Marie Stopes International South London Centre

Quality Report

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

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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

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

Overall summary

Marie Stopes International (MSI) South London Centre is operated by Marie Stopes International. Facilities at the centre include one treatment room with diagnostic services, five consulting rooms, a recovery room and a day room with 13 reclining chairs, and a waiting area.

The service provides surgical termination of pregnancy up to 23 weeks and six days gestation, early medical abortion up to nine weeks and six days gestation, and medical termination of pregnancy. Surgical termination is carried out under general anaesthetic or sedation, by vacuum aspiration, dilation and evacuation, or with no anaesthesia according to the gestation, patient's choice and needs. The service offers consultations, ultrasound

Summary of findings

scans, advice on contraception and the fitting of long acting reversible contraception (LARC) and screening for sexually transmitted infections. The centre runs a vasectomy service.

MSI South London Centre manages six early medical units (EMU) which are satellite clinics across the community. Early medical abortion consultations and consultations in the early stages of pregnancy were offered in private rooms at these facilities.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 6, 7, 8 and 15 August 2019.

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

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

Services we rate

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

We found good practice in relation to:

- The service had enough nursing and support staff to keep patients safe. Staff were trained with the right skills to assess patient risks and act upon them. Staff managed patient's safety well and knew how to protect them from avoidable harm or abuse. There was a good culture of incident reporting and lessons learnt were shared and actions taken.
- There were good systems to monitor the effectiveness of the service. Staff were competent, and patients' pain was well managed.
- Patients were treated with compassion. Staff were kind and non-judgmental and offered emotional support when needed. Patients were treated with dignity throughout their treatment journey.
- The service planned and provided care in a way that met the needs of local people and patients' individual requirements were considered. There was good access to the service and patients did not have to wait too long for treatment.
- Leaders had the integrity, skills and abilities to run the service well and there was a shared vision and values which staff applied in their work**.** There were clear lines of responsibility and accountability in each role. Staff felt respected and valued by the service. The service engaged well with patients and strived to make continuous improvements.

However:

- Not all anaesthetists were logging their daily checks of anaesthetic equipment. However, this was acknowledged on the day of the inspection and actions were being taken to address this.
- The service had missed an engineering check on a general anaesthetic machine.
- There was no record of stock levels for medicines such as mifepristone and misoprostol. It would not be possible to check if there were discrepancies in stock levels. However, the service was taking action to address this.

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

Nigel Acheson

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	Good 	Marie Stopes International South London centre provides medical termination of pregnancy up to nine weeks and six days gestation and surgical terminaton of pregnancy up to 23 weeks and six days gestation. The centre has six satellite clinics providing medical termination up to nine weeks and three days gestation. The service provides a vasectomy service and advice on contraception as well as the fitting of long acting reversible contraception (LARC). We rated this service good overall. Safe effective caring responsive and well led were rated as good.

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Background to Marie Stopes International South London Centre

Marie Stopes International (MSI) South London Centre is operated by Marie Stopes International.

MSI South London Centre is contracted by Croydon, Lambeth Southwark and Lewisham, Sutton and Kingston Clinical Commissioning Groups (CCGs) to provide a termination of pregnancy service for the patients of south London and surrounding areas. The centre also accepts patient referrals from around the UK and abroad. The service receives referrals from general practitioners (GPs), hospitals, family planning services and other independent providers. Patients are also able to self-refer. The service treats adults and young people aged 14 and above. The service saw 104 young people aged 14-16 from March 2018 to July 2019.

MSI South London centre manages six satellite early medical units (EMU) located in Croydon, Greenwich, Lewisham, Waterloo Wimbledon and North London, where medical termination and consultations in the early stages of pregnancy are provided in a private consultation room.

The service provides surgical termination of pregnancy procedures up to 23 weeks and six days gestation as well as early medical abortion up to nine weeks and six days gestation. Surgical termination of pregnancy up to 10 weeks gestation is carried out with or without general anaesthetic or sedation and the procedure includes vacuum aspiration or dilatation and evacuation. The service also provides consultations, ultrasound scans, contraception advice including fitting of long acting reversible contraception (LARC), counselling and screening services for sexually transmitted infections. The service provides a vasectomy service (male sterilisation).

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

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

The service had one registered manager in post during the time of our inspection. The registered manager had been in post since January 2018 and has been working for MSUK since January 2010.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and another two CQC inspectors. The inspection was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Information about Marie Stopes International South London Centre

MSI South London Centre is open six days a week from Monday to Saturday from 7.30am to 5pm. The early medical unit satellite clinics are available throughout the week from Monday to Friday offering two to three clinics a week per location.

Facilities at MSI South London Centre include one treatment room, with a conjoined recovery room, five consulting rooms, ultrasound facilities, a waiting room and a day room with 13 reclining chairs. There are no overnight beds. Early medical unit satellite clinics consist of a private consultation room with scanning facilities.

During the inspection, we visited MSI South London Centre and the Croydon early medical unit satellite clinic,

Summary of this inspection

spoke with 17 members of staff including registered nurses, health care assistants, reception staff, medical staff and the registered manager. We spoke with five patients and reviewed 35 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (April 2018 to March 2019)

- There were 11,290 episodes of care recorded at the early medical unit satellite clinics and MSI South London Centre.
- 7603 were medical terminations of pregnancy
- 3687 were surgical terminations of pregnancy
- 54 vasectomies (from January 2019 to June 2019).

Track record on safety

- There were no never events recorded for the period April 2018 to March 2019.
- There was no serious incident recorded for the period April 2018 to March 2019.
- From April 2018 to March 2019 the service received 18 formal and 29 informal complaints. All complaints received were responded to within 20 days which was in line with the provider's complaints policy.

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?

Good

We rated it as **Good** because:

- The operations manager had received training using a root cause analysis approach to enable the investigation of incidents. This was an improvement since our last inspection. Lessons learnt from incidents were now actively shared through regular team meetings with staff. There was a good reporting culture at the centre.
- There was now sufficient individual seating in the reception area. Due to more oversight and management of the patient list, the centre could accommodate all patients with seats in the reception waiting area.
- There was better staffing levels in the treatment room and recovery area. There was a dedicated staff member to support the anaesthetist at all times.
- The compliance with The World Health Organisation (WHO) and five steps to safer surgery checklist was good and audit results were consistently above compliance targets.

However:

- Not all anaesthetists were logging their daily checks of essential anaesthetic equipment.
- The general anaesthetic machine had not received the six-monthly service. This was highlighted and acknowledged on the day of the inspection, and as a result the policy is currently being reviewed to bring servicing in line with the national guidelines of 12 monthly servicing rather than 6 monthly servicing.
- There was no record of stock levels for medicines such as mifepristone and misoprostol. It would not be possible to check if there were discrepancies in stock levels. However, the service was taking action to address this.

Are services effective?

Good

We rated it as **Good** because:

- Policies we reviewed were up to date and accessible to staff. Policies were in line with national guidance and best practice.
- Staff assessed and monitored patients regularly and gave pain relief in a timely way.
- There was a good compliance monitoring programme, with key topics such as incidents, audit results and complaints. These were monitored through a dashboard.

Summary of this inspection

- The service had been training a member of staff to be a dedicated contraception and sexual health (CASH) champion. They would provide training to nursing staff to achieve a higher rate of uptake for long acting reversible contraception.
- There was a fully trained contraception and sexual health (CASH) champion at the centre.

Are services caring?

Good

We rated it as **Good** because:

- Staff were caring, kind and compassionate and provided a dignified and person-centred approach.
- Staff were non-judgmental and supported patients when they were upset.
- We observed consultations and staff involved patients in all aspects of their treatment journey.
- There were supportive pathways for those patients who required further assistance.

Are services responsive?

Good

We rated it as **Good** because:

- The service had now implemented more time in between patient appointments at the main centre, and this was an improvement since our last inspection. Clinical team leaders and a supernumery nurse were available to step in if appointment times ran over.
- Counselling services were available to everyone either over the telephone or on a face to face basis.
- Complaints were taken seriously and acted upon. All complaints received were responded to within 20 days, which was in line with the service's complaints policy.

However:

- Staff within the Croydon early medical unit satellite, did not always have enough time to complete consultations and treatments and the list often overran.

Are services well-led?

Good

We rated it as **Good** because:

- The centre and the six early medical satellite clinics were managed by the operations manager and clinical services matron. Functions were now split operationally and clinically, which meant there was more oversight and responsibility for each area.

Summary of this inspection

- Staff had a good understanding of the risks within the centre and had access to information relating to risk management.
- There was a good culture in the centre and staff worked together as a team. Staff told us managers were supportive and approachable and there was a good open and transparent environment.
- There was a clear governance structure within the organisation and information was shared across each location.

However:

- There was no checking of stock levels and discrepancies of mifepristone and misoprostol. The issue had been placed on the corporate risk register and the organisation were taking actions to address the concerns.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Termination of pregnancy

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

Are termination of pregnancy services safe?

Good

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff told us mandatory training was effective and essential to their everyday role within the service. We found staff had good knowledge and understanding of mandatory training and this was reflected throughout the inspection, for example in safeguarding and infection prevention and control. Staff said they were well supported and given protected time to complete training.
- Information provided during the inspection showed the overall compliance for completion of mandatory training was 95.7% against the MSI corporate target of 85%. For the topic which was below target, we saw evidence that staff were booked on future courses with dates of no later than October 2019.
- Mandatory training was structured and included core standard topics such as infection prevention and control, information governance, introduction to health and safety, safeguarding, manual handling, lone working essentials fire safety essentials and Care of Substances Hazardous to Health (COSHH) essentials, equality and diversity, general awareness and DSE awareness.
- The centre had closure days for face to face and scenario training. For example, during our inspection, the centre was closed for one day and staff were receiving training for manual handling, conflict resolution and planned quarterly immediate life support (ILS) scenario training. ILS mandatory training included sepsis training, and, on this occasion, training was given in the form of scenario-based situations within the centre. At the time of our inspection the ILS compliance rate was 78% due to three new staff members joining the service. We saw evidence that the three new members of staff had been booked on ILS courses for September 2019. The three new members of staff were still completing their induction training and were not performing duties where they would require using ILS skills.
- There was good oversight and monitoring of mandatory training. The clinical service matron (CSM) monitored clinical staff's mandatory training through the electronic learning and development platform. E-mail notifications were sent to the CSM of staff who were due training and staff had access to the learning system which also flagged reminders of training that was due.
- The operations manager (OM) and CSM received weekly reports on the overall compliance and monitoring of mandatory training for surgeons and anaesthetists. The medical director and lead anaesthetists had oversight of surgeons and anaesthetists mandatory training. At the time of our inspection the overall compliance was 97.5%.

Safeguarding

Good

Termination of pregnancy

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- There was an in date and accessible safeguarding children and safeguarding adults' policy. Staff we spoke with were clear on their roles and responsibilities for reporting and escalating safeguarding concerns.
- All clinical staff were trained to level three in both adults safeguarding and children's safeguarding. The operations manager was trained to level four. All staff were able to confirm how they would escalate a safeguarding concern, either to the safeguarding link nurse, operations manager or clinical service matron.
- We viewed up to date mandatory training compliance figures and found 95% of staff had completed level three safeguarding. All clinical staff were assessed against a set of safeguarding competencies, to provide assurance that team members were confident and competent in assessing patients safeguarding needs and accessing the appropriate pathways. All clinical staff received quarterly safeguarding supervision. This took the form of a 1.5 hour session during which team members were encouraged to present safeguarding cases for discussion and consideration.
- There was a safeguarding link nurse and they had two supernumery days per week to manage safeguarding concerns with the operations manager. There were plans to train the safeguarding link nurse to a level four in safeguarding.
- The centre was piloting a new safeguarding proforma for adults and a separate proforma for patients under 18 years of age. The proforma provided additional safeguarding questions staff could ask the patient. We observed several consultations where the proforma was used and found the proforma provided patients with the opportunity to raise concerns if they wanted to.
- Throughout the inspection, staff were able to provide examples when they had raised safeguarding concerns. For example, reception staff were able to raise a domestic violence safeguarding case using skills they had obtained during their training. Another example included concerns raised by staff of suspected sex trafficking. Staff were able to identify concerns through the safeguarding proforma questions used during consultation and through observations of people who attended with them. Subsequently staff escalated the concern to the appropriate external bodies.
- Staff had good knowledge of female genital mutilation (FGM) and child sexual exploitation (CSE). Staff were able to provide feedback on a patient they identified being sexually exploited and the steps that were taken to protect the patient. FGM referrals were sent to an external agency who specialised in FGM safeguarding incidents.
- PREVENT (WRAP) training was provided to all staff. This training helped staff awareness around the need to safeguard vulnerable people from being exploited to extremism and terrorist purposes.
- Patients under the age of 13 were not treated at the centre. Staff told us the actions they would take, for patients under 13 years, which included a referral to the NHS, safeguarding local authorities and contacting the police. Within the last year the service had two under 13 years of age safeguarding incidents they had escalated to the relevant bodies.
- Patients were seen on their own during the first part of a consultation and this gave staff the opportunity to ask safeguarding questions in a safe private space. The centre encouraged patients not to use their mobile phones to help alleviate any activity of coercion.
- Records we reviewed all had safeguarding risk assessments completed and safeguarding information was flagged within a patient's electronic record. Before a patient had any surgical treatment and entered the treatment room the lead nurse clarified whether there were any safeguarding issues and shared this with other clinical staff.
- The service had regular quarterly meetings with external safeguarding bodies such as local authorities and clinical commissioning groups.
- Staff were offered debriefing and counselling services if they had experienced a safeguarding case they had found particularly upsetting.
- The centre had begun to collaborate with an external charity which specialised in domestic violence to

provide extra support and guidance for domestic violence safeguarding referrals. Domestic violence incidents were the most reported safeguarding referrals within the centre.

Cleanliness, infection control and hygiene

- **The service controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection.**
- There were supportive structures and reliable systems to minimise the spread of infection. All clinical areas we visited were visibly clean and were well maintained.
- We saw hand gel dispensers and hand washing facilities throughout the areas we inspected. There was signage above all clinical hand washing facilities providing information on best hand washing techniques. The service conducted hand hygiene audits and we found consistent results averaging 90%. The infection prevention and control (IPC) link nurse managed spot checks on staff using techniques such as glow light checks, a system which uses UV lighting to highlight germ particles on hands.
- The service had an IPC link nurse and they had received additional IPC training from the MSI IPC lead. The link nurse received supernumery time, up to 15 hours per month to complete IPC audits and reports. The audits included peripheral venous cannula (PVC) personal protective equipment (PPE), facilities and cleanliness and sharps and waste management audits. Reports we reviewed showed that a consistent score of above 80% was met for most audits.
- The IPC link nurse completed a monthly IPC centre report which was sent to the MSI IPC lead. The report provided information on audit results, areas of concern, and actions taken as a result of below average audit results. For example, in March 2019 the sharps and waste management audit score was 43%. The IPC link nurse took actions such as reinforcing the sharps and waste management protocols message to staff through the monthly team meeting. Since March 2019 we saw a consistent improvement in audits, for example in June 2019 the score was 79% and in July 2019 the score was 86%. To further improve the compliance score, the IPC link nurse was overseeing morning and end of day checks, so areas of concern could be narrowed down to particular staff members, and those staff members would be given additional training. During our inspection we found no concerns in relation to sharps and waste management.
- The IPC link nurse had a section in the monthly team meetings and we viewed meeting minutes of June 2019 and saw the message of correct procedures for sharps disposal was mentioned.
- On observations of patients care, we saw staff adhere to good IPC practices. Staff used hand gel and washed their hands before, and after every episode of patient care. We observed staff wearing personal protective equipment (PPE) of clean uniform, gloves, and were 'bare below' the elbows. Those staff who worked in the treatment room wore a disposable apron before any surgical treatments. There was a plentiful supply of PPE equipment throughout the centre which was easily accessible to staff.
- The service had wipe clean recliner patient chairs and this was an improvement since our last inspection. Throughout the centre we observed 'I am clean' stickers which had been placed on all equipment which had been cleaned and ready for use.
- Medical equipment and instruments were a mixture of single use and reusable items. Reusable items were sent to an external company for decontamination and sterilisation. Contaminated equipment was stored in dedicated secured containers and collected on a weekly basis. There was a system where instruments could be tracked and traced.
- A housekeeping service was in operation on a daily basis, in the morning and throughout the day. The clinical services matron was in the process of negotiating a change in rotas to include housekeeping cleaning at the end of the day. A housekeeping audit was completed internally bimonthly, and a monthly audit was completed by the contracted external company, with a deep clean completed every six months. The service conducted their own housekeeping audit and the most recent audit score was 69%. They identified areas of concern, such as dust in some of the consultation rooms. As a result, the service were now meeting with the external contractor to have more oversight and engagement.

- Pregnancy remains following surgical termination were individually packaged, labelled and stored in a freezer before collection, which took place three times a week in accordance with local policy. Records were kept which gave details on when the remains and been stored and collected.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- During the inspection, we found stickers on the general anaesthetic equipment indicating a service had been due in March 2019. We brought this to the attention of the operations manager. They immediately cancelled the following days surgical treatment list and a lead engineer attended and serviced the machine. There were no faults and the machine passed the safety checks. As a future precaution the operations manager set reminders in the system, so they would alerted when equipment was due a service date.
- In line with national guidance anaesthetic machines are required to be serviced on an annual basis. MSI had implemented a six monthly review and whilst the six month check was missed, the equipment was still within the acceptable servicing time frame. There had been no patient safety related incidents. All other equipment had been serviced and calibrated.
- We found not all anaesthetists had been logging their safety checks of the anaesthetic machine at the start of the day. We raised this to the attention of the operations manager who confirmed that they were aware of the issue and had raised this in previous meetings with the anaesthetists. We were told, as part of the daily morning safety huddle meeting; all staff were asked to confirm they had completed their relevant safety checks and all anaesthetists had confirmed they had. As part of a further safety assurance check, registered nurses made a daily check, to ensure the anaesthetists had signed and dated the log book. We visited the centre a week after this had been implemented and found anaesthetists had made the appropriate checks and recorded these as expected. On an organisational level, the lead anaesthetist had communicated to all centres to remind anaesthetists to log their daily checks.
- The entrance to the service was secure with CCTV and buzzers to allow access and this was controlled by receptionists.
- There was one emergency resuscitation trolley and two emergency rucksacks within the centre and defibrillators were accessible to staff. All equipment was checked monthly, unless used in between and we saw these checks had been made.
- There were two haemorrhage kits in the centre and we saw the relevant safety checks had consistently been made.
- We saw suitable arrangements for the disposal of clinical waste. Waste was segregated into appropriate bins with different colour coding. The disposal and storage of hazardous waste was in line with national standards. Clinical waste was locked in sealed containers and collected on a weekly basis by an external specialist waste company.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- All patients completed an initial consultation by telephone or face to face. If by telephone this was followed by a pre-assessment at a centre. At first point of contact patients were given a pin number and set of security questions. All patients were assessed against MSUK pre-existing conditions (PEC) guidelines to determine a patient's eligibility for safe treatment. Any patients identified as not suitable for treatment were referred to the Right Care team.
- Staff completed comprehensive holistic risk assessments to determine a patient's suitability for treatment. During initial pre-assessment consultations, patients' blood pressure, full medical history and height and weight were recorded. Assessment tools such as an ultrasound scan helped confirm gestation and identify any areas of concern which required further medical support. Risk assessments included a discussion on the reasons why the patient was requesting a termination and the different options available to them, such as counselling services.

Good

Termination of pregnancy

- Pre-operative assessments were completed before any surgical treatment. Surgeons and anaesthetists reviewed patient cases the day before treatment to ensure relevant clinical checks were in order and to identify any risks that may require further medical attention. For example, during our inspection the surgeon identified a patient who required further medical assessment, so the surgeon was able to make arrangements and speak to the patient before they were prepared for surgery.
- The centre had a service level agreement with an NHS hospital for the transfer of patients. This agreement had recently been updated and reviewed in June 2019. There had been nine patients transferred between the dates of April 2018 to March 2019, which equated to an emergency transfer rate of 0.08%.
- During our inspection, we observed a staff member refer a patient to an NHS hospital due to complications they identified during the assessment and this was in accordance with the centre's pathway.
- The service used the World Health Organisation (WHO) and five steps to safer surgery checklist and we found this was fully embedded into the service. The WHO checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of perioperative care.
- On treatment days the lead nurse in the treatment room was responsible for managing and completing the WHO checklist. We observed the lead nurse take full control and lead the WHO through different stages of the patient's treatment.
- We reviewed records of patients who had surgical termination of pregnancy treatments and vasectomy treatments and found the WHO surgical checklist had been fully completed. Audits we reviewed from the past year showed staff were consistently compliant with the WHO checklist with scores of 100%
- Staff had a good knowledge of escalation procedures and what to do in the event of a deteriorating patient. Staff used the termination of pregnancy early warning scores (TEWS). This was a modified version of the early warning system which is a guide used to determine the degree of illness of a patient. All TEWS records we reviewed had been completed correctly. Staff were able to show and describe how they completed the TEWS and who they would escalate concerns to. The surgeon and anaesthetists stayed onsite until the last patient had been discharged.
- All registered nurses were trained in immediate life support, anaesthetics, and recovery and there was always a trained nurse who supported the anaesthetists in the treatment room. We observed a patient case where the nurse was able to support the airways of the patient who had general anaesthetic. The anaesthetist and nurse worked in unison to provide support to the patient.
- The service had detailed haemorrhage protocols in place. All staff had received training on what actions they needed to take in the event of patient haemorrhage. There were two haemorrhage kits within the centre and haemorrhage protocols were displayed throughout.
- Risks were explained to patients undertaking vasectomy procedures, such as, long term discomfort, excessive bleeding, swelling and that it was often an irreversible procedure.
- Staff had received sepsis training as part of their immediate life support training. Patients were given information on sepsis as part of their aftercare information and a 24 hour telephone line was available for patients to call. Staff told us of the scenario based sepsis training they had received at the centre and how beneficial the real life examples had been.
- Patients were asked if they had any allergies and we saw those patients who had, wore red wrist bands in the treatment room to alert staff they had an allergy. We observed the anaesthetist change the type of anaesthetic to suit a patient who had a nut allergy.
- A safety huddle took place every morning and we observed the huddle to be comprehensive with detailed information on each patient case and any risks that needed to be considered. The huddle clarified roles of responsibility for the day, for example, emergency role, airway role, transfer role. The huddle was well attended by staff including the surgeon and anaesthetist.
- Patients had a finger prick blood test to determine their rhesus status and blood group. Patients who had a

rhesus negative blood group were given an anti-D injection to help prevent any complications in future pregnancies. We observed a patient receiving an anti-D injection during our inspection.

- The home use of misoprostol in England was approved by the government from 1 January 2019. Staff completed appropriate assessments with women who chose to self-administer the second stage of the medication (misoprostol) at home to ensure it was safe to do so. This option was only offered to women up to nine weeks and six days gestation. The first stage of the medication was taken at the clinic.

Nursing staff

- **The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**
- Staffing and skills mix was planned following safe staffing guidance based on national guidelines including the Royal College of Nursing: Guidance on safe staffing levels in the UK (2017 and 2017) and The National Institute for Care and Health Excellence (NICE): Management and organisational approaches to safe nursing and midwifery staffing.
- A rota master system was implemented in late 2018. The system had information on staff skill levels, mix and competency. It was an automated system and the operations manager and clinical services matron were able to work in conjunction with the capacity team. This meant there was more oversight and empowerment to manage the staffing levels of the service at a local level. There was also a failsafe built into the system, for example if staff were not up to date with their disclosure and barring service (DBS) checks, the system would not allow the staff member to be booked onto a shift. Every centre had a rota master champion.
- At the time of our inspection 16 registered nurses were employed with one current registered nurse vacancy. Agency staff were kept to a minimum, but if required, regular nurses who had worked at the centre over a number of years were used. Agencies that supplied clinical workers to MSUK were required to operate under bespoke terms of business and service level agreements. An induction checklist was completed prior to a shift.
- Staff we spoke with during the inspection said the biggest change they had experienced over the past year, was that staffing levels had increased. In the treatment room there were one or two registered nurses and a health care assistant. On the day of our inspection there was a second registered nurse undergoing training.
- In addition, there were two clinical team leaders who were supernumerary and could step into help the service run smoothly if consultations overran. A float nurse was also available to cover for sickness, leave and again if the service was experiencing periods of extreme pressures.
- A clinical safety huddle was completed each morning, where staff duties were allocated to each staff member and any issues could be raised.
- Registered nurses rotated between the main centre and the early medical unit satellite locations.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.**
- Surgeons who worked within the centre were employed by MSUK. Additionally, the service employed remote doctors who completed the relevant checks before signing HSA1 forms and prescribed medication. The medical director managed the doctors. A HSA1 form is a legal document to allow a termination of pregnancy to be performed and is signed by two medical doctors.)
- Anaesthetists were employed on a sessional basis and the clinical director for anaesthetist's for MSUK had overall oversight.
- The relevant employment checks which included, registration, insurance, qualifications, disclosure and barring service and revalidation checks were completed centrally.

- At the time of our inspection there were no vacancies for medical staff.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Patient records were a mixture of paper and electronic. We viewed in total 35 records, both paper and electronic and they consisted of a variety of treatments ranging from medical and surgical terminations and included vasectomy treatments. All records were consistently completed, legible and dated at different stages throughout the patient's journey.
- Records contained information on the patient's whole treatment journey from initial consultation, pre-assessment checks, medical notes, observation charts, medications and discharge information.
- Records of those patients who underwent surgical termination treatment included the World Health Organisation (WHO) and five steps to safer surgery checklist, pre-operative assessments and post-operative information.
- Electronic patient records were security password protected and paper records were kept securely behind the nurse's station desk.
- During all consultations we observed, discussion took place on whether the patients treatment information could be shared with the patients GP. However, this was always with the patients consent and we found women were always given the option.

Medicines

- **The service used systems and processes to safely prescribe, administer, and store medicines.** However, the service did not always record stock levels for medicines such as mifepristone and misoprostol**.**
- There was a good system of medicine management and optimisation. The role of medicines safety officer was brought in-house following a review from March 2019. The clinical director was now the medicines safety officer.
- Staff told us that access to the medication safety officer was easy and they had recently gained support from them on an issue regarding medication stored at room temperature.
- The service used abortifacient medicines to induce medical termination. These were prescribed by one of the doctors completing the HSA1 form. Nurses then administered these medicines to patients as directed. We found staff followed the relevant legislation and current national guidance when administering medication.
- The centre used controlled drugs (CD) and nursing staff were aware of the organisations policies on administration of controlled drugs. We found CD's were stored in line with recommended legislation and all recordings were entered in a CD register and signed by two registered nurses. CD stock levels were accurate, and the medicines were in date. The lead nurse in the treatment room kept the keys for the CD cupboard. A special request form was used to order CD's and could only be signed and authorised by specific doctors.
- The organisation completed monthly CD audits and from November 2018 to July 2019 the centre consistently scored 100% in their CD audit checks.
- Medicine ordering, stock level checks and checks for expired medications were completed by a registered nurse who had supernumery days to undertake the tasks. We reviewed the treatment rooms checklist for expired drugs and found they had been verified and signed. The registered nurse who had responsibility for ordering and checking medicine levels had help from another registered nurse when completing the checks.
- Stock ordering of medicines was through a central ordering system and expired medicines were placed in a denaturing kit kept within the locked clinical waste area.
- Fridge temperature logs were completed daily to ensure medication was stored correctly. Records showed checks had been consistently completed.
- Human immunodeficiency viruses (HIV) test kits were tested for quality control batch numbers and these were kept in a freezer and appropriate logs and checks had been completed.

- Medicines were couriered to the early medical unit satellite clinics and the main centre in sealed stored containers.
- Medicine audits were completed every two months. From audits we reviewed, over the past 12 months the compliance rate averaged 87% and upwards. The service monitored medicine incidents which were reported electronically. The centre had recently changed their practice following an incident relating to missed Anti-D medication. Following lessons learnt and to ensure Anti-D was not missed, the centre had implemented a failsafe check system that all patients were checked for rhesus status and administration of Ant-D medication in the recovery room and a second check by the nurses in the day room prior to the patient leaving the centre. A checklist was implemented in the centre to ensure, where appropriate, patients having medical abortions were prescribed Anti-D.
- The service treated patients with prophylactic antibiotics to reduce the risk of uterine infection. We found doctors followed the correct protocols on records we reviewed.
- The government legalised/approved the home-use of misoprostol in England from 1 January 2019 for pregnancies that had not exceeded nine weeks and six days at the time mifepristone is taken. The centre had just recently started to offer patients this option, and at the time of our inspection were in the process of conducting an audit to follow up on the patient's experience. Results of this audit were still being processed at the time of inspection. At the consultations we observed we found the service was following the recommended guidelines. Women were given the first stage Mifepristone at the centre, and both verbal and written instructions were provided to women on the symptoms that maybe experienced and signs to look for before seeking urgent help.
- The misoprostol (for home administration) was supplied against a prescription and labelled appropriately. The labelling included the patients name, date of dispensing, name of the medicine, directions for use, precautions, and name and address of supplying pharmacy. In addition, women were given information on how to take the medication and patients records reflected whether the medication had been administered in clinic or been supplied as a take home pack.
- Medical safety alerts were presented in the monthly team meetings. For example, the home use of misoprostol was presented at the meeting and staff had to sign a standard operating procedure once they had read and understood all the information.
- Patients allergy status were clearly recorded on all prescribing documents used.
- There was no record of stock levels for medicines such as mifepristone and misoprostol. Therefore, it would not be possible to check if there were discrepancies in stock levels. However, the service was taking action to address this. At the time of our inspection the risk had been placed on the corporate risk register.

Incidents

- **The service managed patient safety incidents well. Staff recognised and reported incidents and near misses**.
- There was a good incident reporting culture within the centre. Staff reported incidents through an electronic system.
- Once an incident was reported the electronic system sent an alert to the operations manager, clinical service matron and clinical team leader. They investigated the incident recorded the findings and documented any lessons learnt. Lessons identified were shared with staff via the electronic system and in monthly staff meetings. Incidents and lessons learnt were discussed at weekly complaints, litigation, incident and patient feedback (CLIP) calls.
- At the point where the incident was reported, an alert was also sent to the corporate specialist lead, so they were aware and could provide immediate support to the investigating manager.
- The operations manager had received training in root cause analysis as a method for investigating incidents. This was an improvement since our last inspection.
- In the last 12 months there were no never events reported and no serious incidents reported. Never events are serious incidents that are entirely

preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

- The centre operations manager was able to provide information on the escalation process with serious incidents and the actions they would take. They would report the incidents on the electronic incident reporting system and inform the head of governance, regional manager nursing director, and clinical director. A root cause analysis investigation approach was taken, and the operations manager said the support and guidance from the senior team was good.
- 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. There was information displayed on the duty of candour in the main reception of the centre and the duty of candour was monitored through the south London integrated governance dashboard. From January 2019 to July 2019 there had been one incident where the duty of candour was applied.
- Incidents were categorised according to severity and in the last six months there had been 202 incidents reported that were no harm, 55 incidents reported as low harm and three reported as moderate harm. There had been no incidents reported as severe.
- Staff were able to provide examples of lessons learnt and changes made to practice from incidents reported. For example, due to missed allergy checks during the consultation stage a patient was unable to proceed with treatment on the day, as the allergy status had not been identified. As an action, registered nurses completed additional checks on consultation reviews on a daily basis.

Safety Thermometer

- **The service used monitoring results well to improve safety.**
- A local integrated governance dashboard was updated every month. Information collected included safety information which could be shared with staff, such as infections, transfers to hospitals and other complications.
- Staff completed a patient's venous thromboembolism (VTE) assessment on all records we viewed. In the past year the service had completed 7695 VTE assessments for those patients who underwent surgical abortions.

Are termination of pregnancy services effective?

Good

We rated it as **good.**

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice.**
- The service used best available evidence and guidance to support patient treatment and adhere to good outcomes.
- Policies we reviewed had been updated, were in date and followed professional guidelines such as National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG) Department of Health Required Standard Operating Procedures (RSOP) and The Data Protection Act 2018. We reviewed policies such as the deteriorating patient policy and records management and retention policy.
- An up to date standard operating procedure for misoprostol at home had recently been signed and dated by all clinical staff.
- At a local level, there were systems to monitor patient outcomes, such as failure rates, complaints, patient experience and prevention of infections and complications. This was in line with RSOP 16 'Performance standards and audit'.
- The centre screened patients for sexually transmitted infections and offered contraceptive options during assessments and consultations. This was in accordance with RCOG and RSOP 13 'Contraception and sexually transmitted infection (STI) screening'. This states a

woman should be offered testing for STI and all methods of contraception including long acting reversible contraception (LARC) immediately after abortion. We observed different stages throughout patient's pathway of treatment and found these options were offered to all patients.

- The service followed RSOP 14: 'Counselling guidance'. All patients were offered counselling services pre and post treatment and those patients under the age of 16 years of age were required to have a counselling appointment on a day prior to their treatment.
- There were set protocols to make sure patients received appropriate cervical preparation. A patients age and gestational period along with a series of questions were asked at consultation stage to determine whether cervical preparation was required.
- Patients physical, mental health and social needs were holistically assessed, and we saw evidence of these assessments in all patient records we reviewed.
- The Management of Fetal Tissue Policy was in line with The Human Tissue Authority 2009 Code of practice 5: disposal of human tissue HTA London. We found patients were provided with information about disposal of pregnancy remains, so they could make a choice before treatment began.
- Patients were provided with a discharge information pack, which contained details of possible complications and a 24 hour telephone number they could contact to seek support and guidance, included in the guidance was information on sepsis symptoms and when to seek help.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**
- Prior to receiving anaesthetic, patients were given information on fasting and fluids. They were told not to eat for up to six hours before their appointment and to drink clear fluids up to two hours before their appointment. We observed staff ask patients whether they had eaten at different stages during their surgical pathway.
- Patients were offered water, hot drinks and biscuits after they had received treatment.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way**.
- Staff assessed patients pain using a standard pain assessment tool and by asking patients if they were in pain. This was in line with Royal College of Obstetricians and Gynaecologists guidelines.The pain tool enabled staff to measure a patient's pain level by scoring 0 to 10 with 10 being the highest pain score.
- During our observations we saw staff attend to patient's pain needs by offering pain relief such as non-steroidal anti-inflammatory medication. They also offered patients warming pads to help ease pain.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment.** They used the findings to make improvements and achieved good outcomes for patients.
- RSOP16 states that outcomes of patients care, and treatment are routinely collected and that the service should have clear, locally agreed standards against which performance can be audited, with focus on outcomes. The service had systems to measure and monitor patient outcomes in accordance with this.
- The service monitored treatment pathways audits in key areas, through a dashboard which could be compared against other MSI locations. A weekly complaints litigation incident and patient feedback (CLIP) meeting was held and quarterly local integrated governance meeting (LIGM) were held to discuss patient outcome and findings from routine completed audits. Regional managers offered targeted support to those centres who were continually underperforming or going through a period of non-compliance.

Good

Termination of pregnancy

- From January 2019 to June 2019 the centre and its early medical units had undertaken 2985 medical terminations. The main centre had undertaken 1440 surgical termination of pregnancy procedures and 54 vasectomy treatments.
- In the same period there were 39 incidences of retained products of conception for early medical abortions and 34 incidences of early medical terminations with continuous pregnancies. For surgical terminations there were four incidences of retained products of conception and no incidences of continued pregnancy. There were no failed vasectomy outcomes. The failure rate for medical and surgical termination was below the providers target of two percent.
- In the same period there were three emergency transfers to an NHS hospital.
- The service monitored numbers of patients who did not proceed with treatment. Year to date results showed that on average 15% of patients did not procced with medical termination and on average 15% for surgical treatment. The service monitored the reasons why patients did not proceed, and these ranged from gestation too high, unsuitability to treat and referral to NHS as medical history was too acute.
- The service offered long acting reversible contraception (LARC) and had a steady uptake rate of 30% which was in line with other locations. LARC is a method of birth control which provides effective contraception for an extended period without user actions. The service was working towards a higher rate by training more nurses in giving implants. At present all registered nursing staff were trained to administer Depo-Provera (injection). Seven members of staff were competent in fitting implants and the service had introduced a lead at the centre to promote LARC including actively counselling patients. The service ran on average two dedicated LARC clinics per week.
- Staff used and had the availability of pathways to specialist services for women with significant medical conditions.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff work performance and held one-to-one meetings with them to provide support and encourage development.**
- Staff received annual appraisals and information we reviewed showed 100% of staff had received one. Staff told us they found the appraisal system effective and meaningful. Development opportunities, training needs and supportive systems were discussed, and staff said they had the opportunity to have open frank conversations with their manager. Staff also had one to one meeting with their manager every six to eight weeks.
- Staff reported, they received a comprehensive induction, covering both the service at a corporate level and their local area of work. Nursing staff were assessed on clinical competencies which were completed every four, eight and twelve weeks. Competencies were signed off by a senior member of staff. We spoke with a staff member who was completing their induction and they told us the training, mentoring and support was by far the best they had received.
- Poor or variable performance was managed through one to one session with training and set goals and initiatives put in place.
- All registered nurses had received immediate life support (ILS) training and on surgical treatment days a designated nurse was assigned to specifically support the anaesthetist during anaesthetic procedures.
- Nursing staff received specific ultrasound scanning training and attended an external two day course at a university. The course consisted of one day of lectures and the second day of practised skills. Staff were then assessed for six months, which included a minimum of 120 practice hours of scanning and staff had to submit four individual pieces of work. A final assessment was undertaken by the university. Staff then completed a transitional period of eight to 12 weeks where they were supported by a mentor. Staff competencies were assessed every two years.
- Clinical team leaders were in the process of attending a leadership management course and the clinical services matron was booked on anaesthetic and recovery (A&R) training.

Good

Termination of pregnancy

- There were seven long acting reversible contraceptive (LARC) trained nurses at the centre which was an improvement since our last inspection. The centre had a trained contraceptive and sexual health (CASH) champion.
- Nursing revalidation was monitored by the service's central human resources team and notifications were sent to the senior managers at the centre. Disclosing and barring service (DBS) renewal alerts were also sent. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.
- Staff were provided with in-depth haemorrhaging training which had started at the centre through a clinical team leader who was now an educator within the organisation. Part of the clinical induction involved two days face to face training. Two staff members were in the process of completing a train the trainer course to become haemorrhaging champions, so they could deliver refresher training internally.
- Scenario based training was often used and staff told us of examples such as, training on how to assist patients living with a mental health condition. The training included who could be contacted and how to support the patient.
- Many staff had developed through the organisation. The clinical team leaders had been registered nurses when they had started within the centre.
- The infection prevention and control (IPC) link nurse had received support in attending external conferences and courses related to this area.
- During the last year the organisation had developed a dedicated team of clinical educators to provide inhouse training. We were told the impact of the clinical educators had been significant, for example, since the haemorrhage workshop was introduced in mid 2017 there has been a downward trend in post abortion haemorrhage rates. We saw evidence of the downward trend in haemorrhage rates both locally at South London and as a whole organisation. For example, since 2018 to 2019 the haemorrhage rates for the organisation had fallen from 29 patients to 11 patients.
- The in-house clinical educator's future plans included upskilling health care assistants to BTEC Level 3, having student placements and supporting colleagues to train as nursing associates.
- MSI One Call which was a 24 hour, seven day a week aftercare telephone line where patients could speak to a member of staff for advice and support had access to staff members, such as qualified professional counsellors and qualified medical professionals.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- During our inspection, we saw strong multidisciplinary working and staff attended morning huddles where the surgical list for that day was discussed. All staff contributed to the meeting and were able to raise concerns or comment on individual cases.
- We observed good working relationships and teamwork between nurses and medical staff. In the treatment room, there was a good rapport with all staff members and the team discussed all patient's treatment plans as well as their emotional wellbeing.
- There was good interaction between each stage of the patient's pathway. For example, staff provided a handover of the patient's treatment from the treatment room to recovery room and then onto the day room. There were clear lines of accountability and each staff member knew their role and responsibilities.
- The centre had good external partnerships and working relationships, for example with the local authority for safeguarding referrals and NHS hospital when patients were transferred. There were good relationships with the clinical commissioning groups (CCGs).
- If a patient consented to their GP being informed of their treatment, the service sent the patients treatment notes to the GP and on occasions spoke to the patients GP if it related to a medical issue with regards to their treatment.

Seven-day services

Good

Termination of pregnancy

- **There was suitable provision of services at all times to ensure care and treatment delivery and supporting achievement of the best outcomes for patients.**
- MSI South London opened six days a week Monday to Saturday. Surgical lists took place five days a week and the early medical units were available Monday to Friday.
- A doctor and anaesthetist were onsite Monday to Friday and on Saturdays the service ran an early medical termination list and had an on-call doctor to contact.
- Patients could contact MSI One Call 24 hours a day, seven days a week service, for advice and support from clinically trained staff.

Health promotion

- **Health promotion information was available.**
- Patients were provided with advice on contraception and sexually transmitted infections (STI). Patients were offered the choice to be tested for STI tests such as chlamydia and human immunodeficiency virus (HIV).
- There was a variety of health promotional leaflets and booklets giving information on how to protect from infection, guide on anti-D prophylaxis and guides on choosing the best methods of contraception.

Consent and Mental Capacity Act

- **Staff we spoke with were aware of their responsibilities for obtaining consent for treatment and their roles and responsibilities under the Mental Capacity Act 2005 (MCA).**
- During our observation we saw staff obtained consent at several stages of the patient's treatment journey. During initial consultations, staff fully explained the procedures and risks of treatment, so they were enabled to make an informed decision. From all the records we reviewed signed consent had been obtained.
- Staff gained further verbal consent in the treatment room. Patients were asked to confirm if they understood the treatment they were due to have and to verbally confirm that this was their final decision.
- Staff fully understood Fraser and Gillick competencies. Gillick competence is concerned with determining a child's capacity to consent and Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment. Staff we spoke with understood the principles and that they applied when obtaining consent for patients, under the age of 16.
- Staff used a proforma for mental capacity assessment and making a decision on the patient's best interest. The proforma enabled staff to make assessments and refer to different pathways if required.
- Mental health first aiders had recently been introduced into the centre. Two clinical staff had completed a two day course which enabled them to offer advice and referral information for additional support.
- We viewed one patient record where the service did not proceed with treatment as the patient had mental health concerns and further medical conditions, and additional information was required. The staff were not assured the patient fully understood the options available and, therefore, the patient was referred to the Right Care team for an onward referral to the NHS to ensure they received appropriate support. This showed staff demonstrated a good understanding of consent procedures.
- The centre conducted informed consent audits and information we reviewed showed staff consistently scored 100%.

Are termination of pregnancy services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff showed compassion, empathy and treated patients with dignity and respect. Patients we spoke with commented: "Staff have been very kind to me", and "They have been patient and have not rushed me". One patient told us staff had been kind and supportive when she got emotional.

- Staff were non-judgmental and treated all patients in a professional manner.
- Patients privacy and dignity was respected. Those patients undergoing surgical treatment were covered with a blanket after treatment and while they were being transported to the recovery day room. In the day room patients were provided with a further blanket if required and a privacy screen was available if patients wanted more privacy.
- All consultation rooms had signs displayed when they were in use, so staff knew not to enter.
- We reviewed a patient feedback report from January 2019 to March 2019 and results showed that 98% of patients felt they had been treated with dignity and respect and professionalism, and competence of staff scored 94%.
- We observed a nurse being reassuring, kind and sensitive to a patient who had to be referred to an NHS hospital.
- Patients had a private room to change and wait prior to surgical treatment.
- We observed staff building a rapport with patients to make them feel at ease. For those patients who were upset staff were kind reassuring and offered sensitive support.
- Other satisfaction scores from the patient feedback report showed the overall care score was 95%. The way patient were greeted by reception staff was 91%, and the time and attention given to patients was 89%.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** They understood patients' personal and cultural needs.
- We saw staff supporting patients who were upset. Before surgical treatment, we saw staff support a patient who became upset in the treatment room. The patient was guided into another room by a nurse who sat with them and gave them reassuring support. At no time was the patient rushed into making a decision.
- Nurses in the treatment room made patients feel relaxed and calm. They regularly checked to see if patients were comfortable before and during treatment. They reassured patients, for example, telling the patient to take deep breaths when they were anxious.
- Counselling services were offered to all patients and a counsellor was employed to offer face to face services twice a week at the centre. There was access to a 24 hour helpline and post termination counselling services.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients to make decisions about their care and treatment.**
- Staff communicated with patient's and ensured they understood their care and treatment by asking them if they were clear and understood the procedure they were having. Staff did not rush patients into decisions and supplied in-depth non-technical information, so patients could make an informed decision.
- During our observations, staff explained and documented that a discussion had taken place on the disposal of pregnancy remains, in that patients were made aware of what their choices were when following this pathway.
- An aftercare booklet was given to all patients which gave informative instructions and contact details of the 24 hour advice telephone line.
- Throughout the inspection, staff of all levels worked together to support patients when making decisions about their care and treatment. We observed the surgeon take a patient into a private room to explain why they were unable to proceed with treatment and to provide the patient with options on their care.
- The anaesthetist worked with staff and the patient when a different type of anaesthetic had to be used due to the patient's allergy status. The patient was given the information and informed that they would take longer to recover.
- Women who chose the option of taking misoprostol at home were provided with a booklet of information, on how to administer the medication and who to contact if they required further assistance. We observed

consultations where staff explained clearly the steps women needed to follow when taking misoprostol at home and women were given the opportunity to ask questions throughout their consultation.

Are termination of pregnancy services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Facilities at the centre included five consultation rooms, one treatment room, a recovery area and day room with 13 reclining chairs, three of which were in a private room.
- The centre was open six days a week Monday to Saturday from 7.30 am to 17.00. Surgical lists took place Monday to Friday and a vasectomy list took place every other month. There were six early medical satellite units, and these were open throughout the week, from Monday to Friday, where consultations and early medical terminations were offered to patients up to nine weeks and six days gestation.
- Appointments for the centre were booked through the MSI UK One Call system, where patients were given choice of an appropriate location to suit their treatment options dependant on gestation and medical assessment. A text was sent to patients with the appointment time, location and date of their appointment.
- The service held quarterly meetings with the Clinical Commissioning Groups (CCG) to discuss contracts and service data.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Throughout the centre patients had access to a range of information from leaflets offering advice and guidance on contraception methods to information on sexually transmitted infections.
- Patients could gain access to either telephone or face to face interpreters. We observed an interpreter accompany a patient during a consultation to explain treatment options and explain medical terminology.
- The centre was in the process of placing a dashboard in reception which would give patients an estimated time of their appointment. This would allow the patient a little more freedom to manage their time. The patient's identification would be displayed as a pin number for confidentiality purposes.
- Wheelchair users were able to access the service and all consultations rooms, and the treatment room were based on the ground floor. The first floor day room area could be accessed by a lift and wheelchairs were available to assist those patients who required them.
- The service assessed each patients case on an individual basis and those patients with learning disabilities and who required additional help were supported by an extra member of staff.
- Pre-existing conditions' (PEC) guidelines were followed by staff when making assessments and decision making on whether patients were safe to be treated within MS UK Centres, or required onward referral to the NHS. The guidance provided pathway options for those patients who were not suitable for treatment and required specialist support.
- Patients were provided with options on the disposal of pregnancy remains and we found the centre followed guidance on the treatment pathway in a sensitive manner. Staff made sure patients understood the options and gave time for them to answer questions.
- Screens were available for those patients who wanted more privacy, however staff told us on the whole, the majority of patients preferred not to. During our inspection we observed most patients had built up a rapport with the person next to them.

- The day room had a separate private room with three reclining chairs and these were often provided to late gestation stage patients. A television and magazines were provided in the room.
- The centre had changed the chairs in the reception area, and patients now had individual seats, which meant more privacy and dignity.
- During our visit to the Croydon early medical unit satellite site, we found the arrangements for patients to notify the nurse they were waiting in reception were unsatisfactory. Patients were asked to knock on the consulting room door and then wait in reception, until the nurse collected them. However, this meant patients were knocking during consultation visits and there were occasions when this disturbed the flow of conversation between the nurse and patient in the consulting room. We fed this back to the service and they told us they would be engaging with the health centre to find a better system.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- Patients could access the service through general practitioners, self-referral or a family planning service. Contact could be made either by telephone, e-mail or text.
- The centre could react quickly to increased demand by adjusting list structures or adding extra lists at very short notice. The centre was supported by a team in One Call, as well as administration staff in the centre. For example, the centre could see if a surgical list was not required on a day and convert this to a medical list. The clinical services matron, operations manager and clinical team leaders met weekly in the form of a 'management huddle' to discuss diaries, rotas and any issues arising.
- Appointment times were dependent on each patient case, the minimum appointment time was 20 minutes, and this could be extended to 45 minutes if needed. A clinical team leader was able to step in and assist with other patients if the list overran.
- The centre had reduced the patient list by approximately one patient a day to enable staff to complete administrative duties and reduce the pressure on staff. The centre could flex the use of its linked early medical units and main centre to ensure the needs of the current activity levels were met.
- Surgical list structures were pre-planned, and surgeons went through the list the day before to make sure all patients could be seen, and no additional medical assessments were needed. This helped with reducing 'do not proceed' on the day of treatment.
- We visited the Croydon early medical unit satellite location. We were told the patient list often overran as patients turned up late for an appointment and were allowed a ten minute allowance to do so. We were told that the One Call centre often told patients they were allowed to overrun by 20 minutes, but the impact this had on the early medical unit was significant. At the time of our inspection the list overran into the nurse's lunch break.
- The centre monitored waiting times through a central capacity team. There were daily operational 'GRIP' conference calls to discuss patient demand across MSUK where resources were allocated to meet the differing demands and any issues could be escalated. There was a weekly operational 'GRIP' report which highlighted next available appointment times, do not attend and do not proceed rates, capacity requirements (through empty slot analysis) and clinic cancellations. This meant lists could be adjusted and additional appointments could be added.
- As far as possible the provider made sure the total of time from access to treatment was no longer than 10 working days. RSOP11 requires patients should be able to access an appointment within five working days of referral and should be offered a termination within five working days of making the decision to proceed. There was scrutiny and oversight of appointments required and appointment slots available at each centre.
- At MSUK South London for the past three months, the average wait times for next available appointment were, for, medical terminations two to three working days. For pre-assessment the average wait was five working days and for patients under the age of 14, four working days. For patients aged 14 to 19, the average wait was six working days and patients over 19 years of age the average wait was seven working days.

Good

Termination of pregnancy

- We received data on the percentage of patients who waited longer than 10 days for decision to proceed up to termination of pregnancy. From August 2018 to July 2019, 18% of women had their consultation and treatment completed on the same day. From the percentage, 67% of women received treatment within 10 days from point of contact as per the RSOP 11 guidelines. Of the 33% who waited longer than 10 days approximately 16% were for medical termination and 17% for surgical termination. The service received a weekly corporate report with the current waiting times and current number of patients awaiting appointments. Data we reviewed for the month of July 2019 showed the longest wait for an appointment from point of contact was eight working days, but this was for later gestations of 14 weeks and six days or over, and this was for one week only.The centre had the advantage of opening on Sundays if they needed to. The service monitored the reasons why women waited longer than 10 days but did not see any evidence of this. We were told by staff; some women may have chosen to be treated at a different unit or needed extra time in which to decide about whether to proceed to abortion or continue the pregnancy.
- The centre monitored patients who Did Not Attend (DNA) and we found over the past four months from April 2019 to July 2019 the percentage of medical termination patients who DNA averaged 7% and surgical termination patients averaged 10%. The number of patients who did not proceed over the same period of time averaged 13% for medical terminations and 13% for surgical terminations.
- Reasons for do not proceed rates were highlighted in in the weekly GRIP report, such as patient ambivalence, gestation too high for list and unsuitable to treat as too early – rebook.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**
- Patients were encouraged to raise concerns and complaints. Patients were informed about how they could make a complaint in the abortion care booklet provided to them when they attended the centre. 'Giving us your feedback' posters were located around the centre. Formal and informal complaints were logged on the electronic reporting system, complaints module. Formal complaints were managed by MSUK head of customer care who investigated the complaint by liaising with the centre managers. They provided the patient with written acknowledgment of the complaint and findings of the investigation. Any lessons learned, and actions taken were assigned to the managers.
- All complaints received were responded to within 20 days which was in line with the service's complaints policy which states complaints should be responded to within 20 days.
- Informal complaints were managed by local managers. Any trends and lessons learnt were reviewed by centre team managers and at the local integrated governance meetings.
- We were given an example of a change made as a result of a complaint received at the centre. The complaint related to pregnancy remains and the arrangements for collection. Action taken involved increasing the governance arrangements with the external contractor for collection and disposal of pregnancy remains.

Are termination of pregnancy services well-led?

Good

We rated it as **good.**

Leadership

- **Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- The centre and the six early medical satellite clinics were managed by the operations manager and clinical

services matron. Functions were now split operationally and clinically, which meant there was more oversight and responsibility for each area. The operations manager was also the registered manager.

- The clinical services matron managed the clinical staff, registered nurses, midwives and healthcare assistants. They managed staff at the early medical unit satellite clinics. The operations manager had responsibility of the operations team leader, clinic controller and front of house and maintenance staff. Both managers interacted together and staff at the early medical unit satellite clinics could get access to the operations manager if they wanted to.
- The operations manager and clinical services matron had control over the centre and were supported by a regional manager who reported to the MSI corporate operations director, as well as a HR partner, governance partner and finance partner. The operations manager and clinical services matron said they were able to contribute and drive change within the service. For example, they now had more scrutiny and management of the centres activity and were able to roster and match staff skills to the patient treatment list.
- Staff told of us the improvements in the leadership team, and how they could approach and discuss any concerns or issues or even put forward suggestions to help improve the service. Staff said they felt listened to.
- The centre held monthly meetings and on the majority of occasions staff from the early medical satellite clinics could attend. There were set agenda items and time for staff to raise concerns or give feedback on the good things that had happened.
- Staff told us there had been improvements with an increase in staffing levels especially within the treatment room and there was less pressure, as the service had allowed more time for staff to complete their administrative duties. Clinical team leaders were now able to support staff if their patient list was running overtime.
- Staff said managers were highly visible and approachable and the regional manager visited the centre at least twice a week and the head of governance at least once a week. The operations manager and clinical services matron told us how easily accessible the senior team were and how they could contact them to raise any concerns.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress**.
- The services vision and strategy were underpinned by a set of values: mission driven, patient centred, accountable and courageous. The operations manager and clinical services matron were committed to the corporate vision and strategy and staff we spoke with were aware of the organisations mission and were happy with the way in which the organisation was moving forward. The staff survey of 2018 showed 91% of staff understood the mission of MSUK.
- The organisation ensured all staff had the opportunity to participate in strategic decisions, for example, project management groups had been set up for two people from each centre to be involved in meetings and workshops regarding the new customer service system.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff spoke positively about the service and we found an open enthusiastic and team supportive culture across the service.
- Staff said they felt comfortable to raise concerns in an open and non-hostile environment. They told us the organisation was open to hearing new ideas and better ways of working. Most staff we spoke with said the

organisation had moved culturally to a care aspect rather than focussing on numbers. A great deal of work had been done to move towards offering patients individual care in a non-pressurised environment.

- There were regular monthly team meetings with set agenda items and staff said the meetings were non-hierarchical and there was opportunity for everyone to contribute. Staff said they felt the organisation was listening to them.
- The organisation had a lone working policy which was integrated into the main centre. There were panic alarms throughout the main centre and staff were provided with personal alarms when working in one of the early medical satellite clinics. However, at the time of our inspection the staff member working at the Croydon early medical unit satellite clinic had not received one, but we were told the service were in the process of organising one. The Croydon early medical unit satellite centre was based within a large health care centre and was not in isolation.

Governance

- **Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The organisation had governance and management systems in place and they interacted effectively to provide assurance and service improvements. Staff were clear about their roles and responsibilities and what they were accountable for.
- Staff were clear on the governance arrangements and said they were more embedded since our last inspection. For example, information was shared across the service on audit results and operational performance.
- There was regular communication and assurance from the executive team. In June 2017 the complaints litigation, incident and patient feedback (CLIP) meetings were implemented on a weekly basis. The purpose of the meeting was to provide a contemporaneous organisational overview of all complaints, litigation and incidents and to ensure patient feedback received the correct investigation and actions taken. The CLIP meeting also identified emerging trends and risks and incident learning was shared by centre managers.
- Clinical and non-clinical representation from each MSUK centre was required to join the meeting. In recent CLIP meetings themes such as continuing pregnancy, incomplete documentation and medication were reviewed. All CLIP meeting minutes were circulated to all staff and actions were logged.
- There were quarterly local integrated governance meetings (LIGM) and these reported into quarterly regional governance meetings. The LIGM was chaired by the regional manager and the operations manager and clinical services matron and clinical team leaders attended. Minutes we reviewed showed incidents, risks, safeguarding, compliance monitoring, service improvement and any other business was discussed. Actions taken or actions to be reviewed were also reported. The centre was benchmarked against other locations and information was fed into the regional integrated governance meetings.
- There were regular monthly team meetings held at the centre where local incidents, risks, training and learning was discussed. Minutes we reviewed showed a consistent agenda was set and discussed.
- From the end of June 2019 meeting we saw the top three incidents included labelling swab errors, in that the label machine was not working correctly. Staff were able to tell us the actions they had taken to rectify the problem.
- The medical director had oversight of surgeons and a lead anaesthetist's had oversight of anaesthetists. The operations manager and clinical services matron said they were easily accessible and could be contacted for support and guidance if required.
- The early medical unit satellite clinics were now governed locally by MSI South London, so there was better scrutiny and oversight on performance and risks. Staff were rotated to work in the main centre and the satellite clinics.
- The department of health licence was displayed in the main centre and the submission of HSA4 forms was completed electronically and sent to the Chief Medical

Officer (CMO) as recommended by the Department of Health. An HSA4 is the official notification of abortion and must be sent to the CMO within 14 days. The registered nurse completing the second stage of medical termination and the surgeon completing surgical termination were responsible for submitting the HSA4 forms in the system. The forms were sent within 14 days of the termination taking place. This was monitored by the operations manager on a weekly basis.

- Service level agreements with external services were regularly reviewed by the operations manager and clinical services matron. For example, the service level agreement for the transfer of patients to an NHS hospital had recently been ratified and the centre were in the process of arranging regular meetings for improved engagement and relationship.
- The service ensured staff followed protocols regarding delegation of duties in relation to medical terminations. Managers made sure staff were compliant with training, audited staff compliance with policies and procedures. Information and updates were shared in a variety of ways, through e-mails, team meetings, conference calls and notice boards.
- The service delivered care and treatment in accordance with the Abortion Act 1967. Patients were assessed for suitability for an abortion during the consultation stage by a registered nurse and health care assistant. The information was then sent electronically to two remote doctors for review. If the doctors were satisfied and happy to proceed they would both electronically sign the HSA1 form and the forms were kept three years from the date of termination. All records we viewed contained the signed HSA1 form, consent and safeguarding checks.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- The organisation had developed a compliance monitoring programme which was used to audit clinical and non-clinical practice, including infection prevention control (IPC), World Health Organisation (WHO) checklist, deteriorating patient, and fire emergency access. Any areas of non-compliance were noted in audits and discussed in local monthly meetings and the quarterly LIGM's. Results of audits were discussed with staff at monthly team meetings and information was displayed on the staff notice board. Improvement actions were recorded on a local service improvement plan and progress against actions reviewed. The centre was benchmarked against other MSI centres and this was reported at the regional integrated governance meetings.
- All staff were encouraged to identify risks. Risks were identified from incident trends and the outcomes from compliance monitoring tools. Risks were populated on the local risk register held on the electronic reporting system by the operations manager and clinical services matron. Risks could be treated, tolerated or transferred. Where a gap in control was identified, an action and timeframe was assigned to an individual through the electronic system. This allowed the managers to monitor and report on the progress of the action. We reviewed the risk register and found risks staff told us about were aligned with those on the risk register and there were current risk level controls and review dates were in place
- Risks were reviewed regularly dependent on the risk grading and were discussed in the monthly managers meeting and LIGM. The centres top three risks were discussed in team meetings and we were able to verify this from the meeting minutes we reviewed. There was also an 'Updates' folder which documents risks and was available to all staff.
- Following an inspection at another location inspectors found the checking of stock levels and discrepancies of mifepristone and misoprostol were not following the provider policy. Since the inspection the organisation had placed the issue on the corporate risk register and were in the process of taking actions.
- Safety huddles were held each morning and risks, incidents, and resources were discussed, and safety information was shared.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**
- There were good arrangements to ensure HSA4 forms were completed in accordance with The Abortion Regulations 1991 and submitted in a timely manner to the Chief Medical Officer.
- HSA4 forms were submitted electronically on the MSUK client record system or in paper form if the client was a non-UK resident or Northern Ireland resident. All registered nurses administering the second stage of medical abortion or the surgeon completing the surgical procedure were responsible for submitting the form.
- The MSUK corporate office received fortnightly reports from the Department of Health that highlighted any form submitted with errors or that had not been submitted or missed. This was fedback to the relevant staff.
- Quality and sustainability received equal coverage in all the CLIP and LIGM meeting minutes we reviewed.
- The service was in the process of transferring to a new client record system. Staff within the location were involved in the workshops and meetings to ensure there was good input from all staff who would be using the system.
- Information governance training was part of mandatory training and at the time of our inspection 93% of staff were compliant.
- Access to policies, procedures and safety alerts was electronic and easily accessible to all staff.
- Throughout the inspection staff who had to leave their computer screens ensured they were locked so private patient information was kept safe.

Engagement

- **Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Every patient was provided with a client satisfaction questionnaire which was anonymised. The completed satisfaction questionnaires were sent weekly to an external provider for analysis and urgent issues 'red alerts' were reported to local and regional managers within 24 hours. The red alert was logged on a local action plan and shared at team meetings and shared individually if required. We saw client satisfaction results were discussed at team meetings. Throughout the inspection we saw patients completing electronic feedback questionnaires.
- Staff told us staff involvement and engagement had much improved since our last inspection. Most staff said the organisation was making a concerted effort to ensure staff were involved in change and felt they were kept more up to date on progress and quality performance.
- A staff noticeboard supplied up to date information on trends and themes from clinical audits. Staff told us the monthly meetings were useful and provided a good opportunity for staff to raise any concerns but also share experiences of the previous month. Staff said they appreciated the changes the leadership team had made, and it felt more of an inclusive organisation.
- Staff at the early medical clinical satellite sites often worked alone. Most staff told us they were included in meetings and training opportunities. However, one staff member told us they sometimes felt excluded and this was fed back to the managers.
- The operations manager and clinical service matron spoke of how communications between the leadership team had improved. They said there was an open and honest support and communication flow between them. The leadership team were easy to access for support and guidance. Regular governance meetings meant consistency and provided quality and risk assurance at a local level.
- Team members were recognised for their commitment with monthly star awards, presented to team members as anonymised nominations from either their line manager or colleagues.
- Every colleague received a HR bulletin update weekly, with access to 'employee support' telephone line and online resources with everything from emotional, fitness, financial and mental health advice.

Learning, continuous improvement and innovation

Good

Termination of pregnancy

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**
- The centre strived to find ways of improving the quality of the service. They had recently engaged with a charitable organisation to gain their support and guidance with safeguarding incidents particularly in relation to domestic violence, which happened to be the top safeguarding incident reported at the centre.

Outstanding practice and areas for improvement

Outstanding practice

- The centre had begun to collaborate with an external charity which specialised in domestic violence to provide extra support and guidance for domestic violence safeguarding referrals. Domestic violence incidents were the most reported safeguarding referrals within the centre.

Areas for improvement

Action the provider SHOULD take to improve

- The service should keep a record of how much mifepristone and misoprostol were used per day to check discrepancies.
- Anaesthetists should make sure they log, sign and date their daily checks of anaesthetic machinery.
- The service should manage the dates of when their equipment needs servicing.
- The service should find ways of improving the current system when patients check in for their appointments at the Croydon early medical unit.
- The service should make sure staff at the Croydon early medical unit have enough time to complete consultations and treatment without running late.
- The service should find ways to continually improve their waiting lists, so patients do not wait longer than 10 days for decision to proceed up to termination of pregnancy.