Marie Stopes International Central London Centre

Quality Report

108 Whitfield Street
London W1T 5BE
0207 3885771
Tel:0207 388 5771
Website: www.mariestopes.org.uk

Date of inspection visit: 4, 5 and 14 July 2017
Date of publication: 12/10/2017

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Marie Stopes International (MSI) Central London is part of the provider group Marie Stopes International, a not for profit organisation that provides termination of pregnancy service.

MSI Central London was registered with the Care Quality Commission (CQC) in October 2010.

Regulated services are provided at Whitfield Street, Central London and at three early medical units (EMUs), known as satellite clinics: Watford, Hemel Hempstead, and The Whittington Hospital in London.

Services include: early medical abortion (EMA) up to 9 weeks and 3 days, surgical termination of pregnancy (ToP) without anaesthesia or with sedation anaesthesia up to 11 weeks and 6 days, consultations, ultrasound scans, counselling and support, family planning and advice on contraceptive options, and contraception. In addition, vasectomy (male sterilisation) performed under local anaesthetic, well woman screening, well man screening, and sexually transmitted infection testing and screening are also provided.

The organisation provides services to adults and young people above the age of 15.

We had previously inspected MSI Central London in April 2016 when we highlighted numerous concerns. This inspection was carried out to follow up on any previously raised concerns and to assess any improvements made by the provider.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key questions. However, we have not provided a rating for this service.

We regulate termination of pregnancy services, but CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy (ToP) services. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Since our last inspection in 2016, we have noted the following improvements at MSI Central London: a new system for incident reporting, improvements to the environment, replacing carpets with washable flooring, the implementation and monitoring of surgical safety checklists, the management of early warning scores in deteriorating patients, improved clinical governance and monitoring of patient outcomes, risks and complaints, and improved communication with locality managers and the MSI executive management team.

We told the provider MUST take following actions to meet the regulations:

- The provider must ensure fire safety checks and evacuations are carried out.
- The provider must ensure there are processes in place to ensure that equipment is serviced and maintained in line with manufacturer's guidance for both clinical and non-clinical equipment.

We also said the provider SHOULD:

- Carry out and act upon investigation and analysis of staff satisfaction.
- Ensure patient feedback is consistently obtained and used to improve the service.
- Enable all staff to complete training that is necessary for them to fulfil their role(s), including mandatory training and relevant skills training.
- Ensure there are arrangements to monitor and reconcile the stock of medicines.
- Ensure patients' privacy is respected at all times including when they are in the waiting area and recovery lounge.
- Ensure all staff, including medical staff, are appraised regularly and suitable records of revalidation and appraisal are kept.

Professor Edward Baker

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Contents

Marie Stopes International Central London

Services we looked at

Termination of pregnancy

Summary of this inspection

Background to Marie Stopes International Central London Centre

Termination of Pregnancy (ToP) refers to the termination of pregnancy by surgical or medical methods. Marie Stopes International (MSI) Central London is part of the provider group MSI UK and MSI International, a not for profit organisation that was founded in 1976 to provide a safe, legal abortion service following the Abortion Act 1967.

MSI Central London was registered with the Care Quality Commission (CQC) in October 2010. Regulated services are provided at Whitfield Street, Central London and at three early medical units (EMUs), known as satellite clinics: Watford, Hemel Hempstead, and The Whittington Hospital in London. Services include: early medical abortion (EMA) up to 9 weeks and 3 days, surgical termination of pregnancy (ToP) without anaesthesia or with sedation anaesthesia up to 11 weeks and 6 days, consultations, ultrasound scans, counselling and support, family planning and advice on contraceptive options, and contraception. In addition, vasectomy (male sterilisation) performed under local anaesthetic, well woman screening, well man screening, and sexually transmitted infection testing and screening are also provided.

All four 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 predominantly to NHS-funded patients referred by local clinical commissioning groups, as well as to private patients for health screening.

From May 2016 to April 2017, MSI Central London carried out 1811 surgical termination of pregnancy procedures and 1404 early medical abortions. There were 269 vasectomy procedures performed within the same period.

We carried out an announced comprehensive inspection on 4 and 5 July 2017 at MSI Whitfield Street and an unannounced inspection at MSI North London Centre Whittington on 14 July 2017. We have not provided ratings for this service. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy services; amendment to the current Care Quality Commission (Reviews and Performance Assessment) Regulations 2014 is required to enable us to do this.

We observed staff interaction with paients and made checks on the environment and equipment. Before and after our visit we reviewed performance information submitted by the provider. We spoke with staff including: medical staff, registered nurses, health care support workers, administrative staff, and managers. We also spoke with six patients. We reviewed 50 ‘tell us about your care’ comment cards which patients had completed prior to our inspection. During our on-site visits, we reviewed 23 sets of patients' records, including 13 patients who used the termination of pregnancy services and ten who underwent vasectomy.

There were no special reviews or ongoing investigations of the service by the CQC at any time during the 12 months before this inspection. The service was inspected in 2014 and 2016. The most recent inspection took place in April 2016 where we identified a number of areas for improvement in the domains of safe, effective, caring and well-led. We took enforcement action for breaches of the following regulations: Regulation 12 Care and treatment must be provided in a safe way for service users; Regulation 17 Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part.

These regulatory breaches were also found at an inspection of the governance systems at the MSI corporate (provider) level in July and August 2016.

Summary of this inspection

Our inspection team

Our inspection team was led by David Harris, Inspection Manager, and included two CQC inspectors, a specialist adviser with expertise in nursing and midwifery, and a specialist adviser who was a consultant obstetrician and gynaecologist with expertise in fetal medicine.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We have not published a rating for this key question. CQC does not currently have a legal duty to award ratings for those services that provide solely or mainly termination of pregnancy (ToP) services. 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:

- The introduction of a revised incident policy and an electronic patient safety system had increased staff awareness and local reporting and monitoring of safety incidents and risks. There was evidence of shared learning in relation to patients' safety.
- Serious incidents were investigated by a trained panel at MSI UK in a timely manner.
- Staff correctly described their responsibilities regarding the duty of candour. However, there was no evidence of any training provided in this area, and staff could not recall any occasions when this duty had to be applied.
- Safeguarding children and young people and safeguarding adults at risk policies and training were available at appropriate levels for all staff. It included information on female genital mutilation, child sexual exploitation and the Prevent.
- Mandatory training was provided in a range of topics, and completion was monitored by managers. Staff were sent reminders when their attendance was due. Compliance rates had improved since 2016.
- All patients underwent an initial risk assessment to determine their suitability for treatment at the centre(s). If a patient was unsuitable for treatment at MSI Central London, for example due to an existing health condition, they would be referred to another centre or provider.
- There were systems and processes to ensure that standards of cleanliness and hygiene were maintained.
- World Health Organisation (WHO) Five Steps to Safer Surgery checklists were completed for all patients undergoing surgical procedures (ToP and vasectomy).

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

- There was no evidence of fire safety assessments.
- There were limited systems for medicines stock reconciliation.

Summary of this inspection

- Medical equipment was calibrated and safety tested, however there was no evidence of safety testing of office equipment such as computer docking stations, monitors and telephones.

Are services effective?

We have not published a rating for this key question.

We found that the following areas of good practice:

- There were locally agreed policies and standards that referred to evidence based practice and against which performance were audited.
- Policies were kept up to date, and we saw that relevant staff were involved in clinical policy development and review.
- We saw that the intended outcomes for patients were being achieved and were reported upon.
- Learning and development was provided at an appropriate level to enable staff to develop and maintain their skills and competencies in areas such as consent, scanning, Mental Capacity Act and counselling.
- Pain was assessed and treated in accordance with national guidelines.

Are services caring?

We have not published a rating for this key question.

We found the following areas of good practice:

- There was consistently positive feedback from patients about the caring and non-judgmental attitude of staff in written feedback cards and from the patients we spoke with.
- We observed staff were compassionate and gentle in their approach and were seen by patients to be non-judgmental.

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

- Privacy was still limited in the recovery area due to the close proximity of recliner chairs and absence of privacy screens.

Are services responsive?

We have not published a rating for this key question.

We found the following areas of good practice:

- All patients received their treatment from decision to proceed to termination of pregnancy within the recommended Department of Health time frames.

Summary of this inspection

- There was flexibility to re-arrange appointments at very short notice to meet patients' needs. For example, in the event of cancelled appointments.
- Consultations were undertaken either face-to-face or by telephone to meet people's needs.
- There was a clearly defined referral process for patients who required specialist services.
- Complaints were managed in accordance with MSI policies and in the required time frames. Patients and staff understood the processes they should follow.
- Patients were asked if they had any special requests for the disposal of pregnancy remains. We saw these were acted upon in accordance with the policies and procedures for the sensitive disposal of pregnancy remains, which complied with the Human Tissue Authority Code of Practice.

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

- The Whitfield Street location was inaccessible to wheelchair users or people with limited mobility.

Are services well-led?

We have not published a rating for this key question.

We found the following areas of good practice:

- There were systems to monitor and act upon compliance with standard operating procedures, clinical and professional guidance, and professional opinion such as that provided by relevant Royal Colleges.
- Staff spoke positively about the changes to the local, regional and national procedures introduced by the management team since our 2016 inspection. However, many of the changes were in the early stages of development and needed time to be embedded in practice.
- There was evidence of improved governance and communication with managers across the service, for example through the revision and monitoring of new policies and procedures, structured team meetings, and staff newsletters.
- The introduction of an electronic patients' safety system in February 2017 that was accessible by all staff had enabled improved ownership and accountability for reporting and reviewing incidents, risks, and complaints at the centre.

Summary of this inspection

- The appointment of a regional clinical quality and governance lead had enabled improved systems for monitoring performance, and more formal arrangements for managing and communicating risk and governance at local and regional levels within MSI UK.

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

- There had been continued high turnover of staff at senior and executive management level which had led to instability at the centre. There was no evidence of any formal evaluation or analysis of staff satisfaction; we were told this was a work in progress as the closing date for the survey was a week after our inspection and would be reported on a quarterly basis.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents and safety monitoring

- At our inspection in April 2016, we found inconsistent reporting of safety concerns, and a combination of paper and electronic reporting systems which had caused confusion among some staff. At the time, the electronic system was only accessible to two senior managers. This meant most staff we spoke with had not felt engaged with the process or systems in place. We required that improvements were made to local safety incident reporting and sharing of learning from incidents.
- A revised 'Incident reporting' policy was issued to all Marie Stopes International UK centres (MSI UK) in January 2017, followed by the introduction of a new electronic patient safety reporting system for incidents in February 2017. We saw that training had been completed by staff and that all staff we spoke with were confident in its use.
- All staff we spoke with were positive about the training and the improvements the new reporting system had made and perceived it had led to increased reporting. Staff described how learning from incidents was shared formally through staff meetings, emails and face-to-face discussion with colleagues. Records we looked at including minutes from staff meetings confirmed this.
- The MSI incident reporting policy required all incidents to have been reviewed and signed off by managers within seven working days and closed off within ten days. Senior managers told us that incidents and lessons learnt were discussed at the regional monthly quality and governance meetings. Minutes we looked at confirmed this.
- There were 24 reported incidents from May 2016 to April 2017. Of those, 15 were classified as no harm, six as low harm and two as moderate harm.
- There were a further 101 clinical incidents reported from February 2017 to July 2017. All were classified as no harm or low harm. Staff and managers spoke positively about the rise in reporting. They attributed the increase to improved confidence with the new reporting system and training in its use.
- In 2016 MSI UK had established a complaints, litigation, incident and patient (CLIP) group to review and share learning from all incidents across the organisation, including clinical incidents. CLIP met monthly. The main themes recorded in minutes of the CLIP meetings were misplaced notes, medicines errors, and failed medical abortion – which was a known risk. These corresponded with data on the electronic incident reporting system.
- We saw that all incidents were reviewed by managers and that corrective action was taken where applicable. Seven incidents remained under review at the time of our inspection and were dealt with in a timely manner.
- There were no reported never events between May 2016 and July 2017. Never Events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- At our inspection in April 2016, we found that investigations of incidents and analysis of their root causes took place so that outcomes and action plans could be developed to reduce the risk of a similar incident reoccurring. However, at that time managers we spoke with who conducted root cause analyses had not been provided with any training to undertake the role.
- The processes for undertaking root cause analysis (RCA) had been revised in July 2016 to improve consistency across MSI UK. A two day training course was completed

by senior managers in July 2016 and July 2017. We saw that in the event of RCA only individuals who had completed the training were part of a centrally convened RCA panel.

- Since our inspection in 2016 a local integrated governance committee (IGC) had been established and met monthly. We saw in minutes of the last three IGC meetings that incidents were discussed as a standing item.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We were informed there were no duty of candour notifications reported for the last 12 months.
- The MSI UK duty of candour policy was introduced in April 2016 to provide staff with a process to follow when they were dealing with serious incidents. Duty of candour training was not included on the training matrix submitted and we found no evidence at the time of our inspection that training had been provided for nursing staff or medical staff. However, all staff we spoke with were aware of their responsibilities under the duty of candour.

Mandatory training

- MSI UK required that all staff completed mandatory training in a range of topics and enabled protected time for this to be completed either on line or face to face. Topics included safeguarding vulnerable adults (adults at risk) and children, basic life support, intermediate life support, first aid, information governance, display screen equipment fire safety essentials, fire warden training, fire emergency evacuation and drill essentials, first aid, COSHH (Control of Substance Hazardous to Health), lone working, conflict resolution, equality and diversity, informed consent, infection prevention and control, health and safety essentials, and moving and handling. There were reminder systems for staff to prompt them when they were overdue for their mandatory training.
- A 'live' electronic training matrix detailed records of 15 contracted or sessional staff, including nurses, managers, health care assistants and administrative staff at Central London. This was maintained by the operations manager with a RAG (Red Amber Green) rating system to indicate staff compliance. Dates in green indicated when training had taken place within the last twelve months, amber dates indicated the next training date was due within 8 weeks and should be rebooked, and red indicated where the training renewal date had expired. Gaps in training were sometimes accounted for by new staff working through the training as part of their induction.
- The training matrix we looked at was up to date and showed there were variations in compliance. All three of the administrative staff had completed basic life support training. Four out of nine of the nursing staff were up to date with intermediate life support training. Three nurses, with responsibility for caring for patients after surgery, had completed anaesthetic and recovery training.
- We were informed by managers that only medical staff attended advanced life support training. There was no information available locally to confirm that medical staff had completed mandatory training. However, doctors we spoke with confirmed all anaesthetists treating patients had completed advanced life support training.
- Doctors we spoke with told us that they were required to provide evidence of checks on their competency and training as part of their revalidation process and that their records were held at corporate level with the medical director. We were unable to see these records as part of our inspection. 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 manager at MSI Central London was unaware and we were unable to see these records as part of our inspection.

Safeguarding

- No safeguarding concerns were raised at the time of our inspection, in the six months prior to our inspection or from May 2016 to April 2017.
- There were up to date arrangements to protect patients from avoidable harm. MSI UK had reviewed and issued its safeguarding policies in December 2016. Staff we spoke with knew where to locate them and correctly described the principles and processes they would follow.
- Training in safeguarding vulnerable adults (adults at risk) and children was provided at level 2, level 3 and

level 4 in accordance with the intercollegiate document Safeguarding children and young people, 2014. This included a 30-minute electronic learning module for all staff.

- Records we looked at showed that all staff had completed safeguarding training at level two in the last three years as required. 50% of staff were trained to level three, and one member of staff who was the named safeguarding lead to level four.
- The topics of female genital mutilation, child sexual exploitation and 'prevent' training were included. The aim of 'prevent' training is to provide staff with the knowledge to enable them to challenge violent extremist ideologies and behaviour. This training was completed by nine out of 15 staff between May 2016 and July 2017.
- Training on child sexual exploitation was completed by 11 out of 15 staff, and female genital mutilation training was completed by 10 out of 15 staff.
- We saw posters throughout the centre displayed information about safeguarding adults at risk, and safeguarding children and young people, which could be viewed by staff and members of the public. These contained contact details of the safeguarding teams, where to find them and the services they provided.
- NICE Guidance PH 50, 2014 and Quality Statement 116 Domestic Violence and Abuse, 2016, is provided for everyone working in health and social care whose work brings them into contact with people who experience or perpetrate domestic violence and abuse. The guidance states that providers should ensure that health and social care practitioners provide facilities which enable people to speak about their experiences in a private discussion.
- We saw patients were routinely seen on their own in a private consulting room as part of the consultation or assessment process. We also saw evidence in all of the patient records we looked at that this happened.
- There were no recent examples for us to verify if correct safeguarding procedures were used. However, staff we spoke with told us that all safeguarding concerns would be raised with the centre safeguarding lead, and that where required, referrals to social services or the police were managed in accordance with the MSI policy and recorded on the electronic incident reporting system. The provider's safeguarding policy clearly described the procedure staff described to us.
- No children aged below 15 were treated at Central London or any of its associated EMUs in May 2016 to April 2017. Children under the age of 13 would be referred to the safeguarding board and the NHS.
- The operations manager confirmed they had two hours allocated each week to follow up and review any safeguarding concerns where necessary. This included followed up checks on patients and recording their discharge summaries.

Cleanliness, infection control and hygiene

- There were systems and processes to ensure that standards of cleanliness and hygiene were maintained. These included up to date policies, cleaning schedules and checklists, and infection prevention and control training.
- During our inspection, we observed the majority of medical devices used within the treatment room were single use. Any reusable instruments were sent off site for decontamination and sterilisation. An established process to enable tracking and traceability of instruments trays sent for processing was in place.
- At our inspection in April 2016, there were carpets throughout the building including in clinical areas. This meant there was a possibility of cross contamination. We asked that corrective action was taken. At our July 2017 inspection we saw that the carpets had been removed and replaced with hard flooring.
- At our April 2016 inspection, we saw fabric chairs in the waiting area and the recovery area were not easily cleanable, and there were no systems to monitor the cleaning of the chairs. At our July 2017 inspection, we saw the fabric chairs in the waiting area had been replaced with vinyl seating. All the seating we saw was visibly clean with no dust, dirt, debris, stains, adhesive tape or spillages.
- From 6 to 8 March 2017, a 55-point general infection prevention and control (IPC) audit, using a revised audit tool, was undertaken across all Marie Stopes UK clinical locations. This included IPC training, facilities and equipment, adherence to uniform policy and use of personal protective equipment (PPE), waste and sharps management, cleaning and sterile goods. In March 2017, MSI Central London scored 92% and in April 2017 98%.

- Monthly hand hygiene audits were undertaken by staff at MSI Central London observing 20 opportunities for hand washing. This included adherence to the bare below the elbow policy. In May and June 2017, a score of 100% was achieved.
- Auditors reported that the audit was more straightforward, clear, easy to use, and relevant than previous IPC audits. It was recognised there was still scope to improve the instructions for its completion. It also highlighted that there was a need for a bespoke audit programme in the EMUs. At the time of our inspection this had not been introduced.
- Cleaning schedules and checklists had been introduced following our previous inspection. However, we saw that in May 2017 the checklist for the staff toilet on the first floor was not completed on every day it should be. Records were only maintained for 2 – 19 May 2017.
- NICE QS61 statement 3: recommends that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. During our inspection, we observed staff adherence to hand washing at all times. Hand hygiene audits were carried out monthly observing 20 opportunities for handwashing. The ratings for the audits had been consistently within the desired range. If gaps in the handwashing process had been identified, they were fed back to staff through staff meetings and emails.
- We saw adequate supplies of personal protective equipment (PPE) such as disposable gloves, aprons and masks. All staff was observed to adhere to the policy and wear the appropriate protective clothing depending on the task they were undertaking.
- Laboratory spill kits were available across the service. Staff we spoke with knew how to access and use them.
- There were clear processes for managing clinical waste. It included colour-coded system for disposal of waste and clear segregation of clean and dirty equipment.

Environment and equipment

- We asked for evidence that fire safety checks were carried out. Managers told us the MSI policy required that these were conducted weekly and that evacuations should be practised a minimum of two times a year. There was no evidence that the weekly checks or evacuation routines had been conducted. We brought this to the attention of the manager who told us the service was in the process of reviewing fire safety arrangements, and an external organisation had been appointed to undertake a full fire safety assessment.
- Recommended Standards of Practice (RSOP) 22 Maintenance of equipment requires that providers of ToP services should minimise risks and emergencies through a programme of regular checking and servicing of equipment. We looked at records and saw that all clinical equipment owned by the service had been serviced and safety checked in line with the provider's policy. However, during our inspection in 2016 we found that electrical equipment such as computer screens, docking stations and telephones had not been safety tested. There was still no evidence of such safety checks during our inspection in 2017.
- There was one health screening room, two waiting areas, two consulting rooms, one surgical procedure room a recovery area and administrative offices at MSI Central London. There was also a medicine storage area and a records storage area. There was one consulting room at The Whittington and a shared waiting and reception area which was part of the Day Treatment Area.
- 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. Equipment was in tamper proof, sealed containers in line with the MSI UK Resuscitation policy, dated December 2016. Sealed bags and trolleys were checked daily for integrity and a further check monthly. This was in line with current guidance from the UK Resuscitation Council.
- We saw that resuscitation equipment was located in the recovery area adjacent to the procedure room at Whitfield Street and in the consulting room at MSI North London, The Whittington. Staff told us it was provided at all of the satellite locations. We saw this was checked and maintained by the clinical staff at both locations we visited, and that it was in date, suitably stored, and ready for use.
- All staff we spoke with described how to use the emergency equipment provided and had completed regular mandatory life support training at an appropriate level to their job role so that they were able to use the equipment if required.
- Oxygen cylinders were available in treatment rooms and on each resuscitation trolley. The oxygen cylinders we

saw were generally correctly stored and in-date. However, we found one oxygen cylinder lying on top of a counter in the dirty utility area at Whitfield Street that was not in date or correctly stored. We brought this to the immediate attention of the manager who told us that it was waiting for disposal and arranged its removal.

- Managers showed us systems to receive and act on safety alerts for medical equipment and medicines. They provided recent examples of where these had been communicated to all staff. All staff we spoke with correctly described the process.

Medicines

- Staff involved in the supply and administration of medicines were required to comply with the MSI UK medicines management policy which set out arrangements and staff responsibilities in line with national standards and guidance.
- Medicines were prescribed by doctors who worked remotely using an electronic system. Records we looked at showed that all medicines were supplied and administered against the doctors' prescriptions, and were administered by nurses who signed for administration of each medicine electronically. This included medicines used to terminate pregnancy, pain relief, and preventive antibiotics to reduce the risk of post –procedure infection. MSI UK had a centrally managed contract for the purchasing of medicines from an approved pharmacy supplier.
- Orders for medicines were placed electronically and checked by an authorised person. Supplies were delivered directly to the centre(s) by an approved courier service. Managers told us that one nurse had been allocated to manage the medicines supplies and orders.
- There were systems to check for expired medicines and to rotate medicines with a shorter expiry date. We looked at a random sample of medicines at both locations we visited. All the medicines we saw were within the expiry date.
- Medicines administration records were maintained electronically in all patient records we looked at; these were completed in accordance with local policies. We saw that the allergy status of each patient was clearly documented and, where relevant, was acted upon. This correlated with any documented allergies in the patient's medical and nursing records.
- Staff had carried out financial audits in relation to supply and administration and of medicines; however, there was no evidence of local reconciliation of medicines to ensure monitoring of compliance with medicines management policies or guidelines was carried out. Staff confirmed the audits had not taken place.
- There were appropriate security procedures to ensure only approved staff could access medicines, for example the use of digital key pad systems. Medicines were safely stored in accordance with the manufacturer's instructions and in their original packaging.
- The minimum and maximum temperatures of fridges and other medicines storage areas were monitored daily to ensure that medicines that had temperature requirements were stored correctly. We reviewed records of temperature recordings and found them to be up to date and within range.
- NICE QS 61 recommends that people are prescribed antibiotics in accordance with local antibiotic formularies. Records we looked at confirmed that there were local protocols and that prescribers were following them correctly. All patients undergoing ToP were treated with preventive antibiotics to reduce the risk of infection.

Records

- There was a combination of paper and electronic patient records. Arrangements for the management of patient records were set out in MSI UK policies. Compliance with the policies was audited on a monthly basis. From May 2016 to April 2017, compliance rates were consistently above 95 %, with no reported areas of concern.
- The policies stated that all records which included patient-identifiable information must be stored securely and kept strictly confidential within the establishment. We saw this to be the case.
- All paper held records that were transferred to other MSI locations would be taken by courier to ensure their safe and secure delivery.
- We reviewed 23 sets of patient records, including 10 of patients who had undergone vasectomy. All of the records we looked at were filed in individual patient folders and maintained in accordance with national standards from the relevant professional regulators, including the general medical council and nursing and midwifery council.

- An electronic system was used for documenting patient care during the surgery. This included staff members, procedure performed, swab and instrument counts and implant details. Staff were observed to complete swab counts at the end of each operative procedure and record this appropriately on the electronic system.
- Staff we spoke with told us that prior to the termination of pregnancy all patients had an ultrasound scan to confirm the gestational date, which is the term used to describe how many weeks pregnant the woman is. In all of the patient records we looked at, we saw that a record of the ultrasound scan and the reported gestational date took place, and that a print out of the scan as well as an electronic copy was correctly stored and maintained.
- A record of when and how any pregnancy remains are disposed of should be made so that the disposal can be traced. This is particularly important in circumstances when a patient subsequently enquires how the pregnancy remains were disposed of. We saw that these records were made in accordance with national and local guidelines and could provide assurance of the date and time of sensitive disposal.

Assessing and responding to patient risk

- There was an admission policy for patients using the ToP service to determine their suitability for treatment at the centre. This was based on Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. The policy set out the patient pathway from admission to after discharge and included how to provide written information for patients about potential risks and what to be aware of after the procedure. The MSI OneCall centre was given as a contact number (24 hours a day 7 days a week) for reporting any concerns after discharge.
- At their initial consultation, patients were asked about their medical history to assess their suitability for treatment; this included assessment of potential risk factors. If a patient was unsuitable for treatment at MSI Central London, for example due to an existing health condition, they would be referred to another centre or provider.
- There were up to date policies to manage a deteriorating patient. Following surgical procedures, patients were monitored in the immediate post-operative period by a registered nurse in the recovery area until they were fit for discharge.
- Nurses assessed the patient's vital signs : temperature, pulse, respiratory rate, blood pressure, oxygen saturation and blood loss. They used this as part of an adapted national early warning score (NEWS) referred to as Termination of pregnancy early warning score (TEWS to monitor and act upon any clinical deterioration. Once a patient's vital signs were stable and within their baseline recording, they were assessed for fitness to be discharged against the MSI discharge proforma. Nursing staff would escalate any concerns to the anaesthetist who remained on site until the last patient was assessed as fit for discharge. All of the records we looked at showed the TEWS score had been completed and appropriate action was taken.
- All clinical and non-clinical staff we spoke with were able to correctly describe the actions required in the event of a medical emergency and had attended mandatory training in this area.
- Surgical termination of pregnancy (STOP) was undertaken in MSI UK centres with adequate access to medical facilities equipped to provide initial emergency treatment of haemorrhage, incomplete termination and emergency resuscitation. Nominated centres offer late gestation STOP (above 14 weeks gestation) and patients needing this would be appropriately referred to such a centre.
- At our inspection in April 2016, there was no formal service level agreement at MSI Central London for the transfer of patients in the unlikely event that ongoing treatment of acute emergency care is required. In December 2016, the MSI UK policy on the transfer of patients was reviewed and required that every centre must have a service level agreement (SLA) which covers transfer out to an appropriate acute care provide in the case of a medical emergency. An ambulance should be summoned via the 999 system and the call should be made by one of the team members present at the emergency so that information may be given rapidly.
- Staff we spoke with understood that in an emergency patients would be transferred to the neighbouring NHS Trust hospital. We saw work in progress towards a formal service level agreement to support this arrangement, however there was no written agreement in place.
- 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.

- From May 2016 to April 2017, there was one medical emergency at Central London where a patient was transferred to acute NHS services. The transfer had taken place within 15 minutes of the ambulance arriving.
- All of the patient records we looked at contained written venous thromboembolism risk assessments (VTE) which staff completed prior to surgery. The risk assessments informed staff if preventive treatments were required.
- Sepsis arrangements were known by staff who confirmed there was information within the clinical guidelines for nurses and midwives. These set out the appropriate actions taken and continual monitoring and used the termination of pregnancy early warning score (TEWS) and treatment prior to transfer to a local NHS hospital. It was recommended by the National Patient Safety Agency in 2010 that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist should be used for every patient undergoing a surgical procedure.
- At our inspection in April 2016, we found that WHO Five Steps to Safer Surgery checklists were not always completed for patients undergoing surgical termination of pregnancy. We also found that the surgical safety checklist was not completed for any patients undergoing vasectomy. There was no evidence that MSI had a policy to specify where the WHO checklist would be implemented or how its implementation and use was monitored. We required improvements to be made in this area.
- At our July 2017 inspection we saw a policy had been issued to enable the use of the WHO Five Steps to Safer Surgery checklist and monitoring of its use. The policy included the checklist and stated the checklist would be applied for all patients having surgery.
- We observed WHO checks were carried out and documented by staff with all patients undergoing surgery.
- The initial team brief was observed, staffs 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 medicines. We saw in all of the patients notes we looked at that where surgical procedures had been performed there was a fully completed checklist.
- Managers told us that a monthly audit of completion of WHO checklists was introduced in March 2017, and that compliance levels for May 2017 were 87% compliant and for June 2017 89%. Areas of non-compliance were fed back to staff by email and verbally and in the clinical governance and quality newsletter. The monitoring of WHO checklists was in its early development and therefore we were unable to assess its full impact.
- Prior to termination of pregnancy all women should have a blood test to identify their blood group. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the woman have future pregnancies. All records that we reviewed demonstrated that all the women underwent a blood test prior to the termination of pregnancy, and those who had a rhesus negative blood group received an anti-D injection.
- To reduce the risk of retained pregnancy remains 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 the surgeon would rescan the patient and take appropriate action depending on the outcome of the scan.

Staffing: nursing and medical

- RSOP 18: Staffing and emergency medical cover requires that providers of a ToP service should ensure there is a sufficient number of staff with the right competencies, knowledge, qualifications, skills and experience to safeguard the health, safety and welfare of all who use the service and meet their routine and non-routine needs.
- There were nine registered nurses (three full time equivalent (FTE)) working within the service. Four were contracted and five were employed on a sessional basis. The vacancy rate at the time of our inspection was 1.2 full time equivalent. Managers told us that any gaps in staffing would be covered by staff working overtime. Agency nurses were not used. We saw that one surgical operating list was cancelled in April 2017 due to nursing staff sickness. All of the patients scheduled for that list were provided with a suitable alternative appointment.

- There were four doctors (1.7 full time equivalent) employed within the service. There were no vacancies for medical staff at the time of our inspection.
- 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' case notes and medical histories prior to signing the HSA1 forms and prescribing medicines.
- Three administrative staff supported the service (2.8 full time equivalent). At the time of our inspection, one of the administrative staff had been appointed within the previous year and two administrative staff had been appointed within the previous six months. All three members of staff had undergone a structured induction programme. There were no vacancies for administrative staff at the time of our inspection.

Major Incident awareness and training

- We saw the MSI Central London major incident and business continuity plan which provided guidance on actions to be taken in the event of a major incident or emergency. The plan was in date and contained contact details of managers who were the first point of contact, and action to take in event of a major incident such as a bomb threat, widespread fire or flood, prolonged loss of power, heating, communications or water failure. Staff were aware of the plan although they told us they could not recall any specific training or simulated scenarios, or recollection of when they had to apply it in practice.
- We saw that staff had completed fire safety training, however, staff told us, and records confirmed, that fire warden training was not provided.

Are termination of pregnancy services effective?

Evidence-based treatment

- RSOP 16 Performance standards and audit recommends that all providers should have clearly locally agreed standards against which performance can be audited – and that are guided by appropriate national standards. At our inspection in 2016 we saw some out of date policies and required that they were kept up to date. We also required that relevant staff were involved in clinical policy development and review.
- Staff we spoke with showed us that policies were easily accessible via the staff intranet, with out of date policies seen at the 2016 inspection updated and reviewed by relevant clinical staff.
- Staff told us that updates of policy changes and reviews were communicated via the interim chief nurse newsletters and we saw evidence that this happened.
- An evidence based clinical practice guide for registered nurses and midwives was issued in October 2016 through roadshows to staff. However, there were limited systems to ensure that staff were following this guidance.
- Surgical termination of pregnancy at MSI Central London was offered between 6 weeks and 11 weeks and 6 days, by vacuum aspiration; a practice which is reported by the RCOG as effective, and preferable to sharp curettage for surgical abortion under those circumstances.
- For patients with a gestational date of up to 9 weeks and 3 days early medical abortion provided an alternative to surgical intervention.
- At our inspection in 2016, we observed that patients were offered three options for early medical abortion based on gestational date. These were : simultaneous administration where stage one and stage two medicines were given within a 30 minute appointment; administration of both medicines with a six hour interval, and the third option where there was a 24, 48 and 72 hour period between administration of the two medicines used.
- Simultaneous and six hour interval methods of inducting termination of pregnancy were not consistent with the RCOG recommendations for medical termination of pregnancy. There was no evidence of a risk assessment or action plans for the evaluation of the treatment or any evidence of outcome monitoring.
- When we re-inspected MSI at provider level in February 2017, the practice of simultaneous administration of abortifacient medication for EMA had been discontinued with assurance given that this would not be offered as a treatment option until there was a strong evidence base for its use. We saw this remained the case at Central London. Staff we spoke with told us there were no plans to reintroduce the simultaneous administration option at the time of the inspection.
- The six hour interval option remained in place. The interval was dependent upon the patient's preference,

which was established at the point of the initial assessment consultation. All patients were informed of the success rates for each stage two option during the consenting process. The service monitored failure rates. There were five failed medical abortions from February 2017 to July 2017.

- Medical abortion medicines must be administered in a clinic or centre that is registered to provide abortions. Therefore, patients must attend a centre for both stages of the treatment and were not able to take the medicines at home. In all of the records we looked at, there was evidence that this happened, and we saw this to be the case with all of the patients who attended on the days of our inspection.
- RSOP 13: Contraception and sexually transmitted infections (STI) screening states that women should be offered testing for chlamydia trachomatis and undergo a risk assessment for other sexually transmitted infections. A system for partner notification and follow-up for referral to a sexual health service should also be in place. In all of the records we looked at, there was no documentary evidence of any STI screening processes provided by the service or elsewhere. However, staff monitored compliance with the screening and we noted the uptake varied between 86% and 100% from January to June 2017. Staff confirmed that screening for sexually transmitted infections varied according to the commissioning agreement with the relevant clinical commissioning group.
- The Royal College of Obstetricians and Gynaecologists (RCOG) recommend that where possible services should provide surgical termination without resorting to general anaesthesia. General anaesthesia was not provided at MSI Central London centre. If the patient required a general anaesthetic they were referred to another Marie Stopes UK's location.
- RSOP 13: contraception recommends that ToP services should be able to provide all reversible methods of contraception, including long-acting methods (LARC), immediately after abortion. Staff we spoke with told us that patients were routinely advised of the available options. Records we reviewed confirmed that this happened at the initial assessment and before the patient was discharged from hospital, and that contraception was supplied in accordance with patient's preference.
- The RCOG recommend that patients have access to a 24 hour post procedure counselling service following termination of pregnancy. Patients were asked to contact the One Call centre where counselling services were provided by trained counsellors who held a Level 4 Diploma in counselling, and were members of the British Association for Counselling and Psychotherapy. MSI counsellors were required to have knowledge and experience of various cultures and religious beliefs.

Nutrition and hydration

- Staff told us that patients were offered a light snack prior to discharge home. We saw patients being given a drink of their choice and biscuits.
- Patients were given information about when to stop eating and drinking prior to surgery and understood the reasons for this.

Pain relief

- Women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical and medical abortion.
- Pain relief scores were completed using a nought to ten pain relief rating. Patients told us that they were offered pain relieving medicines in a timely manner and we saw this happened. We observed single use abdominal heat pads for patients reduced discomfort following surgery. Staff confirmed that patients could take this home as part of their pain relief support.
- All discussion about pain and the effect of pain relief was documented in the patient's notes.

Patient outcomes

- The RCOG recommend information about the outcomes of patient's care and treatment is routinely collected and monitored. RSOP 16 Performance standards and audit recommends that all providers should have clearly locally agreed standards against which performance can be audited, with specific focus on outcomes and processes. We saw that these were in place and that information showed that the intended outcomes for patients were being achieved.
- We asked for evidence of any benchmarking against Department of Health (DoH) statistics or reports regarding waiting times for treatment, RCOG recommended audits include pathways of care, information provision, pre-abortion assessment, abortion procedures and care after the abortion.
- The provider monitored and audited outcomes which were presented through the quarterly Quality Assurance

meetings. Senior staff shared with us the standard agenda template which included lessons learnt, dissemination of learning and effectiveness of the service. The south regional management meeting agenda also included centre by centre updates which included audits, incidents and collaborative learning in practice (CLIP).

- There were no infection complications reported between May 2016 and July 2017.
- The service performed surgical termination of pregnancy only where pregnancy was confirmed by ultrasound scan to be 11 weeks and six days gestation or under, and performed medical termination to be nine weeks and three days gestation and under.
- From May 2016 to April 2017 MSI Central London carried out 1811 surgical termination of pregnancy procedures and 1404 early medical abortions. There were 269 vasectomy procedures performed within the same period.
- One patient was transferred to another health care provider as they were at higher risk and required increased levels of medical intervention.
- Waiting times were monitored on an ongoing basis by a capacity management team and reported monthly. Data about waiting times was only available from September 2016 as a new way of reporting had been introduced to include this.

Competent staff

- RSOP 18: Staffing and Emergency Medical Cover: states that providers should ensure there is a sufficient number of staff with the right competencies, knowledge, qualifications, skills and experience to safeguard the health, safety and welfare of all who use the service and meet their routine and non-routine needs.
- We saw in patient records and from observations during our inspection, that all assessments, ultrasounds and treatments in relation to ToP were carried out by medical staff or nursing staff who had successfully completed training and assessment, appraisal and supervision. Staff we spoke with confirmed this was the case
- Managers told us that any nurse or health care support worker who performed ultrasound scans to determine gestational date would be required to successfully complete an in-house training programme and assessment of a competency framework in scanning. This was co-ordinated by a lead scanning trainer for MSI UK, who was supported by a regional scanning mentor. We spoke with the regional scanning mentor who gave examples of how they worked with recently appointed nurses and health care support workers towards completing the required training and assessment in order to scan patients without supervision, and we observed this happening in practice.
- We saw training certificates that demonstrated the two staff that were providing counselling to patients on site had successfully completed counselling qualifications at diploma and degree level with the British Association of Counselling and Psychotherapy, who are a national awarding body. Counselling provided by trained counsellors over the telephone was part of the MSI One Call service.
- RSOP 13 states that providers contraception and sexually transmitted infection screening RCOG guidelines 'Care of women requesting induced abortion guideline 6 recommends a regular audit of the number of staff competent to provide methods of contraception and the availability of staff. This data was available on an ongoing basis and reported as part of the annual quality accounts. At the time of our inspection there was one registered nurse and three doctors in the Central London centre trained to supply all methods of reversible contraception.
- There were plans for additional nurses to undertake the LARC training once they completed their induction programme and mandatory training.
- Staff who gave results of tests such as chlamydia and HIV testing were required to complete training in this area as part of the consultation training. The level of training and content of training required for doctors to perform surgical termination of pregnancy or prescribe medication for medical abortion was determined by the individual practitioner's experience and skills identified through the performance review process.
- All the doctors we spoke with told us they had an annual appraisal as part of the GMC revalidation process. There was no information available locally to confirm that medical staff had undergone clinical appraisal. Appraisal and continued personal development rates were published monthly and monitored by the central management team at MSI UK. 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 Central London that confirmed appraisal had occurred.
- We saw that all nursing staff in post for more than one year had completed an annual appraisal. Newly appointed staff understood when the appraisal would be completed and had a confirmed date.

Multidisciplinary working

- Staff gave examples of working with other agencies and services such as early pregnancy units at local hospitals and safeguarding boards.
- We saw that communication with the patient's GP only happened with the patient's consent.
- Patient care was led by the doctor and a named nurse with support from other nursing staff, health care support workers, administrative staff and trained counsellors.

Access to information

- Information was displayed in leaflets and on the MSI website such as availability of chaperones, availability of translation and services for patients with a hearing impairment, providing feedback about the patient experience, what to do if you had been waiting more than 15 minutes for your appointment and how to raise a concern or complaint.
- Standard operating procedures were provided to enable staff to follow national guidelines. They were stored on the MSI intranet which could be accessed by all staff from all MSI location, including One Call. The policies we viewed were all within their review date.
- RSOP 3 states that, on discharge, women should be given a letter that includes sufficient information about the ToP procedure to allow another practitioner to deal with any complications and ongoing care. In all of the records we reviewed, we saw a copy of the discharge letter was filed and that sufficient information was included. Records we reviewed included discharge letters that were addressed to GPs unless patients requested otherwise.

Consent, Mental Capacity Act and Deprivation of Liberty

- RSOP 14 Counselling and RCOG guidelines highlight that women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications as part of the process of gaining consent.
- Staff we spoke with said that if females under the age of 16 years attended, they were encouraged to involve a parent or guardian, and that staff applied the Fraser guidelines for checking rationale and understanding when obtaining consent from girls under the age of 16. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.
- All care records we reviewed contained signed consent from patients. Possible side effects and complications for procedures were documented and the records showed that these had been fully explained. However, the designation of the staff member signing to say they had obtained the patient's consent was not completed in four records we looked at.
- Verbal consent was reconfirmed with each patient in the treatment room prior to the procedure starting.
- There were consent forms for contraception options and the supply of chosen method and testing for sexually transmitted infections.
- We saw in patient records when patients expressed any doubts about treatment, that staff discussed their concerns with them. Patients were offered a second consultation if they were not entirely sure about their decision to terminate the pregnancy. This meant there was no pressure on patients to decide to have an abortion.
- From May 2016 to April 2017 an average of 17% of patients at Central London had decided not to proceed with the ToP procedure following discussion with their surgeon as part of their pre-operative consultation and consent. This compared with a national benchmark of 15%.
- Managers told us Central London historically had a higher rate than the national benchmark as the service treated patients up to 11 weeks and 6 days in gestation. Any patients who had a later gestational date would have to be referred to another centre and would therefore be included in the 'did not proceed' statistics. .
- The MSI UK consent policy stated that registered nurses may obtain patient consent providing they have attended consent training and have competency sign off

by a Clinical Operations Manager, Clinical Team Leader and/or Doctor. Nurses we spoke with confirmed they would normally obtain consent and had completed the required training and competency assessment.
- Patients were informed of the gender of the surgeon as part of the consent process and were asked to state their preference and offered a choice.

Are termination of pregnancy services caring?

Compassionate care

- Patient satisfaction scores were gathered as part of the MSI UK quarterly patient satisfaction survey to establish whether they are meeting the individual needs of people who used the service. The surveys included analysis to compare performance with other MSI UK centres to measure improvements month to month.
- MSI Central London achieved an overall satisfaction score of 91% from April to June 2016, and 92% from January to March 2017. This compared favourably with other centres. There was no patient satisfaction data available at other times within the May 2016 to April 2017 or leading up to our visit. Staff were unclear of the reasons for this.
- All patients had a chance to speak with a nurse privately to make sure that all questions were answered and they received appropriate support to make a decision. We saw that consultations were undertaken in single consultation rooms with the door closed, and that individual changing rooms were provided for patients undergoing surgery.
- The MSI target for patient satisfaction for privacy was 95%. From April to June 2016 the score was 85%, and from January 2017 to March 2017 88%. At our inspection in 2016 we saw that privacy was not always achieved in the surgical recovery area at the Whitfield Street London location and required that this was improved. There were four recliner chairs in close proximity an open plan recovery lounge with no dividing screens or curtains. At that time, staff told us that there were plans to take corrective action by the installation of privacy curtains or a screen, however this had not happened at the time of our inspection and we saw no improvement.
- During our visit we observed all staff showed a compassionate and caring manner when interacting with patients. For example, comforting patients who were visibly upset before or after their procedure, and speaking in a gentle and calm manner. In the recovery area we saw nurses ask patients about their wellbeing and comfort including their pain, and that they responded accordingly.
- We received 50 comment cards with feedback from patients. Patients consistently referred to the non-judgmental and caring attitude of staff. One patient told us, “You are never judged and always supported”; another patient stated, “I was dealt with the utmost care and respect”.
- All patients had a chance to speak with a nurse privately to make sure that all questions were answered and they received appropriate support to make a decision without coercion. Women could be accompanied by someone who was close to them.

Understanding and involvement of patients and those close to them

- All patients having a surgical termination were offered the choice of anaesthesia, sedation or general anaesthesia, as appropriate to their gestational date and proposed procedure. This was discussed with them in detail as part of their consent. Patients requiring a general anaesthetic would be referred to another provider as this was not a service provided at MSI Central London.
- Staff informed patients undergoing termination of pregnancy that the information recorded on the HSA4 form is used to inform the Chief Medical Officer and for statistical purposes by the DoH.

Emotional support

- Nursing staff, doctors and trained counsellors provided emotional support for patients at the centre. In addition, patients had access to the 24-hour telephone line serviced by registered nurses trained in providing emotional support and advice who were managed by the MSI One Call Centre in Bristol.
- The 2014 Department of Health response to the Government review on Independent abortion providers and the Royal College of Obstetricians & Gynaecologists guidelines state that mandatory counselling is not advisable. At our 2016 inspection counselling was mandatory for all patients. The MSI Counselling policy

was revised in December 2016 so that patients could have the choice of whether they accessed counselling or not. The exception to this was for patients under the age of 15 where counselling was mandatory.

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- In accordance with Department of Health guidance, service planning was managed by a business development team in discussion with clinical commissioning groups (CCGs). MSI Central London centre was open five days a week and each of the satellite EMU locations were open two days a week. Surgical termination of pregnancy was normally provided twice a week, and vasectomy procedures once every two weeks at the Central London location.
- Early medical abortion was provided in individual consulting rooms at the Whitfield Street, Watford, Hemel Hempstead and North London Whittington locations. Patients were advised to telephone the 'one call' service to discuss their options.
- At our inspection in 2016, we found that privacy was not always achieved at the central London location due to the occasionally overcrowded waiting area, and the shared recovery lounge which could be used by up to four patients at a time. We asked staff what measures they had taken to improve privacy and dignity since our last inspection. They were unable to provide us with any evidence that this was addressed or resolved.
- There was limited space in the recovery area. We saw four recliner chairs in an open plan recovery lounge with no dividing screens or curtains between patients. Staff told us there were plans to purchase some curtains; however, this had not happened at the time of our inspection. Staff were unclear about the reasons for this. We did not find any improvements had been made to mitigate this.
- During this inspection we saw staff still had difficulty with maintaining privacy and dignity in the recovery area due to the close proximity of the four recliner chairs in the recovery lounge and an absence of privacy curtains or screens.
- The Whitfield Street location was inaccessible to wheelchair users or people with limited mobility. All clients with limited mobility were booked to another MSI's location by staff working at MSI's call centre.
- From their first contact with the service, patients were offered a telephone or face-to-face consultation where a comprehensive medical and obstetric history was obtained. MSI provided pre-existing condition (PEC) guidelines to determine a patient's eligibility for safe treatment in the centre. Where patients did not meet the criteria, they would be referred to another provider of ToP services. This included patients seeking abortion for fetal abnormality.
- There was a policy in place for the sensitive disposal of fetal remains (MSI UK Management of fetal tissue policy dated May 2016) which complied with the Human Tissue Authority Code of Practice.
- Patients were asked if they had any special requests for the disposal of pregnancy remains. 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 documented in patient's personal records as part of the consent to treatment. Staff we spoke with said that patients were advised what documentation was required in order to procure a cremation or burial. Where possible (and with the patient's permission), the centre liaised with funeral directors to facilitate as smooth a process as possible to alleviate stress.
- We observed the storage and labelling processes for pregnancy remains on site which complied with the MSI policy. Staff documented any non-standard disposal option in the patient's record and on a record of the freezer content 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 remained 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 it after three months.

Access and flow

- Appointments were made through MSI's 'One Call' service which is a registered pregnancy advisory service operating 24 hours a day. This enabled secure ease of access for patients to MSI services, or alternative

services where needed, for example where a patient would not be suitable for MSI services, they are signposted to an appropriate alternative provider, such as the NHS.
- From April 2016 to May 2017, the total time from access to procedure did not exceed 10 working days in the reporting period, which met national guidance.
- From February 2017 to July 2017, there were two reported incidents when the surgical list was cancelled. On one occasion, this was due to staff sickness and on the second occasion this was due to an environmental issue. On both occasions, records we looked at showed that all patients were offered an alternative appointment which met the waiting times targets set by the Department of Health.

Learning from concerns and complaints

- We saw a record of informal and formal complaints was maintained as part of the electronic patient safety system. Complaints were investigated locally and escalated to MSI UK executive management team if local resolution was not achieved.
- From April 2017 to June 2017, there were eight recorded complaints. Seven out of eight were resolved at the time of our inspection. The remaining complaint was under investigation within the required time frames.
- There were four complaints from May 2016 to April 2017. One was categorised as formal and three were informal. There were no particular trends or patterns identified.
- Staff we spoke with told us that learning from complaints was shared at governance meetings attended by managers, by emails, and at staff meetings and we saw this happened.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- At the time of our inspection, the leadership team at MSI Central London consisted of an operations manager, a clinical team leader, and a medical director. The operations manager and clinical team leader were based at the Whitfield Street location. The medical director was based at MSI UK central office in Conway Street, London.
- The operations manager was appointed in September 2016 and the clinical team leader in April 2017. The medical director was appointed at the beginning of 2017.
- A new appointment of district clinical operational manager was made in September 2016 with specific responsibility for the day to day management and delivery of services at the EMUs. Staff we spoke with were positive about the management changes. They told us they felt more involved with decisions about the service since the new management team had started and were attending regular monthly staff meetings. Minutes of the meetings showed they were well attended and had taken place with a formal standing agenda.
- Staff we spoke with told us that the management of EMUs within the London region was being monitored and reviewed at provider level at the time of inspection.
- At our inspection in 2016, staff described the leadership and culture to be top down and directive from the executive management team, with minimal opportunities for staff engagement or discussion. This meant that the direction and leadership approach were not always clear.
- There had been frequent changes of managers at MSI Central London centre and MSI UK leading up to our inspection in 2016. This had created some instability. In July 2017, the frequency of changes had not reduced. However, staff we spoke with felt more involved with decisions about the service and were attending regular staff meetings which were scheduled monthly. Minutes of the meetings showed they were well attended and that the meetings had taken place with a formal standing agenda.
- Staff attended regional road shows with colleagues from other MSI centres which allowed them to hear about organisational changes and to network and share learning with colleagues.
- The centre manager or clinical team leader were expected to be on site at the centre every day during core service hours, and we saw that this happened. Managers were on call out of core service hours including Saturdays and would be contactable by telephone if needed.
- Staff at the satellite EMU locations told us that the managers would visit the EMUs on an as needed basis and were readily accessible by telephone or email at all times.

- Staff at the EMUs were sometimes lone workers. Policies set out their responsibilities and arrangements to ensure their personal safety and we saw that staff who were lone workers had completed loner worker training. Staff we spoke with at MSI North London The Whittington showed us they had been issued with a Global Positioning System (GPS) alarm as part of the lone workers' policy. This made it possible for people with ground receivers to pinpoint their geographic location and an automatic call to the police if identified as a need.
- Staff we spoke with told us that communication and training had improved as a result of the recent management changes. For example, monthly staff meetings with a structured agenda had been introduced and face-to-face and email communication had improved.
- There had been no formal staff survey to evaluate the impact of the changes made and to highlight areas of further improvement with staff wellbeing. Staff told us that a survey had been issued with a closing date a week after our visit, however, they were unsure of the response rate.

Vision and strategy for services

- Since the appointment of an interim managing director MSI UK had identified six objectives with deadlines to ensure plans that will continuously move to achieve defined goals by the end of 2017. These goals aimed to ensure that MSI create a culture that values everyone's contribution in establishing a confident multi professional workforce who deliver patient centered quality services and financial success.
- Managers we spoke with understood the vision and strategy for the service entitled 'Fit for Future' which was introduced in April 2017. The vision and strategy were shared with staff from the point of their appointment and induction. However, staff we spoke with had mixed understanding and awareness of the overall strategy and vision.
- All places holding a valid ToP licence issued by the Department of Health are required to follow required standard operating procedures (RSOPs). The Department of Health RSOP 10: professional guidelines states that providers should have regard to authoritative clinical and professional guidance and professional opinion such as that provided by relevant Royal Colleges. Guidelines published by the Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Nursing, and National Institute of Health and Clinical Excellence (NICE) are key resources to aid good clinical practice in ToP, based on published evidence. We saw that reference was made to these documents in the local standard operating procedures we looked at, and that they were monitored and generally adhered to.

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

- At our inspection in 2016 we found that there was insufficient local, regional or national managerial oversight of the service and its delivery. There was limited evidence to support the governance of clinical practice, and management or staff involvement in policy development.
- In March 2017 a new post of regional clinical quality and governance lead had enabled improved oversight of performance. Staff said that they felt it has enabled them to have more formal communication about risk and governance between local, regional and national level within the MSI UK organisation.
- Since our inspection in 2016 a clinical forum for doctors had been established. Regional meetings were held on a quarterly basis, chaired by the MSI UK Medical director. Doctors we spoke with were positive about the forum and its direction.
- A register of people who had undergone ToP was maintained and kept for three years. All four centres, including the three EMUs held a licence from the Department of Health (DH) to undertake termination of pregnancy services in accordance with the Abortion Act 1967. The EMUs were nurse led and staffed by a district nursing team. The executive team included an interim managing director a medical director, a chief nurse, deputy chief nurse and associate director of quality and governance. Staff told us they felt this increased the application of patient and safety-driven quality.
- At our inspection in April 2016, there was no evidence of a local risk register at MSI Central London. Risks were managed at a corporate level. We required that there were improvements in local identification, reporting and management of risks. The introduction of the patient safety electronic incident reporting and local risk

register in February 2017, and the appointment of a regional quality manager in March 2017 had enabled the implementation of a more local approach to risk management.

- We saw the local risk register was readily available to staff and contained eight risks at the time of our inspection. All the managers we spoke with were able to correctly describe the top three risks as environment not being compliant with infection prevention and control guidance, the risk medicines would expire, and the risk of smoke from the diathermy equipment in the procedure room. There were clear instructions on how these would be mitigated.
- The risk register was discussed and reviewed at quarterly quality meetings attended by the centre's management team and the regional quality manager. The risk register should be updated on at least a monthly basis by the operations manager. We saw it was last updated on 22 June 2017.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination of pregnancy is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. The two doctors must then complete, date and sign an HSA1 form, produced by the Department of Health, before the abortion is performed.
- We saw that arrangements for the completion of HSA1 forms were clearly set out in local standard operating procedures. Staff we spoke with correctly described the processes they would follow to ensure this happened. In all of the patient records we looked at the HSA1 form was completed and signed by two medical practitioners in accordance with the legal requirements and local policies.
- Registered medical practitioners are also legally required to notify the Chief Medical Officer of every abortion performed in England and Wales using a form produced by the Department of Health, known as form HSA4, for this purpose. HSA 4 forms should be completed and submitted to the chief medical officer within 14 days. Staff we spoke with confirmed this was the normal practice. Records we looked at confirmed this happened.
- Monitoring service level agreements, for example contracted pharmacy services and maintenance agreements, was managed centrally by MSI corporate team.

Public and staff engagement

- Patients attending each centre were given feedback forms which asked for their opinion of the service. The forms were collected and analysed by an independent organisation that produced a quarterly summary of results. Staff we spoke with told us that due to the sensitive nature of the service and procedure it was sometimes a challenge to get a response.
- We looked at the quarterly summaries of feedback from patients who used the ToP service. Only two out of a potential four quarterly summaries were available. From April 2016 to June 2016, there were 96 responses which was 14 % of patients eligible to respond. From January to March 2017, there were 126 responses which was a 15% response rate. Managers confirmed there was no data collected in two out of four quarters. We were therefore unable to fully assess the impact.
- We also looked at the four most recent quarterly summaries of feedback from patients who used the vasectomy service. The response rate was very low. For two of the four quarters no responses had been submitted. In one quarter 30 responses were received, and another quarter only four responses. 100 % of respondents said they were satisfied with the overall service. 100% of respondents also said they would recommend the service.
- We asked for evidence of staff feedback and were told there were no formal mechanisms to collect staff opinions or to report on this.

Innovation, improvement and sustainability

- Many of the staff working at the clinic were newly appointed to their roles. This included the clinical team leader, operational manager, and administrative and clerical staff amongst others. It was not clear how the provider aimed to minimise staff turnover rate in order to ensure service continuity and sustainability.
- Improvements included: replacing fabric chairs with washable fabric chairs in the waiting ares, replacing carpets with washable flooring throughout the centre, the implementation and monitoring of surgical safety checklists, the management of early warning scores in

deteriorating patients, improved clinical governance and monitoring of patient outcomes, risks and complaints, and improved communication with locality managers and the MSI executive management team.

- In March 2017, a new post of regional clinical quality and governance lead was introduced. This enabled improved systems for monitoring performance and more formal arrangements for managing and communicating risk and governance at local, regional and national level within the MSI UK organisation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure fire safety checks and evacuations are carried out.
- The provider must ensure there are processes in place to ensure that equipment is serviced and maintained in line with manufacturer's guidance for both clinical and non-clinical equipment.

Action the provider SHOULD take to improve

- The provider should carry out and act upon investigation and analysis of staff satisfaction.
- The provider should ensure patient feedback is consistently obtained and used to improve the service.
- The provider should enable all staff to complete training that is necessary for them to fulfil their role(s), including mandatory training and relevant skills training.
- The provider should ensure there are arrangements to monitor and reconcile the stock of medicines.
- Ensure patients privacy is respected at all times, including when they are in the waiting area and recovery lounge.
- Ensure all staff, including medical staff, are appraised regularly and suitable records of revalidation and appraisal are kept.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Termination of pregnancies	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; e. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; **We noted:** The provider did not ensure premises used by the service provider are safe to use for their intended purpose as fire safety checks and evacuations were not carried out. Electrical equipment such as computer screens, docking stations and telephones had not been safety tested. This means the provider did not ensure that the all equipment used was safe, routinely serviced and maintained.