

# Marie Stopes International Leeds Centre


## Quality Report

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

## Ratings

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

## Overall summary

Marie Stopes International (MSI) Leeds Centre is part of the provider group Marie Stopes International, a not for profit organisation that was founded in 1976. Facilities at the centre included a treatment room, three consulting rooms, ultrasound facilities, three waiting rooms and a recovery room with eight reclining chairs.

The service provided termination of pregnancy by either surgical termination of pregnancy (surgical ToP) procedures up to 18 weeks and six days gestation, early medical abortion (EMA) up to 63 days (nine weeks) gestation or medical termination of pregnancy up to nine weeks and six days. Surgical ToP involved vacuum aspiration or dilatation and evacuation and was carried

# Summary of findings

out under general anaesthetic, sedation, or no anaesthesia for up to 18 weeks and six days according to patient choice or needs. EMA and medical termination of pregnancy involved a woman taking two doses of medicine, mifepristone and misoprostol, to terminate a pregnancy. These could be taken simultaneously or at a prescribed interval depending on patient choice or needs. The service also provided consultations, ultrasound scans, contraception advice and administration, including fitting of long acting reversible contraception (LARC) and screening services for sexually transmitted infections. There was also a vasectomy service (male sterilisation) provided at the centre.

MSI Leeds Centre also managed six early medical unit (EMU) satellite clinics located in the community, where EMA and consultations in the early stages of pregnancy were provided in a private consultation room. The MSI Leeds Centre also provided a weekly vasectomy service at the MSI Leeds centre and three satellite units. The units provided a treatment room and a recovery area with a reclining chair.

We inspected this service using our comprehensive inspection methodology. We carried out two unannounced visits on 16 and 18 July 2019.

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

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

At our previous inspection on 13, 14 and 28 July 2017 we found a breach in regulation and we served a requirement notice in respect of:

Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment.

At this inspection we checked that actions had been implemented to address the breach and meet the regulation. We found that improvements had been made

in mandatory training compliance and staff competencies, staff survey provision, participation and results, and completion and monitoring of termination of pregnancy early warning scores (TEWS) documentation.

## Services we rate

We rated this service as **Good** overall.

We found good practice in relation to:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety 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 collected safety information and used it to improve the service.
- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients.
- 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. People could access the service on weekdays. Although there were sometimes waiting lists, management ensured these did not impact negatively on treatment options for patients.
- 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. Staff throughout the service were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff were actively encouraged to speak up and raise concerns.

# Summary of findings

- There was inclusive and effective leadership at all levels. Leaders demonstrated the experience, capacity and capability needed to deliver sustainable care.

We also found some areas of outstanding practice:

- A systematic approach was in place to work with other organisations to improve care outcomes. The service sought to influence care within its sector positively and demonstrated commitment to seeking out new models of care to influence and educate future patients, local partnerships and wider external stakeholders.

- Leadership, governance and culture were used to drive and improve the delivery of holistic person-centred care. There was strong collaboration, teamwork and support and a common focus on improving the quality and sustainability of care and patient experiences.

- Comprehensive and successful leadership strategies were in place to develop the desired culture. Leaders understood issues, challenges and priorities in their service, and beyond.

**Ann Ford**

Deputy Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Termination of pregnancy

### Rating

Good



### Summary of each main service

Marie Stopes International (MSI) Leeds Centre provided surgical termination of pregnancy up to 18 weeks and six days gestation, early medical abortion (EMA) up to nine weeks gestation and medical termination of pregnancy up to nine weeks and six days gestation. The centre also had seven satellite clinics in the community, six of them providing medical termination up to nine weeks and four days gestation. The service also provided contraception advice including the fitting of long acting reversible contraception (LARC) as well as vasectomy (male sterilisation treatment).

We rated this service as good overall.

Safe, effective, caring, and responsive were all rated as good. Well led was rated as outstanding.

# Summary of findings

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Good



# Marie Stopes International Leeds Centre

**Services we looked at:**

Termination of pregnancy;

# Summary of this inspection

## Background to Marie Stopes International Leeds Centre

Marie Stopes International (MSI) Leeds Centre is part of the provider group Marie Stopes International, a not for profit organisation that was founded in 1976.

MSI Leeds Centre opened in its current location in 2006. It is a private single specialty service in Leeds, West Yorkshire. The centre primarily serves the communities of Leeds, Bradford, Wakefield, North Yorkshire and York, Huddersfield, Calderdale and North Kirklees. It also accepts patient referrals from outside these areas.

The centre has had a registered manager in post since May 2013.

MSI Leeds Centre is contracted by Airedale, Wharfedale and Craven, Bradford City, Bradford District, Hambleton, Richmondshire and Whitby, Harrogate and Rural District, Scarborough and Ryedale, Vale of York, Calderdale, Greater Huddersfield, Leeds, North Kirklees, North Lincolnshire and Wakefield Clinical Commissioning Groups (CCGs) to provide a termination of pregnancy services for the patients of West Yorkshire and surrounding areas. The centre also accepts patient referrals from around the UK and abroad. The service receives referrals from general practitioners (GPs), hospitals, family planning services and another independent providers. Patients are also able to self-refer. The service treats adults and young people aged 13 and above. The number of young people aged under 16 forms 0.2% of the patients treated at the centre.

MSI Leeds Centre also manages six early medical unit (EMU) satellite clinics located in the community, where early medical abortion (EMA) and consultations in the early stages of pregnancy are provided in a private consultation room. The MSI Leeds Centre also provides medical termination of pregnancy up to nine weeks and six days gestation at the main Leeds centre. They provide a weekly vasectomy (male sterilisation) service at the main Leeds centre and three satellite units. The units each provide a treatment room and a recovery area with a reclining chair.

The service provides surgical termination of pregnancy (Surgical ToP) procedures up to 18 weeks and six days gestation, as well as early medical abortion (EMA) up to nine weeks gestation and medical termination of pregnancy up to nine weeks and six days. Surgical ToP involves vacuum aspiration or dilatation and evacuation and is carried out under general anaesthetic, sedation, or no anaesthesia according to patient choice or needs. EMA and medical termination of pregnancy involves a woman taking two doses of medicine, mifepristone and misoprostol, to terminate a pregnancy. These can be taken simultaneously or at a prescribed interval depending on patient choice or needs. The service also provides consultations, ultrasound scans, contraception advice and administration including fitting of long acting reversible contraception (LARC) and screening services for sexually transmitted infections.

The service is registered as a single speciality service and provides the following regulated activities:

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

The service had two registered managers in post during the time of our inspection. One registered manager is the operations manager and has been in post since March 2018 and the other registered manager is the regional manager who has been in post since June 2017. The clinical services matron has been in post since May 2019. The operations manager and clinical services matron provide dedicated on-site managerial support for operational and clinical issues.

# Summary of this inspection

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in termination of pregnancy and sexual health services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

## Information about Marie Stopes International Leeds Centre

MSI Leeds centre is open five days a week from Monday to Friday. The centre is open from 8.30am to 5pm every day and can remain open later in the evenings should demand require it. The early medical unit satellite clinics are available throughout the week from Monday to Friday offering one or two clinics a week per location. The vasectomy service is available weekly, rotating between the Leeds centre and three satellite sites.

The service is registered as a single speciality service for termination of pregnancy and is registered for the following regulated activities:

- Diagnostic & screening procedures
- Family planning services
- Treatment of disease, disorder and/or injury
- Termination of pregnancy
- Surgical procedures

The services provided under these activities were:

- Pregnancy testing
- Unplanned pregnancy counselling/consultation
- Medical termination of pregnancy
- Surgical termination of pregnancy using local anaesthetic and conscious sedation
- Surgical termination of pregnancy using general anaesthetic.
- Abortion aftercare
- Miscarriage management
- Sexually transmitted infection testing and treatment
- Contraceptive advice

- Contraception supply
- Decontamination and supply of sterile surgical instruments and packs
- Collection and disposal of clinical waste
- Blood tests and laboratory screening.

During the inspection, we visited the Barrack Road, Leeds Centre and an early medical abortion unit (EMU) in Huddersfield. We spoke with 15 staff including; registered nurses and midwives, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We spoke with seven patients and two partners. During our inspection, we reviewed eight sets of patient records.

In the reporting period April 2018 to March 2019, the centre carried out 1176 surgical terminations of pregnancy (SToP) and 3670 EMA and medical terminations of pregnancy. The centre also carried out 351 vasectomies.

Of all patients the centre treated, 98% were NHS-funded and 2% were self-funded.

Three surgeons were directly employed by MSI. Two anaesthetists, who also worked at NHS trusts and other MSI sites, were employed on a sessional basis. MSI employed 10 registered nurses, one full time equivalent healthcare assistant and two administrators. The centre had used agency staff to cover a total of 43 registered nurses shifts in the twelve months prior to the inspection. However, no agency staff had been used by the MSI Leeds centre since November 2018.

The centre provided one treatment room, three consulting rooms and eight, day care reclining chairs at



# Summary of this inspection

the main location in Leeds for patients undergoing treatment for surgical ToP, EMA and medical termination of pregnancy. Patients did not stay at the centre overnight.

There were six satellite units in Wakefield, Bradford, Batley, Airedale, Hemsworth, Huddersfield and Pontefract. Six of these sites provided EMA and three provided vasectomies on a rotating basis. Each had one consulting room that could also be used as a treatment room. The Pontefract unit provided only vasectomies and provided a treatment room and a reclining chair for patients to use following vasectomy procedures.

## **Track record on safety**

The centre reported no never events and two serious incidents requiring investigation in the period April 2018 to March 2019.

The total number of clinical incidents reported during the same reporting period was 179, with 111 resulting in no harm, 65 resulting in low harm, and three reported as short-term moderate harm. No incidents resulted in severe harm or death.

There were two serious incidents recorded for the period April 2018 to March 2019.

The service reported no healthcare acquired infections.

The centre had received 30 informal and three formal complaints within the same 12 month timeframe. One formal complaint was partly upheld and the remaining two were not upheld. All complaints received were responded to within 20 days which was in line with the provider's complaints policy.

The centre held a current Department of Health licence to practice under the Abortion Act and displayed copies of the licence at each of its registered locations.

The main Leeds centre was open five days a week. Nursing and medical staff rotated out to the satellite sites. No nursing or medical staff worked solely at satellite sites and all staff received support and supervision at the main site. The regional manager provided leadership for two other centres in the North of England and staff supported each other between centres as the need arose such as to provide cover for sickness, share training opportunities and carry out peer review and audit.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service had been inspected twice before. The most recent inspection took place in July 2017 and although CQC did not have the power to rate ToP services, we found the service met most standards of quality and safety it was inspected against.

# 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 rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Processes were in place to safeguard vulnerable adults, young people and children.
- The service controlled infection risk well.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service had enough medical, 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.
- Staff kept detailed records of patients' care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.
- The service monitored information to improve safety.

**Good**



### Are services effective?

We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment.
- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.
- There was suitable provision of services to ensure care and treatment. Staff ensured delivery and achievement of the best outcomes for patients.
- Health promotion information was available.
- Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005.

**Good**



# Summary of this inspection

## Are services caring?

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients to minimise their distress.
- Staff supported and involved patients to make decisions about their care and treatment.

**Good**



## Are services responsive?

We rated it as **Good** because:

- 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 inclusive and took account of patients' individual needs and preferences.
- People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers. The MSI Leeds centre managers had begun a collaborative project with the local authority and police service to share information regarding safeguarding and CSE. Managers had established links with the local MESMAC) group to update staff with HIV screening training. Staff and managers had developed contacts with local CASH services, crisis management team, homeless services, safeguarding teams and the police regarding information sharing for vulnerable patients and topics such as domestic violence.

**Good**



## Are services well-led?

We rated it as **Outstanding** because:

- Leaders demonstrated experience, capacity and capability needed to deliver sustainable care. 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.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.






**Outstanding**



# Summary of this inspection

- A systemic approach was in place to work with other organisations to improve care outcomes. The service was building links with local authorities and others to enable education and drive future improvements for people who may use the service.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.
- Leaders operated effective governance processes throughout the service. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Problems were identified and addressed quickly and openly.
- Leadership, governance and culture were used to drive and improve the delivery of holistic person-centred care.
- Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders and staff collaborated with partner organisations to help improve services for patients.
- 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.
- Leaders were creating a positive culture and conditions suitable for continuing improvement and a common aim to achieve this.
- MSI Leeds Centre took part in new pilots with the aim of further developing the service. Current programmes included
  - working with local prisons to produce to agree a care pathway for prisoners attending the centre
  - working with local universities to build a ToP module for student nurses and midwives
  - working with the local trust to provide a “day in the life of” staff exchange programme for staff in early pregnancy units.

# Termination of pregnancy

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Outstanding 

## Are termination of pregnancy services safe?

Good 

We rated it as **good**.

### Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The service provided a structured induction and mandatory training programme for staff. Staff completed online and face-to-face mandatory training modules. Modules were set by MSI head office and included infection prevention and control, control of substances hazardous to health (COSHH), information governance, safeguarding children, safeguarding adults, first aid, fire safety, basic life support, immediate life support which included training on sepsis, lone working essentials and manual handling.
- At the time of our last inspection in 2017, staff told us access to training was difficult and the training matrix indicated some poor compliance and we noted the training matrix used in the centre did not always match training data held by the provider. At this inspection we found a new electronic learning and development platform which had been in place for several months. This enabled staff to complete mandatory training modules online, book face-to-face courses and apply for additional training courses. There was now a clear indication of timescales for when courses needed to be refreshed with 90 day reminders sent to managers and

staff. Staff received certificates when courses were completed and the system tracked each staff member's compliance. Each staff member had a personal login to the online system and could access the system from work or home.

- Staff we spoke with were positive about the training they received and felt that they received the appropriate training to carry out their role. Protected time was given to new starters and staff could also request additional protected time to complete training modules if they needed it.
- Managers were able to monitor staff training compliance with clarity through the electronic learning and development platform. At the time of our inspection the service's overall compliance for completion of mandatory training modules was 100% against a target of 85%.
- Staff and managers told us the service had closure days once a month where additional face-to-face training was provided according to team need or a theme and where staff had the opportunity to update their mandatory training. The latest closure day allowed all staff to attend child sexual exploitation (CSE) and contraception and sexual health (CASH) training.
- Staff were required to complete a local induction the first time they worked at a satellite centre to familiarise themselves with the workings and the local health and safety policies and procedures at the centre.

### Safeguarding

# Termination of pregnancy

- Processes were in place to safeguard vulnerable adults and young people. Staff we spoke with were all aware of their responsibilities and had access to safeguarding policies for adults and children.
- We reviewed the service's safeguarding children and safeguarding adults policy which were in date and available on the service intranet. The policies detailed roles and responsibilities and processes for reporting and escalation of concerns.
- All clinical staff were trained to level three in both adult and children's safeguarding. The MSI UK named nurse for safeguarding was trained to level four safeguarding. During the time period between April 2018 and March 2019 86.6% of staff had completed level three safeguarding training. This included two new staff who were booked to attend the next training course and at the time of our inspection compliance had improved to 100%. All staff including administrators had completed level two safeguarding training.
- All staff we spoke with demonstrated a good understanding of safeguarding. Staff knew who the named safeguarding leads were and how they would seek advice or raise safeguarding concerns. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to escalate concerns to the safeguarding leads and make a referral. We were given examples of concerns they had identified and where referrals were made.
- We saw safeguarding risk assessments for patients in the records we viewed. These enabled identification of vulnerable adults and any safeguarding concerns for adults or children. Staff told us, and we saw, they made safeguarding referrals to the local authority following discussion with the local safeguarding lead.
- Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) and child sexual exploitation (CSE) which was part of mandatory training within safeguarding level three. We saw posters about FGM displayed at the service. Staff also told us they had undertaken the training module, and a workshop to raise awareness of Prevent (WRAP) which helped staff awareness around the need to safeguard vulnerable people from being exploited for extremist or terrorist purposes.
- Safeguarding information was flagged within patient electronic records. In a sample of records reviewed, we saw that a safeguarding referral had been made and was appropriately flagged within the patient record. Patients under the age of 13 were not treated at the centre. These patients were referred to an NHS provider for treatment and the police and safeguarding authorities were also notified. The service treated young people aged 13 and above. Young people under 16 formed 0.2% of the patients treated at the centre. A specific safeguarding pro forma was used for young people under the age of 18 and a separate CSE tool was used if CSE was suspected. Telephone and face to face counselling was offered to young people under the age of 18. This was provided in a quiet room at the centre.
- Where young people had a social worker, MSI staff would contact them if the young person consented to this.
- Patients were seen on their own during the first part of a consultation so the nurse could go through safeguarding questions. Patients could be accompanied by a partner, relative or friend for the subsequent part of the consultation if they chose. Patients could also request for a number to be called out in the waiting room rather than their name in order to keep their identity confidential.
- The centre and satellite units held a file of local contact numbers to enable staff to quickly access adult and children safeguarding teams. Staff had access to a folder containing local safeguarding resources which had contact details of support and advocacy groups and mental health resources for patients to access in the local community.
- Posters for a domestic violence helpline were also displayed in both male and female toilets at the centre.
- The MSI Leeds centre managers had begun a collaborative project with Leeds police service and attended their CSE board the week before our inspection. The local authority and police service participants told managers of the service they had never been approached by a ToP service before to share information regarding safeguarding and CSE.

## Cleanliness, infection control and hygiene

- The service controlled infection risk well.**

# Termination of pregnancy

- Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service achieved hand hygiene audit results of 100% in most months but this had dipped to 70% in December 2018. Following this result, staff had completed refresher training and reflection and subsequent audits all achieved 100% compliance.
- IPC standard operating procedures were accessible by staff on the provider's intranet. The provider had a dedicated IPC lead who conducted IPC audits and sent action plans for the service to complete. MSI Leeds Centre also had its own IPC link nurse who conducted bi-monthly IPC compliance audits as part of the compliance monitoring programme. Any actions were added to the local service improvement plan and were shared at team meetings.
- All clinical areas we visited were visibly clean and free of clutter. There were sufficient hand washing sinks in clinical areas. Hand sanitisers containing hand sanitising gel were available in all areas of the centre including in the reception area.
- Throughout our inspection all staff were observed to be 'bare below' the elbows. There was easy access to personal protective equipment (PPE), such as aprons and gloves of different sizes. We witnessed staff using PPE effectively. We saw staff decontaminated their hands immediately before and after every episode of direct contact or care. This complied with guidance from the National Institute for Health and Care Excellence (NICE) QS61: infection prevention and control.
- Infection prevention and control (IPC) was part of mandatory training and records for the time period between April 2018 and March 2019 showed a compliance rate of 91% for clinical staff against a target of 85%. However, at the time of our inspection, this had improved to 100%. Staff were able to articulate the IPC training they had received and were able to identify the IPC link nurse for the service. Hand washing posters were displayed throughout the centre instructing staff on hand washing techniques.
- Following a recent internal cleaning audit which showed compliance of 88% with some dust on high and low level surfaces the centre had increased the cleaning contract from four to five days a week with a new contractor. Regular audits were scheduled to ensure compliance was improved and maintained.
- Deep cleaning of the building took place every six months by an external company. If there was a requirement, the operations manager was able to request deep cleans earlier or as necessary.
- We reviewed patient areas including consultation rooms and a waiting room, utility rooms and store rooms and found them all to be visibly clean. We saw green 'I am clean' stickers being used to identify equipment that had been cleaned and ready for use. We found a good level of cleanliness of furniture and equipment. We found toilets were tidy and visibly clean. The service used IPC compliant recliner chairs that could be wiped down and we observed staff wiping equipment with disinfectant wipes after use throughout the centre and at the EMU.
- We viewed the staff changing area which was cramped but scrubs and washable shoes, that were appropriate for the treatment room, were readily available.
- Patients we spoke with were satisfied with the level of cleanliness throughout the centre.
- Medical devices were a mixture of single use and reusable items. Reusable items were sent off site for decontamination and sterilisation. Contaminated instruments were collected by an external company which also delivered the sterilised instrument sets. There was a formal system in place to track instrument sets that had been sent for processing.
- Waste management was handled appropriately, with different colour coding for general and clinical waste. All clinical bins were seen to be foot operated with lids and were not overfilled. Waste management and removal, including contaminated and hazardous waste, was in line with national standards. Laboratory spill kits were available and staff knew how to access these. Clinical waste was stored securely outside in a locked bin in a secure external area at the back of the building and collected by an external company once a week.
- Pregnancy remains following surgical ToP were individually and appropriately collected and stored. There was appropriate segregation and storage of



# Termination of pregnancy

pregnancy remains to enable sensitive disposal or retention if requested by a patient or for criminal investigation purposes. A record log detailed when remains had been stored and collected.

## Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.**
- MSI Leeds centre had facilities which included a reception with a separate waiting area, two further waiting rooms, three consultation rooms, a treatment room and a dayroom including the recovery room. There were eight recliner chairs for patients' recovery following a surgical ToP. The service did not have overnight beds. There were also changing rooms for patients and staff. Facilities for patients were all on the ground floor. The first floor of the building was used by administrative and management staff. There was also a staff tearoom on the first floor. The early medical unit satellite clinics, except one, were located within medical centres. The Huddersfield EMU was located in a second floor suite above shops in the town centre. Patients were told when booking the EMU was located up two flights of stairs.
- The entrance to the service had secure entry with CCTV and buzzers to let people in which was controlled by reception staff. The reception area where patients registered was separate to the main waiting area. Emergency call buttons were located throughout the centre with a telephone system as a backup when assistance was required. Early medical satellite unit consultation rooms were mainly housed within health centres and had a panic button which alerted security staff within the building to provide assistance if required.
- MSI Leeds Centre had a backup generator which meant that there would be uninterrupted power to the centre to ensure equipment still worked in the event of a power cut.
- All premises had fire safety assessments, signage and fire extinguishers located appropriately. The Huddersfield EMU required two staff at all times due to its remote location.

- Resuscitation equipment and medications were checked regularly and resuscitation trolleys were tamper-proof. Trolleys and emergency rucksacks were checked daily when clinics were running and sealed drawers and packs were opened and checked weekly. Other emergency equipment such as defibrillators were checked daily. We saw completed checklists to show checks were carried out. We checked various consumables and found that they were sealed and in date. We also saw that there was a weekly check log for fridges and emergency equipment at the early medical unit satellite clinics.
- We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as blood pressure monitors and ultrasound scanning machines and found they had been safety tested. Safety testing stickers were on all equipment and servicing dates matched the dates recorded in the early medical units' assurance folders.
- Oxygen cylinders were stored securely and were in date. We inspected two sharps bins and found them to be correctly labelled and not filled above the maximum fill line.
- Store cupboards were locked and secure. Evidence of stock rotation was in place and all stock we checked was in date and stored in an appropriate manner.

## Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and acted quickly upon patients at risk of deterioration.
- Patients who were identified at initial consultation as not suitable for treatment or who had complex needs were referred to the provider's centralised clinical Right Care team for onward referral as appropriate. This team also carried out the pre-assessment process to ensure patients unable to be treated by MSI were not booked into consultation appointments at the centres.
- All records we reviewed contained venous thromboembolism (VTE) risk assessments which staff completed prior to treatment. Audit of VTE risk assessments showed 100% compliance.
- We observed the use of the World Health Organisation (WHO) and five steps to safer surgery checklists in the



# Termination of pregnancy

treatment room was embedded in practice. Records we reviewed showed the correct use of the World Health Organisation (WHO) and five steps to safer surgery checklist. We saw the checklist was completed appropriately at each stage. Audits were also being undertaken. All audits from April 2018 showed 100% compliance for the checklist completion.

- Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of termination of pregnancy early warning scores (TEWS). TEWS is a service-specific modified early warning system which allowed early recognition of and reaction to a patient's physical deterioration. We checked TEWS charts in records we reviewed and found them to be correctly completed.
- Anaesthetists were supported by nurses who were trained in anaesthetics and recovery and there was always a dedicated trained nurse who supported the anaesthetists in the treatment room. In the event of sickness, the operations manager told us they would use agency operating department practitioners. Agency usage was kept to a minimum throughout the centre and when this was used, the service used regular agency staff.
- We viewed the deteriorating patient policy which was in date and available on the service's intranet. A major haemorrhage protocol was followed if a patient bled excessively and staff we spoke with were able to describe the process. During our inspection we observed staff care for a deteriorating patient following escalation processes. The clinical matron was called to assist and medical staff acted quickly. Staff completed TEWS appropriately and the patient recovered quickly.
- The service had a service level agreement with a local NHS trust for emergency transfers. This had not been updated for several years. However, at the time of our inspection, the clinical services matron and operations manager had begun work with the local NHS trust to update the transfer agreement.
- Staff we spoke with said they had received training in sepsis within immediate life support (ILS) training. The compliance rate for ILS training was 90% during the time period between April 2018 and March 2019. However, at the time of our inspection this had improved to 100%. New staff were booked to attend training courses. The

compliance rate for advanced life support training for permanent and sessional doctors was 100%. Sepsis warning signs were also printed in the aftercare booklet which was given to patients to take home after their treatment. Patients were told to call the provider's 24-hour telephone line if they were concerned about any symptoms they had.

- We observed staff from the multidisciplinary team checking records and discussing each case before the patient arrived in the treatment room. Staff discussed physical and mental health of patients and complex cases in detail. We observed staff checking with patients about allergies before carrying out treatments.
- There was always a qualified member of staff in the recovery room. Nurses completed three sets of observations of patients prior to discharge and more often for patients they had concerns about. We saw evidence of this during the inspection and in records we reviewed.
- Patients who were booked for surgical ToP attended a pre-assessment clinic which included assessment of the patient's full medical history, an ultrasound scan to confirm gestation and sexually transmitted infection screening. Patients had a blood test to determine their rhesus status and blood group. Patients with a rhesus negative blood group received an anti-D injection (immunoglobulin) to protect against complications in future pregnancies. We saw evidence of anti-D injections being administered to patients in records we reviewed.

## 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.
- Staffing rotas showed that there was a registered nurse or midwife on duty at all times when patients attended appointments at the centre. Staff told us they could access rotas online from home and found this useful.

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- The provider used safe staffing guidance, which ensured that safe and appropriate patient to staff ratios were maintained at all points of the patient's treatment pathway. At the time of our inspection nursing staff were fully recruited to, with 10 registered nurses.
- Managers told us they had purposely over-recruited nursing staff to reduce delays and shortages of appointments at the MSI Leeds centre.
- The use of agency (temporary) staff was kept to a minimum. Due to the need for a specialised skill set, it was not possible to use agency staff for consultations and treatments. However, there was occasional use of agency nurses or operating department practitioners (OPD) in the treatment room. All were known to the service and had completed local inductions. In the last 12 months, 42 shifts for registered nurses were covered by agency staff.

## 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.**
- Anaesthetists were employed by MSI on a sessional basis and were always present on surgical list days which took place two days a week.
- Three doctors were employed by MSI and worked within the centre. In addition, the service employed remote doctors who reviewed patient notes and medical history before signing HSA1 forms and prescribing medication.
- Employment checks including qualifications, insurance, registration, disclosure and barring service checks (DBS) and revalidation reports were conducted corporately by the MSI human resources team. The corporate medical director was responsible for yearly appraisals of the team of doctors.
- Managers told us they had also purposely over-recruited medical staff to reduce delays and shortages of appointments at the MSI Leeds centre.
- MSI Leeds centre had a new surgeon working within the centre. They had completed competencies for early gestation surgical ToP but were supernumerary on the

day of our inspection to enable the experienced surgeon to observe and supervise their practice of later gestation surgical ToP until those competencies were also signed off.

## Records

- **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.
- Records were a mixture of paper and electronic. Records included initial and on-going consultation information, documentation of patient care during the operative phase and anaesthetic records for surgical ToPs. We reviewed records and saw that they included the HSA1 form, The World Health Organisation (WHO) and five steps to safer surgery checklist, TEWS chart for patients having surgical ToP and venous thromboembolism (VTE) risk assessments which staff completed prior to treatment.
- We reviewed eight sets of records for patients who had medical terminations or surgical ToP. Records we reviewed were comprehensive, legible, signed and dated. We saw that records documented full patient details and we saw completed HSA1 forms, pre-operative assessment and post-operative TEWS for patients having a surgical ToP. HSA1 forms are legal documents to allow a termination of pregnancy to be performed and is signed by two medical doctors.
- We saw electronic records in the treatment room which showed patients' previous medical history and HSA1 completions prior to surgical ToP being carried out.
- We also saw that records documented allergies, safeguarding information and preform as for patients under the age of 18. Records also documented that there had been discussion around disposal of pregnancy remains.
- MSI policies stated that all records, which included patient-identifiable information, must be stored securely and kept strictly confidential within the establishment. We saw this to be the case.
- Patient records were stored securely behind the reception area. There was also a lockable cabinet in the recovery room which staff used to store records when a

# Termination of pregnancy

patient was being treated. Archived records were then stored in a locked cupboard to ensure patient information was kept securely. Electronic records could only be accessed by authorised staff members and were password protected.

## Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**

- Medicines were kept in locked cupboards in the treatment rooms and access was by a key which was held by the nurse in charge for the shift. Medicines cupboards in the early medical satellite units were locked and a key was kept by the nurse who conducted the consultation.
- Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001)). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was completed fully and correctly. Two members of qualified staff checked the CD stock levels; the doctor or anaesthetist and a registered nurse. CD stock levels were accurate and the medicines were in date. The keys for the CD cupboard were held by the nurse in charge for the shift.
- The most recent controlled drugs audit showed a compliance rate of 95%. The audit found a pack of Oromorph was due to be collected for destruction. However, this had been actioned at the time of our inspection.
- Checks for expired medicines were completed as well as logs for the daily maximum and minimum fridge temperatures for fridges used to store medicines. The fridge temperature logs that we checked at the main centre and at Huddersfield EMU were all within acceptable range and we saw that these fridges were locked. However, it was not clear how staff at EMU's would know if a fridge temperature had been out of range on days when the unit was not staffed and, therefore, if all drugs and vaccines were safe to use.
- Emergency medicines were noted to be within their expiry date and stored in tamper evident packaging.
- Medicines were couriered to the early medical unit satellite clinics and staff signed for all deliveries. We visited the Huddersfield early medical unit satellite clinic and we saw emergency medicines including adrenaline were received and stocked appropriately. We saw checklists to show medicines were checked weekly.
- Medicines management was audited every two months. Audit results provided for the MSI Leeds centre from May 2018 to March 2019 showed 100% compliance for medicines management. A recent checklist from February 2019 checked medicines delivery, storage, stock control and checks. The auditor had identified the need to rotate stock to ensure the oldest packs were used first. All points noted had been acted upon by the time of our inspection.
- Medical staff at the service used an electronic prescribing system to prescribe medicines remotely. Medication records were completed correctly and completely and also showed that allergies were clearly documented in prescribing documents.
- The service treated patients with prophylactic antibiotics to reduce the risk of uterine infection. Records we reviewed confirmed that doctors followed local protocols for prescribing antibiotics.
- Medicines for EMA and medical termination of pregnancy were always prescribed by a doctor after a face-to-face consultation had taken place with a nurse.
- The government legalised/approved the home-use of misoprostol in England from 1 January 2019 for women that have not exceeded nine weeks and six days at the time mifepristone is taken. However, the MSI Leeds centre had not yet offered this to patients. A pilot with clinical audit had begun at a larger centre and MSI Leeds staff were waiting for initial findings before offering it to women. Results of this audit were still being processed at the time of inspection.
- A medication incident report for the MSI Leeds centre dated between December 2018 to March 2019 showed four medication errors. Two errors were 'wrong drug given' where a drug with contraindications was prescribed and the wrong antibiotic was given. One incident was categorised as no harm and the other incident was categorised as low harm. Both patients were given an apology and the correct drug supplied either directly or via their GP. The remaining two

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medication incidents at the MSI Leeds centre were 'dose not signed for'. Audit results across MSI UK centres showed a trend in 'dose not signed for'. In response to this audit, MSI had introduced a checklist for EMA and medical termination of pregnancy which was a paper form within a patient's records that the nurse had to complete after each stage of the patient's treatment was completed. We saw EMA and medical termination of pregnancy checklists at the MSI Leeds centre and the electronic record and both showed this was now in place.

- The regional manager was the controlled drugs officer and they carried out medicines management audits. A colleague from the MSI Manchester centre had also audited stock and storage of medicines. The clinical director and their pharmacy contact within MSI UK provided pharmacy support and advice to the centre.

## 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.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour fully. Staff could access a duty of candour online module on the provider's electronic learning and development platform.
- The MSI incident reporting policy required managers to review and sign off all incidents. Incidents were investigated by managers and lessons learned were shared by email and at monthly team meetings. Staff attended a monthly collaborative open forum to discuss concerns, complaints and incidents openly. Two staff from each centre attended and staff used these to discuss good practice as well as less than best practice. The operations manager and governance assistant had

completed root cause analysis training in order to take a consistent approach when reviewing incidents. Managers discussed incidents and learning with the regional manager at monthly regional meetings. The regional manager and governance lead also undertook root cause analysis and reviews of serious incidents. In the last 12 months, there were 179 clinical incidents reported by MSI Leeds Centre. Of these 65 were categorised as low harm, and three were moderate harm. There were two serious incidents which took place during this period. A full root cause analysis and 72- hour review was undertaken for each serious incident and immediate actions and learning was sent by email to all staff by the operations manager. Lessons learned from incidents were shared with staff and we saw records to show the duty of candour was applied.

- Managers told us staff were offered debriefs and were signposted to a 24-hour counselling helpline following any incident. The clinical director also offered a group debrief for serious or upsetting incidents.
- There were no never events reported in this 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.
- The service used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they were encouraged to report incidents and could also request individual feedback within the incident reporting form.
- Staff were able to tell us of incidents that had happened at the satellite clinics and MSI Leeds Centre and subsequent learning actions.
- Learning from incidents was shared through email and at team meetings. The operations manager also printed the minutes of the meetings and put them in a shared folder in the staff tea room so staff who were unable to attend the meeting could still access the learning. We also viewed the minutes of weekly complaints, litigation, incident and patient feedback CLIP calls which all staff could attend. Minutes showed that there was discussion around incidents across MSI centres and learning was shared.

# Termination of pregnancy

## Are termination of pregnancy services effective?

Good 

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 and all policies we reviewed were up to date and accessible by staff on the provider's intranet.
- We reviewed eight patient records and found that patient needs had been assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice. For example, we saw that all patients were assessed and treated for venous thromboembolism (VTE) in accordance with National Institute for Health and Care Excellence (NICE) guidance.
- We reviewed a sample of the provider's policies such as the risk management policy, privacy and dignity policy, safeguarding adults policy and resuscitation policy. We found these were all reviewed and in date. MSI policies made appropriate reference to national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE), Association of Anaesthetists of Great Britain and Ireland (AAGBI), Royal College of Obstetricians and Gynaecologists (RCOG) and the Department of Health Required Standard Operating Procedures (RSOP).
- The service conducted audits as part of a compliance monitoring programme. The early medical units were audited every six months by the clinical team leader. Audits included medicines management, information governance and sharps/waste management. Key indicators such as training compliance rates, audit results and complaints were also monitored on a dashboard. This was in line with the Department of Health Required Standard Operating procedures (RSOP)

16 which recommends that all providers should have in place clear locally agreed standards against which performance can be audited, on specific outcomes and processes.

- Patients were screened for sexually transmitted infections as part of their treatment. If there was a positive result, the service called the patient and referred them to sexual health and counselling services in the community. If a patient was not contactable, a notification was sent to their general practitioner (GP) (if the patient had consented to this) to ensure that the information was communicated and treated. However, not all CCGs funded screening for sexually transmitted infections. Since MSI was a charity they could not pay for this and MSI Leeds were unable to offer this service to patients from Wakefield.
- The service treated surgical ToP patients with prophylactic antibiotics to reduce the risk of uterine infection and treat chlamydia which is a sexually transmitted bacterial infection. However, following clinical guidance, they had stopped prescribing antibiotics for women undergoing medical ToP.
- Contraceptive options were discussed at the initial assessment stage and also discussed during the consent process. CCGs had set a target of 40% for long-acting reversible contraception (LARC) administration following a termination although managers told us Public Health England statistics showed the national uptake was 13% across all providers. MSI Leeds centre had achieved 30% and CCGs had agreed any improvement on this would be a remarkable achievement.
- There was a process in place which ensured patients received appropriate cervical preparation. At the consultation stage, patients were asked a series of questions and their age and gestational period were taken into account to determine whether cervical preparation was needed. Women requiring cervical preparation attended the clinic early and received this prior to their procedure.
- All patients were scanned during a surgical procedure to ensure no products of conception remained. We observed staff scanning a patient during a surgical procedure to check this.



# Termination of pregnancy

- We observed the recovery and discharge process of one patient and saw the patient was given an aftercare booklet. A staff member explained possible complications and directed the patient to a 24-hour telephone line if they had any concerns. Discharge letters were sent to patients' general practitioners (GP) if they consented to this.

## Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**
- There were appropriate processes in place to ensure patient's nutrition and hydration needs were met.
- Patients were informed at their pre-assessment about fasting and fluids prior to receiving anaesthetic. They were told not to eat for six hours before their appointment and to drink clear fluids up to two hours before their appointment which was in line with Royal College of Anaesthetists Guidance.
- We observed staff asking patients when they last drank or ate at different stages of the treatment process including prior to surgery. We also observed the surgeon checking with the patient prior to surgery.
- Staff made drinks for patients and provided baskets of wrapped biscuits, water and hot drinks after surgery.

## Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**
- Staff used standardised assessment tools to measure pain which was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidance. A numbering system from zero (no pain) to 10 (extreme pain) to express a patient's level of pain was used. Records we reviewed showed that pain assessments had been completed and pain scores were documented following surgical procedures.

- Medical staff prescribed pre and post-procedural pain relief. Records we reviewed showed that pain relief such as non-steroidal anti-inflammatory medication was prescribed which was recommended in Royal College of Obstetricians and Gynaecologists guidance.
- We also saw that patients were offered a warming pad after procedures to help ease pain.
- We observed staff checking with patients about their pain and patients we spoke with told us that they received pain relief in a timely manner.
- We saw that nurses gave patients good information and advice regarding what to expect post treatment and how to alleviate pain. Patients told us they were given advice on medication to take at home following their procedure.

## Patient outcomes

- **Staff monitored the effectiveness of care and treatment.** Staff used the findings to make improvements and achieved good outcomes for patients.
- The operations manager compared local audit results with those of other MSI locations to learn from them and learning was discussed weekly at complaints, litigation, incident and patient feedback (CLIP) meetings and at quarterly local integrated governance meetings (LIGM). MSI Leeds Centre managers provided Leeds Centre compliance dashboards to show the Leeds centre consistently scored highly in local audits.
- MSI Leeds Centre offered long acting reversible contraception (LARC) which was a method of birth control providing contraception for an extended period without user action. Contraceptive options were discussed at the initial assessment stage and also discussed during the consent process. CCGs had set a target of 40% for LARC administration following a termination although Public Health England statistics showed national uptake was 13%. MSI Leeds centre had achieved 30% and CCGs had agreed any improvement on this would be a remarkable achievement.
- The service had a contraception and sexual health (CASH) qualified nurse and measured LARC uptake monthly. To increase staff awareness and patient uptake the centre named a "LARC champion" each month.

# Termination of pregnancy

- Between May 2018 to April 2019 the centre and its associated early medical satellite units performed 3670 medical terminations. In the same period, the centre performed 1176 surgical ToP and 351 vasectomies.
  - Complication rates such as retained products of conception, on-going pregnancy, post procedure infection and transfer to a local NHS trust were monitored. Data submitted showed that between May 2018 and April 2019 the early medical termination failure rate was below the provider's target of two percent. In the reporting period the failure rate for medical termination (retained products of conception) was 2.2% and incidences of continuing pregnancy was 1.6%. Surgical ToP (retained products of conception) failure rate and incidences of continuing pregnancy was 0%. In the same period, three patients required transfer to a local NHS trust during or after treatment. The post procedure infection rate was 0.07% which was below (better than) than the MSI target of 0.5%. The vasectomy failure rate was 0%.
  - Managers monitored numbers of patients who did not proceed with treatment. Year to date results showed that 17% of patients did not proceed with their planned treatment. In May 2019 15% of patients did not proceed with medical terminations and 10% of patients did not proceed with surgical ToP. Reasons varied from patients who changed their mind about their decision, unsuitability for treatment, or where gestation was too high. Patients were advised of where they could access care if they were continuing the pregnancy.
- Competent staff**
- **The service made sure staff were competent for their roles.** Managers appraised staff work performance and held one-to-one meetings with them to provide support and encourage development.
  - Staff had yearly appraisals and at the time of inspection 100% of staff had completed their appraisals. Staff also had one-to-one meetings with their managers every six to eight weeks. Staff commented that the appraisal process and one-to-one meetings were meaningful and focused on their development. They commented that the managers were very supportive in discussing development and training opportunities in one-to-one and appraisal meetings. Administrative staff also commented that they found their appraisals useful.
  - Managers used performance review meetings to manage any areas where staff did not perform to MSI standards.
  - Staff we spoke with told us they received a comprehensive induction and were supported by the clinical team lead. Nursing and midwifery staff were assessed on clinical competencies during their first three months in post. This was overseen by the clinical team leader. A buddy system was also in place for new starters which was built into a structured induction pathway. Temporary (agency) staff had a local induction process which included orientation.
  - Nursing staff were trained to perform ultrasound scans for dating purposes. Since September 2018, the provider had employed an ultrasound scanning director who had implemented a new in-house training programme for ultrasound scanning. Training involved a two-day focused face-to-face theory course, clinical training with written assessments and summative assessments done by a university. Staff were then assessed on a minimum of three scans. Three-monthly audits were planned.
  - The ultrasound scanning trainer visited the centre regularly and met us during our inspection. They explained the training programme for nurses and how staff could access further scanning training opportunities. The centre used one of the EMUs with extended appointment times to train and support staff in scanning competencies.
  - All registered nurses had been trained to insert LARC implants, except a new member of the team who had a training place booked. This was achieved through collaborative working with another provider of sexual health care who supported and provided training free of charge.
  - Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and was the process nurses and midwives must follow every three years to maintain their registration. The provider's centralised human resources team checked that nursing staff who were required to revalidate, had done so successfully. A tracker was used to monitor NMC revalidation and communicated to senior managers at the centre. The clinical services matron received emails when nursing staff were nearing revalidation.

# Termination of pregnancy

- The provider's human resources team also checked that medical staff were registered with the General Medical Council and completed the revalidation training. Medical re-validation was introduced in 2012 to ensure all doctors were up to date and 'fit to practice'. Managers showed us evidence doctors had received yearly appraisals.
- Anaesthetists were supported by nurses who were trained in anaesthetics and recovery and there was always a dedicated trained nurse who supported the anaesthetists in the treatment room.

## Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- We saw evidence of good multidisciplinary team (MDT) working within MSI Leeds Centre. Staff told us they attended a morning safety huddle where patients on the surgical list that day were discussed. The meeting was attended by nurses, doctors and the anaesthetist conducting the surgical list. We observed inclusive discussions about the patients and saw that there was respect for each member of the multidisciplinary team and the contribution they made. Staff listened to concerns and comments from the anaesthetist during the team discussion prior to a surgical ToP where a patient had had complications following a recent birth. There was a holistic discussion about patients' needs and communication was clear and inclusive.
- We observed all staff listened and took action when the World Health Organisation (WHO) and five steps to safer surgery checklist was read out prior to a surgical procedure. Staff worked together to document medications given, additional equipment used and the swab count following the procedure.
- We saw evidence of good working relationships between nurses and medical staff. All staff we spoke with said they felt comfortable approaching doctors for support or advice. If doctors were not on site, staff used the electronic record system where they could have an online discussion with a doctor regarding suitability for medical termination of pregnancy. Nurses and doctors

could also contact each other by telephone if they needed to discuss a patient in detail. Staff told us that the medical staff were easy to contact through these systems and responded to requests for advice quickly.

- There was evidence of effective multidisciplinary partnership working with external agencies and professionals such as the local authority for safeguarding referrals. The centre also had established links with the local prison service to help make improvements for prisoners attending the service. Communication with the patient's GP only happened with patient consent.
- Managers and specialists were available at the end of the phone if staff needed help or support with other issues such as safeguarding or infection prevention and control. Staff told us they found it easy to access any help needed and specialists and managers were responsive and supportive.

## Seven-day services

- **There was suitable provision of services to ensure care and treatment delivery and supporting achievement of the best outcomes for patients.**
- MSI Leeds Centre was open five days a week Monday to Friday from 8.30am to 5pm. Surgical lists took place two days a week on Monday and Thursday. The early medical unit satellite clinics were available throughout the week from Monday to Friday from 9am to 5pm, offering one to two clinics a week per location.
- Weekend appointments were available at MSI Manchester Centre, but patients would have to make their own travel arrangements.
- A counsellor attended the MSI Leeds Centre one day a week for face to face counselling for any patients who wished to take up this offer.
- Vasectomy appointments were held one day a week on Fridays. The service rotated between the MSI Leeds Centre and three satellite sites. Vasectomies took place on separate days from surgical ToP or medical termination of pregnancy.
- MSI One Call which was a national aftercare telephone service where patients could speak to a member of staff for advice and support. This was available 24 hours a day, seven days a week.



# Termination of pregnancy

## Health promotion

- **Health promotion information was available.**
- We saw a range of health promotion information displayed such as leaflets giving information about cervical screening, testicular cancer, sepsis and antibiotic resistance as well as posters about sexually transmitted infection testing.
- We observed staff discussing future contraception with patients during consultations and providing patients with leaflets on different types of contraception. Screening for sexually transmitted infections was also discussed during consultations.

## Consent and Mental Capacity Act

- **Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).** MCA training formed part of the consent module. Compliance for staff at the time of inspection was 100%.
- At our last inspection, consent was not audited separately. However, at this inspection we saw that informed consent compliance monitoring was now in place. Auditing took place every two months. Results between April 2018 and March 2019 were 100% each time, except for a result of 94% in December 2018. Managers had organised for staff to complete refresher consent training and the following audit showed 100% compliance again.
- Consent forms were pathway specific and listed all possible complications for the treatment the patient had agreed to. The forms acted as a prompt sheet for staff, ensuring they discussed all complications and risks. We saw staff discussed risks and complications and gave patients the opportunity to ask questions before they asked the patient to sign their consent.
- We observed staff obtaining consent and procedures being explained to patients. All patient records we reviewed demonstrated that consent was sought and clearly recorded in patients' notes. We observed staff gaining verbal consent before treatment and we observed patients providing written consent prior to

their treatment. We saw that patients were asked again prior to surgery if termination of the pregnancy was their final decision. For patients whose first language was not English, a face-to-face interpreter was used.

- Staff we spoke with were aware of the requirements of consent and information sharing to safeguard young people and vulnerable adults. They knew what to do if a patient lacked capacity. Patients with learning disabilities were assessed on a case by case basis and referred to an NHS provider if the centre felt that this was more suitable to the patient's needs.
- All medical and nursing staff we spoke with understood the Gillick competency which helps assess whether a child has the maturity to make informed decisions about treatment without consent of a parent. Staff also understood Fraser guidelines which are used specifically for children requesting contraceptive or sexual health advice and treatment.
- Staff were aware of situations where these principles would be applied. Medical and nursing staff were aware of the MCA and the implications for young people below the age of 16.

## Are termination of pregnancy services caring?

Good 

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.**
- We observed consultations and saw that staff were respectful and compassionate with patients. Patients we spoke with commented on the professionalism and non-judgemental manner of the nurses. They commented that "from the person I spoke to on the phone to the nurse today, everyone has been so kind and understanding. They did not judge me and made me feel comfortable". A partner told us "my girlfriend can be very shy and nervous and she has been fine all the way through". One patient undergoing cervical preparation told us they had felt "petrified about

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recovery, staff were so understanding, going that little bit extra". Staff had shown the patient the recovery area, allowed her to ask questions and had given her time to prepare for her procedure.

- Staff promoted patients' privacy and dignity. We saw patients being covered with a blanket after procedures before being taken to the recovery room. Consultation rooms had signs on the doors to indicate when they were in use. Nurses provided a privacy screen for a patient who was visibly upset throughout her visit. She told us she had asked for the screen to protect the other patients' feelings.
- The service had established links with two local prisons. Patients who were prisoners had attended the service in manacles and staff found patient dignity was greatly affected. The clinical services matron had approached prison staff to request a different type of manacle be used to improve dignity but maintain security. The clinical services matron was working with prison staff to prepare a care pathway for future prisoners who used the service.
- Staff we spoke with were passionate about their work and delivering patient centred care. We observed clinical and non-clinical staff talking sensitively to patients. We observed nurses introducing themselves to patients and taking the time to explain what would happen next.
- The service used feedback forms to collect feedback from patients. Feedback from January to March 2019 showed that 97% of respondents felt that their overall care was 'very good' or 'excellent' which met the national average. 99% of patients responded 'yes, completely' to the question 'were you treated with dignity and respect'.
- Feedback from patients was collected and discussed at team meetings. The operations manager provided feedback so staff could see the comments that had been made. Comments from patients included "although this was a hard and sensitive procedure I felt relaxed and safe", "All staff were lovely and caring", and "a difficult decision was made a lot easier with how nice and relaxing the treatment was. It was explained step by step and (the nurse) put me at ease immediately".
- During our inspection, the service was piloting a new survey whereby feedback was collected on electronic

tablets. Staff told us patients liked the system and readily engaged with giving feedback using the tablets. Patients had sufficient time to consider their answers following their treatment when they were waiting to be discharged. The survey included questions about understanding of treatments, contraceptive counselling, dignity and respect, information and support, aftercare and pain management. Patients were able to give a rating alongside questions and submit comments in the free text space. The feedback was made available in the public domain through a website which collected feedback on healthcare providers.

## Emotional support

- **Staff provided emotional support to patients to minimise their distress.** They understood patients' personal and cultural needs.
- Staff described how they would support patients emotionally at all stages of treatment. We saw nurses and healthcare assistants supporting and reassuring a very anxious patient by reassuring them, offering to hold their hand and helping them to calm their breathing before and during a procedure in the treatment room. The surgeon checked the patient's anxiety was not linked to their decision prior to the procedure.
- We observed nurses checking on patients in the waiting room and we saw that nurses spent time speaking to patients who were anxious. We also saw nurses offering tissues to patients and spending time with a patient who was very upset and distressed.
- We saw nurses talking to a patient who had suffered a deterioration in their condition following their procedure. The whole team spoke kindly and gave the patient information on her condition and what would happen next. Staff monitored the patient and they recovered quickly following an additional procedure.
- Counselling services were offered to all patients including patients who attended the service for vasectomy (male sterilisation) procedures. Patient records we reviewed showed that discussion around counselling had been recorded.
- The service employed a counsellor one day a week who provided face to face sessions for any patient, including younger women who wanted support.

# Termination of pregnancy

- Patients had access to a 24-hour helpline following a procedure as well as a post-termination counselling service.

## Understanding and involvement of patients and those close to them

- **Staff supported and involved patients to make decisions about their care and treatment.**
- We observed nurses communicating sensitively with patients, explaining in a way the patient could understand and giving explanations when patients asked. Patients we spoke with told us they felt comfortable asking nurses questions and that questions they had asked were answered and explained fully. Patients also told us they received enough information regarding aftercare and contraception choices.
- Records we reviewed documented that the disposal of pregnancy remains had been discussed during the consultation. We observed consultations and found that staff were thorough and followed guidance for the treatment pathway. Staff ensured that patients understood the discussion and gave opportunities for the patients to ask questions.
- Patients told us staff had given them an aftercare booklet to read or keep if they had any questions, forgot any details or instructions. They had been told about the 24-hour advice telephone line and knew how to find the number from the booklet.
- We observed multidisciplinary approaches to care planning for patients. During our inspection we observed the anaesthetist noting a patient with relevant previous medical history was on the list for a procedure that morning. The doctors spent additional time working together with the nurses to coordinate the patient's care. The patient was very anxious and we observed medical and nursing staff checking on the patient before surgery to make sure they were comfortable and to answer any additional questions they might have.

## Are termination of pregnancy services responsive?

Good 

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 centre was open five days a week and provided medical terminations from Monday to Friday. Surgical lists took place two days a week on a Monday and Thursday. The early medical unit satellite clinics were available throughout the week from Monday to Friday offering one or two clinics a week per location. Early medical unit satellite clinics only offered EMA services. A vasectomy list took place weekly on Fridays and rotated between the MSI Leeds Centre and three satellite sites. There were no other clinics held on those days so men and women would receive their treatment separately.
- Patients booked appointments through the MSI UK One Call system. The booking system allowed for the patient to choose an appropriate MSI service location and the team informed the caller of different treatment options available for termination of pregnancy dependent on gestation. Patients received a text message once they had booked their appointment with the date, time and location of their appointment.
- MSI Leeds centre staff planned operational and clinical service provision a month in advance. These plans included the services available each day and week, skill mix of staff to ensure patients received the right service at the right time and staff received the right support to provide care.
- MSI Leeds worked with the city council and the police regarding protestors outside the service. Staff received messages from MSI UK regarding dates of official

# Termination of pregnancy

protests and staff told us they would give patients a contact number and staff would collect patients from across the main road if they had any problems or worries in accessing the centre.

- Pregnancy remains were stored appropriately and disposed of sensitively and the MSI process complied with the Human Tissue Authority (HTA) Code of Practice (April 2017). Staff told us, and we saw records to show most pregnancy remains were collected by an external company for appropriate disposal according to the Code of Practice. When the service needed to keep pregnancy remains, for example for DNA testing or criminal investigation, the policy stated that staff must use new equipment and a separate storage container. This was in line with HTA guidelines. The contents needed to state the patients name, MSI number, date of birth and date of procedure. In all cases, no pregnancy remains were kept for longer than three months. Options for pregnancy remains were discussed in consultations and we saw evidence of these discussions in records that we reviewed.
- Service level agreements were in place with local laboratories for screening and blood testing if needed. Staff carried out point of care blood testing for haemoglobin (iron levels) and rhesus status during consultations.
- Managers had established links with the local MESMAC group to update staff with HIV screening training.

## 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.
- Patients aged 13 years and over could refer themselves or be referred into this service through traditional referral routes such as their GP or a sexual health clinic.
- Patients were able to choose their preferred treatment option and location, subject to their gestation and medical assessment. If patients needed to use services on days when the main centre was closed, they could use alternative MSI satellite clinics in Yorkshire or further afield. Patients who wanted or needed weekend

services could use the MSI centre at Manchester. If treatments were in two parts, staff worked to provide appointments at other satellite clinics or regional centres to provide patients with more flexibility.

- If MSI Leeds centre could not offer the treatment the patient had chosen, staff helped them to decide where, when and how they could access the treatment they required. We observed nurses making appointments for patients at other Marie Stopes clinics and providing directions to them. We also saw examples where staff had made referrals to other independent ToP services and to the NHS to support the individual needs of patients, especially those with later gestation.
- Patients were allowed to have relatives or friends accompany them in consultations after the safeguarding stage of the consultation had been completed. Relatives, friends and partners were not allowed in the recovery room in order to maintain the privacy of patients. However, staff told us that very occasionally patients with complex needs or particularly vulnerable groups such as very young patients had used the service. When this happened, a friend or relative could accompany the patient to help ensure the patient fully understood the treatment. Depending on the wishes of the patient, the friend or advocate could stay with the patient throughout treatment and examinations, following their private consultation.
- There was a range of leaflets on treatment information, sexually transmitted infections and different types of contraception. We saw some leaflets were provided in languages other than English and consent forms were available in 37 other languages. A patient could request to read the consent form in a different language and were then asked to sign an English version.
- Staff told us telephone and face-to-face interpreters could be requested easily. An interpreter could accompany a patient in the treatment room if a patient was not able to speak any English and could not communicate with the staff.
- The service had implemented a five-minute gap in between consultation times to allow staff the flexibility to spend more time with a patient if needed. Additional support was provided by clinical team leaders and the clinical services matron if a consultation took longer than planned.

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- Patients with learning disabilities were assessed on a case by case basis. We were told that staff would work with the patient to find the best way to support them including allocating a second nurse or the opportunity for a patient to visit the centre before their procedure or appointment.
- MSI Leeds Centre had ramp access for wheelchair users. Any MSI documents or leaflets could be printed in large print for patients with visual impairments.
- Posters in the waiting room informed patients that they could request a chaperone.
- The provider had a 24-hour telephone line which patients could access for additional support and advice following a procedure.
- Water, biscuits, hot drinks and warming pads were offered to patients following treatment.
- When attending the MSI clinics for medical or surgical treatment, following the initial telephone consultation, patients had a 15-minute appointment. Patients under the age of 18 years were given a 45-minute appointment to allow additional time to ensure they understood all the information they were given and for safeguarding checks.
- Appointments involved confirmation of pregnancy gestation by ultrasound scan, observations and point of care testing for rhesus status, sexually transmitted infection screening (if required), discussion of treatment and consent, booking an appointment for treatment, administration of medication and discussion and, or administration of contraception.
- At our last inspection, staff at the early medical unit satellite clinics told us that they did not have enough time between patients. At this inspection, staff told us they had sufficient time between patients. We saw extra time was allowed during ultrasound training clinics and most appointments had a five minute gap in between to allow a small amount of extra time. We observed consultations which were not rushed and saw that staff were able to spend enough time with the patient. Staff told us appointments were carefully scheduled for early medical unit satellite clinics where only one nurse would be working.
- Staff told us they felt that although they had additional time to see some patients, they would always benefit from further flexibility and time to spend with individuals. However, they did accept there would have to be limits set so that all patients could be seen on time.
- We observed that staff always gave patients time according to their individual needs and that appointments were not rushed.
- EMA clinics had to be cancelled on one day in July 2019 due to an MSI-wide IT issue. MSI Leeds staff contacted all the patients on the daily list and offered alternative appointments. Two patients declined another appointment because they had changed their minds about a termination.
- Staff told us if an EMU clinic was cancelled they could offer patients free transport to another EMU or the MSI Leeds centre to ensure they received a timely appointment.

## Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Staff at the telephone booking service carried out an initial consultation and offered patients a choice of dates, times and locations. This ensured patients were able to attend the most suitable appointment for their needs, subject to their gestation and clinical assessment.
- When a decision to proceed was made, One-call made an appointment for the patient at one of the clinics for further consultation, assessment and treatment. This was often on a separate day but MSI Leeds could offer treatment later in the same day subject to a full medical assessment and legal procedures being carried out.
- If a patient's gestation was later than 18 weeks with no other concerns, they would be booked into the MSUK Manchester centre that had facilities to treat patients up to the legal limit for termination. If the consulting nurse had any concerns about a patient's medical condition or history, or if there was a suspicion of an ectopic pregnancy, they referred the patient to a local NHS acute hospital for further assessment and treatment.
- When demand peaked and waiting times were likely to exceed recommendations, the service could provide additional appointments at the MSI Leeds centre or by remaining open later in the evening.



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- Waiting times were monitored weekly by a central capacity team. The service was able to adjust lists and add additional appointments to meet demand. The service also expedited patients who were nearing the legal limit or who were under the age of 18. Internally, the target for appointment waiting times was three working days and from decision to proceed a patient waited on average three days which met the Department of Health RSOP 11: Access to Timely Abortion which states that patients should be offered an appointment within five working days of referral and they should be offered the termination of pregnancy treatment within five working days of the decision to proceed.
- We received data on the percentage of patients who waited longer than 10 days from initial contact to treatment or five days from decision to proceed to treatment. In 2018, 18% of patients waited more than 10 days for a medical or surgical ToP. MSI Leeds Centre ensured appointments were available to patients within the 10 day limit and monitored reasons why some patients exceeded the 10 day limit. Reasons ranged from patients who did not attend, patient choice for the appointment day and patients cancelling appointments. The service also received a weekly report corporately with the current waiting times and current number of patients awaiting appointments. Data which was later provided by the provider showed that for the month of May 2019 the longest wait for an appointment from point of contact was seven working days but this was for later gestations of 14 weeks and six days or over. There were appointments available sooner for patients with earlier gestations.
- Patients were informed of waiting times and any delays on arrival at the centre.
- Staff told us they referred patients to the do not proceed (DNP) team if staff were unable to detect an intrauterine pregnancy, the pregnancy exceeded the nine weeks early medical termination of pregnancy limit, or if the patient was uncertain about their decision. The DNP team was a central team that would arrange further appointments, counselling or treatment for the patient concerned. This included arranging follow up appointments, or appointments or treatment at other MSI clinics or NHS services where necessary.
- The MSI target for DNP was 15% or lower and the latest figure for Quarter 2, 2018 to 2019 for the MSI Leeds centre was 17%. This was an improvement of 1% from the same quarter in the previous year.
- Staff told us the decision to proceed with a termination was entirely the choice of the patient. If nurses found that patients appeared to be uncertain about their decision, they were advised to take time to consider their options before rearranging an appointment. We spoke with one patient who had returned to the EMU for their treatment after taking more time to consider their decision and they confirmed they wished to go ahead with their treatment.
- The did not attend rate (DNA) for the centre was 7% for medical termination of pregnancy and 10% for surgical ToP. This was another improvement of 1% from the same quarter in the previous year.
- If there was a medical or safeguarding concern, the provider's centralised One Call team would follow up a DNA with the patient by telephone. If no risk was highlighted and the patient was of a gestation lower than 14 weeks, a follow up call was not made as staff told us this could be seen to be coercive.

## 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.
- There was a complaints policy with clear responsibilities for all staff and managers. The operations manager recorded and investigated all complaints arising from patients at their centre and complaints were discussed at Central Governance Committee meetings. Managers forwarded written complaints to the Head of Quality and customer services, who acknowledged them all. Staff monitored progress through the complaints action plans on a monthly basis.
- The Marie Stopes website gave information on how to provide feedback or make a complaint.
- There were posters in the waiting room and at satellite clinics informing patients of how to make a complaint.

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Patients told us they felt comfortable speaking directly with staff if they wanted to complain and knew how to make a complaint. Nurses, the operations manager and the clinical services matron told us they tried to address concerns as they arose.

- From April 2018 to March 2019 the service received 30 informal and three formal complaints. One complaint was partly upheld. All complaints received were responded to within 20 days which was in line with the service's complaints policy. All informal complaints had been resolved and the MSI Leeds team had given one patient advice on making a formal complaint. Most concerns were about operational issues such as appointment availability and delays in clinics. The service displayed You said, we did cards to show how they had managed patient feedback, such as, allocating responsibilities to identified staff to inform patient of any delays and supporting patients if they found protestors to be intimidating. Some patients complained the waiting areas were too small and could not accommodate partners. The service had planned a refurbishment to introduce a larger waiting area and a private room for patients to discuss concerns.
- The service used feedback information from patients to improve the service. For example, another centre had received patient feedback whereby a patient had not wanted their name to be called out in the waiting room. In response to this, the MSI Leeds centre introduced an option whereby if a patient did not want their name to be called out, they could be allocated a number at the reception and the number would be called out instead. This number would be recorded in patient's record so it could be used throughout their attendance at the centre.
- Feedback and learning from complaints were shared at team meetings. All complaints were investigated with outcomes and lessons learned documented. We saw an example, in response to a complaint where managers and staff had discussed, agreed and documented actions to be taken and their outcomes. Any trends and lessons learned from complaints were also discussed at weekly complaints, litigation, incident, and patient feedback (CLIP) meetings as well as at quarterly local integrated governance meetings. We saw evidence of discussion of complaints within the minutes of these meetings.

## Are termination of pregnancy services well-led?

Outstanding



We rated it as **outstanding**.

### 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.**
- Comprehensive and successful leadership strategies were in place to develop the desired culture. Leaders understood issues, challenges and priorities in their service, and beyond.
- Leaders had a shared purpose and strove to deliver and motivate staff to succeed. Leaders supported staff to develop their skills and take on more senior roles. Managers demonstrated the experience, capacity and capability needed to deliver care.
- The MSI Leeds centre was set up as a hub and spoke model with six EMA satellite clinics and three vasectomy satellite clinics. The regional manager was responsible for the MSI Leeds and MSI Manchester centres and the registered manager for the MSI Leeds centre. The operations manager was also a registered manager.
- At our last inspection managers worked between MSI Leeds and MSI Manchester centres which meant they were not available every day. At this inspection there were full time managers based on site. Staff told us this had improved visibility and availability of managers and confidence of staff. Managers understood the needs of the service, aims and goals of the organisation and requirements of the staff to provide the correct service for their patients.
- MSI Leeds Centre and the satellite clinics were managed by an operations manager and clinical services matron which meant that there was full oversight by dedicated on-site managers for operational and clinical issues. The operations manager had responsibility for the operations team leader and front of house staff. The clinical services matron had responsibility for the

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clinical team leaders who managed the registered nurses, midwives and healthcare assistants. Staff at the EMU satellite clinics rotated from the main MSI Leeds centre and were managed by the clinical team leader but also had access to both the operations manager and clinical services matron for additional support. The operations manager and clinical services matron were supported by a regional manager who reported to the operations director for MSI corporately.

- The MSI Leeds centre had a full-time nursing team lead who provided day-to-day supervision and support. Staff were also supported by the MSI associate director for ultrasound scanning who visited regularly and provided scanning training, advice and support to staff.
- Staff at all levels told us the regional manager was readily available, visited the main site regularly and we observed they were seen as a part of the team.
- Staff told us senior leaders were approachable and available. The MSI UK managing director had visited the centre the week before our inspection and talked to staff about having the right balance between safety and business, thinking about patients, safety and reducing risks. Staff told us patient safety was MSI's number one priority.
- The clinical services matron and operations manager at the service took ownership of the service and told us they were able to suggest changes and improvements for the service.
- Staff spoke highly of the visibility and involvement of the operations manager and clinical services matron. Staff told us the managers were always available to support staff in the clinic and over the phone for the early medical units. Staff told us they felt comfortable approaching the managers with any issues they had.
- Staff and managers at MSI Leeds centre were involved in working with local universities to build a ToP module for student nurses and midwives, and working with the local trust to provide a "day in the life of" staff exchange programme for staff in early pregnancy units.
- Staff and managers also maintained contacts with local CASH services, crisis management team, homeless services, safeguarding teams and the police regarding information sharing around topics such as domestic violence.

## Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.**
- Leadership, governance and culture were used to drive and improve the delivery of holistic person-centred care.
- The service sought to influence care within its sector positively and had identified strategies to provide care and education for future patients and local partnerships including wider external stakeholders.
- There was a systematic approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.
- The operations manager and clinical services matron were knowledgeable about the corporate vision and strategy. All staff we spoke with were aware of the provider's mission of "children by choice not chance".
- Managers told us of the priorities and desired outcomes for the MSI Leeds centre which were displayed and staff were aware and engaged in achieving. The service called them the "Four Cs". These were around Compliance; to improve quality, consistency and effectiveness and drive IPC compliance; Costs: to ensure appropriate allocation of resources; Colleagues: to invest in team development, improve skill mix and staff feedback; Clients: to improve client experience through improved flow and availability of appointments.
- The operations manager told us that they spoke of the vision of the service to staff at monthly team meetings so staff could be involved in changes. The staff monthly update included information and achievements against the local strategy and staff felt encouraged and motivated towards improvement for the centre and provision for its patients. Staff confirmed they were aware of plans and changes and were able to put forward suggestions for change.

## Culture



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- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.**
- Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were passionate about their work and spoke of good teamwork in a patient-centred environment.
- Staff we spoke with at all levels were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.
- Staff commented that there had been a lot of improvements to management and the clinical service since the last inspection. Staff told us staffing had improved, they now felt listened to, supported in their development and there were now regular meetings where they could voice their concerns.
- There was strong team-working and a common focus on improving the quality and sustainability of care and patient experiences.
- The service provided opportunities for career development if staff wished to specialise or take on a lead role. However, there was no clear leadership development strategy or succession planning at a local level.
- We observed good staff relationships at all levels. Medical staff were seen as members of the team and staff at all levels worked together and supported each other. We observed multidisciplinary team working and collaboration throughout the inspection.
- Staff told us they felt able to raise concerns or ideas, felt listened to and discussed ideas for improvements with their managers and professional leads. Staff we spoke with told us that communication and training had improved as a result of the management changes. For example, monthly staff meetings had a structured agenda, supervision was formalised, and face-to-face and email communication had improved.
- We found an open and honest culture and staff were knowledgeable about the duty of candour. Staff knew about the service's processes and procedures and could give examples of the learning that was shared from an incident.
- All staff we spoke with, including administrative staff consistently told us they felt supported by their managers and spoke of an open-door policy. Staff told us that the management had improved since the last inspection and were a lot more visible and approachable. Staff told us they were encouraged to develop and take part in additional training.
- Managers told us how they managed any staff performance that did not meet professional standards and this supported the rest of the team who worked hard to provide a good service for their patients and colleagues.
- We attended the treatment room during our inspection and observed effective team working. We saw all staff showed respect for each member of the multidisciplinary team and the contribution they made.

## Governance

- **Governance arrangements reflected best practice and leaders operated effective governance processes throughout the service. 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.**
- There was a clear governance system for the organisation and senior staff explained to us how information was shared up to board level and down to staff at the centre. Senior staff told us they felt governance processes were more embedded since the last inspection and there was more visibility from the clinical director. Managers and staff told us they felt more involved in the wider governance of the organisation and that their input was valued.
- Complaints, litigation, incident and patient feedback (CLIP) meetings took place weekly in the form of a teleconference with other MSI centres. The clinical director for MSI also attended the CLIP calls. All staff were invited to attend these meetings and minutes were circulated by email for those could not attend. We viewed minutes of these meetings and saw that topics

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that were discussed included incidents across MSI's UK centres, informal and formal complaints, safeguarding cases and learning and action taken from these. Centre managers took turns to present on learning that had occurred from an incident at their location in order to share learning with other centres on the call.

- There was a quarterly local integrated governance meeting (LIGM) which reported into quarterly regional integrated governance meetings. LIGM meetings were chaired by the regional manager and attended by the centre operations managers, clinical service matrons, clinical and operational team leaders. We reviewed the minutes of these meetings and saw comprehensive discussion of incidents, safeguarding concerns, audits, risk register with action plans and names allocated to the actions with deadlines. The group monitored performance and local compliance against an integrated quality dashboard which was then monitored on a corporate level.
- The Department of Health licence was displayed in the main centre and at the satellite sites.
- We saw completed HSA1 forms, for patients having a medical or surgical ToP. HSA1 forms are legal documents to allow a termination of pregnancy to be performed and is signed by two medical doctors.
- We saw electronic records in the treatment room which showed patients' previous medical history and HSA1 completions by doctors prior to surgical ToP being carried out.
- The service submitted HSA4 forms to the Chief Medical Officer electronically as recommended by the Department of Health. HSA4 forms were submitted electronically through the provider's patient record system. There was a paper form for patients who were non-UK residents or were residents of Northern Ireland. Registered nurses administering the second stage of medical termination or the surgeon completing the surgical procedure were responsible for submitting the HSA4 form on the system which was then sent to the Department of Health within 14 days of the termination taking place. The operations manager reviewed and checked form submissions on a weekly basis to ensure compliance. The system ensured a patient could not progress to the discharge process stage until the HSA4 had been uploaded and submitted.

- Service level agreements with third parties were reviewed by the operations manager and clinical services matron at the centre.

## Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.**
- The service kept a local risk register which was displayed in the staff tea room and discussed and reviewed at the local integrated governance meeting. We viewed MSI Leeds Centre's risk register which had risks with review dates in place, controls currently in place, risk levels and review dates. We saw plans and actions the service had put in place to mitigate the current top risks and to cope with unexpected events.
- The centre was benchmarked against other MSI centres and this was reported at the regional integrated governance meetings. MSI Leeds Centre scored higher (better) for most categories when compared regionally and with similar sized centres.
- The regional manager monitored MSI Leeds Centre's performance compared with other centres including trends in incidents, complaints, safeguarding and risks across the region. We saw in action plans that names were allocated to any actions that arose and had deadlines for completion.
- There were team meetings at MSI Leeds Centre on a monthly basis. Patient and staff feedback, complaints, incidents and learning from them as well as refresher training were discussed at these meetings.
- We reviewed the provider's medicines management policy which stated that the registered manager should be notified of any discrepancies between stock records and levels of medicines. We were aware another centre had not maintained regular stock checks of mifepristone and misoprostol but we found no discrepancies at this site. The operations manager told us the centre had begun to overstock the abortifacient medicines in preparation for a possible national shortage due to European political concerns. These were stored safely and securely and stocks checked and recorded appropriately.

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- Clinical staff met every morning to identify potential risks, allocate resources effectively and disseminate information such as safety alerts.

## Managing information

- **There was commitment to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.**
- During our inspection we observed that the surgeon and anaesthetist both reviewed the reason for termination prior to signing HSA1 forms. We also saw that the reason for the termination of pregnancy was also written on the back of the form. This was in line with the Department of Health Required Standing Operating Procedures (RSOP) which required the provider to ensure that the completion of legal paperwork (HSA1 and HSA4) met the requirements of the Abortion Act 1967.
- Information governance training compliance was 100% and staff were aware of the recent changes to the MSI records management and retention policy which stated that termination of pregnancy records were to be destroyed after 30 years.
- Staff and managers also maintained contacts with local CASH services, crisis management team, homeless services, the police and attending safeguarding team meetings to share information around topics such as CSE and domestic violence.
- Managers submitted statutory notifications to CQC where appropriate in the 12 months prior to our inspection. These included changes to accountable officers for the service and notification of a serious injury.

## Engagement

- **Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients. There was consistent and constructive engagement with staff.**
- Patients' views and experiences were gathered and acted upon to shape and improve the service. Patients were encouraged to share their views on the quality of the service and their experience through paper

feedback forms and questionnaires on electronic tablets. Any feedback that required immediate attention would be investigated by the centre's managers and discussed at local integrated governance meetings. However, the service did not engage with local patient groups or associations to gather views of local men and women who may use the service, although this is difficult given the type of service provided.

- The regional manager produced a monthly staff update and staff were encouraged to nominate a colleague who had gone the extra mile in their work. Nominations were printed and shared with the team.
- At our last inspection we told the service it should carry out and act upon investigation and analysis of staff satisfaction. At this inspection staff told us MSI had introduced employee engagement surveys. The MSI Leeds team had produced local action plans and introduced employee "You said, we did" notices to demonstrate where managers had acted upon staff concerns. One example showed: The team identified an interest in additional continuous professional development opportunities, internal promotions and extra training to expand their skills. Managers responded: "Since receiving this feedback, we have invested in additional non-mandatory training for the team as well as an abundance of extra courses available on (the learning and development package). We have promoted the attendance of local conferences and workshops and promoted internal roles to expand the team's knowledge such as link roles and secondments."
- The regional manager produced a monthly team update for the North region showing staff information, achievements, recognition and good news as well as compliance highlights and targets. Staff told us they felt well informed and part of a team.
- Staff we spoke with told us they felt more involved in the development of the centre as they now had regular meetings where feedback and learning were shared. The clinical services matron attended the weekly CLIP call on behalf of the nursing team and brought up any comments or feedback that nurses asked them to raise.
- Staff told us they found monthly team meetings useful and that they were a good opportunity to voice any concerns they had. Nursing and medical staff who worked at the EMU satellite clinics also worked for part

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of the week at the main MSI Leeds centre so were part of the integrated team. Staff commented that communication between staff and management had improved and managers engaged more with them to create a more inclusive atmosphere.

- Staff at the early medical unit satellite clinics often worked alone and told us they could always pick up the phone to the managers at MSI Leeds Centre if they needed any support or advice. They were also aware of the provider's lone worker policy. However, all staff were integral to the main MSI Leeds centre team and staff told us they did not feel there was any lack of support when working at the EMUs.
- Staff had set up a secure group messaging forum which allowed them to stay in touch with their colleagues and ask for advice when they needed.
- The operations manager and the clinical services matron reported improved communication at a corporate and local level. They regularly fed information up through governance meetings and told us the clinical director for the provider was proactive, attended the CLIP and had visited the centre to meet staff and deliver training. In addition, the operations manager and the clinical services matron told us the new compliance monitoring programme provided quality and risk oversight of services at a local level.
- The MSI Leeds centre worked collaboratively with another provider of sexual health care who supported and provided LARC implant training to MSI registered nurses free of charge.
- Staff attended safeguarding children boards to share relevant information regarding their patients and also worked with the CSE and multi-agency child exploitation (MACE) teams in Leeds.

## Learning, continuous improvement and innovation

- **Managers were committed to continually learning and improving services. There was a clear,**

**systematic and proactive approach to seeking out new models of care. Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**

- Managers told us they were openly encouraged to make suggestions for change. Individual and team skills and knowledge were celebrated and used to drive learning from other organisations and to organise collaborative work with other MSI centres and outside agencies.
- Both the clinical services matron and operations manager told us that MSI Leeds Centre were working with local organisations to learn and share good practice in the field of sexual health and termination of pregnancy. Staff were working with local universities to build a ToP module for student nurses and midwives and working with the local trust to provide a "day in the life of" staff exchange programme with staff in early pregnancy units.
- Managers encouraged staff to attend training or complete additional modules on the provider's electronic learning and development platform. Managers told us there were over 100 courses staff could access. Staff were also encouraged to attend conferences and provide feedback on their experiences and learnings to the team at team meetings.
- Staff and managers at MSI Leeds centre were involved in work with local prisons to produce and agree a care pathway for prisoners attending the centre.
- Managers had established links with the local MESMAC group to update staff with HIV screening training.
- Staff and managers had developed contacts with local CASH services, crisis management team, homeless services, the police and attending safeguarding team meetings to share information around topics such as CSE and domestic violence.

# Outstanding practice and areas for improvement

## Outstanding practice

- Leaders strove for improvement, ensuring staff and patient voices were heard and maintaining patient care and needs at the centre of all they did. Leaders were creating a positive culture and conditions suitable for continuing improvement and a common aim to achieve this.
- The MSI Leeds centre managers had begun a collaborative project with Leeds police service and attended their CSE board the week before our inspection. Managers told us the local authority and police service participants had said they had never been approached by a ToP service before to share information regarding safeguarding and CSE.
- MSI Leeds Centre aimed to be a centre of excellence for learning and often took part in new pilots that the provider planned to roll out with the aim of further developing the service. Staff we spoke with were committed to continually learning and improving the service and spoke of programmes the centre took part in such as:
  - working with local prisons to produce to agree a care pathway for prisoners attending the centre
  - working with local universities to build a ToP module for student nurses and midwives
  - working with the local trust to provide a “day in the life of” staff exchange programme for staff in early pregnancy units.
- Managers had established links with the local MESMAC group to update staff with HIV screening training.
- Staff and managers had developed contacts with local CASH services, crisis management team, homeless services, safeguarding teams and the police regarding information sharing for vulnerable patients and topics such as domestic violence.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The provider should continue to work with the local NHS trust to update the transfer agreement.
- The provider should ensure staff at satellite sites are aware if a fridge temperature has been out of range on days when the unit is not staffed, and action is taken if drugs or vaccines are not safe to use.
- The provider should consider providing a clear leadership development strategy and succession planning at a local level.
- The service should consider ways to engage with local patient groups or associations to gather views of local men and women who may use the service.