Marie Stopes International West London 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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

The Marie Stopes West London Centre is operated by Marie Stopes UK International, which is a specialist reproductive healthcare organisation and registered charity. The West London centre is based in Ealing.

The service provides medical and surgical termination of pregnancy services, screening for sexually transmitted diseases, contraception advice and counselling.

The service provides surgical terminations up to 23 weeks plus six days gestation, and medical abortions up to nine weeks plus four days gestation. They also perform non-scalpel vasectomies. The service treats NHS and private patients.

We inspected this service using our comprehensive inspection methodology under Section 60 of the Health and Social Care Act 2008. The provider was given 23 days' notice of this inspection. We carried out the announced

Summary of findings

inspection on 6 and 7 July 2017. We also visited one early medical pregnancy unit (EMU) providing satellite services at Wembley on 6 July 2017. At the time of our inspection, the operations manager was in the process of registering as the registered manager with the CQC.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well led?

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

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

The breaches were in respect of:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Services we do not rate

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

We found the following areas of good practice:

- Processes and procedures for daily infection prevention and control (IPC) were in place with regular cleaning checks introduced.
- The policies in place to ensure optimum standards of care and patient safety had been updated and were in line with the latest guidance. Staff were able to access these easily.
- Staff on the ward were passionate about their job and believed in what they did. They spoke to patients in a manner in which they would like to be spoken to and were caring and compassionate.
- Staff communication with one another and with the public was good. Staff had a good understanding of safeguarding and female genital mutilation (FGM).
- We found management responsive to issues raised at the inspection and we found that managers had made improvements to processes since the last inspection.
- A revised audit programme had been introduced since the last inspection. We saw individual examples of improvements made and team meeting minutes included discussions of audit scores and arising actions.

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

- Staff had variable knowledge of the duty of candour.
- Some staff expressed concern about the availability of training.
- Usage of the World Health Organisation (WHO) and 'five steps to safer surgery' checklist was not always consistent.
- Although improvements had been made to local governance this was hampered by some disjointed and poor communication from corporate management.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements to help the service improve. We issued a requirement notices in relation to the World Health Organisation (WHO) and 'five steps to safer surgery' checklist. Details are at the end of this report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Termination of pregnancy		We regulate this service but we do not currently have a legal duty to rate when it is provided as an independent healthcare single speciality service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We have a duty to rate this service when it is provided as a core service in an independent hospital.

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Termination of pregnancy

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Background to Marie Stopes International West London Centre

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

Ealing, Hounslow, Hillingdon, Hammersmith & Fulham, Brent and Harrow Clinical Commissioning Groups (CCGs), contracted Marie Stopes West London to provide a termination of pregnancy service for the patients of West London and surrounding areas. It also accepts patient referrals from outside this area. The service was set up as Ealing being the main centre with six Early Medical Units (EMU) in Camberley, Earls Court, Finsbury Park, Hillingdon, Hounslow, and Wembley. The service also treats a small number of private patients.

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 (Termination of pregnancy (TOP) refers to the treatment of termination of pregnancy, by surgical or medicine methods.)
- Surgical Procedures

The services provided under these activities were:

- Pregnancy Testing
- Unplanned Pregnancy Counselling/Consultation
- Medical Abortion
- Surgical Abortion, Vacuum Aspiration, General Anaesthetic, Local Anaesthetic
- Abortion Aftercare
- Miscarriage Management
- Sexually Transmitted Infection Testing and Treatment
- Contraceptive Advice
- Contraception Supply
- Vasectomies

Due to the concerns, we inspected the service again on 6 & 7 July 2017. We carried out this inspection as part of our inspection programme. The Manager for the location joined the service in May 2016, and was in the process of applying to CQC to become the registered manager.

Following this inspection, we found that the provider is no longer in breach of Regulation 12 HSCA 2008 (regulated Activities) Regulations 2010 Cleanliness and infection control. Staff adhered to the dress code policy and followed procedures within the treatment environment and hand hygiene.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two terminations of pregnancy-trained inspectors and an assistant inspector.

We inspected this service using our comprehensive inspection methodology. We carried out an announced inspection on 6 and 7 July 2017 at both the Ealing location and the Wembley Early Medical Unit (EMU).

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

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

During the inspection, we visited the recovery ward, the vasectomy clinic area and the surgical ward and treatment room. We spoke with nine staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with seven patients and one

Summary of this inspection

relative. We reviewed 10 sets of patient records. At the Wembley satellite unit there is one consultation room, which we visited. We spoke with one registered nurse, observed nine patient appointments and spoke with two patients.

This report is based on a combination of what we found during the announced inspection on 6 and 7 July 2017 and included a review of all available evidence during and following the inspection.

Information about Marie Stopes International West London Centre

The location is registered with the Care Quality Commission as a provider of termination of pregnancy services. Registration began in 1988. The main service offered is termination of pregnancies (TOP), either medically or surgically. The centre also provided vasectomies, sexual health screening and contraceptive advice. The Ealing centre provided medical abortion up to nine weeks and four days, and surgical abortions until 23 weeks and 6 days gestation.

The centre operated six days a week. Medical terminations were offered five days per week. Surgical terminations were performed on Mondays, Wednesdays, and Saturdays for terminations up to 24 weeks and Wednesdays for terminations up to 14 weeks. In addition, vasectomy procedures were performed every other Tuesday. Medical terminations were offered at the satellite units. The service at the Ealing location consists of:

- Two treatment rooms
- Three recovery wards
- Five consultation rooms
- Waiting area
- Administration and office areas

Marie Stopes West London (Ealing) has six satellite units located in Camberley, Earls Court, Finsbury Park, Hillingdon, Hounslow, and Wembley. These locations are fully accessible and offer medical terminations. The location holds a licence from the Department of Health to undertake termination of pregnancy services in accordance with The Abortion Act 1967. Services are provided to both NHS and privately funded patients.

Patients are treated from age 13 and older. Between July 2016 and June 2017, 6823 patients accessed the service.

Of the services provided, surgery accounted for 4038 (59.1%) of activity. Medical abortion accounted for 2499, (36.6%) of activity. 286 vasectomy procedures were performed in the same period.

During the inspection, we visited the recovery ward, the vasectomy clinic area and the surgical ward and treatment room. We spoke with nine staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with seven patients and one relative. During our inspection, we reviewed 10 sets of patient records. At the Wembley satellite unit there is one consultation room, which we visited. We spoke with one registered nurse, observed nine patient appointments and spoke with two patients.

The location has 11 contracted registered nurses and midwives, eight contracted care assistants and four contracted front of house assistants as well as usage of the same named agency staff when required.

The provider's track record on safety between May 2016 and June 2017 was as follows:

- There were no never events in this period.
- From January 2017 to June 2017 there were 305 non-clinical incidents reported.
- There were no serious injuries in this period.
- Between February and July 2017, there have been 124 clinical incidents of low harm.
- From February 2017 to July 2017, there were six complaints. Three formal complaints and three informal complaints. The three formal complaints were not upheld.

The service provides counselling for patients and interpreters are available.

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?

- All staff adhered to The Health and Social Care Act 2008, code of practice on the prevention and control of infections and related guidance or associated guidelines. We saw staff using hand gel between patients and this was readily available. Hand hygiene and below elbow signage was displayed on the treatment room walls and staff wore appropriate clothing and shoes in the treatment rooms.
- They followed the dress code practice as outlined by The 'Association for Perioperative Practice' guidance (2011), even though treatment rooms were not deemed to be operating theatres. Staff wore gloves and changed them at appropriate times.Doctors wore sterile gloves.
- Hand washing sinks were marked as 'hand washing only' and taps were hands free.
- Staff had the appropriate levels of safeguarding training to manage safeguarding issues. Staff had a good awareness of safeguarding and their responsibility to report concerns.
- We found patient records to be comprehensive, well documented and complete.
- Staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses.Incidents were centrally investigated.Staff at the West London location received feedback on the outcomes of investigations however, staff at the Wembley satellite unit did not receive feedback.
- There was an official transfer agreement in place with local NHS hospitals; to ensure patients who required higher levels of medical attention had their needs met.
- Equipment was serviced and labelled correctly to show that safety and maintenance had taken place.
- Staff provided all patients with a private consultation to allow patients the opportunity to discuss information of possible abuse or coercion.
- Records we reviewed were of a good standard with assessments and observations recorded.We saw that records were stored safely and securely.
- Staff used a criteria based discharge form for all patient discharges and a doctor confirmed fitness for discharge.

However:

- Staff did not always follow the World Health Organisation (WHO) 'five steps to safer surgery'. There were two instances

Summary of this inspection

where it appeared that stages 3 and 4 of the WHO checklist had been done together out of seven records reviewed. The provider explained that this was due to previous treatment having taken place the same day. However this was not contemporaneous in the notes and was not clear. Staff undertook pre-operative brief and post-operative debriefing stages.

- Staff we spoke with had variable knowledge of the duty of candour; however, they told us this involved being open and transparent.Staff received training on this however; some staff were unaware of the requirement of a formal written apology to patients.

Are services effective?

- Medical and nursing staff observed the treatment guidelines contained in the Required Operating Standard (RSOP) 14 and the Royal College of Obstetricians and Gynaecologists guidelines relating to consent. Only nurses undertook written consent with patients. All staff looked out for safeguarding issues and any signs of abuse.
- Staff we spoke with knew how to access the policies and told us about some of the guidance available. However while policies were accessible to all staff, they were not always kept up to date.
- Pre-assessment of patients enabled staff to decide and discuss whether a patient was able to understand the nature, purpose and possible consequences of investigations or proposed treatments, as well as the consequences of not having treatment.

Are services caring?

- We observed staff being compassionate and caring when treating and supporting patients.
- Staff on the ward were passionate about their job and believed in what they did.They spoke to patients in a manner in which they would like to be spoken to.
- Staff communication with one another and with the public was good.We observed staff working well together and patients were satisfied with information provided.
- Overall, patients told us they had been listened to, understood every stage of their treatment, knew what was happening and were treated with kindness and respect.
- Patients were encouraged to provide feedback on the service. This information was used to assist with forward planning of the service.

Summary of this inspection

Are services responsive?

- The organisation offered patients an out-of-hours service and generally, patients received treatment at their preferred choice of location.
- The provider's audit of patients' satisfaction about waiting times via patient survey results showed reception 92%, consultation 87% and treatment 89% satisfaction.
- There were good systems for the provision of interpreters and counselling services.
- Literature supplying advice on supportive care was available.
- Patients' individual needs were taken into account and the appropriate support was given so patients could proceed with their appointments and treatment.
- Complaints were acknowledged, investigated, and responded to within a specified time. Learning arising from complaints was communicated to staff.

Are services well-led?

- Staff were happy to work at MSI and gave positive feedback of the new local management team at the Ealing centre.
- Patient feedback produced good results and the centre took advice from their patients for future improvements to services.
- The new clinical operations manager had implemented new ideas and processes, which had received positive feedback from staff.
- Staff understood the corporate vision and strategy underpinning the delivery of services.
- A central hierarchical approach meant local managers were unable to make the necessary local decisions and were limited in their ability to make change.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Termination of pregnancy	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

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

Incidents and safety monitoring

- Staff understood their responsibilities to raise concerns and to record safety incidents and concerns. During the inspection, we saw staff reporting incidents appropriately. At the time of our inspection, some staff were still reporting incidents on a paper based system and others were fully using the electronic system.
- There were no never events reported in the last 12 months. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- From January 2017 to June 2017, there were 440 incidents reported. As well as patient related incidents, the service reported anything that impacted on their work or working day as an incident. Therefore, the service had recorded incidents for the way in which chlamydia samples were collected, incorrect completion of admission records and staff shortage. The service had responded to these incidents by making changes in how they collected chlamydia samples, they provided further one to one training on admissions to nurses and used regular agency staff that can cover for sickness or annual leave.
- Following an incident in February 2017 where a patient suffered a known complication of treatment, that required staff to provide emergency intervention, further training for staff on the management of major haemorrhage had been undertaken to further improve services and respond to lessons learned. In addition, in the event of emergency patient transfer, a designated named nurse would be responsible for accompanying the patient and providing a robust handover to ambulance crew or hospital staff.
- Incidents and lessons learnt were discussed at team meetings. We reviewed three meeting minutes, found incidents had been investigated, and recommendations made for improvements.
- There was one team meeting a month and the clinical operations manager accounted to the regional quality assurance board with regard to incidents.The board met quarterly.The current clinical governance & quality lead for the region at Ealing also attended these
- Staff we spoke with felt confident in reporting incidents to the new centre manager. Incidents were still largely completed on paper form then given to the centre manager who entered the incident on to the central electronic system.However, at the Wembley satellite unit, we saw a member of staff record an incident using this electronic system.
- Incidents in satellite clinics (EMUs) were investigated by a management team dedicated to overseeing London-region EMUs. Lessons learned from these investigations were shared during team meetings with EMU staff, which are held monthly, as well as by email.
- Staff did not have a full understanding of the duty of candour. 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 told us the duty of candour meant being open, honest and frank, but did not mention apologising to the patient and formally apologising in writing. This was despite the fact that the MSI policy on "Duty of Candour and Being Open", had been introduced and ratified in April 2016. The clinical operations manager told us that staff had received training on duty of candour via staff meetings and that further more formal training would be given

Mandatory training

- All staff were required to complete mandatory training on areas relevant to their role within the organisation. There were standard topics for all staff to complete annually including infection prevention and control, basic or intermediate or advanced life support (depending on role) and information governance. The MSI Training Matrix stated that there were other topics to be completed every two years such as manual handling level 1 and manual handling level 2 and manual handling 3 to be completed every three years. Data provided post inspection was that all manual handling training was completed annually. Therefore we could not be assured that matrix was kept up to date.
- Two members of staff informed us they had attended a wealth of training. All nurses had been on a three-day anaesthetics and recovery course.
- We saw a training matrix showing levels of training completed and outstanding with names of staff completing training and dates of training completed. However, we were told that there was sometimes an issue with staff being able to access training and this issue had been placed on the local risk register. We did not see any other evidence of managers taking action to improve training access.
- A process was in place to monitor and record staff compliance with mandatory training. Monitoring of training uptake was recorded in Local Quality Assurance minutes and team meeting minutes.
- Information to confirm that medical staff had completed all mandatory training for their role was held at corporate level. Local managers were aware this could be accessed through the corporate 'Open door' portal.
- Staff informed us that the HIV policy had been revised but training on this had not yet been rolled out. The provider subsequently explained that specialist training was not required as staff were only testing for reactivity and not engaged in counselling or referral of patients.
- The corporate training requirement was that reception staff and health care assistants undertook basic life support; nursing staff undertook intermediate life support and anaesthetists advanced life support.We saw data for training compliance rates, these were that 72% staff were trained in basic life support, 67% were immediate life support trained and 100% of active relevant staff were advanced life support trained.
- The nurses who operated from the satellite units were trained in intermediate life support.

Safeguarding

- There were systems and processes in place to safeguard patients from abuse. There was a Safeguarding Adults and Children at Risk policy version 3.1 issued in December 2016. This was accessible to staff.
- In line with MSI UK policy, any patient accessing the service who was under 13 years old, or who had conceived under the age of 13, were referred to their local children's social services department, the police and referred to the NHS. The provider confirmed that they would treat patients aged from 13 years upward.
- Staff had a good understanding of safeguarding and how to report incidents. Staff were trained in safeguarding children and young people in line with intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014). 100% of active administrative staff were trained to safeguarding children and adult's level two.
- At the last inspection, we had identified staff who needed training to safeguarding level three. Clinical staff (health care assistants and registered nurses) were now trained to safeguarding children and adults level three with a training completion rate of 84.6%. This complied with the requirements of The Intercollegiate Document for Healthcare Staff (2014) which states that all clinical staff working with children, young people and/or their

parents/carers involved in or potentially involved in assessing, planning, intervening and evaluating the needs of children and young people and parenting capacity should be trained to safeguarding level three.

- The service had three safeguarding leads for the centre.The operations manager was trained to safeguarding children and adult's level four (100%) and the regional clinical governance & quality lead was trained to level five safeguarding children and adults. The policies set out how staff working within the company worked together to protect and promote the welfare of people at risk. For example, the Safeguarding Children at Risk Policy and Procedures gave clear guidelines on Female Genital Mutilation, (FGM), child sexual exploitation, and Mental Capacity Act.
- There was a safeguarding children pro-forma and a new adult pro-forma, which was being piloted.
- At the last inspection we had said that the new safeguarding policies needed to be cascaded to staff. Staff we spoke with were now all aware of their responsibilities and had access to appropriate safeguarding policies for adults and children.
- From January to June 2017 there were 138 safeguarding concerns reported.
- The centre had a clear escalation pathway for the reporting of safeguarding incidents to local Clinical Commissioning Groups (CCG) and Local Authorities.
- Female Genital Mutilation is defined as "All procedures which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons" (World Health Organisation, 1996).
- Staff told us they had received training for Female Genital Mutilation (FGM) face-to-face and via a 30-minute e-learning module.In 2016, staff undertook an hour-long training from the Home Office.An FGM presentation was also given at a team meeting.The centre had an FGM champion trained to level three in FGM.
- An FGM passport was given to all patients who had previously experienced FGM, which included a wealth of information.FGM was a big focus at the centre as there was a high demographic number in the area.Staff were aware of how to identify FGM cases and understood their responsibilities to report FGM where the individual was less than 18 years of age.
- Staff told us that during pre-assessment there is a safeguarding questionnaire to complete.Staff understood the importance of asking the appropriate questions and looking for signs and reporting any concerns to the safe guarding lead.
- During the inspection, we observed staff at the centre deal with a safeguarding matter that was picked up during pre-assessment.The patient did not accept assistance, however the safeguarding lead later sat with the patient again and the patient consented to help.Referrals were made and the matter was escalated to the UK safeguarding lead and the duty lead nurse.
- The centre did not treat children under the age of 13 and staff told us they would raise a safeguarding referral in line with the 'Sexual offences Act 2003' should a child present themselves at their clinic. All patients that access the service who are under 13 years old, or who have conceived under the age of 13, must be referred to the local children's social services department and referred to the NHS.
- The centre and the UK safeguarding lead would plan the patient's care package and communicate with statutory agencies.The centre manager told us they had good communication links with local authorities and social workers and were able to get guidance and support from them.

Cleanliness, infection control and hygiene

- There were systems and processes in place to ensure that standards of cleanliness, hygiene and infection prevention and control were maintained.
- At the last inspection, we had stated that staff must treat and manage the treatment room as a sterile environment and wear the correct attire in line with national guidelines.
- We observed all treatment rooms, clinical areas and non-clinical environments. They were visibly clean and clutter free.

Termination of pregnancy

- Cleaning schedules were in place and regularly reviewed. Staff confirmed they were aware and following the daily, weekly and monthly checks scheduled. We saw that records to this effect were fully completed.
- At the last inspection, we also stated that the provider needed to address infection prevention and control measures in line with national guidance, so that a consistent approach was adopted by all staff.
- To address this, the centre had an infection prevention control (IPC) link nurse, who was responsible for sharing good infection control practice amongst team members, undertaking infection control audits, and acted as a role model for infection control.
- The IPC link nurse had reviewed the guidance provided by the Care Quality Commission regarding wearing the correct attire in treatment rooms in line with national guidelines.The IPC link nurse found that the UK policy is that caps do not need to be worn in treatment rooms.The full attire did not need to be worn in treatment rooms, as treatment rooms were determined as clean rooms and therefore did not need to be sterile.
- All staff wore scrubs, disposable aprons, gloves and theatre shoes. During all procedures, the surgeon wore sterile gloves.
- At the inspection in June 2016, staff wore jackets outside of the treatment room, and entered the treatment room in outdoor clothing. We did not see this happen at the July 2017 inspection.Previously the hand washbasin was not located away from the area containing prepared sterile instruments. During the inspection in July 2017, we found the basin had not moved, however staff laid sterile instruments on a trolley during procedures.
- Staff told us Infection control and hand hygiene audits were carried out monthly.Twenty observations had been undertaken in regards to hand hygiene.
- A contracted cleaning company was hired centrally.They carried out cleaning services throughout the centre twice in the morning and evening.
- Theatre staff were responsible for cleaning treatment rooms and all areas appeared visibly clean Cleaning was undertaken between treatment episodes of patients.
- Protective personal equipment (PPE) used to prevent and control infection, such as disposable gloves and aprons were readily available, correctly stored and generally worn by staff.
- Hand washing sinks, soap and alcohol hand rubs were in good supply, and we saw instructions for their use clearly displayed. We saw staff use them in accordance with local policy.
- Staff adhered to the management of clinical waste policies and disposal of sharp objects. We saw that the recovery ward sharps bins were assembled and labelled correctly. We saw staff dispose of clinical waste and used medicines into the correct disposal bins in the first stage recovery area. The recovery ward sharps bins were not filled above the recommended line but the temporary closures were not pulled across.
- Staff segregated clean and dirty waste appropriately.
- There were notices on correct clinical and non-clinical waste disposal displayed on the wall.
- The satellite unit we visited in Wembley was visibly clean, cleaned every day and clutter free.Staff adhered to local infection control policies. We saw that weekly audits were undertaken by the site cleaner and monthly audits were undertaken.
- We saw all staff complying with the bare below elbow policy, which enabled good hand washing techniques and reduced cross infection.
- We saw that nurses and consultants in treatment rooms followed good hygiene practices with regard to wearing gloves and washing their hands in between treatments.
- All staff had received infection control training in line with the three yearly mandatory training requirements.
- We saw the recovery ward cleaning checklist for May, June and July 2017.There were no omissions on the checklists for the days the recovery area was operational.Cleaning was comprehensive including, chairs, machines, recliners and keyboards.The area appeared visibly clean.
- Chairs had new covers since the last inspection. Staff told us they were waiting for approval by business management for new recliner chairs which would be easier to keep clean.Once ordered they should arrive in 6-8 weeks.

Termination of pregnancy

Environment and equipment

- The Ealing clinic was based in a large Victorian house.Rooms were spacious and there was sufficient space for emergency services and access for patients with disabilities.
- The treatment room environment was spacious and well laid out, with separate areas to prepare clean equipment and a separate room for dirty instrument cleaning.
- An onsite maintenance staff member checked and ensured the upkeep of equipment and facilities.
- At the last inspection, we found that there were no separate anaesthetic or scrub facilities. Since then the provider had installed separate scrub and dirty sinks in the treatment suite,
- There was a dedicated treatment room and a first stage recovery suite adjacent. A second stage recovery ward was located across from the treatment room on the same floor.
- Maintenance checks had been undertaken on the clinical equipment in the treatment room.
- The treatment room resuscitation trolley was fully stocked.The oxygen cylinder was full, weekly and monthly checks were undertaken. Seals were in place. Drugs and equipment were fully stocked and in date.The trolley was sealed with a security tag and the defibrillator had been tested.
- The anaesthetic system was checked each day that it was used and we saw that it had been serviced.
- On the recovery ward, we saw the ward morning checklist which included checking the emergency bag, pulse oximeter, oxygen cylinders, daily cleaning checklist, daily drug cupboard and fridge temperature checklist.There was also a monthly emergency rucksack check. Blood pressure machines were checked as well as the emergency call pull cord in the toilet.We saw the monthly checklist for emergency bags included a space for expiry dates to be marked, which is good practice.All the external items for the rucksack was checked and signed weekly.
- We saw the daily glucometer checklist between May to July 2017. All readings were within normal range.The suction monitor was due to be PAT tested in May 2018.
- Staff had access to resuscitation equipment including an automated external defibrillator (AED). MSI UK Resuscitation Policy of December 2016 stated that any sealed bags and trolleys should have seals checked daily for integrity and also receive a full monthly check. The defibrillator pads were intact and in date.The centre had three defibrillators, which were maintenance checked in May 2017.
- The seal on the emergency rucksack was intentionally broken so that we could check it.There was a clear checklist with item locations. All items such as ventilation pocket, basic airway equipment, circulation equipment and drugs were all intact and dated.Drugs in the emergency rucksack included adrenaline. Anaphylaxis drugs were in a separate bag and all were intact and in date. The bags were kept in an accessible area and were re-tagged after we undertook checks.
- At the Wembley satellite unit the paper curtains were dated June 2017.The disposal couch cover was clean.There were two sharps bins, one for medication and one for sharps, plus a clinical waste bin.

Medicine Management

- There were systems in place to manage medicines. Staff were required to follow the MSI UK Medicines Management Policy, which outlined requirements including prescribing, ordering, administering, supplying, and disposal of medicines.
- The registered manager had overall accountability for medicines management at MSI West London. The clinical team leader had day-to-day control for medicines. They were empowered to delegate this responsibility as appropriate, but remain accountable. For example, the clinical team leader holds the controlled drugs key each day, but is able to delegate this to the medicines trained senior nurse in charge of the recovery ward.
- All medicines were ordered through an electronic ordering system, from a pre-approved formulary, from pre-approved suppliers. Orders were placed by a registered nurse on site with extra responsibility for drug ordering, signed off by the operations manager, and processed by a central Procurement Officer. Medicines were then delivered directly to the clinic, where they were signed for upon arrival by a registered nurse and

placed immediately into locked medicines storage. The registered manager told us that the person who placed the order for medicines was never the same person authorising the order.

- MSI West London had a service level agreement with an NHS provider remote and off site for pharmacy advice. They conducted ad hoc audits and advised on medicines management. On 17 January 2017, an ad hoc Medicines Storage and Security audit was undertaken by the contracted pharmacy advisor .This audit showed near 100% compliance, with one point lost for finding some medicines being kept outside their original containers. The importance and rationale for keeping medicines in their original containers and a second audit held in October 2017, since the inspection, showed the issue resolved.
- Allergies and medicines administered were both recorded in patients' electronic medical record. Nurses could sign for drug administration electronically, which was automatically time-stamped. Any allergies recorded would flag as yellow at the top of the medical record, to alert the clinician prescribing and the clinician administering medicines.
- Room temperatures where drugs were kept were carefully monitored.We saw a temperature recording chart on the drugs cupboard. For the month of July 2017, the temperature had not been below 18 degrees or above 25 degrees which was appropriate for the medications stored. We saw records for June 2017 which showed that there had been eight occasions when the room temperature had exceeded 25 degrees.Action was taken by resetting the thermometer and the registered nurse informed the duty manager who informed the lead pharmacist for advice on what to do with the medication.
- Fridge temperature checks for those medications requiring cold storage were monitored and recorded daily at the Ealing centre. We saw the fridge temperature chart which showed fridge temperatures were appropriate for the medications stored and within the normal range of between 2 and 8 degrees.
- On the recovery ward, we saw the morphine oral solution register, which showed the drugs, had been checked. The controlled drugs checklist was checked twice a day by two registered nurses and always signed by two registered nurses. However there were several days when controlled drugs had only been checked once. The provider has subsequently confirmed that this issue has been addressed and rectified.
- We saw a set of drugs (Midazolam) that was due to expire on 10th July 2017.A note was made to discard on that date.We were told that drug was not used often; it was last dispensed in May 2017. We saw the Midazolam register which showed two nurses always signed it.It was not always checked twice a day.There was a sign on the control drugs cabinet saying 'this needs to be done twice.'
- There was an established process to identify controlled drugs that were to be discarded. MSI West London policy states that obsolete, expired, damaged or unwanted controlled drugs would be clearly marked, segregated from stock in use, and identified as for denaturing in order to avoid being supplied to patients. The running balance is then amended to reflect the usable stock holding. These drugs are then denatured on site, and disposed of.
- If the recovery ward were out of medicine, medicine would be taken from the main storage in the treatment rooms.Staff informed that the centre had never run out of medicine.They only order what they need.
- In May 2017, there were 11 occasions when the temperature exceeded 25 degrees.This was recorded as 'informed and reset'. Following this, the clinical operations manager contacted thepharmacy advisor for advice on whether the increased temperature would have affected the drugs in any way. The pipes in the drugs room were then insulated. However, when this did not solve the problem the location of the drugs room was changed to a room which did not have central heating pipes in it.
- The procurement officer nurse was responsible for ordering medicines and health care assistants ordered anything non-clinical. The keys for the medicines cabinet were locked away and had to be signed in and out.A manager from outside the centre came in to audit the fridge. Drugs were rotated by date.
- Staff told us that in-house training was provided in October 2016 for medicines management, as well as a

numeracy assessment and external training. The medicines management group for the region, track medicines lot numbers in a logbook for batch numbers and checks are implemented through quality review.

- Medicines at the Wembley satellite unit were locked in a cupboard or the fridge and were in date.We saw the fridge temperature checklist.Fridges were checked daily and showed a normal range.There was no advice if the temperature was out of range, but we saw evidence of resets.We saw a room thermometer. If the temperature was high, staff at the satellite raised an incident report and contacted the pharmacy for advice on medication.This also applied of the fridge was out of range.
- We saw that the drugs key at the Wembley satellite unit was locked in a combination box.Drugs were couriered to various centres where required. Emergency equipment at the Wembley satellite unit was checked weekly and emergency drugs were available. However, there was no adrenaline due to a shortage.

Records

- Patient records were a combination of paper and electronic. Paper records consisted of consent, WHO and 'five steps to safer surgery' checklist and HSA1 forms which is the certificate of opinion before a termination is performed where two doctors are required to sign. Storage of paper records were kept on site in secure areas in line with the Data Protection Act. Electronic records were password protected and only staff requiring access were able to do so.
- Electronic records consisted of the patient's pathway of treatment, which included venous thromboembolism (VTE) assessments, sexual health, and records of medication given.
- We saw the medical records audit, which was undertaken bi-monthly.This showed an overall compliance of 97.7% and included venous thromboembolism (VTE) assessments.
- At Ealing, we reviewed 10 sets of paper notes and one electronic set of notes, which included both medical and surgical treatments and included patients less than 18 years of age. An under 18 pro-forma was used for those patients. All records were well completed. Risks assessments, consent and contraception discussions were recorded.
- We observed a registered nurse in the stage two recovery ward complete the discharge information in the patient's records before they were allowed to leave, this was done on paper and electronically.A discharge checklist was used with each patient.The discharge details included all the information from the paper notes.
- The paper records were kept in envelopes to protect patient's privacy and staff we observed ensured that records were not accessible to the public.
- At the Wembley satellite unit, we saw four paper sets of notes and one electronic record.These were all completed appropriately except one set where the patient had signed a consent form but this had not been countersigned by a responsible nurse. The member of staff at the satellite unit escalated the matter immediately via the electronic system.

Assessing and responding to patient risk

- We looked at records prior to treatment and these confirmed that prior to treatment; patients were assessed for medical fitness by registered nurses and health care assistants. Assessments included blood pressure, pulse, and temperature. Checks for heart conditions, diabetes, asthma, epilepsy, history of thrombosis and allergies were recorded.
- Staff had to indicate whether a patient needed to be referred and used pre-existing guidelines. If a patient's body mass index was higher than 35 they were referred to the NHS for further treatment. All ectopic pregnancies were referred for further treatment. Should further information be required, a request would be made to the patient's GP but only once the patient consented for this to take place.
- At the patient's initial assessment a blood test was taken to show the patients Rhesus factor. It is important that all patients with a Rhesus negative blood group receive treatment with an Anti-D injection. This treatment

protects the patient from any future pregnancy complications. All records we viewed showed this had happened. We observed patients at the Wembley satellite unit being given Anti-D injections.

- With the patient's consent, other relevant blood testing was taken which included chlamydia, HIV, and haemoglobin level testing. Patients were offered screening tests for sexually transmitted diseases.
- The World Health Organisation (WHO) and 'five steps to safer surgery' checklist is a recommended practice for staff to follow for every surgical activity. These are safety steps staff are expected to follow prior to, during and after surgery, to check patient safety throughout their surgical pathway, such as safer surgery, sign in, time out and sign out. We observed the team brief and de-brief steps.

  Staff did not carry out the World Health Organisation (WHO) 'five steps to safer surgery' checklist appropriately. We reviewed seven records, spoke with staff and reviewed audit practices. All seven records reviewed had a completed hard copy checklist. There were two instances where it appeared that stages 3 and 4 of the World Health Organisation (WHO) and 'five steps to safer surgery' checklist had been done together out of seven records reviewed. The provider explained that this was due to previous treatment having taken place the same day. However this was not contemporaneous in the notes and was not clear.

  In addition staff in the operating theatre were observed completing all aspects of the WHO 'five steps to safer surgery' checklist before the surgery had started. This included stage 3 'time out' and stage 4 'sign out' sections. These sections are designed to record the correct number of swabs and instruments after a procedure had been conducted to ensure none were retained and record any concerns in the recovery phase. Staff when questioned stated this was due to the speed of throughput of patients.
- The WHO surgical checks were followed for vasectomy procedures.The last list was on 4 July 17.We saw the checklist was fully filled out and everything ticked as in order.
- We observed staff checking and confirming the patient's identity and medical fitness prior to treatment.
- Of all surgical patients in between April and September 2017: 2.27% received treatment under no anaesthetic; 70.97% received treatment under sedation, and 26.76% received treatment under general anaesthesia. However, of those patients who received treatment under general anaesthesia, more than two-thirds were over 14 weeks' gestation, requiring general anaesthesia. Of those surgical patients actually eligible for sedation, 87% received it. 11% were treated under general anaesthesia instead, by their own choice.
- All anaesthetists were employed on a sessional basis. Treatment lists were only put on the schedule if an anaesthetist had been confirmed as being available. In cases of last-minute anaesthetist sickness, a replacement could be obtained from a list of anaesthetists available.
- All registered nurses and midwives working in the treatment room or first-stage recovery had attended a three-day anaesthetics & recovery course, which included airway management, anaesthetic drugs, anaesthetic complications, anaphylaxis, ECG and CPR. All staff rotated through the treatment room and recovery areas to maintain skill. This provided cover for last-minute sickness in the treatment room or recovery.
- All staff undertook competency assessments, which were kept at the Ealing site.All competencies were reassessed every year and staff were observed by the clinical team leader. Competencies took the form of Observed Structured Clinical Assessments (OSCAs), involving the observation of multiple instances of care giving with multiple patients, and marking against specific criteria. Failure to meet these criteria results in an action plan that may include further training, mentorship, reflection, and ultimately reassessment; staff are not allowed to work autonomously or unsupervised, in the meantime, until they are assessed as competent. Records of these assessments are kept in the management office on site.
- All anaesthetists were advanced life support (ALS) trained, and all surgeons and nursing staff were intermediate life support (ILS) trained. However, the training matrix showed that only 67% of permanent staff had ILS training that was up to date.
- The clinical team leader and two clinical team leaders-in-development were also anaesthetics &

recovery trained and could provide extra cover. One was always on the rota to duty manage and be the nurse in charge, so that this skilled support was available at all times, including the end of the list and on Saturdays.

- A registered nurse monitored patients post-operatively in recovery until they were fit for discharge. Patients had observational checks including blood pressure, heart rate and monitoring of pain and were not discharged to the day ward until the nurse was fully satisfied of their condition.
- We observed a handover of a patient to a recovery nurse. A set of observations taken in the treatment room was given to the recovery nurse.
- Staff told us there was a transfer agreement in place with a nearby NHS provider should a patient require further assistance. Following the June 2016 inspection, which highlighted the lack of a formal arrangement, a transfer agreement was put in place, for a patient deteriorating to an extent where they required further assistance. Staff were aware of processes to follow if a patient deteriorated. We saw the organisations transfer policy providing escalation guidance for staff. Staff told us they would first contact the clinical practitioner and then emergency services. In cases where the senior clinical practitioner was not, present staff would call emergency services and all patient observational check details and medical history would be given to emergency staff. The discharge process was seen to be nurse led. If a patient is transferred to hospital, they receive a discharge summary and feedback is obtained from the hospital for staff to discuss.
- The Management of the Deteriorating Client and Clinical Emergencies Policy v4.2, dated December 2016 included details for the recognition and management of sepsis. In addition, the recognition and management of sepsis had been added to the clinical practice guide for registered nurses and midwives that was issued to staff in October 2016 and reviewed in December 2016. We saw that the Termination of Pregnancy Early Warning Scores (TEWS) was being implemented during patient observation.
- Staff in the first and second stage recovery wards monitored patients vital signs. These included blood pressure, temperature, heart rate, and respiratory rate checks. The new centre manager had introduced respiratory rates checks as part of the observation checks. Records we viewed showed observations were routinely made at regular intervals.
- Patients were not discharged until they had passed urine. We observed a registered nurse in the stage two recovery ward complete the discharge information into the patient's records before they were allowed to leave, this was done on paper and electronically. A discharge checklist was used with each patient. The discharge details included all the information from the paper notes.
- The provider told us that doctors remain on site until all patients are clinically fit for discharge. If doctors are leaving the premises after all patients have been deemed clinically fit for discharge, but before all clients have been administratively discharged, doctors will sign discharge paperwork to confirm that all clients are clinically fit and simply awaiting their discharge packs or their transport home.

Staffing

- At the time of inspection across all sites, there were 15.4 WTE registered nurses/midwives, plus a dedicated registered nurse working at Wembley EMU and nine contracted health care assistants. There was one operations manager (the registered manager), one clinical operations manager, a clinical team leader, two clinical team leaders in development as well as one maintenance technician and six front of house staff. The same agency staff were used when necessary. At the time of our inspection, there were no vacancies. Staff at the Wembley EMU complained that they were under pressure with insufficient time between patients.
- Staffing and skill mix were reviewed daily by the Clinical Team Leaders looking ahead to make adjustments in light of wait times, training requirements, etc. Clinical Team Leaders controlled and completed the staffing rota. Staffing levels were also reviewed weekly, quarterly and annually. Full-time staff worked 7.5-hour shifts, 5 days per week. They worked every other Saturday, with a weekday off to compensate. Shift times varied according to the role the team member was fulfilling in the clinic, and team members rotated through every

role that they were skilled to fulfil. There was always a nurse-in-charge on site from open until close. Staff were expected to be flexible if treatment schedules over-ran the end of their shift.

- The local MSI West London site had access to surgeon's rotas.
- A surgeon and anaesthetist were present during all surgical activity. We were told that there were sufficient numbers of staff for treatment rooms to perform procedures.
- Anaesthetists were employed on a sessional basis.
- MSI West London attempted to use bank staff who were experienced in their procedures and therefore tried to have a regular core of bank staff who were expected to maintain their training and revalidation. Between April and September 2017, average weekly usage of bank staff was 5%-7%.

Major Incident awareness and training

- The service had contingency business plans in place in case of an emergency. The plan included guides to dealing with common emergencies and the relevant contact details. There were action plans to deal with emergencies involving electrical, sewage, fire, fridge, medical gases, gas, bomb threat and adverse weather. Staff were aware of emergency and evacuation procedures and the actions to take in such events.
- There was an emergency backup generator at the location. MSI provided us, post inspection, with records and dates of testing of the generator.
- Staff received fire training on a two yearly basis. Staff were able to describe procedures to follow in the event of a fire. Fire drills were carried out twice per year.

Are termination of pregnancy services effective?

Evidence-based treatment

- We reviewed a range of the organisational policies and procedures and spoke with staff to evaluate how the service ensured treatment was based on professional guidelines and evidence. Staff told us that the parent organisation had recently reviewed and updated many of the group guidelines and policies. Treatment options for different periods of gestation were available in line with Required Operating Standard RSOPs.
- Required Operating Standard (RSOP) 9 relates to the gestational limits with respect to termination. We were told the maximum gestational age accepted for termination was 23 weeks and six days. The service prescribes and administers abortifacient medication for early-medical abortion that is where a pregnancy is up to nine weeks and four days gestation. They also provided surgical abortion, up to 23 weeks and six days gestation, offering no anaesthesia (up to 11 weeks gestation), sedation or general anaesthesia, according to the patient's choice and needs. Surgical abortions were undertaken under general anaesthetic where the gestation was between 14 and 23 weeks and six days.Late surgical abortions were performed from between 20 and 23 weeks and six days. Professional guidance indicates two main surgical methods for TOP, which includes; vacuum aspiration, recommended at up to 15 weeks gestation and dilatation and evacuation (D&E), which is recommended where gestation is greater than 15 weeks.
- There was a process in place to ensure patients received appropriate cervical preparation depending on the patient's age and gestational period. RCOG guidance 7.9 states that cervical preparation should be considered in all surgical terminations and 7.10 details recommend regimes according to gestation. The current protocol for cervical preparation was outlined in the Abortion Policy – Medical and Surgical Procedures v2.1 December 2016 and was in line with RCOG guidance.
- NICE guidance on strategy, policy and commissioning on HIV testing and prevention (2014) states that staff directly involved with testing for HIV should be able to conduct post-test discussions, including giving positive test results. Staff had no training for this.Staff told us the HIV policy had been revised but the training had not been rolled out yet.
- Staff were able to access company policies through the MSI intranet and hard copies were kept at the centre.Team meetings and closure days were held to enable the organisation to keep up-to-date on the latest guidance.

Termination of pregnancy

- All patients were treated with prophylactic antibiotics to prevent infection in accordance with local and national guidelines.
- Blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to patients who were found to be rhesus negative. This was in accordance with RCOG guidance 6.7.In line with RCOG guidance, the centre offered patients early medical abortions with a 6, 24, 48 or 72-hour delay between the two procedures.
- Patients undergoing medical terminations were given a pregnancy test kit to take home with them and complete four to five weeks after treatment. This was to determine if treatment had been successful. We saw patients being told to contact the MSI after care line if they had concerns or a positive pregnancy test.
- If patients consented to Long Acting Reversible methods (LARC) contraception, they were offered the devices at the same time as their treatment. Staff told us they strive to provide a holistic sexual and reproductive health service.We saw statistics demonstrating the percentage of patients accepting LARC, which was 43%, the target for the centre, was 50%.The percentage of patients accepting sexually transmitted infection testing was high at 87%. The results above were consistently amongst the highest when compared to other MSI centres.
- Discharge support was provided to all patients in the form of a 24-hour helpline.We were told a registered nurse provided corporately covered this service.

Pain relief

- Medical staff prescribed pre and post procedural pain relief on medication records. Non-steroidal anti-inflammatory medication (NSAIDs) and intravenous paracetamol were administered during procedures. Nursing staff recorded medication in in patient records.
- A pain score tool was used as part of an early warning system called TEWS (Termination of Pregnancy Early Warning Score). Staff we observed were attentive to patients' needs and frequently asked them if they were in pain and needed pain relief. The pain relief medication administered was recorded electronically. The pain medication and route of medication depended on the surgeon.At the time of the inspection, it was Cocodamol.Paracetamol and a dyslogistic suppository were also offered.
- Patients we spoke with said that pain relief was effective and that access to pain relief was readily available. Staff were able to anticipate pain relief requirements.
- Patients were given advice on discharge regarding the type of pain relief to take. Pain relief was prescribed pre and post treatment for those patients undergoing surgical terminations.

Patient outcomes

- There was a regular audit programme, which included, hand hygiene, infection control, safeguarding, medicine management and record keeping, regulatory compliance, planned preventative maintenance, health and safety, regular venous cannula and WHO 'five steps to safer surgery'. Results were compiled centrally for benchmarking so recommendations for improvement could be made. We were provided with examples of improvements made to processes as a result of audit including empowering nurses to speak up in treatment rooms, familiarising staff with incident reporting procedures, and developing a better pro-forma for reporting safeguarding concerns.
- MSI West London along with the other MSI centres, received a twice weekly waiting times report separated by treatment type (consultation, early medical abortion, early surgical abortion, surgical abortion 14-19 weeks, surgical abortion 19 plus weeks, vasectomy). Waiting times are measured against the RSOP targets of not more than ten days from first contact to treatment.
- MSI West London also receives a monthly quality dashboard with indicators for LARC, STI, DNP, DNA and occupancy for the month.
- A more in-depth quality assurance dashboard was produced quarterly.These dashboards were reviewed at a quarterly Local Quality Assurance meeting. We were told that these were still being developed and while local managers were familiar with the dashboards, frontline staff were not familiar with them at this stage. They were more familiar with local quality indicators such as LARC, STI and DNP rates, audit results and patient feedback.

Termination of pregnancy

- Termination failure rates have been monitored electronically since February 2017. The surgical termination failure rate for MSI West London from April to end of June 2017 was 0.18% and was similar to the rate for centres of a similar size. Treatment failure is defined as continuing pregnancy or retained clots or patients requiring further medical or surgical management as part of treatment already undergone.
- The MSI corporate target for uptake on long acting reversible contraception (LARC) was 50%. MSI achieved this target in February and March 2017. The results for other months varied between 38% and 50%. The service manager told us that the clinic had the highest results in the region. This was confirmed by the MSI data dashboard for the period January to June 2017.
- The MSI corporate target for sexually transmitted (STI) screening uptake was 75% and the average uptake for MSI West London was above this at 94% between February and July 2017. This was a consistent achievement for a longer period. The MSI data dashboard for January to June 2017 showed MSI West London to be in the top two of performers.
- The do not proceed to treatment (DNP) rate for the 12 months leading up to the inspection was above the corporate target of 15% except for March/April and July 2017. The highest month was 22% and the lowest 13%. Main reasons for higher than target levels were patient ambivalence, gestation too high to list and patient choice. In May 2017, two-day appointments were introduced with the aim of reducing DNPs, which subsequently fell below the 15% target.
- During the period February to June 2017 the unplanned return to treatment room rate for MSI West London at 0.49% was higher than the regional average rate of 0.21%.
- No audits were completed for the number of women who had repeat abortions and whether they had left the service with suitable contraception and the availability of a female doctor for women who wished to consult with a woman. .
- Individual staff members were set key performance indicators (KPI's) against the patient's uptake of contraception.

Competent staff

- The induction programme for new staff included three days at the MSI 'One Call' centre covering health and safety, human resources and listening in to patient calls. For new staff the induction period, during which they are supernumerary normally lasts a minimum of four weeks. Probation and preceptorship lasts for six months.
- Both registered nurses and health care assistants performed ultrasound scans. We were told but did not see any evidence that staff undertook in house training and assessment of competence in ultrasound scanning. For accreditation, staff were required to take 100 trans abdominal scans for the first trimester of pregnancy. For the second trimester, 15 transabdominal scans and 25 transvaginal scan. We were told the centre had two ultrasound mentors 30 scans a month were required. All staff were required to undertake scans are trained in both theory and practice. In addition there were two ultrasound scanning mentors to support scanning staff.
- If it was identified that a member of staff required further training a refresher course was provided or the staff member would spend time with one of the mentors.
- We were told if there were any scanning incidents these were reviewed by the scanning lead to assess. If there was a missed ectopic pregnancy, a full investigation was undertaken.
- As part of staff training in clinical areas, staff members were mentored in contraceptive provision and counselling by existing staff and given informational leaflets to read on all forms of contraception but this was not a structured learning course. All registered nurses underwent training to become certified by the Faculty of Sexual and Reproductive health to fit subdermal contraceptive implants. Part of the training involved completing learning by the Faculty and sitting an electronic knowledge assessment, which included not only implants but also all forms of contraception, as well as sexually transmitted diseases and other aspects of sexual health. Post inspection MSI provided us with records of this training completed by staff.
- RSOP 14: Counselling states; all staff who offer counselling should be trained to diploma level. Counsellors were trained to level four and five in

professional counselling and all were members of the British Association for Counselling and Psychotherapy. They all renewed their memberships annually; however, we did not see any evidence to support this.

- Information received prior to our inspection told us working staff, including managers, had received an annual appraisal in the previous 12 months.Staff also had regular one to ones. Appraisals were based on the organisations values, goals, and personal development.
- There was no information available locally to confirm that medical staff had undergone clinical appraisal. Appraisals and competency assessments were carried out by MSI at provider level. All doctors spoken with confirmed they had an annual appraisal as part of the GMC revalidation process. Evidence submitted during the provider inspection at MSI in February 2017 demonstrated 100% compliance. Whilst there was a process at provider level, there was no communication from the corporate team to MSI West London that confirmed appraisal had occurred.
- Surgeons were employed by MSI under the direction of the medical director who carried out their appraisals and revalidations centrallyTheir internal processes for monitoring licences to practice were kept centrally. We were told all medical staff had received an annual appraisal. We saw a schedule for doctors' appraisals and revalidation for 2016-2017.The centre manager and other staff who worked closely with the surgeons had no input or involvement in the appraisals. Pre-employment checks and training for agency staff was managed centrally.
- Nurses we spoke with were aware of revalidation and told us that there was a flagging system in place by email alert to remind them to revalidate every three years. They told us they were supported by MSI to ensure this was completed.
- A full induction was provided to new starters who are given a booklet to work through and informed of other parts of the organisation and the leadership team.
- At Ealing, we observed a new member of staff being inducted by other nurses.The nurses were very friendly, welcoming and gave comprehensive training to the new staff member.
- The training audit summary, which we viewed, showed 96% compliance on consent training via e learning.
- Staff told us that managers were supportive of training and provided encouragement to attend training.

Multidisciplinary working (related to this core service)

- All staff had a clear understanding of their roles and responsibilities and how to work as a team. During our inspection, we observed clinical and non-clinical staff interacting and communicating well with each other and respecting each other's roles. The team identified and discussed those patients requiring further assessment and support and communicated this information with nurses on the ward.
- The service had links with local authorities, safeguarding teams and GPs to support their service.Staff gave examples of collaborative work with these external agencies such as support for emergency transfers to the NHS and referrals for safeguarding vulnerable patients to social services.
- However, senior clinical practitioners had their own doctors' meetings and did not attend the centre's team meetings. We did not see meeting minutes or evidence that information was shared between the senior clinician meetings and the centre's team meetings. However, the operations manager subsequently told us that information was passed from the senior practitioners' meeting to the centre's team meetings and that minutes of the meeting were displayed on the staff notice board.
- Patients had access to a 24-hr dedicated aftercare and advice post-procedure support line.
- Staff told us all patients were offered counselling to discuss options and choices and receive therapeutic support.It is mandatory that all patients under 16 have counselling.The electronic record of a patient did not allow progress to the next page if the counselling option box had not been ticked.We also saw posters on the wall to inform patients of counselling options and domestic violence assistance.
- At the morning staff safety meeting we saw allocation of roles was given to all nurses to ensure the team was aware of who had overall responsibility for the patients' care.

Termination of pregnancy

Access to information

- Staff stated that they requested patients' consent before sending information about their treatment to their GP. If patients refused consent, staff gave them a letter to give a healthcare professional in the event of any complications. This followed RCOG recommendation 8.2 which specified that on discharge all patients should be given a letter providing sufficient information about the procedure to allow another practitioner to manage any complications.
- Patients were provided with a contact number for the 24-hour call centre, called MSI One Call. They were able to get guidance and access to healthcare professionals.
- Patients were handed discharge information, which gave advice on their treatment and recovery. In line with RSOP 3: Post procedure, the booklet gave the 24-hour advice line number.
- The centre was intending to introduce laminates containing information for patients on the waiting room walls. This had not yet occurred at the time of our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty

- We saw consent policies and guidelines in place for staff to follow. Nurses were able to obtain consent. We were told staff had undertaken consent training and were observed for competency for consent and assessed against a number of standards in line with RSOP 12. These included record keeping, understanding the needs of patients and an understanding of medical and surgical treatments. The organisations training report showed in January 2017 94% of staff had completed consent training.
- All except one care record reviewed contained completely signed and countersigned consent forms. In the one record we found to be incorrectly completed, the patient had signed the consent form but the responsible nurse had failed to countersign it. We informed staff at the Wembley satellite unit that consent had not been obtained. Staff escalated the matter immediately. The provider immediately took action to ensure this would not occur in future. We found, apart from this one occurrence, that records were audited and monitored to ensure staff were following correct company policy and procedures.
- Selections of consent forms were available, such as surgical abortion treatment, vasectomy treatment, and Depo-Provera injection. Each consent form was tailored so that patients were made aware of the risks involved.
- We saw the anaesthetist and surgeon check the patient's records and consent form before treatment. The registered nurse checked the consent form and signature with the patient and the surgeon verbally confirmed the procedure with the patient.
- We saw that the MSI Abortion Policy – Medical and Surgical Procedures v 2.1 contained a section on informed consent. Staff used the under 18 pro-forma for consent and to determine if the patient was competent using the Fraser guidelines and Gillick competency. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. Gillick competence is used to determine a child's capacity to consent.
- Staff told us that under 16s must and did receive face-to-face counselling.Staff said that if patients under the age of 16 attended they were encouraged if possible to involve a parent or guardian.
- Staff told us if a patient had a learning disability, they would check their ability to understand and make informed consent decisions. If staff were unable to determine consent, the patient would be referred to the NHS hospital or their GP.Pre-assessment would help determine if a patient had learning difficulties.Patients with learning difficulties had more time and were assessed for capacity.
- The monitoring of consent was undertaken in the medical records audit but was not audited separately and we did not see any results from this. It was intended to undertake a separate audit of consent beginning in October 2017.
- The Mental Capacity Act (MCA) was discussed at staff meetings and a small pocket booklet was published for staff, giving guidance on MCA issues but no formal training was given.

- If the centre needed to contact the patients GP, they needed to gain consent from the patient. If this consent was denied women were given a letter to give to a health care professional in case of complications.

Are termination of pregnancy services caring?

Compassionate care

- Staff we observed were kind and polite to women throughout their pathway of care. We observed compassionate care towards patients during consultations, in treatment rooms and in recovery wards.
- Patients we spoke to found staff kind, non-judgmental, and attentive to their needs.Staff told us that patients were 99% complimentary on questionnaires.We were not provided with details of the response rate for this figure. Negatives were usually about waiting times.Staff told us this is being addressed by arranging extra lists where possible.
- We observed a designated member of staff was present for support during sedation of patients.
- Verbal comments from patients during the inspection were good or excellent and seen without delays.
- At the Wembley satellite unit, we saw six patient feedback leaflets all of which rated the service as very good or excellent.One patient said 'the staff were incredibly professional and supportive and made a rather unpleasant experience much easier.' Patients were positive about the care they received.
- Staff offered a good service and treated patients with dignity and respect.
- The vasectomy service was held on a separate day to the termination of pregnancy services. This meant men and women did not meet during their treatments.
- We observed staff ensuring patients dignity was respected by covering their legs and body with sheets and gowns when the patient was unable to do so.

Understanding and involvement of patients and those close to them

- We found staff explained to patients the available methods for termination of pregnancy, whilst considering gestational age and other clinical requirements.
- Women were offered information on the statutory requirements of the HSA4 forms and where they were sent via a laminate at the point of registration in the centre (prior to any consultation or treatment). There were also notices with this information posted in waiting areas.
- Staff we spoke with told us if they felt a patient was unsure of treatment, they would advise them to seek counselling. Staff explained to us that the patient's decision was always their priority.

Emotional support

- Emotional support was offered to patients at the initial consultation and was available throughout their pathway of care. Staff were able to determine the level of support women required. This ranged from counselling to safeguarding and access to other supportive groups.
- Counselling was provided on site two days a week for face-to-face discussions and women were able to contact counsellors by telephone at other times to suit their requirements.
- Women under 16 were required to have a face-to-face counselling appointment prior to treatment. Staff told us that younger patients were seen alone once to identify any needs, to assess capacity and any safeguarding needs.
- Those who need extra counselling were able to contact the 24hr dedicated helpline for further advice and information. Bereavement/grief counselling and pregnancy counselling was available. The line was operated by registered nurses who were trained to assess and provide advice over the telephone. Individuals could be booked to come back into the centre for further assistance and assessment if required.
- We observed staff dealing with anxious patients at both Ealing and the Wembley satellite unit. Staff were caring and paused when they thought patients were distressed and reassured patients. We observed a designated member of staff was available for emotional support during sedation.

Termination of pregnancy

Are termination of pregnancy services responsive?

Meeting the needs of local people and individuals

- Marie Stopes had a dedicated team who pro-actively monitored and managed capacity on a daily basis via their wait times monitoring system.
- To meet a surge of increased demand, we were told staff were multi-skilled and were able to work at various locations. The same agency staff were available to meet unplanned and planned staff absences and extra lists would be made available where necessary.
- Services were planned with cooperation and discussion from Clinical Commissioning Groups (CCGs). This was in accordance with RSOP 7: The Care of Clients Requesting Induced Abortion, which states, local strategies should provide patients and healthcare professionals with information on access including self-referral.
- The west London centre was open six days a week. The six satellite units offered access six days a week and women had the option of choosing the location they wished to visit.
- The centre was easily accessible by public transport and the satellite sites were located in GP surgeries or medical centres providing easy access to local communities. Men could attend the Ealing service for vasectomy treatment on alternative Tuesdays. No other clinics operated on those days so men and women received their treatments separately.
- If a patient did not qualify for NHS-funded treatment or choose not to use the NHS, they could access the service privately.
- Staff told us if a patient had a learning disability, they would check their ability to understand and make informed consent decisions. If staff were unable to determine consent, the patient would be referred to the NHS hospital or their GP. Pre-assessment would help determine if a patient had learning difficulties. Staff provided patients with learning difficulties with more time and re-assess capacity. Staff told us a patient with Autism who found waiting times difficult was given a separate area on the ward to move about and an area to colour etc. A patient had concerns with having a needle inserted. A member of staff demonstrated the insertion of a needle on another member of staff to ease the patients concerns. The centre is informed in advance if a patient has a learning disability so they have time to prepare. One-call the dedicated phone line will notice this and include information on the patient's notes.
- If a patient had poorer social support or complex needs, the centre provides support counselling and referrals to other organisations for assistance.
- There was a policy for the disposal of pregnancy remains.
- A good selection of information was available to patients on support services and the treatments provided at the centre. They had a good variety of leaflets, were able to have face-to-face discussions and access to the provider's website.
- Staff told us they were hoping to install Wi-Fi to allow patients better access to information. At the time of inspection the provider had installed a digital display informing patients about phone charging, contraceptives and 'ask if you need help.'
- Staff told us about a patient with Autism who found waiting times difficult and who was given a separate area on the ward to move about and an area to colour. In another example, a patient had concerns with having a needle inserted. A member of staff demonstrated the insertion of a needle on another member of staff to ease the patients concerns. The centre was informed in advance if a patient had a learning disability to allow the centre more time to prepare. The One-call phone line would alert the centre to such situations and include information on the patient's notes.
- For those patients who were unsure of their decision, staff encouraged them to seek counselling and re-booked appointments to ensure the patient had made a firm decision before proceeding with treatment.

Access and flow

- Marie Stopes International provided a 365-day service 24 hours a day. Patients were able to contact their 0345 number whereby they were offered a choice of times and suitable locations for their visits.
- RSOP 11: "Access to Timely Abortion Services" states that women should be offered an appointment within five working days of referral and should be offered the

abortion treatment within five working days of the decision to proceed. Records we viewed confirmed this happened. The centre aimed to see patients within five days with the recommended referral to treatment rate (RTT) is 10 days. If the centre cannot accommodate a patient within these timeframes, they liaised with other clinics across the UK and other organisations. The centre paid for taxis for patients to be treated elsewhere. Support was provided and volunteers accompanied patients where it was felt necessary.

- MSI Business Support Team provided daily reports on wait times and these were disaggregated by treatment type and gestation. Any wait times beyond three working days for surgical procedures and one working day for medical treatment was highlighted and centre lists were modified to create an appointment for the patient.
- Staff told us late starts to theatre lists had improved as start times had been adjusted and medical practitioners had to sign in and out. Other delays were due to staff sickness, annual leave and patients arriving late. Staff informed us that there had been an improvement since the new manager arrived. Theatre list start and finishing times were monitored daily and reviewed monthly.
- Patients at Ealing normally had 20 minutes for their consultation appointments. During this time, staff discussed treatment options, consent, confirmation of pregnancy gestation by ultrasound scan, point of care testing for rhesus status, sexually transmitted infection screening, arranging an appointment for treatment, administration of medication and administration of contraception if required.
- Staff told us they would prefer longer consultation appointments, as although they gave patients the time they required they were aware this affected patients who were waiting.
- MSI employed doctors were able to access patients records remotely, in order to approve treatment in line with legal obligations, and to sign the HSA1 form. This afforded more flexibility, in that doctors met patient demand at more than one location without having to be present.
- Staff we spoke with told us if they felt a patient was unsure of treatment, they would advise them to seek counselling. Staff explained to us that the patient's decision was always their priority.
- Staff and patients informed us that treatment was provided as soon as possible. The centre runs limited lists for those of a higher gestation. Patients had access to a phone line to establish if the centre could fit them in. There were processes to expedite treatment for example, if a patient does not turn up, someone else is fitted in. The centre often runs extra lists to accommodate demand. The centre tries to see patients within five days the recommended referral to treatment rate (RTT) is 10 days. If the centre cannot accommodate a patient, they liaise with other clinics across the UK and other organisations.The centre pays for taxis for patients to be seen elsewhere, support is provided and volunteers if required accompany patients
- Staff at the Wembley satellite unit informed us that they still felt they were being rushed, as there was not sufficient time between appointments.
- At Ealing, staff informed us that diaries and lists work on how/what staff think is achievable and therefore the waiting experience for patients has improved.

Learning from concerns and complaints

- We looked at the MSI Complaints Procedure which was in place. Staff could access this as well as the UK MSI Handling Comments, Concerns, Complaints and Compliments Policy. Information for patients on how to make a complaint was available with complaints advice contained in patient literature and displayed in patient waiting areas and in the patient information folder.
- Between February 2017 and June 2017, there had been six complaints. These consisted of three formal complaints and three informal complaints. The three formal complaints were not upheld. The three formal complaints referred to patient dissatisfaction and managers told us these had been addressed. We reviewed the three formal complaints and saw processes were followed in line with the organisation's complaints policy.
- Individual complaints were also discussed in team meetings. Discussion involved what improvements could be made in the future.

- Issues could be raised via the patient feedback questionnaire. The centre manager dealt with patients concerns on a one to one basis or via the telephone, if the issue was raised before the patient left the premises.
- We were shown the complaints file held at the centre and staff were able to describe the complaints process. The centre recorded patient verbal concerns on the central electronic system and a patient feedback book. For issues that were more complex the patient was encouraged to write, so a full investigation could be made centrally.
- Staff told us they would deal with patient concerns if they were raised and knew how to escalate the complaint if needed.

Are termination of pregnancy services well-led?

Leadership/culture of service related to this core service

- The operations manager supported by a clinical team leader and clinic controller led the service at West London.
- The operations manager reported directly to the regional surgical delivery manager.
- The west London centre was set up as a hub with six satellite units. The west London operations manager was in the process of registering with the CQC to become the registered manager.
- A regional manager from central office visited the West London centre to provide support to the local management team.
- Staff gave us positive feedback on the new management team.Staff told us the new centre manager was very approachable, visible, and supportive and had an open door policy. Staff said they were able to approach them with concerns.
- Local managers understood the challenges staff faced.
- The operations manager had been innovative since taking on the role and had made changes to the rota system, the risk register and worked had to look after patient satisfaction.
- In the reception area, the centre displayed the Department of Health Certificate, which is a requirement by the Department of Health.

Vision and strategy for services

- The organisation had clear defined values and goals to deliver high quality care. The senior managers at the centre were clear in their strategy and the vision of the organisation.
- The service shared the values and objectives of the organisation with staff and they had a general understanding of the overall strategy but were not so fully engaged in the corporate goals.

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

- The organisation monitored processes, which enabled them to measure risks and quality of the service. Information was collected in a number of ways. This included incident reporting and trending and the 'did not proceed' report, which took place at corporate level. This would include for example, surgical complications, failed medical abortions. At a local level, they also identified certain outcomes, for example, did not attend appointment, patient flow, LARC, STI, case mix and occupancy.
- The centre had an integrated governance framework. This comprised of a corporate central governance committee and local integrated governance committees to oversee risk and quality management.
- We saw a quality dashboard that provided trend analysis for incidents and complaints. There was also discussion of incidents, complaints, and lessons learned from these both locally and elsewhere in the organisation in team meeting minutes, including the minutes from the team meeting immediately preceding the inspection.
- Legislation requires all non-NHS locations, must have approval from the Secretary of State to carry out terminations of pregnancy. The certificate of approval was on display in the reception area at Ealing as well as in the satellite locations visited.
- Staff told us they were clear about their responsibilities. We observed a morning safety meeting where staff were allocated specific roles for the day.

- Staff told us that the pre-assessment process assisted in keeping incident numbers down, as they were able to assess matters to reduce patient risk.
- Local quality assurance meetings were attended by the full centre management team, which included the operations manager, clinical team leader and clinical team leaders in development along with other key regional staff. Regional quality assurance and operations meetings were attended by the operations manager and information from these was cascaded back to clinic staff via email and in team meetings.
- West London MSI held a local risk register. The local management team at west London knew what the top risks were and knew how to escalate any problems that arose. They told us matters included clinical complications following a haemorrhaging incident in February 2017 and access to training.
- Risks were understood by medical and nursing staff who took steps to mitigate risks such as pre-assessments for patients, which assisted in identifying any issues before treatment commenced.
- Staff told us the centre held regular team meetings to discuss patient care and the correct procedure to follow for the best possible outcomes.
- Legislation requires that for an abortion to be legal two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. The HSA1 certificate is only signed when the two doctors have agreed in good faith that all requirements of the Abortion Act 1967 and Abortions Regulations 1991 have been met. The 15 sets of records we checked showed the HSA1 form had been completed correctly with the reason for termination and the two required signatures. We observed that nurses checked the HSA1 forms were completed correctly prior to treatment.
- In line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991, the medical records audit process, evaluated compliance with the arrangements to ensure two medical practitioners signed the HSA1 certificates of opinion. The medical records audit 2017, completed every two months, indicated 100% compliance with HSA1 form completion.
- The Required Standard Operating procedure (RSOP) standard one requires the provider to ensure that the completion of legal paperwork (HSA1 and HSA4) meets the requirements of the Abortion Act 1967.In order to prevent bulk signing of forms, protected time was given to doctors at the start or finish of each list, to ensure they had sufficient time to sign forms in advance. In addition, an individual ad hoc note was made by the surgeon on each patient's electronic record, confirming their assessment that the patient meets the conditions of the 1967 Abortion Act. The HSA4 form data showed these were completed appropriately and sent electronically on time (within 14 days) to the Department of Health. The centre's electronic system automatically flagged any errors on the HSA4 forms. Any errors that were not caught electronically were returned in paper form for correction.
- Staff told us the joint HSA1 and HSA4 2017 audit had not been launched yet; however, audits were currently undertaken separately. The HSA1 form was monitored in two ways. The HSA1 form was audited as part of the medical records audit. In addition to this, a monthly audit of HSA1 forms for medical abortions was completed from January to August 2017, measuring the time stamp of each HSA1 signature against the time the medical abortion tablets were prescribed. The aim of this audit was to ensure that HSA1 forms were signed prior to the prescription of any medical abortion tablets.
- The HSA4 was also monitored centrally. Staff had training on submitting HSA4 forms electronically to minimise errors and examples were online.

Public and staff engagement

- Patients were provided with a patient satisfaction questionnaire, which contributed to a quarterly report produced by an external company. Patients were happy with the professionalism and competence of the staff. Concerns were flagged by the regional office and cascaded down to local locations where issues were discussed in the team meeting.
- Patients we spoke to found staff kind, non-judgmental, and attentive to their needs. Staff told us that patients were 99% complimentary on questionnaires. We were

not provided with details of the response rate for this figure. Negatives were usually about waiting times. Staff told us this was being addressed by arranging extra lists where possible.

- The centre manager had introduced a visual display which described key trends in incidents and complaints, with lessons learned from these posted alongside them. The visual display was refreshed bi-monthly. There were weekly information minutes for staff alongside any corporate communications that had been issued.

Innovation, improvement and sustainability

- Regular team meetings were held in order to discuss performance and to determine and maintain improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed accurately, used appropriately at each phase of the surgical procedure and quality audit is undertaken.

Action the provider SHOULD take to improve

- The provider should ensure that there is clear evidence that staff have received all mandatory training and formal duty of candour training documented in training records.
- Ensure improvements in corporate and location level communication and engagement to ensure an effective process for governance, quality and risk oversight of services at local level.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (12) (1) Care and treatment must be provided in a safe way for service users. Page 16 (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include-- (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; • Staff did not always carry out the World Health Organisation (WHO) 'five steps to safer surgery' checklist appropriately. We reviewed seven records, spoke with staff and reviewed audit practices. All seven records reviewed had a completed hard copy checklist. However staff in the operating theatre were observed completing all aspects of the WHO 'five steps to safer surgery' checklist before the surgery had started. This included stage three 'time out' and stage four 'sign out' sections. The provider must take action to: • Ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed accurately, used appropriately at each phase of the surgical procedure and quality audit is undertaken.