Marie Stopes International South London Centre

Quality Report

1a Raleigh Garden
Brixton Hill
Brixton
London
SW2 1AB
Tel:08453008090
Website:www.mariestopes.org.uk

Date of inspection visit: 26 July,1,3 August 2017
Date of publication: 01/12/2017

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

Overall summary

Marie Stopes UK International (MSI) is operated by MSI International and is a not for profit organisation. The facilities at MSI south London include a treatment room with diagnostic services and a ward area with 10 day couches (eight in the main ward area and two in a private room). There are also four consultation rooms and a discharge room.

MSI south London provides consultations, medical and surgical termination of pregnancy services, vasectomy procedures, ultrasound scanning, screening for sexually transmitted diseases, long acting reversible contraception and counselling for people who use these services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 26 July 2017, along with an unannounced visit to the centre on 3 August 2107. We inspected the early medical abortion unit (EMU) at Wimbledon on 1 August 2017.

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 identified at corporate level that were relevant to MSI south London.

The breaches were in respect of:

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

Regulation 20 (Registration) A healthcare service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users carrying on a regulated activity.

We followed up these concerns as part of this inspection.

Summary of findings

Services we do not rate

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

We found the following areas of good practice:

- Nursing staff had received additional anaesthetic and recovery training to support the anaesthetist during patient care.
- Nursing staff received support and training from the clinical operations manager and clinical team leader. Additional training had been provided, such as duty of candour and haemorrhage control training.
- Staff respected patient's wishes and provided dignified and supportive care.
- New systems were in place to check infection prevention and control and cleaning practices.
- Policies had been reviewed and updated to follow national guidelines. These were readily available to all staff.
- All staff at the centre were up to date with their safeguarding vulnerable children, young people, and adults training.
- Equipment servicing records were organised and well maintained.
- Patient records and risk assessments scores were detailed and legible.
- Systems were in place to escalate and transfer deteriorating patients to an NHS hospital if required.
- Translation services were available for those patients where English was not their first language.

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

- Patients faced frequent delays with their appointments and treatment due to the heavy caseload at the centre and lack of consultation time. This meant delays to the clinical lists, which then led to cancellations.
- The registered manager had not received root cause analysis (RCA) training to help investigate serious incidents.
- The waiting area was not able to accommodate all the patients on busy days. Staff told us patients often sat on the floor in the waiting area.
- Lessons learned from incidents were not consistently shared with staff.
- The revised audit programme had been introduced but was not fully embedded at the centre. There were no recommendations made from poor outcomes of these audits to help improve standards.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Interim 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 at the time of our inspection we did not yet have a legal duty to rate, when it is provided as an independent healthcare single speciality service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We have a duty to rate this service when it is provided as a core service in an independent hospital.

Summary of findings

Contents

Location name here

Services we looked at
Termination of pregnancy.

Summary of this inspection

Background to Marie Stopes International South London Centre

Marie Stopes UK International (MSI) south London is operated by the provider group MSI International. The service opened in June 1989. MSUK is an independent provider of sexual and reproductive health services. The clinic primarily serves the communities of South London but also accepts patient referrals from outside this area.

At the time of the inspection the manager had been in post for a year, and had achieved their registration with the CQC in July 2017.

Our inspection team

The team that inspected the service was comprised of a CQC lead inspector,Jane Brown, another CQC inspector who had received training in termination of pregnancy procedures, and a CQC assistant inspector.

The inspection team was overseen by Nick Mulholland, Head of Hospital Inspection.

Information about Marie Stopes International South London Centre

Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy by surgical or medical methods. The centre prescribes and administers abortifacient medication for early medical abortion, where a pregnancy is up to nine weeks + three days, medical abortion and surgical termination of pregnancy up to 23 weeks + six days. Surgical termination is carried out either using general anaesthesia, or conscious sedation, by vacuum aspiration or dilatation and evacuation or no anaesthetic according to patient choice and needs.

Surgical and early medical termination of pregnancies are performed six days per week, Monday to Saturday, with optional Sunday openings if required.

A vasectomy list is performed every eight weeks and counselling services are provided on site two days per week. The service also offers contraception and screening for sexually transmitted infections.

The centre has one treatment room, with a recovery bay, one-day ward (with a distinct private area), four consultation rooms, and a separate area for discharge. The location is registered to provide:

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

Six early medical abortion units (EMUs), known as satellite sites, are linked to the south London location. These are located in Waterloo, Lewisham, Croydon, Guildford, Greenwich, and Wimbledon. Medical termination and consultations are provided in a private room at each of these satellite sites. All locations hold a licence from the Department of Health 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 locations. Surgical termination of pregnancy only takes place at MSI south London. Counselling services are offered to all patients, before and after treatment, either by telephone or face-to-face appointments. There is a 24-hour aftercare line, which offers support services to patients. Patients make appointments through the 24-hour registered pregnancy advisory centre.

During the inspection, we visited all areas of the service. We spoke with 18 staff including; registered nurses, health

Summary of this inspection

care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with three patients and one relative. During our inspection, we reviewed 19 sets of patient records.

We visited by short announcement on 26 July 2017, and subsequently unannounced, on 3 August 2017. The report describes what we found during the inspection and a review of available evidence after the inspection. We visited one early medical unit (EMU) in Wimbledon on 1 August 2017 and spoke with one staff member and two patients.

Activity (January 2017 to June 2017)

- In the reporting period January 2017 to June 2017, there were 3,979 inpatient and day case episodes of care recorded at the service. Of these 3809, patients were NHS-funded and 170 other funded.
- The location sees approximately 8,000 patients for termination of pregnancy each year. Of these 63% were for surgical terminations and 37% for early medical terminations. Of the surgical terminations performed, 3.6% took place after 19 weeks gestation.

The current track record on safety:

- There were no never events recorded between May 2016 and June 2017.
- There were 36 clinical incidents reported from January 2017 to June 2017. These were categorised by degree of harm, such as no harm, low harm, moderate harm, severe harm, or death.
- There were 104 non-clinical incidents reported in the same period.
- There were two serious incidents reported between May 2016 and June 2017.
- There were 30 informal and seven formal complaints made between January 2017 and June 2017.

Services provided at the hospital under service level agreement:

- Clinical and non –clinical waste removal
- Central sterilisation services
- Maintenance of medical equipment
- Interpreting services
- Grounds maintenance

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 always ask the following five questions of each service:

Are services safe?

- Staff had a clear awareness of safeguarding concerns and knew who the safeguarding lead was. We observed good management of safeguarding issues during our inspection. All staff had completed safeguarding vulnerable children, young people, and adult training modules.
- Staff were up to date on most mandatory safety training topics, except for information governance.
- The environment was visibly clean and clutter free. There were systems in place to check cross-infection and cleaning practices. Monitoring took place on a daily basis. There was good availability of equipment and safety checks had been made on these items.
- There were sufficient staff to provide good patient care. Nursing staff who had received additional anaesthetic and recovery training supported the anaesthetist.
- Staff completed patient records correctly and stored them in accordance with the Data Protection Act 1998.
- Medicines were stored safely and nursing staff administered medicines to patients in a timely manner.
- There was an escalation process in place for the urgent transfer of a deteriorating patient to a neighbouring NHS trust.

However:

- Since the last inspection in May 2016, a new electronic system for reporting incidents had been introduced. At the time of our inspection systems for sharing learning and actions from incidents were not fully established at the centre. Staff did not always receive feedback and the outcomes of reported incidents. However, the clinical operations manager was working on ways of improving the sharing of incident information.
- The registered manager had not received root cause analysis (RCA) training to investigate serious incidents. (This is a method of problem solving used for identifying the root causes of faults or problems).

Summary of this inspection

Are services effective?

- Policies and procedures had been reviewed and revised and were in line with recommended national guidelines. Staff could access policies and procedures at the centre.
- Staff were encouraged to gain competencies and skills through training. The clinical team leader monitored training needs. They had oversight of nursing revalidation and provided support with this.
- MSI south London provided effective sexually transmitted infection (STI) screening and patients received comprehensive contraception advice.
- The service monitored patient outcomes. The regional management team had more oversight of these and were able to compare results with other locations, in order to identify trends. The COM had access to other locations outcomes through the South Region Quality Assurance Dashboard and was able to describe action they had taken as a result.
- Registered nursing staff obtained patient consent. Records we viewed demonstrated complications and risks associated with treatment were explained to patients.

However:

- There was a new revised audit programme in place. The audits allowed the centre to monitor the quality of the service, for example staff compliance with handwashing. However, this was still in its infancy and not yet fully embedded into practice.

Are services caring?

- Staff provided a good standard of treatment and care. We observed staff being kind, compassionate, and treating patients with dignity and respect.
- Information was provided to individuals using the service, which enabled them to make informed choices.
- Counselling services were offered and available to all patients. This was through face-to-face appointments or telephone discussions. There were supportive pathways of care for patients. For example, staff sign posted vulnerable patients to bereavement services and support helplines for victims of domestic abuse.

Are services responsive?

- MSI south London had facilities, which included private rooms for children, young people, and vulnerable adults, and a private ward area for women in the later stage of pregnancy.

Summary of this inspection

- Patients were offered information about disposal of pregnancy remains during consultation. Patients had the necessary information to make an informed choice about their options.
- The service was open between specific hours. Arrangements could be made to attend alternative locations if more convenient for the patient.
- Translation services were available for those patients who did not speak or understand English.
- Complaints were acknowledged, investigated, and responded to within a time frame set by the organisation.

However:

- Patients often experienced long waits due to the busy patient lists. Staff we spoke with told us there were occasions when patients had to return on another day for treatment. However, we were not provided with any evidence to say how many times this had occurred.
- The reception area did not have enough patient seating to cope with busy periods. Staff told us patients often sat on the floor.
- Staff told us to during patient consultations, to enable thorough assessments and checks for patient care, often meant, they ran late over the allocated 15 minutes appointment time.
- Information from complaints was not always communicated to staff and they could not provide any example of learning from such feedback.

Are services well-led?

- The clinical operations manager (COM) was able to describe the new governance structures and who they reported to within this. They attended regional meetings with other regional teams to share learning and to keep up to date with the latest clinical and corporate guidance.
- There were improved processes in place for oversight of local professional practice, staff adherence to professional standards and monitoring of standards. The COM now had access to records of staff who worked outside of the location.
- The COM and clinical team leader (CTL) were supported to make local decisions. However, there was still room for improvement, for example, with managing the volume of work and consultation times.
- There was good leadership within the centre and staff felt their development needs were taken into account.
- Staff felt proud to work for MSI and there was a positive culture of continuous professional development.

However:

Summary of this inspection

- Most concerns we raised during our previous inspection had been addressed, apart from the lack of sufficient seating in the waiting area during busy periods. Although extra seating had been purchased, it was still not sufficient to cope with demand. However, MSI south London was trialling new ways of staggering patient appointments to help alleviate the pressure of overcrowding.
- Although the risk register was updated and fed into the regional team by the COM, staff did not have involvement in discussions regarding risks at the centre.
- The sharing of incidents was not fully embedded at the centre. The COM recognised there was still work to be done to ensure the system was effective, and that other methods of communicating lessons learnt from incidents was needed.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

We regulate this service but we do not currently have a legal duty to rate single specialty termination of pregnancy services. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We do have a duty to rate this service when it is provided as a core service by an independent hospital.

Incidents and safety monitoring

- At our last inspection in May 2016, we found an inconsistent approach to the reporting of incidents. Incident reporting was paper-based and the electronic system was only accessible by senior managers. Staff did not receive feedback on reported incidents and lessons learned were not shared with staff.
- During this inspection (2017), we found staff reported incidents through the new electronic reporting system, which had recently been installed. Staff gave positive feedback on the new electronic system. They told us they had received good one to one training and information on the different types of incidents to report. A staff member was able to describe what happened when they reported an incident relating to the administration of a drug. Actions they had to take as a result of the incident included reviewing the Medicines Management policy v1 February 2017, and writing a reflective statement of the incident. The staff member said they had learned lessons from the incident through these mechanisms.
- There were enough computer terminals throughout the centre for staff to access the system and report incidents. Staff were allowed time away from clinical duties to complete incident reports. A staff member showed us the electronic system and how they would report an incident.
- Although staff were positive about the new incident reporting system, they told us they did not always receive feedback on incidents they had reported. Lessons learned from incidents were not always shared. However, the clinical operations manager (COM) recognised the new system was not yet fully embedded into the organisation and there was still work to be done to ensure the system was effective, for example, exploring further avenues to communicate the sharing of information
- The staff member at the early medical abortion unit (EMU) told us they never received any feedback on incidents they had reported.
- We saw examples of incidents staff had reported, which ranged from no hot water in the consultation rooms, incomplete documentation, needle stick injury, continuous pregnancy, team member shortage and threatening behaviour by a patient. We saw actions taken against each incident recorded.
- The centre had seen an increase in the reporting of incidents since the introduction of the new system and training. Between January 2017 and June 2017, there were a total of 140 incidents reported. Of these, 36 incidents were of a clinical nature, with the other 104 of a non-clinical nature.
- The reporting trends showed there had been an increase in the reporting of non-clinical incidents and a static trend for the reporting of clinical incidents. We saw from the South Region Quality Assurance Dashboard, comments that the centre appeared to be under reporting clinical incidents compared to other MSI centres. As a result the COM had arranged for discussions to take place at the next team meeting (which was two weeks after our inspection) to reiterate the message on the importance of reporting incidents of all severities.

Termination of pregnancy

- There had been two serious incidents recorded in the reporting period. One of the incidents was still pending further investigation. One serious incident we reviewed, from January 2017, related to a patient being consented after treatment.
- We reviewed the investigation, root cause analysis (RCA), and lessons learned from this serious incident. The investigation team comprised of MSI staff members, which included the deputy chief nurse and the registered manager, who was also the clinical operations manager (COM). The south London COM was appointed as the family liaison lead, to ensure the patient was kept up to date with the investigation and to act as a point of contact to raise concerns. We saw evidence of the communication between MSI and the patient.
- The investigation methodology included RCA, using tools, which helped investigate both the cause and effect, and contributory factors. The investigation report we reviewed was chronological in analysis and included a clear list of the causes of the incident. The report was sent to the local clinical commissioning group (CCG). A team meeting was arranged purely based on the lessons learned from the incident and information about the incident was shared with staff. We viewed the meeting minutes and saw recommendations from the report, included a surgical list structure to allow for flexibility, if team members were sick and the list was overrunning.
- The investigation showed that staff had not completed the World Health Organisation (WHO) and five steps to safer surgery checklist. This is a checklist tool used to reduce complications in surgery. Part of the checks include asking the patient to confirm consent for treatment. The WHO checklist was not completed to ensure all relevant checks occurred before the patient was sedated. No one staff member acted as an effective clinical lead in the treatment room and this resulted in the WHO safety checklist being missed.
- Actions taken as a result included ensuring a lead registered nurse was responsible for leading the World Health Organisation (WHO) and five steps to safer surgery checklist during surgery. We saw this was evident during our inspection in July 2017. Staff we spoke with told us they had attended a meeting to discuss the incident and what lessons could be learnt. Staff said they received extra training on the importance of the WHO checklist.
- During the inspection, we saw an additional registered nurse who acted as a theatre circulator, whose sole purpose was to be an extra staff member within the treatment room, who could be called if the surgical team needed additional resources. The location also changed the layout of trays where records were kept within administration. They now had three different trays for patient records, one used for patients awaiting consent. We saw this system was in use during our inspection.
- The clinical team lead and nursing staff within the treatment room told us that since the incident, they had felt more empowered to stop the surgical list at any point if they felt patient safety was being compromised. Staff told us they had done this on a few occasions, when surgical lists had been so full, that they felt they would not have sufficient time to complete the necessary safety checks. Staff told us when they stopped surgical lists; they had the full support of the COM and clinical team lead.
- The registered manager had not received root cause analysis training, (This is a method of problem solving used for identifying the root causes of faults or problems).The registered manager was supported by the regional governance team, who had received the training, along with oversight from the corporate quality assurance team.
- There were no reported never events in the reporting period. 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.
- A complaints, litigation, incidents, and patient (CLIP) group had been established. This group provided an open invitation to all MSUK staff, regardless of level. A weekly teleconference call was held, where incidents were reviewed and discussion took place on shared learning from incidents across all locations.
- The COM attended CLIP meetings and told us the CLIP meetings were highly beneficial in the sharing of information on incidents and how they were graded. These meetings also gave the COM an opportunity to discuss current incidents and get feedback on how other managers may have dealt with the same incident.

Lessons from incidents, which occurred in other regions, could be shared with a wider group of staff. However, we did not see any evidence of sharing of information from other centres.

- Incidents were discussed in the daily team briefing, which took place at the start of the day. The briefing involved as many staff members as possible, including the doctor and anaesthetist.
- There was a revised and updated Incidents management policy version 1, dated January 2017 which staff were able to describe. Staff told us discussion of the new policy was included as part of the training given with the introduction of the new electronic system.
- The Duty of candour and being open policy version one was introduced and ratified in April 2016. The duty of candour (DoC) 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 has 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.
- At our last inspection in May 2016, we raised concerns relating to the duty of candour with regards to a serious incident, which occurred at the centre. We found for the serious incident, which occurred in January 2017, the COM was the main contact with the patient and was able to describe the communication process they followed to keep the patient up to date with the investigation. Information we received from the director of quality and governance told us that in relation to the serious incident of January 2017, no duty of candour was done for this incident, as no physical harm was done to the patient. We were told this reflected the company's The Duty of candour and Being Open policy version 1. The patient was contacted via telephone by the COM and apologised to.
- Staff had received training DoC training in March 2017. This training had been devised by the COM at the centre. We were told the training package had now been distributed for other centres to use. The training package involved discussion on professional standards on what staff should do if something goes wrong during patient care.

Mandatory training

- All staff were required to complete mandatory safety training on a range of topics, dependent on their role within the organisation. There were standard topics all staff had to complete annually, which included subjects such as: infection prevention control, basic life support, and intermediate life support. Other topics were completed every two to three years. For example, manual handling, and information governance.
- The COM was able to upload on the computer the training timetable (matrix). This showed for each individual staff member, dates when they had completed mandatory training modules and whether they were due to complete training. The training could be uploaded centrally for everyone within MSI UK to view.
- The training matrix had a red, amber, and green (RAG) system, to indicate when staff needed to complete training. Green indicated staff had completed the training and remained in date. Amber acted as an alert, indicating the course was three months away from expiry. Red showed the date for a particular topic had expired.
- The training matrix submitted to us in August 2017 showed the majority of staff were up to date with their mandatory training. All staff were up to date with their safeguarding training, informed consent, and consent to capacity training, as well as basic and intermediate life support training.
- Out of 39 staff listed on the training matrix, there were 14 amber ratings for staff that required information governance training and 10 red ratings for fire and emergency evacuation drill participation. However, the red ratings represented staff who were on annual leave and long term sickness. Staff had completed the fire and emergency drill training on 27 March 2017. We confirmed with staff they had participated in this training.
- Doctors were required to provide evidence of their training as part of their revalidation process. These records were kept at a corporate level by the medical director. We did not see evidence of any of these records.

- Anaesthetists were required to be advanced life support (ALS) trained. The COM was able to access the training records for the two medical practitioners who had been working at the location during our inspection. From records shown to us, all anaesthetists had competed ALS training.
- Seven registered nurses (including the clinical team lead) had received and were up to date with mandatory anaesthetic and recovery training.
- There were effective processes that ensured staff had completed and had the competence for ultrasound-scanning training, which was conducted internally throughout the organisation. The two staff members who were undergoing training were supported by mentors during their training.
- 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 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.

Safeguarding

- There were up-to-date arrangements in place to protect patients from avoidable harm. The Safeguarding Adults and Children's at Risk Policy version 3.1 had been updated in December 2016. Staff we spoke with were familiar with the policies and had easy access to them.
- The policy included a process staff could follow in relation to patients under the age of 16 years of age.
- A safeguarding proforma was completed for all patients at their consultation appointment. There were separate proformas for patients under 18 years of age.
- During our previous inspection (May 2016), we found staff were not trained to the appropriate level of safeguarding as recommended by the Intercollegiate Documents for Healthcare staff (2014). The document advised all staff working with children, young people and or their parents/carers and who would 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.
- The organisation had taken action to rectify the concerns regarding safeguarding training levels. From the training matrix, we saw all registered nurses and health care assistants were trained to level three in safeguarding adults and vulnerable children. The training included the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Front of house staff were trained to safeguarding adults and vulnerable children level two, which included the MCA and DoLS.
- The clinical operations manager (COM) and clinical team lead (CTL) were trained to level four. Both the CTL and the COM were safeguarding leads for the location to account for annual leave and ensure there was always a safeguarding lead contactable.
- Staff we spoke with were able to describe different safeguarding concerns, in terms of identifying an issue and what actions they would take.
- All staff who worked at the centre had received training on female genital mutilation (FGM), child sexual exploitation (CSE) and PREVENT strategy, which is a government directive. The aim of PREVENT is to provide staff with the knowledge to enable them to be aware of people who are at the risk of becoming radicalised and to stop them from being drawn into terrorist activity.
- With the introduction of the new electronic reporting system, the location had seen an increase in the reporting of safeguarding incidents. Data provided showed 67 safeguarding incidents had been reported from January 2017 to June 2017. The centre had seen a gradual increase for each month. From February 2017 to July 2017, there were 24 FGM incidents reported. We reviewed incident reports, which gave a description of each incident and actions taken. The incident report demonstrated staff had a good understanding and knowledge of FGM and the supportive actions they had provided to women. Each incident was reported to the safeguarding lead. Some incidents showed a good level of escalation to social services and the involvement of external organisations to support women. We observed FGM being discussed during consultations with patients.
- FGM cases were reported to the local multi-agency safeguarding hub (MASH). MASH was developed by the police, local authorities, and other agencies to co-locate safeguarding agencies and their data into a secure research and decision-making unit.
- The centre distributed a booklet entitled ‘A statement opposing FGM’, which described the UK law in relation to FGM and contained numbers for supportive helplines for women to contact.

- The centre worked closely with their local clinical commissioning group (CCG) and attended regular safeguarding meetings. Staff had received training on domestic violence. The training was delivered by staff from a Domestic Violence Centre that was linked to the CCG, and they delivered the training session during a team meeting.
- During the inspection, we observed two occasions where the COM had to deal with safeguarding concerns raised by staff. One related to a patient who presented themselves for treatment and concerns were raised whether the patient was coherent enough to proceed. The initial incident was raised by the registered nurse, who alerted the COM as the safeguarding lead. The COM assessed the patient and sought further assessment from the anaesthetist. A mutual decision was taken to postpone the patient's treatment until further assessments were completed on a different day, with the potential to refer the patient to an NHS hospital and GP for further assessments. The patient was given a full explanation and informed of their options for re-booking or referral to their GP.
- MSI south London did not see patients under 13 years of age; they would be referred to the safeguarding board and NHS. Between January 2017 and June 2017, the centre had not treated any patients below the age of 15 years. They had treated six patients aged 15 years of age within the last six months.

Cleanliness, infection control and hygiene

- An infection control link nurse at the centre had received level three training in infection control prevention (IPC). The COM and a further registered nurse had also received level three IPC training. We viewed evidence, which showed staff had completed this training in February and June 2017.
- In March 2017, a 55-point IPC audit was conducted across MSI UK locations. The audit measures included compliance with IPC training; governance and risk management, facilities and equipment, adherence to uniform policy and use of personal protective equipment (PPE). Other areas covered included: sharps management, waste management, cleaning linens, curtains and scrubs and sterile goods. The audit was carried out in the main surgical centre. MSI south London achieved an overall compliance of 81%. However, we were not provided with a compliance target and therefore did not know if they were achieving compliance or not.
- The audit showed areas of strength in each location. At MSI south London, strengths included good management of sterile goods, linens, and scrubs, with robust documentation and records of cleaning. However, areas of improvement included sharps bins, which were often left freestanding on floors and other work surfaces which posed a risk of being knocked over. During our inspection, we saw some sharps bins were freestanding. However, they were not placed on the floor and were placed in areas away from other equipment, which limited the chance of patients or staff sustaining a needle stick injury.
- There was an IPC policy, which had been reviewed in December 2016. Staff could describe the policy and were able to show us how they could access this on the computer terminals.
- We found equipment was visibly clean throughout the centre, and staff had a good understanding of responsibilities in relation to cleaning and infection prevention and control. We saw daily cleaning checklists for all areas of the centre. For example, the checklist for the ward area included checking the sink and taps were clean, as well as patient side tables, recliners, including armrests and covers. The first check was completed by a registered nurse or healthcare assistant, and a secondary check was completed by the lead nurse for that area. We saw all checklists had been completed and countersigned for the month of June and July 2017.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment in between patients, and we witnessed staff using these.
- We saw staff complying with infection and control policies. For example, we observed seven members of staff wash their hands in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'. We saw hand-sanitising gel was available at points of care in all clinic rooms. This was in line with Health Technical Memorandum (HTM) 'Infection control in the built environment'. Posters were displayed which explained the 'five moments for hand hygiene' in line with WHO guidance.
- All clinical staff we observed complied with bare below the elbow policy, which enabled good hand washing techniques and reduced the risk of cross infection.

- Monthly IPC audits were in place across the organisation, yet were not fully embedded into the location. Information provided by the South Region Quality Dashboard showed monthly hand hygiene data was only available for the month of May 2017, with a compliance rate of 91%.
- We saw an audit for peripheral venous cannula, which showed a compliance rate of 62% for May 2017. In medicine, a peripheral venous cannula is a small, flexible tube, which is placed into a patient's peripheral vein in order to administer medication or fluids. Upon insertion, the line can be used to draw blood. However, we did not see any further audits for the months of June or July.
- At our last inspection, we raised concerns regarding theatre staff not adhering to The Health and Social Care Act 2008 Code of Practice, on the prevention and control of infections. We observed staff working in the treatment room were not following standard infection prevention and control precautions related to personal protective equipment (PPE). Clinical staff in the treatment room did not use an apron to protect their uniform from potential contamination during procedures. When clinical staff left the environment, they did not cover their uniform with a clean over jacket or change into daywear.
- During this inspection, we saw staff wear over gowns to cover their scrub uniforms when leaving the treatment room environment and visiting other areas of the centre. During treatment, we observed the surgeon wear a single-use disposable apron for every treatment procedure they completed.
- Personal protective equipment (PPE) such as gloves and aprons were available for use by all staff. We observed they were stored appropriately on wall-mounted holders in the clinical rooms.
- Waste in all clinical areas was separated and in placed in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations. All waste was kept appropriately in bulk storage bins on the centres premises, which was collected by a specialist waste company every two days.
- The examination recliners seen within the consulting and treatment rooms were clean, intact but were not made of wipeable material. Staff were using disposable bed pads for each patient. These pads covered the main seating area. The COM told us that new recliner chairs had been purchased, which were made with wipe clean materials. We were provided with information that told us the recliners had been ordered through the executive management team (EMT) to ensure a consistent model across all centres. The EMT was currently awaiting exact arrival dates, but the order had been processed with the provider.
- MSI south London had an agreement with a contracted cleaning company. We saw cleaning certificates to evidence quarterly 'deep' cleans of the treatment room. The centre was cleaned daily before opening hours, and during the day up to three to four times per week. We saw daily cleaning checks had been completed for all bathroom facilities. The senior service delivery manager did random spot checks to monitor cleaning completed by the external company. They would directly feed back any concerns highlighted with cleaning standards.
- Lab spillage kits were available across the centre. Staff were able to show us where they were and how they were used.
- We saw certificates to show the water systems were compatible to Health Technical Memorandum (HTM) 04-01 'the control of Legionella'.
- The service sent reusable medical instruments to an outside provider to be decontaminated and sterilised. We were told the external company sent notifications of any difficulties, but they had not received any notifications in the previous three months. There was a system in place to enable tracking of instrument trays sent for processing. Instruments were sent in closed lidded boxes to a central sterilisation services department (CSSD).

Environment and equipment

- Recommended standards of practice (RSOP) 22: Maintenance of equipment requires providers to minimise the risk and emergencies through a programme of regular checking and servicing of equipment. We looked at records and saw all equipment had been serviced and maintained, with safety checks completed in line with the provider's policy.
- There was an onsite maintenance facilitator. They checked all equipment was functioning correctly and dealt with any environment and equipment issues. We

saw orderly records were kept which showed equipment had been maintained and serviced. The maintenance facilitator liaised with external specialist companies who serviced specialist equipment.

- We saw in the treatment room and ward area staff had fully completed the equipment checklist throughout June and July 2017, providing evidence they had checked equipment was working. For example, there were daily checks on equipment such as the pulse oximeter, suction machine, oxygen cylinder, glucometer, and blood pressure machines. The checklists were countersigned by a second staff member.
- There were two haemorrhage control packs in the centre, one in the treatment room and the other in the recovery ward area. They contained equipment to help manage such incidents, and the contents were checked on a monthly basis. We saw staff had completed the relevant checks, and records showed two staff members had signed the checklist, one being a registered nurse.
- We saw anaesthetists completed daily checks on the anaesthetic machine and airway equipment and these were documented.
- We saw there was a difficult intubation trolley, which contained specialist equipment for use in management of a difficult airway. The equipment was available and easily accessible in an emergency.
- Emergency equipment was supplied in the treatment room and recovery ward area. The treatment room contained a resuscitation trolley, which contained all the required equipment for an emergency, including medication to help with life threatening conditions. There were sealed tags attached to the trolley and records showed the equipment was checked on a daily basis. We viewed the checklists for both May 2017 and June 2017 and found all the checks had been completed.
- In the recovery ward, lifesaving equipment was kept in sealed tagged bags and included an automated external defibrillator (AED). A defibrillator is a machine used to deliver therapeutic shock to the heart, and is used to treat life-threatening conditions that affect the rhythm of the heart. We saw evidence checks were recorded by staff on a daily basis. The machine showed the next check was due in October 2017.
- We saw electrical safety checking labels were attached to electrical items showing they had been tested and were safe to use. The public entered the building through the main door which was security locked. Access was gained by speaking to the front of house staff member through an intercom. There was CCTV coverage of all parts of the building, which was monitored by the front of house staff member.
- The recovery ward area was air-conditioned and staff were able to manually control the temperature of the room for patient comfort.
- The service had two private changing rooms available for patients to prepare for an examination. These rooms were accessed via keypad entry.

Medicine Management

- There were systems in place to manage medicines. Staff were required to follow the MSI UK Medicine Management Policy, which outlined requirements including prescribing, ordering, administering, supplying, and disposing of medicines.
- Keys for the medicine cupboards were kept in a locked storage cupboard with a combination lock, which only a few registered nurses had access to.
- Anti-D stocks were kept in a fridge, which had a lock and key system. Registered nurses were the only staff members who had access to the fridge. Anti-D is recommended as a treatment option for all women undergoing abortion either early medical abortion or surgical termination, who are rhesus-D (RhD) negative and who are not known to be sensitised to the RhD antigen.
- The registered nurse lead for the day ward held the keys to the drugs cupboard. We saw staff had to complete a daily sign in and out sheet. There was a daily ward checklist for drugs, which had recently been introduced, and this checklist was countersigned by two registered nurses.
- Controlled drugs (CDs) were stored in a double locked cupboard. The lead nurse held the keys for access. We saw two members of staff, which included registered nurses and the anaesthetist, checked CDs. All stocks documented in the CD register were correct.
- At the early medical abortion unit (EMU), we saw medicines were kept in locked cupboards and daily checks had been completed and recorded. We were told drugs were transported to and from the EMU by a specialist company, which had been approved at corporate level. The drugs were stored in a secure container and records were completed for the signing in and out of drugs.

- Doctors using an electronic prescribing system prescribed medicines remotely. Medicines used in the treatment of abortion were only prescribed and administered once the legal requirements had been met for obtaining the opinions of two doctors that the termination could go ahead. Other medicines prescribed included pain relief medications and preventative antibiotics, used to reduce the risk of infection post procedure.
- There was a corporate centrally managed contract for the purchasing of medicines from an approved pharmacy supplier. Orders for medicines were placed electronically by a designated registered nurse. The nurse also checked stock and ordered top-up supplies. We saw the ordering and checking system, which was overseen by the COM.
- MSI south London had access to a corporate pharmacist. In December 2016, they conducted a pharmacy audit of the centre. We saw the audit, which provided recommendations for areas of improvement. For example, in the day ward, the pharmacist noted rotation of drugs was not undertaken. During our inspection, we saw staff now checked and recorded drug expiry dates.
- Room temperature control checks where medicines were stored were completed and recorded on a daily basis. We saw the checks made in July 2017. There were no concerns recorded. A staff member explained that the temperature was kept slightly under 20 degrees Celsius, as suppositories required a storage temperature, which did not exceed 20 degrees Celsius. This temperature suited all medicines stored at the centre.
- Fridge temperature checks for those medications requiring cold storage were monitored on a daily basis and we saw the checks made for July 2017. Prior to July, the checks were not being completed so actions taken involved a nominated member of staff to check daily.
- There was a list kept of maximum temperature for drugs kept on the ward. Staff told us if temperatures were not in the normal range they would inform the lead nurse. For example, if the temperature was too high for over 24 hours, they would remove the drugs out of the cupboard and place them in the main storage area.
- We spot checked 10 items of medicine in the main storage area and found them to all to be within their expiry date. The medicines were stored in an orderly fashion and rotated so medicines with a shorter expiry date were used first. We saw the checklists for June and July 2017 made for drug expiry dates. These checks were completed on a monthly basis.
- An audit of medical records was conducted in February 2017. A random set of 30 patient notes were reviewed and checks were made to see if anaesthetic notes were being completed, with drugs prescribed correctly. All 30 patient notes had been completed correctly.
- We saw nurses verbally checked the patients name and date of birth and gave verbal instructions of how to take medication. In the treatment room, staff verbally asked patients if they had any allergies before they commenced with treatment.

Records

- Records were both paper-based and electronic. Paper-based records were kept secure behind the nurse area or in a locked room. Electronic records were password protected.
- We reviewed 19 sets of records. The records were a combination of medical termination, surgical termination, vasectomy procedures, and treatment for patients under 18 years of age. The records were comprehensive and had been fully completed. They included details of initial consultation, medical details, signed and dated consent, and risk assessments. For surgical procedures, we saw World Health Organisation (WHO) and five steps to safer surgery checklist had been completed. The records also included signed and dated consent forms for treatment and two independent doctors signatures to authorise treatment procedures.
- We reviewed a records audit conducted on February 2017. Overall, the location achieved a compliance of 94.9%. The audit looked at six sections of record keeping, which included One Call booking information documented, the central records system (where patients information was electronically kept), workflow, ultrasound scans, pre-operative and procedure documented patient details. For example, for the pre-operative section, checks were made on consent being signed, logged and noted, and consent being re-affirmed, a venous thromboembolism (VTE) assessment completed, an under 18 pro-forma completed, an algorithm completed, the World Health Organisation (WHO) and five steps to safer surgery checklist completed, and a HSA1 record completed, that was signed and legible.

- There were procedures in place for reporting of patient's death to the CQC and Department of Health. There had been no deaths reported for the service within the last twelve months.

Assessing and responding to patient risk

- The MSI UK Abortion policy: Medical and Surgical procedure V2.1 dated December 2016, outlined the woman's journey for termination of pregnancy. The journey started with contact with the MSI UK call centre 'One Call' for a screening and clinical assessment. This assessment involved a telephone conversation to obtain basic details on the patients, such as confirmation of positive pregnancy test, date of birth, demographic information, special requirements (such as the need for an interpreter), and the offering of counselling services.
- Patients who wished to proceed with treatment were given a preliminary screening and assessment within 'One Call'. The consultation covered the patients' medical and obstetrics history, reasons for seeking termination of pregnancy, contraception choices, and abortion procedure options. Using pre-existing condition (PEC) guidelines, referrals and concerns with patients were referred to the lead consultant, in line with the agreed one call process.
- A physical assessment and initial risk assessment was undertaken at a face-to-face consultation or admission at the south London centre. The physical assessment included the patient's baseline observations, such as pulse, blood pressure being taken, point of care blood tests being collected, sexual transmission infections (STI) testing, ultrasound scanning and physiological assessment.
- During our last inspection, we found arrangements for the World Health Organisation (WHO) and five steps to safer surgery checklist were not fully embedded at the location. The checklist is a tool designed to improve the safety of surgical procedures, by bringing together the whole operating team to perform key safety checks during vital phases in peri-operative care.
- At this inspection, we observed an improvement with staff now using the. World Health Organisation (WHO) and five steps to safer surgery checklist . We observed three procedures, where the five steps were carried out at the appropriate stages of each of the patient's care and were documented by staff. The WHO structure and staff responsibility were discussed during the pre-surgery briefing at the start of the day.
- The World Health Organisation (WHO) and five steps to safer surgery checklist was audited on a monthly basis, to ensure staff were following the correct system. We saw for the months of July and August 2017, the audits achieved compliance of 96% and 100%.
- Prior to the patient's surgery, venous thromboembolism risk assessments (VTE) were conducted. VTE is a collective term for deep vein thrombosis, a blood clot that forms in the veins. The risk assessments allowed staff to provide prophylactic treatments if any concerns were identified. Nineteen records we viewed showed VTE assessments had been conducted.
- Point of care blood tests included testing for Rhesus factor. Routine antenatal Anti-D is recommended as a treatment option for all women undergoing abortion, either early medical abortion or surgical termination, who are rhesus-D (RhD) negative and who are not known to be sensitised to the RhD antigen.
- At the start of every day, a pre-theatre team briefing took place. As many staff attended as possible, including ward staff. We observed this meeting on the day of inspection. Approximately 10 members of staff attended the meeting, which included the anaesthetist and surgeon. It was led by the treatment room lead nurse, and covered issues relating to patient care. Discussions took place on each patient due for surgical treatment and concerns were raised. For example, a patient with mental health difficulties was discussed and all relevant records were collated. Staff were able to ask questions relating to patient assessments.
- We observed four pre-operative procedures checklists undertaken on patients by the registered nurse. Questions asked included when the patient had last drank and eaten (according to treatment), allergies, confirmation of completion of consent form, and the type of anaesthetic they were to have.
- For surgical procedures, there were always one registered nurse present who had received additional anaesthetic and recovery training. The anaesthetist was advanced life support (ALS) trained. On days when general anaesthetic was provided, an extra nurse acted as a circulator to assist with any patient concerns and to help with the smooth running of the treatment room.

Termination of pregnancy

- An ultrasound scanner was used throughout each procedure. This helped reduce the risk of retained products of conception. The surgeon visually checked pregnancy remains following each procedure.
- After surgical treatment, patients were 'recovered' in a separate room adjacent to the treatment room. A registered nurse (who had received recovery training) assisted the patient and took observations of care, such as blood pressure. The nurse was assisted by a health care assistant. The patient was then taken by lift in a wheelchair to the ward area by a registered nurse who was immediate life support trained. Oxygen was stationed in the lift, as an added precaution should the nurse need to access this for the patient.
- A handover sheet had recently been introduced at the centre. The sheet included the patient's name, gestation of the pregnancy, what recliner number the patient was to have, the level of anaesthesia, and time of admission, Rhesus factor, and allergies. The clinical team leader had also introduced a laminated card which contained a situation, background, assessment and recommendation (SBAR) summary and reminder card that all clinical staff could keep with them. The SBAR technique is used to facilitate prompt and appropriate communication. Staff we spoke with said the SBAR tool was beneficial and helped with handover of patient care. Bank nurses were also provided with an SBAR card when they arrived at the centre.
- During recovery on the ward, staff followed the adapted version of the national early warning score (NEWS). The adapted version was a termination of pregnancy early warning score (TEWS). This score was used to determine and act upon deterioration of a patient. Staff had received clinical training on the assessing and recording of patients vital signs at the centre from the clinical team lead. The clinical team lead was a registered midwife. We observed and checked five patients' TEWS scores and found the patients had all been correctly assessed.
- We observed nine patients being discharged. Staff completed a clinical fitness for discharge record, which had to be signed by the anaesthetist or doctor. Nursing staff monitored patients and medical staff stayed on the premises until either all patients were discharged or they conducted a ward round and were satisfied all patients were fit for discharge. Patients were provided with a discharge pack, which included written instructions and information, as well as an emergency 24-hour telephone contact number.
- There were emergency haemorrhage kits in both the treatment room and ward area. We saw daily checks of the equipment had been documented. Staff had received training on managing haemorrhaging emergencies from the clinical team leader during a 'skills and drills' session. The day of training included how to manage haemorrhaging situations and the use of the haemorrhaging kit and the importance of close monitoring of the patient. Staff we spoke with were able to describe the additional skills training and what processes they would follow in the event of a patient haemorrhaging. Staff told us the training from the clinical team leader was "invaluable".
- Sepsis arrangements were known to staff and they were able to describe the actions they would take in the event of recognising and managing sepsis within a patient. 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. In addition, the Management of the Deteriorating Client and Clinical Emergencies Policy v4.2, dated December 2016, included details for the recognition and management of sepsis.
- MSI south London had a transfer service level agreement (SLA) in place with a local NHS hospital. The centre had the bleep numbers of the gynaecology department and staff within the hospital. If a patient had to be transferred, the centre would provide a discharge summary to the hospital and the COM would contact the patient the following day.
- From July 2016 to June 2017, there had been a total of six transfers. The transfers included a patient who held bled heavily post-operatively, patients whose temperature had increased and a patient with unmanageable pain. We saw the incident reports and actions taken for each patient transfer.
- Resuscitation simulations for all staff were completed on a quarterly basis. We saw evidence the last simulation had taken place in May 2017. There were no recommendations for improvement made.

Termination of pregnancy

Staffing

- The required standard operating procedures (RSOP) 18 states 'staffing and emergency medical cover require, that providers of a termination of pregnancy service should ensure there is 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 found there were sufficient numbers of qualified staff at MSI south London.
- At the time of our inspection (26 July 2017) there were 10 registered nurses in post and six health care assistants (HCAs). All nurses were employed on a full time basis and there were three full time HCAs and three part time HCAs. The centre had two vacancies for registered nurses. At the time of our inspection, we were told the two posts had been filled and they had received confirmation of acceptance for the role.
- The COM told us staffing was based on clinical activity, with flexibility within the workforce to rotate staff into consultation or treatment room. Staff rotas were managed locally using an electronic rostering system. One permanent bank staff member was an operating department practitioner (ODP). We saw the ODP records of registration and completed checks of competency, which had been made by the organisation.
- There were no vacancies for medical staff at the time of our inspection. Medical staff were employed by the organisation and were subject to professional checks at a corporate level. Doctors worked both remotely and in the centre. There was always one doctor and one anaesthetist present on all surgical treatment days.

Major Incident awareness and training

- Staff received fire training via E-learning on a two-yearly basis. We spoke to five members of staff who were able to describe the procedures they would follow in the event of a fire.
- Training in a fire and emergency drill and preparation was an additional scenario based training and was mandatory every six months. All staff we spoke with during the inspection were able to describe the actions they would take and the role they played during a fire drill including where they would assemble if there was a fire.
- We saw the business continuity plan for the south London location. The plan included guides when dealing with common emergencies and the relevant contact details. There were action plans in place to deal with failures for emergencies such as: electrical, sewage, fire, fridge, medical gases, lifts, gas, bomb threat, and adverse weather.
- The COM told us there was an emergency back-up generator. We saw records to show this had recently been serviced and tested.

Are termination of pregnancy services effective?

Evidence-based treatment

- We reviewed a range of the organisational policies and procedures and audit schedule. We spoke with staff to evaluate how the service ensured treatment was based on professional evidence. Nursing staff and health care staff told us the company had reviewed and updated many of the organisational policies and procedures and staff were able to describe some of the key changes, for example, the Incidents Policy. Staff were able to tell us of the changes made in way the reporting of incidents into the electronic system. The polices were accessible and staff were able to show how to access them during the inspection.
- The Department of Health Required Operating Standards (RSOPs) take account of legal requirements and best practice for locations providing abortion services. In total, there are 25 RSOPs that providers must ensure they follow to enable them to provide safe and effective care.
- RSOP16 'Performance standards and audit' recommends all providers should have in place clear locally agreed standards against which performance can be audited, with specific focus on outcomes and processes. There was a system in place to monitor patient outcomes, such as failure rates, complaints, patient experience, and the prevention of infectious complication.
- RSOP 9 relates to the gestational limits with respect to termination. We were told the maximum gestational age accepted for termination was 23 weeks + six days. The service prescribed and administered abortifacient medication for medical termination. The provider offered four treatment options for this. Medication could be administered at the centre in two stages with six hours, 24 hours, 48 hours, or 72 hours in between each stage. The centre also provided surgical abortion

between five and 14 weeks gestation using local anaesthesia (LA), conscious sedation, and general anaesthetic (GA). Surgical abortions were undertaken under GA where the gestation was between five weeks and 23 weeks + six days. Late surgical abortions were performed from between 19 weeks and 23 weeks + six days.

- Professional guidance indicates two main surgical methods for termination of pregnancy. These are vacuum aspiration, which is recommended up to 15 weeks gestation, and dilation and evacuation (D&E) which is recommended where gestations are greater than 15 weeks. The service was following professional guidance in respect to this.
- RSOP 2 relates to medical terminations including early medical abortions (EMAs), delegations and duties and protocols. The COM told us and we saw different methods were available to terminate a pregnancy, which depended on the pregnancy gestation. The medical method involved the use of abortifacient drugs. Registered nurses administered these drugs once these had been prescribed by a doctor. This was in accordance with the Abortion Act, which required that only a registered medical practitioner may carry out an abortion.
- In accordance with the Royal College of Gynaecologists (RCOG) guidance 6.7, blood was tested at the patient's initial appointment to determine Rhesus factor and Anti-D immunoglobulin was administered to patients who were found to be rhesus negative.
- The Royal college of Obstetricians and Gynaecologists (RCOG) and RSOP 13: Contraception and Sexually Transmitted Infections (STI) screening, states a woman should be offered testing for STIs and all methods of contraception, including long acting reversible contraception (LARC), immediately after abortion. We observed staff offered testing for chlamydia and other STIs. We reviewed 12 sets of records, which confirmed these discussions took place.
- The centre had recently introduced additional long acting reversible contraception (LARC) clinics to help promote and provide contraception options. These extra clinics were managed by a contraception sexual health nurse employed by MSI UK. We saw LARC was discussed in the team meeting minutes of June 2017.
- MSI south London followed the RCOG guidelines for women with conditions such as ectopic pregnancy. The centre had a service level agreement (SLA) with a local NHS trust and patients were transferred to their care if necessary.
- We found the service followed RSOP 14: Counselling guidance. Patients were offered counselling services at their initial consultation. The patient had the choice of telephone discussions or face-to-face counselling. Trained counsellors were available in person at the location two days per week and available throughout the week for telephone discussions.
- At our last inspection, we raised concerns relating to RSOP 15: Disposal of fetal tissue. We found patients were not provided with information about disposal of pregnancy remains, so they could make a choice before treatment began. During this inspection, we found women were provided with information prior to treatment. Before the new procedures were put in place, the COM requested more information corporately, so staff were fully trained and knowledgeable about the information they were going to provide. This demonstrated the centre ensured staff were fully informed and understood the guidance relating to RSOP 15, in order to enable best practice.
- There had been a recent revised corporate audit plan. We found it was not yet fully embedded into the centre. Audit data was inconsistent. For example, for hand hygiene audits, data was only available for May 2017. Information was not available for March and June 2017 when we requested this.
- In accordance with National Institute for Health and Care Excellence (NICE) 61 Quality Statement 1'Antimicrobial stewardship', patients undergoing termination of pregnancies were treated with preventative antibiotics

Nutrition and hydration

- Patients were offered a hot or cold drink and a choice of biscuits prior to discharge.
- There were water machines in both the waiting areas and the recovery ward for patient use.
- Patients were given information prior to treatment about when to stop eating and drinking for surgical preparation. Information provided stated no food should be eaten six hours before the appointment, and fluids could be drunk up to two hours before. However, due to delays in in the daily list of treatments, this

sometimes meant patients had 'fasted' for an unnecessary length of time. The centre had introduced staggered admission times to help reduce the wait for patients and to ensure they were without food and water for the minimum amount of time.

Pain relief

- We observed patients being given appropriate pain relief, such as non-steroidal anti-inflammatory drugs, during our inspection.
- Staff used a pain score tool to record the level of patients' pain. The scores ranged from zero to 10. In this scale, zero meant no pain and 10 was extreme pain. For the 19 sets of patient records we reviewed, we saw the pain score had been correctly employed and medication had been given in a timely manner and recorded appropriately.
- Single-use abdominal heat pads were provided to patients throughout the inspection. The heat pads aided comfort to patients post-treatment and were offered to every patient.
- Staff provided pain relief information to patients as part of discharge discussions. Pain relief was prescribed pre and post treatment for those patients undergoing surgical terminations.

Patient outcomes

- RSOP16 states that outcomes of patient care and treatment are routinely collected and that the service should have clear locally agreed standards against which performance can be audited, with focus on outcomes. The service had systems to monitor and measure patient outcomes in accordance with this RSOP.
- We viewed the South Region Quality Assurance Dashboard, which included information that was collated by the regional clinical and quality lead. The dashboard displayed clinical data, such as failure rates, LARC uptake and the do not proceed with treatment rate (DNP).
- From January 2017 to June 2017, the service carried out 2,004 surgical terminations and 1,482 medical procedures. There were 18 vasectomy procedures performed. The service had recently started vasectomy procedures (May 2017), so there was limited data available to capture patient outcomes.
- From January 2017 to June 2017, the surgical termination of pregnancy treatment failure rate was 0.2%. For early medical abortion treatment, this was 0.4%. This was similar to other locations based in the south of England.
- Marie Stopes International corporate target for uptake of long acting reversible contraception (LARC) was 50%. The LARC uptake for the centre for the reporting period was 30%, which was relatively low. The worst months were February 2017 with 27%, May with 28% and June with 23%. The introduction of separate additional LARC lists had been introduced as a way of tackling this low uptake.
- The sexually transmitted infection (STI) screening uptake for the reporting period January 2017 to July 2017 was 58% overall. The best month was April 2017 with 88%. The remaining months averaged 50%. Comments on the South Regional Quality Assurance dashboard stated there was an unexplained and unsustained spike from April 2017, which should be investigated and learned from. We were not provided with ant information to say whether this has been investigated.
- The do not proceed with treatment (DNP) rate for the reporting period was 20% overall. The top three reasons given for not proceeding were: the gestation was too high for the list or the gestation too low, NHS referral, and more information required from GP.
- There was one return to theatre treatment from January 2017 to July 2017. This related to a patient who had post-abdominal pain which was unresolved with analgesia and further investigation was required.
- The regional managers were able to compare outcomes from each location in the south. This enabled them to recognise trends and investigate adverse outcomes.
- Nursing and other clinical staff we spoke with were not familiar with the South Region Quality Assurance Dashboard. However, this new tool was in the early stages of implementation. The COM was aware of the dashboard and the data the dashboard provided. The COM was able to tell us that information from the dashboard showed that MSI south London had reported fewer incidents than other locations and as a result, they were going to discuss this with staff at the next team meeting.

Termination of pregnancy

Competent staff

- There was evidence that an induction programme for new staff was in place. The clinical team leader assessed clinical staff competencies and the clinical team leader had recently introduced a new revised induction pack. We were told by the COM this had since been introduced at other locations.
- The induction involved a super-numery period of four weeks, where staff (either registered nurse or health care assistants) were provided with all induction material courses, and e-learning modules to complete. Staff were 'un-operational' during the four weeks. The new staff members had competencies assessed for each module they completed.
- The probationary period lasted six months and was based on objective structured clinical assessment (OSCA). Scanning and working in all areas within the centre were part of the probation.
- The new induction had been trialled on four nurses currently in their probationary period. We spoke with two staff members during the inspection, and they were complimentary of the induction training and support they had received.
- The clinical lead had also provided support for nurse's revalidation. We saw four reflective accounts were set for nurses to complete to help them through their revalidation. We saw the plans displayed on the clinical team leads white board in their office. Each registered nurse's name was displayed and a tick box was completed when the nurse had completed their reflective account.
- The COM had access to the 'open door' computer package, which was a system to access staff skills and competencies records of MSI staff working outside the location. We saw records which showed the anaesthetists working on the day of our inspection were up to date with all training.
- All staff had received an appraisal, except for those who were still undergoing their probationary period. Appraisals were conducted on an annual basis. Nursing staff we spoke with confirmed they had received an appraisal and were able to describe learning needs that were identified and the support they received from their line manager.
- Staff told us they had received additional training to help with their development. A health care assistant told us they were training to undertake ultrasound scans. The training involved attending an external accredited training programme. Assessments were made using a competency framework. Staff were required to perform a certain amount of scans before they were competent and had a scanning mentor assigned throughout their training.
- 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. They still took scans under supervision until they had completed their proficiency. All nursing staff who worked in the treatment room had successfully completed the ultrasound-scanning programme.
- All nurses who worked at the centre had validation of professional registration, which meant the centre made appropriate checks to ensure all nurses were registered with the Nursing and Midwifery Council (NMC).
- Registered nurses were receiving electronic knowledge assessment (EKA) for sexual health and training to fit the intrauterine coil. This is a form of contraceptive. Previously staff had internal training. The training was conducted by an external accredited course. MSI UK paid for the EKA exam fees and 15 hours of study time. In order to be certified, the registered nurse had to demonstrate fitting and removal of the coil and for this to be proven by competency letter. As this was still in the early stages of implementation, we did not see any evidence to show any staff member had achieved certification.
- Records of competency for medical staff were held centrally. Doctors we spoke with confirmed they had an annual appraisal as part of the General Medical Council (GMC) revalidation process. The monitoring of medical staff was managed by the central management team at MSI UK.
- Anaesthetists' received annual appraisal, which was undertaken in the NHS hospital where they had main employment. The medical director sought assurance of their appraisal to ensure records were complete.
- Training days were held at the centre. We viewed the training agenda of March 2017 and training included duty of candour, haemorrhaging skills, fire participation

drill, IPC, and a visit from a women's refuge centre. Nursing staff we spoke with were able to verify the training took place and described the knowledge they had received as a result of this training.

- We reviewed three registered nurse staff records. We saw competency based assessments had been completed by the clinical team lead for each nurse. One included the on-boarding and induction checklist, which showed completion of competencies such as consent, safeguarding, anaesthetics, and recovery training. The nurse had to score above 80% to pass.
- There were objective structured clinical assessments (OSCA) for all three staff records we viewed. The OSCA' s we viewed related to measuring and recording vital signs. Staff were observed and assessed on three separate patients and these were signed and completed by the clinical team lead. For all three staff records we viewed the members of staff had passed the competency checks with 100% for each check.
- We viewed the OSCA for vasectomy patients and observations of three patients were conducted by the clinical team lead. They observed and assessed the staff member's competencies for vasectomy knowledge, equipment and drugs used for this treatment, pre-operative checks, the treatment itself and recovery and discharge. The staff member had to demonstrate these competencies on an annual basis. We saw the staff member had completed all competencies observed.

Multidisciplinary working

- Clinical and administrative staff worked well together. There were clear lines of accountability set out in job descriptions.
- We observed good communication between the surgeon, anaesthetists, and nursing staff.
- Patients had access to a 24-hour post-procedure support line. Patients could speak to a registered nurse or midwives and could be referred to counsellors if necessary.
- There were good working relationships with the local clinical commissioning group (CCG) and local NHS hospital. Staff had bleep numbers of the gynaecology department within the hospital.
- Team meetings were held on a monthly basis and topics discussed included incidents and medicine management. We saw minutes of these meetings, which showed a good attendance of all staff, including the doctor.
- RSOP3 Post-procedure recommends that wherever possible a woman's GP should be informed about their treatment. Patients attending the service were asked if they wanted their GP to be informed by letter about the care and treatment they received. Their decisions were recorded and respected.

Access to information

- RCOG guidance 8.2 recommends on discharge, women should be given a letter providing sufficient information about the procedure to allow another practitioner elsewhere to manage any complications. We saw evidence the centre was following these guidelines. Discharge letters were sent with all patients who were transferred to the local NHS hospital.
- We found the surgeon and anaesthetists had access to the patient care plans and relevant information pre-treatment. For two patient cases we saw the service had received information from the patients GP and local authorities in relation to patient care. This information was available in hard copy and on the electronic system. The information was received and could be discussed with other staff at the morning pre-theatre meeting.

Consent, Mental Capacity Act and Deprivation of Liberty

- RSOP 8 relates to consent, including adults and children under 16 years of age. At out last inspection, we raised concerns relating to the competency of obtaining consent for patients. Following our last inspection, the organisation had reviewed consent training and competence. A revised and updated consent policy outlined only registered nurses or clinicians were able to gain patient consent. During our inspection, we saw only registered nurses were obtaining consent during consultations. If a HCA provided patient consultation, a separate consent appointment with a consent nurse was provided. The consultation and separate consent appointment occurred on the same day.
- We viewed the training matrix, which showed all registered nurses had completed consent with capacity training as well as informed consent training and this was all in date. Although a HCA could not obtain consent from patients, they too had completed both

modules of consent training. This was seen as a developmental tool for each HCA. The safeguarding vulnerable adults and children levels two and three training included information on Mental Capacity Act 2005 and Deprivation of Liberty standards. All staff had completed this training.

- We observed nursing and medical staff gain written and verbal consent during four consultations, and five confirmations of consent prior to surgical procedures, in the treatment room.
- Due to the serious incident which took place in January 2016, where a patient was consented after treatment, there had been greater focus on consent training by the COM. Part of the process of ensuring consent had been correctly obtained for surgical procedures included ensuring the World Health Organisation (WHO) and five steps to safer surgery checklist t was complete. All patients were introduced prior to surgical treatment and had to announce their name, date of birth, allergies, and confirmation of consent to all staff in the treatment room. This information was recorded. We saw discussions on the importance of consent and when to obtain this took place in the south London team meeting in March 2017.
- Staff applied the Fraser guidelines and Gillick competence when obtaining consent from patients under 16 years of age. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. The Gillick competency determines a child's capacity to consent.
- We viewed 19 sets of patient records and saw consent was obtained from all patients for their treatment. All consent forms were signed, dated and legible. A range of consent forms were available for specific treatments and a list of all possible complications were included on each of these for the patient to see. There were consent forms for surgical or medical termination of pregnancy and for LARC.

Are termination of pregnancy services caring?

Compassionate care

- We saw staff providing compassionate and considerate care to patients. Staff from across the service interacted with patients in a sensitive and thoughtful manner.
- We saw front of house staff handle patients in a professional and caring manner. The patient's privacy was respected. Staff told us they made sure other people waiting nearby could not hear private conversations. Patient's private details were not discussed at the reception area.
- We saw on numerous occasions staff deal with patients who were upset. Staff were kind, non-judgmental, and reassured patients. An example, was a patient who was upset in the treatment room prior to a procedure. Staff spoke kindly to the patient, did not rush the patient, and made sure they were comfortable to proceed with the treatment. There was no pressure placed on the patient to go ahead with the treatment. The issue was dealt in a dignified and considerate manner.
- Staff in the recovery ward area were considerate to patient's needs. For example, staff responded quickly to patient's wellbeing with regards to pain relief and comfort. Staff frequently asked patients if they felt comfortable or needed anything to drink.
- The patients we spoke with were complimentary about the quality of care they received. Some patients told us nurses were "kind and gentle". Another patient described staff as "kind" and said, "They dealt with my pain", and a further patient told us staff "were kind and explained things to me".
- At provider level, MSI produce quarterly patient satisfaction surveys to see if they are meeting the needs of patients who use the service. The surveys are used to benchmark performance and make comparisons across different MSI locations.
- Data from the Regional Quality Assurance dashboard showed there was no patient satisfaction feedback collated from January 2017 to March 2017, due to the low response rate (15 patients). Results from the April to June 2017 survey showed the service received a total of 834 responses, which represented a response rate of 38%. We saw for overall care the location scored 93% against a corporate target of 95%. The location scored below average for process of booking appointments at 77% and amount of time and attention given at 87%. The location scored high for helpful and understanding at 96% and treated with dignity and respect at 95%. The

survey did not show any recommended actions for the low scores. However, the COM told us they would discuss low rates in team meetings but we did not see any evidence to corroborate this.

- Comments made by the regional clinical and quality lead on the regional quality dashboard noted there was no means of coding patient questionnaires for the satellite sites or specific locations. This meant the patient feedback for the early medical abortion unit (EMU) satellite sites was lost.
- The provider collected patient feedback for vasectomy procedures. At the time of our inspection MSI, south London had just started to provide vasectomy treatment and no patient feedback had been collected.

Understanding and involvement of patients and those close to them

- Most of the patients we spoke with were involved as much as they wanted to be in their care and treatment. They told us staff explained things to them in a way they could understand, and were clear about the additional support available to them, such as counselling.
- Staff involved patients throughout their pathway of care. Staff explained procedures to patients in a calm way. However, there were occasions consultations appeared hurried, due to the heavy caseload. Despite this, staff always allowed time for conversations about any concerns the patient might have if required.
- During the inspection, we saw staff inform patients that the HSA4 form was used for statistical purposes to inform the Chief Medical Officer of termination of pregnancy in the Department of Health. This was in accordance with The Abortion Act 1967.

Emotional support

- RSOP 3 – Counselling requires providers to have protocols in place to offer patient support following the termination and access to alternative pathways of care. Counselling services were available to all patients' pre and post treatment. Any patient under 16 years of age was provided with counselling on a different day to their treatment.
- We observed counselling support services offered to patients throughout five consultations. One patient confirmed they had been offered access to counselling services should they wish to have this. Counselling services were also available to men who underwent vasectomy procedures.
- Counselling services included bereavement counselling, relationship and self-esteem building, pregnancy related distress, fear of pregnancy or parenthood, and ectopic pregnancy. Other concerns commonly discussed were vasectomy, self-worth, and managing emotions. We saw information displayed throughout the centre on supportive services for counselling and other external organisations, such as support organisations for women subject to domestic violence.
- Patients had access to a 24-hour aftercare support line, made available with discharge information and advertised on the MSI website. Counselling was offered as a face-to-face or by telephone, depending on patient preference.

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- The services were operational six days a week, Monday to Saturday, with additional lists on a Sunday if required. The services were available to local people and to those further afield. Patients could self-refer or be referred via the clinical commissioning group (CCG), as a NHS patient. The service planning was managed by the business development team within MSI UK.
- MSI south London had five consultation rooms, which allowed for privacy where discussions could take place without any interruptions.
- At our last inspection in May 2016 we found privacy and dignity was not always respected within the waiting area, due to the lack of seats and cramped environment. We were told by staff, patients often sat on the floor during busy times at the location, due to overcrowding and lack of seating.
- During this inspection, the COM told us more seats had been placed within the waiting areas, but we were unable to see a noticeable difference since the last inspection. Five members of staff we spoke with said the waiting areas were still overcrowded on busy days and patients frequently sat on the floor. Staff told us the last time this happened was the day before we inspected.
- The seating environment within the waiting area meant patients sat close to each other. This meant patients did not receive the privacy and dignity they might have expected during their visit to the centre, especially for those who were more vulnerable.

- We saw evidence MSI south London the centre worked with external organisations to provide the correct treatment pathway for a patient with mental health concerns. Before treatment started, staff ensured they had the relevant background records and documents from the local council and the patient's GP. Conversations regarding the patients treatment took place during the pre-theatre briefing meeting at the start of the day, so all staff were aware of the patient's needs before they arrived. The COM attended to the patient when they arrived to ensure they were comfortable and ready for treatment. In the treatment, room staff had another pre-briefing before collecting the patient to re-enforce the sensitivity of the patients care plan.
- We reviewed formal guidance, which was followed by staff at south London centre to determine the eligibility for treatment. This was known as 'Pre-existing conditions' (PEC). Where additional information was required, or a patient was not suitable for treatment, staff liaised with the respective GP with the patient's consent.
- We saw information displayed and available for patients for concerns such as victims of domestic violence.
- Patients had access to a 24-hour aftercare telephone line that was manned by registered nurses. We were told nurses were trained to assess and provide advice over the telephone. Individuals could be booked to come back into the centre for further assessment if required.
- At our last inspection in May 2016, we raised concerns regarding the lack of information women were provided regarding the disposal of pregnancy remains. At this inspection, we saw changes had been made to improve and provide choice for women regarding pregnancy remains. A new policy and procedure was in place, the MSI UK Management of Fetal Tissue policy, dated May 2016. This policy was in line with guidance provided by The Human Tissue Authority (HTA) Code of Practice.
- Women were given information during their consultation phase and records we reviewed demonstrated this. Staff told us conversations on supplying this information often made them feel uncomfortable, but they understood the reasons why these conversations needed to take place, and women should be given the choice.
- We saw the storage of pregnancy remains complied with the organisation's policy. There were records to show collection was made by a specialist company and freezer records showed the reason for storage and date. Pregnancy remains were only released to patients after checks had been completed and discussions with either police (for police cases) or funeral directors had taken place. Patients were provided with information on the steps they needed to take with regards to pregnancy remains.
- An interpreting service was available for those patients who did not speak English. Translating services could be booked via 'One Call' at the initial consultation. During the inspection, we saw the centre use the services of an interpreter for a patient.
- Patients were able to store their belongings whilst they had their treatment. Within the ward, area patients had the use of side tables with drawers where their belongings could be stored.
- There was good access throughout the building for disabled people. The centre could accommodate patients with wheelchairs. There was lift access to other floors and consultation rooms were spacious.
- Patients had access to information in the form of leaflets and through the MSI website. Information on the website included availability of translation services and how to raise a concern or complaint.

Access and flow

- The service could be accessed via a 0345 telephone number, which was free to call from all landlines and mobiles. Patients could also access the service by e-mail, text, and website enquiry form. The call centre operated 24 hours a day.
- RSOP11 – Access to Timely Abortion Services, states women should be offered an appointment within five working days of referral and they should be offered the abortion treatment within five working days of the decision to proceed. The service monitored its performance against the waiting time guidelines set by The Department of Health.
- From January 2017 to June 2017, the average appointment wait time in days for surgical terminations less than 14 weeks gestation was 5.6 days. For surgical terminations over 14 weeks of gestation was 12 days. However, these figures showed a steady decrease in the waiting times. In February 2017, the appointment waiting time for over 14 weeks gestation was 24 days. In April 2017, this had decreased to 15 days and for June

2017, this was down to five days. One of the measures that the centre had taken in response to increased wait times was opening on a Sunday to help alleviate the delays.

- MSI south London had a process to manage booked appointments. The number of patients booked each day depended on the patient's gestation. During our inspection, we saw approximately, 26 to 30 appointments were booked each day. Staff told us overbooking was routine, to allow for those patient who did not attend.
- Most staff told us the did not have enough time to see patients. Staff were given 20 minutes to complete consultations, which sometimes included point of care tests, ultrasound scanning, assessing safeguarding concerns, taking informed consent, and completing risk assessments for patients.
- The cancellation rate for MSI south London for the reporting period January 2017 to July 2017 was 5%. In total, 181 patients had their treatment cancelled or rebooked. In June 2017, 50 patients were cancelled or re-booked. The figure was high this month due to the pilot schemes the centre was trialling. The centre was trialling the 'Pilot 1' scheme, which meant patients could be seen, assessed and treated on the same day.
- The COM told us the scheme was not entirely effective and due to overrun lists, the centre ensured patients had completed all assessments in the first appointment and guaranteed a follow-up appointment the next day. However, this meant the pilot scheme was not working effectively. At the time of our inspection, the centre was still in discussion with regional management on the next steps they needed to follow concerning the pilot scheme.
- The centre had an increase in activity and patient lists due to several of the satellite locations being closed for refurbishment. It was recognised that once the satellite sites were reopened this would relieve the pressure from the main centre. We did not see any information which related to how long the EMU centres had been closed but did see time frames that the centres were due to reopen in September and October 2017. MSI south London had the flexibility to open on a Sunday dependant on patient demand. Staff cover was offered through overtime and the treatment lists provided were dependant on the amount of staff available.
- The service did not run on time. Information provided showed between June and August 2017 there were late finishes for half of the working time. For June 2017 there were late finishes on 15 occasions with an average 'minutes late' mean time of 30 minutes. In July 2017 there were 14 occasions of late finishes and for August 2017 another 14 occasions of late finishes. For some days, late finishes were of one hour and above. The COM told us the centre was still in discussion with the regional and corporate team to devise ways of improving the timeliness of the service.

Learning from concerns and complaints

- In relation to RSOP17 – Complaints and feedback, the service received a total of seven formal complaints. Two complaints were upheld.
- The top three complaint trends were waiting times, staff shortages and staff behaviour. For complaints relating to staff behaviour, the COM spoke directly to the complainant and the staff member. The staff member was then asked to produce a reflective account.
- There was an updated MSI UK Handling Comments, Concerns, Complaints and Compliments Policy, which staff could access and follow.
- We were shown the complaints file held at the centre and staff were able to describe the complaints process. A dedicated staff member dealt with complaints. We saw replies to complaints were sent to patients in a timely manner. The centre acknowledged written complaints within 48 hours, and within 24 hours for a telephone complaint. The aim was to have the complaint reviewed and completed within four weeks. If the location could not meet this expectation, a letter was sent to the person to explain why.
- We reviewed three complaints and saw processes were followed in line the organisation's complaints policy. The complaints involved acknowledgment and receipt. The full response to each complainant was thorough and investigatory findings were shared. However, we did not see any evidence to indicate shared learning from complaints among staff, or any evidence to show changes made in response to a patient complaint or feedback.

Termination of pregnancy

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 also the clinical operations manager (COM). They were supported by the clinical team leader (CTL) and a clinic controller.
- The COM reported to the senior service delivery manager. The COM told us they a had a good working relationship with their line manager and felt well supported. They said they were able to make contact with their manager and other members of the senior team at any time. Regular weekly catch-up sessions were held, where the COM could share concerns and discuss the latest clinical and corporate news.
- Staff at the service told us there had been constant changes at the executive team level since 2016. They were concerned that with each new manager that came, new procedures or processes would be implemented. This caused confusion and made them feel unsettled. Staff said they wanted a period of staff stability at a senior level so they could focus on delivering the current changes the organisation had asked them to make.
- At a local level, nursing and administrative staff told us they were happy with the leadership of the registered manager. There was also high praise from the nursing staff for the CTL. Most nursing staff said the CTL made them feel motivated, was supportive and encouraged their development. Staff said the centre was now more nurse-led than a year ago, which was positive.
- The CTL had focused on clinical nursing skills and competencies since being in post since May 2016. They had introduced a new induction starter pack for all new clinical staff. The induction process ensured staff had support with training, and that competencies had to be assessed and signed off before a staff member could pass their induction period. The induction pack has since been used by other MSI locations for new staff.
- The CTL is a registered midwife and through their experience and previous training, had introduced 'skills and drills' training sessions for nursing staff. These were focussed on improving clinical nursing skills. Staff told us they had received training on managing haemorrhaging incidents and how to use the TEWS tool effectively, for example. We received good feedback from nursing staff on these training sessions.
- There was an 'open door' policy within the centre. During our inspection, we found staff were able to speak with the COM and CTL freely. The atmosphere throughout the centre was very relaxed and friendly. Most staff we spoke with enjoyed working at the centre and said the teamwork and support from colleagues was good.
- Team meetings occurred on a monthly basis. Previous minutes indicated that topics discussed included IPC, incidents, lessons learnt from serious incidents and the locations operational treatment list. Opportunities for staff to raise any other business was structured into the meeting format.
- The COM told us the organisation had allowed each location six hours per month for meetings and training. It was up to the COM how they managed these hours. Time was factored into each month for the centre to close to allow for these meetings/training to take place.
- At out last inspection, we raised concerns relating to the organisations heavy top-down approach and how local managers were not allowed to make decisions to enable them to effectively run their centres. During this inspection, the COM and CTL said they felt more empowered to make decisions that affected the service. However, the operational requirements of the location were still corporately-led.
- The main complaint from staff working at the centre was the lack of time given for consultations and the heavy daily caseload. Although staff would stop patient lists if they felt patient safety was compromised, there was lack of clarity in managing the daily lists. Staff said they felt their voice was not heard when they raised concerns regarding the heavy caseload. The COM explained that they were actually seeing 100 less patients per month, but with new safety checks made during consultation and treatment, there was still insufficient time, and lists still overran.
- The structure and management of the early medical abortion units (EMU) within the southern region was being reviewed at provider level at the time of the inspection. There was no on-going monitoring or oversight of the EMU by the COM at MSI south London. This had been delegated at provider level to a nominated district team lead; however, the appropriate

registration amendments had not been applied at the time of inspection to ensure compliance with registration regulations. This matter was raised previously during an inspection in another south region location, the provider responded, and stated actions would be taken to address this.

- There was effective process in place by the nominate 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 integrated governance committee as exception reporting. Early medical abortion unit (EMU) staff attended a monthly team meeting, which was held on the first Friday. Staff we spoke with during the inspection at the EMU were positive on the changes the district team had made, especially with rostering. Staff were now given advanced notice of their rosters and were located in locations that were close to their homes. We were provided with positive feedback from the staff member about the district team leads.
- Legislation and regulations require that in non-NHS services, the place where termination of pregnancy is carried out, must display a certificate of approval issued by the Department of Health. We observed the certificate of approval (issued by the Department of Health) was on display in the main reception area and waiting room for treatment.

Vision and strategy for services

- Marie Stopes International had a vision, core values, and strategy to deliver high quality care to promote good outcomes for patients and encompass key elements such as compassion, dignity, and equality in the business.
- A new vision and strategy had been implemented for the organisation. The new strategy was quality driven and focussed on patient care. During our inspection, we found staff understood the vision and how more emphasis had been placed on patient care. However, staff told us they had not been included in any stage of incorporating the new vision.

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

- There was a new governance structure in place. The COM was able to describe the reporting structure and local governance arrangements. They included having a regional clinical quality and governance lead, which had oversight of the greater London and South East team.
- The COM told us the overall governance structure, including meetings and sub-committees, was not yet fully embedded into the organisation, and was still in its infancy.
- The COM attended a monthly regional managers meeting. We were told discussion took place on incidents and risks. The COM told us this was an invaluable meeting, as there was shared discussion of learning and support given amongst the managers.
- The COM told us they attended the clinical effectiveness meeting with the clinical team leader on a monthly basis. Other attendees included the regional governance lead, IPC lead and other centre managers and clinical team leaders. Issues such as, clinical performance, IPC and clinical incidents were discussed across each region.
- There was a South Regional Quality Assurance dashboard, which was updated on a monthly basis. The dashboard provided information on clinical information and issues on each location in the south region. This information was then fed through to the central governance committee. Under the headings: safe, effective, caring, responsive and well-led, quality data was collected. This included information such as: reported incidents, risks, local IPC audits, compliance, complaints and staff sickness. This enabled regional managers to benchmark, monitor, and compare locations to identify trends and manage risks.
- Comparisons were made between outcomes in each of these areas for each location. We saw comments which suggested MSI south London were under-reporting incidents when compared to other locations. As an action, the COM told us at the next team meeting, they would discuss incidents and the importance of reporting all types and severities.
- MSI south London held separate monthly clinical staff meetings and team meetings. The clinical staff meetings were attended by all clinical staff and the focus was placed on clinical issues such as contraception, STI testing, LARC and communication.

- The general monthly team meetings were attended by all staff at the location, and topics discussed included, incidents, IPC, the operational list. There were opportunities for staff to discuss any additional concerns or raise further topics for discussion at the end of the meeting. We viewed minutes of both meetings and found them to be structured and informative.
- Concerns from our previous inspection in May 2016, relating to IPC procedures had been addressed. There were more robust arrangements and checks in place with regards to infection control.
- There was a revised audit programme, but this was not fully embedded into the location. Information from the South Region Quality Assurance dashboard showed inconsistencies in the reporting audit outcomes for each location. Data captured from March 2017 to June 2017 for hand hygiene, World Health Organisation (WHO) and five steps to safer surgery checklist and IPC audits was only available for two of the reporting four months for MSI south London.
- With the introduction of the patient safety incident reporting system and new regional clinical and quality lead, there was a more robust oversight of local risks. The centre had a risk register and the COM was able to tell us the three top risks. The risks were incorporated into the South Regional Quality Assurance dashboard, which was escalated to the corporate governance team.
- The top three risks for the location were: evacuation from a toilet in an emergency, the operational list ('Pilot 1' scheme) and medicine management. Actions taken against the risks included the purchasing of a patient 'slide sheet' that could be used to help remove patients more easily from the toilet, if they collapsed. Discussions were taking place around the effectiveness of the 'Pilot 1' scheme, which were still on-going at the time of our inspection.
- The COM told us staff at the service did not have input into the local risk register, and we were therefore not assured all risks were being captured. Staff we spoke with could not tell us what the top three risks were.
- Legislation requires that for an abortion to be legal, two doctors must agree in good faith, the grounds for abortion in the Abortion Act are met, and documented in a certificate of opinion. Arrangements were seen which indicated certificates of opinion (known as HSA1 forms) were signed by two medical practitioners, in line with the requirements of the Abortion Act 1967 and Abortion regulations 1991. The forms were signed and uploaded onto the electronic database.
- Arrangements for the completion of the HSA1 forms were set out in local standard operating procedures and staff were able to describe the process. For all of the patient records we reviewed, the HSA1 form had been completed and was signed by two medical practitioners. This was in line with the Abortion Act 1967.
- The COM was able to describe the processes they followed when submitting the HSA4 form to the Department of Health. The regional director monitored the submission of HSA4 forms to ensure they had been submitted within the time frame. This information was displayed on the South Region Quality Assurance dashboard. From April 2017 to June 2017, a total of 37 HSA4 forms had been submitted after the 14-day period. This was due to the practices of two doctors and this was being managed by the medical director.

Public and staff engagement

- Patients who attended the centre were provided with feedback forms. The forms asked patients for feedback and their opinion of the service. The forms were then collated by an external company and a quarterly report was produced.
- Patients were able to provide feedback via the organisations website through 'share your experience'. Patients were required to complete an online form in order to share their experience; however, we did not see any examples for this location.
- We saw noticeboards within the staff area. One clinical board displayed clinical updates, outcomes and the organisations missions and values. The other noticeboard displayed management structures within the location.
- The COM told us patients positive comments were fed back to staff and they were able to use this feedback as part of their revalidation process.

Innovation, improvement, and sustainability

- The service had recently introduced a separate long acting reversible contraception (LARC) clinic, with support from the organisation's contraceptive and sexual health nurse.

Termination of pregnancy

- During our inspection, we found improvements from our May 2016 inspection, including better IPC practices and an improvement in the reporting of incidents.
- Since our last inspection in May 2016, nursing staff told us the training had improved and they felt more empowered to make clinical decisions with the support of the clinical team leader.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should make sure there is sufficient time for consultations, so appointment times do not overrun.
- The provider should monitor overall patient caseload to ensure patient delays and cancellations are kept to a minimum.
- The provider should provide root cause analysis (RCA) training to the clinical operations manager (COM) so they are equipped with the essential tools to investigate serious incidents.
- The provider should make sure there is sufficient seating, or effective processes, in place to provide seating for all patients and their family/friends or carers at all times. Patients should have a dignified and peaceful area available to wait for their treatment.
- The provider should make sure there is a robust system in place to share learning from all incidents and complaints with all staff.
- The provider should ensure that the risk register is shared with all staff and that they have an input and understanding into the risks of the centre.