Marie Stopes International Manchester Centre

Quality Report

5 Wynnstay Grove
Fallowfield
Manchester
M14 6XG
Tel: 0345 300 80 900
Website: www.mariestopes.org.uk

Date of inspection visit: 6 August and 17 August 2018
Date of publication: 28/11/2018

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Marie Stopes International (MSI) Manchester Centre is operated by Marie Stopes International. Facilities include a treatment room, outpatient and ultrasound facilities. There are three consulting rooms and eight day care beds.

The service provides surgical termination of pregnancy procedures (SToP) up to 23 weeks and six days gestation along with early medical abortion (EMA) and medical termination of pregnancy (MToP) up to nine weeks and four days gestation. Treatment can be provided under no-anaesthesia, conscious sedation and general anaesthesia, according to patient choice and needs. The service also provides consultations, ultrasound scans, long acting reversible contraception and sexually transmitted infection screening services. In addition to these services, they also provide vasectomy (male sterilisation) under local anaesthetic.

In addition, MSI Manchester has eight satellite clinics, (early medical units EMU) across Greater Manchester and Lancashire, where they carry out consultations and early medical abortions.

We inspected this service using our comprehensive inspection methodology. We carried out unannounced inspections on 6 August 2018 and 17 August 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

At our previous inspection on 19 June 2017 we found breaches in regulations and we served requirement notices in respect of:

- Regulation 10 Health and Social Care Act (Regulated Activities) Regulations 2014 Dignity and respect.
- Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment.
- Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance.

At this inspection we checked that actions had been implemented to address these breaches. We found that some improvements had been made but not all concerns had been fully addressed in relation to Regulation 10 for privacy and dignity.

Services we rate

We rated it as good overall.

We found good practice in relation to:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. This included resuscitation and safeguarding for nursing and medical staff at appropriate levels.
- Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. We observed appropriate infection prevention and control measures in place including hand washing and use of personal protective equipment.
- The service had suitable premises and equipment and looked after them well. Equipment was well maintained and serviced. Daily checks were recorded and completed appropriately.
- Risk assessments were in place and monitoring carried out before, during and following procedures such as venous thromboembolism checks (VTE) use of the World Health Organisation (WHO) and five steps to safer surgery checklist and the termination of pregnancy early warning score (TEWS).

Summary of findings

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment. Experienced staff were supporting newly appointed staff at the main clinic. . All staff had received an appraisal in the 12 months before inspection.
- The service prescribed, administered and recorded medicines in line with trust policies and procedures. Medicines, including controlled drugs and abortifacients (medicines that induce a termination of pregnancy) were managed well. Daily checks of stock were carried out. Take home medicines included pharmacy dispensing labels as well as manufacturers' instructions.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the provider.
- The service provided care and treatment based on national guidance such as the Royal College of Obstetricians and Gynaecologists (RCOG), the Department of Health Required Standing Operating Procedure (RSOP) and the National Institute for Health and Care Excellence (NICE).
- Staff monitored patients' comfort needs and provided pain relief as required. Light refreshments were provided following surgery.
- The service monitored the effectiveness of care and treatment and used the findings to improve them and benchmarked internally. An integrated dashboard was maintained and audits were carried out routinely.
- Staff worked together as a team to benefit patients. There was effective multidisciplinary working both internally amongst staff and externally with other health professionals.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. Consent was obtained both verbally and in writing before care and treatment. Staff understood principles of Fraser guidelines and Gillick competence in assessing mental capacity. (Fraser guidelines and Gillick competence are used specifically for patients under the age of 16 requesting contraceptive or sexual health advice and treatment.)
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We observed respectful, sensitive and non-judgemental care for patients by all staff.
- Staff provided emotional support to patients to minimise their distress. There was telephone counselling available via the 24-hour helpline service.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients were encouraged to be supported by someone close to them through the care pathway.
- The service planned and provided services in a way that met the needs of local patients. Bookings were made centrally through MSI UK One Call. This meant patients were offered a choice of appointments at MSI Manchester or alternative MSI locations to ensure treatment occurred in a timely manner.
- The service took account of patients' individual needs at the main clinic. There was an accessible entrance for patients with reduced mobility, a hearing loop and an interpreter service for patients whose first language was not English. The website could be translated into a wide-range of languages.
- The service treated complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The service had managers at all levels with the right skills and abilities. The leadership structure had changed to include local leadership as well as regional.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action which had been developed with involvement from staff. The service followed the provider's vision and had regional focus.
- Managers at the service promoted a positive culture that supported and valued staff. Managers encouraged an open and transparent culture and actively engaged with staff.
- The HSA4 forms were discussed with patients during the booking process and written information was provided at the main centre. (Providers have a statutory requirement to complete HSA4 form to notify a termination of a pregnancy to the Department of Health)

We found areas of practice that require improvement:

Summary of findings

- Whilst a governance framework was in place we found this was not fully embedded due to the introduction of a new management structure, therefore local oversight of risk was not fully effective at the time of inspection.
- The probes used for trans vaginal scans (TVS) were cleaned only to minimally accepted standards, although senior managers told us that infection control processes were being reviewed.
- The door to the cleaning cupboard was not locked and included accessible cleaning fluids.
- There were plans to reorganise the surgical treatment and recovery areas that included privacy curtains for each chair space. However; this was not in place at time of inspection.
- There was no face-to-face counsellor available at the time of inspection, although the position had been appointed into and the staff member was completing the induction process.
- The level of screening provision was dependent on a patients address and commissioning arrangements. Patients were not signposted to other health professionals if unable to access the full range of screening provision.Managers locally could access demographic details for staff, including emergency contact details and proof of professional registration, however; details provided of full records were not consistent. Complete personnel records were held centrally by the human resource department for the provider; the registered managers were not able to access all records.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and it should make other improvements to help the service improve. We also issued the provider with one requirement notice in respect of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014 Good governance. Details are at the end of the report.

Ellen Armistead
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	Good 	The Manchester Centre is part of the provider Marie Stopes International UK (MSI UK). The centre provides surgical termination of pregnancy up to 23 weeks and six days gestation and medical termination of pregnancy up to nine weeks and four days gestation. There are also eight clinics for medical terminations up to nine weeks and four days gestation throughout the northwest. The service also provides family planning services, including advice on contraceptive options including oral contraception and long acting reversible contraception (LARC) as well as male sterilisation (vasectomy). We rated this service as good overall. Safe, effective, caring and responsive were rated as good and well led was rated as requires improvement.

Summary of findings

Contents

Good

Location name here

Services we looked at:
Termination of pregnancy

Summary of this inspection

Background to Marie Stopes International Manchester Centre

Marie Stopes International (MSI) Manchester Centre is operated by Marie Stopes International. The service opened in 2004. The main clinic and the eight satellite clinics (early medical units), serve the communities of Greater Manchester and Lancashire. It also accepts referrals from outside these areas including internationally. The main clinic is located in south Manchester with good transport links to the city centre and to the airport.

The service provides both medical termination of pregnancy, up to nine weeks and four days gestation and surgical termination up to 23 weeks and six days gestation.

Early medical abortion, up to nine weeks gestation, is offered as simultaneous dosing. Medical termination is offered over two stages, with either 24, 48 or 72 hours in between the medications..

Surgical termination is offered without anaesthesia, with conscious sedation or under general anaesthetic.

The service also offers a male vasectomy sterilisation clinic on alternate Thursdays.

The service provides a service for those self-paying as well as via a central booking system, self-referrals and GPs.

Recent changes with leadership at MSI Manchester had necessitated a change in registered managers. At the time of inspection one of the two current registered managers had deregistered with CQC on leaving the organisation. One registered CQC Manager remained in post whilst two other applications were in process for an operations manager and a clinical manager.

Our inspection team

The team that inspected the service comprised two CQC inspectors, and a specialist advisor with expertise in termination of pregnancy. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Marie Stopes International Manchester Centre

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the main centre and two satellite early medical unit clinics. We spoke with 17 members of staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients and one relative. During our inspection, we reviewed 20 sets of patients records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected four times, and the most recent inspection took place on 19 June 2017.

Activity (July 2017 to June 2018)

- In the reporting period July 2017 to June 2018, there were 5040 early medical terminations and 3615 surgical terminations. There were 299 terminations after 20 weeks gestation. In addition to this there were 397 vasectomies.

There was one full-time surgeon, at the time of inspection. Anaesthetists were employed by the provider

Summary of this inspection

on a sessional basis and assigned where needed. There were registered nurses, care assistants and receptionists, as well as regular agency staff employed as required. The accountable officer for controlled drugs (CDs) was the regional manager.

Track record on safety, between June 2017 and June 2018.

- There were no never events reported
- There were 335 clinical incidents, three incidents classified as moderate harm and all others were either low or no harm. There were no incidents classified as severe harm, or death.
- There were two serious incidents.
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- There were no incidences of hospital acquired Meticillin-sensitive Staphylococcus aureus (MSSA)
- There were no incidences of hospital acquired Clostridium difficile (C.difficile)
- There were no incidences of hospital acquired Escherichia coli (E-Coli)
- There were 18 complaints, of which four were upheld.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Pharmacy

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?

Good

We rated safe as good because:

- Staff received mandatory training including resuscitation and safeguarding. Managers monitored compliance rates to ensure staff had the correct skills and knowledge.
- We observed appropriate infection prevention and control measures in place including hand washing and use of personal protective equipment.
- Equipment was well maintained and serviced. Daily checks were recorded as completed appropriately.
- Risk assessments were in place and monitoring carried out pre, during and following procedures such as venous thromboembolism checks (VTE) use of the World Health Organisation (WHO) and five steps to safer surgery checklist and the termination of pregnancy early warning score (TEWS).
- There were sufficient numbers of staff with experienced staff mentoring junior staff.
- Medicines, including controlled drugs and abortifacients were managed well. Daily checks of stock were carried out. Take home medicines included pharmacy dispensing labels as well as manufacturer's instructions.
- Staff reported incidents and lessons were shared and learned following serious incidents.

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

- The probes used for trans vaginal scans (TVS) were cleaned only to minimally accepted standards, although senior managers told us that infection control processes were being reviewed.

Are services effective?

Good

We rated effective as good because:

- The service provided care and treatment based on national guidance such as the Royal College of Obstetricians and Gynaecologists (RCOG), the Department of Health Required Standing Operating Procedure (RSOP) and the National Institute for Health and Care Excellence (NICE).
- Refreshments were offered as appropriate and pain relief was available when needed.
- The service monitored outcomes for patients and benchmarked internally. An integrated dashboard was maintained and audits were carried out routinely.

Summary of this inspection

- Staff had received training for their roles with competencies monitored and assessed. All staff had received an appraisal in the 12 months prior to inspection.
- There was effective multi-disciplinary working both internally amongst staff and externally with other health professionals.
- Consent was obtained both verbally and written prior to care and treatment. Staff understand principles of Gillick and Fraser guidelines and assessing mental capacity.

Are services caring?

Good

We rated caring as good because:

- We observed compassionate, respectful, sensitive and non-judgemental care for patients by all staff.
- There was overwhelmingly positive feedback from patients either through feedback questionnaires or directly contacting the service.
- There was telephone counselling available via the 24-hour helpline service.
- Patients were encouraged to be supported by someone close to them throughout the pathway.

Are services responsive?

Good

We rated responsive as good because:

- Bookings were made centrally. Patients were offered a choice of appointments at MSI Manchester or alternative MSI locations to ensure treatment occurred in a timely manner.
- The service met individual needs in that, at the main centre there was an accessible entrance for patients with reduced mobility, a hearing loop was available and there was an interpreter service was available for patients whose first language was not English. The website could be translated into a wide-range of languages.
- There was a 24-hour helpline available both pre- and post-termination for advice and support.
- Discussions took place, for surgical terminations about disposal of pregnancy remains.
- There was a complaints process and complaints were managed in a timely manner.

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

- Patients were not signposted to other health professionals if screening provision was not comprehensive.

Summary of this inspection

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The leadership structure had changed to include local leadership in the Manchester centre as well as regional. The two local managers were new in post and oversight of governance, risk & quality improvement were not fully embedded, at the time of inspection.
- At the time of inspection there was a lack of managerial oversight at the satellite clinics.
- A well led framework was in development as well as a quality improvement plan but this was not fully embedded at the time of inspection.
- Managers locally could access demographic details for staff, including emergency contact details and proof of professional registration, however; they could not access the employees full employment records and would have to request information to be sent to them from the human resources department if required; the registered managers were not able to access all records
- The service followed the providers vision and had regional focusses.
- Risk registers were maintained for the main centre and the clinics.
- Managers encouraged an open and transparent culture and actively engaged with staff.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Termination of pregnancy

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are termination of pregnancy services safe?

Good

Mandatory training

- Training was provided on a range of subjects including infection prevention and control, information governance, general data protection regulation, lone working essentials, health and safety, equality and diversity, fire safety, manual handling and life support. The clinics mandatory compliance dashboard showed that the overall compliance for completion, at the time of inspection was 91%. We were informed that MSI UK target was 95% but they strived to achieve a target of 100%. This dashboard was updated at least monthly to monitor compliance.
- Basic life support training was provided for healthcare assistants and front of house staff. Registered nurses were trained in immediate life support and anaesthetists were trained in advanced life support. The dashboard showed that there was 100% compliance for basic life support and advanced life support. Immediate life support compliance was 92%.

Safeguarding

- The service had systems and policies to identify and report any safeguarding concerns.
- A safeguarding adults policy was available for staff to refer to. This was ratified in March 2017 with a review date of March 2020. This included signposting to other internal policies such as safeguarding children and young people, female genital mutilation, and domestic abuse.
- Safeguarding proformas were completed for adults and for young people under the age of 18 years. Staff we spoke with understood the process of how to report a concern including female genital mutilation and child sexual exploitation.
- The service had not treated any child under the age of thirteen years. Any patient younger than 13 years would be signposted to a NHS hospital. Between July 2017 and June 2018, there were 16 children between 13 years and 15 years treated. All those under 16 years age were seen by registered healthcare professionals for all consultations as well as treatment. Any concerns were discussed with social services.
- At the time of inspection there was no face-to-face counsellor for young people to speak to prior to consenting to treatment. The service was available only by telephone. A new counsellor had been appointed but was awaiting safeguarding level three training prior to seeing patients.
- There was a named safeguarding lead (level four trained) who worked across the North region. Safeguarding referrals were discussed with staff at monthly meetings as part of monitoring and sharing of information.
- There was a named safeguarding link nurse, for this centre and the satellites (early medical units), who had been recently allocated the role and was awaiting further training. This meant there was a colleague available locally to support staff.

Good

Termination of pregnancy

- Between June 2017 and July 2018, there were 256 safeguarding referrals made. These included 82 adults, 94 children, one child sexual exploitation, four female genital mutilation and 75 who scanned over the legal limit for termination.
- At the time of inspection, the compliance dashboard showed that 97% of staff had completed safeguarding level one and level two training. Compliance for safeguarding level three was 81% against a target of 95%. A senior manager told us that the remaining staff were booked on a course to be completed by the end of the month. Senior managers told us that there were two staff booked on a safeguarding level three course and then 100% of clinical staff would be trained.
- All patients were seen on their own for the first part of the consultation. This gave the patient an opportunity to discuss any concerns they may have. Patients could be accompanied by a friend or relative for the subsequent consultation and treatment if preferred.

Cleanliness, infection control and hygiene

- The service controlled infection risks well. Equipment and the premises were visibly clean and cleaning schedules updated.
- All areas we visited were visibly clean and organised.
- Infection prevention and control was included in mandatory training. At the time of inspection, compliance for clinical staff was 91% and compliance for health and safety training was 93% against a target of 95% for both.
- Hand washing facilities with washing instructions were available on entry to clinical areas. Personal protective equipment was available including gloves and aprons. Hand sanitizers were also available.
- For audits of personal protective equipment and infection prevention and control, there was compliance of 69% in November 2017. We observed that action plans were in team meeting and corporate meeting minutes to capture staff to improve compliancy. Actions plans identified included the employment of a lead for infection prevention that was accountable directly to the Managing Director and responsible for the infection control strategy. Link nurses were kept up to date with link development days in infection and prevention control. In addition training was now available via the new iLearn package. A target was set at 95% to allow for sickness or absences and on review of this we observed improvement with an overall compliance of 85% in May 2018. We observed appropriate handwashing by staff throughout the patient pathway as well as the use of hand gel following handwashing.
- We observed staff adhering to 'arms bare below the elbow' which followed local policies and protocols in all clinical areas.
- We observed the surgeon using an appropriate surgical technique to maintain sterility throughout the surgical procedures.
- Hand hygiene audits carried out showed 100% compliance in October 2017 but had decreased to 50% by April 2018. The most current audit in June 2018 was 100% compliant.
- Equipment included 'I am clean' stickers' that were dated. Equipment was inspected and all were clean.
- For transvaginal scans, we were told that sterile and single use condoms were applied over the probe prior to the procedure. At one satellite early medical unit clinic, we observed that these were outside of the manufacturer's expiry date. This was addressed by the registered nurse and they were discarded. We were also told that abdominal scans were more common than transvaginal scans.
- Staff told us probes from the transvaginal scans were cleaned and decontaminated. We were told that particular wipes were used which were in line with policy and in line with HSE guidance QPWD-GL-028-01. We did not see an infection control policy to confirm which wipes should be used. We reviewed MSI UK annual gap analysis for 2018 in which action plans were highlighted to ensure that governance procedures are put in place for infection prevention and control. There was no definitive time frame for this. We were informed during the inspection that the infection prevention and control lead was exploring further decontamination options for the probes following guidance from the Health and Safety Executive which advocates a more in depth cleaning process.
- We were provided with a tour of the Manchester centre when no patients were present. We found that the door to the cleaning cupboard that included cleaning liquids, was not locked. The cupboard was located in the corridor between the waiting room and the treatment room, and was therefore accessible to patients which meant a potential safety risk. We addressed this on-site with the clinical manager who assured us that it would now be locked at all times.

- Within the surgical treatment room there was a clean and a dirty utility room. Both were clean and tidy.
- From the previous inspection, in June 2017, chairs were observed to be covered in a fabric material. We observed that chairs were now covered in material that could be wiped. We observed that this was carried out appropriately before and in-between patients using these chairs.
- In the surgical treatment room we observed clinical trolleys being cleaned before and after use as well as sterile surgical equipment being set up using an appropriate technique.
- A sharps bin was located within the treatment room, this was assembled, signed and dated correctly and all staff knew of the requirement to lock and dispose of the bin when three quarters full. There were colour coded bags for clinical and domestic waste.
- Audits of sharps and waste disposal showed 69% in January but had improved to 92% in July 2018.
- Cleaning schedules were in place for staff to follow and were completed.
- The service completed an annual gap analysis plan for infection control and prevention. This showed that the service was either on track or requirements had been completed. Action plans were in place for requirements identified as delayed. For example, a decontamination lead was to be identified within MSI and a target demonstrated for which quarter in the year it should be implemented.
- We observed that the disposable privacy curtains were dated as last being changed in August 2018.
- We were told that a clinical team leader was being recruited, for medical terminations, to support staff in the clinics as well as monitor those environments.

Environment and equipment

- The main clinic was located in a large house with three floors and a basement. Access to each floor was by stairs only. The basement included the surgical services with one threatment room, a small ward and a waiting area. The ground floor included the reception and initial waiting areas. The first floor included a further waiting room, a counselling room and three consulting rooms, one of which included the medicines for medical terminations of pregnancy. The top floor included staff facilities and offices.
- The entrance to the clinic was controlled via an intercom system. We observed all patients and their friends and relatives were escorted through the building.
- There were systems and processes to ensure the appropriate maintenance checks were carried out on equipment. There was a planned preventative maintenance schedule in place.
- The service maintained records of routine servicing that showed equipment was routinely monitored.
- At the main clinic, in the consulting rooms and treatment room areas, all electrical equipment that we inspected was marked as being electrically tested within the previous 12 months, such as ultrasound machines, suction machines, the anaesthetic machine, blood pressure monitoring and weighing scales. At one of the satellite early medical units the portable ultrasound included an electrical testing sticker indicating it was overdue the checking date. We addressed this on site and we were provided with evidence that the check had been completed appropriately.
- We observed the anaesthetist and the operating department practitioner (ODP) completing checks together on all the equipment that was needed for safe induction of general anaesthesia.
- The emergency intubation equipment was checked by the anaesthetist on a daily basis prior to surgical lists commencing.
- Emergency resuscitation equipment was stored in the recovery area (in the basement). It was maintained in a transportable rucksack bag that also had wheels if required. There was no emergency equipment stored on the other floors in the building.
- The resuscitation trolley included a plastic tamper-proof tag with a unique code. This equipment was checked monthly with records of full checks done. Additional checks were completed if any equipment was used. Guidance from the Royal College of Anaesthetists (2012) advocates daily checks in all clinical areas. All equipment was checked and correct.
- Emergency medication, including medicines for anaphylaxis, was stored in the medicines cabinet in the treatment room. This cabinet was locked at all times. During surgery emergency adrenaline was placed on the top of the anaesthetic machine for easy access for the anaesthetist should this be required. There was also an emergency tracheostomy kit available in the treatment room.

- There was a room with five chairs inside that was used for patients to sit in before they went for their treatment. This room was not staffed at all times but had a call bell and a camera in place so that staff in the recovery room area could monitor patients safely. We were assured that the camera did not record but was solely used for live observation. Following our concerns around patients privacy and dignity on our previous inspection, management were now in the process of making alterations. During this inspection we were shown drawn up plans and a business case that was currently being processed at national level. We were informed by management that the business plans had been approved but there was no set date for implementation.

Assessing and responding to Patient risk

- Initial consultations were completed prior to treatment either by phone or face-to-face. These were completed by registered nurses, midwives or health care assistants. The initial assessment requested information about previous medical history and suitability for treatment.
- The providers pre-existing conditions guidelines was considered to ascertain if the patient was eligible for treatment at one of the clinics. Each condition was risk assessed and scored. If the score was too high to treat, the patient was referred to an NHS location. There was a dedicated team at the providers national call centre (MSI One Call) where referrals were processed to ensure the treatment was not unduly delayed. Surgical patients now had the option of pre-assessment where set appointment times were provided for checks prior to surgery on a later pre-arranged date. This meant that patients did not need to wait at the clinic unnecessarily.
- Venous Thromboembolism (VTE) assessments were routinely carried out. Of the 20 records we reviewed we found evidence of an assessment being carried out in all 20 records.
- A safety huddle was carried out at 9am within the recovery/day room prior to any patients being treated. This ensured everyone was introduced and that their roles and area to work for that day were identified.
- Records for patients on the surgical treatment list were reviewed by medical staff prior to treatment. If any concerns were identified, they would discuss these with the patient. At the time of inspection, we observed a patient who was assessed as needing referral to an NHS hospital.Information had not been identified at booking and therefore treatment was delayed. Appropriate action was taken by staff and management and the patient was referred promptly.
- The World Health Organisation (WHO) and five steps to safer surgery checklist was in place. This is used to assist with safety, using a checking system for those undergoing surgical procedures. An operating department practitioner (ODP) trained in airway management was present in all procedures to assist the anaesthetist in the theatre room. In addition to the ODP there was a Registered General Nurse (RGN) trained in immediate life support and a healthcare assistant (HCA) present in the theatre room assisting the surgeon with the procedures. Of the 10 surgical termination records we reviewed, all had a completed checklist.
- At the time of inspection, we observed three surgical procedures and the World Health Organisation (WHO) and five steps to safer surgery checklist was completed appropriately. However, we observed an anaesthetist on one occasion drawing up the anaesthetic agents whilst the checklist was being carried out which meant they were not fully focused and participating in the check which could result in an error occurring. We addressed this with the senior managers who assured us that they would hold a team meeting with all staff to discuss this and also they would speak with the anaesthetist that day. Further training in the WHO five steps to safer surgery checklist would be carried out for all staff.
- We observed staff carrying out a count of swabs used before and after the procedure.
- Audits of the the World Health Organisation (WHO) and five steps to safer surgery checklist showed 93% compliance in October 2017, 86% in December 2017 and 79% in February 2018. In April 2018, it was 93% compliant and 100% in June 2018. We were informed that following the current implementation of the new management structure auditing of processes had improved.
- The provider had introduced the termination of pregnancy early warning score (TEWS) to monitor vital signs of patients. Observations were carried out prior to the treatment, as a baseline, then checked a minimum of three times following surgical procedure prior to discharge.
- The TEWS is a monitoring scoring tool to identify any patient that may be deteriorating and when to escalate

to the medical team. In December 2017 an audit of the TEWS showed an average of 77% compliance however this had now improved and compliancy was now demonstrating 100% in April 2018.

- For patients who had elected to receive a contraceptive intrauterine device during the surgical procedure, they were advised to see their GP six weeks after the implant to check that it was still in the correct place. Advice was also given in using other forms of contraceptive until the six-week check-up.
- Emergency medicines, such as those to treat anaphylaxis were stored in a drugs cabinet in the surgical area. We were told that staff had access to anaphylaxis medicines in the satellite clinics in the event of an emergency.
- Between July 2017 and June 2018, there had been five transfers to the neighbouring NHS hospital. We reviewed the service level agreement between MSI and the local NHS trust for patients that required transfer to the NHS and noted that it was dated 2013. We informed senior management and were told that they were currently updating this agreement. Between July 2017 and June 2018 there had been five transfers to the neighbouring NHS hospital. These included a patient with a mental health illness, two seizures, one for anaphylaxis and one miscarriage prior to treatment.
- There was a back-up generator, at the location, in case of a power failure particularly during a treatment.

Nurse staffing

- The service had enough staff with the right qualifications, skills and training and experience to keep people safe from avoidable harm and abuse to provide the right care and treatment.
- There were registered nurses, midwives and health care assistants employed at the location.
- There were no vacancies at the time of inspection, although there had been some short term sickness but this had not impacted on the service.
- Shortfalls in safer staffing rotas were identified and regular agency staff were employed such as operating department practitioners. In the 12 months prior to inspection, 200 shifts had been covered with agency staff. An induction checklist was completed for any staff new to the clinic with a requirement to have skills and qualifications to work in this type of environment.
- Staff were allocated to either the main clinic or one of the satellite clinics. Recently recruited clinical staff were being mentored and supported at the main clinic, thereby over allocating staff. This meant that some clinics had been temporarily closed until staff were fully trained.

Medical staffing

- Medical staff were all employed by the provider. Surgeons were based at a clinic, although surgeons from other centres covered for abscenses such as annual leave or sickness..
- Anaesthetists were employed by MSI on a seasonal basis and present for surgical procedures. They also assessed patients prior to discharge.

Records

- Patient's records were a combination of paper-based notes and electronic records. Electronic records included the initial and on-going consultation and assessment records, prescriptions, surgical and anaesthetic records (if surgical termination). Additional text could be added as additional notes that were individual to each patient.
- Paper records included consent for treatment, VTE forms, HSA1 form, World Health Organisation (WHO) and five steps to safer surgery checklist and the TEWS chart (if surgical termination).
- We reviewed the records for 20 patients; 10 for medical terminations and 10 for surgical terminations. These were legible, complete and up-to-date. All records were stored securely in locked cabinets to ensure patient information was kept safe. MSI UK policy stated that all records which include patient identifiable information must be stored securely and kept strictly confidential within the centre. We saw that only authorised staff had access to the patient records.

Medicines

- There was a policy for medicines management, including controlled drugs, that included prescribing, ordering, storage, administration, transport and disposal.
- Medicines were provided by a third-party arrangement with a neighbouring NHS trust and a private pharmaceutical company. Staff were able to contact the trust for medicines support and advice if required.
- There were no controlled medicines stored at satellite clinics or in the consulting rooms at the main clinic. All other medicines at the satellite early medical unit clinics

were stored in a locked cabinet within a locked cupboard. There were key safes to access the cupboards as some clinics were shared with other health professionals when not used by the provider.

- Since the last inspection, there was more choice for medical termination of pregnancy (MToP), dependent on gestation. Abortifacients were now offered either simultaneously (both medicines at the same time), at intervals of 24, 48 or 72 hours. MToP was only offered at MSI Manchester to patients with a gestation period of up to 9 weeks and 4 days.
- In the main centre medicines were stored in one of the consultation rooms in a locked cupboard or in locked fridges, if appropriate.
- We observed that fridge temperatures were recorded at a satellite unit, for a period of two weeks, and the maximum temperature was consistently recorded as over the excepted range at 9 degrees centigrade. This was not in line with the provider's medicines management policy issued in August 2018. . The clinical manager had not been alerted to this and was addressing it via discussions at team meetings and face to face contact with staff. It was considered it may have been that the door was opened for a prolonged period, when recorded, to remove daily items required to be at room temperature prior to use. The clinical manager told us that the usual procedure was to contact the neighbouring trust pharmacist for advice about the efficacy of medicines stored but this had not taken place as they had been unaware of the issue, once we raised this they took appropriate action.
- We observed that fridge temperatures at the main site were recorded daily in the clean utility room in surgical treatment room and all were within the range limit of two and eight degrees. Staff informed us that they would contact the pharmacist at the local NHS trust for advice if ranges were not in line with policy.
- Environmental room temperatures were checked daily within the surgical treatment room and the recovery room and all were within the range as per policy.
- Controlled drugs were stored in a locked cupboard within the surgical treatment room and were checked daily at the start and finish of every surgical treatment list. A random selection of controlled medicines was checked during the inspection and all were in date and stored in chronological order.
- Other prescribed medicines, such as antibiotics and anti-emetics (to help with nausea or vomiting) were stored in a locked cupboard within the surgical treatment room. A sample of medicines was checked and all were within the manafacturers' expiry dates and stored in chronological order.
- We observed qualified staff drawing up anti-emetics and then a further check was made by a qualified member of staff prior to administering it to a patient. At all times the patient's details were checked prior to administration by ensuring that it was the right patient, the right drug, the right dose, the right route and the right time.
- We observed the anaesthetist drawing up controlled drugs for anaesthesia and noted that all key parts were covered in a clean tray prior to induction.
- A de-naturing kit was located in the treatment room room for the disposal of controlled drugs.
- We were told that fridges in the satellite clinics were locked when not in use. However, during our inspection the fridge was unlocked, we addressed this with the registered nurse in clinic who actioned this promptly.
- A sample of records of clinic environmental room temperature checks, at the satellite clinics and the main site, were provided. These showed that ranges were recorded between March 2018 and June 2018, however; no ranges were included in July 2018 or August 2018 at the main site. In addition, the thermometer was recorded as missing from 6 August 2018 and no further readings recorded. The temperature range was recorded at 27 degrees, on 30 June 2018, however; no indication of action other than turning air conditioning on was evident. We raised this with senior management at the time of inspection and were assured that an action plan would be implemenented that day and staff informed via team meetings and emails on the correct procedure on carrying out environmental checks.
- Any allergies were documented in the patient's records and were highlighted on the electronic system. We were told that, in the event of an emergency, adrenaline was available at satellite early medical unit clinics and that staff had received training in basic and intermediate life support.
- Antibiotics were prescribed as prophylaxis treatment for infection and provided to take home. Take home medicines and contraception, if required, were dispensed by registered nurses or midwives prior to being discharged.
- Medicines, to take home were labelled with pharmacy stickers indicating the dose and duration to take as well as including the manufacturers instruction leaflet.

Good

Termination of pregnancy

Incidents

- Incidents were reported on an electronic system. Staff we spoke with were aware of the process and understood their responsibilities.
- Between June 2017 and July 2018 there was a total of 335 incidents of which three were assessed as moderate short-term harm caused. All other incidents were assessed as no, low or minimal harm caused. The greatest number of incidents were in the category of clinical complication, followed by service delivery.
- There were no never events reported for the same time period. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic barriers are available as at a national level and should have been implemented by all healthcare providers.
- From July 2017 to June 2018, the provider reported two serious incidents. These occurred on the same date but at different locations. The service used a root cause analysis approach for investigations. Both incidents shared a common theme and we discussed the investigations with senior staff. We were told that immediate actions were put in place. We were assured that external training, with accreditation from a local university, was being provided to staff and staff had to attend this training to be signed off on their competencies. Lessons learned from these incidents were shared with staff and duty of candour to all parties was applied.
- Staff we spoke with understood the principles of the duty of candour as being open and transparent.
- Feedback from incident investigations as well as learning from incidents was provided at team meetings. We observed team meeting minutes and clinical governance committee meetings included clear action plans in place.

Are termination of pregnancy services effective?

Good

Evidence-based care and treatment

- The service provided care and treatment based on national guidance such as the Royal College of Obstetricians and Gynaecologists (RCOG), the Department of Health Required Standing Operating Procedure (RSOP), Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the National Institute for Health and Care Excellence (NICE). We reviewed eight polices, all were version controlled and contained evidence based references. We noted that the privacy and dignity policy had recently become out of date and we were assured that it was being reviewed whilst we were on inspection.
- Patients were offered a choice of procedures and alternative options within agreed timeframes according to gestation, this was in line with RSOP 9, Gestational limits.
- Screening was offered for identification of any sexually transmitted infections however funding arrangements for this varied between different clinical commissioning groups (CCG) depending on the patient's home address.
- Contraceptive options which included Long Acting Reversible methods (LARC) were discussed with patients at their initial assessment and a plan was agreed and put in place. We observed this discussion taking place again during the consent process prior to surgical terminations.
- We observed documentation demonstrating MSI Manchester consistently in the top two MSI United Kingdom (UK) centres for the percentage of LARC given. Figures for July 2018 demonstrate MSI Manchester as the top MSI UK centre for the month. In addition to this we observed documentation demonstrating that the satellite centres account for five out of the top ten satellite centres for LARC percentages.
- LARC training for nurses was ongoing and we saw a clear action planned of nurses trained and those that were booked onto courses to complete by set deadlines.
- The ultrasound policy advocated intra-operative ultrasound scanning for all surgical terminations. We observed this being carried out with every treatment.
- The centre ensured patients were informed and given a booklet 'Abortion Care – Your options and treatment information'. Patients were also given information on how to access the 24-hour helpline should they have any concerns or require advice. These were in line with RCOG recommendations.

Nutrition and hydration

- Patients were provided with written information on fasting and fluids prior to receiving an anaesthetic.

Patients were informed at their pre-assessment not to eat for six hours and drink clear fluids for up to two hours before their appointment. This was in line with the Royal College of Anaesthetists Guidance.

- We observed staff asking patients when they last ate and drank and we also observed the surgeon checking this again prior to surgery. Anti-emetics were available if required.
- Patients identified as diabetic were advised to book early appointments to lower the risk of hyperglycemia or hypoglycemia occurring. This was in line with the National Institute of Health and Care Excellence (NICE) and the National Health Improving Quality guidance (April 2011)
- Water coolers were available for patients, without fluid restrictions, and their friends and relatives in waiting areas.
- After surgery, patients were offered biscuits and water as part of their initial recovery.

Pain relief

- Pain scores were recorded on the termination of pregnancy early warning score (TEWS) observation forms, that were completed during and following surgical procedures. All of the records reviewed had a pain score documented.
- We observed staff checking the comfort and pain levels of patients.
- Heat packs were available to provide extra support.
- We observed that analgesia was offered and advised following medical terminations.
- Royal College of Obstetricians and Gynaecologists guidance recommends the use of non-steroidal anti-inflammatory medication such as ibuprofen. We reviewed 10 records for patients following medical termination. All had been prescribed paracetamol and ibuprofen. Codeine was also available if needed.

Patient outcomes

- The service monitored the effectiveness of procedures and treatments in an integrated dashboard which was in line with the Department of Health Required Standard Operating Procedures (RSOP) 16. This standard 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.
- In the reporting period June 2017 to July 2018 there were 5040 early medical abortions and 3615 surgical abortions. In this period there were 61 incidences of retained products of conception following early medical abortions and 38 incidences of early medical abortions with continuing pregnancies.
- Between June 2017 and July 2018, there were nine incidences when patients needed to return to treatment room for clinical complications.
- In the same period there had been five transfers to the neighbouring NHS hospital. These included a patient with a mental health illness, two seizures, one for anaphylaxis and one miscarriage prior to treatment.
- The service offered the long acting reversible contraception to patients. The target was 40%. Between July 2017 and June 2018, the service averaged 23% a month. There were plans to increase the competencies of staff and new staff employed so that they were able to administer the long acting reversible contraception. We did not observe any training plans but we were informed that now that they had new a new managerial structure at the Manchester centre this would be addressed.
- Of the 397 vasectomies carried out we were told that two patients treated in January and March contacted the one-call after care-line for possible signs of infection. Both patients were offered post-operative appointments at MSI Manchester but they both opted to see their General Practitioner (GP) for review Information provided post inspection identified actions were taken to improve this area which included revising the vasectomy policy, consent form and aftercare vasectomy scripti. This would enable staff to provide clear advice to patients on expectations and prevention of infection.

Competent staff

- There was 100% compliance for appraisals for medical staff, registered nurses and healthcare assistants.
- Mandatory training was available for all staff and following the last inspection, individual staff files included specific competencies necessary for their role. Competency records were maintained for each nurse. We looked at five staff competency records and all were

in date, we noted that there were competency documents that included, safeguarding, basic life support, immediate life support, vital sign observations and health and safety.
- A training programme was in place for new recruits with competencies assessed for each area including scanning.
- Ultrasound scanning training had recently changed to an external education facility. The policy included details of expectations about level of competency for staff including attendance at an accredited scanning course delivered by appropriately qualified staff.
- New staff completed a corporate and a local induction. We spoke to two new members of staff who stated that they regularly receive one to one support and following induction they have continually received peer support.
- Staff confirmed that management and colleagues were approachable, friendly and very supportive.
- Staff had defined roles and responsibilities. We observed a morning safety huddle that included, nurses, healthcare assistants, operating department practitioners, a surgeon and an anaesthetist. During this huddle all staff stated their roles and responsibilities for that day so that the team were aware of who was responsible for each task that day.
- We reviewed five registered nurses registration on their electronic system and all were in date. We were informed by local management that the corporate human resources (HR) department kept these details and a request had to be made for access for us to review them.
- We did not observe appraisals for medical staff as local management could not access these records. We were informed by the surgeon and the anaesthetist on inspection that they were required to provide evidence on their competencies as part of their GMC revalidation process.

Multidisciplinary working

- We observed effective teamwork between registered nurses, midwives, health care assistants, administrative staff and medical staff.
- Staff we spoke to stated that they had a good relationship with the neighbouring trust who provided emergency treatment for patients who became unwell.
- The service contacted the pharmacist at the neighbouring trust for advice and support when needed.
- The service had effective links with local safeguarding teams and other professionals to support patients.
- Bookings for patients, in the Manchester area were made by another independent provider, on behalf of the service and therefore provided different options for patients.

Seven-day services

- The main clinic was open Tuesday to Saturday for medical and surgical terminations, except for when the vasectomy clinic was open on alternate Thursdays.
- The satellite clinics were available throughout the week, except Sundays offering clinics one or two days per week when fully operational.
- A 24-hour advice and helpline was available before and after terminations as well as a dedicated website.

Health promotion

- Information leaflets were available regarding sexual health, however; there were no formats seen other than in standard English.
- Information about screening for sexually transmitted infections and future contraception was discussed during consultations.

Consent and Mental Capacity Act

- We observed staff gaining verbal consent prior to care and treatment.
- We observed two patients providing written consent prior to surgery and saw that they were asked again if terminating the pregnancy was their final choice. We also observed the discussion of possible complications and discussion regarding options for sensitive disposal of pregnancy remains.
- Staff we spoke with were familiar with Gillick and Fraser guidelines when consenting children. Consent training was provided for registered nurses.
- Since the last inspection, registered nurses were now obtaining written consent from the patients with the doctors re-confirming verbally prior to surgery.
- The service assessed individual patients to check that they had the mental capacity to provide their consent. Training in the Mental Capacity Act (2005) was provided in safeguarding training. Staff we spoke to stated that if a patient lacked capapcity to consent then they would be referred back to the NHS as per MSI policy.
- Records we reviewed showed that all patients had provided written consent for treatment.

Good

Termination of pregnancy

- For patients whose first language was not English, an interpreter service was used to translate for consent purposes.

Are termination of pregnancy services caring?

Good

Compassionate care

- Patients observed at the main centre and the clinics were treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. This was observed from them booking in at the reception area, during the consultation and on discharge to home.
- On observing appointments; staff were empathetic and sensitive to patients' needs and those close to them. Staff were non-judgemental, calm, caring and very supportive throughout the patient's attendance at the clinic. The registered general nurse carrying out the consultations displayed the ability to understand the patient's concerns and share their feelings
- Staff maintained privacy and dignity throughout the patient's journey. Surnames were not called out in the waiting room; staff spoke quietly and only called out their first names which helped to maintain confidentiality and protect the patient's privacy.
- We observed reception staff when requiring further information from the patient going to the patient directly and not calling them back up to the reception desk. The reception staff were very softly spoken and nothing confidential could be heard.
- In surgical treatment rooms all patients were treated with kindness and compassion by the nurses, operating department practitioner (ODP), health care assistant, surgeon and anaesthetist. At all times the patients were re-assured and informed of every step of the surgical process.
- In surgical treatment rooms we observed staff maintaining the patient's dignity including when they were under general anaesthesia. We also observed that patients' dignity were preserved on transferring to the recovery room.
- In recovery all patients were treated with dignity and respect. On observing a patient who became upset, a screen was placed around her and a member of staff sat with them for support.
- Patients informed us that introductions were made by staff at all times and they could tell us the name of the nurse who was looking after them. They also stated that staff were friendly, they felt emotionally supported, their privacy and dignity was maintained at all times and they felt that they were in very relaxed surroundings.
- At the time of inspection there was one screen that could be used to partition off a patient's bed space for privacy. We were informed that six more screens were on order and that they would be delivered the week after our inspection.
- Privacy and dignity was on the risk register and the privacy and dignity policy that we were provided had a review date of July 2018. A business plan was shared with us demonstrating future changes to the environment to maintain this aspect of a patient's care. This involved room changes which would see the waiting room have eight to ten new chairs; the preparation room have six reclining chairs including locked cabinets, a television and sink area and the recovery/day room to have six reclining chairs including locked cabinets and curtain rails to partition each recliner chair. Following our previous inspection privacy and dignity was a concern and this business plan was a positive movement in improving the patient treatment pathway.
- Feedback posters were located around the centre including the recovery day room. Feedback was shared with individual staff and at monthly team meetings. Collated feedback information for the quarter ended April 2018 was as follows:
  - 99% overall care was very good or excellent
  - 99% of patients answered, 'yes completely' to were you treated with dignity and respect?
  - 99% of patients rated the professionalism of staff as very good or excellent.
  - 99% of patients rated the way you were greeted on arrival as very good or excellent.
- Compliments were also shared at monthly team meetings such as "I have never met friendlier staff. The most professional, most helpful and nicest people I have met".

Emotional support

Good

Termination of pregnancy

- Staff demonstrated that they understood the importance of providing patients with emotional support. We observed staff providing reassurance to patients who were anxious.
- During a consultation for a patient younger than 18, the patient became upset. The registered general nurse was compassionate and empathetic and with her consent, her mother attended the consultation for support. This helped to alleviate some of her anxieties and worries, which in turn calmed the patient down.
- We were informed that a counsellor was available at the time of inspection by telephone only. Data from the provider, following the inspection, indicated that counselling was offered at initial booking, and recorded on the electronic patient record however; it was not evident from the records reviewed that this was offered to every patient. Staff informed us that this was discussed in the consultation but not documented. No other form of face to face counselling was available at the time of inspection. Required Standard Operating Procedure 13 states that all women should be offered the opportunity to discuss their options and choices with, and receive therapeutic support from, a trained pregnancy counsellor and this offer should be repeated at every stage of the care pathway.
- We were informed that a counsellor had been appointed and was completing mandatory training prior to commencing work.
- All patients were provided with a contact number for 24-hour support. This was provided by the services national call-centre. Additionally, each patient had access to a general advice line and a dedicated team of health professionals.
- Following a procedure, each patient received an aftercare booklet detailing the 24-hour helpline and are offered a follow up appointment if required.

Understanding and involvement of Patient and those close to them

- Patients that we spoke with post-procedure stated that they had received adequate information about the procedure they were having.
- Discussions were held on abortion methods appropriate to gestation, however; it was not evident from the records reviewed that alternatives to abortions, for instance adoption and motherhood were discussed.
- Different treatment options were discussed and documented so that patients could make informed choices. Patients were informed about completion of the HSA4 form, at the main centre. Following the inspection, the provider told us that an updated privacy leaflet was now displayed that explained how information is shared with the Department of Health.
- We saw the disposal of pregnancy remains being sensitively discussed with a patient during a consultation.
- We were informed that the service was considering using advocates to support patients and staff for those patients with a pre-existing mental health condition, although there was no confirmation of any plans when this would be implemented.

Are termination of pregnancy services responsive?

Good

Service delivery to meet the needs of local people

- Service level agreements were in place with commissioners from different regions of Greater Manchester and Lancashire. This meant there were some variation in the service provided depending on where a patient lived, for example, screening options for sexual diseases were offered dependent on the commissioning arrangements for particular areas. There was no signposting to where this screening was offered.
- A central call centre was available 24 hours a day, as well as a website with information that included the phone number and online consultation booking system. There was also an arrangement in place, in Manchester areas, whereby another provider referred patients from their call centre to have treatment locally.
- This location offered services in Greater Manchester and Lancashire although only surgical termination was available at the main clinic. There were eight satellite clinics known as early medical unit (EMU) where medical termination of pregnancy was offered up to nine weeks and four days gestation. These clinics were generally open one or two days per week between Monday and Saturday, however; due to shortfalls in staffing, there were temporary closures at certain clinics to ensure full staffing requirements in the main centre. This was highlighted on the service's risk register. Patients were able to choose the location and travel to

other locations, outside the region, if preferred. We were informed that closure of these satellites did not affect access and flow. Patients were signposted to other clinics. We were told that one patient could not afford the transport costs to the next nearest clinic from the one closed and therefore MSI funded their transport costs to ensure that the patient was seen in a timely manner.

- We were told that alternative options were offered to patients and financial support had been provided for travel in exceptional circumstances.
- The satellite early medical unit clinics were discreetly located in GP surgeries and clinics.
- The main clinic also offered a vasectomy service that was available on alternate Thursdays.
- A discreet free taxi service was also available for airport transfers.
- Following the initial contact by patients, to the service, they were offered either a telephone consultation or a face-to-face consultation at the main clinic or one of the eight satellite early medical unit clinics.

Meeting people's individual needs

- The care and treatment provided by the service was individual depending on the needs of the patient. Staff were aware of how to adapt to the differing needs depending on the age of the woman in clinic, for example when patients were under 16 years of age.
- Clear signage was in place at the main clinic, although located in a quiet residential street. There was no signage at the satellite early medical unit clinics we visited, although reception staff directed us to the appropriate areas.
- The main clinic was a four-storey building with only stairs to reach each level. There was an alternative entrance for patients with reduced mobility. This was accessed at road level to the area where care and treatment occured. Future plans, for the clinic included flooring changes and adapting the entrance to be completely level. Patients with reduced mobility were able to access either medical or surgical termination.
- There were accessible toilet facilities available.
- Hearing loops were available for patients with a hearing impairment.
- For patients identified with a learning disability, someone close to them could accompany them through the process. Where possible, the patient would be treated first to minimise their distress.
- We were told that a patient identified with diabetes, requiring surgery, would be listed early to help maintain stable blood glucose levels.
- A telephone interpreter telephone service was available for patients whose first language was not English. In addition, the website was available in an extensive list of languages other than English.
- Information booklets, including discreet mini guides, for either a medical termination or a surgical termination, were provided to patienst following face-to-face consultations.
- Options prior to treatment were provided in the abortion care booklet provided to patients.
- The abortion care booklet included information about possible protestors and staff offered the option for patients to be accompanied if needed.
- Patients were encouraged to be accompanied by a friend or relative and this was checked prior to treatment.
- For patients booked for surgical terminations of pregnancy, the consent process included a discussion regarding sensitive disposal of pregnancy remains. Examination of pregnancy remains were carried out by the surgeon carrying out the treatment to ensure the procedure was complete, in addition the surgeon logged the tissue for traceability, ensured correct storage and disposal and managed patient requests to arrange private burial if required. Pregnancy remains were placed sensititvely in individual bags and collected together in one receptacle for disposal separate from other clinical waste. This complied with the Human Tissue Authority Code of Practice (April 2017).

Access and flow

- The service received referrals for patients from different sources including GPs, hospitals, family planning services, another independent provider and self-referrals.
- Appointments were arranged to ensure that patients accessed the service in a timely manner. Wait times were monitored weekly, and on-going, to prioritise patients with the greatest needs. Between July 2017 and June 2018 there were 28 out of 8655 patients who waited longer than 10 days from decision to proceed up to termination of pregnancy. This equates to less than 1% of patients waiting beyond MSI's UK target of 10 days. The Department of Health RSOP 11 states that

patients should be offered an appointment within five working days of referral and they should be offered the termination of pregnancy treatment within five working days of the decision to proceed.
- The did not attend rate figures for the centre and the satellite units were provided as year to date figures. Local management at the time of inspection could not break the figures down to monthly statistics. Year to date figures for the centre demonstrated a did not attend rate of 7% which was in line with the national target of 7%. However the satellite unit based at Rochdale demonstrated a percentage of 24%.
- Management informed us that staff would not routinely follow up patients that did not attend unless there was a specific concern where a safeguarding issue may have been identified at a pre-assessment or consultation stage. If this was the case staff would follow up with either the GP, safeguarding midwife, police or social services. Follwing the inspection, the provider told us that text reminders were sent to patients, with their consent and patients would be offered the next nearest appointment to limit wait times.
- For patients who contacted the 24-hour helpline, following treatment, they could be provided with an appointment for a further consultation or, in the event of an emergency, directed to their local NHS accident and emergency department.

Learning from complaints and concerns

- Between July 2017 and June 2018, the clinic received 18 complaints, of which four were upheld and five were partially upheld. The service used the information to produce "you said, we did…" that was displayed in waiting areas. For example we reviewed a complaint where a patient had stated they were not informed of the long waiting time. We saw evidence in the team meeting minutes that this was discussed and an action plan put in place to ensure patients were kept informed at all times throughout their appointments.
- Feedback was also used to identify trends and themes. These again were discussed in team meetings and action plans put in place. For example, complaints were logged due to uncomfortable chairs, this was addressed in April 2018 by purchasing new chairs. The business plan that was in place for new equipment and space would also address this theme.
- Feedback from complaints was shared in monthly team meeting in order to promote lessons learned.
- The initial complaints policy provided was due for review July 2018, however; following the inspection the updated policy was forwarded to CQC.

Are termination of pregnancy services well-led?

Requires improvement

Leadership

- The management structure had recently changed at the location. The provider had appointed an operations manager and clinical manager to work at the centre and clinics rather than be employed across the North of England. The purpose was to be able to have oversight of the clinic daily with managers based at the location.
- The newly-appointed managers were supported by regional managers and, at the time of inspection, the process of changing registered managers with CQC had been implemented.
- The operations manager had responsibilities for the front of house staff, and the clinical manager was responsible for the clinical staff: doctors, registered nurses, midwives and health care assistants.
- Clinical staff had been employed for varying lengths of service with some allocated senior roles to support less experienced members of staff.
- The operations manager and regional matron were available for contact by the staff at the satellite centres on the day on inspection. We were informed that the new structure for local management will ensure that staff will be supported further, with additional leadership being recruited.

Vision and strategy

- The provider's mission is for an individual's fundamental right to have "children by choice not chance". This was written on the rear of the abortion booklet. Their vision is "a world in which every birth is wanted". This information was included in the provider's statement of purpose that was available to view on the provider's website.
- Senior managers told us that they focussed on the four C's of clients, compliance, colleagues and costs.
- Staff we spoke with understood the ethos and focusses of the provider.

Good

Termination of pregnancy

Culture

- There was an open and transparent culture that encouraged the recording of incidents. This was clear from meeting minutes where, for example, staff were encouraged and supported with safeguarding referrals.
- Staff we spoke with felt supported by their managers. They were visible, approachable and contactable from the satellite early medical units.
- We were told that there was good teamwork with all staff involved in decision-making. Many staff had worked at the service for a number of years and reported that there had been changes in recent months that were positive.

Governance

- A well-led framework had been commenced that focussed on key lines of enquiry at location, region and corporate levels. The framework was being developed and not fully embedded but highlighted requirements, with evidence and timescales to complete tasks.
- There was a governance framework for the location as outlined by the provider. Policies and procedures were agreed across the organisation with locally agreed risks identified.
- Since the last inspection team meetings had been introduced on a monthly basis. These were well attended with minutes available for those unable to attend, for example if on annual leave. Regular agenda items were included that recognised positive actions from staff. In addition, particular staff were highlighted in the star awards.
- Meeting minutes for the quality sub-committee for the period March 2018 – June 2018 were provided to show that regular agenda items discussed included regional updates, the quality dashboard, incidents, safeguarding, training and patient feedback. Re-scanning, during the procedure, had been raised as a concern with inaccuracies for dating later gestations with clarity being sought.
- Whilst a governance framework was in place we found this was not fully embedded and local oversight of risk was not fully effective. For example, the service level agreement in place with the local trust for transferring patients if required was significantly out of date (2013). We spoke with senior management who assured us that they would get this renewed as a matter of urgency.
- Local compliance with provider standards were monitored in the services integrated dashboard. This was available to the senior managers daily and data was submitted to monitor compliance and achievement of targets. Management at a corporate level had the ability to benchmark the centre in comparison to other MSI centres however this could not be undertaken at the time of inspection due to the recent appointment of the operations manager. which meant that local leaders could not demonstrate easily if performance was improving or declining.
- There was a lack of managerial oversight from local leaders of the EMUs. We raised concern over medication management in monitoring storage temperatures during the inspection that the senior team were unaware of, therefore we were not assured that all processes for monitoring and quality improvement were fully embedded or effective.
- We found that the local oversight of surgeons and anaesthetists was not effective. For example local managers could not access the electronic system for employment checks and authorisation was required from the national human resources department. We were then provided with details of checks required for clinical staff prior to offer of employment including application form, proof of identification, registration details, convictions declaration, health checks and references. However, the details received were not consistent such as not all included a rehabilitation of offender's declaration form.
- Doctors were required to provide evidence of current professional indemnity insurance documents as per the Health Care and Associated Professionals (indemnity Arrangements) Order 2014. Although the surgeon and anaesthetist informed us that they had to demonstrate their competencies to the GMC for revalidation purposes, local managers could not access their records to check compliancy for either insurance or validation purposes.
- Records of disclosure and barring service (DBS) records were maintained separately showing level of checks and date of renewals.
- The Department of Health licence was displayed in the reception area of the main clinic. We were shown evidence of renewal certificates for the satellite clinics. These were displayed within the locked cabinets that included the computer and medicine cabinet.

Good

Termination of pregnancy

- The service's termination of pregnancy register was maintained electronically. A paper register, as well as paper documentation for the patient was also available in case of electronic failure.The service also recorded the numbers of vasectomies undertaken at the location.
- There was a standard operating procedure for completion of HSA1 forms. These forms included the grounds for the termination and needed signatures from two doctors to be in line with the Abortion Act 1967. Following a consultation, a reason for termination is discussed. The reason for termination was recorded in patients records. The HSA1 form was forwarded to the early medical abortion (EMA) inbox if medical abortion was chosen, or to the surgeon and anaesthetist if surgical. Doctors reviewed the grounds for termination, and if acceptable signed the HSA1 form. Doctors are required to document the reason for termination. The HSA1 form was sent back to the team member to upload to the patient's medical record.
- The form was then viewed by the consenting nurse before medical or surgical procedure consent was discussed and taken.
- HSA4 documents were completed and sent electronically for patients with a NHS number and paper-based for other patients. (HSA4 forms were completed for statistical purposes to notify a termination of a pregnancy to the Department of Health). There was a laminated sheet, at the reception desk to inform patients, although we did not see any further discussion. Administrative staff prepared the forms for the doctor to complete following the treatment. The process was monitored to ensure submission complied with the requirement of within 14 days of treatment. We were shown that any error was highlighted, weekly. Between 18 June 2018 and 4 August 2018, there were 12 incidences of clerical errors noted all within the 14-day timeframe. These errors were noted in monthly team meetings and on-site training given to staff to reduce these errors occurring.
- Records of employed staff were maintained centrally for the provider by the human resources team. Mangers of clinical and administrative staff, locally, could access demographic information including emergency contact details and evidence of a professional registration check, if applicable; all other employment checks were accessible only by the human resources team.

Managing risks, issues and performance

- The service maintained a risk register for the main clinic and also an additional register for the satellite early medical unit clinics. These registers were maintained in the services electronic recording system. They included a description, cause, level and consequence of the risk, controls in place and next review date.
- There was an extensive list of risks identified with a variety of review dates, however; one risk included a review date of January 2018. When discussed it was found that the risk had been reviewed but date not changed.
- Senior managers had a bi-weekly call to review all risks and update as required with a focus on quality as well as commercial risks.
- There was a weekly call with heads of departments where complaints, litigation, incidents and patient feedback (CLIP) were discussed.
- There was an audit programme in place and recorded electronically. Action plans were generated that included the required actions and deadline for completion. An example of this audit programme was that their medicines management errors were highlighted and had shown a decrease in errors from 79% to 58% following the action plan implemented.

Managing information

- The electronic system, at the clinic was backed up in the central office at another location.
- Paper-based records were stored at the location for three years prior to being centrally archived.
- There were 100% compliance for information governance training and 96% for general data protection regulation (GDPR).
- The information governance policy did not include reference to GDPR, however; an updated version of this policy, the information governance policy and management framework was provided following the inspection that included GDPR regulations.
- Staff were required to sign when policies read and understood.

Engagement

- Feedback from both female and male patients was requested to monitor experiences. Details of how to provide feedback were provided during appointments, displayed at the main clinic and included in the

abortion care booklet and the vasectomy after care booklet. The bookletsalso included an alternative address to complain if dissatisfied with a complaint response.
- Feedback from patients was requested from patients by a questionnaire provided either to complete at the clinic or to take home. Each patient received a client satisfaction questionnaire which had the postage paid for them to be sent directly to their external provider. There was a 26% response rate for completed questionnaires for the quarter ended April 2018.
- Patients could also provide feedback on the provider's website by 'sharing stories'. This provided an opportunity to share with other patients directly.
- Information received from patients was displayed in waiting areas in "you said, we did..." posters.
- Senior managers told us that staff had not always felt included in all the clinic's activities and reported the importance of staff being involved in all aspects of the service.
- When at the satellite early medical unit clinics, staff were allocated to work on their own in a nurse led service. There was 100% compliance with lone worker training. This had been identified on the risk register. Control measures were in place to ensure that staff had access to phones and security buzzers as well as other staff in the building.
- We were told that the medical director sent regular updates to staff and had visited the clinic to talk to staff. Senior managers were required to inform staff where they were working and could be contacted if needed.
- A client co-ordinator was being recruited following staff suggestions to liaise between administrative staff, clinical staff and patients attending for treatments.

Learning, continuous improvement and innovation

- The service had implemented the termination early warning score (TEWS) to monitor patients following a surgical termination.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that governance processes are effective and local oversight improves to ensure patient safety and quality improvement.
- The provider must ensure that a counsellor is available for face to face contact for patients under the age of 16 years.
- The provider must ensure that local managers can access all staff employment records to ensure patient safety.
- The provider must ensure that effective process are in place to monitor medication storage temperatures and actions taken when required.

Action the provider SHOULD take to improve

- The provider should ensure that plans progress to amend the environment to ensure patients privacy and dignity is maintained.
- The provider should continue to review alternative decontamination processes for ultrasound probes to ensure best practice guidance is followed.

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 17 HSCA (RA) Regulations 2014 Good governance Face to Face counselling was not available . Local managers not able to access employment records and processes were not fully embedded. Out of range fridge temperatures were not escalated. Regulation 17 (1)(2)(3)