy is carried out under

general anaesthetic, sedation, by vacuum aspiration or dilatation and evacuation or no anaesthesia for up to 10 weeks according to the patient's choice or needs. The service also provides consultations, ultrasound scans, contraception advice including fitting of long acting reversible contraception (LARC), counselling and screening services for sexually transmitted infections. The service also provides a vasectomy service (male sterilisation).

The service is registered as a single speciality service and also provides the following regulated activities:

- Termination of pregnancy
- Family planning
- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures

The service had two registered managers in post during the time of our inspection. One registered manager who was the operations manager had been in post since March 2018 and the other registered manager who was the deputy clinical services matron had been in post since May 2019. The operations manager and deputy clinical services matron provided dedicated on-site managerial support for operational and clinical issues.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector and a CQC inspection planning coordinator. The inspection was overseen by Terri Salt, interim Head of Hospital Inspection.

## Information about Marie Stopes International West London Centre

MSI West London Centre is open six days a week from Monday to Saturday. The centre is open from 7.30am to

5pm from Monday to Friday and 8am to 4pm on Saturdays. The early medical unit satellite clinics are available throughout the week from Monday to Friday offering two to three clinics a week per location.

# Summary of this inspection

Facilities at MSI West London Centre include two treatment rooms, five consulting rooms, ultrasound facilities, a waiting room and three day rooms including a recovery room with 14 reclining chairs. There are no overnight beds. Early medical unit satellite clinics consist of a private consultation room with scanning facilities.

During the inspection, we visited MSI West London Centre and the Wembley early medical unit satellite clinic, spoke with 27 members of staff including registered nurses, health care assistants, reception staff, medical staff and registered managers. We spoke with two patients and reviewed 40 sets of patient records.

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

## Activity (May 2018 to April 2019)

- There were 10,559 episodes of care recorded at the early medical unit satellite clinics and MSI West London Centre.

- 6867 were medical terminations of pregnancy
- 3692 were surgical terminations of pregnancy
- 328 vasectomies

## Track record on safety

- In the last 12 months, there were 108 incidents reported by MSI West London Centre. Of these 77 were categorised as low harm, two were high and 29 were moderate harm.
- There were no never events recorded for the period May 2018 to April 2019.
- There was one serious incident recorded for the period May 2018 to April 2019.
- From March 2018 to February 2019 the service received seven informal and four formal complaints. All four formal complaints were not upheld. All complaints received were responded to within 20 days which was in line with the provider's complaints policy.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We rated it as **Good** because:

We found the following areas of good practice:

- Compliance around the use of The World Health Organisation (WHO) and five steps to safer surgery checklist had improved. We saw in records, and observed during surgical procedures, that the surgery checklist was now being completed appropriately at each stage. Audits were also now being undertaken.
- Staff knowledge and awareness of the duty of candour had improved since the last inspection.
- Mandatory training was now up to date and tracked through a new electronic learning and development platform.
- There was a good culture of incident reporting and staff at the early medical unit satellite clinics now received feedback and learning from incidents that had happened at the centre.

However:

- Hand hygiene audit results were low and we observed isolated occasions where staff did not wash their hands after touching computer keyboards when treating a patient.
- We found a cleaning cupboard which was left unlocked and contained passwords to the keypad lock for the door pinned on the wall within the cupboard. However, when we notified the operations manager, this was rectified immediately.

Good



### Are services effective?

We rated it as **Good** because:

We found the following areas of good practice:

- At our last inspection we found policies that were not up to date. At this inspection, policies we reviewed were up to date and accessible by staff on the provider's intranet. Policies made appropriate reference to national guidance and best practice.
- Staff assessed and monitored patients regularly and gave pain relief in a timely way. Pain assessment tools were used and records we reviewed showed pain scores were documented.
- The service now had a comprehensive compliance monitoring programme. Key indicators such as training compliance rates,

Good





# Summary of this inspection

audit results and complaints were monitored on a dashboard. The early medical unit satellite clinics were audited every six months by clinical team leaders and the deputy clinical services matron.

- The service had been training a member of staff to be a dedicated contraception and sexual health (CASH) champion to provide training to nursing staff to achieve a higher rate of uptake for long acting reversible contraception.

However:

- Health promotion information was limited, although there were some examples of health promotion information such as posters displaying information about cervical screening.

## Are services caring?

We rated it as **Good** because:

We found the following areas of good practice:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- We observed consultations and saw that staff were respectful and compassionate with patients.
- Staff we spoke with were passionate about their work and delivering patient centred care.
- We observed clinical and non-clinical staff talking sensitively to patients.
- We observed nurses introducing themselves to patients and taking the time to explain to patients about procedures.

**Good**



## Are services responsive?

We rated it as **Good** because:

We found the following areas of good practice:

- The service had now implemented a five minute gap in between consultation times to allow staff the flexibility to spend more time with a patient if needed.
- There was access to both telephone and face-to-face interpreters and staff told us they could be requested easily.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. All complaints received were responded to within 20 days which was in line with the service's complaints policy.

**Good**



# Summary of this inspection

- Telephone counselling was offered to patients including patients who had vasectomy procedures. If a patient requested face-to-face counselling, the service referred the patient to the south and central London MSI centres.

## Are services well-led?

We rated it as **Good** because:

We found the following areas of good practice:

- MSI West London Centre and the five early medical unit satellite clinics were managed by an operations manager and deputy clinical services matron which meant that there was now full oversight by a dedicated on-site manager for operational and clinical issues.
- Staff spoke highly of the visibility, involvement and support from the operations manager and deputy clinical services matron.
- Staff were passionate about their work and spoke of good teamwork in a patient-centred environment.
- There was now a clear governance system for the organisation and senior staff explained to us how information was shared up to board level and down to staff at the centre. Managers told us they felt that the process was more embedded since the last inspection and there was more visibility from the clinical director.

However:

- We reviewed the provider's medicines management policy which stated that the registered manager should be notified of any discrepancies between stock records and levels of medicines. While stock records and levels were recorded for controlled drugs, there was no record kept for medicines such as mifepristone and misoprostol which meant the service was not following the medicines management policy and it would not be possible to check if there were discrepancies in stock levels.

**Good**








# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Termination of pregnancy

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

## Are termination of pregnancy services safe?

Good 

We rated it as **good**.

### Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The service provided a structured induction and mandatory training programme for staff. Staff completed online and face-to-face mandatory training modules. Modules included infection prevention and control, control of substances hazardous to health (COSHH), information governance, safeguarding children, safeguarding adults, first aid, fire safety, basic life support, immediate life support which included training on sepsis, lone working essentials and manual handling.
- At the last inspection, staff told us access to training was difficult and we were not assured that the training matrix was kept up to date. At this inspection we found that the service had a new fully electronic learning and development platform which had been in place since March 2018. The electronic platform allowed staff to complete mandatory training modules online, book face-to-face courses and apply to additional training courses. There was now a clear indication of timescales for when courses needed to be refreshed. The system produced certificates when courses had been

completed, reminded staff when training was due and tracked each staff member's compliance. Each staff member had a personal login to the online system and could access the system from work or home.

- Staff we spoke with were positive about the training they received and felt that they received the appropriate training to carry out their role. Protected time was given to new starters and the operations manager told us that staff could also request additional protected time to complete training modules if they required this.
- Managers were now able to fully monitor staff training compliance with the new electronic learning and development platform. Data submitted by the service showed that the service's overall compliance for completion of mandatory training modules at the time of our inspection was 94.7% against a local target of 95%. The MSI corporate target for mandatory training was 85%.
- Staff we spoke with told us the service had closure days once a month where additional face-to-face training was provided according to team need and where staff had the opportunity to update their mandatory training. Staff described to us the most recent closure day where they had additional infection prevention and control (IPC) training led by the IPC lead nurse.

### Safeguarding

- We reviewed the service's safeguarding children and safeguarding adults policy which were in date and available on the service's intranet. The policies detailed individual responsibilities and processes for reporting and escalation of concerns. A whiteboard in the reception area of the centre informed staff and visitors of who the safeguarding leads were at the service.

# Termination of pregnancy

- Staff were trained to level three in both adult and child safeguarding. The operations manager was trained to level four safeguarding training. At the time of our inspection, 95% of staff had completed level three safeguarding training. The data accounted for one member of staff who was non-compliant and employed on a bank contract but was on extended leave when the data was collected.
- All staff we spoke with demonstrated a good understanding of safeguarding. Staff knew who the named safeguarding leads were and how they would raise safeguarding concerns or seek advice. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to escalate concerns to the safeguarding leads and make a referral. We were given examples of concerns they had identified and where referrals were made.
- Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) and child sexual exploitation (CSE) which was part of mandatory training within safeguarding level three. We saw posters about FGM displayed at the service. Staff also told us they had undertaken the training module, and a workshop to raise awareness of Prevent (WRAP) which helped staff awareness around the need to safeguard vulnerable people from being exploited for extremist or terrorist purposes. Between June 2018 to May 2019 the service made 48 safeguarding referrals to the relevant local authority. Of these referrals, four were for adults, 20 were for children, 18 were for FGM and six for women who were found on scanning to be over the legal limit for termination.
- Safeguarding information was flagged within a patient's electronic record. In a sample of records reviewed, we saw that a safeguarding referral had been made and was appropriately flagged within the patient's record. Patients under the age of 13 were not treated at the centre. These patients were referred to an NHS provider for treatment and the police and safeguarding authorities were also notified. The service treated young people aged 14 and above. Young people aged 14-16 formed 2% of the patients treated at the centre. Specific safeguarding proformas were used for young people under the age of 18 and a separate CSE tool was used if CSE was suspected. Telephone counselling was offered to young people under the age of 18. This was provided in a quiet room at the centre or alternatively, face-to-face counselling could be arranged at another centre if more convenient.
- Patients were seen on their own during the first part of a consultation so the nurse could go through safeguarding questions. Patients could be accompanied by a partner, relative or friend for the subsequent part of the consultation if they chose. Patients could also request for a number to be called out in the waiting room rather than their name in order to keep their identity confidential.
- Staff had access to a folder containing local and national safeguarding resources which had contact details of support and advocacy groups and mental health resources for patients to access in the local community.
- Posters for a domestic violence helpline were also displayed in both male and female toilets at the centre.

## Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, hand hygiene audit results were low and we observed isolated occasions where staff did not wash their hands after touching computer keyboards when treating a patient.
- The service achieved hand hygiene audit results of 90% in December 2018 and 89% in February 2019. However, audit results were significantly lower in April 2019 with 37%. To improve compliance rates, the IPC link nurse had undertaken face-to-face training at the monthly team meeting which included video presentations and demonstrations on hand washing techniques. This included the use of an ultraviolet light box which highlighted areas that could be missed during hand washing. Following our inspection, hand hygiene compliance rates for May was 89.5% with a re-audit planned every two weeks until the service achieved above 90% compliance.
- IPC standard operating procedures were accessible by staff on the provider's intranet. The provider had a dedicated IPC lead who conducted IPC audits and sent

# Termination of pregnancy

action plans for the service to complete. MSI West London Centre also had its own IPC link nurse who conducted bi-monthly IPC compliance audits as part of the compliance monitoring programme. Any actions were added to the local service improvement plan for example actions such as spot checks for hand hygiene were to be carried out by clinical team leaders on daily walkabouts of the centre.

- All clinical areas we visited were visibly clean and free of clutter. Hand sanitisers containing hand sanitising gel were available in all areas of the centre including in the reception area.
- Throughout our inspection all staff were observed to be 'bare below' the elbows. There was easy access to personal protective equipment (PPE), such as aprons and gloves of different sizes. We witnessed staff using PPE effectively. We saw that most staff decontaminated their hands immediately before and after every episode of direct contact or care. This complied with guidance from the National Institute for Health and Care Excellence (NICE) QS61: infection prevention and control. However, we saw isolated incidents where staff did not wash their hands after touching computer keyboards when treating a patient.
- Infection prevention and control (IPC) was part of mandatory training and records showed a compliance rate of 89.6% for clinical staff. Staff were able to articulate the IPC training they had received and were able to identify the IPC link nurse for the service. Hand washing posters were displayed throughout the centre instructing staff on hand washing techniques.
- We observed housekeepers working throughout the day completing cleaning tasks to maintain the cleanliness of the centre. The centre's cleaners were available for six hours during the day and two hours during the evening. Deep cleaning of the building took place every six months by an external company. If there was a requirement, the operations manager was able to request deep cleans earlier or as necessary.
- We reviewed patient areas as well as the waiting room, "dirty" utility room and store rooms and found them to be visibly clean. Patients we spoke with were satisfied with the level of cleanliness. We saw green 'I am clean' stickers being used to identify equipment that had been cleaned and ready for use. We inspected various items of equipment including blood pressure cuffs, ultrasound scanner, recliner chairs and found a good level of cleanliness. We also checked a sample of toilets and found them to be visibly clean. We saw disinfectant wipes throughout the centre and observed staff wiping equipment after use. Since the last inspection, recliner chairs had been replaced with IPC compliant recliner chairs that could be wiped down.
- We viewed the staff changing area which was visibly clean and free of clutter. Scrubs and washable shoes, that were appropriate for the treatment room, were also readily available.
- Medical devices were a mixture of single use and reusable items. Reusable items were sent off site for decontamination and sterilisation. Contaminated instruments were collected once a week in dedicated sealed blue boxes identified by labels which said 'contaminated'. The external company which collected contaminated items would also deliver the sterilised instrument sets. There was a system in place to track instrument sets that had been sent for processing.
- Waste management was handled appropriately, with different colour coding for general and clinical waste. All clinical bins were seen to be foot operated with lids and were not overfilled. Waste management and removal, including those for contaminated and hazardous waste, was in line with national standards. Laboratory spill kits were available and staff knew how to access these. Clinical waste was stored outside in a locked bin at the back of the building and collected by an external company once a week.
- Pregnancy remains following surgical termination were individually bagged, labelled and collected in a hazardous waste bin. Pregnancy remains were then stored in a freezer before collection which took place three times a week or kept if requested by a patient or for criminal investigation purposes. We viewed a record log which detailed when remains had been stored and collected.

## Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.**

# Termination of pregnancy

- The entrance to the service had secure entry with CCTV and buzzers to let people in which was controlled by reception staff. The reception area where patients registered was separate to the main waiting area. Emergency call buttons were located throughout the centre with a telephone system as a backup when assistance was required. Early medical satellite unit consultation rooms had a panic button which alerted security staff within the building to provide assistance if required.
- Medicines were kept in a locked cupboard in the treatment room and access was by a key which was held by the nurse in charge for the shift. Medicines cupboards in the early medical satellite units were locked and a key was kept by the nurse who conducted the consultation.
- There were two emergency trolleys at MSI West London Centre. We found that they were secured with a plastic snap lock so it was clear if someone had accessed the resuscitation equipment. Resuscitation trolleys were checked once a month as per MSI policy; however, we saw that there was one month where one trolley was not checked. We checked various consumables and found that they were sealed and in date. We also saw that there was a weekly check log for fridges and emergency equipment at the early medical unit satellite clinics.
- We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as blood pressure monitors and ultrasound scanning machines and found they had been safety tested. However, an ultrasound scanner printer in the Wembley early medical unit did not have a safety test sticker. We fed this back to the operations manager who sent a message to all of the early medical units to ensure the latest safety testing stickers were on all equipment and that servicing dates matched the dates recorded in the early medical units' assurance folders.
- Oxygen cylinders were stored securely and were in date. We inspected two sharps bins and found them to be correctly labelled and not filled above the maximum fill line. At our last inspection we found that temporary closures on sharps bins were not pulled across. At this inspection we found closures had been pulled across.
- We saw that recliner chairs in the recovery room were in a good state of repair. We also saw that there were enough chairs and side tables in the main waiting room.
- However, we found a cleaning cupboard which was left unlocked and contained passwords to the keypad lock for the door pinned on the wall within the cupboard. We fed this back to the operations manager who immediately removed the passwords, locked the door and put a sign on the door informing staff to keep the door locked.

## Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and quickly acted upon patients at risk of deterioration.
- The use of the World Health Organisation (WHO) and five steps to safer surgery checklist was embedded in practice and we saw in records we reviewed that staff consistently used this. Records we reviewed including records for vasectomy procedures showed the correct use of the World Health Organisation (WHO) and five steps to safer surgery checklist. This was an improvement from the last inspection where we found that staff did not always carry out the checklist appropriately. At this inspection we reviewed records and observed surgical procedures and saw that the checklist was completed appropriately at each stage. Audits were also now being undertaken. The latest audits as at May 2019 showed 93% compliance for the checklist completion.
- Staff we spoke with were aware of escalation protocols for deteriorating patients and the use termination of pregnancy early warning scores (TEWS). TEWS is a service-specific modified early warning system which allows early recognition of and reaction to a patient's physical deterioration. We checked TEWS charts in records we reviewed and found them to be correctly filled in.
- Anaesthetists were supported by nurses who were trained in anaesthetics and recovery and there was always a dedicated trained nurse who supported the anaesthetists in the treatment room. In the event of sickness, the operations manager told us they used



# Termination of pregnancy

agency operating department practitioners. Agency usage was kept to a minimum throughout the centre and where agency was used, the service used regular agency staff.

- We viewed the deteriorating patient policy which was in date and available on the service's intranet. A major haemorrhage protocol was followed if a patient bled excessively and staff we spoke with were able to describe the process.
- The service also had a service level agreement with a local NHS trust for emergency transfers. However, there was no review date on the agreement. At the time of our inspection, the operations manager and deputy clinical services matron had refreshed the transfer agreement and were in the process of discussing the new document with the local NHS trust.
- Staff we spoke with said they had received training in sepsis within immediate life support training. The compliance rate for immediate life support training was 90%. The compliance rate for advanced life support for permanent and sessional doctors was 100%. Sepsis warning signs were also printed in the aftercare booklet which was given to patients to take home after their treatment. Patients were told to call the provider's 24-hour telephone line if they were concerned about any symptoms they had.
- A safety huddle took place every morning. We observed the safety huddle and found it to be detailed and comprehensive with discussion of the day's patients and any complex cases.
- There was always a qualified member of staff in the recovery room. Nurses completed hourly observations of patients pre-operatively and quarter-hourly observations post-operatively. We saw evidence of this during the inspection and in records we reviewed.
- We observed staff checking with patients about allergies. We also saw staff asking if patients were asthmatic as they could react to certain medicines.
- Patients who were booked for surgical termination of pregnancy attended a pre-assessment clinic which included assessment of the patient's full medical history, an ultrasound scan to confirm gestation and sexually transmitted infection screening. Patients had a blood test to determine their rhesus status and blood

group. Patients with a rhesus negative blood group received an anti-D injection (immunoglobulin) to protect against complications in future pregnancies. We saw evidence of anti-D injections being administered to patients in records we reviewed.

- The operations manager told us that pregnancy remains were not kept for longer than 12 weeks which was in line with the Human Tissue Authority (HTA) guidance. We checked the log on the freezer which confirmed this.
- MSI West London Centre had a backup generator which meant that there would be uninterrupted power to the centre to ensure equipment still worked in the event of a power cut.

## Nurse staffing

- **The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.** Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Staffing rotas showed that there was a registered nurse or midwife on duty at all times when patients attended appointments at the centre. Staff told us they could access rotas online from home and found this useful.
- The provider used safe staffing guidance, which ensured that safe and appropriate patient to staff ratios were maintained at all points of the patient's treatment pathway. At the time of our inspection nursing staff were fully recruited to with 16 registered nurses. The use of agency (temporary) staff was kept to a minimum. MSI West London Centre used regular agency staff who were familiar with the service. In the last 12 months, 4% of shifts for registered nurses were covered by agency staff.
- At our last inspection, staff at early medical unit satellite clinics told us that they did not have enough time between patients. At this inspection, staff told us they had sufficient time between patients. We also observed consultations which were not rushed and saw that staff were able to spend enough time with the patient. The deputy clinical services matron manager also told us that no more than 13 appointments were scheduled in one day when there was one nurse on duty in an early medical unit satellite clinic.



# Termination of pregnancy

## Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- Anaesthetists were employed by MSI on a sessional basis and were always present on surgical list days which took place four days a week.
- Doctors were employed by MSI and worked within the centre. In addition, the service employed remote doctors who reviewed patient notes and medical history before signing HSA1 forms and prescribing medication.
- Employment checks including qualifications, insurance, registration, disclosure and barring service checks (DBS) and revalidation reports were conducted corporately by the MSI human resources team. The corporate medical director was responsible for yearly appraisals of the team of doctors.

## Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Records were a mixture of paper and electronic. Records included initial and on-going consultation information, documentation of patient care during the operative phase and anaesthetic records if a patient was having a surgical termination. We reviewed records and saw that they included the HSA1 form, World Health Organisation (WHO) and five steps to safer surgery checklist, termination of pregnancy early warning scores (TEWS) chart for patients having surgical termination and venous thromboembolism (VTE) risk assessments which staff completed prior to treatment.
- We reviewed 40 sets of records for patients who had either medical terminations, surgical terminations or vasectomies. Records we reviewed were comprehensive, legible, signed and dated. We saw that records documented full patient details and we saw completed HSA1 forms, pre-operative assessment and post-operative TEWS for patients having a surgical termination. HSA1 forms are legal documents to allow a termination of pregnancy to be performed and is signed by two medical doctors.

- We also saw that records documented allergies, safeguarding information and proformas for patients under the age of 18. Records also documented that there had been discussion around disposal of pregnancy remains.
- Patient records were stored securely behind the reception area. There was also a lockable cabinet at the clinic coordinator's office which staff used to store records when a patient was being treated. Archived records were then stored in a locked cupboard to ensure patient information was kept securely. Electronic records could only be accessed by authorised staff members and were password protected.
- The service ensured patient records were kept confidential by using a cover sheet in front of a paper patient record to prevent patient identifiable information from being seen.

## Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001)). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was stored within the cupboard and identified the expected stock of medicine. Two members of qualified staff checked the CD stock levels. Staff recorded in the CD register patient details, date, time, drug, dosage administered, dosage not used and balance left in stock. Each entry was signed by the doctor or anaesthetist that administered the drug and a second check was signed by a qualified member of staff. We checked the CD stock levels and found them to be accurate and the medicine in date. The keys for the CD cupboard were held by the nurse in charge for the shift.
- Checks for expired medicines were completed as well as logs for the daily fridge temperatures for fridges used to store medicines. The fridge temperature logs that we checked were all within acceptable range and we saw that these fridges were locked. Emergency medicines were noted to be within their expiry date and stored in tamper evident packaging.

# Termination of pregnancy

- Medicines were couriered to the early medical unit satellite clinics. At our last inspection we found that there was no adrenaline stocked at the Wembley early medical unit satellite clinic. During this inspection, we found that adrenaline was available, and the clinic had all the required stock of medicines on site. Adrenaline and glucagon were checked weekly and we saw records of this.
- Medical staff at the service used an electronic prescribing system to prescribe medicines remotely. Medication records showed that allergies were clearly documented in prescribing documents.
- The service treated patients with prophylactic antibiotics to reduce the risk of uterine infection. Records we reviewed confirmed that doctors followed local protocols for prescribing antibiotics.
- Medicines for medical terminations were prescribed after a face-to-face consultation had taken place with a nurse which included consenting and completion of the HSA1 form.
- The government legalised/approved the home-use of misoprostol in England from 1 January 2019 for women that have not exceeded nine weeks and six days at the time mifepristone is taken. To prepare for this change, the deputy clinical services matron told us staff at MSI West London Centre undertook training and a standard operating procedure was in place which outlined criteria for offering patients the option to undergo the second stage of treatment for early medical abortion at home. The second tablet to take at home was only offered to patients who attended MSI West London Centre and not at its associated early medical unit satellite clinics. The option was not offered to patients who had learning disabilities or required interpreters. From the 8th March 2019, MSI West London Centre had begun to issue patients who chose to, with the second tablet to take at home. The first 100 patients were also given an extra telephone appointment with MSI's 24-hour aftercare support team after they had taken the second tablet to follow up on their experience. Results of this audit were still being processed at the time of inspection. At the time of inspection, we were told by the operations manager that 50% of patients who attended the centre had taken the option to undergo the second stage of treatment for early medical abortion at home.
- Medicines management was audited every two months. Audit results between March 2018 and January 2019 showed an average compliance rate of 87.8%. Audit results showed a trend in 'dose not signed for'. In response to this audit, the service introduced checklists for medical termination which was a paper form within a patient's records that the nurse had to complete after each stage of the patient's treatment was completed. The introduction of the paper checklists had reduced 'dose not signed for' incidents significantly and there had been no incidents of this kind since December 2018 at the service. The provider was also in the process of improving the electronic patient records system where there would be a 'hard stop' within the computer system which would mean that nurses would not be able to discharge patients until medication had been signed for.
- Until February 2019, the provider had a service level agreement with an NHS trust for the provision of medicines optimisation support. However, in February 2019, the contract was terminated. This did not impact medicines supply functions and from March 2019, the provider began to review third party medicines optimisation arrangement. The review and transition period was supported by an independent adviser with experience to chief pharmacist level within the independent sector. From March 2019 the role of medication safety officer was brought in-house and the position was now held by the clinical director. The provider was also looking to recruit a pharmacist and pharmacy technician corporately.

## Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.** Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the

# Termination of pregnancy

duty of candour fully. At our last inspection, staff we spoke with had variable knowledge of the duty of candour. At this inspection, we saw that duty of candour awareness and knowledge had improved. Staff we spoke with were able to describe duty of candour fully. There was also a new duty of candour online module on the provider's electronic learning and development platform.

- The MSI incident reporting policy required managers to review and sign off all incidents. Incidents and lessons learnt were discussed at weekly complaints, litigation, incident and patient feedback (CLIP) calls.
- In the last 12 months, there were 108 incidents reported by MSI West London Centre. Of these 77 were categorised as low harm, two were high and 29 were moderate harm. There was one serious incident which took place during this period which was a complication during late stage termination. A full root cause analysis and 72-hour review was undertaken and immediate actions and learning was sent by email to all staff by the operations manager. Lessons learned from the incident were shared with staff and the duty of candour was applied. Staff were offered debriefs and were signposted to a 24-hour counselling helpline. There was also a group debrief conducted by the medical director.
- There were no never events reported in this period. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The service used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they were encouraged to report incidents and could also request individual feedback within the incident reporting form.
- At the last inspection staff at the early medical unit satellite clinics told us they did not receive feedback from incidents and investigations. Feedback from incidents and sharing of learning had improved at this inspection. Staff at the early medical unit satellite clinics were able to tell us of incidents that had happened at MSI West London Centre and subsequent learning actions.

- Learning from incidents was shared through email and at team meetings. The operations manager also printed the minutes of the meetings and put them in a shared folder in the staff tea room so staff who were unable to attend the meeting could still access the learning. We also viewed the minutes of weekly complaints, litigation, incident and patient feedback (CLIP) calls which all staff could attend. Minutes showed that there was discussion around incidents across MSI centres and learning was shared.

## Safety Thermometer

- **The service used monitoring results well to improve safety.** Staff collected safety information and shared it with staff, patients and visitors.
- All records we reviewed contained venous thromboembolism (VTE) risk assessments which staff completed prior to treatment.

## Are termination of pregnancy services effective?

Good 

We rated it as **good**.

## Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.** Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- At our last inspection, we found that policies were not always kept up to date. At this inspection, policies we reviewed were up to date and accessible by staff on the provider's intranet.
- We reviewed 40 patient records and found that patient needs had been assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. For example, we saw that all patients were assessed and treated for venous thromboembolism (VTE) in accordance with National Institute for Health and Care Excellence (NICE) guidance.

# Termination of pregnancy

- We reviewed a sample of the provider's policies such as the anaesthetic policy, deteriorating patient policy, adult and children safeguarding and informed consent policy. We found they were in date and made appropriate reference to national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE), Association of Anaesthetists of Great Britain and Ireland (AAGBI), Royal College of Obstetricians and Gynaecologists (RCOG) and the Department of Health Required Standard Operating Procedures (RSOP).
  - Patients were screened for sexually transmitted infections as part of their treatment. If there was a positive result, the service called the patient and referred them to sexual health and counselling services in the community. If a patient was not contactable, a notification was sent to their general practitioner (GP) (if the patient had consented to this) to ensure that the information was communicated and treated.
  - The service treated patients with prophylactic antibiotics to reduce the risk of uterine infection and treat chlamydia which is a sexually transmitted bacterial infection.
  - Contraceptive options were discussed at the initial assessment stage and also discussed during the consent process.
  - There was a process in place which ensured patients received appropriate cervical preparation. At the consultation stage, patients were asked a series of questions and their age and gestational period were taken into account to determine whether cervical preparation was needed.
  - All patients were scanned during a surgical procedure to ensure no products of conception remained. We observed staff scanning a patient during a surgical procedure to check this.
  - We observed the discharge process of one patient and saw that the patient was given an aftercare booklet. A staff member explained possible complications and directed the patients to a 24-hour telephone line if they had any concerns. Discharge letters were sent to a patient's general practitioner (GP) if they consented to this.
  - **Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**
  - There were appropriate processes in place to ensure patient's nutrition and hydration needs were met.
  - Patients were informed at their pre-assessment about fasting and fluids prior to receiving anaesthetic. They were told not to eat for six hours before their appointment and to drink clear fluids up to two hours before their appointment which was in line with Royal College of Anaesthetists Guidance.
  - We observed staff asking patients when they last drank or ate at different stages of the treatment process including prior to surgery. We also observed the surgeon checking with the patient prior to surgery.
  - The service had a kitchen where staff made drinks and prepared fruit for patients. We observed patients being offered biscuits, fruit, water and hot drinks after surgery.
- ## Pain relief
- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**
  - Staff used standardised assessment tools to measure pain which was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidance. A numbering system from zero (no pain) to 10 to express a patient's level of pain was used. Records we reviewed showed that pain assessments had been completed and pain scores were documented following surgical procedures.
  - Medical staff prescribed pre and post-procedural pain relief. Records we reviewed showed that pain relief such as non-steroidal anti-inflammatory medication was prescribed which as recommended in Royal College of Obstetricians and Gynaecologists guidance.
  - We also saw that patients were offered a warming pad after procedures to help ease pain.
  - We observed staff checking with patients about their pain and patients we spoke with told us that they received pain relief in a timely manner.

## Nutrition and hydration

# Termination of pregnancy

## Patient outcomes

- **Staff monitored the effectiveness of care and treatment.** They used the findings to make improvements and achieved good outcomes for patients.
- The service conducted audits as part of a compliance monitoring programme. The early medical units were audited every six months by clinical team leaders and the deputy clinical service matron. Audits included medicines management, information governance and sharps/waste management. Key indicators such as training compliance rates, audit results and complaints were also monitored on a dashboard. This was in line with the Department of Health Required Standard Operating procedures (RSOP)16 which recommends that all providers should have in place clearly locally agreed standards against which performance can be audited, on specific outcomes and processes.
- The operations manager compared local audit results with those of other MSI locations to learn from them and learning was discussed weekly at complaints, litigation, incident and patient feedback (CLIP) meetings and at quarterly local integrated governance meetings (LIGM).
- MSI West London Centre offered long acting reversible contraception (LARC) which is a method of birth control providing contraception for an extended period without user action. LARC was offered to women accessing termination of pregnancy services but the centre also offered a separate dedicated list once a month to fit LARC for women who made the decision later on. Uptake for LARC was 30% however the service was working to achieve a higher rate of uptake by training more nurses to fit implants and increasing the number of dedicated LARC lists. The service had been training a member of staff to be a dedicated contraception and sexual health (CASH) champion to provide training to nursing staff.
- Between May 2018 to April 2019 the centre and its associated early medical satellite units performed 6867 medical terminations. In the same period, the centre performed 3692 surgical terminations and 328 vasectomies.
- Complication rates such as retained products of conception, on-going pregnancy, post procedure infection and transfer to a local NHS trust were

monitored. Data submitted showed that between May 2018 and April 2019, there were 238 incidences of retained products of conception following early medical terminations and 138 incidences of early medical terminations with continuing pregnancies. The early medical termination failure rate was below the provider's target of two percent. In the reporting period the failure rate for medical termination (retained products of conception) was 1.9% and incidences of continuing pregnancy was 1.4%. Surgical termination (retained products of conception) failure rates was 0.5% and incidences of continuing pregnancy was 0%. In the same period, 17 patients required transfer to a local NHS trust during or after treatment.

- Of the 328 vasectomies carried out, there was one patient in December 2018 who reported possible infection but opted to see their general practitioner (GP). However, no further issues were reported by the patient.
- The deputy clinical service matron monitored numbers of patients who did not proceed with treatment. Year to date results showed that 15% of patients did not proceed with medical terminations and 16% of patients did not proceed with surgical terminations. Reasons varied from patients who changed their mind about their decision, unsuitability for treatment, or where gestation was too high. Patients were advised of where they could access care if they were continuing the pregnancy.

## Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held one-to-one meetings with them to provide support and encourage development.
- Staff had yearly appraisals and at the time of inspection 100% of staff had completed their appraisals. Staff also had one-to-ones with their managers every six to eight weeks. Staff commented that the appraisal process and one-to-ones were meaningful and focused on their development. They commented that the managers were very supportive in discussing development and training opportunities in one-to-one and appraisal meetings. Administrative staff also commented that they found their appraisals useful.



# Termination of pregnancy

- Staff we spoke with told us they received a comprehensive induction and were supported by the clinical team lead. Nursing and midwifery staff were assessed on clinical competencies during their first three months in post. This was overseen by the clinical team leader and deputy clinical services matron. A buddy system was also in place for new starters which was built into a structured induction pathway. Temporary (agency) staff had a local induction process which included orientation.
- Nursing staff were trained to perform ultrasound scans for dating purposes. Since September 2018, the provider had employed an ultrasound scanning director who had implemented a new inhouse training for ultrasound scanning. Training involved a two-day focused face-to-face theory course, clinical training with written assessments and summative assessments done by a university. Staff were then assessed on a minimum of three scans. Three-monthly audits had also been planned.
- Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses and midwives must follow every three years to maintain their registration. The provider's centralised human resources team checked that nursing staff who were required to revalidate, had done so successfully. A tracker was used to monitor NMC revalidation and communicated to senior managers at the centre. The deputy clinical services matron would receive emails when a staff member was nearing revalidation.
- The provider's human resources team also checked that medical staff were registered with the General Medical Council and completed the revalidation training. Medical re-validation was introduced in 2012 to ensure all doctors were up to date and 'fit to practice.' Doctors we spoke with confirmed they received yearly appraisals.
- Anaesthetists were supported by nurses who were trained in anaesthetics and recovery and there was always a dedicated trained nurse who supported the anaesthetists in the treatment room.
- Agency usage was kept to a minimum throughout the centre and where agency was used, the service used regular agency staff.
- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- We saw evidence of good multidisciplinary team (MDT) working within MSI West London Centre. We attended a morning safety huddle where patients on the surgical list that day were discussed. The meeting was attended by nurses, the doctor and anaesthetist conducting the surgical list. We observed inclusive discussions about the patients and saw that there was respect for each member of the multidisciplinary team and the contribution they made. There was a holistic discussion about patients' needs and communication was clear and inclusive.
- We saw evidence of good working relationships between nurses and medical staff. Nursing staff said they felt comfortable approaching doctors for support or advice.
- There was evidence of effective multidisciplinary partnership working with external agencies and professionals such as the local authority for safeguarding referrals. The centre also had links with a local counselling service which they could onward refer patients who requested additional counselling support. Letters were sent to a patient's general practitioner (GP) following discharge if a patient consented to this.

## Seven-day services

- **There was suitable provision of services at all times to ensure care and treatment delivery and supporting achievement of the best outcomes for patients.**
- MSI West London Centre was open six days a week Monday to Saturday. Surgical lists took place four days a week on Monday, Tuesday, Wednesday and Friday. The early medical unit satellite clinics were available throughout the week from Monday to Friday offering two to three clinics a week per location.
- Vasectomy appointments were held on one day every two weeks.
- MSI One Call which was an aftercare telephone line where patients could speak to a member of staff for advice and support was available 24 hours a day, seven days a week.

## Multidisciplinary working

# Termination of pregnancy

## Health promotion

- **Health promotion information was limited.**  
However, there were some examples of health promotion information such as posters displaying information about cervical screening.
- We observed staff discussing future contraception with patients during consultations and providing patients with leaflets on different type of contraception. Screening for sexually transmitted infections was also discussed during consultations.

## Consent and Mental Capacity Act

- **Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).** MCA training formed part of the consent module. Compliance for staff at the time of inspection was 100%.
- At our last inspection, consent was not audited separately. However, at this inspection we saw that informed consent compliance monitoring was now in place. Auditing took place every two months. Results for February 2019 showed a compliance rate of 94%.
- We observed staff obtaining consent and procedures being explained to patients. All patient records we reviewed demonstrated that consent was sought and clearly recorded in the patients' notes. We observed staff gaining verbal consent before treatment and we observed patients providing written consent prior to their treatment. We saw that patients were asked again prior to surgery if termination of the pregnancy was their final decision. For patients whose first language was not English, a face-to-face interpreter was used.
- All medical and nursing staff we spoke with understood the Fraser and Gillick competencies which helps assess whether a child has the maturity to make informed decisions about treatment without consent of a parent. Staff were aware of situations where these principles would be applied. Medical and nursing staff were aware of the MCA and the implications for young people above the age of 16. Patients with learning disabilities were assessed on a case by case basis and referred to an NHS provider if the centre felt that this was more suitable to the patient's needs.

## Are termination of pregnancy services caring?

Good 

We rated it as **good**.

## Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We observed consultations and saw that staff were respectful and compassionate with patients. A patient we spoke with commented on the professionalism and non-judgemental manner of the nurses. They commented that "everyone is really nice, they are not intimidating, and the decision is left to you".
- Staff promoted patients' privacy and dignity. We saw patients being covered with a blanket after procedures before being taken to the recovery room. Consultation rooms had signs on the doors to indicate when they were in use. Privacy screens were available in the recovery room if requested.
- Staff we spoke with were passionate about their work and delivering patient centred care. We observed clinical and non-clinical staff talking sensitively to patients. We observed nurses introducing themselves to patients and taking the time to explain to patients what would happen next. We also saw nurses offering tissues to patients when they were upset or distressed.
- The service used feedback forms to collect feedback from patients. Feedback from January to March 2019 showed that 95% of respondents felt that their overall care was 'very good' or 'excellent' which met the national average. 98% of patients responded 'yes, completely' to the question 'were you treated with dignity and respect' and 95% rated the professionalism and competence of staff as very good or excellent. Feedback from patients was collected and discussed at team meetings. The operations manager also put feedback in a folder in the staff tearoom so staff could see the comments that had been made. Comments included "thank you, you have made this experience

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just a little less scary and manageable” and “all of the staff, nurses especially were amazing, so helpful and kind. I cannot thank them enough for making this a positive experience or me.”

- During our inspection, the service was also piloting a new survey whereby feedback was collected on electronic tablets with more targeted questions including, but not limited to, treatment understanding, contraceptive counselling, dignity and respect, understanding of information, support, aftercare and pain management. Patients were able to give a rating alongside questions and submit comments in the free text space. The feedback was made available in the public domain through a website which collected feedback on healthcare providers.

## Emotional support

- **Staff provided emotional support to patients to minimise their distress.** They understood patients’ personal and cultural needs.
- Staff described how they would support patients emotionally at all stages of treatment. We saw a nurse supporting and reassuring an anxious patient by offering to hold their hand during a procedure in the treatment room.
- We observed nurses checking on patients in the waiting room and asking if they were ok. We saw that nurses spent time speaking to patients who were anxious.
- Counselling services were offered to all patients including patients who attended the service for vasectomy (male sterilisation) procedures. Patient records we reviewed showed that discussion around counselling had been recorded.
- Patients had access to a 24-hour helpline following a procedure as well as a post-termination counselling service. The service also had strong links with a counselling service run by the tri-borough clinical commissioning group (CCG).

## Understanding and involvement of patients and those close to them

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

- We observed nurses communicating sensitively with patients, explaining in a way the patient could understand and repeating explanations when a patient asked. Patients we spoke with told us they felt comfortable asking nurses questions and that questions they had asked were answered and explained fully. Patients also told us they received enough information regarding aftercare and contraception choices.
- Records we reviewed documented that the disposal of pregnancy remains had been discussed during the consultation. We observed consultations and found that staff were thorough and followed guidance for the treatment pathway. Staff ensured that patients understood the discussion and gave opportunities for the patients to ask questions. We saw staff reassuring a patient and telling them where they could get information (in the aftercare booklet or the 24-hour advice telephone line) if they were unsure or forgot any details or instructions.
- We observed multidisciplinary approaches to care planning for patients. During our inspection we observed a doctor noting a young patient with complex needs. The doctor spent additional time working together with the nurses to coordinate the patient’s care and personally checking on the patient before surgery to make sure they were comfortable and to answer any additional questions they might have.

## Are termination of pregnancy services responsive?

Good 

We rated it as **good**.

## Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- MSI West London centre had facilities which included a reception with waiting area, a separate main waiting area with 31 chairs, two small private quiet rooms, five consultation rooms, two treatment rooms and three



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dayrooms including the recovery room. There were 14 termination and six vasectomy recliner chairs. The service did not have overnight beds. There were also changing rooms for patients and staff. Facilities for patients were across two floors and there was lift access to the second floor. The third floor of the building was used by administrative and management staff. There was also a staff tearoom on the ground floor. The early medical unit satellite clinics were located within medical centres.

- The centre was open six days a week and provided medical terminations from Monday to Saturday. Surgical lists took place four days a week on Monday, Tuesday, Wednesday and Friday. A vasectomy list took place every other Thursday. The early medical unit satellite clinics were available throughout the week from Monday to Friday offering two to three clinics a week per location. Early medical unit satellite clinics only offered early medical abortion services.
- Patients booked appointments through the MSI UK One Call system. The booking system allowed for the patient to choose an appropriate MSI service location and the team informed the caller of different treatment options available for termination of pregnancy dependent on gestation. Patients received a text message once they had booked their appointment with the date, time and location of their appointment.
- Patients who were identified at initial consultation as not suitable for treatment were referred to the provider's centralised clinical Right Care team for onward referral as appropriate.
- There was a service level agreement with a local NHS trust where patients could be transferred to in an emergency. The agreement had recently been updated with additional detail about patient requirements and the operations manager and deputy clinical services matron were in the process of discussing the new version with the NHS trust.
- Pregnancy remains were disposed of sensitively and complied with the Human Tissue Authority Code of Practice (April 2017). We were told that pregnancy remains were not kept for longer than three months. If requested, pregnancy remains were kept in a fridge for

24 hours to give the patient time to think about options for the remains. Options for pregnancy remains were discussed in consultations and we saw evidence of these discussions in records that we reviewed.

- Patients were allowed to have relatives or friends accompany them in consultations after the safeguarding stage of the consultation had been completed. Relatives, friends and partners were not allowed in the recovery room in order to maintain the privacy of patients. However, in circumstances such as termination of pregnancy due to fetal abnormalities or if a patient had learning disabilities or was under 16 years of age, screens were put up around a recliner chair and partners, relatives or friends were allowed to stay with the patient.

## Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences.** Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- There were a range of leaflets on treatment information, sexually transmitted infections and different types of contraception. These leaflets were not available in languages other than English however, consent forms were available in 37 other languages. A patient could request to read the consent form in a different language and were then asked to sign an English version.
- Staff told us telephone and face-to-face interpreters could be requested easily. We observed an interpreter who accompanied a patient to explain medical terminology. There was also a separate entrance for the interpreter to accompany a patient in the treatment room if a patient was not able to speak any English and could not communicate with the staff.
- The service had implemented a five-minute gap in between consultation times to allow staff the flexibility to spend more time with a patient if needed. Additional support was provided by clinical team leaders if a consultation took longer than planned.
- Patients with learning disabilities were assessed on a case by case basis. We were told that a second nurse would be allocated to the patient to act as an advocate and help with reading and writing. We were told that

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patients with additional needs were allowed to walk around the centre or were given colouring/drawing activities to keep them calm while waiting for their procedure or appointment. We observed a morning safety huddle where a patient with complex needs was discussed.

- MSI West London Centre had ramp access for wheelchair users and lifts within the building. Hearing loops were also installed and guide dogs were accommodated for. Documents or leaflets could be printed in large print for patients with visual impairments.
- Posters in the waiting room informed patients that they could request a chaperone.
- There were pull-down chairs around the centre where patients, friends or relatives could have a quiet moment away from the waiting room.
- However, some patients told us the recliner chairs in the recovery room were not very comfortable.
- The service had conducted an audit in January 2019 to understand patients' views on the use of privacy screens. Results showed that most patients preferred not to have the screen. However, privacy screens were offered when a patient arrived in the recovery room and could be requested to give patients additional privacy after their procedure.
- The provider had a 24-hour telephone line which patients could access for additional support and advice following a procedure.
- Fresh fruit, light snacks, biscuits and hot drinks were offered to patients following treatment. Relatives and partners were able to buy hot drinks on site. The centre also sold warming pads for patients who wanted to use these at home. However, patients commented that the service did not have Wi-Fi for public use on site.
- Counselling was offered to patients including patients who had vasectomy procedures. Counselling was offered over the telephone at this centre. If a patient requested face-to-face counselling, the service referred the patient to the south and central London MSI centres. If a patient was under the age of 18, the patient was asked to come to the centre where they would receive counselling over the telephone in a private room or referred to the south and central London MSI centres for

face-to-face counselling. The service also had strong links with a local counselling service run by the local clinical commissioning groups and patients were also referred to this organisation for additional support.

## Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- The service received referrals from general practitioners (GPs), hospitals, family planning service and another independent provider. Patients were also able to self-refer.
- Waiting times were monitored weekly by a central capacity team. The service was able to adjust lists and add additional appointments to meet demand. The service also expedited patients who were nearing the legal limit or who were under the age of 18. Internally, the target for appointment waiting times was three working days and from decision to proceed a patient waited on average two to four days which met the Department of Health RSOP 11: Access to Timely Abortion which states that patients should be offered an appointment within five working days of referral and they should be offered the termination of pregnancy treatment within five working days of the decision to proceed.
- We received data on the percentage of patients who waited longer than 10 days from decision to proceed up to termination of pregnancy. In 2018, 33% of patients waited more than 10 days for a medical termination and 67% of patients waited more than 10 days for a surgical termination. Subsequent data post inspection detailed that there had been improvement with access to the service. MSI stated that additional capacity had been built in with standby appointments that had resulted in a 45% higher appointment capacity to actual booked appointments. Data for January to July 2019 demonstrated that 14% of patients waited more than 10 days for a medical termination and 45% of patients waited more than 10 days for a surgical termination. MSI West London Centre ensured appointments were available to patients within the 10 day limit and monitored reasons why some patients exceeded the 10 day limit. Reasons ranged from patients who did not attend, patient choice for the appointment day and

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patients cancelling appointments. The service also received a weekly report corporately with the current waiting times and current number of patients awaiting appointments.

- Patients were informed of waiting times and delays when they arrived at the centre and this was also displayed on a digital screen within the waiting room.
- The did not attend rate (DNA) for the centre and the early medical unit satellite units were 7% for medical termination and 10% for surgical termination for the year to date. If there was a medical or safeguarding concern, the provider's centralised One Call team would follow up with the patient by telephone. If no risk was highlighted and the patient was of a gestation lower than 14 weeks, a follow up call was not made as this could be seen to be coercive.

## Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received.** The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- From March 2018 to February 2019 the service received seven informal and four formal complaints. All four formal complaints were not upheld. All complaints received were responded to within 20 days which was in line with the service's complaints policy which states complaints should be responded to within 20 days.
- The service used feedback information from patients to improve the service. For example, the service displayed 'you said, we did' posters in the waiting area. One 'you said, we did' poster was in response to patient feedback whereby a patient had not wanted their name to be called out in the waiting room. In response to this, the service created an option whereby if a patient did not want their named to be called out, they could be allocated a number at the reception and the number would be called out instead. This number would be recorded in patient's record so it could be used throughout their attendance at the centre.
- Feedback and learning from complaints were shared at team meetings. All complaints were investigated with outcomes and lessons learned documented. For example, in response to a complaint where a patient

was able to see their scan pictures, the service now included a front sheet for patient documents so that no information could be seen by the patient or anyone else. Nurses and healthcare assistants were also told to keep scan pictures face down when in use and to put them in an envelope when they were no longer required. Any trends and lessons learned from complaints were also discussed at weekly complaints, litigation, incident, and patient safety meetings as well as at quarterly local integrated governance meetings. We saw evidence of discussion of complaints within the minutes of these meetings.

- There were posters in the waiting room informing patients of how to make a complaint. Patients told us they felt comfortable speaking directly with staff if they wanted to complain and knew how to make a complaint. Nurses, the operations manager and the deputy clinical services matron told us they tried to address concerns as they arose.

## Are termination of pregnancy services well-led?

Good 

We rated it as **good**.

## Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- MSI West London Centre and the five early medical unit satellite clinics were managed by an operations manager and deputy clinical services matron which meant that there was now full oversight by a dedicated on-site manager for operational and clinical issues. The operations manager had responsibility for the clinic controller, operations team leader, front of house and maintenance staff. The deputy clinical services matron had responsibility for the clinical team leaders who managed the registered nurses, midwives and healthcare assistants. Staff at the early medical unit

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satellite clinics were managed by the clinical team leaders but had access to both the operations manager and deputy clinical services matron for additional support. The operations manager and deputy clinical services matron were supported by a regional manager who reported to the operations director for MSI corporately.

- The deputy clinical services matron and operations manager at the service took ownership of the service and told us they were able to suggest changes and improvements for the service. MSI West London centre was involved in hosting pilots such as inviting student nurses from a local university to help with their learning of termination of pregnancy services and being one of the first centres to try out a new staff wellbeing package which was being rolled out.
- Staff spoke highly of the visibility and involvement of the operations manager and deputy clinical services matron. Staff told us the managers were always available to support staff in the clinic and over the phone for the early medical units. Staff told us they felt comfortable approaching the managers with any issues they had.
- Staff commented that there had been a lot of improvements to management since the last inspection. Staff told us staffing had improved, they now felt listened to, supported in their development and there were now regular meetings where they could voice their concerns.
- The operations manager and deputy clinical services matron together held monthly team meetings which formed part of a closure day where a whole day was dedicated to face-to-face training, simulation training and learning from incidents. Administrative staff were present at the beginning of the meeting for general non-clinical updates and messages from the managers. Early medical unit satellite clinic staff were also invited to these meetings. Minutes were emailed to staff who were unable to attend the meeting. In addition, early medical unit satellite clinic staff had telephone meetings with the operations manager and deputy clinical services matron. Staff said this was a good opportunity to feedback on any issues and told us that the operations managers and the deputy clinical services matron always listened to their concerns.

## Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The operations manager and deputy clinical services matron were knowledgeable about the corporate vision and strategy. All staff we spoke with were aware of the provider's mission of "children by choice not chance".
- The operations manager and deputy clinical services matron told us that the local vision for MSI West London Centre was to become a centre of excellence in teaching. They told us the centre was proactive in encouraging learning and wanted to be a centre where staff from other MSI centres could attend training courses.
- The operations manager told us that they spoke of the vision of the service to staff at monthly team meetings so staff could be involved in changes.

## Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were passionate about their work and spoke of good teamwork in a patient-centred environment.
- We found an open and honest culture and staff were knowledgeable about the duty of candour. Staff knew about the service's processes and procedures and could give examples of the learning that was shared from an incident.
- All staff we spoke with, including administrative staff consistently told us they felt supported by their

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managers and spoke of an open-door policy. Staff told us that the management had improved since the last inspection and were a lot more visible and approachable. Staff told us they were encouraged to develop and take part in additional training. A staff member told us how they had started as front of house staff and was supported to become a team lead.

- We attended a safety huddle during our inspection and found that there was respect for each member of the multidisciplinary team and the contribution they made.

## Governance

- **Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- Complaints, litigation, incident and patient feedback (CLIP) meetings took place weekly in the form of a teleconference with other MSI centres. The clinical director for MSI also attended the CLIP calls. All staff were invited to attend these meetings and minutes were circulated by email for those could not attend. We viewed minutes of these meetings and saw that topics that were discussed included incidents across MSI's UK centres, informal and formal complaints, safeguarding cases and learning and action taken from these. Centre managers took turns to present on learning that had occurred from an incident at their location in order to share learning with other centres on the call.
- There was now a clear governance system for the organisation and senior staff explained to us how information was shared up to board level and down to staff at the centre. Senior staff told us they felt that the process was more embedded since the last inspection and there was more visibility from the clinical director. The deputy clinical service matron told us that they now sat on the provider's medicines management committee and the clinical effectiveness group which reviewed policies. They told us they felt more involved in the wider governance of the organisation and that their input was valued.
- There was a quarterly local integrated governance meeting (LIGM) which reported into quarterly regional integrated governance meetings. LIGM meetings were chaired by the regional manager and attended by the centre operations managers, clinical service matrons, clinical and operational team leaders. We reviewed the minutes of these meetings and saw comprehensive discussion of incidents, safeguarding concerns, audits, risk register with action plans and names allocated to the actions with deadlines. The group monitored performance and local compliance against an integrated quality dashboard which was then monitored on a corporate level. The centre was benchmarked against other MSI centres and this was reported at the regional integrated governance meetings. We saw minutes of regional integrated governance meetings which was chaired by the regional director and showed MSI West London Centre's performance compared with other centres, trends in incidents, complaints, safeguarding and risks across the region. We saw in the minutes of these meetings that names were allocated to any actions that arose and had deadlines for completion.
- There were team meetings at MSI West London Centre on a monthly basis. Complaints, incidents and learning as well as refresher training were discussed at these meetings. At the last team meeting the IPC link nurse presented to the team handwashing techniques in response to low hand hygiene audit results.
- Early medical unit staff reported that managerial oversight of the satellite clinics had improved. Each satellite clinic had a quality assurance folder which included an asset register, equipment audits and the Department of Health certificate for approval licence for termination of pregnancy. The operations manager had also implemented teleconference meetings to increase communication with the staff at the satellite clinics.
- There was now local oversight of medical staff with the introduction of a doctors' manager.
- The Department of Health licence was displayed in the main centre. The service submitted HSA4 forms to the Chief Medical Officer electronically as recommended by the Department of Health. The operations manager explained the process that was in place for submission of HSA4 forms. HSA4 forms were submitted electronically through the provider's patient record system. There was a paper form for patients who were non-UK residents or were residents of Northern Ireland. Registered nurses administering the second stage of



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medical termination or the surgeon completing the surgical procedure were responsible for submitting the HSA4 form on the system which was then sent to the Department of Health within 14 days of the termination taking place. The operations manager reviewed and checked form submissions on a weekly basis to ensure compliance. We were told that a patient could not progress to the discharge process stage until the HSA4 had been uploaded and submitted.

- The service received quarterly quality reviews from associated clinical commissioning groups (CCGs) and the centre has received visits as part of the reviews. Results from a peer review in January 2019 showed that there were high level and low-level cleaning (dust) issues. In response to this, the service changed their cleaning contract and the contractors also held a training session for staff as well.
- Service level agreements with third parties were reviewed regularly by the operations manager and deputy clinical services matron at the centre.

## Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- The service kept a local risk register which was discussed and reviewed at the local integrated governance meeting. We viewed MSI West London Centre's risk register which had risks with review dates in place, controls currently in place, risk levels and review dates.
- We reviewed the provider's medicines management policy which stated that the registered manager should be notified of any discrepancies between stock records and levels of medicines. While stock records and levels were recorded for controlled drugs, there was no record kept for medicines such as mifepristone and misoprostol which meant the service was not following the medicines management policy and it would not be possible to check if there were discrepancies in stock levels.

- The service held safety huddles which took place every morning to identify potential risks, allocate resources effectively and disseminate information such as safety alerts.
- There was a comprehensive compliance monitoring audit programme in place and results were discussed at local integrated governance meetings with action plans in place.
- Incidents were investigated by managers and lessons learned were shared by email and at monthly team meetings. Managers had received root cause analysis training in order to take a consistent approach when reviewing incidents. Managers discussed incidents and learning with the regional manager at monthly regional meetings.

## Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**
- During our inspection we observed that the surgeon and anaesthetist both reviewed the reason for termination prior to signing HSA1 forms. We also saw that the reason for the termination of pregnancy was also written on the back of the form. This was in line with the Department of Health Required Standing Operating Procedures (RSOP) which required the provider to ensure that the completion of legal paperwork (HSA1 and HSA4) met the requirements of the Abortion Act 1967.
- Information governance training compliance was 91.7%. The operations manager was aware of the recent changes to the MSI records management and retention policy which stated that termination of pregnancy records were to be destroyed after 30 years.
- The operations manager told us that the provider would soon be transferring to a new patient records system and that MSI West London Centre would be piloting the new system. The operations manager had encouraged staff from MSI West London Centre including a

# Termination of pregnancy

healthcare assistant to be involved in the procurement process of the new system. These staff members would then become champions for the system and train fellow colleagues at other centres.

## Engagement

- **Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

- Patients' views and experiences were gathered and acted upon to shape and improve the service. Patients were encouraged to share their views on the quality of the service and their experience through paper feedback forms and questionnaires on electronic tablets. Any feedback that required immediate attention would be investigated by the centre's managers and discussed at local integrated governance meetings.
- The service had created a 'team member of the month' award where staff were encouraged to fill in a form to nominate a colleague who had gone the extra mile in their work. Nominations would be announced at monthly team meetings and the staff member would be presented with a voucher. The provider was also a member of an online discounts website where all staff members could access discounted services in a variety of areas such as gym membership or wellbeing classes.
- Results from the annual 2018 staff survey for the provider showed a mixed response from staff. 94% of staff agreed with the statement: 'I feel data security and protection are important for MSUK', 91% said 'I understand the mission of MSUK' and 'I would recommend the services of MSUK'. However, 49% of staff said 'MSUK has effective communication throughout the organisation'. Senior staff told us that the provider was about to start a new way of surveying by sending out individual staff surveys on a monthly basis to engage better with staff.
- Staff we spoke with told us they felt more involved in the development of the centre as they now had regular meetings where feedback and learning were shared. A nurse told us they attended the weekly CLIP call on behalf of the nursing team and brought up any comments or feedback that nurses asked them to raise.

- Staff told us they found monthly team meetings useful and that they were a good opportunity to voice any concerns they had. Staff at early medical unit satellite clinics also commented that they felt communication between the centre and the units had improved and that management engaged more with them to create a more inclusive atmosphere.
- Staff at the early medical unit satellite clinics often worked alone and told us they could always pick up the phone to the managers at MSI West London Centre if they needed any support or advice. They were also aware of the provider's lone worker policy. We viewed the lone worker policy and saw that it was in date. Staff at the early medical unit satellite clinics also had a group messaging forum which allowed them to stay in touch with their colleagues and ask for advice when they needed.
- The operations manager and the deputy clinical services matron reported improved communication at a corporate and local level. They regularly fed information up through governance meetings and told us the clinical director for the provider was proactive, was always on the CLIP call and occasionally came to the centre to deliver training. In addition, the operations manager and the deputy clinical services matron told us that MSI West London Centre had opportunities to get involved in the provider's pilot schemes and that locally, the new compliance monitoring programme provided quality and risk oversight of services at a local level.
- MSI West London Centre had engaged with the local council and police and was granted a public spaces protection order in 2017. This meant that there was now a 'buffer zone' around the centre which prevented anti-abortion protestors from congregating within 100 metres of the service. The operations manager told us that this had significantly improved staff and patients' experience when accessing the service.

## Learning, continuous improvement and innovation

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

## Termination of pregnancy

- Both the deputy clinical services matron and operations manager told us that MSI West London Centre aimed to be a centre of excellence for learning and often took part in new pilots that the provider implemented. For example, the centre was part of a pilot inviting student nurses from a local university to help with their learning of termination of pregnancy services. Staff members from the centre were also involved in testing a new patient records system which would be implemented in the coming months. These staff members would then become 'champions' for the new system and help colleagues at the centre and at other MSI centres to use the new system.
- The provider was also about to roll out a new wellbeing section of their intranet which would initially be piloted at MSI West London Centre. Staff would be asked to feedback to other MSI centres on how they have used the wellbeing services offered.
- We were told by the deputy clinical services matron that the service had been training a member of staff to become a contraception and sexual health (CASH) champion. The CASH champion would provide training to nursing staff including training on fitting contraceptive coils (long acting reversible contraception).
- The operations manager encouraged staff to attend training or complete additional modules on the provider's electronic learning and development platform. Staff were also encouraged to attend conferences and fed back their experiences and learnings to the team at team meetings. The operations manager had supported staff in their learning by creating a small card with useful information such as names of the safeguarding leads, the 'speaking up champion' and details around the duty of candour and the three most detrimental risks to a patient.



# Outstanding practice and areas for improvement

## Outstanding practice

- MSI West London Centre aimed to be a centre of excellence for learning and often took part in new pilots that the provider planned to roll out with the aim of further developing the service. Staff we spoke with were committed to continually learning and improving the service and spoke of the pilot

programmes the centre took part in. For example, MSI West London Centre was part of a pilot inviting student nurses from a local university to the centre to help with their learning of termination of pregnancy services.

## Areas for improvement

### Action the provider SHOULD take to improve

- The service should continue to improve hand hygiene compliance rates and continue to educate all staff on hand hygiene such as washing hands after touching computers when treating a patient.

- The service should continue to make sure that rooms with keypad locks such as cleaning cupboards are kept locked at all times.
- The service should keep a record of how much mifepristone and misoprostol were used per day in order to check discrepancies and follow provider policy.