MSI Reproductive Choices

MSI Reproductive Choices District Treatment Centre - South London

Inspection report

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

Date of inspection visit: 9th March 2023 to 13 March 2023
Date of publication: 19/05/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always ensure that medicines were managed in a safe way. Expired medicines were found in all areas medicines were stored. This included medicines used in emergency situations.
- Mandatory training completion rates did not always meet the provider's benchmark standards.
- Women waited longer than five days between initial appointment and treatment which did not meet national guidelines.
- Leaders did not always have clear oversight of the risks to the service.
- The layout of the service did not always allow for women's emotional needs to be met.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy	Good 	Our rating of this service stayed the same. We rated this service as good because it was effective, caring, responsive, and well led although safe requires improvement. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to MSI Reproductive Choices District Treatment Centre - South London

MSI Reproductive Choices District Treatment Centre South London is operated by MSI Reproductive Choices. The treatment centre is a dedicated standalone building retrofitted for clinical care, including surgical procedures. The treatment centre has five consulting rooms, a surgical theatre suite, a ward area with eleven chairs, and outpatient facilities including ultrasound.

The service provides surgical termination of pregnancy up to 23 weeks and six days gestation and early medication abortion up to nine weeks and six days gestation. Surgical procedures are available with a range of sedation options, including general anaesthesia. The service provides consultations, ultrasound scans, contraception, and sexual health screening, and is a host site for vasectomy procedures. Vasectomy procedures were not included in the scope of this inspection as they were provided by a different service. Telemedicine for early medical abortion, a remote service for abortion pills, was not provided at this service.

The district treatment centre provides the full range of care services and is the registered location. The service also offers early medication abortion, consultations, and ultrasound scan services from 2 satellite clinics across the region.

The service is registered to provide the following regulated activities:

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

We last inspected the service in August 2019. At that inspection we rated the service good overall and good in each domain.

How we carried out this inspection

We carried out an unannounced inspection of the service from the 9 March 2023 to 13 March 2023 using our comprehensive inspection methodology.

The inspection team was comprised of a CQC inspection manager and a lead CQC inspector.

The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During the inspection, the team spoke with service leads, 8 staff and 6 patients. We looked at 5 patient records and observed care.

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that effective systems and processes are in place to safely administer, record and store medicines, and that all staff are aware of these systems and follow the guidance. This includes ensuring all medications available for use are within their use by date and any expired medications are removed. (Regulation 12 (2)).

Action the service SHOULD take to improve:

- The service should ensure that all staff undertake regular mandatory training in key skills in line with the provider's benchmarks.
- The service should ensure that the layout of the ward area meets the emotional care needs of both pre and post operative patients.
- The service should continue to reduce the waiting times for patients undergoing surgical termination of pregnancies.
- The service should ensure that leaders identify and escalate relevant risks to the service, and identify actions to reduce their impact.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Termination of pregnancy

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

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Staff did not always receive and keep up-to-date with their mandatory training. The provider's target rate for completion of mandatory training was 85%. 6 out of the 20 mandatory training modules did not meet the target. This included basic life support, infection prevention control, and manual handling level 2. Managers told us that this was due to newly employed staff not yet having completed the training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff spoke positively about the standard of training, which included simulated exercises and online self-study. The provider ensured staff had protected time to complete training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse. Clinical staff were trained to level 3 in safeguarding vulnerable children and adults. The safeguarding lead provided specific training related to handling suicidal conversations. The safeguarding lead had been trained to level 3. A new safeguarding champion had been recruited and managers told us they were joining the team the next week.

There was safeguarding supervision by a named midwife. A virtual group was accessible to safeguarding staff and every two weeks there was a meeting used for sharing information and asking advice.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. A safeguarding policy set out adverse child and adult experiences including a specific section of child sexual exploitation, and female genital mutilation (FGM).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was a clear system for recording safeguarding matters on a patient electronic record. Alert flags were attached to patient records for any future attendances at the service by the patient. Staff were able to view information and consider this as part of the patients' discussion and care.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a well-managed system and process for recording the escalation of concerns to external agencies where needed. Referrals included to the Multi-Agency Risk Assessment Conference (MARAC), which was a meeting where professionals shared information on high-risk cases of domestic abuse and put in place a risk management plan.

The lead for safeguarding had a responsibility to oversee the safeguarding data base and the separate incident reporting system. They made onwards referrals and provided support to patients, including a welfare call back where needed. A security code and pin number was used when making calls maintaining confidentiality for the patient.

On days where surgical activity was taking place, the safety huddle before surgery commenced included discussions about any safeguarding alerts.

Cleanliness, infection control and hygiene

The service managed infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. The service employed cleaners who carried out routine cleaning of all clinical areas. Staff cleaned their clinical space before and after each list and used antibacterial processes between patients. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service generally performed well for cleanliness. In the previous 12 months hand hygiene compliance averaged 96% which was above the provider's national compliance standards of 85%. The service achieved 84% for one audit. Actions had been put in place including speaking with staff and re-educating them regarding correct hand hygiene practices. The service achieved 100% for the following audit.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Each area of the treatment centre had a cleaning checklist in place. All the records we checked were up to date. While we found clean and well maintained facilities during our inspection, audits identified there was a need for sustained improvement. In the previous 12 months, the facilities and cleaning audit found 86% compliance, which was above the above the provider's 85% compliance standard, but below the provider's national average of 89%.

Ultrasound probes were decontaminated in line with the infection prevention and control guidance lines set out by the service and decontamination certificates were completed for any equipment being sent off site to the manufacturers for example. This was in line with the Department of Health and Social Care Health Technical Memorandum on decontamination.

Good

Termination of pregnancy

Staff followed infection control principles including the use of personal protective equipment (PPE) and the use of aseptic techniques in the treatment room. All staff were observed to be wearing PPE that was appropriate for the task they were carrying out at the time and were all bare below the elbow. We saw staff regularly cleaning their hands in between seeing patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All areas were clutter free and facilities and equipment were maintained regularly to keep patients safe. Annual service schedules and portable appliance testing was undertaken. And safety checks, such as water safety were undertaken under a service level agreement annually.

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment and equipment used for treating life threatening allergic reactions. A weekly fire alarm test was undertaken within the building. Fire extinguishers were located throughout the service which had been checked and tested in line with professional guidance.

Clients could reach call bells and staff responded quickly when called. Daily checks on both the emergency buzzer and client call bell tests were undertaken.

Staff disposed of most clinical waste safely. There were appropriate waste bins in each area which were clearly labelled with what could be disposed of in them. The bins in each room were regularly emptied. Sharps bins were clearly labelled with dates of construction, as well as disposal. However, the external clinical waste bin located outside the building was found to be unlocked. Managers told us that the bin was locked immediately after the inspection team highlighted this.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The risk assessments were part of the electronic patient record and included risks related to blood clots, allergies, and safeguarding.

Staff checked if the patient had taken any recreational drugs prior to their surgery. If they had, because of the risks associated with such medicines, the decision to treat would be made by an appropriate member of staff.

Staff knew about and dealt with specific matters arising from known or anticipated risks. Staff used an adapted tool to identify deteriorating patients and escalated them appropriately. The tool used to monitor patients was known as TEWS, which was Termination of Pregnancy Early Warning Score. The tool required nursing staff or health care assistants to measure and record the patient blood pressure; heart rate; temperature and pain levels for example. The combined score for these assisted in identifying if a patient needed to be escalated to a doctor for assessment.

Good

Termination of pregnancy

Staff used a modified surgical safety checklist based on the World Health Organisation (WHO) and five steps to safer surgery checklist when undertaking surgical terminations of pregnancy. WHO checklists are a tool designed to improve the safety of surgical procedures. Although no surgical procedures were being undertaken on the day of the inspection, documents showed that staff completed the checklist at all stages throughout surgery.

Staff shared key information to keep patients safe when handing over their care to others. Staff knew there was an agreement with the local NHS trust to transfer any acutely unwell patients in the event of complications. The service had clear guidelines and policies in place for staff to follow in the event that a patient needed emergency transfer. The service had a transfer pack which contained a flowchart to instruct staff what to do when transferring a patient, telephone numbers for the trust, as well as all required documentation.

The service did not have any blood products on site and had an arrangement with a nearby London NHS Trust for the transfer of patients whose condition deteriorated.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. All staff had received training specific to termination of pregnancy.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants in accordance with national guidance. Managers could adjust staffing levels daily according to the needs of patients. The service had low vacancy rates, and low staff turnover rates.

The service had low rates of agency staff. Agency staff were used to cover staffing gaps when staff attended training sessions. Agency staff received a full induction from the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave sessional staff a full induction.

As a nurse-led service there was no doctor on site when only outpatient activity was taking place. Staff told us the surgeons and anaesthetists did not only work at one centre and were assigned by a central team according to surgical needs. The service had enough medical staff to keep patients safe. On the day of inspection there was no available surgeon and therefore no surgery taking place.

Medical staff were directly employed by the service. Anaesthetists were employed by the service under practising privileges. Practising privileges means that staff are employed elsewhere but are allowed to work for another service in a limited, defined capacity. When doctors were employed under practising privileges their clinical background was checked and a set of criteria for the patients they could see was drawn up.

Records

Good

Termination of pregnancy

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were detailed. All clinical staff could access them easily via the electronic system, using their own secure access. Paper records, such as the TEWS, scans, consent forms and safety check for surgical patients were labelled with patient identifiable information and stored safely.

We observed records being completed by nursing staff during pre-assessment, and noted all sections were marked or commented on where needed in the electronic record.

Scans were uploaded onto the patient record and were accessed by remote doctors, so they could review them prior to prescribing abortion medicines.

We checked five sets of patient notes and found these to be clear and fully completed. They were easily navigated, and additional notes had been added where further information about the patient was required.

All the abortion records contained a DHSC abortion form, signed by two doctors with a valid reason for carrying out the termination, in line with national legislation.

Staff audited records for quality compliance in line with the provider's standards. In the previous 12 months the service performed consistently well, with 99% compliance.

The service managed patient records in line with Royal College of Obstetricians and Gynaecologists (RCOG). For example, they provided each patient with a discharge letter that included enough information about their care to allow another practitioner to manage future needs and complications. The discharging member of staff asked each patient for consent to send a copy of the discharge letter to their GP. Staff respected confidentiality and GP involvement was not a requirement of treatment.

Medicines

The service did not have effective systems and processes in place to safely administer, record and store medicines.

Medicines were stored in 3 locked areas within the treatment centre including a storeroom on the ground floor, a medicine trolley on the ward, and in medicine cupboards in first stage recovery. All three areas contained medicines that had passed their expiration date, with some medicines having expired two months prior to the inspection. These included injectable medicines, oral medicines, and rectal medicines, and included medicines used in emergency situations.

The only cylinder of oxygen ready and available for use in first stage recovery had expired. Oxygen is used in emergency situations and is often used to assist patients when they are waking from anaesthesia. Unused, in-date cylinders were available in a separate store cupboard; however, they were not ready for immediate use as they were not housed within an administration cannister. During the inspection managers were made aware that the oxygen cylinder had expired and told inspectors it would be replaced, however at the time of the completion of the site visit the expired cylinder had not been replaced.

Staff told us there were 2 nurses with a lead role for medicines. Their responsibilities included checking medicines, including the expiration date, and this was overseen by managers. End of month medicine checks for January 2023 and February 2023 showed that expired medicines had been disposed of, however during the inspection medicines were found to have expired January 2023 and February 2023. Medicines management audits for the 12 months prior to the inspection showed a 95% average compliance rate, with 100% compliance in January 2023.

The service had an up to date medicines management policy in place. The policy stated that stock with the shortest expiry date should be used first and "Use first" labels should be used, however 'use first' labels were not seen to be used during the inspection, and none of the expired medicines had 'use first' labels in place.

Since the inspection managers have told us all drug expiry checks will be completed routinely by two registered nurses or midwives and red stickers will be added to all medicine packs/boxes/oxygen that are due to expire in the next month.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Doctors reviewed patients' current prescription medicines to ensure abortion medicines were safe and minimise the risk of contraindications.

Staff explored patient wishes related to contraceptives, including the use of long-acting reversible contraception (LARC). This is the term used for birth control that helps prevent pregnancy after just one treatment and includes implants and hormone releasing internal devices (coils). Staff went through the options with patients and provided leaflets to assist in decision making. They recognised the decision of what to use was up to the patient.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with provider's policy. The electronic system used to report and capture information for incidents or adverse events was viewed by inspectors. We saw this was a reliable system to support the oversight and management of incidents.

Incidents reported on the electronic system were escalated to the manager for investigation. Learning was shared at meetings, via email and in huddles.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Managers debriefed and supported staff after any serious incident. A recent example was given to us of an adverse event which had happened, and staff confirmed debrief discussion had taken place after this.

The service had no never events in the 12 months prior to inspection. Never events are "Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers".

Good

Termination of pregnancy

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The clinic adhered to the guidelines of the Royal College of Obstetricians and Gynaecology (RCOG) for the treatment of women for termination of pregnancy for fetal anomaly and ectopic pregnancy.

Policies were centrally developed at the organisation's head office in line with Department of Health Required Standard Operating Procedures (RSOP) guidelines and professional guidance. Polices were held electronically. Staff knew where to locate the policies and were able to navigate the electronic system without difficulty.

Staff protected the rights of patients subject to the Mental Health Act and followed the code of practice. All staff had received training in the Mental Health Act. Staff described the process to follow if they had concerns.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff provided guidance to patients on required fasting times before surgery. Surgery times were staggered from the early morning, which meant patients did not need to fast all day.

Refreshments were available for patients and visitors throughout the building. Staff provided refreshments and biscuits to patients in the recovery area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

During pre-assessment nursing staff discussed pain management and checked if there were any medicines the patient could not have. The patient had the opportunity to say what they wished to have following a surgical procedure from the available medicines. Staff also explained about the side effects of tablets used for abortion, which included a degree of pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff advised women on which over the counter medicines they could take. We saw staff advise women about taking ibuprofen rather than paracetamol in accordance with Royal College of Obstetricians and Gynaecologists guidelines 'Care of Women Requesting Induced Abortion' 2.26 and 7.17 (2011).

Staff prescribed, administered, and recorded pain relief accurately. We viewed five medical records and saw pain relief information was clearly written. Staff could assess client pain levels using a facial expression scale for those clients who had difficulties communicating or whose first language was not English.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant clinical effectiveness audits in line with Department of Health and Social Care required standard operating procedures (RSOPs) for independent abortion providers. Managers and staff carried out a comprehensive programme of repeated audits to monitor compliance and assurance. The compliance monitoring programme included 25 audits planned to take place at key points during the year and included audits such as hand hygiene audits and compliance with the WHO Surgical Safety Checklist. The service consistently achieved higher than the provider's national average in the outcome of the audits. Where the service did not achieve the provider's 85% target, systems, and processes were in place to ensure improvement was seen.

Surgical outcomes were also measured by each surgeon. Outcomes for patients were positive, consistent, and met expectations, such as national standards. We reviewed the surgical outcomes report for 2022 and saw 11,930 patients had attended for surgery. Out of these there had been 54 adverse events, some of which were acceptable risks, such as bleeding, cervical laceration or an unplanned return to theatre. Overall, this represents less than 0.05% of those patients, suggestive of a high standard of patient management during the surgical procedure and afterwards.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The service was nurse-led, with registered nurses and midwives, as well as healthcare assistants.. They provided treatment and care according to their role and competencies.

Managers gave all new staff a full induction tailored to their role before they started work. The treatment unit manager supported new staff through the induction process. The induction programme was developed at provider level and detailed specific competencies for each role. Staff were expected to be signed off as competent in key skills in the first six months of employment. Managers told us staff were not assigned to any duties for which they had not been signed off as competent. Examples of competency training seen included subdermal contraceptive device implants, consent and gestational scanning. The latter required the individual to attend a two-day training workshop and to undertake 100 scans with supervision or checking before their final exam. Staff told us they undertook announced scenario training, which included dealing with haemorrhage or the deteriorating patient and sepsis.

Good

Termination of pregnancy

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection, 100% of staff had received an appraisal within the last 12 months. The treatment unit manager gave staff the date of their annual appraisal in order that staff could plan their time to prepare for the meeting. Staff advised us they appreciated this and meant the time spent during appraisal was more meaningful.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us a two-hour team meeting took place monthly. During this they were updated on audit results and incidents, as well as changes in practice or learning. A weekly debrief email was circulated to staff too and a virtual group was used for daily discussions and updates.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and ensure their care was planned safely. Huddles were held at the start of surgical days and for outpatient activity. Debriefs happened at the end of theatre lists.

Staff worked across health care disciplines and with other agencies when required to care for patients. This included liaising with GP's where patient consented to this and working with local authorities and social services when required. The service worked alongside the local refuge to support women in accessing the service.

Staff could refer patients for external mental health assessments if they showed signs of mental ill health and depression.

Seven-day services

Key services were available six days a week to support timely patient care.

The treatment centre was open Monday to Friday 8am to 4pm. Occasional Saturday clinics took place according to demand. The service aimed to hold surgical days 3-4 times per week. Patients wishing to access services on a Sunday could attend other MSI reproductive clinic centres.

MSI operated a telephone support service for patients wanting to book an appointment at the services and this was available from 7am to 6pm seven days a week. MSI also offered an aftercare support telephone service for patients who had received treatment that was available 24/7. In addition to this MSI also had an online chat service that was available Monday to Friday 8am to 8pm, and 8am to 4pm on weekends.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Good

Termination of pregnancy

The service had relevant information promoting healthy lifestyles and support available in waiting areas and consultation rooms. Information was available on contraception and seeking help where domestic abuse was happening.

Staff assessed each patient's health as part of their telephone assessment and face-face meeting. They provided support for any individual who needed additional information or guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. They were aware of Fraser guidelines and Gillick competencies, which help those who work with children and young adults to balance the need to listen to their wishes with the responsibility to keep them safe.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. The prescribing of abortion medicines could only be carried out if two separate doctors had reviewed all available information and were satisfied, they consented to this option of treatment.

The service audited consent documentation. In the previous 12 months the service achieved 94% compliance, which was above the provider's 85% compliance rate.

Staff received and kept up to date with training in the Mental Capacity Act (MCA). Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The named safeguarding lead was the MCA lead and worked with staff to develop their knowledge, skills, and practice.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff followed policy to keep patient care and treatment confidential. They understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when undertaking their pre-assessment and discussing their health. Staff approached the subject of safeguarding with sensitivity and explained the purpose of the respective questions.

Good

Termination of pregnancy

We observed staff being friendly and kind to all patients. We saw that women undergoing surgical procedures for fetal anomalies had the option of being cared for in a separate single room before and after their procedure and could have a loved one with them for support.

Patients said staff treated them well and with kindness. Patients we spoke to said staff in every part of their pathway were kind, considerate, and non-judgemental.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Staff were able to seek support if they were unsure of the cultural needs of any women. Staff were aware of women's different cultural and religious needs when dealing with disposal of pregnancy remains.

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. This included supporting them through the provision of information, available choices and respecting their decisions.

Staff mostly understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. However, one patient told us they found it distressing that while waiting for their procedure they were sat directly opposite patients who had already had their procedures. Pre-operative patients and post-operative patients were cared for in the same room and the recliner chairs for pre-operative patients directly faced the recliner chairs for the post-operative patients. Although no surgery was performed on the day of the inspection, staff confirmed that pre and post operative patients sat directly opposite each other and could see each other.

Understanding and involvement of patients and those close to them

Staff supported patients to understand their condition and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. Staff were seen to support patients to make informed decisions about their treatment options according to the stage of their pregnancy.

We heard staff explaining all the available information and discussing a range of choices to them in a manner which helped them to make their own decisions. They used language, diagrams, and screen images to help share information with the patient and answered questions as they arose, checking understanding afterwards.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A 'your views matter' feedback method was used by the service to gain information on the patient experience. This could be accessed via a QR code. The patient feedback response rate was 14.9% against the organisational target of 14%. 95% of the 66 patients that gave feedback said their care was either excellent (80%) or good (15%).

Staff supported patients to make informed decisions about their care including whether the patient would like a burial of the pregnancy remains or not. Leaflets were provided to clients detailing how medical records were kept and anonymised data from the statutory HSA4 form was used for statistical purposes by the Department of Health and Social Care.

Good

Termination of pregnancy

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service was in an area with several types of transport. A bus stop outside the service travelled directly to the train station and motorway networks were close by. Car parking was available at the front of the building.

The outpatient facilities and premises were appropriate for the services being delivered, although some areas were looking tired and in need of a decorative update.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had wheelchair access into the building and lifts available for those requiring support. Hearing loops were also available

Managers ensured that patients who did not attend appointments were contacted and that any appointments cancelled by the service were rescheduled as quickly as possible.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were able to identify where they could seek assistance for women with additional communication needs. Hearing loops were located in the building.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients could get help from interpreters or signers when needed. Staff were able to use a translation service for women who did not speak English as a first language. This was done through an external company as soon as identified as a patient need. Staff did not use family and friends as translators so that the women's decision was not influenced, and they could ensure the women understood all information given to them and could make informed choices that were their own.

Staff recognised the importance of understanding patients' gender identity and worked with them to tailor their care. For example, they made sure the patients' preferred pronouns were included in care documentation and where their gender identity differed from their biological, documented gender in NHS records, they worked together to reduce stress and stigma.

Good

Termination of pregnancy

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times however patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. Women regularly waited longer than the national guidelines to receive treatment for surgical terminations of pregnancies. Women should not wait more than 5 working days from initial contact to consultation and the same from the decision to proceed to having treatment (RSOP RCOG). The total time from initial contact to the procedure should not exceed 10 working days.

Managers told us that demand for services has increased, with the service experiencing a 312% increase in the demand for surgical terminations in the six months prior to our inspection. Managers said this was due to post lockdown patients presenting at higher gestations, the cost of living crisis, a reduction of NHS services, closures of other independent termination of pregnancy clinics, and a lack of available surgeons and anaesthetists.

We requested data (numbers or %) of women that received a consultation within 5 days of initial contact for the 12 months prior to the inspection. The service did not provide this however they did provide the average number of working days patients waited for their initial consultation which was 3.95 days.

Patients waiting for medical abortions waited on average 8 working days for their treatment after their initial consultation/ decision to proceed to treatment. Patients waiting for surgical terminations of pregnancies waited an average 14.98 working days for their treatment after having their initial consultation/ decision to proceed to treatment. Women undergoing surgical terminations of pregnancies waited on average 18.93 working days from the time they contacted the service to the time their treatment was completed.

The service told us that 95.86% of patients waiting medical abortions received their treatment with 10 working days, which was above the organisation's target of 85%, but slightly worse than the providers' national average of 97.17%.

39.67% of patients waiting surgical terminations received their treatment within 10 working days, which was below the organisation's target of 85%, but in line with the provider's national average of 39.45%. Managers told us that several interventions had been put in place to reduce the waiting times for surgical terminations at the service. This included relocating the pills by post service to another hub so that the service could increase their surgical capacity, establishing an additional treatment centre within 30 minutes travel-distance of South London, and increasing the number of operating days. UK-wide provider interventions included recruiting more nursing and medical staff, increasing pills by post capacity so that patients can have treatment earlier in their pregnancies and avoid the need for surgical termination, introducing an online booking service so that patients can access services quicker, and introducing telephone consultations.

Managers told us patients were able to receive their treatments at other MSI locations in order to reduce their treatment wait time. However, this was not always at a location that was easily accessible to the patients. One patient told us they were offered treatment at a location that would take them many hours to travel and was too far and expensive for them to travel. The patient told us that due to the delay in getting an appointment, they could no longer have the treatment of their choice as their pregnancy had become be more advanced, so their choice of treatment was no longer an option.

Good

Termination of pregnancy

Managers worked to keep the number of cancelled appointments to a minimum. Automatic text messages were sent to patients to remind them of their appointment. Patients were able to choose to cancel or re-book their appointments if needed. This was monitored daily by the service, and available slots are offered to other clients. We saw the number of patients that did not arrive for their appointments was low. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and on the website. Staff understood the policy on complaints and knew how to handle them. In the previous 12 months the service received one formal complaint that was not upheld.

Staff knew how to acknowledge complaints and felt able to offer an immediate apology. Where necessary they escalated to the clinical team leader or management.

Managers investigated complaints and explained the process for identifying any themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff told us that patients felt the text messages reminding them of their appointments were helpful.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders within the service undertook accredited leadership training to ensure they had the skills and ability to run the service. Leadership peer support was in place and close working and collaboration with leaders across other services throughout the organisation provided a network of support. Managers understood their priorities.

We saw a copy of the clinic's certificate of approval to carry out termination of pregnancy in accordance with Department of Health requirements.

Staff we spoke with were positive about the leadership and told us that managers were approachable and visible. All staff spoke highly of the local leadership. Staff knew the different managers and their areas of responsibility. Staff said they felt supported and gave examples of when they had received support with personal circumstances as well as professional development. During the inspection we observed positive interaction between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a well-established mission, vision, and values framework. Staff shared this with patients through information printed and displayed in the treatment centre, which reflected an organisational focus on working transparently with patients. The provider's values centred on providing personalised, high-impact services to patients that empowered them to have children by choice. The strategy to deliver this work reflected an ethos of pushing boundaries and stretching goals, which we found staff personified at all levels during our discussions and observations.

The provider had a strategy in place to improve access to care, streamline booking appointments and reduce the overall waiting time for women. The strategy had resulted in the introduction of a live webchat service, a digital booking system and the trialling of telephone consultations at other locations. Locally, not all staff were aware of a specific strategy but had some understanding of the plans for the future, and these had been discussed in meetings.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff who spoke with us enjoyed working at the service, for some this had been many years. They reported feeling valued, respected, and part of an inclusive team. They said there were shared values and a positive ethos for the patients who came to the service. There was a strong sense of teamwork and a culture of feeling like 'family'. The core values were known and understood, and they were proud to provide a service to women in local and wider community.

Staff told us there was good communication with one another and medical staff, with no feeling of hierarchy or lack of respect. Staff felt able to raise any concerns they may have.

Patients told us they were very comfortable in the clinic and although they did not have any worries to raise, they felt they were able to without being concerned their care would be affected.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider had a national governance structure that provided regional staff with support and operational frameworks. The UK divisional board included one independent specialist advisor supporting scrutiny of national oversight. The director of nursing, midwifery, and quality and the regional quality and governance business partner led the regional governance system with support from registered managers.

The service had a senior quality and governance lead who had held the post for 5 years. They had a responsibility to support the service with compliance monitoring. Information related to performance and the local service improvement plan was communicated to quarterly meetings. The senior quality and governance lead chaired a weekly meeting related to complaints, litigation, incidents, patient feedback and safeguarding. Leads for each of these areas were involved, as was the medical director. Discussion included any patient harm and the level of seriousness of this. A summary was sent out following the meeting. Where there were themes or trends these were identified. Cascade of information was via local staff information notice boards, team meetings and huddles

An integrated quality and performance meeting took place with contributions from all services. Information on location performance was shared and any learning or important information was communicated.

A quality and governance report was prepared for the quarterly Medical Advisory Committee (MAC) meeting. The most recent meeting took place in January 2023. Staff told us the meeting considered information related to serious incidents, levels of harm, a report from the associated director of surgery, complaints, and policy updates.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated some relevant risks and issues and identified actions to reduce their impact, however, not all risk were identified. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The governance and leadership teams used an integrated governance dashboard to benchmark local activity and performance against the provider's national network. The dashboard included incidents and clinical outcomes and enabled the senior team to measure these against national guidance and policies. They carried out local monitoring monthly and national benchmarking quarterly. The integrated governance committee monitored assurance processes and provided the board with escalation and oversight of risks.

The senior team used a risk register to document and track risks. At the time of our inspection the service had 38 active risks. There was documented evidence of a continual tracking and mitigation by named staff who adopted accountability for specific risks. Risks deemed as high related to the risk of deteriorating patients, incomplete abortion, abnormal ultrasound scans, anaphylactic shock, risk of the spread of COVID 19, failure to comply with the Abortion Act 1967 - HSA1 Forms, faulty lift, haemorrhage, inappropriate delivery of medicines to the centre and the risk of injury during manual handling. Although the management of medicines was on the risk register it was scored as a medium risk, and there was no risk identified on the register for women not receiving their treatment in line with national standards. This was not in line with the risks identified during the inspection. Since the inspection, managers have told us that this risk is on the corporate risk register and is managed by the corporate team'.

The team used an overarching CLIPS ('complaints, litigation, incidents, patient feedback and safeguarding') system to monitor performance weekly. Representatives from every treatment centre joined weekly meetings and used the time to collaboratively solve problems and benchmark outcomes. The clinical director and medical director led this process for surgical services.

Staff told us quality and governance reports were completed once per month related to surgeon and anaesthetist activity and outcomes. This was shared for their appraisals. Any poor outcomes were addressed through appropriate means.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used electronic systems to report incidents and to hold all their policies. The main policies from the corporate entity were all available on the electronic system and were amended to fit the local environment using local operating procedures.

All clinical records were electronic, with the exception of surgical records. Electronic records meant if a patient's care was handed to another clinic in the wider corporate group the notes were immediately available, as there was an integrated electronic record system.

The electronic patient record was managed safely with secure access to designated staff. Information collected was easy to access and review. Where data was needed to look at activity such as number of children attending the service or incidents, this could be retrieved from the system with relative ease.

The service completed formal notifications to CQC for known risks, and informed the Integrated Care System (ICS) of these. In England, an ICS is a statutory partnership of organisations who plan, buy, and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups, and independent care providers.

The service submitted data to the Department of Health and Social Care regarding abortion procedures in line with national requirements.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Women were encouraged to provide feedback; we saw forms and contact information displayed in communal areas. MSI had added QR codes to feedback forms, to enable women to use modern methods of communication to provide feedback, as well as encourage younger women to give their opinions regarding the service they received at the unit.

The treatment unit manager organised short informal staff catch ups on an ad hoc basis. These were used to check staff well-being and discuss any urgent learning or complaints. Team meetings were held monthly and minuted in order that staff who could not attend were kept informed. The service provided staff with 'Friday Update' emails to round up learning from the week.

Good

Termination of pregnancy

MSI conducted 6 monthly staff surveys. The last survey highlighted staff wanted better communication, clearer responsibilities from managers, newer equipment, regular huddles and debriefs, and more recognition of good work. In response the service had introduced a weekly round up email, strengthened 1:1s to include creating an individualised training plan for each member of staff, ordered new equipment, introduced morning huddles for outpatient and surgical lists, introduced a colleague of the month award, and held team lunches and breakfasts to recognise hard work and achievements.

Staff worked closely with partner organisations such as the local authority, and the local women's refuge. The service had a service level agreement with the local women's refuge which included staff from the refuge working at the service one day a week in order to support with any adult and child safeguarding concerns such as women and girls who are at risk of domestic violence, sexual violence, stalking, trafficking, modern slavery, 'honour' based violence, forced marriage, female genital mutilation, involvement in prostitution and child sexual exploitation.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Learning arising out of adverse events was discussed with staff via their internal processes, such as huddles, team meeting, via the notice board and emails. Staff were committed to improving the service.

Leaders told us of improvement projects such as the introduction of clinical supervision, a system by which staff debriefed and reflected on often emotive subjects and were given the opportunity and to identify ways to improve clinical practice.

The service had plans in place to improve patient experience and outcomes for surgical termination through the introduction of video call and telephone consultations. However, this had not yet been introduced at the service or embedded in practice.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Termination of pregnancies Surgical procedures Family planning services Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have effective systems and processes in place to safely administer, record and store medicines. Expired medications were available for use in all areas medications were stored. This included medications that are used in emergency situations.