Marie Stopes International Birmingham

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Marie Stopes International (MSI) Birmingham Centre is operated by Marie Stopes International, a not for profit organisation that was founded in 1976 to provide a safe, legal abortion service following the Abortion Act 1967.

MSI registered the Birmingham Centre with the Care Quality Commission (CQC) in July 2012.

MSI provides regulated activities at the Birmingham Centre and at seven other associated locations known as satellite clinics that provide early medical abortion. These are Central Birmingham Early Medical Unit (EMU), Sparkhill EMU, Erdington EMU, Walsall EMU, Wolverhampton EMU, Stourbridge EMU and Handsworth EMU.

MSI Birmingham Centre provides surgical termination of pregnancy procedures up to 23 weeks and six days along with medical termination of pregnancy and early medical termination of pregnancy up to nine weeks plus four days gestation. Surgical termination of pregnancy is available under conscious sedation, under general anaesthetic or no anaesthetic according to patient choice and needs. The service also provides family planning services, including advice on contraceptive options. The service provides oral contraception and long acting reversible contraception (LARC) as well as male sterilisation (vasectomy).

MSI Birmingham Centre provides services to adults and young people above the age of 15 years.

We had previously inspected MSI Birmingham Centre in June 2016 where we highlighted a number of concerns. We have had on-going contact with the provider since that time about the implementation of its quality improvement plan. We carried out this inspection to follow up on those concerns and to assess the improvements made by the provider.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key questions. We regulate termination of pregnancy services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Since our last inspection in June 2016, we have noted the following improvements:

- A new electronic system for incident reporting
- The introduction and monitoring of surgical safety checklists
- The introduction of Termination Early Warning Scores (TEWS) used to detect deteriorating patients. However this was not yet embedded at the time of inspection.

We found the following areas of good practice:

- There was an electronic incident reporting system in place to report incidents. Staff had received training in its use.
- All MSI Birmingham Centre staff were trained to the appropriate safeguarding level. We saw good awareness and recognition of adult safeguarding, children's safeguarding, child sexual exploitation (CSE), and female genital mutilation (FGM).
- Mandatory training was provided in a range of topics, and management had the systems in place to monitor compliance.
- Checklists were undertaken for all patients undergoing surgical procedures.
- Patient records were accurate, complete, legible, up to date and stored securely. This was in line with the Data Protection Act, 1998.
- Learning and development was provided at an appropriate level to enable staff to develop and maintain their skills and competencies in areas such as consent and scanning.

Summary of findings

- The clinic managed treatment in accordance with relevant, current, evidence based guidance such as Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute of Health and Care Excellence (NICE).
- Pain was assessed and treated in accordance with national guidelines.
- We saw good multi-disciplinary teamwork in the clinic.
- We observed staff treating patients in a non-judgmental, non-directive and supportive manner.
- Patient satisfaction survey scores were consistently high.
- Marie Stopes offered private telephone counselling for patients.This included issues such as miscarriage or ectopic pregnancy.
- Staff had access to telephone translation services for patients whose first language was not English.
- Staff discussed treatment options depending on the patient's individual circumstances, needs and gestation.
- The layout of the building did not support access to patients with physical disabilities. Therefore, staff were able to redirect disabled patients to an alternative clinic.
- There were clear patient pathways for surgical and medical patients that eased the flow of patients through the clinic.
- Between April 2016 and March 2017, all patients were offered an appointment in less than five working days from the decision to proceed.All patients had a procedure less than 10 working days from their first attendance. This was in line with RCOG guidance.
- Staff were committed to the organisation's vision of parenthood choice and women being in control of their own fertility. The organisation had developed a 'Future Fit' vision, although staff at the clinic did not refer to it.
- Appropriate protocols were in place to comply with the Abortion Act (1967).The Department of Health licence requirements and Royal College of Gynaecologists recommendations for good practice.
- There was an appropriate system in place to ensure HSA1 and HSA4forms were completed.
- The provider organisation had identified the need for the service at the clinic to undergo a 'supportive peer review'. It had begun to take urgent action just before our inspection visit to mitigate risks identified by this review.
- The provider was taking action to reconfigure the management and governance arrangements to support the service.

However, we also found the following issues that the service provider needs to improve:

- Staff incident report training was below the provider's target. Staff told us they did not receive feedback either on an individual or group basis, therefore the systems in place to report incidents and learn from them, were not effective.
- Compliance with training targets was not achieved; however, this was due to the high level of new starters in the clinic.
- Some aspects of infection control needed improvement. For example, we found equipment to be dusty in both the day care room and treatment room.
- We observed that clinical staff did not always decontaminate their hands immediately before or after every episode of direct contact or care in line with the World Health Organisation five moments of hand hygiene. For example, we saw staff removing their gloves but not washing their hands after patients contact.
- We found that anaesthetists were not checking equipment on every day of use in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.
- We found the medicine cupboard did not lock therefore medicines were not stored securely.
- Staff used the Termination Early Warning Scores (TEWS) to detect deteriorating patients. However this was not yet embedded at the time of inspection. This meant staff may not recognise patient deterioration in a timely manner.
- We saw no identified restraint specific training or any other training that would indicate knowledge or understanding of restraint.
- Due to the close proximity of recovery chairs and open plan layout, patients could overhear conversations with other patients. Staff were therefore unable to protect patients' dignity and privacy.
- There was a lack of clarity around what constituted a formal and informal complaint. We saw an example of how this had resulted in a complaint still being open after a three month period.

Summary of findings

- At the time of inspection the registered manager was in the process of applying to cancel their registration as they no longer had day-to-day responsibility for the MSI Birmingham Centre. Progress on the provider's action plan to address required improvements identified at our 2016 inspection had been slow, not always effective and lacked oversight.
- Staff did not feel engaged or supported in the change programme.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		We regulate this service but we do not currently have a legal duty to rate when it is provided as an independent healthcare single speciality service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Location name here

Services we looked at
Termination of pregnancy

Summary of this inspection

Background to Marie Stopes International Birmingham

Marie Stopes International (MSI) provides services throughout England. In July 2012, MSI registered to provide family planning, termination of pregnancy services, surgical procedures and treatment for disease, disorder and injury at the Birmingham Centre. Its main service is termination of pregnancy.

The MSI Birmingham Centre is registered to provide surgical termination of pregnancy procedures up to 23 weeks plus six days weeks along with medical termination of pregnancy and early medical termination of pregnancy up to nine weeks plus four days gestation. Surgical termination of pregnancy is available under conscious sedation, under general anaesthetic or no anaesthetic according to patient choice and needs. The service also provides family planning services including advice on contraceptive options. It also provides oral contraception and long acting reversible contraception (LARC) as well as male sterilisation (vasectomy).

We inspected termination of pregnancy services. We did not inspect vasectomy services.We previously carried out a comprehensive inspection of this service in June 2016 as part of the first wave of inspection of services providing a termination of pregnancy service.

CQC undertook enforcement action, following an inspection of the governance systems at the MSI corporate (provider) level in late July and August 2016. There were several breaches in regulation that were relevant to this location, which we have followed up as part of this inspection.The breaches were in respect of:

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

CQC has been monitoring compliance with the above enforcement actions taken in order to ensure services operated in a manner, which protects patients from avoidable harm. The MSI regional director for the North was present throughout this inspection and informed us that the registered manager was in the process of applying to cancel their registration as they no longer had day-to-day responsibility for the MSI Birmingham Centre. The regional director told us as an interim arrangement they had day-to-day responsibility and a recently appointed operations manager would be applying for the registered manager position. Following our inspection the CQC received an application to cancel the registered manager's registration and it was cancelled on 29 August 2017. We subsequently received an application to register another manager.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Nicola Davies, two other CQC inspectors, and a specialist advisor with expertise in maternity and nursing. The inspection team was overseen by Tim Cooper, Head of Hospital Inspection.

Summary of this inspection

Information about Marie Stopes International Birmingham

MSI Birmingham Centre held a license from the Department of Health to undertake termination of pregnancy services in accordance with the Abortion Act 1967. MSI Birmingham Centre was first registered with the Care Quality Commission (CQC) in July 2012 and eight 'satellite' clinics offering early medical termination of pregnancy were attached to this registration. These services were accessible by public transport.

Clinical commissioning groups (CCGs) in Birmingham contracted MSI services in the Birmingham and Black Country area to provide a termination of pregnancy service for NHS patients predominantly from the Birmingham areas but patients may come from further afield through the service's national contact centre. The service was also available for self-funded patients. Satellite clinics were run from rooms in shared office buildings or leased consulting rooms in health centres.

MSI Birmingham Centre Clinic (Edgbaston) has five private consulting rooms, five screening rooms, one treatment room, five day care beds and administration and office areas. MSI Birmingham Centre was open Monday 8am to 4pm and Tuesday to Friday 8am to 5pm. MSI Birmingham Centre was providing the following regulated activities:

- Termination of pregnancies
- Surgical procedures
- Family planning
- Treatment of disease, disorder or injury

MSI Birmingham Centre offered a range of services:

- Consultation
- Counselling
- Termination of pregnancy
- Contraception
- Vasectomy
- Chlamydia screening

The regional director who was acting as the interim manager and who was responsible for MSI Birmingham Centre and its satellite clinics was supported by a team of nurses, health care assistants and administrators. Doctors provided on site and remote support. This included assessment, confirmation that the lawful grounds for abortion were fulfilled, and prescribing of abortifacient medicines, from other clinics within the organisation (approved places).

There were 13 registered nurses and eight health care assistants working at the clinic. Staff also worked at MSI Coventry, Telford and Sandwell clinics on a rotational basis.

MSI accepts both individual and GP referrals. From April 2016 to March 2017, 51% of the clinics attendees came from self-referrals, 24% from GP referrals, 2% from family planning clinics, 1% from walk in centres, 4% from other abortion clinics, 7% were previous patients, 10% were not disclosed and no referrals were received from genitourinary clinics.In June 2017,

MSI carried out 5442 terminations of pregnancy. Of these, 515 were carried out at MSI Birmingham Centre.

Between May 2016 and April 2017, MSI Birmingham Centre carried out 2874 surgical terminations of pregnancy and 1522 early medical abortions.

Between May 2016 and May 2017, 30 patients under the age of 16 years were treated at MSI Birmingham Centre . From May 2016 to April 2017 MSI Birmingham Centre treated 98 patients with a gestation between 20 to 23 + six weeks. Two of these patients were under 16 years of age.

Track Record on Safety:

- MSI Birmingham Centre reported no never events in the six months prior to our inspection.
- The service received five complaints between July 2016 and July 2017.
- Staff at MSI Birmingham Centre reported 98 incidents between April and June 2017. The top three incidents were continuing pregnancy; patient details incorrectly recorded and failure to follow policies and /procedures.
- No clinical complications were reported in quarter one of 2017/18. Clinical complications could include infection, perforated uterus, and continued pregnancy.

Summary of this inspection

Services provided at the Centre under service level agreement:

- Clinical and or non-clinical waste removal.
- Maintenance of medical equipment .
- Emergency transfer of patient.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas of good practice:

- There was an electronic incident reporting system in place to report incidents. Staff had received training in its use.
- All MSI Birmingham Centre staff were trained to the appropriate safeguarding level. We saw good awareness and recognition of adult safeguarding, children's safeguarding, child sexual exploitation, and female genital mutilation (FGM).
- Mandatory training was provided in a range of topics, and management had the ability to monitor compliance.
- Safety checklists were undertaken for all patients undergoing surgical procedures.
- Patient records were accurate, complete, legible, up to date and stored securely. This was in line with the Data Protection Act, 1998.
- There was a sufficient number of staff.

However, we also found the following issues that the service provider needs to improve:

- Staff told us they did not receive incident feedback either on an individual or group basis, therefore the systems in place to learn from them, were not effective.
- Compliance with training targets was not fully achieved; however this was due to the high level of new starters in the clinic.
- Some aspects of infection control needed improvement. For example, we found equipment to be dusty in both the day care room and treatment room.
- We found that anaesthetists were not checking equipment on every day of use in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.
- We found staff did not monitor patients in line with termination early warning systems (TEWS) that had been put in place. This meant staff were not in a position to recognise patient deterioration in a timely manner.

Are services effective?

We found that the following areas of good practice:

- The clinic managed treatment in accordance with relevant, current, evidence based guidance such as Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute of Health and Care Excellence (NICE).

Summary of this inspection

- Learning and development was provided at an appropriate level to enable staff to develop and maintain their skills and competencies in areas such as consent and scanning.
- Pain was assessed and treated in accordance with national guidelines and patient needs.
- We saw good multi-disciplinary teamwork in the clinic.

However, we also found the following issues that the service provider needs to improve:

- We saw no identified restraint specific training or any other training that would indicate knowledge or understanding of restraint.

Are services caring?

We found the following areas of good practice:

- We observed staff treating patients in a non-judgmental, non-directive and supportive manner.
- Patient satisfaction scores were consistently high.

However, we also found the following issues that the service provider needs to improve:

- Managers and staff told us that the facilities in for surgical services did not always allow patients' privacy and dignity to be maintained.

Are services responsive?

We found the following areas of good practice:

- Marie Stopes offered private telephone counselling for patients with issues such as miscarriage or ectopic pregnancy.
- Staff had access to telephone translation services for patients whose first language was not English.
- Staff discussed treatment options depending on the patient's individual circumstances, needs and gestation.
- There were clear patient pathways for surgical and medical patients that eased the flow of patients through the clinic.
- Between April 2016 and March 2017 all patients were offered an appointment in less than five working days from the decision to proceed. All patients had a procedure less than 10 working days from their first attendance. This was in line with RCOG guidance.

However, we also found the following issues that the service provider needs to improve:

Summary of this inspection

- There was a lack of clarity around what constitutes a formal and informal complaint. We saw an example of how this had resulted in a complaint still being open after a three month period.

Are services well-led?

We found the following areas of good practice:

- Staff were committed to the organisation's vision of parenthood choice and women being in control of their own fertility. The organisation had developed a 'Future Fit' vision, although staff at the clinic did not refer to it.
- Appropriate protocols were in place to comply with the Abortion Act (1967), the Department of Health licence requirements and Royal College of Gynaecologists recommendations for good practice.
- The provider organisation had identified the need for the service at the clinic to undergo a 'supportive peer review'. It had begun to take urgent action just before our inspection visit to mitigate risks identified by this review.
- There was an appropriate system in place to ensure HSA1 and HSA4 forms were completed on each patient file we reviewed.
- The provider was taking action to reconfigure the management and governance arrangements to support the service.

However, we also found the following issues that the service provider needs to improve:

- There was no registered manager in post to oversee the day-to-day operational control of the service. Interim management support arrangements were not in place to monitor the day-to-day issues affecting the quality of patient's care.
- Progress on the provider's action plan to bring about required improvements from the issues we identified at our 2016 inspection had been slow, not always effective and lacked oversight.
- Staff did not feel engaged or supported in change implemented.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents and safety monitoring

- The service had an incident reporting policy in place. Staff we spoke with were familiar with this and could access it electronically. As of August 2017, 81% of staff had undertaken incident report training. This was below target of 85%.
- We reviewed the incident log and saw that staff had correctly graded incidents according to impact of incidents and level of harm. However, we did not see any near miss incidents recorded. This meant staff may miss opportunities to prevent such incidents from happening again in the future. A near miss is an event not causing harm, but has the potential to cause injury or ill health.
- MSI Birmingham Centre reported no never events in the six months prior to our inspection.Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff at MSI Birmingham Centre reported 98 incidents between April and June 2017. The top three incidents were continuing pregnancy; patient details incorrectly recorded and failure to follow policies and / procedures.
- There was an electronic incident reporting system in place to report incidents. Staff we spoke with understood their responsibilities to raise concerns and safety incidents. However, staff told us they did not receive feedback either on an individual or group basis, therefore the systems in place for sharing and learning from incidents was not effective. For example, staff told us managers had not formally told them of the two recent serious incidents that had occurred at MSI Birmingham Centre and Coventry locations. Staff also confirmed there was no team debrief following a serious incident they were directly involved in. Staff told us they usually only heard about serious incidents when MSI changed a relevant policy as a result. This meant opportunity had been missed to share lessons learnt from incidents at the earliest opportunity, to ensure they did not happen again in the future. However, interim mangers had debriefed the team following a serious incident on the 20th July as part of the haemorrhage drill training. This showed interim managers were starting to put systems in place to share learning from incidents with staff.
- We did see a fortnightly chief nurse newsletter, with incident learning information within it. Management told us they had introduced Complaints, Litigation, Incident and Patient feedback (CLIP) weekly meetings. The meetings had the option for a dial in conference call to enable staff from all regions to attend. Staff were not aware of this option, which, suggests that local managers had not made staff aware of these channels to learn from incidents.
- Managers revised the processes for undertaking root cause analysis (RCA) in July 2016 to improve consistency across MSI UK. Senior managers completed a two day training course in July 2016 and July 2017. Only individuals who had completed the training were part of a centrally convened RCA panel. MSI established a regional integrated governance committee (IGC) in 2016 and the committee met quarterly. We looked at three sets of meeting minutes of the IGC and saw that incidents were discussed as a standing item, and that

trends, themes and action points were recorded and given as actions for the managers. However, there was no evidence of dissemination with staff from these discussions.

- The provider's quality improvement plan formulated as a result of the 'supportive peer review' identified staff had not been consistently reporting incidents formally and clinic managers had not been attending governance meetings. This supported our findings that there was no effective system in place for giving staff feedback on reported incidents.
- We asked the provider before our inspection visit to send us a copy of a route cause analysis investigation of a recent serious incident, but it was not sent. During our inspection visit, we asked again and were shown the draft incident report. Under the heading, 'root cause analysis' was written 'no root cause'. The regional director agreed not identifying any route causes was insufficient to address the gravity of the incident. This meant the investigation had failed to identify learning and improvement opportunities.It also may demonstrate that the investigator may have required additional training and support.
- The Clinical Commissioning Group (CCG) shared the final investigation report with us in August 2017. Upon reviewing the report, we noticed it was much more thorough, identified root causes and had a clear action plan.We spoke with the senior clinical manager for quality and contracting at the CCG who told us they shared concerns regarding the original report and had returned it to MSI to revisit. MSI received support from the CCG to produce an adequate report, which addressed both the CQCs and CCGs concerns. This suggests relevant staff were not proficient in investigating incidents and carrying out route cause analyses.
- The regional director for the North of the region identified within the quality improvement plan in July 2017 that staff reported that they did not enter incidents on to the electronic reporting system due to lack of time during the clinical day. However, post inspection the interim manager told us they believed this was due to the early stages of the implementation of a new reporting system at the time. We were unable to verify this without speaking to staff members again. The regional director also identified that there was no evidence of lessons learnt, this supported our findings. Staff we spoke to confirmed this also.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The provider organisation introduced the MSI UK duty of candour policy in April 2016 to provide staff with a process to follow when they were dealing with serious incidents. Duty of candour was included within safeguarding training.
- We found that managers did not always exercise the duty of candour. For example, MSI Birmingham Centre reported two incidents that triggered duty of candour. We reviewed a serious incident that took place in March 2017 that resulted in harm. There was no clear evidence the duty of candour had been properly exercised in relation to this incident. However Information provided post inspection was that a telephone call had been made on 20 March 2017 and a duty of candour letter sent on 20 June 2017.

Mandatory Training

- MSI required that all staff completed mandatory training in a range of topics, and enabled protected time for this to be completed either on line or face to face. Topics included safeguarding vulnerable adults (adults at risk) and children, basic life support, intermediate life support, first aid, information governance, display screen equipment, fire safety essentials, fire warden training, fire emergency evacuation and drill essentials, first aid, COSHH, lone working, conflict resolution, equality and diversity, informed consent, infection prevention and control, health and safety essentials, and moving and handling. There were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- A 'live' MSI Birmingham region electronic training matrix detailed records of all contracted or sessional staff, including nurses, managers, health care assistants and administrative staff. As all nursing staff at both sites worked across Birmingham and the Midlands region on a rotational basis. • We looked at the regional training

matrix and saw it included staff who worked at MSI Telford Centre. The training matrix was maintained by the operations manager with a red, amber, green (RAG) rating system to indicate staff compliance.

- The provider supplied mandatory training figures which showed that fire training, fraud, infection control and prevention, safeguarding, FGM, child sexual exploitation and PREVENT training levels met the provider standards of 85%. The remainder which included manual handling (25%), consent (80%),basic life support (0%), incident reporting (78%), medical gases (55%) and scanning (18%).
- A green rating indicated when training had taken place within the last twelve months, amber indicated the next training date was due within eight weeks and should be rebooked, and red indicated the training renewal date had expired. Gaps in training were sometimes accounted for by new staff working through the training as part of their induction.
- The training matrix was up to date and showed there were variations in compliance.

Safeguarding

- The provider had a policy on safeguarding for adults and children and young people which was in date. The clinical team leader was the safeguarding lead for the clinic. They were responsible for acting on local safeguarding concerns ensuring MSI had adequately trained staff to act as a point of contact for staff seeking advice on safeguarding concerns.
- The training was a combined course for adults and children. As of 17 August 2017, administration staff were trained to safeguarding Level 2 (91%), clinical staff were trained to safeguarding Level 3 (89%) and the safeguarding leads were trained to level four.Training for level two and three met the provider's standard of 85%; training
- The training in safeguarding adults at risk and children at level 2, level 3 and level 4 was in line with the intercollegiate document 'Safeguarding children and young people, 2014'. This included a 30-minute electronic learning module for all staff.
- Nurses were clear about the safeguarding pathway and aware of the agreed protocol for patients under the age of 16 years. Between May 2016 and May 2017, 30 patients were treated at the Birmingham Centre that were under 16 years of age.
- Staff told us they would refer children under the age of 13 to the safeguarding board and the NHS termination of pregnancy services. This was in line with the provider's abortion policy (2 December 2016) which stated, 'All patients under 13 years will be designated as complex, will be referred to the NHS for management'.
- The provider had introduced an electronic learning module for staff to cover the topics of child sexual exploitation (CSE), female genital mutilation (FGM) and 'PREVENT' training. The aim of 'PREVENT' training is to provide staff with the knowledge to enable them to be aware of patients who are at risk of becoming radicalised and to stop them from supporting terrorism. The training followed recommendations from 'Working Together to Safeguard Children (2015)' and the Intercollegiate Document (2014 and 2015).
- We saw a compliance tracker for FGM, CSE and PREVENT staff training compliance. 97% of staff members were trained in CSE, 94% were trained in FGM and 97% were trained in PREVENT.
- We saw an up to date 'female genital mutilation at risk' policy and procedure that clinic staff were able to access. We reviewed two cases of female genital mutilation (FGM) that staff reported and saw that they had taken appropriate action. Staff would check with any FGM victim whether she had any female children that needed safeguarding. We reviewed the incident-reporting log and saw that staff reported cases of FGM.
- On the first day of our unannounced inspection, regional managers had closed the clinic to the public for staff mandatory training. Safeguarding training awareness was included and covered for example; warning signs of abuse, statutory reporting duties, referral pathways and documentation.The training content included safeguarding scenarios.
- NICE Guidance PH 50, 2014 and Quality Statement 116 Domestic Violence and Abuse, 2016, is relevant for everyone working in health and social care whose work brings them into contact with people who are at risk or

staff have reason to suspect they are experiencing domestic violence and abuse. The guidance states that providers should ensure that health and social care practitioners provide facilities, which enable patients to speak about their experiences in a private discussion.

- Patients were routinely seen alone in a private consulting room as part of the consultation or assessment process regardless of age.This was evident in all of the patient records we looked at.
- We saw that staff completed a safeguarding proforma for all patients as part of the patient assessment. This helped to highlight safeguarding issues and protect patients from abuse. The proforma incorporated questions about genital mutilation, child exploitation and child trafficking risks.
- We reviewed safeguarding incidents reported in the electronic incident reporting system. These included a description and detail of the incident and action that staff took within one hour of the incident. We found management dealt with incidents proportionately and appropriately.

Cleanliness, infection control and hygiene

- The Midlands clinical team leader had completed their level three infection prevention control training.
- Staff were compliant with bare below the elbow and the uniform policy. It is best practice to be 'Bare Below the Elbows' (BBE) to facilitate good hand hygiene when delivering direct care to patients.
- Some aspects of infection control needed improvement. For example, we found equipment to be dusty in both the day care room and treatment room. We raised this concern with the regional director who was managing the service at the time of our inspection. Staff then attended to it to ensure the equipment and environment was thoroughly cleaned before attending to patients. Management had identified issues with infection protection and control (IPC) in their recent supportive peer review of the centre.
- Managers carried out hand hygiene audits monthly at MSI Birmingham Centre. These audits showed staff achieved full compliance in May and June 2017.However, we observed that clinical staff did not always decontaminate their hands immediately before or after every episode of direct contact or care in line with the World Health Organisation five moments of hand hygiene.For example, we saw staff removing their gloves but not washing their hands after patients contact.
- We reviewed staff training compliance for IPC. As of August 2017 64% of clinical staff had completed level one and level two IPC training, and 44% of non-clinical staff had completed level one IPC training. The provider's target was 100%, therefore we could not be assured that staff were able to apply basic IPC practices.
- During our inspection, we observed that there were a number of medical devices that were single use such as intravenous (IV) giving sets used within the treatment room. This helped to minimise the risk of cross contamination.
- Clinical waste management practices were in place. There was a colour-coded system for disposal of waste.Staff had use of clean and dirty utility rooms.
- Washbasins, hand wash, hand gels, paper towels and personal protective equipment such as aprons and gloves were readily available throughout the clinic.
- Managers completed an environmental audit in March 2017. The audit showed 82% compliance against the provider's target of 100%. The audit looked at areas such as waste management, cleaning, sharps and equipment. Managers were required to complete the audits every month; however, we saw no evidence of a follow up audit or any associated action plans.
- Between January 2017 and March 2017, 97% of patients reported the cleanliness and standard of the clinic was 'very good' or 'excellent'. Between April 2017 and June 2017, this worsened slightly with 94% of patients responding 'very good' or 'excellent' in the patient satisfaction survey.
- In April 2017, staff undertook an IPC audit, which found overall compliance across the clinic was 93%. The audit found mixed compliance, for example, the safe handling of sharps was 82%; handling of linen and uniforms was 88%; environmental cleanliness was 96% and team areas was 88%.We did not see an action plan to improve compliance.
- The clinic scored 100% for the use of personal protective equipment (PPE), such as gloves, and management of clinical equipment.

- Staff had safely constructed sharps bins. Staff had clearly marked and secured containers close to the areas where medical sharps were used. None of the sharps bins were more than three quarters full. This was in line with Royal College of Nursing sharps safety guidance.
- Posters were displayed which outlined what action staff must take if a member of staff sustained a sharps injury. This was in accordance with the Health Technical Memorandum (HTM) 07-01: Safe Management of health care waste and control of substance hazardous to health (COSHH), health, and safety at work regulations.

Environment and equipment

- Records indicated that all clinical equipment owned by the service had been serviced and safety checked in line with the provider's policy. This was in line with Required Standard Operating Procedure (RSOP) 22.
- Staff told us they had access to all the equipment necessary to carry out their roles safely.
- We found that anaesthetists were not checking equipment every day of use. This was not in line with the A lack of daily checks could result in theatre staff not being aware of a potential fault with medical devices such as anaesthetic machines, resulting in failure and therefore posing a risk patient safety.
- Resuscitation and emergency equipment was available and fit for purpose and staff checked and tested this in line with professional guidance. For example, all equipment was in date and ready for emergency use. The planned preventative maintenance assurance audit tool audit for April and July 2017 showed partial compliance. This tool ensured that equipment was checked to ensure it was operating correctly and was safe for patients and operators. It identified radiators in areas where patients or vulnerable adults were likely to be exposed to them needed to be fitted with covers that limited the contact temperature to a maximum of 43 degrees centigrade. The clinic was awaiting the delivery of this equipment.
- Security systems were in place. CCTV was operating outside the clinic and patients had to ring a bell for staff to grant them entry to the building.
- Managers told us staff would receive safety alerts for medical equipment and medicines by email, and provided recent examples of where management had communicated an alert to all staff. All staff we spoke with correctly described the process.

Medicine management

- Staff had access to the MSI medicines management policy. The policy had been revised in February 2017, but remained in draft form at the time of our inspection and needed to be ratified at committee stage. The policy covered areas such as prescribing, administration of medicines, education and training and storage. Interim management confirmed with us post inspection that the redrafted and ratified policy was implemented on December 25th 2017.
- Medicines used for resuscitation and other medical emergencies were available and accessible for immediate use. Guidance from the Resuscitation Council (November 2016) was followed and there were arrangements in place to ensure that medicines for resuscitation were protected from being tampered with.
- The service did not employ or use any nurse prescribers. Doctors prescribed all medication at the clinic. Nurses were only permitted to administer abortifacient medication that doctors had prescribed and we saw this was the practice in place. This was in line with The Abortion Act and regulations (1967).
- We observed nursing staff administering medication to patients in line with the Nursing and Midwifery Council Standards for Medicine Management. Nurses informed patients of the purpose, action and potential side effects of the drugs they were administering.
- Staff clearly documented allergies as an alert on patient records. We saw staff issued red wristbands to patients with medicine allergies to alert clinical staff of potential risks.
- There was no record on the training matrix of any medicine management training for nurses at MSI Birmingham. However, information provided to us following out inspection identified that staff completed this training on 20 July 2017.
- The provider told us that the medical gases training was provided both electronically and as part of a three day anaesthetic and recovery training course. We saw that

86% of staff required to undertake recovery training had attended the three day course. However the training matrix included medical gasses training separately and did not reflect this number and showed only one out of 25 had attended. This meant we could not be assured management kept the matrix up to date.

- There was a controlled drugs cabinet which contained midazolam and morphine oral solution (Oramorph) 10mg in 5mls. Although the strength of Oramorph did not meet controlled drugs schedule two criteria, the provider policy stated that it must be treated as such. We found the medicine cupboard did not lock therefore medicines were not stored securely. Staff told us they were aware that there were problems with the storage of their drugs and they had ordered a new medicine cabinet. The stock of medication was correct against the administration records.
- All medications we checked were within their expiry date. However, there were no audits of stock for these medications. We saw an audit checklist, dated March 2017 for the control of pharmaceutical supplies. We did not see a completed audit. This meant there was no oversight of the supply, storage and safety of pharmaceutical supplies.
- We noted individual ampoules of medicine in various cupboards and drawers. This meant they were not safely stored in their original packaging. We brought this to the attention of the registered nurse and she confirmed that staff were meant to store these medicines in their packages and corrective action would be taken.
- We found the medication fridge unlocked on our inspection visit. We also found intravenous fluids were stored in an open cupboard in an area which patients passed. We raised this with a nurse who confirmed that the cupboard was in the patient pathway and that they only locked the cupboard at night. This meant that storage of fluids was not tamper proof and the fridge medicines were not secure either.
- Staff recorded medication fridge temperatures daily. We found no temperatures outside the safe working range. Staff were aware of the process for reporting temperatures that fell outside the safe ranges.
- Staff reported medication associated errors. In 2017 staff reported 41 medication error incidents, which included 28 cases of not signing for medicine administration. This indicated these incidents
- Prior to termination of pregnancy all women should have a point of contact finger prick test to identify their rhesus status. It is important that any patient who is rhesus negative receives treatment with an injection of anti-D. This treatment protects them against complications should the woman have future pregnancies. We noted four incidents reported in 2017 where staff failed to administer anti-D immunoglobulin to a patient who was Rh-negative. We did not see any action plan or wider learning from these incidents. This meant the risk of staff failing to give treatment to protect patients against such complications had not been addressed.

Records

- There had been no records of patient deaths at the clinic and therefore no notifications of death to the Department of Health or to the CQC were required.
- Patient records were accurate, complete, legible, up to date and stored securely. Paper records were stored securely in a locked room. This was in line with the Data Protection Act, 1998.
- In all of the patient records we reviewed, all patients had an ultrasound scan to determine their gestational date, prior to a termination of pregnancy procedure-taking place. This ensured the type of termination of pregnancy took place within the appropriate and legal gestational limits.
- We reviewed the records of a sample of one patient who privately paid for their treatment. We noted that in keeping with the RSOP 24 there was an appropriate system in place to avoid exploitation.
- Managers told us that paper records that were transferred to and from other MSI locations should be taken by courier to ensure their safe and secure delivery. However, staff told us the courier service had not been in regular attendance, particularly since the surgical services had been diverted from July 2017. We saw that staff were required to transport records to and from other MSI locations on a regular basis. Information

received following our inspection identified that the courier service was a new service that was under review, and was therefore being embedded at the time of our inspection.

- All Birmingham staff were trained in information governance.

Assessing and responding to patient risk

- Staff used the termination of pregnancy early warning score (TEWS) to assess patients. The TEWS was adapted from the Modified Early Obstetric Warning System (MEOWS). The provider had redesigned it to reflect the physiological parameters and triggers for intervention and escalation for clinically well women undergoing termination of pregnancy, prior to, during and after treatment.
- We looked at TEWS records for 20 patients who had undergone a surgical termination of pregnancy. We found nurses and health care assistants were not monitoring patients in line with TEWS or local policy. This meant deteriorating patients might not be recognised in a timely manner. When staff were taking observations that indicated further action was required, such as an unexpected increase in the patients temperature, there was no evidence that further action was taken. This meant patients were at risk of harm. Furthermore, there was no effective monitoring system in place to provide assurance that staff were using the TEWS appropriately.
- Management had identified 'management of a deteriorating patient' as a risk in their supportive quality review prior to our inspection. This meant management were already aware of the risk prior to us identifying it during our inspection. The provider had mitigated the risk of deteriorating patients not being recognised quickly enough by adopting an early transfer of such patients to an emergency centre and medical staff remained on site until all patients were discharged.
- A service level agreement (SLA) was in place with a local acute trust for patients whose physical and mental health deteriorated.
- Managers reported two patients required transfers to local NHS acute services for on-going clinical complications between October 2016 and December 2016. Both patients received further care and were discharged the next day from the hospital.
    - Following a surgical procedure, staff accompanied patients to the recovery room to fully recover before being discharged. Nurses monitored patients for signs of sickness and pain. However, this did not fully mitigate the risk to patient safety arising from non-compliance with the TEWS charts.
- There was a clear discharge criteria outlined in the general anaesthetic policy that included patient observations, orientation, mobilisation, minimal bleeding and pain control, had passed urine and where applicable had arranged someone to accompany them home. This helped to ensure patient safety.
- Staff advised patients prior to treatment to have someone to accompany them home upon their discharge. We saw staff confirming with patients whether they had someone to accompany them home on the day of treatment. Staff offered to call a taxi for patients arriving alone.
- MSI One Call (the customer service centre) staff carried out medical assessments mainly by phone. Staff recorded comprehensive medical history and pre-existing conditions. In addition, women were able to access face-to-face consultation, if preferred.
- We saw that staff had completed venous thromboembolism (VTE) assessments in all of the records we reviewed. The satellite clinics undertook low risk medical terminations of pregnancy up to nine weeks and four days gestation. These clinics were nurse led. Nurses who led the satellite clinics told us that they could contact the Birmingham Centre clinic for advice and support and we saw this when we visited the Handsworth clinic.
- Nursing staff could also access remote doctors based at other MSI locations. We saw evidence of remote doctors having signed HSA 1 forms to facilitate medical terminations. This ensured compliance with
- We saw staff had completed the World Health organisation (WHO) and five steps to safer surgery in all of the surgical records we reviewed. The checklist

identifies three phases of an operation, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia "sign in", before the incision of the skin "time out" and before the patient leaves the operating room "sign out". In each phase, a checklist coordinator must confirm that the surgery team have completed the listed tasks before the operation can continue. Staff completed these in all cases;. Managers completed a World Health Organisation and 5 steps to safer surgery audit in March 2017, which identified 84% compliance. We did not see an action plan to address the shortfall in compliance. However, interim management assured us they had provided training and put in place an improvement plan in July 2017.

- The Management of the Deteriorating Client and Clinical Emergencies Policy v4.2, dated December 2016 included details for the recognition and management of sepsis. In addition, the recognition and management of sepsis had been added to the clinical practice guide for registered nurses and midwives that was issued to staff in October 2016 and reviewed in December 2016. Sepsis arrangements were known by staff who confirmed the use of a national early warning score (NEWS) to monitor patients and appropriate actions for escalation.

Staffing

- RSOP 18 : Staffing and emergency medical cover requires that providers of a TOP service should ensure there is a sufficient number of staff with the right competencies, knowledge, qualifications, skills and experience to safeguard the health, safety and welfare of all who use the service and meet their routine and non-routine needs.
- RSOP 18 also requires that there should be a first level registered nurse or midwife on duty in the clinic at all times when there are patients who will need their care. We looked at staffing rotas that confirmed this happened and managers and nurses we spoke with also confirmed this.
- There were 13 registered nurses and eight health care assistants working at the clinic. The regional director confirmed there was high turnover of nurses at the Birmingham Centre and this put pressure on the 'experienced all-rounders' needed to run the nurse led 'satellite' clinics. However, the clinic reported no medical or nursing vacancies as of August 2017.
- Staff also worked at MSI Coventry, Telford and Sandwell Centres on a rotational basis.The rotas were created on excel documents; however, managers told us the provider was in the process of rolling out an electronic rota management system across the country. The training for this took place on 9 August 2017 and the Birmingham Centre clinic was aiming to start using the system between October 2017 and December 2017.
- Staff told us they often received their rota for the following week on the Friday before. The regional manager had also identified this as an issue that needed to be corrected through the quality improvement plan. This showed management had already identified this as an issue prior to our inspection and supported what staff told us.
- The Centre did not use bank/agency staff. Managers filled staff shortages such as annual leave by arranging for substantive staff to work overtime.
- The general anaesthetic policy included the requirement that anaesthetists remained on site at locations until all patients were clinically fit for discharge. This meant that there was a clinician on site to provide emergency support and treatment should a patient deteriorate.
- We noted only one member of staff worked at the Handsworth EMU. This was a trained nurse, however, this position could put them at risk as a lone worker.

Major Incident awareness and training

- We saw there was a business continuity policy in place. This covered areas such as telephones, electric, floods, fridges, fire evacuation, medical emergencies and computer failures.

Are termination of pregnancy services effective?

Evidence-based treatment

- We observed the clinic managed treatment in accordance with relevant, current, evidence based

guidance such as Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute of Health and Care Excellence (NICE), including gestation limits for the types of treatment provided.

- Staff managed surgery in line with RCOG and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- The service performed surgical termination of pregnancy only where pregnancy was confirmed by ultrasound scan to be under 23+6 days.
- The percentage of patients taking up long acting reversible contraceptives (LARC) was 37% between July 2016 and July 2017. The target was 50% and the clinic did not achieve this target in any of the 12 months reported. This meant staff at the Centre were not minimising the risk of future unwanted pregnancies.
- Staff offered patients testing for sexually transmitted infections. Testing patients depended on the contractual agreement with the commissioning group. . This was in line with RSOP guidance on contraception and sexually transmitted infections (STI) screening. Staff tested five patients for HIV, one for syphilis and 38 for chlamydia between January 2017 and March 2017.The highest proportion of patient opt out reasons given was 'declined to give reason'.
- Nurses discussed all methods of contraception with eligible patients at their initial assessment and staff agreed a plan for after the termination. Nurses also had access to table top flip charts explaining the different types of contraception available. We saw posters around the clinic and staff gave patients a leaflet upon arrival on the different types of contraception.
- We did not see staff offering condoms to patients as recommended by the Royal College of Obstetricians and Gynaecologists. However, condoms were available in the waiting rooms and the dayrooms in the centre.
- Up to 23 weeks and six days of pregnancy was the gestation limit staff worked to in all MSI Centres. Staff referred patients on to an appropriate external agency if they presented outside of this gestation limit. This was in line with the MSI policy.
- All medical terminations involved administering two separate medicines. This was in line with the RCOG recommendations for medical termination of pregnancy. Nurses offered patients a choice of taking the two sets of tables either six, 24, 48 or 72 hours apart. Nurses explained the benefits risks and success rates of each option. This ensured the patient could make an informed choice depending on the individual circumstances and preference.
- The RCOG advises that services should provide treatment as early as possible. Staff informed us during our inspection that the service had to cancel a high number of patient's appointments due to closing the centre for staff training. We wrote to the MSI nominated individual and asked for assurance of how the regional manager ensured these patients were subsequently safely treated, Information provided stated that these patients were all treated by within ten days of cancellation (by the end of July 2017).
- We saw nurses give patients a pregnancy test and advise them to use it three weeks after their abortion to assess whether their abortion has been successful. Nurses advised patients to contact the free aftercare line if the test was positive in order to book an appointment for another ultrasound, and further treatment if needed.

Nutrition and hydration

- We saw staff informing patients that food could be eaten up to six hours and clear fluids consumed up to two hours before surgery. This was in line Royal College of Anaesthetists guidance in relation to fasting before surgery.
  - Staff offered patients hot and cold drinks and biscuits following their surgical procedure in the recovery room.

Pain relief

- We observed and saw in patient records that staff routinely offered patients pain relief during medical and surgical abortions.
- Advice on pain relief was given to patients in the 'your treatment information' booklet and in the aftercare booklet. We saw staff reminding patients of pain relief options throughout their treatment journey.
- Doctors and nurses administered pain relief in line with best practice. For example, staff offered patients n (NSAIDS routinely) instead of paracetamol due to ineffectiveness.

Termination of pregnancy

Patient outcomes

- Staff offered all patients counselling as part of their initial phone call. Staff were unable to book an appointment on the electronic booking system unless this had been offered. In order to audit this, MSI One Call (the call centre that handled all MSI Birmingham Centre calls) performed call audits to monitor the quality of calls in an automated system. If staff had not offered counselling, there was a weighting in the system that would determine the call did not meet the minimum quality standard of 85%. Managers would then feedback the monitoring results to the team member and coaching would be provided. The most recent audit for call centre staff offering under 16 year old patients counselling was 100% compliance.
- We saw the 2017 audit plan for Birmingham Centre clinic. It covered for example, hand hygiene, IPC, safeguarding, medicines management, medical records, regulatory compliance plan, and health and safety. We did not see evidence of any compliance monitoring between April and June 2017 and therefore could not be assured management had implemented a quality improvement process in order to improve patient care and outcomes during this period. Following the inspection the provider confirmed that a compliance monitoring programme had been revised, improved and launched in October 2017.

Competent staff

- No anaesthetist was able to run a treatment room without a valid Advanced Life Support certificate.
- We saw a draft version of an induction, probation and preceptorship workbook that was in circulation for consultation. This included areas such as an overview of Marie Stopes and reflective practice portfolio. Due to the high number of new staff at the Birmingham Centre, management told us there was a low rate of compliance with mandatory training and competency frameworks. This meant managers could not assure the provider organisation of staff member's competencies. This restricted the areas of the service staff could work in. MSI Birmingham were running an active recruitment and training programme to address this situation.
- New staff were not allowed to work until relevant training and competencies had been completed. Due to the high number of new staff, this put pressure on the established staff who had completed relevant training.
- Regional managers had identified 'Induction, competency and staff engagement' as an area of risk for the service through their 'supportive quality review' in July 2017 just prior to our inspection. This supported what we found.
- All MSI counsellors were accredited members of the British Association for Counselling and Psychotherapy.
- MSI had implemented a bespoke ultrasound training course to date pregnancy provided by a qualified external sonographer delivered in line with the requirements of MSI policy.
- Staff told us that any nurse or health care assistant who performed ultrasound scans to determine gestational date would be required to successfully complete an in-house training programme and assessment of a competency framework in scanning. This was co-ordinated by a lead scanning trainer for MSI UK, supported by a regional scanning mentor. Training records showed 26% of eligible staff were up to date with ultrasound scanning training. A regional scanning mentor performed the scans when there was no other competent member of staff available. The mentor also worked with staff to complete the required training and assessment, in order to scan patients without supervision and would attend the centre to scan patients in the absence of a competent member of staff to do so. During our inspection, we saw that staff who had undertaken the relevant training and assessment performed scans.
- Only staff who had completed this training and the attached competency framework could perform ultrasound scans at the Birmingham Centre. The regional scanning mentor supported staff with this process. Provider records showed 26% of eligible staff were up to date with ultrasound scanning training. This may have been due to the high level of new staff in post. Managers confirmed MSI had trained staff to date pregnancy gestation only and staff did not screen for abnormalities. This was in line with their policy.
- The MSI quarterly patient survey showed for January to March 2017, 84% of patient that completed a

questionnaire said the professionalism and competence of staff was excellent, 14% said it was very good and 2% said it was good. For April to June 2017 it was 83%, 12% and 5% respectively.

- The provider did not offer clinical supervision to staff.
- There was no information available locally to confirm that medical staff had completed mandatory training. We questioned the interim manager about this and they confirmed that this was held at corporate level, however they were unable to show these records to us and no completed local checks of competency and training of clinicians were undertaken despite this being raised at the last inspection in April 2016. Information provided following the inspection indicated this data was stored on the MSUK intranet (at provider level) to enable all managers to check compliance when required.
- Medical staff spoken with confirmed they were up to date with training but there was no local evidence to confirm that this had occurred. Information provided following the inspection indicated this data was stored on the MSUK intranet to enable all managers to check compliance when required. However, at the time of inspection, the interim manager at MSI Birmingham was unaware and no checks had been taken by them to provide assurance that medical staff were in date.
- All staff had completed their revalidation.

Multidisciplinary working

- We saw good multi-disciplinary teamwork in the clinic. Patient care was led by a specialist doctor. For example, we saw surgeons and anaesthetists working effectively with nurses and health care assistants to deliver care.
- Nurses asked for patients consent to send a discharge summary letter to their GP. This would enable the GP to manage any complications following the termination of pregnancy. This was in line with Royal College of Obstetricians and Gynaecologists guidance.
- Staff told us they would contact other professionals such as the patients GP, or social worker, if they needed any further information to ensure patients safety.
- All patients had the opportunity to discuss options and choices with, and receive therapeutic support from, a trained pregnancy counsellor.
- The specialist doctors were responsible for the overall care and safe discharge of surgical patients.

Access to information

- Staff could access MSI policies and procedures and standard operating procedures online.
- Staff had access to information such as case notes, risk assessments and test results. We saw, and staff told us, there was effective coordination of the electronic and paper based systems. This ensured effective care and treatment of patients.
- RSOP 3 states that, on discharge, women should be given a letter that includes sufficient information about the TOP procedure to allow another practitioner to deal with any complications and on-going care. In all of the records we reviewed, we saw that information about discharge was included. Discharge letters were sent with the patient's consent to their GP as contractually required. This was noted on the electronic system for each patient and was automatically populated when required.

Consent, Mental Capacity Act and Deprivation of Liberty

- Staff referred to Fraser and Gillick guidelines when taking consent from patients under 16. The Gillick competency and Fraser guidelines help practitioners balance children's rights and wishes with their responsibility to keep children safe from harm. We saw these guidelines displayed on the consultation room walls for staff to refer to.
- Only nurses trained to Level 3 competence in safeguarding took patients consent.
- RSOP 14 Counselling and RCOG guidelines say women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications as part of the process of gaining consent. We saw nurses ensuring patients were fully informed, understood the likely consequences and risks of the abortion, as well as alternative options before taking written consent. We saw staff obtaining written consent for contraception choices.

Termination of pregnancy

- The training matrix identified that MSI Birmingham had trained 20 staff members in 'consent with capacity'. The target was 24. This equalled 83% of eligible staff..
- We saw nurses checking with patients that they were certain of their decision to proceed with their termination of pregnancy at different stages of the patient's treatment journey. For example, we saw nurses asking patients if they were sure of their decision to continue immediately prior to the medication being administered. This ensured informed consent and assured staff patients hadn't changed their minds or weren't having second thoughts.
- The inspectors witnessed a patient with extreme confusion following treatment under a general anaesthetic. The patient received emergency sedation under medical supervision to prevent them from harming themselves. At the time of the time of receiving the treatment the patient was not able to give informed consent to this treatment and the doctor therefore acted in their best interest in giving the medication
- The provider told us that while they had a policy on conflict resolution this policy did not cover these types of rare clinical incidents. Since our inspection the interim managers identified that there was a need for restraint guidance for such situations.
- We noted that only 17% of staff had training in conflict resolution. Therefore, we were not assured that staff were enabled to de-escalate conflict in the centre in respect of patients challenging behaviours. We were informed post inspection that the provider was reviewing training provision to address this need.
- The MSI abortion policy stated the provider was unable to treat patients who did not have the capacity to consent to treatment. The policy indicated that where a patient did not have the capacity to consent to treatment, staff should refer the patient to the NHS for assessment and treatment. The lead safeguarding nurse confirmed this is what staff would do under the circumstances. This could include patients living with a learning disability.

Are termination of pregnancy services caring?

Compassionate care

- We observed staff treating patients in a non-judgmental, non-directive and supportive manner. This supported the positive patient satisfaction scores. For example, the quarterly patient survey showed for January 2017 to March 2017, 99% of patients who completed a questionnaire said staff treated them with dignity and respect and for March to June 2017, this was 98%.
- We saw staff addressing patients concerns in a caring and empathic manner. For example, we saw a nurse repeating the low risk of complications and the relative ease of the procedure to a patient who was scared of going into surgery.
- We saw staff drawing curtains for scans to protect each patient's dignity.
- The recovery area comprised of one room. This meant patients recovering from anaesthesia or sedation did not have a sufficiently peaceful environment. Due to the close proximity of recovery chairs and open plan layout, patients could overhear conversations. Staff were therefore unable to protect patients' dignity and privacy.

Understanding and involvement of patients and those close to them

- We saw staff informing patients that abortion was a safe procedure for which major complications and mortality was rare at all gestations. This helped with patients who were feeling anxious about their procedure.
- Staff discussed complications and risks including failed abortion and continuing pregnancy in a way that patients could understand.
- Staff provided women with information about the physical symptoms that they may experience after abortion.
- Costs and fees were explained in the patient handbook.
- Staff did not explain or provide information so that women were aware that the contents of the HSA4 form was used to inform the Chief Medical Officer of termination of pregnancy and was used for statistical purposes by the Department of Health. We saw a small framed notice on reception; however, patients could easily miss this.

Termination of pregnancy

- The patient information booklet ('your treatment information)' detailed two alternative options to general anaesthesia. These were sedation and no anaesthetic. We heard the anaesthetist explaining sedation to patients in a way they could easily understand.
- An MSI quarterly survey analysed by an independent company asked patients a range of questions about the care they had received and these results were fed back to clinic staff.
- MSI Birmingham Centre did not permit companions to sit with patient throughout their treatment or recovery. This was to protect other patient's confidentiality. The centre provided companions with a separate waiting room with seating and vending machines offering hot and cold drinks and snacks.

Emotional support

- Patients were offered advice and support on pregnancy, grief, relationships and self-esteem. Patients could access this information and support by telephone or online via the Marie Stopes website.
- We saw that staff signposted patients who needed extra support to appropriate agencies such as those offering support with domestic violence.
- Patients had access to a 24 hour helpline number for women to get support after treatment. This was in line with the Royal College of Obstetricians and Gynaecologists guidelines.
- All patients under the age of 16 had to attend a counselling session before undergoing a termination. The counselling policy stated that counselling sessions should not happen on the same day as the procedure, to allow time for the patient to reflect.

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- Commissioners were involved with planning of services. They reviewed the local need and set key performance indicators for MSI to achieve.
- The service provided a range of services for early medical termination of pregnancy up to a gestation of 9 weeks + four days and surgical termination of pregnancy up to 23 + six days.
- MSI Birmingham accepted referrals from a GP or medical consultant. NHS funded patients could access services through routes agreed via local commissioning arrangements.
- MSI Birmingham provided both NHS and privately funded treatment, with 98% of patients in 2017 NHS funded.
- We noted from patients' files we reviewed that staff referred some patients to the NHS for complex terminations including late stage medical and surgical terminations where a scan had showed a gestation stage later than the patient reported.
- Staff discussed treatment options depending on the patient's individual circumstances, needs and gestation. However we found the provider had no pathway in place to support patients with a learning disability. This meant we could not be assured staff would be able to offer appropriate support to these patients.
- The availability of female doctors when requested by patients could not be guaranteed due to the national shortage of female doctors available for gestations over 13 weeks plus six days. However, a female surgeon worked weekly at the Birmingham centre and practiced within a gestational limit of 18+6 weeks.
- Staff gave patients written information about the different methods of abortion appropriate to gestation, the potential adverse effects and complications, and their clinical implications. Staff used interpreters to ensure patients fully understood the information given.
- We found appropriate arrangements for medical and surgical terminations of pregnancy and gestation dates in line with RSOP 2. These were integral to the appointment and treatment booking process of the clinic and the MSI One Call contact system flexibility to book patients into appropriate clinic and appointments across the geographical area.
- The Marie Stopes International policy, in accordance with national guidance stated that irrespective of the gender of the clinician, patients should be offered a chaperone when staff are carrying out intimate

procedures that could be embarrassing or distressing for patients. However, we noted when we visited the Handsworth EMA clinic it was staffed by one nurse only working alone. Managers confirmed this was usual practice. However, following the inspection senior management told us that if a patient requested a chaperone they would be booked into a clinic that could accommodate this.

- Staff had access to telephone translation services for patients whose first language was not spoken English. Staff told us this service was efficient. We saw a nurse using this service for a patient. This ensured patients understood all of the information given and assured the nurse that they were obtaining informed consent. The patient fed back to us that they found the service helpful.
- Patients could access face-to-face interpreters in advance if required, including British sign language.
- **The MSI website translated the information on the website into 90 languages via the search engine translate feature.**
- Adapted 'easy read' materials could be sourced dependant on need, for example for patients living with a learning disability.
- The layout of the building did not support access to patients with physical disabilities. However, staff would redirect disabled patients to an alternative clinic which was fully accessible.
- Marie Stopes offered private telephone counselling for patients with issues such as miscarriage, ectopic pregnancy fear of pregnancy or parenthood, relationships, self-worth, grief and managing emotions. We saw staff reminding patients they could access post abortion counselling throughout their treatment journey. MSI provided details on how to access counselling and the 24 hour number to contact was in the patient information booklet.
- We saw staff gaining patient consent for the disposal of pregnancy remains.Information on disposal options was also set out in the patient information booklet. Options for disposing of pregnancy remains were included in the patient information booklet. Staff gave patients the options and documented this in patient's personal records as part of their consent to treatment. This was in line with disposal of pregnancy remains and the Human Tissue Authority guidance.

Access and flow

- The call centre in Bristol ('One Call') provided the booking service, telephone consultations and the 365 day / 24hr aftercare support line. Also located at MSI One Call was an experienced counselling team.
- MSI accepted both individual and GP referrals. From April 2016 to March 2017, 51% of the clinics attendees came from self-referrals, 24% from GP's, 2% from family planning clinics, 1% from walk in Centres, 4% from other abortion clinics, 7% were previous patients, 10% were not disclosedand no referrals were received from genitourinary medicine clinics.
- Administration staff at the Birmingham Centre clinic used an electronic system to manage appointments and waiting times.
- Staff confirmed and a patient told us that patients often attended one centre for consultation, and a different centre for treatment. This meant that staff did not always provide patients with seamless care and familiar surroundings.
- The Clinical Commissioning Group (CCG) monitored waiting times for treatment. This ensured MSI was meeting CCG waiting time targets and contact to treatment time was in line with RCOG guidelines.
- Staff could access remote doctors to sign the HSA1 forms. This limited unnecessary delays in patient's treatment and waiting times.
- There were clear patient pathways for patients requiring surgical and medical abortions. This eased the flow of patients within the clinic.
- Between April 2016 and March 2017, all patients were offered an appointment in less than five working days from the decision to proceed. This was in line with RCOG guidance.
- Between April 2016 and March 2017, staff saw 82% to 97% patients within 30 minutes of their appointment time.

Termination of pregnancy

- Between April 2016 and March 2017 all patients underwent their procedure in less than 10 working days from their first attendance. This was in line with RCOG guidance
- Between January 2017 and March 2017, 4% of patients seen at the clinic were under 18 years of age. The clinic saw no patients aged less than 13 years of age during this time.
- The average patient time in MSI care at MSI Birmingham Centre clinic was 72 minutes in April 2017, 107 minutes in May 2017 and 108 minutes in June 2017. The target was 100 minutes.
- The 'did not proceed' rate in June 2017 was 16%. The target was 15%.
- MSI did not cancel any treatments between April and September 2016 and January 2017 to March 2017. MSI cancelled 1% of treatment in October 2016 to December 2016. MSI followed a standard operating procedure for clinic cancellations. However, we were made aware of cancellations on day one of the inspection to provide essential staff training; since our inspection the interim manager informed us that 10 patient appointments were cancelled. These patients were offered alternative dates to have their procedures undertaken on the 24th, 28th & 31st of July.
- Women were able to choose to delay their appointment or booked procedure with further counselling if requested.
- Between April 2016 and March 2017, 9% to 15% of patients did not attend for their planned treatment. The 'did not attend' rate in June 2017 was 8%. This was in line with the average for the Midlands and North area. Managers informed us that as a rule they did not follow up patients who did not attend their appointments. This was because they did not want patients to feel staff were pressuring them in any way. However, managers did confirm that they would use their discretion if they had any safeguarding concerns for example.

Learning from concerns and complaints

- Details on how to make a complaint was in the 'your treatment' information booklets.
- Patients could make a complaint by completing the**patient questionnaire**given to every patient before leaving the centre, by telephoning the call centre, by email, in writing or by contacting the local Clinical Commissioning Group (CCG) or NHS England.
- Birmingham Centre received five complaints between July 2016 and July 2017. These related to poor care, bruises, staff fitting the wrong contraception, antibiotic query, conflicting information, inappropriate language by a nurse, failed surgical termination of pregnancy, and staff not removing contraception.
- The providers' policy was that they would acknowledge any written complaint within two working days of receipt and any telephone enquiries within 24 hours. Staff would then carry out a full investigation and a full response would be made within a reasonable time, usually between three to four weeks. Staff should keep patients informed of any delays to this process.
- There was a lack of clarity around what constituted a formal and informal complaint. We saw an example of how this had resulted in a complaint still being open after a three month period. This was not in line with the MSI complaints policy.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- All locations outside of the NHS (approved places) must hold a valid termination of pregnancy licence issued by the Department of Health. The service providers are required to follow standard operating procedures (RSOPs). The Department of Health RSOP 10: professional guidelines, states that providers should have regard to authoritative clinical and professional guidance and professional opinion such as that provided by relevant Royal Colleges.
- RSOP 16: Performance standards and audit recommends that all providers should have in place clear locally agreed standards against which management can audit performance– and that are guided by appropriate national standards. We noted MSI had updated a range of corporate, regional and

local policies during 2016. Staff told us that MSI communicated updates of policy changes and reviews via the interim chief nurse newsletters and we saw evidence that this happened.

- We asked the operations manager to see the register of patients who had undergone termination of pregnancy. The operations manager could not show us this and was not aware that this information was held centrally.
- MSI received support from the CCG to produce an adequate root cause analysis report, which addressed both the CQCs and CCGs concerns. This suggests relevant staff were not proficient in investigating incidents and carrying out route cause analyses.
- Following SToP, multiple pregnancy remains were individually bagged and collected in a single hazardous waste bin in a sluice room next to the treatment room. At the end of the list, the container was then sealed and taken to the freezer before collection. Segregation of pregnancy tissue only occurred if there were specific requirements to do so (on either patient request, requirements for DNA identification or criminal investigation). This was in line with current Human Tissue Authority guidance and the MSI UK Management of Fetal tissue policy and the Safe Management, Handling and Disposal of Waste Policy and Procedures May 2016 which had been updated since the last inspection. Staff stated that the pre-treatment consultation included discussion about the individual options for the pregnancy remains.
- The regional director who was acting as the interim manager and who was responsible for MSI Birmingham Centre clinic and its satellite clinics was supportedby a team of nurses, health care assistants and administrators.
- Further MSI clinics within the West Midlands were serviced by the Birmingham Centre clinic and the same management team, for example at Telford and Coventry.
- The arrangements to manage the service at the time of our visit included the presence of the regional director for MSI northern region 'covering' day to day operational responsibilities at Birmingham Centre. The regional director was supported by the regional clinical operations manager, an interim operations manager and the MSI deputy chief nurse.
- There was limited skill and knowledge available within the leadership team to access and interrogate the software system. Local managers were not familiar with the standard RCOG patient outcome audits we asked to see.
- We received an application to cancel the manager's registration on 24 July 2017 and we approved this on 30 August 2017. The provider told us it had identified a suitable applicant for registration and we received this application in September 2017.
- The regional manager for the North told us they were proposing significant changes in the regional management structures and these would reviewed by the Board at the end of August 2017.
- Four weeks after our visit the provider told us a matron from a clinic in the provider's southern region was spending four days each week at the Birmingham Centre, tasked to improve clinical systems in the interim.

Vision and strategy for services

- The MSUK vision that women should be in control of their fertility was visible and clear in the clinics information and was articulated by staff in all roles. We saw that staff were committed to the vision. We did not hear staff refer to the 'Fit for Future' strategy that MSI introduced earlier in 2017 although we did note this was in the monthly staff bulletin.
- We found clearly defined responsibilities within the clinic in respect of medical staff and nursing staff.Also for the administrative support staff who managed the electronic records system for the effective use of remote medical practitioner's input.The reception staff contributed to management of the appointments diary and lists.

Governance, risk, management and quality measures for this core service

- We saw in the Birmingham Centre clinic the Department of Health certificate displayed in a prominent position to demonstrate the clinic was an 'approved place' to carry out terminations of pregnancy. However at the Handsworth clinic, within a location shared by other health and care services, it was not on display but

stored in a folder in a cupboard. This certificate did not include the name of the clinic premises as it should. This meant staff were not complying with the Department of Health requirements.

- The Birmingham Centre clinic displayed a statement informing patients the extent to which their data would have to be shared with the Department of Health as a legal requirement. However at the Handsworth clinic it was not on display but stored in a folder in a cupboard.
- We noted management kept a risk register to identify and minimise any risks to patients and staff within the premises as required by RSOP 21. However, we found this register was not fit for purpose. For example, although the register identified the risk of delayed transfer of a deteriorating patient from the building because of the elevator size and staircase configuration, managers had not re-assessed this risk in light of the March 2017 incident although it had been routinely 'reviewed' two weeks after the event. Managers had failed to identify other risks. For example, the risk of staff being required to use restraint to safely complete a surgical procedure, although staff told us such an incident had happened.
- We followed the process of the serious incident at the Birmingham Centre clinic that resulted in harm in March 2017 and found little evidence that even when incidents were reported through the software system with a duty of candour trigger, the provider had properly exercised its duty of candour.
- The provider had undertaken a 'peer review' of the services provided by the clinic in December 2016. This reported a number of areas for improvement and associated action plans. For example it identified the size of the recovery area was insufficient to provide a peaceful and private environment for patients and infection prevention and control as requiring rigorous monitoring.
- The action plan aimed to have these improvements in place by between the end of February and the end of March 2017. However, we noted many of these issues were still in evidence at the time of our inspection visit at the end of July 2017 although the provider had instigated a 'supportive quality review' of the service by the regional director by that time. Staff reported there was tension between the 'one call' appointment booking service system and the regional manager's decision to reduce the lists in order to reduce pressure on staff and implement effective changes.
- The deputy chief nurse who was present at the clinic during our visit told us the service was in week three of a four week project of change. This was an internal project led by the regional director (North) with the clinical operations manager (North) to carry out a quality and safety assessment of the clinic (a supportive quality review) and propose plans for change.
- The regional director told us an interim report of the assessment had been sent to the integrated governance committee, on to the clinical governance committee and then to the Board of the organisation at the end of August 2017.
- As a result of the supportive quality review the regional director reported to the provider's senior leadership on 14 July 2017 with a view to; decide if the service was sufficiently safe to continue providing services and agree the actions necessary to improve its safety. This forum included the chief nurse, acting medical director, associate director for quality assurance, the medical director and quality review participants including the regional manager. Some immediate changes were agreed and managers had implemented a programme of work to incorporate changes with review dates.
- We noted the risks identified by the supportive quality review were red, amber and green rated. Twenty two items were about safety, eight of these rated as 'red' and the remainder were 'amber'. These included under track record on safety 'KPI data submitted did not reflect the delivery of a safe service'.
- A governance assistant post had been created and filled at the Birmingham Centre during June 2017. Staff told us this role was to include undertaking clinical audit and incident report tracking to report to weekly regional incident review meetings. The post holder had yet to receive training in the reporting software system at the time of our visit.
- The supportive quality review and action project included a two day intensive training event for the whole staff team, including management of a haemorrhaging patient. It also involved an assessment of whether the premises were fit for the purpose of

surgical procedures. Some local change had already been made to manage risk for example, the layout of the surgical area so sedated patients did not have to use a staircase to access a toilet.

- We asked the provider for information about how it had safely managed this disruption to the local termination of pregnancy care services and the impact it had on the ability of local services to respond appropriately within the required time limits to gestational stage. MSI sent us their standard operating procedure for cancellation of clinics but no evidence of how the decision for each patient against their gestation time and preferred method was managed.
- We found in keeping with RSOP 1, there was an appropriate system in place to ensure HSA1 forms were completed on each patient file we reviewed and included the signatures of two medical practitioners in good faith. Signatures were dated and timed to demonstrate the independent opinion of a single permissible criteria for the termination of pregnancy. At the Birmingham Centre clinic the HSA1 forms were signed by doctors who were present at the clinic two days each week.
- At the Handsworth nurse led clinic for early medical terminations of pregnancy we saw the signatures of two registered medical practitioners had been made electronically after the patient's notes and medical history were sent to them with the uploaded HSA1 form electronically. We noted for example a medical practitioner signing from the provider's Bristol Centre and a medical practitioner signing from the provider's Leeds Centre on the same form. For the patients whose care and treatment we observed we saw the HSA1 forms for each were completed and signed before the termination was undertaken.
- There was a checklist on the front of each set of patient records to check off the process as fully completed including the electronic dispatch of the signed HSA4 form to the department of health. We noted for the sample of 12 patient files we reviewed at the Handsworth clinic the HSA4 forms had been submitted within 14 days of the procedure. There was an electronic system in place for this.
- Appropriate arrangements were in place to ensure the clinic did not carry out procedures exceeding its licence gestation limits.
- Oversight had been lacking and governance arrangements were not identifying risk and taking timely action to mitigate it. The internal investigation report of the March 2017 incident for example, was still at draft stage and national level managers required the support of the local CCG to produce an effective report. We had made requirements for improvement at our inspection in May 2016. The provider sent us an improvement plan in the autumn of 2016 of how it intended to address the issues. We have continued to have regular contact with the provider at national level to monitor improvements.
- The Birmingham Centre clinic 'regulatory compliance plan audit' carried out by the provider in February 2017 showed full compliance. At the time of the inspection there was evidence that improvements in governance and management action were in place and being effective and it was assuring that the interim senior leadership team had brought these issues voluntarily to the attention of the CQC before the inspection. This meant they were already aware of the risks prior to us identifying it during our inspection and that they were putting systems in place to address the risks. However, we still had concerns staff were yet to embed these systems.
- We found the interim management team, although focussed on identifying risk and bringing about change, were not on top of the day to day quality of the service to patients at that time. For example they had not identified the poor level of completion of TEWS tools, IPC issues or the absence of a stage in the World Health Organisation (WHO).

Public and staff engagement

- The service collected feedback from patients who used the service through independent analysis of questionnaires given by staff when treatment was complete. This analysis was undertaken on a quarterly basis and the provider received a report on a clinic by clinic basis which was used for benchmarking. This feedback was then sent to the clinic for local action. For

example, improvement had been made as a result of feedback about patients having to wait outside until their appointment time to be admitted to the Birmingham Centre clinic.

- Between January 2017 and March 2017 the number of patients completing the patient satisfaction survey was 539, as a percentage of eligible patients this represented 42%. The number of patients completing the survey between April 2017 and June 2017 had dropped to 37%.
- Staff were very committed to the service they provided to give women choices and control over their fertility. However, many staff we spoke with expressed a sense of alienation at the amount of change in the service. While they said they respected the direction of travel, the change was rapidly imposed top down by managers who were not engaging with them as their sight was focused on bringing about high level change in the region. They were also concerned about the number of appointments that had been cancelled at the Birmingham Centre in the week of our visit.
- Management told us a staff satisfaction survey had been undertaken, however the results were not yet available at the time of our inspection.
- Staff we spoke with told us they did not have team meetings. However, records showed there had been a team meeting in Birmingham Centre clinic in May 2017 and the whole staff team was spending two days together in a training event when we visited.

Innovation, improvement and sustainability

- We found surgeons at the clinic continued to be cautious and transfer any patient to the local NHS hospital where clinical need was identified.
- The service had been slow to respond to the findings of our 2016 inspection. Early opportunities to learn from the March 2017 incident of haemorrhage and delayed emergency transfer to an acute service were missed and a similar incident occurred in early July 2017 at another clinic in the region managed by the same team. By the time of our inspection visit, this meant the provider was moving quickly to catch up in a very short time frame with newly recruited staff during these changes. The provider had identified several improvement actions in regard to haemorrhage management that were being undertaken across all MSUK locations
- We saw that haemorrhage training and drills were taking place at Birmingham centre on the day of our unannounced inspection. Since then, managers assured us that the haemorrhage poster and a standardised haemorrhage kit were in place, and a new, more suitable evacuation route had been identified through joint working with local ambulance services, as well. We confirmed this with the clinical commissioning group. This supported what the interim manager told us post inspection. Managers now discussed Incidents, including emergency transfers in the weekly CLIP call and shared the minutes with the teams.
- As result of the supportive quality review carried out by the provider in July 2017, strategic changes in the configuration of services in this part of the region were to be proposed to the Board at the end of August 2017.
- The provider intended to develop the new electronic software reporting tool within the service and aimed to include a risk register function in the near future.
- The provider reported it is intending to pilot the simultaneous administration of medical abortifacients at the Birmingham Centre in the near future to offer greater flexibility to patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is appropriate management oversight to assess, monitor, and improve the quality and monitoring of the services provided.
- The provider must audit the use of the termination of pregnancy early warning score (TEWS) to ensure patients are being safely assessed and monitored for deterioration.
- The provider must improve mandatory training uptake , for safeguarding, manual handling, consent, advanced life support; basic life support, incident reporting, infection prevention and control, scanning, conflict resolution, information governance, and offer supervision.
- The provider must improve risk assessment on the day if it is unsafe to proceed with all surgical terminations due to capacity to ensure the risk of breaching lawful gestation for termination is not breached.
- The provider must ensure that the policy on conflict resolution covers all aspect of challenging behaviour.
- The provider must ensure all risks relating to surgical services are identified on the local risk register.
- The provider must ensure a consistent approach to action planning and ensuring lessons learnt from incidents are shared with all relevant staff locally and reviewed regionally to enable wider learning.
- The provider must ensure appropriate and safe storage and disposal of medicines.
- The provider must ensure that anaesthetists are checking equipment on every day of use in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance to ensure risks and emergencies are minimised.
- The provider must put in place pathways for support gaining informed consent from learning disabled patients.
- The provider must ensure the duty of candour requirements are met when a notifiable safety incident.
- The provider must include the name of the clinic premises on the Department of Health certificate and ensure it is placed in a prominent position to demonstrate its satellite clinic is an 'approved place' to carry out terminations of pregnancy in line with Department of Health requirements.

Action the provider SHOULD take to improve

- The provider should consider the fitness of the room used as the recovery room. It was difficult for staff to manoeuvre around patients, and for staff to move the patients' bed from the treatment room into the recovery room.
- The provider should ensure that records that are stored offsite are picked up by the approved courier service.
- The provider should consider recording of the waiting times every month to monitor variability effectively.
- The provider should ensure that staff at each location appropriately report and record incidents.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Arrangements for the safe and appropriate storage of medicines were not met** We found the drugs treated as 'controlled' such as anaesthetic drugs were stored alongside non-controlled drugs. This is not in line with the Department of Health, Controlled Drugs (Supervision of management and use) Regulations 2013. Intravenous fluids were stored in an area which was accessible to the general public. This put them at risk of tampering. **Staff had not received required mandatory training** Compliance with training uptake was not meeting the provider's target; however, this was due to the high level of new starters in the clinic. **Anaesthetists were not checking equipment before use** We saw this was not being done and was not in compliance with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance to ensure risks and emergencies are minimised. **Risk assessments were not used to identify and protect patients from safety issues** Cancellations of termination procedures were undertaken without risk assessment of impact on patients gestation dates. Regulation 12 (1)(2) (a)(b)(e)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was insufficient day to day management oversight and insufficient assessment and monitoring of the quality and safety of the service** We found there was insufficient management grip to use all information available as a driver to improve the service. Where concerns had been identified, there was either no plan for improvement, or when an action plan was in place there was little oversight to ensure dates of completions were monitored for slippage. Learning opportunities were missed and audit activity was either not undertaken or did not result in improvements for the service. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Termination of pregnancies	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **The provider missed opportunities to comply with the duty of candour requirements when notifiable safety incidents occurred** We noted that despite prompts on the incident reporting system this regulation was not met on at least two occasions. Regulation 20 (1)(2)(3)(4)(5)(6)(7)(9)

Regulated activity	Regulation
Termination of pregnancies	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

The provider must put in place pathways to support gaining informed consent from learning disabled patients

Staff discussed treatment options. However, we found the provider had no pathway in place to support patients with a learning disability.

Regulation 11 (1) (2) (3)