Marie Stopes International Birmingham

Quality Report

4 Arthur Road
Edgbaston
Birmingham
England
B15 2UL
Tel:
0345 300 8090
0345 300 1202
+44 1454 457 542
Website:www.mariestopes.org.uk

Date of inspection visit: 2 , 13, 15, 16 and 17 June 2016
Date of publication: 20/12/2016

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Termination of pregnancy (ToP) refers to the treatment of termination of pregnancy by surgical or medical methods. Marie Stopes International Birmingham is part of the provider group Marie Stopes International (MSI). The service at MSI Birmingham was located within non-purpose built premises run by MSI. Seven satellite clinics connected to its registration operate around the city of Birmingham and in other towns nearby in a variety of leased premises including suites in community health centres. The services are provided under contract with local clinical commissioning groups for NHS patients. MSI Birmingham also accepts private patients.

The service was registered in July 2012 as a single specialty termination of pregnancy service providing a range of services for medical termination of pregnancy up to a gestation of 10+0 weeks and surgical termination of pregnancy up to 23+6(days). This included pregnancy testing, unplanned pregnancy counselling/consultation, early medical abortion, abortion aftercare, sexually transmitted infection testing, contraceptive advice, contraception supply and vasectomy services.

We carried out this announced comprehensive inspection on 2 June 2016, as part of the first wave of inspection of services providing a termination of pregnancy service. The inspection was conducted using the Care Quality Commission's new methodology.

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities it provides.

The inspection team included two inspectors, an assistant inspector and a consultant obstetrician and gynaecologist by phone.

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

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

Our key findings were as follows:

Is the service safe?

Staff reported incidents but the systems that supported this were not reliable and investigation and learning was variable. There was sometimes delay in uploading reports to the electronic system, staff could not easily track the progress of incident investigations and some patterns of incident reported were not identified and investigated. Staff did not consistently follow some safety systems such as national guidelines to safer surgery, use of emergency equipment checklists and good hand hygiene practices. Not all staff were up-to- date with their mandatory training including safeguarding, life support skills and supporting anaesthesia. Many staff including local leaders had not undertaken safeguarding training to the level appropriate for degree of vulnerability presented by many patients. Staff followed policies and procedures for safeguarding children and vulnerable adults. Risks to patients were assessed and staff made referrals and emergency transfers to local acute hospitals when it was appropriate for patients. Sufficient numbers of experienced doctors and nurses staffed the service.

Is the service effective?

Summary of findings

Systems in place to collect information about the effectiveness of the services did not provide the local leaders or staff with a clear picture of how their service was performing against regional and national clinical standards. Clinical audits recommended by the Royal College of Gynaecologists were not specifically addressed. The results of local audits did not always match with what we observed or the patterns of errors shown on the provider's incident reporting records. There was no established pathway for effectively supporting women with learning disabilities to give informed consent to treatment. Health care assistants were taking consent to treatment without the appropriate level of safeguarding training and competency for the vulnerability and complex needs of many patients receiving the service.

Staff checked patient's medical and health history before treatment and the clinic carried out only procedures for which it was registered and within national guidelines. Other patients were referred to more appropriate services to meet their needs. Patients were given information about contraception and sexually transmitted infection. Nurses and doctors were competent and worked with other healthcare providers locally for the benefit of patients.

Is the service caring?

Staff treated patients with respect, kindness, dignity and care. Patients spoke positively about staff attitudes towards them. Patients received a lot of information from staff about their treatment and a 24-hour help line was available to provide additional information and address concerns. Staff checked patients decisions at each stage of the process and went over the options with patients on more than one occasion. Counselling was made available to all patients over the phone or face-to-face. This was compulsory for patients under 16 years of age and we saw bookings on record with independent counsellors. There was no 'easy read' additional material available to enable patients with learning disabilities to access the information about treatment, treatment options and contraception.

Is the service responsive?

Services were planned to provide surgical and early medical terminations of pregnancy at a main clinic and in satellite clinics around the city and outlying towns within neighbourhood health centres. Patients accessed services and appointments through a national call centre, this system managed waiting times across clinics to respond flexibly to local demand, legal requirements, and targets set by commissioners of the services. Translation services were available to patients from the first point of making contact with the organisation and staff helped patients to access other services for help with domestic violence or drug abuse. Patients could receive counselling prior to receiving any procedures. There were a variety of means by which patients could comment on the service, raise concerns or make a complaint. Waiting times within the clinics was a challenge for the service and patient satisfaction with this had fluctuated during 2015/16. Access to some clinics was limited for people with some disabilities.

Is the service well led?

The provider had clear philosophical and political vision for the service and all staff at the clinics were committed to this, highly motivated and engaged in providing the best service they could to each patient. The clinics were led by a manager registered with the Care Quality Commission and staff felt well supported by the local leadership team. Patient's views were routinely sought and there was engagement with the wider public and other professionals locally. The organisation aimed to improve by trying out new ways of providing the service and increasing its presence in new locations. However, the service had stretched its staff in order to set up a new service in the region at the expense of continuity of some existing clinics. Organisational structures in place to ensure legal compliance, manage risk and monitor quality had weaknesses that meant some risks, repeated mistakes and serious incidents were not properly dealt with and learned from.

We saw one area of outstanding practice:

- Reception staff were highly skilled at putting patients at their ease and discretely confirming personal and private details when patients arrived including within small areas shared by other patients waiting for their consultations.

However, there were also areas of where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Put in place an effective incident reporting system that can provide assurance the provider can consistently learn from incidents and error, notify incidents to the appropriate authorities, and exercise its duty of candour.
- Put in place effective cleaning arrangements in Birmingham Central clinic (Navigation St.).
- Take steps to ensure clinical staff consistently follow good hand hygiene practices.
- Ensure emergency equipment checklist systems are used effectively.
- Ensure all staff are up-to-date with mandatory training.
- Put in place protocols for obtaining consent, pathways, and support for all patients who lack capacity to consent, including those patients with a learning disability, in keeping with required standard operating procedures.
- Ensure clinical audits recommended by the Royal College of Gynaecologists for termination of pregnancy are undertaken in order to continuously improve the services offered by the clinics and provide feedback effectively to staff about the services clinical performance.
- Improve the reliability of local clinical and safety audits of MSI Birmingham and satellite clinics at Birmingham Central and at Erdington.
- Put in place protocols to support getting informed consent for treatment from learning disabled adult patients.
- Review the governance arrangements in place to provide effective assurance and auditing systems or processes.
- More effectively assess, monitor and drive improvement in the quality and safety of the services provided.
- More effectively assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others.
- Continually evaluate and seek to improve governance and auditing practice.

In addition the provider should:

- Consider major incident planning in particular for the Birmingham Central (Navigation St.) clinic.
- Explore methods of giving patients with learning disabilities access to information about the service and their treatment so they can have a better understanding and be involved.

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

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

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

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

Regulation 11 Consent

Regulation 12 Care and treatment must be provided in a safe way for service users

Regulation 13 Service users must be protected from abuse and improper treatment in accordance with this regulation

Regulation 15 Premises and equipment must be kept clean to the standards of hygiene appropriate to their purpose.

Regulation 17 Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part (Good governance)

Summary of findings

Regulation 20 of the Care Quality Commission (Registration) Regulations 2009

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Contents

Summary of this inspection

Background to Marie Stopes International Birmingham

Marie Stopes International (MSI) provides services throughout England. The Birmingham Clinic was previously known as the Calthorpe Clinic and was operated previously by another provider. In July 2012, Marie Stopes registered to provide this service.

MSI is an international non-governmental organisation providing contraception and abortion services in 38 countries around the world. Founded in 1976, Marie Stopes International grew out of the organisation originally set up by Marie Stopes in 1921.

The MSI mission statement is that choice is fundamental to everything that it does and it gives people the information they need to make their own choices about whether and when to have children. It enables people to prevent or terminate unplanned pregnancies.

The Birmingham Clinic was registered to provide surgical termination of pregnancy procedures up to 24 weeks along with medical termination of pregnancy up to 10 weeks gestation. Surgical termination of pregnancy was available under non-anaesthesia, sedation anaesthesia and general anaesthesia. The service also provided family planning services including advice on contraceptive options, provides oral contraception and long acting reversible contraception (LARC) and male sterilisation (vasectomy).

During 2015, the service carried out 1106 (27%) medical terminations of pregnancy and 2982 (73%) surgical terminations of pregnancy.

The clinic was open on Mondays, for medical termination of pregnancy and consultation only, Tuesdays and Thursdays for surgical termination of pregnancy and Fridays for medical termination of pregnancy. (These days were subject to change depending on bank holidays). The clinic had five screening rooms, five consulting rooms and one procedure room (theatre). There are five day beds and no overnight beds.

The manager of the clinic was registered with the Care Quality Commission and managed a number of other services throughout the provider's West Midlands and South West of England regions. The Birmingham Clinic had seven satellite clinics linked to its registration providing consultations and medical termination of pregnancy (up to 10 weeks). These were at Sparkhill, Erdington, Central Birmingham and Handsworth. Clinics at Wolverhampton, Walsall and Stourbridge were also linked to the Birmingham Clinic (Edgbaston) location.

We carried out this inspection under our Comprehensive Inspection of acute services programme. We inspected termination of pregnancy services. We did not inspect vasectomy services.

Our inspection team

Our Inspection team comprised two CQC Inspectors, one CQC Assistant Inspector and a Consultant Obstetrician and Gynaecologist was available by telephone.

How we carried out this inspection

Before the inspection visit, we asked the provider to send us data and information about the service and we reviewed this.

We visited the Birmingham centre clinic at Edgbaston announced 2 June 2016, the Erdington clinic unannounced on 13 June 2016, the Sparkhill clinic unannounced on 15 June 2016 and the Birmingham Central clinic unannounced on 17 June 2016.

During our visits, we followed the care and treatment pathway and spoke with eight patients undergoing

Summary of this inspection

medical terminations of pregnancy, and one patient undergoing surgical termination of pregnancy. We spoke with 11 staff members including reception staff, nursing staff, surgeons and the registered manager and regional manager for the service. We looked at patient notes, policy and procedure documents and electronic records. We looked around the premises.

Information about Marie Stopes International Birmingham

The 'Birmingham Centre' (clinics at Edgbaston, Birmingham Central, Sparkhill, Handsworth and Erdington) held a license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with the Abortion Act 1967.

MSI Birmingham was registered with CQC in July 2012 and seven 'satellite' clinics offering early medical termination of pregnancy were attached to its registration. These services were accessible by public transport.

MSI Birmingham was contracted by clinical commissioning groups (CCGs) in the Birmingham and Black Country area to provide a termination of pregnancy service for NHS clients predominantly from the Birmingham areas but patients may come from further afield through the national contact centre. The service is also available for self-funded clients. MSI Birmingham did not share its accommodation at the Birmingham clinic (Edgbaston) but other satellite clinics were run in suites in shared office buildings or leased consulting rooms in health centres.

Birmingham clinic (Edgbaston) has:

- five private consulting rooms
- five screening rooms
- one theatre
- waiting areas
- administration and office areas
- five day care beds.

The Birmingham clinic (Edgbaston) opened on Tuesdays, Thursdays and Fridays from 7.30am to 5pm.

Satellite clinics around the city linked to the Birmingham clinic were at: Handsworth (Tuesday 9am to 5pm and Thursday 9am to 5pm), Sparkhill (Wednesday 8:30am to 12pm and Friday 8:30am to 4:30pm), Erdington (Monday 8:30am to 4:30pm and Wednesday 1:30pm to 4:30pm) and Birmingham Central (Navigation St.) (Thursday and Friday from 8am to 4pm and Saturday from 8am to 1pm).

The following services were provided:

- pregnancy testing
- unplanned pregnancy counselling/consultation
- medical abortion up to 10 weeks of pregnancy
- Surgical abortion up to 24 weeks of pregnancy
- abortion aftercare
- miscarriage management
- sexually transmitted infection testing and treatment
- contraceptive advice and contraception supply
- vasectomy services.

A registered manager who was responsible for eight other MSI clinics in Birmingham and the West Midlands and was supported by a team of nurses, health care assistants and administrators managed the service. Doctors provided on site and remote services that included assessment, confirmation that the lawful grounds for abortion are fulfilled, and prescribing of abortifacient medicines, from other clinics within the organisation (Approved Places).

Between January 2015 and December 2015 MSI Birmingham clinic undertook 2982 surgical terminations of pregnancy representing 73% of procedures; 3% of which were between 20 and 24 weeks of pregnancy. The Birmingham clinic and satellite clinics undertook 1106 early medical terminations of pregnancy (27% of procedures). This included patients aged between 13 and 15 years.

The service had contractual arrangements with local clinical commissioning groups (CCG) but also saw some privately paying patients including some from abroad. The clinic carried out surgical terminations of pregnancy using manual vacuum aspiration and dilation and evacuation. The service employed two doctors, 10 registered nurses and five administration staff.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The MSI services registered at the Birmingham clinic (Edgbaston) included seven 'satellite' nurse led clinics around the City of Birmingham and nearby towns in the West Midlands. We visited the Birmingham centre clinic at Edgbaston as an announced inspection on 2 June 2016 and the Erdington clinic unannounced on 13 June 2016, the Sparkhill clinic unannounced on 15 June 2016 and the Birmingham central clinic at Navigation Street unannounced on 17 June 2016. At the Birmingham clinic (Edgbaston) and the Birmingham central clinic (Navigation St.), we looked at every area of the clinic including treatment and procedures rooms and the theatre. The clinics at Erdington and Sparkhill were not running when we visited. We did not visit the clinics at Handsworth, Walsall, Stourbridge or Wolverhampton.

During our visits, we followed the care and treatment pathway of patients. We spoke with eight patients undergoing medical terminations of pregnancy and one patient undergoing surgical termination of pregnancy. We spoke with 11 staff members including reception staff, nurses and surgeons and the registered manager and regional manager for the service.

During 2015, the clinics carried out 2982 surgical terminations of pregnancy representing 73% of procedures and 1106 medical terminations (up to 10 weeks) of pregnancy (27% of procedures). This included patients aged between 13 and 15 years. During the same period 76 (3%) of terminations of pregnancy were at 19+ weeks gestation. The clinic Birmingham clinic (Edgbaston) carried out surgical terminations of pregnancy using manual vacuum aspiration and dilation and evacuation. The service employed two doctors, 10 registered nurses and five administration staff.

The Birmingham clinic (Edgbaston) opened on Tuesdays, Thursdays and Fridays. There was a surgery list on Thursdays. Ten nurses, four doctors and five administrative staff were employed by the service. This team moved between the Birmingham clinic (Edgbaston) and the providers other registered service at Sandwell each week. The satellite clinics at Birmingham central (Navigation St) and at Erdington were each staffed by one nurse who led the service.

Other nurse led 'satellite' clinics situated in community healthcare centres, offering medical termination of pregnancy services (up to 10 weeks) within Birmingham were linked to the Birmingham clinic's registration.

Although we visited the clinics at Sparkbrook and at Erdington, we found the provider had suspended activity at these clinics and we had received no notification of this. We did not visit the Handsworth clinic. Medical termination of pregnancy services clinics at Wolverhampton, Stourbridge and Walsall were also linked to the Birmingham clinic's registration. We did not visit those clinics on this occasion.

Termination of pregnancy

Summary of findings

We found staff reported incidents but the systems that supported this were not reliable and investigation and learning was variable. There was sometimes delay in uploading reports to the electronic system, staff could not easily track the progress of incident investigations and some patterns of incident reported were not identified and investigated.

Staff did not consistently follow some safety systems such as national guidelines to safer surgery, use of emergency equipment checklists and good hand hygiene practices. Not all staff were up-to- date with their mandatory training including safeguarding, life support skills and supporting anaesthesia. Many staff including local leaders had not undertaken safeguarding training to the level appropriate for degree of vulnerability presented by many patients.

Staff followed policies and procedures for safeguarding children and vulnerable adults. Risks to patients were assessed and staff made referrals and emergency transfers to local acute hospitals when it was appropriate for patients. The service at the Birmingham clinic (Edgbaston) was staffed by sufficient numbers of experienced doctors and nurses but the satellite clinics at Birmingham Central (Navigation St.) and at Erdington were staffed and led by only one nurse.

We found systems in place to collect information about the effectiveness of the services did not provide the local staff with a clear picture of how their service was performing against regional and national clinical standards. The results of audits undertaken by the clinic about its own practice, such as staff hand hygiene did not always reflect what we found. Staff checked each patient's medical and health history before treatment and the clinic only carried out procedures it was registered for and within the national guidelines. It referred patients it should not or could not treat to more appropriate services that could help them.

Patients were given plenty of information and advice and nurses and doctors were competent and experienced. However, there was not proper support to help women with learning disabilities give informed consent to treatment. Some staff were taking consent to treatment without the appropriate level of safeguarding training and competency for the vulnerability and complex needs of many patients receiving the service.

We found all staff treated patients with respect, kindness, dignity and care. Patients spoke positively about staff attitudes towards them. There was a 24-hour help line available to give extra information and talk through patient's worries. Staff checked patient's decisions at each stage and went over the options with patients more than once along the way. Counselling was available to all patients over the phone or face to face. Patients under 16 years of age had to have the counselling prior to procedures and we saw bookings made with external professionals on patient's records. There was no 'easy read' information to help patients with learning disabilities to understand the treatment, the choices available and the birth control options.

We found the services were planned to provide surgical and early medical terminations of pregnancy at a main clinic and in smaller clinics around Birmingham. Patients rang a national MSI One Call centre for appointments. It had translation services if needed and this system managed waiting times across the clinics. Staff also helped patients to find other services they needed such as help for domestic violence or drug taking.

It was difficult for the service to manage well the waiting times for patients during their appointments in the clinics but this had been improved. Patients were asked their views on the service they received. The Birmingham (Edgbaston) clinic had a passenger lift. Access to the Birmingham Central clinic (Navigation St.) was difficult for people with physical disabilities. However, anyone with a known disability would be booked into one of the fully accessible clinics.

We found the service had a clear view of its purpose and all staff at all clinics we visited were committed to this and to giving the best service they could to each patient. The clinics had a manager registered with the Care Quality Commission and staff felt well supported by the managers. The service got involved with the local communities to educate people and find out their views.

Termination of pregnancy

Organisational structures in place to ensure legal compliance, manage risk and monitor quality had weaknesses. This meant some risks, repeated mistakes and serious incidents that staff reported were not properly dealt with and learned from to make improvements. The service had also stretched its staff to set up a new clinic in Coventry but had stopped the services at some existing clinics in Birmingham while they did this.

Are termination of pregnancy services safe?

- The systems in place to report incidents and investigate and learn from them were not effective.
- There was sometimes delay in uploading reports to the electronic system, staff could not easily track the progress of incident investigations and some patterns of incident reported were not identified and investigated.
- The duty of candour was not consistently exercised and the service did not have a policy in place for 12 months after the duty came into force.
- A 'never event' although reported by staff was not recognised or investigated. Errors made by staff around record keeping for medication were repeated without action taken to mitigate them.
- Staff did not consistently follow some safety systems such as the checklist for safer surgery practice, hygiene and control of infection and checking emergency equipment. For example, the emergency bag in the recovery room should have been checked weekly but records showed gaps in each of the eleven months preceding our inspection visit.
- Not all staff were up-to-date with their ongoing mandatory training including safeguarding, life support skills and supporting anaesthesia.
- Many staff including local leaders were not up to date with safeguarding training to the level appropriate for degree of vulnerability presented by many patients. Only one staff member, the clinical operations manager had safeguarding training at level three.
- Level three safeguarding training was not a mandatory topic. Staff who had not completed this training were scheduled in for the end of July 2016.
- Satellite clinics were staffed and led by only one nurse working alone with an administrator. For example the Birmingham central (Navigation St.) one nurse undertook medical terminations of pregnancy assessed as 'low risk' and the nearest clinical support was at Edgbaston clinic.

However:

- Sufficient numbers of experienced doctors and nurses worked at and for the service at the Birmingham clinic (Edgbaston).

- Staff followed policies and procedures in place for safeguarding children and vulnerable adults including female genital mutilation.
- There were systems in place to assess risks to patients and staff made referrals and emergency transfers to local acute hospitals when it was appropriate for patients.

Incidents

- Incident reporting procedures included an incident-rating matrix which was based on the national patient safety model for incident rating. Staff told us it could be used to rate incidents and events that occurred within MSI as well as potential risks identified via risk assessments. There was a category of harm and reporting escalation matrix.
- Local leaders told us incident reporting was in paper format. Staff we spoke with said they wrote down what had happened, when and who was involved and then passed this on to a senior member of staff who would then report the incident on their computer system and decide if lessons needed to be learned depending on the type of incident. This learning was then disseminated to the operational staff.
- During our visit, we saw reception staff reporting a safeguarding incident directly onto the electronic reporting system. They told us they had confidence in the incident reporting procedures involved. We saw from the electronic system there was a reporting escalation and risk assessment process in place and we saw it used when we 'tracked' the progress of an incident reported in January 2016. Local leaders told us they were engaged in fostering a reporting culture among clinical staff who may feel too busy to make a report of an incident. We noted from the provider's incident reporting matrix that staff at the Birmingham clinic (Edgbaston) made incident reports.
- Local leaders told us they may request an out of region team to investigate a serious incident to ensure objectivity or provide extra capacity to make sure the providers target of 45 working days from the time of the incident was met.
- We noted the provider had a corporate policy on incident reporting. The reference to openness with patients over incidents within this policy predated the duty of candour regulation that came into force for independent health care providers in April 2015. It therefore did not take it into account. This policy had not been amended and was not due for review until June 2016.
- We saw a corporate duty of candour policy and procedure document dated April 2016. This was a comprehensive response to the regulation. However, we noted it was as version one and staff confirmed it was a new policy.
- This meant the provider had no policy and agreed procedures in place to comply with the Duty for 12 months after it came into force. Staff told us no incidents had occurred at the Birmingham clinic that triggered the Duty during 2015 or 2016.
- After our visit, we asked the provider to confirm the number of duty of candour requirement applicable incidents. It told us only, 'We approach all client concerns within the duty of candour framework'.
- The provider reported in data requested by us prior to the inspection visit, there were no serious incidents requiring investigation (SI) at the clinic during 2015. During our visit, regional governance staff told us there were two serious incidents reported to that date during 2016 for the Birmingham clinic.
- One was a cautionary emergency transfer to local acute services for a suspected perforation (this was then found not to be the case). We noted the provider had sent notifications of this incident to the Care Quality Commission and local service commissioning groups as is required. The second reported incident relating to a query retained tissue was in fact not from the Birmingham clinic but another registered location run by the provider locally.
- After our visit, we asked the provider to send us a record of all incidents reported through the provider's services in their South West and Midland region for 2015/16. We noted the provider identified four incidents at the Birmingham clinic as needing an investigation in quarter four (Q4) of 2015/16 and two incidents in Q1 of 2016/17.
- We also noted incidents we had been told occurred in the provider's Sandwell clinic, a separately registered location, were classified on the provider's incident reporting system as Birmingham Centre.

- This created confusion as we could not determine at a glance exactly where incidents were occurring. We raised this with local leaders and they told us the same clinical and administrative team provided the services at the Sandwell and Birmingham clinic locations.
- In correspondence subsequent to the inspection visit the provider told us that it could run reports of incidents by location.
- The provider policy on incident reporting was that all incidents, including safeguarding concerns, were reviewed for learning opportunities.
- The provider told us 'Incidents are investigated in accordance with MSI Incident Management Policy and a Root Cause Analysis, tabular time line of events along with an appropriate action plan to ensure lessons are learnt and shared across the organisation takes place.'
- However, we found, from the provider's incident report matrix that in February 2016 staff reported what is classed as a 'never event'. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Neither local staff nor leaders recognised this incident as a never event. A patient had to attend the local acute services ED in order to have a retained surgical swab removed after 'prolonged' pain following a surgical termination of pregnancy.
- The provider logged this incident as requiring investigation. We asked the provider for details of this investigation. It told us that no investigation had in fact been undertaken and no regulatory notifications made. This also meant the duty of candour had not been triggered as it should have been.
- In March 2016, staff repeated the same three errors relating to administering and recording medication administration. There was also a pattern of record keeping errors repeated in relation to contraceptive implants. However, the provider had rated these on the incident system on each occasion as 'no action required'.
- We noted there were three unplanned returns to theatre reported in February and March 2016 and recorded on the incident log as 'requiring no action'. In correspondence after our inspection visit the provider explained, 'Incidents are investigated to establish whether there is further action (for example with the patient or the healthcare professional, or the system) required, to avoid a recurrence. In the event a return to theatre is simply an unavoidable consequence of the particular patient journey, with no specific learning points to be extracted, the incident will be marked as 'requiring no action'.
- The provider told us, 'Incidents are recorded within 24 hours or 2 hours for serious incidents with appropriate triggers to alert senior management. This system interfaces with other organisations. To ensure the implementation of risk management policies, MSI carefully monitors risk through a process of audit using an audit schedule and Nominated Individual audit'.
- However, when we asked during our visit to 'track' the progress of the last serious incident reported through the Birmingham clinic (although pertaining to another location the same staff team worked in) we found it took a member of staff over one hour to find it for us.
- A regional lead said this was because the operations managers post was vacant at that time. It was the operations manager task to deal with recording and monitoring the progress of reported incidents and any investigations.
- We found a regional leader was triaging a large volume of incidents from the whole of the provider's services in their South West and Midland region before they were logged on the system.
- The triage system operated so that managers and reception staff could log any serious incident requiring investigation (SI) straight away so the operations manager could get the regulatory notifications sent out.
- We saw an example of this where a serious incident occurred on 21 January 2016 (suspected perforation of the uterus) and was 'uploaded' to the reporting system on 22 January 2016 and notifications were sent straight out as appropriate.
- However, other incidents could take longer to report, especially as the operations managers post was vacant at the time of our inspection. This meant delays in reporting, for example, we observed an incident that occurred (retained tissue) was reported in paper form by the surgeon on 18 May 2016 and was uploaded to the system on 2 June 2016.
- We observed the process of finding a reported incident involved staff going in and out of an email account to find correspondence about it. Staff confirmed that without the incident number it was very difficult to search the system for an incident; there was too much room for error if a search 'type' was entered.

- We noted the system in use had many limitations and did not for example, allow managers to see at a glance progress and trends. There was no 'note' or 'flagging' capacity to show a handover of a stage. This required reliance on staff memory and the presence on duty of particular staff to prompt time lines for investigation and reporting back.
- We observed staff going into their e-mail accounts to check the progress of escalation and investigation. Local leaders confirmed the system was not efficient and the provider was considering getting new incident reporting software.
- Staff said they have quarterly team meetings and managers put incidents and lesson learned on the meeting agenda and they were discussed. We noted however from the incidents reporting table that for example, out of the 134 incidents reported and logged for Q4 2015/16, 101 were categorised as 'no action required', 15 as 'other preventive action' and only four identified a change that was necessary for example, change to training.
- Some staff told us they had submitted incident forms and had received no documented feedback but were 'spoken to in passing'.

Cleanliness, infection control and hygiene

- The provider had policies and procedures in place for hygiene and infection control. We noted in all three clinics we visited there were wash basins with no touch taps, hand wash, alcohol gel and paper towels around the premises and in consulting and procedures rooms.
- We saw staff wore appropriate personal protective clothing including gloves during procedures with patients.
- We noted the environment in the Birmingham clinic (Edgbaston) and the satellite clinic at Erdington were clean, uncluttered and well organised.
- However at the Birmingham Central (Navigation St.) clinic we noted the consulting room was half vinyl covered and half carpet. The sink area was carpeted and this meant it could not be cleaned effectively.
- There was clutter in the consultation room for example; we saw a vacuum cleaner, boxes of paper and printer cartridges. There was thick dust on some areas of the floor and debris on floor such as elastic bands, a lollypop stick and a needle sheath. Nurses told us the provider did not employ a cleaner and nurses were expected to clean the room.
- In consultations with three out of the four patients we observed, nurses did not wash their hands before taking blood or sample/administering medication; they did do so afterwards
- The Birmingham clinic (Edgbaston) audit matrix showed a hand hygiene audit carried out in March 2016 by the provider scored 94.4% compliance. A hygiene and infection control audit in April 2016, two months before our inspection visit, scored 98.6% compliance
- However we observed that the surgeon removed their gloves but did not wash their hands after the procedure and went straight to writing notes.

Environment and equipment

- We noted at the Birmingham clinic (Edgbaston) and the Birmingham Central clinic (Navigation St.) facilities and equipment were appropriate for clinical purpose and patient comfort. There were equipment checklists in consulting and procedure rooms. We noted portable appliances were tested.
- However, in the Birmingham Central clinic (a satellite clinic) the sharps bin was on the floor and not wall mounted for safety. We also noted the emergency equipment checklist was not used effectively. For example, there were no checks recorded for February 2016, a weekly check during March 2016 but no signatures; and only one check recorded for each month in April, May and June 2016 when it should be checked weekly.
- We noted when we arrived at the Birmingham clinic (Edgbaston) there was a security procedure in place including CCTV at the entrance. Only one patient at a time was allowed through the front door and only at their appointment time by reception staff.
- This also enabled privacy for patients checking in at the reception desk situated directly inside the door. The provider had arrangements in place and facilities for patients and people accompanying patients to wait in an external building if they arrived early and this opened at 7am each day the clinic was running.

Medicines

- The provider had policies and procedures in place for the safe management of medication and we saw staff followed those procedures during our visits.
- Local leaders told us they did not use patient group directives (PGD's) at the time of our inspection as an organisation although referenced in its medicines

management policy it was not practised. This meant nurses did not administer medication that had not been prescribed by registered medical practitioners (doctors). This complied with The Abortion Act and regulations and we observed this was the practice during our visit.

- We saw at the Birmingham clinic (Edgbaston) nurses administered all prescribed medications; medications were kept in a locked cupboard and keys were kept with the senior nurse running the clinic who was responsible for the keys.
- We noted in the Birmingham Central clinic (Navigation St.) the drugs fridge temperatures were checked and recorded but the fridge was not locked. We checked the stock of medication at the clinic and found it to be correct against the records of administration.
- We observed in the Birmingham clinic (Edgbaston) for surgical termination of pregnancy procedures gave specific coloured patient wristbands to patients with medication allergies to alert clinical staff during treatment.
- We heard nurses explain the function of the drugs used in medical termination of pregnancy and describe abnormal signs of bleeding.
- We noted from the provider's incident reporting matrix there were clear patterns of error in medication management. For Q4 2015/16, staff reported 12 medication/administration errors at the Birmingham clinic.
- These incidents mostly involved nurses not signing for medicines administration but included one incident of a medication called anti-D immunoglobulin (anti D) not being administered to an Rh-negative patient, as it should have been. This is in order to protect the mother against a mismatch between her rhesus status and the baby's rhesus status.
- Staff reported thirty six medication/administration errors in Q1 2015/16, twenty seven of which were 'dose not documented'. The provider had rated each incident as 'no action required'. Ten of these incidents were nurses not signing for fitting contraceptive implants to patients.
- However, the Birmingham clinic (Edgbaston) audit matrix showed medicines management audits carried out by the provider in February 2016 and May 2016, each scored 100% compliance.

Records

- The provider had an electronic client record system in place and this logged patient appointments, stored patient records.
- We noted records held risk assessments made by staff during their initial consultation. Patient history was taken and recorded and noted as re checked at further consultations. Patient's allergies were logged on the electronic patient records.
- Secure systems were in place for patient notes on paper and electronically stored to move through to the appropriate procedure stream for clinical staff to access for consultations and procedures including surgery. It enabled records to be confidentially shared with other staff within the clinic including surgeons and remote doctors on duty within the organisation. We saw this working for patients undergoing surgical and medical terminations of pregnancy.

Safeguarding

- The provider had policies and procedures in place for safeguarding children and vulnerable adults which staff were aware of.
- Staff confirmed for example, it was the provider's policy that staff initially saw each patient for a consultation alone regardless of their age. This meant staff could assess that a patient was making her own choice to attend the clinic and discuss the options and procedures without duress.
- The provider reported three out of ten staff involved in the care of patients less than 18 years old had updated level three, face-to-face safeguarding training for adults and children. Staff on duty on the day of our visits all confirmed they had this level of training. All other nurses had level two safeguarding training.
- However, we noted from the provider's training matrix for the staff team, level two safeguarding training compliance stood at only 77% at April 2016.
- The providers training matrix showed level three safeguarding training was not a mandatory topic and was not recorded. Due to sickness absence, course availability or annual leave one nurse and two Health Care assistants (HCA's) did not hold level two safeguarding training but were booked in for it at the end of July 2016.
- Nurses were clear about the safeguarding pathway and aware of the agreed protocol for under 16 year old patients. For patients less than 13 years old they confirmed they would escalate to the registered

manager. Staff told us six patients aged under 16 had received counselling at the clinic over the last six months as per the provider's policy. Patients who were flagged by a counsellor as requiring more specific counselling not related to termination of pregnancy were advised to see their GP.

- We saw electronic patient records where a patient under 16 years of age did not attend for a medical termination of pregnancy and noted her GP was contacted to inform them she had continued with her pregnancy. Staff told us however, if the patient was over 16 years, the clinic would only contact a patient's GP if there was a risk involved.
- During our visit, we noted a patient with possible safeguarding needs and saw nurses and reception staff flagged this on the patient record message system. This meant other staff members along the patient treatment pathway could be informed confidentially without phone calls into clinic rooms.
- Staff knew the procedure for contacting the clinics safeguarding leads when necessary. We were told safeguarding concerns were discussed at team meetings. Female genital mutilation (FGM) awareness training was being given to staff locally by one of the surgeons at the clinic.
- We noted from the incidents reporting log that staff reported evidence of FGM as an incident and established with the patient involved whether she had female children. We observed during the clinics that staff were checking with the patient about their home circumstances, who they lived with, how they got to the clinic and how they were getting home.
- We noted the clinic had contact details of local agencies such as social services readily available and staff confirmed the clinic had good working relationships with those agencies. Staff signposted clients with specific requirements where needed, for example women suffering domestic abuse or drug abuse.

Mandatory training

- We noted from the provider's mandatory training matrix that as of April 2016 the clinic was 100% compliant with health and safety, fire safety, COSHH, manual handling and information governance training.
- Infection control was at 95% compliance, safeguarding level one was 91% compliant, equality and diversity was not rated (but only six of nineteen applicable staff had a date of completion against their names). Supporting anaesthesia was 84% compliant with four out of seven RGN's and two appropriate health care assistants without up-to-date training. Lead nurses and managers did not appear on the matrix.
- Intermediate life skills/basic life skills were 77% compliant. Staff told us they were booked to attend an advance and basic life support training the following day after our inspection visit. They also said they were up-to-date with their mandatory training.
- We asked what subjects they covered however, the only examples they gave were manual handling and COSHH. They said senior staff kept records of their completed and uncompleted training.

Assessing and responding to patient risk

- We asked nurses supporting surgical procedures how they responded to a patient whose condition required escalation for clinical support. Nurses confirmed the use of a national early warning score (NEWS) system. They also said the anaesthetist and surgeon on site were very supportive if a patient required further clinical support and if they were at risk, they would always be transferred to an acute NHS trust.
- The provider reported the clinic transferred five patients to local NHS acute services in the 12 months prior to our inspection; two patients were transferred as an emergency and three were referred to an early pregnancy advice unit.
- There was a service level agreement in place with a local NHS specialist provider.
- We saw an example of an emergency transfer in January 2016 through the incident reporting and investigation system in respect of a query ectopic pregnancy. We also noted incident reports of patients being returned to theatre from the recovery room because they were experiencing higher than expected levels of pain or discomfort.
- In data sent to us before our inspection visit the provider told us The Birmingham clinic (Edgbaston) carried out surgical terminations of pregnancy under general and local anaesthesia. We looked at seven patients records for surgical procedure and we saw that they contained a completed World Health organisation (WHO) Five Steps to Safer Surgery' safety checklist.
- The provider reported 100% of patients undergoing surgical termination of pregnancy and 100% of patients undergoing medical termination of pregnancy during

2015 were risk assessed for venous thromboembolism, a blood clot that forms within a vein (VTE). We saw that surgical patient's records contained completed VTE assessment forms.

- Local leaders told us patients were given the option to receive an initial medical assessment by telephone or at the Birmingham clinic. We noted from patient records the consultation covered comprehensive medical history checks to identify any existing health conditions.
- Pre-existing condition (PEC's) were risk assessed in accordance with its PEC policy. With permission, staff would make contact with the relevant medical practitioners to obtain additional medical information and work with the patient's GP or consultant.
- We noted minutes of the central governance committee in November 2015 identified a slow response within the organisations to the need for a risk assessment for deteriorating patients.

Nursing staffing

- The provider told us the service employed 10 registered nurses, this represented seven full -time equivalent staff. We observed there were sufficient nurses on duty at the Birmingham clinic (Edgbaston) on the day of our visit to support the number of patients. There was a lead nurse on duty.
- The Birmingham central (Navigation St.) clinic was nurse led, undertaking medical terminations of pregnancy assessed as 'low risk'. One nurse worked for the eight hours opening on Thursday and Fridays and five hours opening on Saturdays. Staff told us this clinic gets 'very busy'.
- We raised this matter with the senior nurse that attended for our inspection visit, before we left the premises. They told us the clinic was in close touch with the main Birmingham clinic (Edgbaston) from where advice, support and help could be quickly accessed.
- In subsequent correspondence the provider also told us, 'Suitable breaks are built into the list to ensure a break for the staff involved, and different nurses do different days'.
- The provider reported three nursing vacancies during 2015/16 were due to expansion of the service however, there was zero use of agency staff.

Medical staffing

- The service employed four registered medical practitioners including an anaesthetist (doctors). They worked 12.4 days within the Birmingham clinic in a typical three month period. The anaesthetist worked for the provider on a sessional basis. We noted there were two doctors including an anaesthetist on duty carrying out the surgery list at the Birmingham clinic (Edgbaston) on the Thursday we visited the service.
- Remote doctors working at other locations (Approved Places) within MSI were also available to nursing staff to facilitate medical terminations of pregnancy.
- The provider reported zero medical vacancies and zero use of agency doctors during 2015/16.

Major incident awareness and training

- We saw there was a business continuity plan in place in the event of an emergency at the Birmingham clinic (Edgbaston). The maintenance and health and safety advisor had completed test calls to all contacts within the plan. The plan was also reviewed on an annual basis.

Are termination of pregnancy services effective?

- We found although the provider had systems in place collect information about the effectiveness of its services these did not provide the local leaders or staff with a clear picture of how their service was performing against regional and national standards.
- Local leaders undertook a series of monthly audits of infection control, record keeping and medicines management and the results were passed on to senior leaders for monitoring but we found the results did not always match with what we observed or the patterns of errors shown on the provider's incident reporting records.
- The provider was not effectively undertaking clinical audits recommended by the Royal College of Gynaecologists for termination of pregnancy in order to continuously improve the services offered by the clinics.
- Health care assistants were taking consent to treatment without the appropriate level of safeguarding training and competency for the vulnerability and complex needs of many patients receiving the service.
- There was no established pathway for effectively supporting women with learning disabilities to give informed consent to treatment.

However:

Termination of pregnancy

- Patient's medical and health history was checked before treatment and the clinic carried out only procedures for which it was registered and within national guidelines. Other patients were referred to more appropriate services to meet their needs.
- Patients were given information about contraception and nurses gave advice about sexually transmitted infection.
- Nurses and doctors were competent and experienced and worked with other healthcare providers locally for the benefit of patients.

- We found although the provider had systems in place collect information about the effectiveness of its services these did not provide the local leaders or staff with a clear picture of how their service was performing against regional and national standards.
- Local leaders undertook a series of monthly audits of infection control, record keeping and medicines management and the results were passed on to senior leaders for monitoring but we found the results did not always match with what we observed or the patterns of errors shown on the provider's incident reporting records.
- The provider was not effectively undertaking clinical audits recommended by the Royal College of Gynaecologists for termination of pregnancy in order to continuously improve the services offered by the clinics.
- Health care assistants were taking consent to treatment without the appropriate level of safeguarding training and competency for the vulnerability and complex needs of many patients receiving the service.
- There was no established pathway for effectively supporting women with learning disabilities to give informed consent to treatment.

However:

- Patient's medical and health history was checked before treatment and the clinic carried out only procedures for which it was registered and within national guidelines. Other patients were referred to more appropriate services to meet their needs.
- Patients were given information about contraception and nurses gave advice about sexually transmitted infection.
- Nurses and doctors were competent and experienced and worked with other healthcare providers locally for the benefit of patients.

Evidence-based care and treatment

- The provider had policies and procedures in place and treatment was offered reflecting the Royal College of Obstetrician and Gynaecologists guidelines.
- We noted from the provider's incident reporting matrix that staff identified and referred on patients whose gestation period was outside of the services' registration criteria for treatment offered.
- We followed the care and treatment pathway of six patients across both clinics we visited. We noted staff had recorded their medical history on their files. We saw staff discuss all choices concerning the pregnancy and methods of termination of pregnancy with patients.
- Nurses gave information on methods of future contraception including long-acting reversible contraception (LARC) and GP follow up.
- However, we noted not all nurses actively discussed this with the patient so patients could ask questions.
- Nurses gave patients information on sexually transmitted infection (STI) at the initial consultation and at discharge and carried out sexual health screening for each patient. This was also in the form of a patient information booklet. Nurses made all methods of contraception available to patients.
- The provider's information booklet identified common symptoms and side effects likely when taking oral abortion medication and details of a 24-hour help line that was available to access any post treatment support they needed.
- However, we noted the provider's client feedback report for Q3 and Q 4 2015/16 suggested the service at 76/77% was below its target (of 80%) for ensuring patients left the clinic with contraception.
- We noted reception staff at the Birmingham clinic (Edgbaston) gave each patient a leaflet on contraception when they arrived. Contraception advice on posters and leaflets and small demonstration flip chart packs were all around both clinics.
- The provider information booklet 'Your treatment information' set out three different options to sedation depending on patient choice together with the gestation period:
- 'Local Anaesthetic , which is a topical surface anaesthetic performed to desensitise the cervix dilatation, and this is done by the surgeon before the procedure; Sedation Anaesthetic , formerly known as conscious sedation which is a state where the patient is

shortly asleep with some slight movements possible as a reaction to the pain stimuli , rather easily rousable and with the quick emergence from it, this type being suitable for cases where the pain stimulation issued by the procedure is not expected to be significant; General Anaesthetic , where there is no reaction to the pain stimulus, breathing might need to be supported and recovery and emergence from it takes longer (but still within day case parameters).

- We observed a surgeon attended surgical procedures. Surgeons we spoke with told us they did not use the term 'conscious sedation' with patients they just said 'sedation'. Local and general anaesthetic was offered.
- We spoke with surgeons about conscious sedation. We found their response was not clear; they did not communicate to us a clear understanding of it. Local leaders told us they did not use the term 'conscious sedation' as it made patients anxious they would experience pain.
- The service treated patients for medical termination of pregnancy where pregnancy was confirmed by abdominal or transvaginal scan to be under nine weeks and four day's gestation. There were varied treatment options available for patients undergoing medical termination of pregnancy.
- The option of simultaneous administration of medicines for medical termination of pregnancy, with the patient taking both tablets at one appointment, was not available at the Birmingham clinic or its satellite clinics. This regimen is outside of the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines 2011 and the provider should make sure any departure from these guidelines is supported by:
- The treatment / administration interval being evidence based; the staff informing patients of the most up to date information about risks and benefits so that they can make an informed decision and the provider is monitoring and auditing outcomes.
- Marie Stopes International had started to offer simultaneous administration in the spring of 2016 but had not updated its medical termination of pregnancy policy dated October 2015 to reflect the introduction of simultaneous administration of medicines, engaged with its staff or put in place a national plan to audit and review its administration and effectiveness.
- Marie Stopes International reached the corporate decision three days after, the beginning in April 2016 of the CQC comprehensive inspection of its services nationally, to suspend the practice of simultaneous drug administration to enable a substantiating review to ensure best practice and support both patients and staff.
- At the time of our visits, we noted all medical termination of pregnancy procedures (up to 10 weeks) involved administering the two medications by the 'interval regimen at 24 hours or 48 hours.

Pain relief

- We saw during surgical procedures clinicians prescribed and administered appropriate pain relief to patients.
- When we asked surgeons about sedation, they told us they did not use opiates for pain relief.

Patient outcomes

- Information about the clinic sent to us by the provider as requested told us, 'We benchmark ourselves against the DH [Department of Health] abortion statistics produced annually. Data on failed procedures is continually collected and analysed using a web based management system. On a quarterly basis, clinical reports are produced e.g. failure rate by surgery and medical treatments, infections, transfers and for what reason. These numbers are also converted into rates, which allow us to trend against previous results. We operate a robust Integrated Governance Framework in line with the NHS governance agenda and the CQC Essential Standards of Quality and Safety. The corporate Central Governance committee (CGC) meets four times a year and reports directly to the MSI Board. Local IGC; s meet four times a year. On a quarterly basis MSI UK Governance Support Team produces national clinical governance reports that are shared with the team to ensure best practice is recognised, benchmarks are set and improvement in practice take place.'
- However, during our visits we asked regional governance staff how they obtained an effective and accurate picture of outcomes for patients for the Birmingham clinic service at any time.
- They said the 'overall systems' would 'provide it with internal communications and patient feedback; for example, the new female doctor appointed offered expertise in female genital mutilation and this improved the benefit of the service for many Birmingham women'. This did not address our question.

Termination of pregnancy

- We asked specifically if, for example, the provider undertook the audits recommended by the RCOG for termination of pregnancy services. Regional governance staff told us it largely did not as 'pathways of care' were mostly CCG controlled so the provider did not audit this;
- the provider undertook no audit of 'information provision', 'women's choice' or 'pre abortion assessment'. Audit of 'abortion procedures' were not made not although there was corporate wide data on surgical verses medical procedures that were responded to by local clinics; 'care after termination of pregnancy' was not audited directly although the post-operative workflow and notes were on the records audit.
- The provider had a programme of local clinic audits in place. We saw the audit programme for 2016. Regional governance staff told us the audit schedule was the same each year. The provider had introduced a governance dashboard in April 2016 that was informed on a monthly basis by these audits.
- The audit plan covered infection prevention and control (IPC), hand hygiene, medicines management, safeguarding, medical records, regulatory compliance plan and PPM audit tool.
- We noted for example, the provider set the hand hygiene compliance target at 95 %. It reported during the 2014/15 cycle the Birmingham clinic (Edgbaston) scored overall 97% for IPC and 100% for hand hygiene.
- However, the March 2016 hand hygiene audit showed a compliance score of only 94.4 %. Local leaders told us the clinic had an IPC lead and link person to drive the audit programme and put in corrective actions where identified. Yet during our visit in June 2016, we observed non-compliance with hand hygiene among surgeons. This suggested audit outcome action plans were not effective.
- Staff we spoke with confirmed that senior staff carried out audits.

Competent staff

- Nurses we spoke with at both clinics said they were up-to-date with their appraisals and confirmed they had an annual appraisal. The matrix sent to us by the provider confirmed compliance for appraisals at 100% for 2015/16.
- Compliance for appraisals for medical staff was confirmed as 100% for 2015/16 by the matrix the provider sent us.
- Nurses told us they were encouraged to reflect and were supported with their nursing and midwifery revalidation process and continuing professional development within their nursing role. They felt well supported with good supervision with development including their imaging skills and competence.
- The provider organised periodic meetings in London for its doctors to gather and discuss practice issues.
- Staff at the Birmingham clinic (Edgbaston) told us they had three monthly team meetings and could not have monthly meetings due to the busy surgical list.

Multidisciplinary working

- We observed staff in different roles worked together for the benefit of patients.
- The clinic had an arrangement in place to refer patients to local NHS acute services in emergencies and to refer to NHS early pregnancy advice units (EPAU's). We noted these events as reported incidents on the provider's matrix.
- There was a service level agreement in place for the transfer of patients to Local NHS Trust in the event of complications (including patients from abroad). Staff told us the clinic had a very good working relationship with the NHS provider.
- Staff told us they regularly liaised with other healthcare professionals such as patients' GPs and local social services and safeguarding teams, they felt they had good networks outside of their organisation with social workers and safeguarding leads.

Seven-day services

- The clinic did not offer treatment seven days a week. It usually opened on Tuesdays, Thursdays and Fridays each week. There was a surgery list on Thursdays. Satellite clinics offered a range opening hours across the week including some evenings.
- The MSI 24-hour helpline via the One Call centre was available out-of-hours and counsellors could provide services locally on Saturday and Sunday mornings to patients if necessary.

Access to information

- Staff had access to the provider's policies and procedures to consult through electronic systems. Policies were also available in hard copy. These were updated and accessible to all staff members.

Termination of pregnancy

- RCOG guidance sets out in recommendation 8.2 that "On discharge, all women should be given a letter providing sufficient information about the procedure to allow another practitioner elsewhere to manage any complications."
- We noted on discharge nurses gave patients a letter providing sufficient information about the procedure to enable other practitioners to manage complications if required.
- Nurses sought patient's consent to send a copy of the letter to their GP and we noted the GP letter contained adequate information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed registered nurses taking patient consent for early medical termination of pregnancy procedures. Nurses discussed with patients the risks involved including the failure rate. Patient's read and signed the consent forms.
- We also observed that health care assistants (HCA) were taking patient's consent to treatment and signing the forms. Staff told us HCA's completed training to be able to complete this task. The provider sent us certificates of in house e-learning attainment on informed consent for these staff dated 2013.
- However the clinics' training matrix showed these staff had trained to only level two competence in safeguarding. This is insufficient for the complex needs and vulnerabilities of many patients who used the service.
- We saw the clinic had leaflets with information on learning disabilities and mental capacity. We asked staff how they supported patients who were not able to consent and they said they would seek advice from the NHS or transfer the patient to their local NHS hospital complex termination of pregnancy service.
- Local leaders confirmed the provider had no established pathway for addressing consent to treatment for women with learning disabilities.

Are termination of pregnancy services caring?

- We found all staff treated patients with respect, kindness, dignity and care. Patients we spoke with and those who responded to the provider's patient feedback surveys spoke positively about staff attitudes towards them.
- Patients received a lot of information from staff about their treatment and there was a 24-hour help line available to provide additional information and address concerns.
- Staff checked patients decisions at each stage of the process and went over the options with patients on more than one occasion.
- Counselling was made available to all patients over the phone or face-to-face. This was compulsory for patients under 16 years of age.

However:

- There was no 'easy read' additional material available to enable patients with learning disabilities to access the information about treatment, treatment options and contraception.

Compassionate care

- We noted positive patient feedback about the Birmingham clinic received through the provider's 'One Call' service. For example, patients said, "I wanted to say how wonderful each and every staff member was. They were the kindest most non-judgemental people I have ever met. It goes right from the receptionist to the doctor who spoke with me prior to the anaesthetic"; "Thanks to all the staff for making a very difficult decision and process a lot easier than I first thought. They should all be commended."
- The provider did audit patient experience through an external contractor. We saw a copy of the Q4 2015/16 report for the Birmingham clinic. The percentage of respondents was 48% and showed the overall rating of care for the clinic at 99% as 'very good' or 'excellent' compared with 95% nationally with other MSI clinics. The survey broke down figures, identified trends, and made regional comparisons and comparisons between surgical clinics and medical clinics.
- During our inspections visits we observed that staff were kind and caring towards patients.

Termination of pregnancy

- The provider had generally organised the environment at the Birmingham clinic (Edgbaston) to promote the greatest possible privacy for patients.
- However, due to the reception layout and its very close proximity to the front door, we noted patients waiting for a number of minutes on the doorstep to be admitted after the previous patient had given their details privately and moved beyond reception into the clinic.
- We observed reception staff at the Birmingham Central (Navigation St.) clinic were skilled at maintaining patient's confidentiality and privacy within a suite of small rooms.
- We noted the clinics scored high rates of patient satisfaction for dignity and respect (99%) against a target of 100% for Q3 and Q4 2015/16.

Understanding and involvement of patients and those close to them

- Patients received 'Your Treatment Information' booklets through the post or staff gave them to patients on arrival at the clinic. This also included details of the 24-hour helpline and additional information was also available on the Marie Stopes website for patients to access.
- Staff confirmed there was no 'easy read' additional material to enable patients with learning disabilities to access this information.
- Patients we spoke with undergoing medical termination of pregnancy said they were satisfied with the service and found staff were 'amazingly helpful'; 'staff made me feel empowered and I was not pressured to make a decision'; 'Staff were non-judgmental and had time for me to talk and discuss.'
- Nurses checked the decisions on record for all patients attending for their first appointment for early medical termination of pregnancy and options were discussed again before proceeding with treatment.

Emotional support

- The provider's policy was to make counselling available to all patients either over the telephone or face-to-face prior to any procedures and was available following procedures. We saw from patients records that patients aged 16 years were referred to external counsellors.
- We saw nursing and administration staff providing comfort and support to upset patients and those close to them when appropriate. We saw reception staff give each patient a leaflet explaining how to contact the clinic or 24-hour helpline at any time.
- Partners, relatives or friends were not allowed to accompany patients during consultations and treatments. Specific waiting areas were provided so they could wait for the patient away from the consultation rooms.
- The provider offered mandatory counselling for patients less than 16 years old. Local leaders told us this face to face counselling was undertaken by an external counsellor.
- Required standard operating procedure (RSOP) standard three requires that there are protocols in place to support women following a termination, including access to counselling and support services.
- There was the opportunity for emotional support from a trained pregnancy counsellor. This would be offered at any time pre or post termination. This was completed either face to face or by telephone by staff at the One Call centre. Staff we spoke with locally stated that there was no counselling training provided for nurses, as the provider did not offer this training to nurses.

Are termination of pregnancy services responsive?

- The services were planned to provide surgical and medical terminations of pregnancy (up to nine weeks and three days) at a main clinic and in satellite clinics around the City and outlying towns within neighbourhood health centres.
- Patients accessed services and appointments through a national call centre, this system managed waiting times across clinics to respond flexibly to local demand, legal requirements, and targets set by commissioners of the services.
- Translation services were available to patients from the first point of making contact with the organisation. Staff helped patients to access other services they needed such as help for domestic violence or drug abuse.
- All patients could receive counselling prior to receiving any procedures and were not rushed into making a decision about their termination if they were unsure.

- Patients were offered choices about disposal of the remains of their pregnancy and there were proper procedures in place for the dignified disposal of pregnancy remains.
- There were a variety of means by which patients could comment on the service, raise concerns or make a complaint. An external company who provided a report to the organisation quarterly each year looked at formal feedback gathered from patients.

However:

- Waiting times for patients within the clinics was a challenge for the service and patient satisfaction with this had fluctuated during 2015/16.
- The Birmingham clinic (Edgbaston) had a lift. Access to the Birmingham Central clinic (Navigation St.) was limited for people with physical and sensory disability.
- There were no arrangements to support the specific needs of patients with learning disabilities to understand the information about the procedures or to support getting informed consent for treatment from learning disabled adult patients.

Service planning and delivery to meet the needs of local people

- We saw the Department of Health 'Certificate of Approval' to carry out terminations of pregnancy on the premises was displayed in the reception area of the services.
- The provider had contractual arrangements with local clinical commissioning groups (CCG's). The majority of patients received treatment funded by the NHS. Some patients paid privately including patients from abroad.
- Patients from outside of the West Midlands region could receive treatment at the clinic. Under these circumstances, the clinic reception staff had to contact 'One Call' to add the patient onto the records system for them.
- Staff told us the whole team supporting the Birmingham clinic (Edgbaston) went to its Sandwell location each week to provide services. In subsequent correspondence the provider explained **'**The whole team at Birmingham do not go to Sandwell; individual members of our teams are rostered to work across all sites. The rota runs every week without fail in order to support local services.'
- We found the service offering was stretched because they were also setting up a clinic in Coventry the provider had recently acquired the contract to provide.
- This had led to some satellite clinics not operating for months. We found when we visited them unannounced, that at least two satellite clinics linked to the provider's Birmingham clinic (Edgbaston) in Birmingham and offering medical terminations of pregnancy were not running. Staff working for other care providers in those locations told us the MSI clinics had not been running for some time.
- We asked local leaders about this and they told us staff in Birmingham were busy preparing the newly acquired service at Coventry and did not have the capacity to run the satellite clinics at the same time. This meant all local patients had to travel to Edgbaston or central Birmingham.
- In subsequent correspondence the provider assured us it had assessed each service and closed the services with the lowest impact in terms of patient numbers so the impact of short term closure was low.
- Staff told us the pressure was increased in Birmingham because the provider had decreased the capacity within the Coventry service it had recently acquired.

Access and Flow

- Patients could access treatment privately by self-referral or could be referred directly by their GP in which case a GP referral form was kept on the patient record file.
- The provider had systems in place to manage appointments to ensure short waiting times and access to all of the services at the clinic. The provider was required to regularly send data on waiting times to the CCG's.
- The provider's UK business support team in London monitored and flagged target times for the clinic. We saw the MSI wait times report that was sent through to the clinic daily. The provider added extra clinics to lists if there was a risk of not meeting target times against demand locally.
- Local leaders told us the main challenge they faced was the control over the patient location list for surgical and medical terminations of pregnancy. Staff felt they were not able to accommodate some patients especially those close to their 23 weeks gestation.

- This meant at times they had to postpone appointments of other patients to be able to accommodate those who needed an emergency appointment.
- Staff confirmed the clinics diaries were constantly reviewed and adjusted to ensure access and full availability for the clinic. The provider told us, during 2015 patients who waited more than 10 working for days for consultation were those who requested to wait for personal reasons for example, they were undecided about whether to proceed.
- On the day of our visit to the Birmingham clinic, (Edgbaston) doctors told us their list was thirty surgical terminations that day and this was usual. However, a number of patients subsequently cancelled their appointments.
- Administration staff told us the service was experiencing pressure meeting the national five days target for waiting times for patients with pregnancies above 14 weeks gestation. When we visited, staff at the usually 'very busy' Birmingham central clinic for medical terminations of pregnancy said this clinic was also under pressure.
- At the Birmingham Central satellite clinic (Navigation St.), we found patients were given a choice of appointment follow-up and time for medical termination of pregnancy treatment.
- Administration staff conducted reminder calls to clients two days ahead of their appointment with late gestation appointments as the appointment could take up to three slots (a few hours). During the call, patients were given a personal pin number when they booked the appointment and a security question such as their favourite colour to maintain confidentiality.
- We noted from the patient feedback survey report for the clinic patients reported complete satisfaction with waiting times within the clinics within a fluctuating range of 82 to 96% between January 2015 and April 2016.
- The provider had a system in place for managing patient flow and reducing waiting times. This included using the electronic patient records system to access remote registered medical practitioners, for agreeing independently 'in good faith' decisions for a patient and to sign the HSA1 forms and prescribe termination of pregnancy medication.
- Staff told us waiting times had produced a number of complaints in the past but had greatly improved.
- The provider had put in place a patient flow system within the Birmingham clinic (Edgbaston) that allowed a separate pathway through the building for surgical and medical consultations and procedures. This also ensured as much privacy as possible for patients from other patients.
- A surgeon anaesthetist attended all surgical procedures at the Birmingham clinic (Edgbaston). We noted the provider employed a female surgeon as well as male surgeons. Staff told us this surgeon was experienced in treating victims of female genital mutilation (FGM).

Meeting people's individual needs

- We noted the provider website gave patients direct access to translation services to make contact with the organisation. Telephone translation services were available for patients whose first language was not English. Staff contacted an external company telephone translation service with which the provider has a contract.
- Information was also available on the MSI website in over 90 different languages through the translate feature.
- A face-to-face interpreter was also available if required and would be booked through the One Call centre when the patient made the appointment. These were organised through a local CCG funded organisation. Staff confirmed they used an interpreter phone line for patients who did not speak English. Patients told us they had used this service and found it very helpful.
- The Birmingham clinic (Edgbaston) occupied a Victorian period, detached house with surrounding gardens that had been converted for use as a clinic. It had a lift. There was limited car parking and the clinic was on a bus route with a stop nearby.
- The Birmingham Central (Navigation St.) clinic was situated in an office suite of a Victorian period building within yards of the Birmingham New Street railway station and a variety of bus routes in the City and the surrounding areas. However, it had no lift and entry depended on use of an entry phone system for security reasons.
- The provider informed us that though the Birmingham Central (Navigation St.) clinic does not have full disabled access, anyone with a known disability would be booked into one of the fully accessible clinics.
- The satellite clinics we visited in Erdington and Sparkhill were rooms in purpose built and accessible local health

and social care centres. Patients could be offered appointments at those clinics or at another registered location run by the provider at Sandwell for accessible surgical services.

- The provider told us treatment options were presented to the patient determined by their specific needs and requirements. During the consultation, their reasons were discussed along with their contraception requirements.
- However, we found the provider had no arrangements in place to support the specific needs of patients with learning disabilities to access information about the procedures. Nor did it have pathways to address consent from adult patients with learning disability.
- We observed reception staff directly contact a lead counsellor in order to add another clinic to their list on a Saturday to ensure a patient had counselling before treatment. Counselling appointments were available on Saturdays and Sunday mornings if required by patients.
- If requested staff gave patients information about the options available for the disposal of pregnancy remains and were aware patients expectations had to be appropriately managed. We saw the leaflet that supported this.
- We noted the disposal of pregnancy remains at the clinic complied with to the Human Tissue Authority Code of Practice. The 'Management of Fetal Tissue' MSI Policy detailed the process of disposal conducted by an external clinical waste disposal company.
- MSI had a national contract with a clinical waste company that was renewed centrally. The waste disposal contractors collected samples on non-surgical days in order to avoid upset to patients.
- Staff told us the majority of patients expressed no preference regarding the disposal of pregnancy material. Where a patient did not request a specific method, the clinic used incineration. The pregnancy remains were double bagged and stored in a clinical waste container in the locked clinical specimen freezer awaiting twice-weekly collections for incineration by an approved and registered clinical waste contractor.
- If pregnancy remains needed to be retained for the purpose of a criminal investigation or were required for DNA, testing a separate clinical storage container was used and labelled appropriately.
- Staff told us because of lack of demand; the provider had no arrangements in place with local undertakers. However, the clinic could support patients in making these arrangements if required and also took into account the religious requirements of the local population.
- Reception staff maintained patient confidentiality and it was well embedded within the staff culture to maintain confidentiality at the clinic. Staff addressed patients by their first name only to maintain confidentiality, they said this was considered more personal than the numbered system previously used. We noted staff repeated back only part of the patient's mobile phone number to maintain confidentiality during the identification process.

Learning from complaints and concerns

- The provider had a system in place for patients to raise concerns, make a complaint or just provide feedback. Patient feedback was formally analysed and reported on a quarterly basis by an external contractor. The provider told us the service had received two complaints during 2015.
- Staff we spoke with in the Birmingham clinic (Edgbaston) confirmed they did receive feedback about complaints or compliments. However, they also said they were unclear of the action taken following a complaint from a patient about waiting times to get the abortifacient medication because the nurse was waiting for the HSA1 form to be signed.
- Local leaders told us a common theme of complaints from patients had been the waiting time within the Birmingham clinic (Edgbaston). This had been addressed by improving patient flow through the diary system to a target of two hours and complaints had 'dropped off'.
- Staff told us a complaints manager based in London had recently given a talk at a team meeting about reviewed complaints and lessons learned across the organisation.

Are termination of pregnancy services well-led?

- We found the provider had a clear philosophy and vision for the service and all staff were committed to this, highly motivated and engaged in providing the best service they could to each patient.

- The clinics were led by a manager registered with the Care Quality Commission and staff felt well supported by the local leadership team.
- The service routinely sought the views of patients and ran programmes of engagement with the wider public and other professionals locally.
- The organisation aimed to improve by trying out new ways of providing the service and increasing its presence in new locations.

However:

- The organisational structures put in place to ensure the service complied with the law, regulations and its license and to manage risk and monitor quality had weaknesses. This meant some risks, repeated mistakes and serious incidents that staff reported were not properly dealt with and learned from.
- Governance structures were slow to ensure response to the effective management of some organisation wide risks when identified such as risk assessment for the deteriorating patient.
- The provider took on new services within the region at the expense of the continuity of providing those it was already running.

Vision and strategy for this this core service

- All staff we spoke with were aware of and personally committed to the provider's vision of 'children by choice not chance'. Staff told us the provider's strategy was to expand its services to make them accessible locally within as many communities as possible.
- We saw posters and publications available to patients communicating the provider's vision and purpose.
- Governance, risk management and quality measurement for this core service
- The provider told us it had put in place a UK assurance framework governance structure. This set out that 'centre integrated' governance meetings reported to the health systems committee, reporting to the central governance committee and then to the UK executive.
- We saw minutes of the central governance committee meetings through 2015. We noted this process identified in the November 2015 meeting for example, 'Slow speed and reaction; concerns raised by Executive team as to the delay of the production of the risk assessment for 'management of deteriorating patients' referencing explicit RCOG guidelines including all as minimum standard'.
- The provider had recently set up a Local Governance Committee for South West and the Midlands and this was headed by the regional manager. A governance score card system was developed to audit local governance arrangements. Staff told us these arrangements were still very new and not fully embedded.
- Staff told us there was a health systems committee oversaw clinical leads and operations plus resuscitation, the committee structure for infection prevention and control (IPC) and safeguarding.
- The UK health services director was supported by a director of governance, lead surgeon and lead anaesthetist who led the operational staff. The provider had created a new post of regional governance officer in its South West and Midlands Region.
- We noted the provider had put in place arrangements for compliance with the Abortion Act 1967 and 1991 regulations and with its conditions of CQC registration.
- We saw that most procedures in place were adequate to reflect the required standard operating procedures (ROSP's) for a department of health licence for termination of pregnancy. For example; timely onward referral where the service could not offer an abortion after a specific gestation, routine ultrasound scanning, VTE risk assessment, offering antibiotic prophylaxis, discussion and advice on contraception, pain relief and information after termination of pregnancy.
- We saw the 'Birmingham centre/team' risk register but noted many of the risks identified were generic to the organisation and its clinics.
- We saw no link between clinical risks identified locally for the Birmingham clinics and rated through the incident investigations process and the risk register.
- This meant locally risks were not always identified or addressed. For example a satellite clinic was in a building within metres of the main line railway station and shopping mall in Birmingham and could be vulnerable during a major incident. The risk of a patient's condition deteriorating in a satellite clinic staffed only by one nurse.
- Leaders told us they had already identified the incident reporting system used by the provider was not effective. We were told a new system was to be installed by the end of 2016.
- However the provider had put in place no interim measures to mitigate the risks in incident capture and

duty of candour compliance. The provider responded to some incidents in a manner that underestimated their gravity and this indicated a poor understanding of what was required for effective governance of the service.

- For example, the provider had failed to recognise a reported incident that was a 'Never Event'. It failed to ensure the investigation was undertaken although its own procedure identified one was required; it therefore failed to report it to the clinical commissioning group as is required and failed to exercise its duty of candour in respect of this incident.
- The provider's incident reporting matrix showed patterns of repeat error at the clinic and the provider's systems of governance had not addressed this.
- The systems the provider had in place for hygiene and control of infection were not always effective and no audit had identified the breaches we found in the Birmingham central clinic.
- We found the provider had suspended its services at some satellite clinics around Birmingham linked to the Birmingham clinic (Edgbaston) registration. It did not inform the Care Quality Commission of this.
- The provider did not respond in a timely way to our request for further data after our inspection visit because key staff were on leave. This meant effective governance arrangements were not consistently in place to communicate with and respond to a regulator.
- The provider had a system in place to fulfil the legal requirements under the Abortion Act 1967 and Abortion Regulations 1991 to certify an agreed independent 'good faith' opinion against criteria for a termination of pregnancy. Also to notify the Department of Health with details of each termination of a pregnancy. This was not always effective.
- We saw that HSA1 forms for each patient whose treatment we followed and also the sample of records we looked at, were properly completed and signed and dated by two registered medical practitioners, as required by law.
- However, an incident reported by staff where a patient received treatment for medical termination before the legal form was appropriately signed indicated a weakness in systems. The provider had not addressed this through effective risk management.
- An incident was reported in May 2016 concerning a nurse giving medical termination of pregnancy treatment before the HSA1 form was signed by registered medical practitioners. This meant a termination of pregnancy was undertaken outside of the protection provided to registered medical practitioners by the Abortion Act.
- The provider confirmed to us that its response at that time had been no more robust than to 'change induction procedure and remind the nurse that no treatment should be given before the form is signed'.
- The provider's 'live' patient record system directly gathered information on each procedure and automatically populated the HSA4 form (to notify the Department of Health with details of each termination of a pregnancy).
- The clinicians who authorised the HSA1 form signed the HSA4 forms as required by law. At the point of patient discharge, the administrator checked the HSA4 for completeness before pressing send to the Department of Health.
- When the electronic process was not available, local leaders told us the provider kept hard copies on site. These were to be completed by the registered medical practitioners once the procedure had taken place and sent by post in the appropriate Department of Health envelopes.

Leadership / culture of service

- A manager registered with the CQC over saw the clinic along with a number of other services within the South West and Midland region. A lead nurse was on duty in the Birmingham clinic (Edgbaston) whenever the clinic was open. The registered manager was also the organisation's South West and Midland regional manager.
- Staff told us they felt the service was well led by the management team in place. They confirmed our observations of good relationships between reception staff and clinical and senior staff. Staff in both clinics told us the senior staff team were approachable and would listen to any issues or concerns they had.
- Local leaders told us they were engaged in fostering a reporting culture among clinical staff including near misses. However, we found some medical staff defensive in their response when we spoke with them about a serious incident requiring investigation (SI) we were tracking through the provider's reporting and investigation procedures.

Termination of pregnancy

- Local leaders explained this was an organisation wide sensitivity to criticism as the organisation was often under attack for its activity and purpose.
- Public and staff engagement
- We observed in each clinic staff routinely gave each patient a questionnaire to rate the quality of the service. These were completed anonymously and the provider submitted them to an external analysis organisation.
- The provider's governance structure included a communication and engagement committee (CEC). Staff confirmed this committee included some staff from the Birmingham clinics and it held quarterly meetings which could be attended by any member of staff.
- The provider published papers and under 16s 'Share Your Story' articles were made available on its website.
- We noted the provider had published a UK community engagement plan for 2016. Arrangements for public engagement were made centrally in line with this plan. The provider also engaged with the public through social media.
- Staff told us locally some senior staff from the clinic had given talks at GP surgeries and held debates/talks at the universities. In addition, the service worked closely with national charities such as Women's Aid who had provided a representative to attend a recent team meeting. A safeguarding lead for South Gloucester had also attended a team meeting as a guest speaker.
- Staff in all roles told us they were proud to work for MSI and the service they provided to people. All staff we spoke with in every role were knowledgeable about and committed to the providers values and vision. They were highly motivated to provide the service.
- The provider had a 'Star' award recognition scheme in place and two members of staff at the Birmingham clinic had been recognised and mentioned in the 'One' staff magazine at the time of our inspection.
- Innovation, improvement and sustainability
- Local leaders recognised the challenges in the future such as, increasing patient demand and a more flexible approach needed for early medical terminations of pregnancy services situated within local communities. They stated that the plan was for continuous improvement through increased leadership support and staff development to manage increasing demands for the services going forward.
- However, we found the provider took on new services within the region at the expense of the continuity of providing those it was already running.

Outstanding practice and areas for improvement

Outstanding practice

Reception staff were highly skilled at putting patients at their ease and discretely confirming personal and private details when patients arrived, including within small areas shared by other patients waiting for their consultations.

Areas for improvement

Action the provider MUST take to improve

Action the clinic MUST take to improve

- Put in place an effective incident reporting system that can provide assurance the provider can consistently learn from incidents and error, notify incidents to the appropriate authorities and exercise its duty of candour.
- These systems should; address the delay in uploading incident reports to the electronic system, enable staff to easily track the progress of incident investigations; enable local and regional leaders to identify patterns of incident reported and check investigations are carried out.
- Ensure staff consistently follow all safety systems such as national guidelines to safer surgery, use of emergency equipment checklists and good hand hygiene practices,
- Ensure all relevant staff undertake mandatory training including life support skills and supporting anaesthesia.
- Ensure all appropriate staff undertake safeguarding children and adults training at level 3.
- Put in place effective cleaning arrangements in Birmingham Central clinic (Navigation St.)
- Put in place protocols for obtaining consent, pathways, and support for all patients who lack capacity to consent including those adult patients with a learning disability.
- Ensure clinical audits recommended by the Royal College of Obstetricians and Gynaecologists for termination of pregnancy are undertaken in order to continuously improve the services offered by the clinics and provide feedback effectively to staff about the services' clinical performance.
- Improve the reliability of local clinical and safety audits of the clinics.
- Ensure arrangements are put in place to support the specific needs of patients with learning disabilities to understand the information about the procedures. Review the governance arrangements in place to provide effective assurance and auditing systems or processes.
- More effectively assess, monitor and drive improvement in the quality and safety of the services provided.
- More effectively assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others.
- Continually evaluate and seek to improve governance and auditing practice.

Action the provider SHOULD take to improve

- Consider major incident planning in particular for the Birmingham Central (Navigation St.) clinic.
- Explore methods of giving patients with learning disabilities access to information about the service and their treatment so they can better understand and be involved.
- Improve any service expansion planning to ensure it does not adversely affect the continuity of the running of existing clinics.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Termination of pregnancies	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Health and Social Care Act (Regulated Activities Regulations 2014** **Regulation 15 Premises and Equipment** 1. All premises and equipment used by the service provider must be— A. clean, B. secure, C. suitable for the purpose for which they are being used, D. properly used E. properly maintained, and F. appropriately located for the purpose for which they are being used. 2. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. 3. For the purposes of paragraph (1)(b), (c), (e) and (f), "equipment" does not include equipment at the service user's accommodation if— A. such accommodation is not provided as part of the service user's care or treatment, and B. such equipment is not supplied by the service provider. **In that:** **The consulting/treatment room at the Birmingham Central (Navigation St) clinic was half vinyl covered and half carpet. The sink area was carpeted and this meant it could not be cleaned effectively.** **There was clutter in the consultation room, thick dust on some areas of the floor and debris on the floor such as elastic bands, a lollypop stick and a needle sheath.**