Marie Stopes International Coventry

Quality Report

Marie Stopes Coventry Centre
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Date of inspection visit: 4 and 14 September 2017
Date of publication: 13/12/2017

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Marie Stopes International Coventry is operated by Marie Stopes International (MSI). MSI Coventry was registered with the Care Quality Commission (CQC) in June 2016 and holds a license from the Department of Health to undertake termination of pregnancy (ToP) services in accordance with the Abortion Act 1967. Services are provided predominantly to NHS-funded patients referred by local clinical commissioning groups, as well as to private patients.

Regulated activities include medical ToP, surgical ToP, consultations, ultrasound scans, counselling, family planning, contraception advice, oral contraception and sexual health screening. Surgical ToP had not been provided at MSI Coventry since July 2017 and were not taking place at the time of our inspection.

Facilities at the MSI Coventry main site include a surgical treatment room with two recovery areas, two consulting

Summary of findings

rooms and an ultrasound scanner. Regulated activities are also provided at two satellite clinics, known as early medical units (EMUs). The EMUs are located at: Nuneaton and Stratford-Upon-Avon, where medical termination of pregnancy is offered.

We inspected this service using our comprehensive inspection methodology. We gave the provider three working days' notice that we would be inspecting the service. We carried out the announced part of the inspection at MSI Coventry on 4 September 2017. We carried out an unannounced inspection at the EMU at Nuneaton on 14 September 2017. We did not visit the EMU at Stratford-upon-Avon as part of this inspection.

We observed activity levels, staff interaction with patients, and made checks on the environment and equipment. We spoke with seven members of staff including; MSI regional managers (there was no registered manager available), medical staff (by telephone as they were not onsite during our inspection), registered nurses, and administrative staff. We also spoke with seven patients. We reviewed 14 patient records including four patients who had used the surgical ToP services. Before and after our announced and unannounced inspection visits, we reviewed performance information submitted by the service.

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?

We have not provided a rating for this service.

We regulate termination of pregnancy services, but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Serious incidents were investigated by a suitably trained panel at MSI UK, and acted upon.
- Policies for safeguarding of children and young people and safeguarding adults at risk were available. Staff received safeguarding training at appropriate levels.
- Patient records were accurate, complete, legible and up to date, and were maintained in accordance with the Data Protection Act 1998.
- There were locally agreed policies and standards that referred to evidence-based practice and against which performance was audited and reported upon.
- Learning and development was provided at an appropriate level to enable staff to develop and maintain their skills and competencies.
- Pain was assessed and treated in accordance with national guidelines.
- We saw good multi-disciplinary teamwork and collaboration with remote services at other MSI locations.
- There was consistent positive feedback from patients about the caring and non-judgmental attitude of staff, and we saw this in patient interaction we observed.
- Patient satisfaction was monitored. Four out of 15 indicators met the MSI target from April 2017 to July 2017, which was an improvement on the previous quarter's ratings.
- The early medical abortion service met patients' needs; however, the surgical service was being redirected to other MSI UK locations at the time of our inspection.
- Patients had access to telephone translation services for languages other than English.
- There were clear patient pathways for patients having a surgical or medical abortion and a clearly defined referral process for patients who required specialist services.
- Complaints were managed in accordance with MSI policies and in the required time frames.
- Staff spoke positively about the changes introduced by the new leadership team and the pace at which the changes had taken place.

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

- Staff told us there was no consistent system in place for patients or visitors to report to a receptionist or to sign in. On the day of the inspection there was a receptionist and sign in location available. However nursing staff told us they normally worked alone and there would not normally be a receptionist to greet patients.
- Incidents were reported however, limited evidence of learning was shown.

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- Staff told us failures in information technology at MSI Coventry were not always reported as an incident, investigated, or immediately acted upon. This meant staff could not access internal monitoring and reporting systems.
- Medicines were not always securely stored. There were insufficient arrangements in place to monitor and reconcile the stock of medicines.
- Safety checklists for the resuscitation and anaesthetic equipment were not always complete.
- There were gaps in staff completion of mandatory training; mainly due to a large number of new starters.
- The staff appraisal process was not embedded.
- Patients had to attend another location of their choice to be fitted with reversible contraceptives.
- Average waiting times for procedures were outside of RCOG recommendations.
- Compliance with testing for sexually transmitted diseases was low.
- The premises at MSI Coventry were not entirely appropriate for the services being delivered, as the lift did not support the emergency transfer of patients from the building.
- Privacy was limited in the waiting area and the surgical recovery area at Coventry.
- There was limited oversight of the services. There was no registered manager at the time of our inspection; however, interim leadership arrangements were in place.
- Risk management was not always prioritised or resolved in a timely way.
- Lone working arrangements at MSI Coventry had not been reviewed since the surgical service had stopped.
- There were gaps in the governance of medicines management, for example limited evidence of corrective actions in response to identified risks such as security of medicines storage and the risk of misappropriation of prescribed medicines.
- Variations from the chaperoning policy were not reported as an incident and acted upon.
- There was limited evidence of any remedial action taken following incidents or of learning being shared.
- Many of the improvements to governance were in the early stages of development and needed time to be embedded in practice.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected termination of pregnancy services. Details are at the end of the report.

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. We have a duty to rate this service when it is provided as a core service in an independent hospital.

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Background to Marie Stopes International Coventry

Marie Stopes International Coventry is operated by Marie Stopes International (MSI). MSI Coventry was registered with the Care Quality Commission (CQC) in June 2016 and holds a license from the Department of Health to undertake termination of pregnancy services in accordance with the Abortion Act 1967. Services are provided predominantly to NHS-funded patients referred by local clinical commissioning groups, as well as to private patients.

Termination of Pregnancy (ToP) refers to the abortion of pregnancy by surgical or medical methods. MSI Coventry is part of the provider group MSI UK and MSI International, a not for profit organisation that was founded in 1976 to provide a safe, legal abortion service.

MSI Coventry also provide regulated services at two satellite clinics known as early medical units (EMUs). The EMUs are located at Nuneaton and Stratford-Upon-Avon.

We carried out an announced comprehensive inspection at MSI Coventry on 4 September 2017 and an unannounced inspection at the EMU in Nuneaton on 14 September 2017. We did not visit the EMU in Stratford-upon-Avon as part of this inspection.

There were no special reviews or ongoing investigations of the service by the CQC at any time during the 12 months before this inspection. The service had not been previously inspected by the CQC.

We have not provided ratings for this service. We regulate termination of pregnancy services but we do not currently have a legal duty to rate them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Our inspection team

Our inspection team was overseen by Julie Fraser, Inspection Manager, and included three CQC inspectors with expertise in regulation, nursing, and termination of pregnancy.

Information about Marie Stopes International Coventry

Marie Stopes International (MSI) Coventry is registered to provide the following regulated activities:

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

Services are offered two days a week at Coventry, Nuneaton and Stratford-upon- Avon and include: early medical abortion (EMA) and medical termination of pregnancy (ToP) up to nine weeks and four days, surgical ToP up to 19 weeks and six days, consultations, ultrasound scans, counselling and support, family planning and contraception advice, and oral contraception. In addition, well woman screening, well man screening and sexually transmitted infection screening are also provided.

From January 2017 to August 2017 the service carried out 403 EMAs at Coventry, 175 EMAs at the EMU at Nuneaton, and 265 EMAs at the EMU Stratford upon Avon. This accounted for 58% of the ToP service.

The service is also registered for surgical ToP up to 19 weeks and 6 days gestation without anaesthesia, with general anaesthesia, or with sedation anaesthesia

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according to patient choice and needs. From January 2017 to July 2017 MSI Coventry carried out 286 surgical ToPs procedures, which accounted for 42% of the ToP service.

Surgical services had been provided at MSI Coventry until July 2017. Although registered for surgical termination of pregnancy, MSI executives had made the decision to only undertake medical termination of pregnancy at the time of our inspection. This was as a result of a regional quality review after a serious incident that occurred at MSI Coventry. Since the closure, patients who attended MSI Coventry and required a surgical ToP were offered the choice of attending another MSI location or service. This was done as a precautionary measure prior to a planned estate and quality review to assess whether egress could effectively be achieved in the event of an emergency transfer to an NHS provider. Surgical services were not planned to re-commence until after the investigation and further risk assessments were completed. These were ongoing at the time of our inspection. MSI had informed the NHS commissioners that the surgical service at MSI Coventry would remain diverted until further notice. We observed the medical termination service only at the time of our inspection; however we also sought evidence about the surgical service up until the closure of service in July 2017.

As a condition of registration, there must be a registered manager appointed by the provider (MSI) to manage the regulated activity on their behalf. There was no registered manager at the time of our inspection; however interim leadership arrangements were in place. The CQC received an application to cancel the previous registered manager's registration on 24 July 2017, as they no longer had day-to-day responsibility for MSI Coventry. This was cancelled on 29 August 2017. The executive management team at MSI told us a suitable applicant for registration had been identified; however, this application had not been received at the time of our inspection.

A senior service delivery manager who had day-to-day responsibility for the service provided interim management. The service delivery manager was supported by the regional director, a clinical team leader, the MSI deputy chief nurse and a team of nurses, health care assistants and administrators.

Services provided at the centre under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance of medical equipment
- Transfer of patients to acute medical services

During our announced and unannounced visits, we observed activity levels, staff interaction with patients, and made checks on the environment and equipment. We spoke with seven members of staff including; managers, medical staff, registered nurses, and administrative staff. We also spoke with seven patients. We reviewed 14 patient records including four patients who used the surgical ToP services. Before and after our announced and unannounced inspections, we reviewed performance information submitted by the service.

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 do not currently have a legal duty to rate termination of pregnancy services where these services are provided as an independent healthcare single speciality service.

We found the following areas where the service provider needs to improve:

- At the time of inspection the environment at MSI Coventry was under review following a serious incident that had occurred in July 2017. A temporary transfer of surgical services to other MSI locations was initiated to enable this to take place..
- The consultation room was cluttered and there was insufficient seating in the waiting areas.
- Incidents were reported however, limited evidence of learning was shown.
- Medicines were not always securely stored. There were insufficient arrangements in place to monitor and reconcile the stock of medicines. There was inconsistent monitoring of the medicines fridge and ambient room temperatures.
- The World Health Organisation (WHO) and the five steps to safer surgery checklist were not consistently undertaken before the surgical service was discontinued.
- Staff told us failures in information technology were not always reported as an incident, investigated or immediately acted upon. This meant staff could not access internal monitoring and reporting systems. Information provided following our inspection identified that should there be problems with information technology they should immediately be escalated to senior management for action.
- Resuscitation equipment was not consistently checked.
- There were gaps in staff completion of mandatory training; mainly due to a large number of new starters.

We also found the following areas of good practice:

- Serious incidents were investigated by a suitably trained panel at MSI UK, and acted upon.
- Policies for safeguarding of children and young people and safeguarding adults at risk were available. Staff received safeguarding training at appropriate levels.
- There was an admission policy to determine patient suitability for treatment at each MSI centre based on Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Summary of this inspection

- Patient records were accurate, complete, legible and up to date, and were maintained in accordance with the Data Protection Act 1998.

Are services effective?

We found the following areas of good practice:

- There was evidence to show staff were following evidence based guidance and practice against which performance was audited and reported upon.
- Policies were kept up to date. We saw that relevant staff were involved in their development and review.
- 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, scanning, and counselling.
- Pain relief was provided in a timely manner in line with national guidelines.
- There were defined patient pathways from admission to discharge.
- Patients' nutrition and hydration was accounted for.
- We saw good multi-disciplinary teamwork and collaboration with remote services at other MSI locations. Patient care was led by a specialist doctor with support from managers, registered nurses, and from administrative staff and trained counsellors at the MSI 24 hour customer contact centre (MSI One Call).

However, we also found the following areas where the service provider needs to improve:

- There was no evidence held locally that doctors had completed appraisals and there was no monitoring of nursing staff appraisals.
- Chaperoning training had not taken place and there was limited opportunity to offer chaperone due to lone working.

Are services caring?

We found the following areas of good practice:

- There was consistent positive feedback from patients about the caring, and non-judgmental attitude of staff, and we saw this in patient interaction we observed.
- We observed staff were compassionate and caring in their approach.
- All consultations were carried out in private rooms without interruptions.

Summary of this inspection

- Patient satisfaction was monitored and satisfaction rates were generally high. .Four out of 15 indicators met the MSI target from April 2017 to July 2017; however, this was an improvement on the previous quarter's ratings.
- Counselling was available and was mandatory for patients under 16 years old.

Are services responsive?

We found the following areas of good practice:

- The provider liaised with the clinical commissioning group (CCG) to ensure services met the needs of the local population. Surgical procedures were carried out at MSI Coventry; however, these had stopped from July 2017. Patients were offered an alternative location or provider.
- There was flexibility to arrange appointments at very short notice to meet the needs of patients.
- First assessments and consultations were undertaken either face to face or by telephone. Private telephone counselling was also available for patients.
- Patients had access to telephone translation services for languages other than English. Information leaflets were available in different languages.
- There were clear patient pathways for patients having a surgical or medical abortion and a clearly defined referral process for patients who required specialist services.
- Complaints were managed in accordance with MSI policies and in the required time frames. Patients and staff understood the processes they should follow.

However, we also found the following areas where the service provider needs to improve:

- Average waiting times for procedures were outside the RCOG recommendations however were beginning to show a downward trend since January 2017.
- Patients would have to attend another location of their choice for surgical services and to be fitted with reversible contraceptives.
- After surgical services stopped in July 2017 there was only one member of staff meaning they could not adhere to the MSI Lone Working policy. This also meant chaperoning could not be offered.
- From January to August 2017, an average of 11% patients underwent chlamydia testing.
- There was not always a receptionist to greet patients, which meant patients' needs might not be met while they were left unattended.

Summary of this inspection

- Privacy was limited in the waiting area and the surgical recovery area at Coventry.

Are services well-led?

We found the following issues that the service provider needs to improve:

- There was no registered manager at the time of our inspection and no operations or clinical managers worked regularly on site. There are details within the report outlining local leadership.
- There was no protected time to enable the clinical team leader or manager to attend the EMUs to identify, monitor and address risks. This meant risk management was not always prioritised or resolved in a timely way.
- Lone working arrangements at MSI Coventry had not been reviewed since the surgical service had been diverted.
- There were gaps in the governance of medicines management, for example limited evidence of stock reconciliation, and corrective actions in response to identified risks such as security of medicines storage and the risk of misappropriation of prescribed medicines.
- Chaperoning and chaperoning training were not carried out in accordance with national and local guidance. Variations from the policy were not reported as an incident and acted upon.
- Incident reporting and trend analysis was not yet embedded or effective at a local level.
- Many of the improvements to governance and managing risk were in the early stages of development and needed time to be embedded in practice.
- A staff satisfaction survey had recently been undertaken but there were no results available at the time of our inspection.

We also found the following areas of good practice:

- Staff spoke positively about the changes introduced by the new leadership team and the pace at which the changes had taken place.
- There were systems in place to monitor and act upon compliance with standard operating procedures and clinical and professional guidance.
- There were effective processes in place for HSA1 and HSA4 completion.
- Patients had the opportunity to give feedback.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents and safety monitoring

- A revised incident reporting policy was issued to all MSI centres in January 2017, followed by the introduction of a new electronic patient safety reporting system for incidents in February 2017. Training had been provided to inform staff about the new system. The percentage of staff trained in incident reporting was 81%, which was below the provider's target of 85%.
- A manager told us that since the introduction of the electronic patient safety system there had been an increase in reporting as staff awareness and understanding of the reporting process had improved. Staff we spoke with were familiar with the new system; however, they could not provide examples of when they had reported an incident.
- Although the electronic reporting system was in place, incident management and trend analysis was not yet embedded at a local level. Trend analysis was undertaken at a corporate provider level; with limited evidence of a consistent process to share learning with the local team.
- There was one serious incident in July 2017, which involved the delayed emergency transfer of a patient who required further medical treatment at the local NHS trust. The investigation into this incident was on-going at the time of our inspection. An immediate decision was made to redirect all surgical services from MSI Coventry to other MSI locations. The surgical register confirmed no surgery had taken place after this incident. Surgical services were not planned to re-commence until after the investigation was completed and further risk assessments were carried out.
- We were not assured that there were robust arrangements for learning from serious incidents. For example, managers told us that they were aware of similar incidents involving delayed transfer of patients following medical complications, at other MSI locations. There was no evidence that learning from these incidents had been shared or implemented at MSI Coventry prior to the serious incident occurring. However, following the serious incident at Coventry, there had been a two day closure for staff training, competency and lessons learnt.
- There were 46 incidents reported from January to August 2017. All incidents were graded according to the level of harm.
- The greatest number of incidents was classed as service delivery (15) and clinical complication (14). Other incidents included eight relating to medication errors, three to failure to follow clinical procedure, three to equipment, one to health and safety, one to information governance and one to violence and aggression towards staff.
- The MSI incident reporting policy required all incidents to have been reviewed and signed off by managers within seven working days and closed off within ten days. Senior managers told us that incidents and lessons learnt were discussed at the regional monthly quality and governance meetings. Minutes we looked at confirmed this.
- In 2016, MSI UK had established a Complaints, Litigation, Incident and Patient feedback (CLIP) group to review and share learning from all incidents across the organisation, including clinical incidents. CLIP met weekly. The main themes recorded in minutes of the CLIP meetings were misplaced notes, medicines errors, and failed medical abortion – which was a known risk. These corresponded with data on the electronic incident reporting system (incident log).

- There were no reported never events from July 2016 to June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were arrangements in place for reporting deaths and there were no reported deaths within the previous 12 months or from July 2016 to June 2017.
- Processes for undertaking root cause analysis (RCA) were revised in July 2016 to improve consistency across MSI UK. A two day training course was completed by senior managers in July 2016 and July 2017. In the event of RCA, only individuals who had completed the training were part of a centrally convened RCA panel nominated to complete the RCA. We saw this happened in relation to the investigation of the serious incident in July 2017, which was under investigation at the time of our inspection.
- A regional integrated governance committee (IGC) was established in 2016 and met quarterly. We looked at the last three meeting minutes of the IGC and saw that incidents were discussed as a standing item. Trends, themes and action points were recorded and acted upon by managers. However, there was no evidence of sharing learning with local staff.
- There was an MSI duty of candour policy for staff dealing with serious incidents. It was identified on the regional quality improvement plan in July 2017 that there was no evidence of duty of candour training. Duty of candour training was not included in the training matrix and we found no evidence at the time of our inspection that training had been provided for nursing or medical staff. However information received following our inspection identified that the duty of candour training was included within safeguarding training and complaints handling training for MSI staff working within the Midlands region. All staff we spoke with were aware of their responsibilities under the duty of candour. 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.
- We were informed there had been two incidents that triggered duty of candour from January to August 2017. MSI policy was to escalate any candour incidents to the acting medical director who would address issues in a timely manner through an honest, open conversation with patients. The acting medical director would then arrange for reasonable support to be provided to the relevant person and to follow-up conversations in writing. Information received following our inspection identified that a duty of candour letter had been sent from the acting medical director, and followed up with a meeting with the patient with full disclosure of time line and sharing of what went well and what could have gone better

Mandatory training

- MSI UK 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, control of substances hazardous to health (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 regional 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 MSI Coventry could work across the Midlands region on a rotational basis, there was no separate training matrix for Coventry.
- 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 some of the topics met the provider's' targets. However some, which included safeguarding, manual handling, consent, advanced life support, basic life support, incident reporting, medical gases and scanning did not.
- We were informed by the provider that medical gases training was provided both electronically and as part of a three day anaesthetic and recovery training course. We saw that 11 out of 13 staff (86%) required to undertake anaesthetic and recover training had attended the three day course. However the training

matrix included medical gas training separately and did not reflect this number, and showed only one member of staff out of 25 had attended. Therefore we could not be assured that the matrix was kept up to date.
- As of August 2017 75% (24 of 32) staff were up to date with basic life support or intermediate life support training.
- The provider's target was 100%. In addition, 13 staff were up to date with anaesthetic and recovery care training.

Safeguarding

- MSI UK had a policy on safeguarding for children and young people which was in date.
- Training in safeguarding adults and children at risk was provided at level 2, level 3 and level 4, in accordance with The Royal College of Paediatrics and Child Health intercollegiate document Safeguarding children and young people, 2014. This included a 30-minute electronic learning module for all staff.
- Administrative staff were trained to safeguarding level two clinical staff were trained to safeguarding level three and the safeguarding leads were trained to level four. Training for level two and three met the provider's standard of 85% or above. An audit of safeguarding knowledge and procedures was undertaken on 10 February 2017. This showed that the location was 100% compliant with the providers' audit standards.
- Two patients under the age of 16 were treated at MSI Coventry in the reporting period. The provider did not carry out termination of pregnancy (ToP) for children less than 13 years of age at this location, in accordance with MSI UK abortion policy version 2 December 2016.
- MSI UK had a policy on female genital mutilation (FGM) which was in date. Staff asked patients at each consultation about this as part of the safeguarding assessment. We saw this was documented on each individual patient safeguarding form we looked at. Staff knew to report this to the safeguarding lead and the police if the patient was less than 18 years of age.
- As of August 2017, child sexual exploitation (87%) and PREVENT (88%) training levels met the provider standards of 85%. FGM training level was 84%. The aim of 'PREVENT' training is to provide staff with the knowledge to enable them to be aware of people who are at risk of becoming radicalised and to stop them from supporting terrorism or becoming terrorists.
- There was one safeguarding referral made from July 2016 to July 2017 where a young person did not attend two appointments. We saw that this was raised as a safeguarding concern in line with local and national policies and recorded on the electronic safety reporting system.
- In all of the patient records we looked at, and all the consultations we observed, we saw that a safeguarding assessment was carried out and recorded on a safeguarding proforma that was age specific.
- Staff told us that any safeguarding concerns would be raised with the centre safeguarding lead, and that where required, referrals to social services or the police were made, in accordance with the MSI policy. Safeguarding referrals were recorded on the electronic incident reporting system. Staff were able to name the safeguarding leads and knew how to contact them.
- NICE Guidance PH 50, 2014 and Quality Statement 116 Domestic Violence and Abuse, 2016, is provided for everyone working in health and social care whose work brings them into contact with people who experience or perpetrate domestic violence and abuse. The guidance states that providers should ensure that health and social care practitioners provide facilities, which enable people to speak about their experiences in a private discussion. We saw patients were routinely seen on their own in a private consulting room as part of the consultation or assessment process. and observed this happened in practice.

Cleanliness, infection control and hygiene

- There were systems and processes in place to monitor standards of cleanliness and hygiene. These included up to date policies, cleaning schedules and checklists, and infection prevention and control training.
- Patient satisfaction rates for cleanliness were shown to be 92% from January to March 2017 and 96% from April to July 2017. The target for this indicator was 95%.
- There was a colour-coded system for disposal of waste, including disposal of unused or expired medicines and we saw this was followed, with clear segregation of clean and dirty equipment.
- We were told that domestic cleaning was conducted through each host site's cleaning contract.
- We saw five boxes of HIV/syphilis testing kits stacked up on the floor in consulting room two at MSI Coventry. This was not in line with national guidance as storing items on the floor means they are susceptible to

damage and contamination. One member of staff told us the boxes were normally stored in this manner, which made it difficult to clean them and the floor. In addition, two of the boxes contained expired stock; dated 4 August 2017 and 9 February 2017. We brought this to the immediate attention of the manager, who removed the boxes.

- Hand hygiene audits were carried out monthly at MSI Birmingham. Staff we spoke with told us that as all of the nurses and healthcare assistants at MSI Coventry also worked at MSI Birmingham on a rotational basis, the outcomes of the audit would apply to the service and the audit would not be repeated at Coventry, as the results were comparative. The hand-washing audits included observing 20 opportunities for hand washing among the staff working at MSI Coventry. It also included adherence to the arms bare below the elbow policy. In May and June 2017, a score of 100% was achieved in the hand-washing and arms bare below the elbow audits. During our inspection, we observed staff adherence to hand washing and arms bare below the elbow requirements at all times.
- Infection, prevention and control (IPC) audits included areas such as waste management, cleaning, and management of sharps and equipment. Managers were required to complete the audits every month; however, there was no evidence of audits being carried out after March 2017. Compliance with IPC standards in March 2017 was 82%, but there was no evidence of an action plan to improve.
- At our inspection, we observed single used medical devices at MSI Coventry and the early medical unit (EMU) at Nuneaton.
- All staff were provided with training in IPC as part of the MSI UK mandatory training programme. As of August 2017, compliance was below the MSI target of 100%. Nine out of 14 (64%) of clinical staff had completed level one and level two IPC training, and four out of nine (44%) of non-clinical staff had completed level one IPC training.
- We saw adequate supplies of personal protective equipment (PPE), such as disposable gloves, aprons and masks. All staff were observed to adhere to the uniform policy and wore the appropriate protective clothing depending on the task they were undertaking.

Environment and equipment

- There were 14 seats available in the shared main waiting area and six seats available immediately outside the MSI centre at Coventry. Staff reported on days when surgical lists were running there could be from 24 to 26 patients. Prior to our inspection a manager told us there were plans in place to review the contract with the host site to come to an alternative agreement about the seating, waiting areas and toilet facilities. However, this had not happened at the time of our inspection. Information received following our inspection identified that the review of the agreement had been put on hold whilst the surgical services were diverted.
- Patients at the EMU at Nuneaton waited in a spacious reception area and reported they were satisfied with the arrangements.
- There were separate recovery areas, for the immediate and later recovery period, with six recliner chairs. There was also a changing area for patients and one toilet.
- There was one toilet shared by staff and patients located in the recovery area. Staff told us this could cause difficulties when patients need to empty their bladders before treatment or before trans-vaginal scanning.
- The clinics were air conditioned to maintain a comfortable temperature on hot days.
- Clinical areas appeared visibly clean. However, some areas were cluttered. For example, there were a number of boxes stacked on the floor along the back wall in a consulting room that contained surplus stock that would be used in surgical ToP. The clinic was not providing surgical services at the time of inspection; however, none of the left over stock had been collected or moved into locations that are more appropriate. The boxes were out of the way of patients. Also, there were approximately 20 unused sharps bins stacked on the floor in the dirty utility room at Coventry, which we were told were surplus to requirement.
- There was a freezer specifically allocated for the storage of pregnancy remains at Coventry. We looked in the freezer and found it was clean and empty.
- Staff recorded the temperature of the freezer on a chart, and we saw this was recorded when the freezer was in use. Staff confirmed it was last used in July 2017.
- Records showed most of the clinical equipment owned by the service had been serviced and safety checked in line with the provider's policy. This was in line with the Department of Health Required Standard Operating Procedure (RSOP) 22 Maintenance of equipment, which

requires providers of ToP services to minimise risks and emergencies through a programme of regular checking and servicing of equipment. However, there was no record of when scales used to weigh patients at Coventry were last calibrated, which meant there was no assurance of their accuracy. There was also no evidence to show when a glucometer used to measure blood sugar levels was last checked.

- Resuscitation equipment, including suction and oxygen cylinders were available at MSI Coventry and the EMU at Nuneaton. At the Coventry location, there were two rucksacks containing resuscitation equipment to be used in the event of a medical emergency. One with an automatic external defibrillator (AED) was stored in the treatment room, the other (without an AED) in the surgical recovery area. At the EMU at Nuneaton, there was a similar rucksack in the consulting room, however there was no AED. Staff we spoke with told us they would have the use of the host site AED that was readily accessible in the shared reception area, and checked daily, and we saw this to be the case.
- All resuscitation bags (rucksacks) were sealed. However, at Coventry there was no completed daily checklist. Equipment was in date, however the last monthly check was June 2017. We brought this to the attention of managers at the time of our inspection, who told us corrective action would be taken. Although basic life support training compliance was below the MSI target, all staff we spoke with correctly described the use of the emergency equipment. The MSI UK resuscitation policy, dated December 2016, stated that any sealed bags and trolleys should have seals checked daily for integrity and then a full check monthly. Any unsealed equipment should be checked daily which is in line with current guidance from the UK Resuscitation Council.
- There were first aid kits in the consulting rooms and recovery area at MSI Coventry, and the consulting room at the EMU at Nuneaton. All were found to be intact and within the expiry date.
- We saw an eye wash station in the clean utility room at MSI Coventry to be used by staff in a first aid situation, for example if there was an injury to the eye. However, the eyewash dispensers were empty. Staff informed us the eyewash had been removed as it had recently expired, however they were unsure whether any replacements had been ordered.
- The EMU at Nuneaton was located on the ground floor of a host site GP surgery. Patients reported to the host site GP receptionist and were directed to a nearby waiting area.
- Managers we spoke with told us staff would receive safety alerts for medical equipment and medicines by email, and provided recent examples of where these had been communicated to all staff. All staff we spoke with correctly described the process.

Medicines management

- Staff involved in the supply and administration of medicines were required to comply with the MSI Medicines Management policy which had been revised in February 2017 and remained in draft form. The acting medical director confirmed that this was the current version and that the final authorisation of the policy was expected in September 2017.
- Medicines were not always managed in a way that kept people safe. This included the storage, monitoring and reconciliation of medicines stock. Reconciliation of medicines is the process of comparing a patient's medicines order to all of the medicines that the patient has taken. The medicines management policy that set out arrangements and staff responsibilities for the management of medicines, including controlled drugs (CDs) that require additional security. However, during our inspection we found that the policy was not always followed.
- During our announced inspection, we found an unlocked cupboard containing medicines in a consulting room at MSI Coventry. As well as being used for patient consultations, the consulting room was used as an administrative office. The room was accessed by authorised staff only using a digital keypad system. We saw the cupboard contained some spare IT equipment and stationery as well as medicines including those used to induce a medical abortion, pain relief, antibiotics, and pregnancy tests. This did not comply with Home Office guidance (May 2016). We brought the lack of secure storage of medicines to the immediate attention of the manager who located the correct key and ensured the cupboard was locked. The nurse on duty confirmed the cupboard had been unlocked at the beginning of the consultation list that morning and that the room would not be accessed by anyone other than nursing and administrative staff.

Termination of pregnancy

- There was a controlled drugs cabinet at MSI Coventry which contained a sedating agent known as midazolam, and morphine oral solution (Oramorph) 10mg in 5mls. Although both medicines have a lower potential for abuse than some other medicines and do not have to be stored or managed as controlled drugs, the provider policy stated that they would be treated as such in order to mitigate the risk of them being misappropriated.
- Managers told us that it was the responsibility of the nursing staff to ensure that the stock balance of sedating agents and the morphine oral solution was recorded in a controlled drugs register. We found both medicines were stored securely and the keys were locked away in a passcode controlled key cabinet, which was accessed by nursing staff only. The passcode was changed at regular intervals. However, stock balances were recorded on two occasions in March and July 2017 only. This was not in line with the medicines management policy which required this was performed at least monthly.
- Medical gases were not always stored safely. For example, at MSI Coventry we found two oxygen cylinders loose on the floor in the dirty utility room. Medical gases, such as oxygen, should be stored securely in appropriate brackets with empty cylinders stored separately. In addition, records we looked at showed that compliance with medical gases training was below MSI target. We brought the oxygen cylinder storage to the immediate attention of the manager who told us corrective action would be taken.
- A medicines storage and security assessment was undertaken and reported at MSI Coventry in May 2017 which had identified some areas for development such as secure storage of medicines, however there was no evidence of any follow up action or further assessments.
- We asked about the monitoring and reconciliation of medicines stock and were told there was no documentation of stock control, or records of disposal of medicines at a local level or on a daily basis. Managers told us the lack of local reconciliation had been added to the risk register, as a result of reported incidents at other MSI locations, and we saw this to be the case. To mitigate the risk there was a monthly financial audit carried out centrally at provider level to check the supply of medicines against patient treatment, which meant it could be up to one month before any discrepancies would be identified.
- Doctors prescribed medicines remotely from another MSI location via an electronic prescribing system. Patient records we looked at showed that all medicines were supplied and administered against each prescription, and when they were administered by nurses were signed for electronically.
- During our inspection, we saw nursing staff clearly explained the purpose and instructions for each of the medicines given, including what to do if the medicines were not effective and how the patient would identify this.
- Patient records we looked at confirmed that doctors followed local protocols for prescribing antibiotics. This was line with NICE QS61 which recommends that people are prescribed antibiotics in accordance with local antibiotic formularies.
- We saw nursing staff administered prescribed antibiotics alongside the medicines prescribed for a ToP. This was to reduce the risk of infection during and following an early medical abortion (EMA).
- In all 14 patient records we reviewed, staff had recorded allergies and taken relevant action to ensure known allergies were acted upon.
- Managers told us that MSI UK had a centrally managed contract for the purchasing of medicines from an approved pharmacy supplier. We were told that orders for medicines would be placed electronically, and checked centrally by an authorised person at MSI UK. Staff we spoke with told us that supplies were normally delivered directly to the centre(s) by an approved courier service, except in an emergency. However, managers and nurses we spoke with also told us there had been no courier service at Coventry since the surgical service had been diverted in July 2017, and that staff were regularly required to transport medicines between different MSI locations. Medicines would be stored in security tagged bags during transportation. We saw this to be the case during our inspection.
- We asked what instructions staff had received to ensure this was managed safely and that staff were protected. The staff we spoke with were unaware of any particular instructions. We brought this to the attention of the manager who told us the instructions were included within the medicines management policy and that these would be discussed at the MSI medicines management training provided in July 2017. Managers also informed us that the courier service was under review.

Termination of pregnancy

- There were systems in place to check for expired medicines and to rotate medicines with a shorter expiry date. We looked at a random sample of medicines at both sites we inspected. All the medicines we saw were within the expiry date.
- There were security procedures in place to ensure only approved staff could access medicines, for example access to keys to the medicine storage areas was restricted to nurses using a digital key pad system. However, there was no record of who had held the keys or when they were taken and returned.
- Medicines were safely stored in accordance with the manufacturer's instructions and in their original packaging.
- MSI medicines management policy required that the minimum and maximum temperatures of fridges and other medicines storage areas were monitored daily to ensure that medicines that had temperature requirements were stored correctly. The fridges were in the required temperature range during our inspection. However, we saw no temperature logs for any of the medicines cupboards, or the CD cupboard. Staff reported they were not aware of these records. At the Coventry site, there was no record of temperature monitoring for July 2017 and there was only one record of the temperature in August 2017. Therefore, we could not be assured that medicines were always stored at the appropriate temperature to ensure they were safe for use.
- At the Nuneaton location, we looked at records, which showed that daily temperature checks of the medicines refrigerator were maintained by staff at the host site. The records were fully completed within the previous three months and showed the fridge temperatures were consistently within the required range.

Records

- Records were stored securely and maintained in a way that kept patient information safe. A combination of paper and electronic patient records was in place. Arrangements for the management of patient records were set out in MSI UK policies. Compliance with the policies was audited on a monthly basis. Overall compliance with records standards from July 2016 to June 2017 had been 94%. This was slightly below the MSI target of 95%.
- MSI UK policies stated that all records which included patient-identifiable information must be stored securely and kept strictly confidential within the establishment. We saw this to be the case during our inspection as only authorised staff had access to the patient records.
- 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.
- During our announced inspection, we reviewed 14 sets of patient records, including 10 patients who had undergone medical abortion and four who underwent surgical abortion. All of the records we looked at were filed and maintained in accordance with national standards from the relevant professional regulators, including the General Medical Council and Nursing and Midwifery Council. For example, records were contemporaneous, legible and safely stored.
- Staff we spoke with told us that prior to the ToP, all patients had an ultrasound scan to confirm their gestational date, which is the term used to describe how many weeks pregnant the woman was. In all of the patient records we looked at, we saw a record of the ultrasound scan and the reported gestational date, and a print out of the scan. An electronic copy was also correctly stored and maintained.
- The provider carried out medical record audits in January, March, May, and July 2017. Audit reports showed that the provider target of 95% was met in January, March and May 2017 with respective scores of 100%, 96% and 95%. In July 2017, the audit score was 94%. The provider had an action plan in place to address the specific issues highlighted in the audits. This included completion of the patient identification number and pain scores on the termination of pregnancy early warning score (TEWS) form. TEWS was used to assess and respond to acute illness of a patient undergoing ToP. However there was no effective monitoring of TEWS audits.

- There was 82% of staff trained in information governance, against the providers' target of 85%.

Assessing and responding to patient risk

- There was an MSI UK admission policy to determine patient suitability for treatment at each MSI centre. At their initial consultation, all patients were asked about their medical history to assess their suitability for treatment; this included assessment of potential risk factors. If a patient was unsuitable for treatment at MSI Coventry and the EMU satellite sites, for example due to an existing health condition, they would be referred to a suitable alternative centre or provider.
- The facilities for providing surgical ToPs were located on the third floor of the premises at MSI Coventry. There was a lift, but this was not large enough to accommodate a stretcher. If patients required emergency transfer in a horizontal position, staff could access an evacuation sledge. For example, patients who are bleeding heavily should be kept in a horizontal position to stabilise blood loss. As of August 2017, 75% (24 of 32) staff were up to date with basic life support or intermediate life support training. The provider's target was 100%. In addition, 13 staff were up to date with anaesthetic and recovery care training.
- There were up to date policies in place in to care for patients following surgery and to manage a deteriorating patient. We were unable to observe these policies being applied in practice as the surgical service was temporarily closed at the time of our inspection. However, records we looked at showed that following surgical procedures patients were monitored in the immediate post-operative period for at least 30 minutes by a registered nurse in the recovery area until they were fit for discharge. Nurses and doctors we spoke with confirmed this happened.
- Staff used the termination of pregnancy early warning score (TEWS) to assess and respond to acute illness of a patient. The provider had redesigned it to reflect the physiological parameters and triggers for intervention and escalation for clinically well patients undergoing ToP, prior to, during and after treatment. TEWS was recorded and scored appropriately in the four surgical patient records we looked at. However, there was no effective monitoring or audit system in place to provide assurance that staff continued to use the TEWS score appropriately.
- After a surgical procedure, once a patient's vital signs were stable and within their baseline recording, they would be assessed for fitness to be discharged against the MSI discharge proforma that included assessment of their physical, social and emotional needs. Nursing staff told us they would escalate any concerns to the anaesthetist who remained on site until the last patient was assessed as fit for discharge. Patients were given the contact number of an MSI call centre for reporting any concerns after discharge. The call centre was open 24 hours a day, seven days a week.
- There was a bag labelled 'haemorrhage kit' in consulting room two at the Coventry location which was in a tamper proof pack and was in date.
- In December 2016, the MSI UK policy on the transfer of patients was reviewed and required that every centre must have in place a service level agreement (SLA) which covers transfer out to an appropriate acute care provide in the case of a medical emergency. Staff were aware of the process to follow which was that an ambulance should be summoned via the 999 system and one of the team should make the call. We saw a service level agreement with the neighbouring NHS trust at the time of our inspection. However, there was no date or review date on the document.
- Managers informed us that only medical staff were required to attend advanced life support training. There was no information available locally to confirm that medical staff had completed the required mandatory training as this information was held and monitored centrally at another MSI location. However, doctors we spoke with confirmed all anaesthetists treating patients would complete advanced life support training and this would be monitored as part of their supervision and revalidation requirements.
- All of the patient records we looked at contained venous thromboembolism (VTE) risk assessments which staff completed prior to treatment. VTE is where a blood clot forms in a vein. The risk assessments informed staff if preventive treatments were required.
- It was recommended by the National Patient Safety Agency in 2010 that the World Health Organisation (WHO) and the five steps to safer surgery checklist should be used for every patient undergoing a surgical procedure. We saw a policy had been issued across MSI UK to enable the use of the World Health Organisation (WHO) and the five steps to safer surgery checklist, and monitoring of its use. Staff were required to complete

audits of the checklist on a monthly basis; however, there was no evidence of any other audits from March 2017 to July 2017 when surgical services stopped, and staff could not recall these happening. . All of the surgical patient records we looked at included a completed checklist.

- Prior to termination of pregnancy, all women should have a blood test to identify their blood group. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the woman have future pregnancies. All records that we reviewed demonstrated that patients underwent a blood test prior to the termination of pregnancy and those who had a rhesus negative blood group received an anti-D injection.
- To reduce the risk of retained products of conception, an ultrasound scanner (USS) was used during each surgical procedure. In addition, the surgeon visually checked pregnancy remains following each early gestation procedure to identify the sac and reduce the risk of the products being retained. If there was any doubt the surgeon would rescan the patient and take appropriate action. This was in line with best practice.

Staffing: nursing and medical

- The Department of Health Required Standard Operating Procedure (RSOP) 18: 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. Staffing rotas showed that there was a registered nurse or midwife on duty at all times when patients were seen in the clinic. This was in line with the RSOP.
- There were established recruitment policies overseen by a central human resources team and there were no medical or nursing vacancies as of August 2017.
- Nursing staff that provided the service at MSI Coventry were part of a cohort of 13 registered nurses and eight health care assistants expected to work at other MSI centres in the Midlands region on a rotational basis. This was to enable staff to keep up to date with practice and ensure they were regularly supervised.
- Nursing staff we spoke with told us that those regional managers were based at another MSI location and visited MSI Coventry as required. Staff would contact regional managers for advice and support, and felt satisfied with the response time and outcomes.
- Doctors working remotely provided medical staffing at the EMUs, and medical staff were on site at MSI Coventry when the surgical service was open. The doctors worked remotely at other MSI locations, including the MSI 24 hour call centre. Their role was to review patient case notes and medical histories prior to signing the HSA1 forms and prescribing medicines. The HSA1 form is the certificate that has to be completed by two doctors before a ToP is performed under the Abortion Act 1967.
- A clinical team leader managed the staffing rotas, and allocated the nursing staff to work at each of the centres on a day-to-day basis. This was in accordance with RSOP 18 staffing and emergency medical cover, which requires that a named senior manager should be responsible for ensuring that staff attended according to the staffing rota.
- Managers told us they were in the process of introducing an electronic rota management system across the country. The training for this took place in August 2017 and the centres aimed to introduce the system by January 2018. At the time of our inspection, rotas were created on local spreadsheets. Staff told us they often received their rota with less than one week's notice. Managers had identified this as an area for improvement in the quality improvement plan and informed us that it was anticipated that the new system would alleviate staff receiving their rota the week before.
- Gaps in staffing were covered by staff working overtime. Agency nurses were not used. We saw that prior to the transfer of surgical services; one surgical operating list was cancelled in October 2016 due to no available anaesthetist. Another surgical list was cancelled in December 2016 due to staff sickness. Staff told us that all of the patients scheduled for those lists were provided with a suitable alternative appointment.

Major incident awareness and training

- A major incident and business continuity plan for MSI Coventry was reviewed in March 2017. The plan contained details of managers as a first point of contact and what to do in the event of a major incident, such as a bomb threat, widespread fire or flood, prolonged loss

of power, heating, communications or water failure. Staff were aware of the plans, although they could not recall any specific training or when they had to apply it in practice.

- Fire evacuation plans were seen across all areas; however, there was no evidence that weekly fire safety checks or evacuation routines had been conducted in line with MSI policy. information provided post inspection stated that weekly fire safety checks were undertaken by the host site. To get assurance, MSUK undertook audits with the host site to ensure they had been completed. The April 2017 audit demonstrated 100% compliance in the fire section.
- The MSI policy required that evacuations should be practised at least twice a year. Staff we spoke with could not recall when they last practised the fire evacuation drill. A fire risk assessment was last carried out in July 2017 and included assessment of the environment, personnel, training and evacuation plans. Fire training was not undertaken in line with company policy.

Are termination of pregnancy services effective?

Evidence-based treatment

- Care and treatment was delivered in line with evidence-based guidance. Terminations of pregnancy (ToPs) were performed in line with national recommendations and legislation. For example, the service performed surgical ToPs where gestation was confirmed by ultrasound scan to be 19 weeks and six days or under. Medical termination was performed where scans showed gestation to be nine weeks and four days or under.
- All services holding a valid ToP licence issued by the Department of Health (DH) are required to follow required standard operating procedures (RSOPs). MSI had corporate, regional and local policies were in place that reflected up to date guidance, in line with RSOP 16: Performance standards and audit. RSOP 16 recommends that all providers should have clear, locally agreed standards against which performance can be audited and that are guided by appropriate national standards.
- A policy defined the patient pathway from admission to after discharge, and stated the limit on treatment in relation to gestational date. This was based on Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. It included how to provide written information for patients considering having a ToP about potential risks, and what to be aware of after the procedure. This was in line with RSOP 10: professional guidelines, which states that providers should have regard to authoritative clinical and professional guidance and professional opinion such as that provided by relevant Royal Colleges.
- Patients could contact the MSI call centre for counselling services after their procedures. This was in line with the RCOG recommendation that patients should have access to a 24-hour post procedure counselling service following ToP.
- Prior to the suspension of the service, surgical ToP at MSI Coventry had been offered, by vacuum aspiration; a practice which is reported by the RCOG as the preferred effective practice.
- For patients with a gestational date of up to nine weeks and four days medical abortion provided an alternative to surgical intervention. We saw that patients were offered options for medical abortion based on gestational date. The options were: two medicines administered with a six ,24, 48 or 72 hour interval. This was in line with national guidance.
- We saw that there were posters displayed to provide information about evidence-based practice and national guidance. However, we found the UK Resuscitation Council guidance Adult basic life support and automated external defibrillation displayed was dated 2008,and was not the most recent version published in 2015. We brought this to the attention of the manager who told us corrective action would be taken.
- We saw the nurse explained to patients the correct method of taking the medicines to induce medical abortion, and provided with two pregnancy tests. They explained to each patient when to complete the pregnancy test and what to do in the event of a positive result. This was in line with best practice.

Nutrition and hydration

- Staff told us that when patients underwent surgery they were offered a light snack prior to discharge home. We saw there were tea and coffee making facilities available to provide this, as well as cold drinks.

- Patients were given information about when to stop eating and drinking prior to surgery and understood the reasons for this.

Pain relief

- Patient records we looked at showed that where patients underwent termination of pregnancy pain relief scores were completed using a nought to ten pain relief rating. This was in accordance with RCOG guidance The care of women requesting induced abortion recommendation 7.16, 2011, which states women should routinely be offered pain relief during surgical and medical abortion.
- Patients told us that they were offered pain relieving medicines in a timely manner and we saw this happened. We also observed patients were advised to use single use abdominal heat pads as part of their pain relief support.
- In all 14 patient records we looked at, we found discussion about pain, and the effect of pain relief was documented appropriately.

Patient outcomes

- The Department of Health Required Standard Operating Procedures (RSOP) 16 Performance standards and audit recommends that all providers should have in place clearly locally agreed standards against which performance can be audited, with specific focus on outcomes and processes. We saw that these were in place and that information showed that the intended outcomes for patients were being measured and largely achieved. Patient outcomes were presented and discussed at quarterly quality assurance meetings.
- The Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for Care of women requesting induced abortion recommend a regular audit of the number of staff competent to provide methods of contraception and the availability of staff. This data was available on an on-going basis and reported as part of the annual quality accounts. At the time of our inspection, there were no nursing staff trained to supply all methods of reversible contraception. We were told that there were plans in place for nurses to undertake the training but saw no evidence of this. In the meantime, doctors would provide contraception. However, as there were no doctors working at MSI Coventry EMUs, patients would have to attend another location of their choice to be fitted with reversible contraceptives.
- From July 2016 to June 2017, there were seven reported failed medical abortions that equated to 1% of all EMAs within that period which was in line with national figures. There were no reported failed surgical ToPs in the same period.
- The service monitored how many patients proceeded to termination of pregnancy. From July 2016 to June 2017, 22% of patients did not proceed with the ToP procedure following their pre-operative consultation and consent. This compared with a national benchmark of 15%.Managers told us MSI Coventry had a higher rate than the national benchmark as the service treated medical patients up to nine weeks and four days and surgical patients up to 19 weeks and 6 days in gestation. Any patients who had a later gestational date would have to be referred to another centre and would therefore be included in the 'did not proceed' statistics.
- From July 2016 to June 2017, an average of 8% of patients did not attend their appointments. Of those, two patients did not attend for the second appointment for EMA. There were 52 patients (4%) who attended for post-operative follow up appointments.
- In all of the records we looked at, there was no documentary evidence of any STI screening processes provided by the service or elsewhere. Staff confirmed that screening for sexually transmitted infections varied according to the commissioning agreement with the relevant clinical commissioning group. This was not in line with RSOP 13: Contraception and sexually transmitted infections (STI) screening which states that women should be offered testing for Chlamydia (C. trachomatis) and undergo a risk assessment for other sexually transmitted infections.
- However, staff told us that all patients were offered sexual health screening and this was carried out with the patient's consent. From January to August 2017, an average of 11% patients underwent chlamydia testing. The highest proportion of opt out reasons given was 'declined to give reason'.
- RSOP 13: contraception recommends that ToP services should be able to provide all reversible methods of contraception, including long-acting reversible methods of contraception (LARC), immediately after abortion. LARC includes contraceptive implant, contraceptive

injection, intrauterine device (IUD) or intrauterine system (the coil). Options such as the depot injection, and oral contraception could be supplied by a suitably trained nurse. However, LARC could only be administered by a doctor or suitably qualified nurse and this service was not provided at the time of our inspection.

- From July 2016 to July 2017, the average uptake of LARC by patients was 40%. The target was 50%, which was not achieved in any of the twelve reported months.

Competent staff

- All the doctors we spoke with told us they were required to provide evidence on checks on their competency and training as part of the GMC revalidation process. This included an annual appraisal. All doctors we spoke with confirmed that they had an annual appraisal. Doctors and managers told us that appraisal and competency assessments were carried out by MSI at provider level. Appraisal and continued personal development rates were published monthly and monitored by the central management team at MSI UK. Evidence submitted during the MSI UK provider level inspection in February 2017 demonstrated 100% compliance.
- An evidence-based clinical practice guide for registered nurses and midwives was issued to staff in October 2016 through road-shows. Staff were required to have the clinical competencies related to the practice guide signed off once they had successfully completed training and assessment, however; there were limited systems in place to monitor this.
- RSOP 18: Staffing and Emergency Medical Cover states that providers 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. There were arrangements in place to ensure this happened, including recruitment strategies, job descriptions, on-going learning and development programmes, and the use of competency frameworks.
- 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 scans were performed by staff who had undertaken the relevant training and assessment.
- Staff were not trained to act as a chaperone for patients, which was required in MSI policy. The MSI training matrix showed no evidence that chaperoning training had been completed.
- Counselling services were provided by trained counsellors who held a Level 4 Diploma in counselling, and were members of the British Association of Counselling and Psychotherapy. (BACP).
- Staff told us that they were not always given protected time to complete training and that on occasions training had been cancelled due to insufficient numbers of nominations from staff. This had included safeguarding and anaesthetic and recovery training.
- We saw a 'Marie Stopes Induction, Probation and Preceptorship, Workbook for Clinical Team Members'. This included areas such as an overview of MSI and a reflective practice portfolio. Staff we spoke with told us this was relatively new and not yet embedded in practice.
- All nursing staff had completed their revalidation when it was due. Revalidation is the process that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) who are the professional regulatory body for nurses and midwives in the UK.
- Staff who gave results of tests such as chlamydia and HIV testing were required to complete training in this area as part of the consultation training.

Multidisciplinary working

- Patient care was led by a specialist doctor with support from managers, registered nurses, and from administrative staff and trained counsellors at the MSI contact centre.

- Callers to the 24-hour contact call centre could speak to a registered nurse or midwife who assessed the patient through a triage system in order to prioritise treatment or refer them to a counsellor as required.
- Staff gave examples of working with other agencies and services such as early pregnancy units at local NHS hospitals, and safeguarding boards.
- Nurses asked for patient consent to send a discharge summary letter to their general practitioner (GP). This would enable the GP to manage any complications following the termination of pregnancy. This was in line with RCOG guidance. We saw discharge summaries were completed on the day of discharge and given to patients to take to their GP as required.
- Staff told us they would contact other professionals such as the patient's GP, or social worker if they needed any further information to ensure their patients safety.

Access to information

- Staff told us that internet connections were always very slow at MSI Coventry and the early medical unit (EMU) at Nuneaton locations and that this could delay consultations. Staff we spoke with told us this had been raised as a concern. We saw it was an identified risk on the risk register and that some mitigating actions were in progress.
- A patient we spoke with described an example of staff not being able to access the information technology. This resulted in staff having to telephone another MSI location so they could create a handwritten record of the appointment.
- Staff could access policies and standard operating procedures on the MSI intranet. The policies we considered as part of the data we requested were all within their review date.
- In all patient records we reviewed, we saw that information about discharge was included. This was in line with RSOP 3, which 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.

Consent, Mental Capacity Act and Deprivation of Liberty

- Consent was sought in line with national policy and legislation including the requirements of the Mental Capacity Act 2005 and The Children's Act 1989 and 2004. RSOP 14 Counselling and RCOG guidelines highlight that 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.
- Staff we spoke with said that if patients under the age of 16 years attended, they would be encouraged to involve a parent or guardian. They told us that staff applied the Fraser guidelines for checking rationale and understanding when obtaining consent from patients under the age of 16. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.
- Patient records we looked at showed that the options and their success rates were discussed as part of the consent process.
- All care records we reviewed contained signed consent from patients. Possible side effects and complication rates for the different intervals of medicine administration for medical abortion were documented, and the records showed that these had been fully explained. However, the designation of the staff member signing to say they had obtained the patient's consent was not completed in any of the records we looked at.
- We saw consent forms in place for contraception options and the supply of chosen method, and for testing for sexually transmitted infections.
- The MSI UK consent policy stated that registered nurses may obtain patient consent providing they have attended consent training and had competency signed off by a Clinical Operations Manager, Clinical Team Leader and/or Doctor. The training matrix showed that 20 out of 24 eligible staff members were up to date with training in 'consent with capacity. Nurses we spoke with confirmed they would normally obtain written consent and we saw this to be the case in all the records we looked at. We saw nurses checked with patients that they were certain of their decision throughout their treatment journey.
- Patients would be informed of the gender of the surgeon as part of the consent process and were offered a choice.
- 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 with a learning disability did not have the capacity to consent to treatment, they should be

referred to the local NHS trust for assessment and treatment. Staff and managers confirmed this is what staff would do under the circumstances; however, they could not recall an occasion when this had happened.

Are termination of pregnancy services caring?

Compassionate care

- Early medical abortions (EMAs) were carried out in one of two consulting rooms at MSI Coventry on an individual basis, which ensured privacy. However, we observed that there was little sound proofing between the consulting rooms and the corridor and we could overhear conversations in consulting room one. Staff we spoke with were aware of this and told us that only one patient would be seen at a time and that the patients waited in an area which meant people other than authorised staff could not overhear conversations in the consulting room.
- During our inspection, we saw all patients at MSI Coventry and the early medical unit (EMU) at Nuneaton were treated in accordance with their individual needs in an unhurried manner, and that staff spoke with them and people accompanying them in a quiet and calm voice.
- Feedback from patients consistently referred to the non-judgmental and caring attitude of staff. One patient told us 'I was given enough information to understand the process and found the staff very helpful, the doctor was very polite'. Another told us: 'She (the nurse) did not judge me'.
- Staff provided patients with the 24-hour telephone helpline number for the MSI contact centre, to use after abortion if they had any concerns. This was included in the patient booklet and aftercare booklet. We saw staff reminding patients of the number throughout their treatment journey.
- Patient satisfaction scores were gathered as part of the MSI UK quarterly patient satisfaction survey to establish whether they were meeting the individual needs of people who used the service. The surveys included analysis to compare performance with other MSI UK centres to measure improvements month on month.
- Patient satisfaction scores were available between January to March 2017 and April to July 2017. The scores for overall care rated 92% from January to March 2017 and 96% from April to July 2017 in the patient satisfaction survey. There were 15 quality indicators used to measure patient satisfaction. Four out of fifteen met the target from April 2017 to July 2017 which was an improvement from the January 2017 to March 2017 ratings, where only one out of 15 indicators met the target.
- Patient satisfaction with the competence and professionalism of staff was reported to be 96% from January 2017 to March 2017 and 94% from April 2017 to July 2017, against a target of 95%.
- Indicators below MSI target from April to July 2017 were the appointment booking process (73%) and privacy (82%).
- Indicators below MSI target from January to March 2017 that remained below target in April to July 2017 were: how well staff understood your needs, the way you were greeted on arrival, the amount of time and attention given, the standards of the facility, and the overall quality of care.
- During our observation of patient consultations and EMA, we saw that patients were encouraged to ask questions about their treatment plan, and that the nurse answered these fully, referring to an information booklet given to patients on their first appointment.
- We saw all patients who attended MSI Coventry and the EMU at Nuneaton were able to speak with a nurse privately to make sure that any questions were answered, they could disclose any information about their personal safety or wellbeing, and to ensure they received appropriate support to make a decision. We saw individual consultations were undertaken in single consultation rooms with the door closed.
- Aftercare advice was provided; such as how long to wait before commencing sexual activity.

Understanding and involvement of patients and those close to them

- We saw patients attending for medical abortion at MSI Coventry and the EMU at Nuneaton were offered a choice in the interval between taking the first and second medicine, and that a verbal and written explanation of the failure rates for each option was provided as part of the consent process. One patient we spoke with told us: "I was given lots of information and they (the nurse) asked me if I understood everything".

- We saw that staff fully explained the risks and side effects of medicines used for medical ToP, including prolonged bleeding. Advice to contact the 24 hour helpline was given should the patient be concerned about their treatment.
- In the patient satisfaction survey, patients reported satisfaction levels about the information contained in literature they were given as 90% from January to March 2017 and 96% from April to July 2017, against a target of 95%.

Emotional support

- Nursing staff, doctors and trained counsellors provided emotional support for patients either at the centre or by accessing the 24-hour telephone line. Nurses were trained to providing emotional support and advice at the MSI 24 hour contact centre.
- One patient wrote in the most recent client satisfaction survey "Considering I feel low and emotional everyone was lovely and I know they all care".
- Against a target of 95%, patients reported 90% satisfaction with the information given on how to look after yourself after treatment from January to March 2017, and 96% from April to July 2017.
- The 2014 Department of Health response to the government review on independent abortion providers, and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines state that mandatory counselling is not advisable. The MSI Counselling policy was revised in December 2016 so that patients could have the choice of whether they accessed counselling or not. The exception to this was for patients under the age of 16 who would have counselling.

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- The MSI UK business development team planned the service in discussion with clinical commissioning groups (CCGs). This was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines recommendation 4.1, which states that commissioners and providers of abortion services should have local strategies in place for providing information for patients and healthcare professionals on routes of access including self -referral.
- Until July 2017, surgical procedures were carried out at MSI Coventry. These were performed in a designated procedure room specifically provided for this purpose. Managers told us that the surgical service at MSI Coventry was temporarily closed from July 2017 until a quality and safety review could be completed. In the meantime patients were offered an appointment at an alternative MSI location. Records we looked at confirmed this.
- Access to the waiting area at the Coventry location was through automatic opening doors. There was no system in place for patients or visitors to report to a receptionist or to sign in. This meant the immediate needs of the patient were not met as they were left unattended.
- Registered nurses were normally lone workers in the early medical unit (EMU). The lone working arrangements meant that chaperoning could not be offered, and that nurses had to complete all administrative roles. This was not in line with MSI policy, which stated that the provision of chaperones required two staff members; one who should be trained in chaperoning. The provider told us after our inspection that if patients requested a chaperone they would be booked into a larger clinic.
- There were no administrative support staff at MSI Coventry or the EMU in Nuneaton. This meant that nursing staff had to prepare and maintain the patient records at each consultation, which slowed the pace at which they completed the appointment. Managers told us this arrangement was under review as part of the quality improvement plan. Receptionists from the GP surgery host site at the EMU in Nuneaton would greet the patients on arrival and record their attendance.
- MSI Coventry was open two days a week. Where appointment times did not suit patients, they were offered a choice of other MSI providers.
- All admissions were pre-planned. This allowed staff to assess and plan patient care to meet patients' requirements, including cultural, linguistic, or physical needs. There was a lift and wheelchair access, which allowed patients with limited mobility to attend the centre.
- Initial assessment was provided by phone or face-to-face.

Termination of pregnancy

- At the initial assessment, patients were assessed for suitability to attend the centre. If they were identified as not suitable for MSI Coventry, they would be referred to another MSI location or another provider that could accommodate their needs.
- A telephone interpreting service for patients whose first language was not English was available and staff knew how to access it. During our inspection, we observed the nurse access the telephone interpreter service for one patient and checked the patient's understanding throughout the consultation.
- Patients had access to a variety of information leaflets, such as information on domestic abuse, long acting reversible contraception and chlamydia. However, all information leaflets were in English only. Staff told us they could access written patient information in other languages through an electronic system and obtained this when required.
- Staff told us that although they rarely treated patients with a learning disability, they were able to make reasonable adjustments, such as ensuring patients were accompanied by a friend or carer who could stay with them during their consultation and or treatment. However, they could not recall any occasions when they had treated a patient with a learning disability in the previous year.
- An information leaflet titled 'your treatment information' was available for patients attending any MSI location. This leaflet contained information about different options available for termination of pregnancy including what to expect when undergoing a surgical or medical termination, possible risks, warning signs and aftercare.
- Patients, and those accompanying the patients, were asked to sit in one particular area of the reception so the MSI nurse could easily identify them. We saw, and patients told us, that this did not impact negatively upon their experience. One patient commented that they liked that they were sitting with other individuals who were attending the same service.
- There was a sign directing patients to wait in the shared main waiting area. However, the sign also instructed patients to check in at reception first. On the day of our inspection there was a receptionist to meet and greet patients; however, staff told us this was not normally the case.
- Patients we spoke with told us that the location of the Coventry clinic was convenient. It was 1.5 miles away from the railway station and served by three bus routes, which were a one minute walk away. There was a large, free car park for use by patients attending the clinic.
- Managers and staff told us that the facilities in for surgical services did not always allow patients' privacy and dignity to be maintained. For example, staff said due to the close proximity of the recliner chairs and an absence of privacy curtains or screens in the surgical recovery area, they could not always provide private areas for patients. We did not see any patients using the recovery area at the time of our inspection as the surgical service was temporarily closed. We were therefore unable to fully assess the impact of this.
- There was a policy and procedure in place for the sensitive disposal of pregnancy remains following a surgical termination at MSI Coventry (MSI UK Management of fetal tissue policy dated May 2016). This complied with the Human Tissue Authority Code of Practice.
- A patient information leaflet was provided which detailed the options for disposing of pregnancy remains. Patients were given the option to have pregnancy remains kept separately and this was documented in patient's personal records as part of their consent to treatment. Staff we spoke with said that patients were advised what documentation was required in order to procure a cremation or burial. Where possible (and with the patient's permission), staff liaised with funeral directors to facilitate as smooth a process as possible to alleviate stress.
- Processes for the storage and labelling of pregnancy remains at Coventry complied with the MSI policy. Staff we spoke with told us they documented any non-standard disposal option in the patient's record and on a record that indicated the reason for storage and date for either collection or disposal.
- We saw the treatment areas were painted in different colours, which would visually aid any patients with a learning disability, for example.

Access and flow

- The service was not meeting RCOG guidance on waiting times. Waiting times were monitored on an on-going basis by a capacity management team and reported on monthly. Data about waiting times was only available from January to August 2017 as a new way of reporting

had been introduced RCOG guidelines state that patients should be offered an assessment within five working days of referral or self-referral. From January to August 2017, patients attending for medical abortion had waited an average of five to ten days. Patients attending for surgical abortion with a gestational date less than 14 weeks had waited an average of five to 25 days, and patients with a gestational date over 14 weeks, had waited an average of 18 to 31 days.

- However the trend since January 2017 had been downward and Coventry had reduced their average waiting times by seven days for late gestation patients
- Appointments were made through MSI UK 'One Call' service, which is a registered pregnancy advisory service operating 24 hours a day. This enabled secure access for patients to MSI services, or alternative services where needed, for example where a patient would not be suitable for MSI services, they were signposted to an appropriate alternative provider, such as the NHS.
- Each appointment was scheduled for 25 minutes. Extra time was allocated for patients with additional needs, such as patients who needed the interpreter service, those who required a trans vaginal scan, or patients who were under the age of 16, for example. We saw the nurse gave each patient the time they needed which led to delays in other patients' appointment start times.
- We noted from records we reviewed that there were processes in place for clinical referral of patients to other services. For example where they required more specialist services for complex termination of pregnancy, including late stage medical and surgical abortion, where a scan had showed a gestation date later than the patient had reported. From June 2016 to May 2017, onward referral rates varied from 1% to 3% each month.

Learning from concerns and complaints

- Patients and other people who used the service could make a complaint by raising it with staff at the time, 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 CCG or NHS England. Details on how to make a complaint were set out in the 'your treatment' information booklets. Staff and patients we spoke with were clear about the complaints process.
- The MSI UK policy required acknowledgement of any written complaint within two working days of receipt and acknowledgement of any telephone enquiries within 24 hours. A full investigation would then be carried out and a response made within a reasonable time, usually from three to four weeks. Patients should be kept informed of any delays. We saw that the policy was followed in the record of complaints we looked at.
- Managers told us that a record of informal and formal complaints was maintained as part of the electronic patient safety system. From March 2017 to September 2017, there had been three formal complaints and one informal complaint. These had been resolved at the time of our inspection. Complaints were investigated locally and only escalated to MSI UK executive management team if local resolution was not achieved.
- Staff we spoke with told us that learning from complaints would be shared at governance meetings attended by managers, and by emails. Records we looked at confirmed this happened.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- Normally there was no centre manager or clinical team leader at Coventry during core service hours. The registered nurse running the early medical abortion (EMA) clinic would manage the service on a daily basis. The clinical team leader worked at the early medical unit (EMU) at Nuneaton for an average of one day a week.
- There was a newly formed leadership structure at Coventry and this had impacted the level of governance and risk oversight. However, staff we spoke with told us they were starting to feel more involved with decisions about the service.
- The CQC received an application to cancel the previous registered manager's registration on 24 July 2017, as they no longer had day-to-day responsibility for MSI Coventry. This was cancelled on 29 August 2017. The provider told us it had identified a suitable manager for registration. However, at the time of our inspection the application had not been received, and interim staff were managing the service. At the time of our inspection, the leadership team at MSI Coventry consisted of a regional director, a clinical operations manager, a non-clinical senior service delivery manager

and an interim medical director. All of the leadership team worked across the Midlands region, with the exception of the interim medical director who worked across the whole MSI UK organisation and was based at the MSI UK central office in London.

- Staff told us that the managers would visit the centres on an as-needed basis, and that this was rare. Staff also told us they had telephone and email access to managers at all times and that they would respond to calls promptly.
- Staff we spoke with at the EMU in Nuneaton told us they did not have a regular contact with managers or the opportunity to attend team meetings because they were held at the other MSI locations. This meant staff did not always have the opportunity to share and exchange information, receive feedback and offer support to one another.
- A clinical team leader had been appointed in January 2017. They told us they were completing an induction programme which meant being largely based at another MSI location until they were authorised to act independently. They also told us they had been on site at the Coventry location the week before our inspection but could not recall the date of their previous visit. They worked at the EMU at Nuneaton on a regular basis.
- < >nce they were assessed as competent to perform ultrasound scans to determine gestational date, registered nurses would work as lone workers. Policies set out the responsibilities of lone workers and arrangements to ensure the personal safety of staff.
- MSI Coventry and the EMUs at Nuneaton and Stratford upon Avon each held a separate license from the Department of Health (DH) to undertake termination of pregnancy services in accordance with the Abortion Act 1967. As a matter of good practice, DH have asked all providers to display a certificate of approval in a prominent position. We saw the license was clearly displayed at MSI Coventry, and that it was valid until July 2018. The licence at Nuneaton was not displayed but was filed in a folder we were shown and was valid until July 2018.

Vision and strategy for services

- Since the appointment of an interim managing director in April 2017, MSI UK had identified six objectives with deadlines to ensure plans continuously moved to achieve defined goals by the end of 2017. These goals aimed to ensure that MSI created a culture to value everyone's contribution in establishing a confident multi professional workforce who delivered patient centred quality services and financial success.
- Managers we spoke with understood the vision and strategy for the service entitled 'Fit for Future' which was introduced in 2017. The vision and strategy were shared with staff from the point of their appointment and induction. However, staff we spoke with had mixed understanding and awareness of the overall strategy and vision.

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

- There was limited governance and quality assurance oversight across the location, for example, audits were not consistently undertaken and appraisals were not completed.
- Processes were in place to ensure that clinical practice was provided within the scope of the law (Abortion Act, 1967, Required Standard Operating Procedure 1 and 2). This included staff abiding by the MSI UK protocols, policies and procedures in place for each type and method of termination of pregnancy procedure available, and the associated gestational limits. This was evidenced by the consultations we observed, by talking with staff about clinical practice and in the care records we reviewed.
- Staff we spoke with told us that they were unable to follow the chaperoning policy due to lone working. This was not in line with MSI policy, which 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. The policy also stated that occasions where there were no suitable chaperones available should be reported as an incident and escalated to the regional manager. However, we saw no evidence of such incidents being reported between July 2016 and August 2017 despite staff telling us this was a regular occurrence. The provider told us after our inspection that if patients requested a chaperone they would be booked into another MSI location where a chaperone would be available.
- Managers told us lone working arrangements were under review as part of the planned reconfiguration of services. Concerns about lone working had become exacerbated at the Coventry site whilst the surgical

service was temporarily closed, as the nurse normally worked at the centre on their own. The lone worker arrangements meant that there was very limited capacity for the nurse to monitor stock control of medicines or equipment, check and act on email correspondence, complete safety checklists or have sufficient time to set the room up prior to the first patient's attendance.

- As a result of a serious incident at MSI Coventry in July 2017, where a patient had a delayed transfer following medical complications after a surgical ToP, a quality review (site visit) of the surgical service was undertaken by two members of the MSI governance team and a clinical team leader. Findings, actions taken during the site visit and recommended actions were set out in the Coventry quality review report. A number of immediate actions had been put into place, including the redirection of the surgical services and a full review of the surgical services. An action plan with recommendations, action owners, and timeframes for the reintroduction of the sugical services was being led by the acting medical director and monitored by the executive management team.
- The risk of the lift being too small to accommodate a stretcher was identified when surgical services opened in April 2016. Actions to mitigate this risk included training staff to use an evacuation sledge to transport patients down the staircase in a horizontal position. However at the time of our inspection, staff were unable to provide evidence that they had been trained in the use of the evacuation sledge through any simulated learning.
- At the time of our inspection, there was no indication of how long the surgical service would remain diverted or whether the service would be resumed. The reason given was so that a full review of the environment and quality of care provided could be conducted. Staff we spoke with told us they felt relieved about this decision.
- We saw the surgical procedure room at MSI Coventry was set up ready for use with no indication that it would not be used. In the surgical procedure room, we saw an anaesthetic machine which we were told was not in use. However, there was no notice attached to the machine or displayed in the room to indicate this. We asked to see the records of safety checks for the anaesthetic machine and were told that the anaesthetist carried out daily checks when the service was open. However, these could not be located as the service was closed. Information received following our inspection identified that the anaesthetic machine was serviced and inspected by an external provider and that the record of this was kept electronically at MSI Birmingham.
- There was also evidence of incorrect information in risk assessments, particularly relating to emergency transfer of patients. For example, the risk assessment stated that the treatment room and recovery area were all on the ground floor at MSI Coventry for easy access; however, this was not the case. Both the treatment room and recovery area were on the third floor.
- RSOP 21: risk management requires that all providers should have in place a formal risk management system and keep a risk register to identify and minimise any risks to patients and staff within their premises. MSI UK had an up to date risk management policy, dated January 2017. The policy described the governance structures in place to ensure that risks are managed and escalated through MSI UK as appropriate.
- The policy also set out respective responsibilities for corporate and operational risk management for the Board and staff throughout MS UK. The policy required that all identified risks will be required to be recorded with a core minimum amount of information; be assessed on the likelihood of the risk being realised and the level of impact should the risk be realised; and have an identified risk owner and action owners.
- Managers identified the top three risks to MSI Coventry as: day to day availability of management cover to support the organisation's recovery plan, embedding organisational changes to ensure a consistent approach and to be able to cope with further changes, and review of incidents. We saw risks identified at our inspection were included in the risk register: delay in transferring patients, medicines security, failure in IT systems, and infection control risks, for example. However, we could not see any particular risks attached to the surgical service had been updated since the incident involving the delayed transfer of the patient was undertaken. Managers we spoke with told us this was because the investigation into the serious incident was not complete at the time of our inspection and that the risks had been mitigated against by temporarily closing the surgical service.
- The local risk register was maintained electronically as part of the MSI regional risk register. The risk register for MSI Coventry had 25 reported risks which had been graded as low, moderate or high risk and there was a

brief description of the proposed actions to mitigate against the risks. The risk register was accessed by managers only which meant staff did not see what the risks were or have the opportunity to update the risk register.

- In 2016, a clinical forum for doctors had been established. Regional meetings of the clinical forum were held on a quarterly basis, chaired by the MSI UK Medical director. Doctors we spoke with were positive about the forum and its direction.
- Arrangements for the completion of HSA1 forms were clearly set out in local standard operating procedures. All staff we spoke with correctly described the processes they would follow to ensure this happened. In all of the patient records we looked at the HSA1 form was completed and signed by two medical practitioners, in accordance with the legal requirements and MSI policy. Legislation requires that two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination of pregnancy is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. The two doctors must then complete, date and sign an HSA1 form, produced by the department of health, before the abortion is performed.
- We saw the signatures were made electronically after the patient's notes and medical history were uploaded with the HSA1 form and sent to the doctors based at other MSI locations.
- All records we looked at during our inspection showed that HSA4 forms had been submitted to the Chief Medical Officer within 14 days. This was in line with legislation that requires registered medical practitioners to notify the Chief Medical Officer at the Department of Health (DH) of every abortion performed in England and Wales using a HSA4 form. There was a checklist attached to each set of patient notes to monitor the electronic submission of the signed HSA4 form. An audit in March 2017 showed 100% compliance in HSA4 form completion and submission.

Public and staff engagement

- Patients attending each centre were given feedback forms, which asked for their opinion of the service. The forms were collected and analysed by an independent organisation that produced a quarterly summary of results. Staff we spoke with told us that due to the sensitive nature of the service and procedure it was sometimes a challenge to get a response.
- We asked for examples of staff engagement and were told a staff satisfaction survey had recently been undertaken but as this closed on 14 July 2017 had not yet been published and therefore was not available. Staff we spoke with could not recall completing a survey or being asked for their feedback.
- Managers told us that staff engagement was mainly through training sessions, and through informal discussions.
- Staff told us that updates of policy changes and reviews were communicated via the chief nurse newsletters, and we saw that this happened.
- Staff told us they were unsure about the plans to re-open the service . Staff we spoke with felt that the priority amongst managers was to bring about organisational change at a national and regional level.

Innovation, improvement and sustainability

- We saw most changes to the service in the previous year were in the early stages of development and needed time to be embedded in practice. Changes to the management team were ongoing so we were unable to assess the sustainability or full impact of the improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that there is appropriate management oversight to assess, monitor and improve the quality and monitoring of the services provided. Audit the use of the termination of pregnancy early warning score (TEWS) to ensure patients are being safely assessed and monitored for deterioration.
- Ensure resuscitation equipment is checked on a daily basis to ensure it is safe for use in an emergency.
- Ensure effective medicines management processes are in place. in line with policy, including security of storage, reconciliation of stock, transportation of stock and audit of temperature of medicines storage.
- Ensure staff complete required mandatory training including basic life support, intermediate life support and use of evacuation sledges.
- Conduct fire evacuation drills every six months in line with MSI policy.
- Ensure all risks relating to surgical services are identified on the local risk register.

Action the provider SHOULD take to improve

- Ensure there is evidence of shared learning from incidents to ensure that lessons are learned.
- Ensure that there is a system locally for confirmation that all staff have had an appraisal.
- Ensure an effective appraisal process is embedded, involving full participation and discussion to enable staff development.
- Review the security arrangements and access to the premises at MSI Coventry to ensure it is safe for staff and patients.
- The provider should ensure that chaperoning and chaperoning training is carried out in accordance with national and local guidance and that any variation is reported as an incident and acted upon.

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 **Care and treatment must be provided in a safe way for service users.** **Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—** • assessing the risks to the health and safety of service users of receiving the care or treatment; • doing all that is reasonably practicable to mitigate any such risks; • ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; **How the regulation was not being met:** • The service was usually staffed by one nurse working alone per site, which meant if a patient deteriorated there would be no other member of staff on-site to escalate to. Both sites were situated within healthcare centres with other providers; however, at the Coventry site we were not assured that others would be able to hear a nurse if they were to attempt to summon help in the event of an emergency. • There was limited evidence of completed daily checklists of resuscitation equipment at the Coventry site and the last recorded monthly check was dated June 2017. Therefore, we could not be assured that resuscitation equipment was fit for purpose and safe to use at the time of inspection. • There was inconsistent monitoring of the medicines fridge and ambient room temperatures. • There were gaps in staff completion of mandatory training; mainly due to a large number of new starters.

This section is primarily information for the provider

Requirement notices

- Fire evacuation drills had not been completed every six months and fire training was not undertaken in line with company policy.

Regulated activity	Regulation
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. **Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** 2. **Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—** • assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; • evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). **How the regulation was not being met:** • There was no effective monitoring or audit system in place to provide assurance that staff continued to use the TEWS score appropriately. • Not all risks were included in the risk register Actions to mitigate risks were not always in place. • Lone-working nurses meant safety checks and governance were not consistently carried out. • There was no evidence thatfire safety evacuation routines had been conducted in line with MSI policy. • Medicines were not always securely stored. There were insufficient arrangements in place to monitor and reconcile the stock of medicines.