Marie Stopes International Essex Centre

Quality Report

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

Ratings

Summary of findings

Letter from the Chief Inspector of Hospitals

Marie Stopes UK International (MSI) Essex is operated by MSI International. Facilities include a treatment room, 14-day couches and diagnostic facilities.

The service provides termination of pregnancy by surgical or medical methods. MSI Essex provides consultations, ultrasound scans, medical and surgical termination of pregnancy and counselling and support for patients who use this service. The procedure of vasectomy is performed under local anaesthetic. Long acting reversible contraception (LARC) and sexually transmitted infection testing and screening are offered.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 8 June 2017, along with a further unannounced follow up on 14 June 2017 and inspections at early medical abortion units (EMU) at Romford and Enfield.

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.

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

The breaches were in respect of:

Regulation 11 Consent

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

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

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

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

Services we do not rate

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

We found the following areas of good practice:

- Processes and procedures for daily Infection Prevention and Control (IPC) and cleaning checks had been introduced.
- The policies reviewed were updated and in line with the latest guidance and staff were able to access these easily.
- There was a trained anaesthetic staff member in the treatment area to support the anaesthetist to administer anaesthesia and monitor patients undergoing conscious sedation or general anaesthesia.
- Staff were helpful, caring and treated patients with dignity and respect.
- Translation services were available for patients who did not have English as a first language.

Summary of findings

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

- Equipment maintenance and service records were not fully itemised, organised or maintained.
- Compliance was below the target for the majority of mandatory training. For example, 56% of staff had completed basic life support training and 55% had completed intermediate life support, both yearly updates.
- The process for incident reporting was unclear. We received some conflicting information regarding how incidents were captured, investigated and lessons learnt shared.
- There were concerns raised by staff locally around sustainability of services with current staffing level.
- The process for complaints handling was unclear. We received some conflicting information regarding how complaints were managed and recorded.
- The governance, quality and risk oversight of services at local level was not effective. The registered manager was unclear as to the local, regional and corporate governance structures.
- There was no effective process in place for management and oversight of staff compliance with mandatory training, despite a red, amber and green (RAG) system being in place. There was no information available locally to confirm that medical staff had completed mandatory training
- There was no ongoing monitoring or oversight of the early medical abortion units (EMU) by the registered manager. This had been delegated at provider level to a nominated district lead; however, the appropriate registration amendments had not been applied at the time of inspection to ensure compliance with registration regulations.
- The revised audit programme had been introduced and was just beginning to be utilised. Whilst the audits demonstrated areas of non-compliance, there were no formalised process or evidence of outcome review and recommendations to improve 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, to help the service improve. We also issued the provider with two requirement notice(s) that affected MSI Essex. 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 it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Summary of this inspection

Background to Marie Stopes International Essex Centre

Marie Stopes UK International (MSI) Essex is operated by the provider group MSI International. The hospital/service opened in August 1992. It is a private hospital in Buckhurst Hill, Essex. The hospital primarily serves the communities of Essex. It also accepts patient referrals from outside this area.

The hospital has had a registered manager (RM) in post since October 2010. At the time of the last inspection, a new manager had been appointed and was registered with the CQC in April 2017.

MSI Essex opened on 6 August 1992 and provides consultations, ultrasound scans, medical and surgical termination of pregnancy, and counselling and support for people who use the service. In addition, vasectomy, performed under local anaesthetic, long acting reversible contraception (LARC) and sexually transmitted infection (STI) testing and screening are offered.

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy, by surgical or medical methods. The centre provides medical termination to nine weeks + three days and surgical termination of pregnancy to 23 weeks + six days. Surgical termination is carried out either under general anaesthetic, conscious sedation, by vacuum aspiration or dilatation and evacuation or no anaesthetic according to patient choice and needs.

Our inspection team

The team that inspected the service comprised a CQC lead inspector Christine Craven, a CQC inspection manager and one other CQC inspector.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 8 June 2017, along with a further unannounced follow up on 14 June 2017 and inspections at early medical abortion units (EMU) at Romford and Enfield.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

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

During the inspection, we visited all areas of the service. We spoke with 18 staff members including managers, doctors, registered nurses, health care support workers and administration staff. We reviewed the care records of 30 patients, seven of which had undergone surgical termination of pregnancy, and three had undergone medical termination of pregnancy and 20 patients following vasectomy. We observed interactions and communication with patients and those close to them during our inspection. We spoke to nine patients following treatment including vasectomy patients.

This report is based on a combination of what we found during the two unannounced inspections on 8 June 2017 and 14 June 2017 and included a review of all available evidence during and following the inspection. We visited two early medical abortion units (EMUs) in Romford and Enfield and spoke to three staff members and interviewed the district team manager by telephone.

Summary of this inspection

Information about Marie Stopes International Essex Centre

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy, by surgical or medical methods. The centre provides medical termination to nine weeks + three days and surgical termination of pregnancy to 23 weeks + six days. Surgical termination is carried out either under general anaesthetic, conscious sedation, by vacuum aspiration or dilatation and evacuation or no anaesthetic according to patient choice and needs. Marie Stopes UK International (MSI) Essex is part of the provider group Marie Stopes International.

The centre has one ward divided into three areas with a treatment room and is registered to provide the following regulated activities:

- Diagnostic and screening procedures,
- termination of pregnancies,
- treatment of disease,
- disorder or injury,
- family planning and surgery procedures.

MSI Essex provides consultations, ultrasound scans, medical and surgical termination of pregnancy, and counselling and support for people who use the service. In addition, vasectomy, performed under local anaesthetic, long acting reversible contraception (LARC) and sexually transmitted infection (STI) testing and screening are offered.

MSI Essex also provides services via six early medical abortion units (EMU) known as satellite units. These are located in the community where medical termination and consultations in the early stages of pregnancy are provided in a private consulting room. All locations hold a licence from the Department of Health (DH) to undertake termination of pregnancy services in accordance with The Abortion Act 1967. Services are provided to both NHS and privately funded patients.

Patients of all ages, including those aged less than 18 years are seen and medically treated at all of the locations however surgical termination of pregnancy (SToP) only takes place at MSI Essex. Counselling services are offered to all patients before and after their treatment and are provided face to face or by telephone. There is an aftercare support service via a 24-hour telephone service number. Appointments are made through a 24 hour registered pregnancy advisory centre (MSI One call centre).

The building at MSI Essex is not purpose built but modified to provide four consulting rooms, one treatment room, one screening room and 14 day couches. Opening hours are 7.30am to 5.30pm six days a week (alternative Wednesdays). A small-gated car park is available on site and there are facilities in place to support people with a physical disability.

Activity (June 2016 to May 2017)

- In the reporting period June 2016 to May 2017, there were 6,812 inpatient and day case episodes of care recorded at the centre; of these 97% were NHS-funded and 3% privately funded.

The current track record on safety shows that:

- There are no never events recorded for May 2016 to June 2017
- Between February 2017 and May 2017, 128 incidents were recorded on the incident electronic reporting system.
- There were no serious incidents reported between January 2017 and June 2017. Two serious incidents were reported relating to retained products of conception, following surgical procedures, between October 2016 to December 2016.
- There were twelve formal complaints received by MSI Essex between January and December 2016.

A counselling service is available at the centre during periods of activity and for pre booked appointments.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Central sterilisation services
- Maintenance of medical equipment

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?

- The process for incident reporting and complaints handling was unclear. At a local level, there was no effective process for incident investigation, trend analysis or sharing of lessons learnt.
- Current staffing levels were dependent on bank and agency staff with 5.3wte vacancies at the time of inspection.
- The equipment maintenance and service records were not itemised, organised or maintained.
- Compliance was below the target for the majority of mandatory training. The training matrix data submitted, as of 12 June 2017, identified 56% of staff had completed basic life support training and 55% had completed intermediate life support training.

Are services effective?

- The revised audit programme had been introduced and was just beginning to be utilised. Whilst the audits demonstrated areas of non-compliance there were no formalised process or evidence of outcome review and recommendations to improve practice.
- We found an ineffective process for ensuring staff competency. An assessor, that had not completed their own competency checks, was responsible for signing other staff as competent.
- The appraisal systems was not undertaken effectively. This was being undertaken as a two stage process without any face to face meetings between the registered manager and individual member of staff.
- There was no information available locally to confirm that medical staff had undergone clinical appraisal despite this being a concern raised at the previous inspection in April 2016.
- MSI Essex patient vasectomy survey results for 2016 identified poor control of patients pain during vasectomy procedures yet no identified actions plans had been put in place to address this.

Are services caring?

- Staff were observed delivering non-judgemental and supportive care.
- All patients we spoke with informed us they were fully prepared regarding the different options and that the staff were very supportive.

Summary of this inspection

- Data for MSI Essex between January and March 2017 showed the overall satisfaction score was 88%, which was below the national average of 95%. 88% patients were satisfied with information provision, 85% patients were satisfied with how well the service understood their needs and 88% patients were satisfied with the overall quality of care they received.
- MSI completed separate quarterly patient satisfaction surveys for vasectomy patients and we saw in 2016 the overall satisfaction score for Q1 was 100%, Q2 was 99%, Q3 was 99% and Q4 was 99%.

Are services responsive?

- MSI Essex had facilities that included a small private room where young people and people in vulnerable circumstances could be taken; ensuring a discreet service and the room was purposefully 'non-clinical'.
- Staff stated there was easy access to interpreters when English was not the patient's first language. This service was advertised on the website in addition to the availability of over 90 languages via the Google translate service.
- A personal identification number and a password were given to the patient which were checked at every call to ensure that information was only given to the correct individuals as agreed.
- The service had direct access to electronic information held by community services, including general practitioners, which meant that MSI Essex staff could access up-to-date information about patients
- From January to December 2016, no patients waited longer than 10 days from first appointment to termination of pregnancy unless they requested a delay.
- The order of cases on the treatment list were adjusted to allow cervical preparation to be given.
- There was a process in place to manage booked appointments. The number of patients booked each day was organised and determined on the level of complexity and patient gestation.
- From December 2016 to May 2017, the average rate for procedures that did not proceed (DNP) was 22% and the number of patients that did not attend (DNA) rate was 8%.
- Contraception arrangements included long acting reversible contraceptive (LARC) which achieved an average of 35% completion rate between December 2016 to May 2017.
- The process for complaints handling was unclear. We received some conflicting information regarding how complaints were managed and recorded.

Summary of this inspection

Are services well-led?

- The governance, quality and risk oversight of services at local level was not effective. The registered manager was unclear as to the local, regional and corporate governance structures.
- There was no effective process in place for management and oversight of staff compliance with mandatory training, despite a RAG system being in place. There was no information available locally to confirm that medical staff had completed mandatory training.
- Not all concerns raised at the previous inspection in April 2016 had been addressed. There was no effective process in place for governance, oversight of risk and quality measurement at location level.
- There were no formalised process or evidence of patient outcome reviews and recommendations to improve practice. There was no evidence of an effective process to share learning.
- There was inconsistent completion of the debrief section of the World Health Organisation (WHO) five steps to safer surgery checklist. Debrief enables the opportunity for review and learning. The revised audit schedule included monthly WHO audits but this was yet to be embedded, with only two audits undertaken at the time of inspection.
- There was no ongoing monitoring or oversight of the early medical abortion units (EMU) by the registered manager. This had been delegated at provider level to a nominated district lead; however, the appropriate registration amendments had not been applied at the time of inspection to ensure compliance with registration regulations.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents and safety monitoring

- At our previous inspection of MSI Essex, in April 2016, there was an inconsistent approach to categorising incidents; action planning and ensuring lessons learnt were shared with relevant staff. During this inspection (June 2017), we found that an electronic incident reporting system had been introduced corporately across all locations in February 2017. Staff we spoke with knew how to report incidents using the new electronic system.
- Although the electronic system was in place, incident management and trend analysis was not yet embedded or effective at a local level. Trend analysis was undertaken at a corporate provider level. There was no evidence of any action taken following incidents or lessons learnt being shared with the team.
- The registered manager recognised that they needed more training in managing incidents, trend analysis and report generation on the new electronic system and was in the process of arranging this. In the interim, the governance assistant was supporting the registered manager and they reviewed the incident reporting system together every two weeks.
- Between February 2017 and May 2017, 128 incidents were recorded on the incident electronic reporting system for MSI Essex. The reporting levels were an increase from the previous reporting process when from December 2016 to January 2017, 15 incidents had been reported. There was disparity between two sets of incident data provided by MSI Essex, which meant that we were not assured that all incidents were being captured and accurately included in data analysis.
- At our previous inspection in April 2016, we found that incidents were not always being categorised to allow the service to identify trends. During this recent inspection, we found that all incidents were now categorised under headings such as service delivery, clinical complications, health and safety and information governance. However, we were not provided with data that demonstrated whether incidents were additionally categorised according to a degree or level of harm.
- The need to improve incident reporting and categorisation was recognised and had been discussed at the south regional managers meeting on 9 June 2017 as an action for all location managers.
- Of the 128 incidents reported between February 2017 and June 2017, 50 were categorised as service delivery. These included incidents related to information technology such as difficulties submitting HSA4 forms (a notification for pregnancies terminated in England and Wales). Patients who had scanned over the legal limit for termination, patients who had rebooked for a surgical termination as they were over the limit for an early medical abortion, booking errors and patients who could not proceed with treatment due to a pre-existing medical history which had not been disclosed at the point of phone consultation.
- There were 39 incidents categorised as clinical complications and six clinical failures, which included incidents that related to failed treatment, retained products of conception, suspected ectopic pregnancies, emergency transfers and other complications following surgical procedures resolved on site.
- The registered manager confirmed the incident log had 49 open incidents from 27 February 2017 to 8 June 2017 awaiting final approval or currently being reviewed. We reviewed the Incidents management policy, version 1,

dated January 2017.The policy requires all incidents to have a managerial review within two working days, and managerial sign off for closure within five days. We received different information from senior staff during inspection that was not in line with this process. Senior staff stated that they were required to provide an incident response to the corporate team within a week of an incident occurring, following which a review of incidents to identify themes and trends would occur at the corporate level.

- There were no reported never events from May 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.
- Serious incidents are largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. The MSI UK serious incident management policy stated that all serious incidents and never events should undergo a comprehensive investigation using root cause analysis (RCA) methodology. The registered manager had undertaken this training in June 2016. Serious incidents were discussed at serious incident review panels and integrated governance meetings.
- There were no serious incidents reported between January 2017 and June 2017. There had been two serious incidents reported from October 2016 to December 2016, one related to retained products of conception following surgical intervention and one related to the migration of a long acting reversible contraceptive implant. Learning was identified in both cases that included support and development for staff.
- Incidents were an agenda item at the south regional management meetings. We reviewed meeting minutes for March, April and June 2017. Incident processes were discussed but there was no evidence of any specific review of incidents to enable shared learning across locations.
- The acting clinical governance and quality lead for the South stated that incidents and lessons learnt had been discussed at the regional integrated governance meeting however local registered managers did not routinely attend the IGC meetings and therefore were not clear how incidents and lessons were disseminated. When questioned it was stated that this would be reviewed and the local manager may be asked to attend for exception reporting.
- There was no evidence that feedback from incidents, actions required or lessons to be learnt had taken place. We requested team meeting minutes for the six months prior to inspection. Three meeting minutes were provided (October 2016, February 2017 and May 2017). However, on review the data entitled February 2017 was a repeat of the October minutes. There was no evidence of any feedback to staff relating to specific incidents and lessons learnt.
- Three staff spoken with confirmed that they reported incidents through the electronic incident reporting system, which then triggered the senior management response. Staff told us that a standard feedback response was provided via the system however, individualised feedback and actions were not communicated.
- The Duty of candour and Being Open policy version one was introduced and ratified in April 2016.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 service users (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. As soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Senior staff during inspection were aware of the requirements under duty of candour and told us they spoke to patients directly. Early medical abortion unit (EMU) nursing staff confirmed that two out of three of staff had received duty of candour training and four MSI Essex staff had completed duty of candour E-learning training from their alternative NHS roles. We requested details of duty of candour training and the submitted response from MSI Essex was that no nursing staff had received this training.
- The MSI UK Incidents policy version one, January 2017 stated that all managers have a responsibility to "Ensure

effective communication with individual patients about specific incidents that may have affected them". MSI Essex had reported one incident where duty of candour was required in the last twelve months. The registered manager was unable to confirm that this happened as this process was completed at provider level. On review of the two serious incident investigation reports there was evidence that a duty of candour discussion had taken place between the Interim Chief Nurse and the patient

- At provider level, MSI had recently introduced weekly complaints, litigation, incidents and patient feedback group (CLIP) meetings. These organisational meetings for registered managers supported shared learning and professional development. The registered manager was invited to the last two CLIP meetings but had not been able to attend.

Reliable systems, processes and practices

Mandatory Training

- Mandatory training included yearly updates for basic life support, intermediate life support, information governance, informed consent and infection prevention and control. Two yearly updates were required for manual handling and three yearly updates for display screen equipment, fire safety, control of substances hazardous to health (COSHH), equality and diversity, safeguarding people in vulnerable circumstances and children, medical gases, consent with capacity, child sexual exploitation (CSE) and female genital mutilation (FGM).
- The Management of the Deteriorating Client and Clinical Emergencies Policy v4.2, dated December 2016 included details for the recognition and management of sepsis. In addition, the recognition and management of sepsis had been added to the clinical practice guide for registered nurses and midwives that was issued to staff in October 2016 and reviewed in December 2016. Sepsis arrangements were known by staff who confirmed the use of a national early warning score (NEWS) to monitor patients and appropriate actions for escalation.
- The training matrix data submitted as of 12 June 2017 identified the overall target for staff training was set at 95%. A process was in place to monitor and record staff compliance with mandatory training at a provider level via a training matrix that is RAG rated to indicate when staff compliance is due to expire. However the low percentage of staff compliance was indicative that the system, and oversight at a local level, were not fully effective in ensuring staff remain in date. Compliance was below the target for the majority of mandatory training. For example, 56% of staff had completed basic life support training and 55% had completed intermediate life support, both yearly updates.
- Training records reviewed at the inspection showed that 73% of staff had completed information governance, 75% had completed informed consent and 81% had completed the yearly infection prevention and control delivered by electronic learning.
- Compliance levels for manual handling were 85% (updated every two years with staff attendance at a training day), display screening equipment 85%, health and safety essentials 92%, fire safety 85%, COSHH 85%, equality and diversity 100%, female genital mutilation 88% and child sexual exploitation 81% (three yearly training delivered by electronic learning).
- The nursing staff training matrix provided utilised a red, amber and green (RAG) rating system to indicate staff compliance. Dates in green indicated when training had taken place within the last twelve months, amber dates indicated date was within eight weeks and should be rebooked; red indicated where the training renewal date had expired. On reviewing the training matrix provided we saw inaccuracies within the system with staff training marked as within date when the date was beyond a year; for example level two infection prevention and control training was yearly yet training completed on 9 March 2016 remained green.
- There was no information available locally to confirm that medical staff had completed mandatory training. We questioned the registered manager about this and they confirmed that this was held at corporate level, however there were no records available locally to support this and no completed local checks of competency and training of clinicians were undertaken despite this being raised at the last inspection in April 2016.
- Medical staff spoken with confirmed they were up to date with training but there was no local evidence to confirm that this had occurred. Information provided following the inspection indicated this data was stored

on the MSUK intranet to enable all managers to check compliance when required. However, at the time of inspection, the registered manager at MSI Essex was unaware and no checks had been taken by them to provide assurance that medical staff were in date.

- The registered manager confirmed that the service had closure days to support staff training. Managers told us that staff were allocated time to complete mandatory training which was confirmed by four members of staff.
- Not all staff spoken with had received conflict resolution training. Data provided showed that out of the possible 27 members of staff, six (22%) had completed conflict resolution training and of these one was out of date. The remaining 21 did not have a conflict resolution training recorded.

Safeguarding

- There were systems and processes in place to safeguard patients from abuse. There was a Safeguarding Adults and Children at Risk policy version 3.1 ratified in December 2016, which was accessible to all staff. This included arrangements in relation to patients under 16 years of age who were allocated an extended appointment time to meet their requirements.
- In line with national and MSUK policy, all patients that accessed the service who were under 13 years old, or who had conceived under the age of 13, were referred to the local children's social services department and referred to the NHS. Urgent protection advice for children and young people could be obtained from the local authority's out-of-hours service through Emergency Duty Team. This information was kept in the local folder centre.
- The Intercollegiate Document for Healthcare staff (2014) advised that all clinical staff working with children, young people and or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of children and young people and parenting capacity where there are safeguarding or child protection concerns should be trained to level three safeguarding.
- At the last inspection, April 2016, not all staff had the appropriate level of safeguarding training. During this inspection, we saw that some action had been taken to address this. Training data provided demonstrated that 85% of staff had completed the three yearly level one safeguarding vulnerable adult and children e-learning training. Safeguarding vulnerable adult and children level two which included Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs) was completed by 85% of staff which was electronic learning.
- A training day for safeguarding adult and children level three, which included MCA and DoLS, was completed by 80% of staff. This was still below the provider target of 95%.
- Staff we spoke with could name the two safeguarding local leads. Contact details for the leads were displayed on a poster within the counselling room. Both staff had updated level four safeguarding people in vulnerable circumstances and children training. The registered manager confirmed they were due to undertake level five safeguarding training and that they attended the monthly safeguarding meetings.
- Data figures provided during inspection incorporated safeguarding concerns in the number of incidents reported. Therefore, we were unable to ascertain, and staff could not tell us, what impact the additional training or the new electronic reporting system had regarding the reporting and handling of safeguarding incidents.
- An electronic learning module was introduced for staff to cover the topics of child sexual exploitation, female genital mutilation and 'PREVENT' training. 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. The training followed recommendations for training from Working Together to Safeguard Children (2015) and the Intercollegiate Document (2014 and 2015).
- Staff told us that MSI Essex was the pilot site for a safeguarding app that was available on their mobile telephones. The app provided further information around safeguarding. They showed us how they were able to access instant advice related to frequently asked safeguarding questions.
- The registered manager confirmed they had set aside dedicated administration time, two hours each week, to follow up and review any safeguarding concerns.

- Staff had access to the FGM policy via the electronic system. The policy had been ratified and was in date for review. FGM training was mandatory for all staff. Staff training records showed that 88% had completed and updated training.

Cleanliness, infection control and hygiene

- There were systems and processes in place to ensure that standards of cleanliness and hygiene were maintained.
- The training matrix records demonstrated that 81% of staff had an updated level one infection prevention and control (IPC) awareness via electronic learning training and 75% of staff had completed level two IPC training course (nine out of 12 staff level 2 training was applicable to).
- We requested the attendance record for the infection control link nurse workshop held on 17 February 2017 and the submitted evidence confirmed the attendance of the nominated lead from MSI Essex.
- During our inspection, we observed that areas were kept visibly clean. Cleaning schedules and checklists were reviewed and in place and staff confirmed they were familiar with the daily, weekly and monthly checks required. Records showed that these had been fully completed from April to June 2017.
- Staff planned and completed random checks, peer review and a repeat monthly audit to continue to monitor and measure practices. An infection prevention and control (IPC) corporate lead was appointed in April 2017 and there was a local IPC lead identified, and they had attended level three IPC training on 17 February 2017.
- The audit schedule for 2017 was being reviewed at corporate level at the time of our inspection. Therefore, audits were just beginning to start in line with the new audit calendar. There had been one hand hygiene audit undertaken in May 2017 that demonstrated 100% compliance. This was planned to be a monthly audit undertaken to measure compliance with the World Health Organisation's '5 Moments for Hand Hygiene' (revised August 2009). These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
- During this inspection, we observed three members of ward staff wearing stone rings during clinical practice which was against clinical guidance.
- Monthly infection control audits had been introduced and completed between March 2017 and May 2017. Since March, the results had progressively improved with results being 91%, 92% and 99% respectively. Areas recorded as non-compliant were "IPC discussed at team meetings" and "IPC recorded in the sites quality improvement action plan" with responses for both being no for March and April 2017 but yes for May 2017.The results of the IPC audits were not included in monthly governance or team meetings. On review of the team meeting minutes for May 2017 there was no recorded evidence of IPC discussion, therefore we were not assured that the audit score for May was accurate.
- The treatment room environment was visibly clean. Staff cleaned appropriately between patients.
- There was adequate supply of personal protective equipment (PPE) such as gloves, aprons and masks. All staff within the treatment room were observed to adhere to the policy and wear the appropriate protective clothing depending on the task they were undertaking.
- Staff prepared instrument trays using a non-touch aseptic technique. The majority of medical devices used within the treatment room were single use. Any reusable instrumentation was sent off site for decontamination and sterilisation. Collection and delivery was three times a week. An established process to enable tracking of instruments trays sent for processing was in place. Staff sprayed instruments with a pre-treatment foam spray prior to transportation. The foam is a recommended pre-treatment when there is a delay between instrument usage and decontamination. Blue boxes were used to transport instruments to the central sterilisation services department (CSSD).

- We reviewed several single use consumable items such as manual vacuum aspirators, flexible cannulas, flexible curettes, trimester tray packs and straight forceps. All seven items checked were intact and within sterility date.
- Laboratory spill kits were available across the service and staff knew how to access these.
- Following SToP, multiple pregnancy remains were individually bagged and collected in a single hazardous waste bin in a sluice room next to the treatment room. At the end of the list, the container was then sealed and taken to the freezer before collection. Segregation of pregnancy tissue only occurred if there were specific requirements to do so (on either patient request, requirements for DNA identification or criminal investigation). This was in line with current Human Tissue Authority guidance and the MSI UK Management of Fetal tissue policy and the Safe Management, Handling and Disposal of Waste Policy and Procedures May 2016 which had been updated since the last inspection. Staff stated that the pre-treatment consultation included discussion about the individual options for the pregnancy remains.
- One improvement observed from the last inspection was the introduction of the "doorbell" which was implemented to reduce staff entry into the treatment room and reduce access by multiple staff during treatments.
- There was a system in place for the cleaning and monitoring of water quality to reduce conditions suitable for bacteria development. Records between January and March 2017 were reviewed and were complete.
- We reviewed two water-testing reports for January and April 2017. Both reports confirmed the water required an increased level of inhibitors added to the water system as part of the water cleansing process. Senior staff initially could not locate documentation and were unable to confirm if the inhibitors had been added to the water system following the external company visits. However, assurance was later provided that this had been undertaken. We saw communication from the external company which confirmed the next service visit was booked for July 2017. The MSI UK Legionella policy July 2014 had not been updated in line with new guidance.

Environment and equipment

- MSI Essex did not have an effective process in place to ensure that equipment was serviced and maintained in line with the manufacturer's guidance. We saw equipment maintenance and service records that were disorganised, not fully itemised, and not maintained. There was no completed inventory held for equipment on site.
- Not all patient monitoring equipment had service stickers that detailed the last service date and when the next service was due, for example blood pressure monitors. The patient monitor found in the recovery area had a service sticker from 22 May 2016 but there was no record of a service planned or undertaken in May 2017.
- An ultrasound scanner in the treatment room had an asset number that did not match the maintenance records. We raised this with the registered manager and operational manager who were not able to provide any understanding of this system. The registered manager and operational manager confirmed that equipment maintenance would be reviewed as a matter of urgency.
- There was access to resuscitation equipment including an automated external defibrillator (AED). These devices are able to diagnose life threatening cardiac conditions and enable treatment through defibrillation. 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 British Heart Foundation and Resuscitation Council.
- The resuscitation trolley in the treatment room was tagged, sealed, and checked in line with MSI UK Resuscitation policy, version 7.2 issued in December 2016. Records reviewed confirmed completed daily checks had been undertaken between January 2017 to June 2017. The tag in situ corresponded to the record stating items were checked, present and in date at the beginning of June 2017.

- The ward's resuscitation equipment had daily completed checks and the oxygen cylinder on the resuscitation trolley was in date and full.
- Staff recorded the humidity and temperature of the treatment room at MSI Essex. Records included the expected normal range for temperature (normal range 68-75 degrees Fahrenheit) and humidity (20-60% normal range). We reviewed records between March and June 2017, which had been completed daily but had no actions recorded for the three occasions when readings had been outside the normal range for this environment. Senior staff were unable to confirm any actions taken when this occurred.
- We saw an effective system for security on site that included restricted access to the building and CCTV was operational around the exterior of the building and car park.
- The equipment at the early medical abortion units (EMU) were not monitored by MSI Essex. We were informed that equipment records at the EMU were now overseen by the lead for the district team. Equipment reviewed at Enfield and Romford EMUs was noted to be within date for servicing.
- The ultrasound scanner, blood pressure and weigh scales found at Romford EMU had no record of calibration but had last service stickers which were within date. We raised the lack of calibration records as a concern with staff at the EMU who stated they would raise this with the district team lead to be rectified. Staff informed us that when they reported any equipment problems to the contracted service company there was a prompt response.
- The Enfield early medical abortion unit (EMU) room temperature recorded 24-32 °c exceeding the normal range of 18-25 °c and was on the district teams' incident reporting system. The Romford EMU room had an allocated fan to maintain temperature within the normal range for patients.

Medicine Management

- The clinical operational manager was responsible for medicine managements at MSI Essex. They had attended a medicines management-training day on 3 February 2017 alongside 12 staff from other MSI locations.
- There was a Medicines Management policy v1 February 2017 in place however, this was a draft document unratified at the time of inspection.
- The Medicines management policy v1 February 2017 stated there was an annual corporate medicine management audit. An audit was undertaken at MSI Essex on 27 March 2017 that included review of various standard points such as ordering, receipt, storage, waste and disposal of medicines. 29 out of 35 standard points passed; six failed giving an amber rating overall (82%). There was no evidence that an action plan had been put in place to address the areas found non-complaint.
- There had been seven medication incidents reported for MSI Essex between February 2017 to June 2017. When reviewed the identified themes included three incidents of missed doses, three incidents of incorrect dose and one incident of a patient's discharge prescription was unsigned.
- There were no Controlled Drugs kept at MSI Essex. Non-controlled drug storage checks were reviewed and completed appropriately. Medications were stored securely in a locked cupboard. Keys were held by the registered nurse within the ward area.
- Daily monitoring and recording of the medication fridge temperatures and ambient room temperatures where medications were stored was in place. The drug fridge temperature was recorded daily for the recovery area. We reviewed completed records, at MSI Essex, from January to 8 June 2017 and saw the minimum and maximum range of temperature recorded. A drug expiry check was undertaken in the treatment room at MSI Essex on the final working day of each month and records showed this was completed from February 2017 to June 2017.
- Doctors could prescribe medications remotely via an electronic system. Medication was given as per prescription and signed for electronically. Patients were prescribed antibiotics in accordance with local antibiotic formularies.
- We reviewed thirty-six sets of patients' records. Staff had recorded patients' allergies clearly in the records and patients wore red wristbands to indicate a sensitivity or allergy.

- Staff at MSI Essex identified that MSI at provider level had requested in August 2016 that doctors sign the sealed antibiotic medication and oral contraception boxes prior to the patient being discharged. However the prescription was electronic, and medical staff were not visually opening and checking the contents of medication boxes prior to administration and we were unsure as to why this was instigated. Information from the provider was that this was an interim measure as eventually; pre labelled stickers would be pre-signed by the providers' pharmacist. This was not included in the Medicines management policy version 1 February 2017.
- During the inspection, at Enfield EMU, out of date drugs were found in the emergency bag. We raised this with staff; the drugs were removed and this was reported as an incident. A process for checking the drugs daily was implemented to mitigate the risk of reoccurrence.
- Staff told us that pharmacy advised the EMU to shorten the manufacturer's expiry date on some of the drugs that were stored in the drug cupboard, which did not follow the MSI Medicines management policy version 1 February 2017. This was due to the high temperature of the room exceeding the acceptable range and the expiry date had to be shortened. This procedure was discussed with a pharmacy specialist who confirmed this action was within guidance due to the short expiry dates and high turnover of drugs.

Records

- Patient records were a combination of paper records and electronic records. Patient records were stored securely behind the reception area or in locked boxes. Electronic records were password protected and access was limited to those staff with a right to access them. Local electronic records were uploaded to a central database system.
- An electronic system was used for documenting patients' care during the operative phase. This included staff members, procedure performed, swab and instrument counts, consumable items and implant details. Staff were observed to complete swab counts at the end of the operative procedure and record this appropriately on the electronic system.
- Staff undertook twice-yearly audits of 30 sets of patient records.The last audit was completed on 31 January 2017 and recorded a compliance score of 98%. The audit included six sections which included one call booking, central records system (CRS) workflow, ultrasound scans, pre-operative, procedure and post-operative. We saw that a section was added to the audit to include the review of records for under 18 year olds, this was introduced following the last inspection in April 2016.
- We spoke with administration staff at MSI Essex who checked records to ensure any medical history concern had been flagged on the patient record system; for example, patients with previous heart conditions, to maintain record compliance and avoid wasted appointments.
- We reviewed 30 sets of patient's notes which staff had completed fully with appropriate patient risk assessments. Records included completed treatment decision flow charts, signed and dated consent forms for treatment and two independent medical signatures obtained to authorise the termination procedures.
- We reviewed twelve paper records specifically in relation to medical signatures. All twelve had two signatures with the doctors' General Medical Council (GMC) stamp but all signatures reviewed were illegible. We were informed that a central register of signatures was held to identify staff signatures. We asked on site during inspection to see the register but this was not provided.

Assessing and responding to patient risk

- Staff were observed, during the inspection, to complete the World Health Organisation (WHO) Five Steps to Safer Surgery checklist at the appropriate stages of the surgical procedure.Appropriate checks of swabs and surgical instruments were completed both verbally and recorded on the WHO checklist (paper record) and on the electronic patient record.
- A daily treatment room checklist had been introduced that had recorded sections for steps one and step five of the World Health Organisation (WHO) Five Steps to Safer Surgery checklist (team brief and debrief). The initial team brief was observed, staff were introduced and identified roles for the team were confirmed such as the nominated ultrasound scanner, circulating member of staff, anaesthetic assistant, and staff member responsible for swabs, implants and medications. The transfer nurse was identified and noted on the white board in the treatment room for easy reference.

Termination of pregnancy

- Surgical procedures were observed for eight patients. Staff introduced the team and verbally confirmed patients' identification, allergy status and offered the opportunity for patients to ask questions. The patient was also asked to confirm that they were happy to proceed, identify who would be taking them home and be with them for 24 hours and what ongoing contraception method had been agreed prior to procedure beginning. Two patients on the morning surgical lists were noted to have allergies, paperwork and the electronic record had this recorded and both patients wore red wristbands to indicate the allergy.
- Whilst the team brief and steps two through to four of the checklist were in place we found that the completion of the debrief section of the treatment room checklist was not consistent. We reviewed records from the 1and 8 June 2017, seven in total, and the debrief section was not complete in four out of the seven records, demonstrating compliance at 57%
- The assessment of patient's clinical history by both the surgeon and anaesthetist was observed prior to patient treatment. Four patients were identified prior to the list commencing as requiring further information provided by either the nursing staff or a further medical assessment. The anaesthetist reviewed one patient and gave an updated assessment to the surgeon prior to the procedure taking place.
- It was noted in one patient's record that they had been admitted to a local NHS trust two weeks before with a suspected ectopic pregnancy, however there was no further detail provided. The surgeon requested sight of the discharge letter before proceeding, and stated that if the patient could not submit this then the appointment would need to be re-arranged. This was actioned immediately by staff as the patient had brought the discharge letter with them to clinic, it was reviewed and the procedure went ahead. Full documentation of this was completed by the surgeon on the electronic patient record system.
- Patient records contained venous thromboembolism risk assessments (VTE) which staff completed prior to the patients surgery. The risk assessments informed staff if prophylactic treatments were required. The pre-admission checks were reviewed and all VTE assessments were completed on the electronic patient records system.
- The majority of patients received treatment under local anaesthetic or conscious sedation however on occasion a general anaesthetic would may be necessary. During our previous inspection in April 2016, we were not assured that there were adequately trained staff to assist the anaesthetist with an emergency of a patient with a difficult airway. This had been addressed and there was a trained agency anaesthetic nurse on duty that had worked at MSI Essex since February 2017.
- Data provided demonstrated that 40% of staff had completed an anaesthetic and recovery care three yearly training programme. We were assured by the registered manager that staff were on the roster to provide cover at all times andhad sufficient airway knowledge to enable prompt and competent support to the anaesthetist should a general anaesthetic be required.
- Emergency intubation equipment and medication was available in the treatment room should they be required. There was a range of different sized endotracheal tubes and airways available which were all in date for sterility. Emergency drugs were noted to be within expiry date.
- To reduce the risk of retained products of conception an ultrasound scanner (USS) was utilised throughout each procedure. In addition, the surgeon visually checked pregnancy remains following each early gestation procedure to identify the sac. If there was any doubt that not all pregnancy remains had been removed, the surgeon would rescan the patient and potentially perform further evacuation.
- The MSI UK Abortion policy – Medical and Surgical Procedures v2.1 dated December 2016 outlined the physical assessment of patient's baseline observations, body mass index, blood tests, sexual transmitted infection status and ultrasound scan. Ultrasound dating scans were used to determine a patient's eligibility to proceed with a particular treatment type.
- There was a process in place to determine the level of patient risk and appropriateness for patients to receive treatment at MSI centres. Patients may either opt to have a telephone consultation carried out by a separate MSI team at the One Call centre, or face-to-face

consultation at any MSI centre. A treatment decision flow chart was utilised to determine treatment options, and a pre-existing conditions guideline was utilised to determine clinical risk.

- Patients who had any pre-existing conditions, such as a high body mass index or ectopic pregnancy were referred to an NHS provider of termination services. If further information was required to complete the assessment, a referral to the patient's general practitioner was requested for further information with the patient's consent.
- The MSI One Call centre staff processed these referrals and informed MSI Essex if the patient could be treated safely at the centre.
- We observed that all patients treated on the day of inspection had baseline observations of pulse, respiration and blood pressure performed in the treatment room as part of the medical assessment. A set of observations were then completed post treatment.
- There was a national early warning score (NEWS) chart in use to record patient observations during the medication phase of a late (staged) termination. The NEWS assisted staff in the early recognition of a deteriorating patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating and there was evidence of continuation of monitoring and treatment.
- A staged termination is a two-stage termination and is performed between 19 and 23 weeks + 6 days gestation. The first stage involves softening the cervix and the second stage is surgical removal of the fetus under general anaesthetic. This meant that closer observation was in place during the pre-surgical stage of the termination. The NEWS chart had clear escalation steps to escalate any patient deterioration.
- Staff confirmed how they used NEWS and described the steps taken if a patient's deteriorating condition required them to be transferred to the local NHS hospital for treatment. This was in line with MSI UK Management of the Deteriorating Client and Clinical Emergencies policy version 4.2 issued in December 2016.
- There had been five emergency transfers to a local NHS hospital between December 2016 and May 2017Data provided stated that three patients were transferred due to haemorrhage, one had been due to an ectopic pregnancy and detail was not provided for the fifth. This equated to an average of 0.1% of patients seen. In addition, there were three other Essex Centre patients during this period who attended hospital directly due to retained products of conception or ongoing bleeding. The centre had an updated emergency patient transfer service level agreement with the local NHS hospital which included a direct line through to the admitting doctor to ensure a timely response when needed
- Staff we spoke with stated that patients were considered fit for discharge once vital signs were stable and within the patient's baseline and they had no signs of inappropriate bleeding. Any concerns were escalated to the doctors for medical assessment.
- Nursing and healthcare assistant staff monitored patients until discharge and medical staff remained on the premises until all patients were discharged or they had completed a ward round and were satisfied that the patients were fit for discharge. The Management of the Deteriorating Client and Clinical Emergencies version 4.2 issued December 2016 instructed staff about what process to follow when caring for patients post-surgery.

Staffing

- At the time of inspection, the registered nursing staff vacancy rate was 5.3 whole time equivalent (WTE). Managers confirmed there was a rolling advert for registered nurse posts on the MSI UK website. The registered manager confirmed they had sufficient staff to meet the needs of the patients for that day despite one member of staff reporting sick.
- Nursing staff numbers and the skill mix was reviewed on the electronic rota for three months from March to June 2017. Staffing levels were seen and senior staff confirmed the planned registered nurses rostered for the centre is nine whole-time equivalent and three healthcare assistants. These staff covered the treatment room, recovery ward area, consultation and medical procedure area.
- The clinical staff shifts were 08.30am until 5.30pm. Staff recognised the need for flexibility due to the demands of

the job and told us the shift patterns were regularly extended due to clinics and treatment lists that overran. There were concerns raised by staff locally around sustainability of services with the current staffing level.

  - Vacancies were covered by the use of bank and agency staff. From March to May 2017, the average bank staff used was 17% and agency used was 7%. The registered manager had responsibility to ensure that all agency staff had the necessary checks appropriate for the safety and quality of the local service. The induction process for bank and agency staff on the day of inspection was seen and complete for those staff on site.

- Staff stated that there was a flagging system of an email alert to remind them to revalidate every three years. Staff confirmed they were supported by managers and the system to ensure this was completed.

Medical staffing

- Medical staffing was provided by doctors working both remotely and within the centre. The remote doctors were employed by Marie Stopes International (MSI); their role was to review patients' notes and medical history prior to signing the HSA1forms and prescribing medications.
- Surgical treatment lists occurred at the centre five days per week and an anaesthetist was always present. The anaesthetists worked at NHS trusts and other MSI sites which employed them on a sessional basis.
- Consultant urologists were employed on a sessional basis to perform vasectomies every alternate Wednesday at this location.

Major Incident awareness and training

- There was a contingency plan in place in the event of an emergency. The centre had a backup emergency battery should the power fail and was classed as a priority for restoring services with the power company should the need arise.
- Fire evacuation plans were seen across all areas of the centre.

Are termination of pregnancy services effective?

Evidence-based treatment and outcomes

- The audit schedule was being reviewed at corporate level at the time of this inspection. The revised audit plan for MSI Essex demonstrated a plan for monthly audits of IPC, Hand hygiene, peripheral venous cannula and World Health Organisation (WHO) five steps to safer surgery. A peer audit month was indicated and planned for February, May, August and November.
- The audit plan had just been implemented with May 2017 the first month where all four audits had been undertaken. The audit covered an extensive number of sections however; data provided did not include any action plans as a result of audit outcomes.
- A monthly audit relating to the World Health Organisation (WHO) five steps to safer surgery checklist was undertaken in March and May 2017 but was omitted in April 2017. Data provided demonstrated that compliance in March was 90%, increasing to 100% compliance in May. The aspect identified as non-compliant in March related to completion of the debriefing section of the checklist, with zero out of five completed. We were not assured of embedded practice as findings on inspection demonstrated inconsistency with the debrief record with only four out of seven records seen during inspection completed.
- Staff confirmed that policies were easily accessible. Action had been taken at provider level to review and update those policies that were out of date. At the last inspection there was no reference to difficult airways management in the general anaesthetic and sedation anaesthesia policy, which on review was now included. Staff stated that updated policy changes had been communicated to them via the interim chief nurse newsletters.
- Managers confirmed that they used the alternative weekday when there were no surgical termination treatment lists, to hold team meetings and update staff on changes of practices. However only three team meetings had taken place since October 2016.
- Staff told us that they informed the patients about the different available treatment options with the risks and

benefits for each method in order for the patient to make an informed choice about the method of treatment that was suitable to their individual requirements.

- Prophylactic antibiotics were prescribed on the electronic patient records prior to the surgical procedure which is recognised as best practice.
- RCOG guidance 7.9 states that cervical preparation should be considered in all surgical terminations and 7.10 details recommend regimes according to gestation. The current protocol for cervical preparation was outlined in the Abortion Policy – Medical and Surgical Procedures v2.1 December 2016 and was in line with RCOG guidance however, information from MSI Essex stated that the policy is currently being reviewed to strengthen the regime and it would be re-ratified in coming weeks.
- There was a process in place to ensure patients received appropriate cervical preparation depending on the patient age and gestational period. The observed patient preparation undertaken on the day was in accordance with guidance and MSI abortion policy. The cervical preparation times for patients were noted on the white board in the treatment area to ensure surgery was performed only when the full preparation time was completed.
- Sexually transmitted infection tests were completed for an average of 76% of patients from December 2016 to May 2017 which was above the 70% target recorded on the balanced scorecard.
- Contraception arrangements included the provision of long acting reversible contraceptive (LARC). The average total of patients receiving LARC between December 2016 to May 2017 was 35%. Team meeting minutes submitted for May 2017 included discussions about the very low LARC rates and that staff must clearly document when a patient does not take any form of contraception and that they are supported with all LARC options. We noted on reviewing these minutes they were incorrectly dated as May 2016.
- Incident data demonstrated that there had been eight treatment failures reported as incidents between December 2016 and May 2017 equating to an average of 0.2%. There had been no reported infections in the same time period.

Nutrition and hydration

- Fasting requirements were observed and explained to patients before admission. Patients were observed being offered water and light snacks following recovery and before discharge. There was a variety of provisions available for patients including tea, biscuits and juice.

Pain relief

- Medical staff prescribed pre and post procedural pain relief on medication records. Non-steroidal anti-inflammatory medication and intravenous paracetamol were administered during the procedure. Non-steroidal anti-inflammatory medication is recognised as being effective for the pain experienced during termination of pregnancy. In addition, there were other medications that could be administered if the patients still experienced pain.
- All patients spoken with agreed that staff anticipated their requirements and that access to pain relief was not a problem. The medical records audits and patient comment feedback cards did not indicate concerns with pain management.
- Staff recorded pain relief scores using the 0-10 pain relief assessment tool. Patients confirmed that they were offered pain relief in a timely manner. We saw the single use abdominal heat pads for patients which reduced discomfort following surgery. These were applied prior to discharge and used by the patient in the initial hours following discharge. Staff confirmed that they used single use heat pads so the patient could take them home as part of their pain relief support.
- Staff provided patients advice on discharge regarding the type of pain relief to take should they require it.
- The MSI Essex patient vasectomy survey results for 2016 demonstrated that in 2016 overall satisfaction with the service received ranged between 97% in Q2 to 100% in Q4. However the percentage of patients stating they experienced pain during the procedure remained significantly below the overall result with 54% (red) in Q1 and Q2, slight improvement in Q3 to 56% (amber) with a worsening result in Q4 45% (red). Included in the vasectomy survey was a system for “red alerts”. If a problem was identified the survey was red alerted and sent to the centre for investigation. There was no evidence that any actions had been taken in regard to

pain management for vasectomy patients. None of the incident or complaint data provided by MSI Essex post inspection had been categorised to identify if pain management as an issue.

- The termination of pregnancy patient survey for MSI Essex highlighted a pain management score of 84% for December 2016 and March 2017 (10% below target) this was a decrease from the July to September 2016 score of 91%.

Competent staff

- There were systems and processes in place to ensure new staff received an induction however ongoing checks of staff competency were not fully embedded or effective. The clinical team lead (CTL) was the designated member of staff who assessed staff's competencies outlined in the clinical practice guide and provided additional one to one training if necessary.
- Staff completed competencies that were applicable for their specific role. We reviewed competency records for five staff. Not all sections of the documentation were fully completed and assessments had been undertaken, and staff signed as competent, by the clinical lead in November 2016. However, the clinical lead had not completed their own competencies assessment prior to assessing others. When we raised these points with the registered manager, they stated that the assessment for the clinical lead was in the process of being arranged at another location but no date was yet confirmed.
- Staff completed their own appraisal paper, which would then be signed off by the registered manager. However, we reviewed five appraisals which did not contain any dates or managers sign off when completed. The registered manager confirmed that appraisals were being undertaken as individual two-part processes. At no point were face-to-face meetings taking place with the member of staff to discuss and agree objectives.
- Information provided prior to inspection stated that 100% of medical staff, 100% of nursing staff and 80% of administrative staff had undergone an appraisal between January and December 2016. However, during inspection administration staff confirmed they had an appraisal date but had not yet completed the process. Nursing staff we spoke with confirmed they had received an appraisal where they had identified their own learning needs and completed the appraisal form but had not yet received their manager's feedback.
- There was no information available locally to confirm that medical staff had undergone clinical appraisal. Appraisals and competency assessments were carried out by MSI at provider level. All doctors spoken with confirmed they had an annual appraisal as part of the GMC revalidation process. Evidence submitted during the provider inspection at MSI in February 2017 demonstrated 100% compliance. Whilst there was a process at provider level, there was no communication from the corporate team to MSI Essex that confirmed appraisal had occurred.
- Clinicians covered periods of annual leave for colleagues and there was no checks or records held at MSI Essex to provide assurance that competency for clinicians were up to date despite this being raised as a concern at the last inspection in April 2016.
- Senior staff confirmed there was a procedure in place for the recruitment and induction of new staff. The induction programme covered such topics as policies, treatment types, fire safety, health and safety and confidentiality. Shadowing opportunities were provided to support new starters and all staff were required to rotate and work in all areas.
- The registered manager and district team lead stated that they could access the "Open door" computer system to access the skills and competencies of MSI staff working from outside of the locality.
- We spoke to staff who had attended degree level programmes supported by MSI. Staff described how they rotated across this service to maintain updated awareness in all aspects of the treatment.
- There were two members of staff that had undertaken training on ultrasound scanning programme but were at different stages of completion. One staff member had attended the training and examination and had a named qualified mentor. Their scanning folder was reviewed and noted as complete and up to date. The other member of staff had completed the training last year but needed to maintain their skills and complete the proficiency examination.

- The health care assistant undertaking scanning during the procedures in the treatment room had no formal scanning training but operated the scanner under direct supervision of the surgeon.
- A registered staff revalidation flagging system was in place in accordance with General Medical Council and Nursing and Midwifery Council requirements. Staff described how they were sent an email from Human Resources (HR) which informed them of the revalidation date, as well as receiving notification from the appropriate council.
- Medical revalidation was completed every five years and this information was held by the central HR team. Anaesthetists' revalidation was undertaken in the NHS hospital where they had main employment. We were informed that this was then reviewed by the corporate health systems director of MSI to ensure it was complete.

Multidisciplinary working

- We observed good communication and teamwork within the treatment room team, anaesthetist and surgeon. The team identified and discussed which patients required further assessment and communicated with nurses on the ward what information was required.
- Staff spoke about a good multidisciplinary teamwork approach that supported the care pathway. Medical support was easily accessible with contact numbers available within the centre. Staff were heard asking the patient's consent prior to contacting the general practitioner (GP) and when printing off discharge letters for the patient to deliver to their GP after their discharge. This was in line with RCOG guidance 8.2.Care pathways were in place to ensure that following treatment, patients had the correct discharge support for ongoing care, counselling, follow up appointments and future contraceptive support.
- Staff gave examples of collaborative working with external agencies such as staff at the local NHS hospital to support emergency transfers and referrals for safeguarding people in vulnerable circumstances (adults and children).
- Examples of interactions and collaborative working with social services to safeguard vulnerable patients who were at risk of domestic abuse or sexual exploitation was described by staff who outlined the care received by an under 16 year old who had received treatment at the centre.

Access to information

- Staff stated that the patient's consent was sought prior to information being given to their GP following the treatment. If consent was denied patients were given a letter to give to a health care professional should complications occur. This was in line with RCOG recommendation 8.2 that "On discharge, all women should be given a letter providing sufficient information about the procedure to allow another practitioner elsewhere to manage any complications."
- We saw one patient confirm she would take the discharge letter to her GP and another who declinedbut had taken the letter after staff explained that she would need to hand it to any health care professional attending to her in case if there were of any complications.

Consent, Mental Capacity Act and Deprivation of Liberty

- The Abortion policy – Medical and Surgical Procedures v2.1 issued December 2016 was reviewed and a section on Informed consent was included. Any patients aged under 16 years of age will be assessed for Fraser competence before obtaining consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. All patients we spoke with confirmed they were given sufficient information in order that they could make an informed choice.
- All staff we spoke with confirmed that they were aware of the policy and processes if patients were uncertain. Staff said that if females under the age of 16 years attended, they were encouraged to involve a parent or guardian. These staff applied the Fraser guidelines for checking rationale and understanding when obtaining consent from girls under the age of 16.
- Following the last inspection a full review of consent training and competence had been undertaken at provider level. As a result, changes were implemented and patient consent was only completed by either a registered nurse or clinicians. The submitted training

matrix demonstrated that thirteen out of 26 staff (50%) had completed consent training and 80% of staff had completed safeguarding level three training. We were informed by the registered manager that only nominated staff, who had completed both the consent and safeguarding level three training, had been signed off as competent by the clinical team lead. This provided assurance that staff taking consent had the appropriate knowledge, skills and competence to support patients who may be vulnerable or lack capacity to make a decision.

- There had been a new consent form recently introduced that had three sections requiring signatures from the patient, nurse and surgeon and the interpreter (where appropriate). Verbal consent was again confirmed with each patient in the treatment room prior to the procedure starting. At which point the surgeon was observed to sign the consent form once the patient had confirmed they wished to proceed with treatment.
- The six monthly medical records audits monitored compliance with consent practices. The audit encompassed a quantitative check of 30 patient records and checked that all consents were signed, logged, noted and reaffirmed and that anaesthetic choice was recorded and noted.
- There was a section included in the records audit that considered consent for children and young people, assessment of capacity to consent. This had been updated from the last inspection and the last audit completed was dated 31 January 2017 with overall compliance of 98.2%. Results identified 100% compliance in relation to consent however, none of the records however none of the 30 records used in the audit related to a patient under the age of 18.
- There were consent forms in place for contraception options and the supply of chosen method and testing for sexually transmitted infections.
- The 30 records we reviewed during inspection contained signed consent forms from patients for the procedures and in addition, where women had agreed to contraception implants, possible side effects and complications were recorded.

Are termination of pregnancy services caring?

Compassionate care

- Staff communicated with patients in a very sensitive manner and were polite and helpful to patients who they treated with dignity and respect. An example was a patient under 18 years being supported by her mother and grandmother but still given time on her own to discuss any concerns with staff.
- Staff were polite and helpful to patients who attended and to patients on the telephone. Administration staff told us they were careful of what was discussed at reception to prevent patients in the adjacent waiting area overhearing any confidential information.
- During the inspection, we witnessed a distressed patient who was taken to a private room to discuss her needs and offered additional support from staff. Staff displayed a non-judgmental attitude towards the patient's decisions. On speaking with the patient before her discharge, she told us of her concern and how supportive staff had been to her.
- Two further distressed patients were seen in the treatment area who were visibly upset, especially when questioned before the procedure. Staff handled this well with sensitivity and amended timing of questions to meet the individual needs of the patients.
- All patients we spoke with informed us they were fully prepared regarding the different options and that the staff were very supportive.
- MSI at provider level, action quarterly patient satisfaction surveys, to establish whether they are meeting the individual needs of people who use the service. The surveys included comparative analysis to measure improvements month on month but also to compare the performance across the different Marie Stopes locations.
- Data for MSI Essex between January and March 2017 showed the overall satisfaction score was 88%, which was below the national average of 95%. The same quarter report in 2016 scored 95%. Further breakdown of the survey identified that 88% patients were satisfied

with information provision, 85% patients were satisfied with how well the service understood their needs and 88% patients were satisfied with the overall quality of care they received.

- The 12 patient comments cards reviewed during the inspection supported these findings and comments included " Staff were respectful and professional, caring and non-judgmental", " "Staff made a difficult time more bearable by the compassion shown to me" and "Thanks to the staff I now know I have the support I need". The majority of feedback was positive about the care received however; two comments mentioned that waiting times meant they had experienced delays with their treatment.
- Patients who had treatment for vasectomy commented that they were satisfied with information provision and felt involved in the decision making process. MSI completed separate quarterly patient satisfaction surveys for vasectomy patients and we saw in 2016 the overall satisfaction score for Q1 was 100%, Q2 was 99%, Q3 was 99% and Q4 was 99%.
- Patients we spoke with praised the doctors and staff for their professionalism.

Understanding and involvement of patients and those close to them

- Staff were observed to introduce themselves to patients using the "my name is approach" throughout the service and informed the patient of their roles and responsibilities on the patient's arrival.
- Relatives, partners and friends were able to support patients prior to and following consultations and treatments. They were unable to accompany them during or immediately after the surgical procedure to protect other patient's privacy and dignity.
- During the unannounced inspection on 14 June 2017, we spoke with vasectomy patients before, during and after treatment. They confirmed that they were informed of all aspects of the treatment and were confident in asking any questions or contacting the centre after their discharge.

Emotional support

- The required standard operating procedures (RSOP) standard three requires that there are protocols in place to support women following a termination, including access to counselling and support services. We saw support services contact details available in the counselling room and met with the counsellor who described the availability for the service. We saw in the medical records reviewed that all patients had the opportunity to receive counselling support from a trained counsellor.
- There was a 24 hour after care support line available and advertised on the MSI Essex website which confirmed that counselling was offered to all patients before, during and after treatment for as many sessions as needed. Counselling support was offered as a face to face or by telephone by staff.
- In addition counselling services provided covered grief counselling, relationships, self-esteem and empowerment, personal development and managing emotions.
- During inspection, the counsellor was observed supporting a patient who was tearful and received additional counselling support. The counsellor confirmed time out was recognised and treatment deferred if the patient was not sure of their decision.
- All staff confirmed that any patient who was uncertain about treatment was offered support by counselling and was given an appointment for the following day to allow them time to consider their options thoroughly. Any patient under 16 years of age was offered a counselling appointment on a separate day to the procedure.
- Staff discussed several patients who were ambivalent regarding treatment and staff recalled counselling sessions were provided prior to the procedure taking place.

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- MSI Essex had facilities that included a small private room where young people and people in vulnerable circumstances could be taken; ensuring a discreet service and the room was purposefully 'non-clinical'.

Termination of pregnancy

- Staff we spoke with said that if a health condition related to mental health and capacity issues the centre would work with the relevant agencies and services to ensure that the patient experience and care pathway fulfilled the physical and mental health needs of the patient. Treatment options were presented to the patient determined by their specific needs and requirements. For example, patients in vulnerable circumstances who had experienced abuse were sign-posted to specific, appropriate and agreed external agencies for further support.
- Information leaflets were displayed and readily available for specific concerns such as patients with a learning disability.
- Patients were asked if they had any special requests for the disposal of pregnancy remains on request. A patient information leaflet was provided which detailed the options available. Patients were given the option to have pregnancy remains kept separately and this was acknowledged in the patient record system. 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 patients permission) the centre liaised with the funeral directors to facilitate as smooth a process as possible to alleviate stress.
- There was a policy and procedure in place for the disposal of fetal remains (MSI UK Management of fetal tissue policy dated May 2016) which complied with the Human Tissue Authority Code of Practice. Inspectors observed the storage and labelling processes on site which complied with MSI policy. Staff documented any non-standard disposal option in the patient's record and on a freezer log sheet indicating the reason for storage and date for either collection or disposal. Pregnancy remains were only released to the patient or the police once stringent checks had taken place. Where pregnancy remains were uncollected, staff would contact the patient, if appropriate to do so, to ask for further instruction. If not, senior staff would make a decision to dispose of the pregnancy remains after three months.
- MSI provided a service 24 hours a day, 365 days a year. There was a contact number, which was included in free call packages from landline and mobiles. Women could also access the service by email, text and by a website enquiry form which provided patients with timely access to appointments.
- Clinical commissioning groups (CCG) funded the majority of patients. Commissioners and stakeholders were involved in service planning. The growth of the "Early medical abortion units" (EMU) in the community had seen a slight reduction of medical terminations within the Essex main centre for 2016.
- < > and partners had access to written information explaining what to expect during and after the abortion (to include potential side effects, complications and any clinical implications).
  At our last inspection, MSI Essex closed every other Wednesday. Since 10 May 2017, MSI had undertaken a pilot to provide extra capacity by opening every Wednesday to enable an additional medical termination of pregnancy list. This created additional demand on staffing, and having reviewed the effectiveness of this additional service the registered manager informed us that this was discontinued on 7 June 2017 as data provided had demonstrated that there had been no significant changes to waiting times.
- Services had been planned and delivered to meet the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided. MSI Essex opening times were designed to ensure short wait times and allow access to the full range of services. From January to December 2016, no patients waited longer than 10 days from first appointment to termination of pregnancy unless they requested a delay.
- The medical staff reviewed the notes of patients of later gestations at the beginning of the day. This meant that any additional information required could be requested and that the appropriate cervical preparation was prescribed. The order of cases on the treatment list were adjusted to allow cervical preparation to be given.
- There was a process in place to manage booked appointments. The number of patients booked each day was organised and determined on the level of complexity and patient gestation. On the day of the inspection we saw approximately 28 units listed (a unit is a group of similar patient cases). Staff stated that lists

were overbooked to allow for 'did not attend' (DNA) and 'did not present' (DNP) to avoid wasted spaces. However, on occasion all patients arrived and proceeded which meant late finishes. From December 2016 to May 2017, the average (DNP) rate was 22% and the (DNA) rate was 8%.

- Marie Stopes International had a dedicated team who monitored and managed capacity on a daily basis via the wait times monitoring systems. The business support team (located in the main MSI support office) provided daily reports on wait times and worked with the centre team to ensure patients were offered a range of treatments within three working days. Staff managed patient flow through the centre effectively and in 2016, the average patient time spent in the centre was 106 minutes (against a target of 110 minutes), currently there is no agreed target and the waiting times remain consistent.
- The vasectomy service occurred on a separate day to the termination of pregnancy services; this ensured that males and females did not meet during their treatments.

Access to information

- Staff stated there was easy access to interpreters when English was not the patient's first language. This service was advertised on the website in addition to the availability of over 90 languages via the google translate service. Although we saw no available patient leaflets in another language on site or in the storeroom, staff stated they could be printed as required. Notices displayed in the reception areas informed patients this service was available.
- We heard staff confirm with a patient that if a family member or friend telephoned into the MSI service on behalf of the patient, a personal identification number and a password given to the patient were checked at every call to ensure that information was only given to the correct individuals as agreed.
- The service had direct access to electronic information held by community services, including general practitioners. This meant that MSI Essex staff could access up-to-date information about patients, for example, details of their current medicine.

Learning from concerns and complaints

- There was a complaints procedure in place and a MSI UK Handling Comments, Concerns Complaints and Compliments Policy which staff could easily assess. Information for patients on how to make a complaint was available with complaints advice given in the back of patient literature and displayed in the patient information folder in waiting areas.
- This service reported an increased level of 12 complaints between January 2016 and December 2016, compared to 11 complaints received between January 2015 and December 2015. At the time of our recent inspection, they had one formal complaint recorded between January 2017 and June 2017. The previous complaints received were themed as patient treatment, patient care, staff attitude and retained products of conception
- The local team described the process for complaint handling. Senior staff stated they investigated any complaint received initially, then passed it to the central team who completed the process and fed back the outcome to the local team. Timeframe for response was 25 days. The registered manager had received support following the last complaint when a patient had raised a complaint about the screening process. The issue identified was around screening where the patient was not told about the exclusion criteria and was referred back to the NHS.
- The registered manager confirmed that they were unable to complete an in-depth analysis for local complaints on the new incident and complaints reporting system. They had arranged for one to one training to improve this knowledge. A report shown on site confirmed that there was one formal complaint in the previous month.
- However, an informal complaints log with 17 informal complaints was reviewed for January to June 2017 with eight informal complaints that had been raised following cancelled treatments, four complaints raised about staff attitude, three for waiting times and two for information given. These were not recorded centrally or on the incident reporting system and therefore we were not assured that there was an effective process for reviewing and identifying trends from complaints to inform possible changes in practice to improve services.

- The registered manager stated that the majority of additional unlogged local informal complaints related to waiting times and they felt those could be improved with better communication. At the time of inspection the registered manager stated they were working with colleagues in the one call centre to improve communication given to patients when they booked for treatment to help inform patient expectations around the expected waiting times.
- The registered manager's contact details were available in reception, along with CQC information leaflets on 'how to make a complaint' if patients were not satisfied with the centres response.
- Patient stories were presented at the provider integrated governance meetings. One patient concern reviewed was about not being able to contact the centre by telephone as all lines were constantly occupied. The patient emailed the centre asking for alternative options and raised the concern that they were unable to make an appointment, as they were unable to make contact, however the response received did not rectify the issue as the same number was provided.
- Issues raised from the patient feedback questionnaires would prompt a "red alert" for individual locations. Senior staff reported that positive and negative feedback was communicated at team meetings and the feedback reports received quarterly were shared with the team. However, team meetings were infrequent and this was not evident in the three-team meeting minutes reviewed between October 2016 and May 2017.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- The service was led by the registered manager who was supported by a clinical team lead and an operational team lead.
- The registered manager reported directly to the regional surgical service delivery manager. The registered manager confirmed that they were able to pick up the phone at any point to senior management, including the interim UK managing director. They stated they received support via weekly catch-ups and had the opportunity to discuss any successes, changes, concerns, centre issues and staffing sickness.
- Senior staff confirmed there had been multiple staff changes at the corporate provider level. However, they stated they had confidence in the new interim UK managing director who had a clinical background and held regular two weekly communication meetings with them.
- The Department of Health certificate was displayed in a prominent place in the entrance to the centre (in accordance with good practice by the Department of Health).
- Team meeting minutes were requested and reviewed. Staff had highlighted concerns with patient waiting times but we saw no evidence of action plans to support any changes in practice to prevent reoccurrence. The team meeting minutes provided were for October 2016 and May 2017. We were not assured that regular team meetings were in place or that there was an effective process for feedback of patient outcomes, incidents or complaints.
- The structure for management of EMU within the southern region was being reviewed at provider level at the time of the inspection. There was no ongoing monitoring or oversight of the early medical abortion units (EMU) by the registered manager at MSI Essex. The registered manager at MSI Essex stated that the day-to-day management and delivery of services at the EMU was undertaken by a district lead. This arrangement had been in place since November 2016, however, the appropriate registration amendments had not been applied at the time of inspection to ensure compliance with registration regulations. We raised this with the registered manager and regional manager on site at the time of inspection, the provider responded and stated actions would be taken to address this.
- There was an effective process in place by the nominated district lead to ensure sufficient staffing and quality monitoring, with regard to the EMUs, was in place. There was a district incident dashboard in place for monitoring of incidents, themes and trends Regular

monthly team meetings were established, alongside quarterly district team quality assurance meetings with process to feed into the bimonthly regional managers meeting and CGC/IGC as exception reporting.

- Early medical abortion unit (EMU) staff attended a monthly team meeting that was held on the first Friday of each month and staff spoken with confirmed they felt well supported. Regional meeting minutes included discussion about plans to register EMU under one site. The three EMU staff spoke in a positive manner about the district team leads who provided solid leadership support.
- Staff we spoke with at MSI Essex viewed the culture as being top down and corporately led. Although staff confirmed the current management team were visible and approachable. However, they felt supported by the current local management team. Senior staff told us of how they worked clinically when needed.

Vision and strategy for services

- The vision and strategy of MSI Essex was to deliver high quality care, promote good outcomes for patients and encompass key elements such as compassion, dignity and equality.
- Overall staff confirmed the vision and strategy in place for MSI. They described the desire by staff to provide high quality care and all staff were passionate about the care they gave the patients.

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

- The governance, quality and risk oversight of services at a local level at MSI Essex were not effective. Not all concerns raised at the previous inspection in April 2016 had been addressed
- There was a lack of management and oversight of staff compliance with mandatory training. With no information available locally to confirm medical staff had completed mandatory training or appraisal.
- The registered manager was unclear as to the local, regional and corporate governance structures. They stated they prepared a report for the acting clinical governance and quality lead, which they believed went to the clinical governance committee however, as they did not attend CGC meetings, they could not be certain.
- There was a limited awareness by the registered manager of their responsibilities to maintain oversight of EMUs under the current registration. We raised this as a concern during the inspection. The acting clinical governance and quality lead confirmed that this would be raised at the next south regional management meeting on 9 June 2017, however on review of the minutes from this meeting there was no detail of any discussion regarding this.
- Monthly regional meetings had been introduced to improve communication between the corporate team and MSI locations. We reviewed minutes from three regional team meetings (March, April and June 2017). It was evident from the minutes that these meetings were evolving. Meeting minutes contained (but not exclusive) a discussion around incident reporting, training, complaints, wait times and recruitment.
- Evidence of incident trend analysis, review and identification of actions or changes to practice to improve care was not in place. There was no evidence of an effective process to share learning. Senior staff stated that duty of candour, complaints and root cause analysis (RCA) investigations were completed at provider level.
- Whilst audits had started there was limited evidence that action plans to address areas of non-compliance and improve practice had been implemented. There were no formalised process or evidence of patient outcome reviews and recommendations to improve practice.
- The registered manager stated the top three risks were staffing, complaints and waiting times but this did not correlate with the local register provided which included staff safety, environmental risks and treatment complications. The risk register was part of the provider level electronic incident reporting system and could be filtered to specific locations. 13 risks were identified for MSI Essex, with details of consequence of risks and controls in place. However, none of the 13 risks had owners identified or dates for actions to be taken and completed by.
- The lack of safety risk assessments for specific lone workers at the early medical abortion clinics was raised at the last inspection. Action had been taken to address this and EMU staff had been issued with Global

Positioning System (GPS) alarms, which alert central staff when they are in a vulnerable situation with an automatic call to the police when necessary. There had been an increase in reported incidents relating to violence and aggression with one incident per month reported between February and May 2017.

- The Abortion Act 1967 clearly outlines that a termination can take place only if two registered medical practitioners are of the opinion, formed in good faith, that at least one and the same grounds for a termination is met, within the terms of the Act. The following notifications are a legal requirement under the Abortion Act: HSA1: two doctors are required to sign the HSA1 form, which is the certificate of opinion before a termination is performed. HSA2: to be completed by the doctor within 24 hours of an emergency termination and HSA4: notification to the Department of Health, either manually or electronically, within 14 days of the termination taking place.
- The Required Standard Operating procedure (RSOP) standard one requires the provider to ensure that the completion of legal paperwork (HSA1 and HSA4) meets the requirements of the Abortion Act 1967. Concerns were raised at the last inspection regarding bulk signing of HSA1 forms. Surgeons did not raise this as a concern during this inspection and this practice was no longer observed.
- During the inspection, both the surgeon and anaesthetist reviewed the reason for termination prior to signing the HSA1 forms (approx. 8-10). Further discussion and review of medical history was also observed to take place throughout the operating list. The reason for termination was written on the back of the form. Both clinicians confirmed verbally that they would not sign if they had any concerns or further questions. Seven procedures were observed and all HSA1 forms were completed and signed by two doctors prior to surgery.
- The surgeon was observed to review the individual patients' medical history on the electronic computer system. They confirmed that limited information may be available which meant a full medical history review of all patients before the treatment list was not possible. For example, if the patient was yet to arrive or be admitted by nursing staff, baseline recordings will not be entered on the system which led to an ongoing check throughout the operating list.
- Medical record audits were completed biannually and we saw the last overall compliance score of 98.2% for 31 January 2017. This audit included an assurance check that the HSA1 forms were clearly completed with two legible signatures. On reviewing the available HSA1 forms completed on the day of inspection there were two signatures on each form but the signatures were illegible but each had the doctors individuals stamp. The registered manager informed us that she had a book of all signatures to confirm staff involvement.
- The registered manager described the process in place at MSI Essex to ensure that the submission of HSA 4 forms to the Department of Health had been undertaken within the 14-day legal timeframe. A daily tracking report for the HSA4 forms was published centrally and escalated to the appropriate line manager to address the notification being completed. This was also part of the medical records audit check and was reviewed at the last audit as 100% compliant for 31 January 2017.

Public and staff engagement

- Staff knew about the Whistleblowing policy and how to escalate if they had any concerns. Staff stated senior members of the corporate team had undertaken site visits across locations following the previous inspections in 2016. They confirmed that they had attended the provider roadshows which had been undertaken in September and October 2016 to roll out new policies and provided training to staff.
- We saw three examples of the Interims Chief Nurse's newsletter, which shared good practice and informed staff of recent changes across the service. The interim chief nurse had asked for staff opinion and feedback following recent changes and staff were aware of the chief nurse email as a route to provide feedback.

Innovation, improvement and sustainability

- MSI Essex is the pilot site for the safeguarding mobile phone application that gave instant advice to frequently asked safeguarding questions.

Termination of pregnancy

- The introduction of Global Positioning System (GPS) alarm to EMU staff meant that action had been taken to support staff that may be in vulnerable lone working environments.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure an effective process for incident reporting and trend analysis. Ensuring recording is consistent to enable analysis of data to highlight areas of improvement.
- Ensure a consistent approach to action planning and ensuring lessons learnt from incidents are shared with all relevant staff locally and reviewed regionally to enable wider learning.
- Ensure that equipment maintenance and service records are fully itemised, organised and maintained.
- Ensure an effective process for complaints handling, sharing information and taking actions to identify areas for development to improve services.
- Ensure an effective appraisal process is embedded, involving full participation and discussion to enable staff development.
- Ensure there is an effective process, and oversight at a local level, for monitoring staff competency and compliance with mandatory training.
- Ensure that all staff undertaking ultrasound scanning, including those under direct supervision, are trained and competent to do so.
- Ensure following audits there is a process in place for action plan and review to improve services.
- Ensure improvements in corporate and location level communication and engagement to ensure an effective process for governance, quality and risk oversight of services at local level.

Action the provider SHOULD take to improve

- Monitor and ensure staff compliance to bare below the elbows guidance in clinical areas.
- Ensure that there is system locally for confirmation that medical staff had completed mandatory training and appraisal.
- The provider should ensure a review of analgesia provided to patients during vasectomy procedure.

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
Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met • The governance, quality and risk oversight of services at local level was not effective. The registered manager was unclear as to the local, regional and corporate governance structures. • Not all concerns raised at the previous inspection in April 2016 had been addressed. There was no effective process in place for governance, oversight of risk and quality measurement at location level. • There was no effective monitoring to ensure staff compliance with mandatory training. • There was no information available locally to confirm that medical staff had completed mandatory training. • Staff undertaking scanning in the treatment room had not undertaken any formalised training • There were no formalised process or evidence of patient outcome reviews and recommendations to improve practice. • There was a lack of information sharing following incidents and action plans following audit. • There was inconsistent completion of the debrief section of the World Health Organisation (WHO) five steps to safer surgery checklist. Debrief enables the opportunity for review and learning. Revised audit schedule included monthly WHO audit but this was yet to be embedded, with only two audits undertaken at the time of inspection. Regulation 17 (1) (2) (a) (b) Regulations 2014 Good governance