Marie Stopes International

Quality Report

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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Marie Stopes International (UK) is operated by Marie Stopes International (MSI). MSI is a not for profit organisation that was founded in 1976 to provide a safe, legal abortion service following the Abortion Act1967. It performs in the region of 70,000 abortions (both medical and surgical) a year which is representative of around a third of abortions performed in England. MSI also provides a vasectomy service, family planning, sexually transmitted infection (STI) testing and screening.

The last unannounced inspection at provider level took place on 28 and 29 February 2017. Whilst improvements had been made since the initial provider inspection in July and August 2016, many processes were yet to start or were so new they needed to be embedded. Therefore, the impact of these measures on ensuring patients were protected from harm could not be determined. We remained concerned around the fragility of the leadership team, governance processes and oversight of risk and quality assurance.

Following this inspection, we undertook enforcement action and served a warning notice on 6 July 2017, at provider level, under Section 29 of the Health and Social Care Act 2008 in respect of Regulation 17: Good Governance.

We carried out a focussed announced inspection at provider level, on 21 November 2018 to follow up specifically on compliance with the 14 points of concern within the Section 29 warning notice. We found that the service had improved and adequate actions had been taken to meet the requirements of the Section 29 warning notice.

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.

CQC regulate termination of pregnancy service providers and from August 2018 have the legal duty to rate these services. Ratings are provided at location level. As this was a focussed follow up inspection at provider level there are no ratings attached to this inspection.

We found the following areas of improvement:

- Processes to monitor patient safety and risk had been strengthened and reporting systems had been embedded into practice across locations.
- Work had been undertaken to strengthen leadership across the organisation both at provider and location level.
- There had been improvements in compliance of mandatory training, safeguarding, infection prevention and control and equipment monitoring and reporting.
- The human resources (HR) structure had been revised and strengthened with several new appointments within the team. There had been a focus on staff recruitment, with positive results.
- Several initiatives were underway to improve staff engagement, leadership and accountability, recognition and motivation and training and development.
- The arrangements for governance and management of risks, issues and performance had been strengthened. Regional governance meetings were now embedded with standardised format and reporting procedures to improve consistency.
- Implementation of several digital systems had improved the data collection and analysis capability of the service with the aim to strengthen quality assurance and improve services.
- We had seen a positive impact on patient safety at location level. Safe had been rated as good in the three most recent MSUK location inspections undertaken between August and September 2018 (MSI Maidstone, MSI Manchester and MSI Essex). Processes had been established and inconsistencies between locations had reduced.

Summary of findings

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

- Continued changes of leadership, structure and processes had impacted on the pace of change. A sustained period of stability, at provider and location level, was not yet achieved.
- Revised governance process had not progressed significantly. There was no effective process in place to ensure recent changes had been reflected appropriately in policies, procedures and the organisation's Statement of Purpose.
- Assurance systems were weak, processes were not robust, data analysis was not fully quantifiable and there was limited check and challenge undertaken by the executive leadership team.
- Risk, issues and poor performance were not always dealt with appropriately or in a timely manner. Meeting minutes were of poor quality and recording of outcomes was not always accurate or specific.
- Whilst there had been improvements, the pace of progress in some areas remained slow. Many of the actions stated in the improvement action plan were not yet fully operational, and some were not due to begin until mid-2019.
- In two of the three most recent location inspections, MSI Manchester and MSI Essex in August and September 2018 respectively, well led was rated as requires improvement. The findings were reflective of those at provider level. Whilst governance frameworks were in place, they were not yet fully embedded and local oversight of risk was not fully effective. In both centres there had been changes in local leaders and registered managers.

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

Amanda Stanford
Deputy Chief Inspector of Hospitals

Summary of findings

Background to Marie Stopes International

Marie Stopes International (UK) is operated by Marie Stopes International. Marie Stopes International is a charity providing a range of reproductive healthcare services. Marie Stopes UK (MSUK) is a country programme within Marie Stopes International. MSUK has 12 registered locations in total; five centre locations in the South region, five in the North region, a vasectomy centre and a contact centre, MSI One Call. In addition, there are a number of early medical units (EMU) managed through the location centres.

The providers mission is to ensure the individual's right to have children by choice not chance.

MSI provides the following services across nine clinical locations; consultations, ultrasound scans, medical and surgical termination of pregnancy, and counselling for people who use the service. In addition, vasectomy, long acting reversible contraception and sexually transmitted infection (STI) testing and screening are offered.

The EMUs provide pregnancy testing, unplanned pregnancy consultations, medical termination of pregnancy, advice and provision on contraceptive options and STI screening and treatment.

MSI One Call is the main contact centre for all MSI services in the UK. It provides the following: centralised patient booking, telephone consultation pre-assessment, post procedure support and advice line and telephone counselling for patients attending any MSI clinics nationwide. MSI One Call is available 24 hours a day, seven days a week and is the first point of call for patients wishing to access any of the clinic services provided at any MSI location.

The provider is registered for the following regulated activities:

- Diagnostic and screening
- Family planning
- Surgical procedures
- Termination of pregnancy
- TDDI and
- Transport services, triage and medical advice provided remotely.

During our inspection, we visited the provider's office at Conway Mews, London. We spoke with nine members of staff including administration and support staff, training team administrations and senior managers. We reviewed the providers improvement action plan and multiple documents and supporting evidence provided in relation to aspects outlined within the Section 29 warning notice.

Our inspection team

The team that inspected the service comprised a CQC Head of Hospital Inspection, Fiona Allinson, a CQC Inspection Manager and one other CQC inspector.

How we carried out this inspection

Marie Stopes International is a charity providing a range of reproductive healthcare services. Marie Stopes UK (MSUK) is a country programme within Marie Stopes International.

Services are provided across multiple locations and include consultations, ultrasound scans, medical and surgical termination of pregnancy and counselling for people who use the service.

Summary of findings

Family planning services, including advice on contraceptive options, as well as male sterilisation (vasectomy) and sexually transmitted infection (STI) testing and screening are offered.

CQC regulate termination of pregnancy services and ratings are provided at location level.

As this was a focussed follow up inspection at provider level there are no ratings attached to this inspection.

Summary of findings

Our judgements about each of our five key questions

	Rating

Are services at this provider safe?

Are services safe?

- An electronic training platform had improved compliance with mandatory training. The system enabled in depth monitoring and analysis.
- Safeguarding training had been adapted to better reflect the services provided.
- Safeguarding training, Prevent training and appraisal compliance had improved.
- The Infection prevention and control (IPC) structure had been revised and strengthened and processes had improved.
- Policy and procedures relating to management of equipment had been reviewed, updated and implemented.
- The termination of pregnancy early warning score (TEWS) had been fully implemented across all locations in the organisation.
- Regular monitoring of the World Health Organisation (WHO) and five steps to safer surgery checklist was in place.
- Resuscitation scenario drills had been introduced and were delivered by a third-party provider.
- The electronic incident reporting system was fully embedded across the organisation.
- Duty of candour training had improved but remained below the provider target.

However, we also found the following areas that the provider needed to improve:

- Monitoring of serious incidents was not fully effective.
- Monitoring of clinical competencies happened at locations with limited oversight at provider level.
- The safeguarding children's assurance framework did not reflect latest national guidance.
- The duty of candour policy had not been updated in line with governance changes and committee restructures.
- The provider was not monitoring that duty of candour had been applied in a timely manner, within stipulated timeframes.

Are termination of pregnancy services safe?

Safe means the services protect you from abuse and avoidable harm.

Mandatory training

Summary of findings

In February 2017 monitoring of training compliance was not effective with variance across locations and job roles. There was a lack of oversight with nurse clinical competencies and in relation to anaesthetic and recovery training. Nursing appraisals were not being undertaken. Insufficient numbers of staff were trained in child sexual exploitation (CSE), female genital mutilation (FGM) and Prevent training (the aim of this training is to help stop vulnerable people from being exploited and drawn into terrorism).

- **The service had made improvements to mandatory training compliance, monitoring and reporting.** The provider had created a training needs analysis according to job role and launched an electronic training programme 'iLearn' on 1 April 2018. Staff had an individual log on, to enable access to courses applicable to their job role. Individuals could search and undertake additional training for their professional development. Bookings for face to face training as well as e-Learning could be made directly on the system. The system provided a 90-day forecast report to identify what training subjects were due to expire in the upcoming three months, which meant the training team could schedule appropriate courses in a timely manner. The training team informed us that bespoke packages could be created. For example, the team were looking to develop a training module in the use of the electronic incident reporting system.
- The system identified training that was pending, in progress or completed. An alert system identified when courses were overdue, at which point automatic reminder emails were generated. We viewed the system on site and found it was extremely responsive and could be filtered to various levels such as compliance overall, per region, location, subject, job role or individual employee. This provided oversight at executive board level, regional and local level. At a location level, line managers could easily identify per individual member of staff how many courses had been completed and how many were outstanding. Dates of available courses and details of bookings could be viewed.
- Training team administrators provided a monthly report, compiled on the last day of the month, to board for oversight and analysis. Reports could be generated at any time and to any level depending on the specific analysis request. The iLearn platform was a live system, linked to the human resource (HR) system and updated overnight. This meant that it automatically captured any staff joining or leaving the organisation. The platform could be filtered to Marie Stopes UK (MSUK) and Marie Stopes International (MSI). Therefore, the executive team could

be confident that data reported was an accurate representation of the compliance status of MSUK staff. On the day of our inspection MSUK overall mandatory training compliance for all staff was 94.2% against a key performance indicator of 85% and aspirational target of 95 %.

- We reviewed overall training data provided from January 2018 to October 2018. Prior to the iLearn launch in April the average compliance with mandatory training was 70% in the South region, 80% in the North region and 60% for other departments' (specialist services, district team, One Call, support office and doctors). In quarter one no data had been recorded for either sessional or permanent doctors. From May to October 2018 there had been a steady increase in compliance rates across all locations in the regions and other departments. Results in October 2018 showed average compliance of 97% in the South region, 95% in the North region and 93% for 'other departments', with sessional doctors' compliance at 97% and permanent doctors at 99%.
- Safeguarding training compliance had improved. On the day of our inspection overall training compliance for safeguarding children level one and two was 95% and level three was 90%. Overall compliance for safeguarding adult training level one was 94%, 95% for level two and 88% for level three. Prevent training compliance was 97% overall whilst workshop to raise awareness of Prevent (WRAP) training was 87% overall. We were informed that safeguarding children level three training had recently been brought in house and redesigned to reflect scenarios and issues specific to the organisation.
- The iLearn platform was evolving at the time of our inspection. Subcategories that were in development were iBelong, iCan, iAspire, iProgress, iRevalidate and iMatter. The HR senior team explained these subcategories would map to staff appraisal, development and wellbeing. The majority of training for these subcategories were planned to be face-to-face sessions. At the time of our inspection induction for new staff was undertaken at location level. However, the subcategory 'iBelong' was the corporate induction package that was due to be launched at the end of December 2018.
- The three most recent MSUK location inspections, MSI Maidstone, MSI Manchester and MSI Essex, undertaken between August and September 2018, indicated inconsistencies between locations, found during the 2017 inspections, had significantly reduced and overall compliance with training had improved. One hundred percent of nursing staff in all three locations had received an appraisal at the time of the location

inspections. Appraisal rates were included as part of HR assurance and exception report to the quality subcommittee (QSC), in June 2018, along with absence rates and turnover rates against target.

- The clinical practice guide for registered nurses and midwives, introduced in 2016, was under review due to numerous policy and practice changes. We were provided with a draft copy of the clinical practice guide and clinical core competencies for health care assistants. We were informed that development was underway to design an electronic solution to monitor competency assessments undertaken but at present this remained at location level. The improvement action plan indicated that a level of assurance was built into internal inspections. We reviewed the supportive quality review inspection framework and saw that competencies were included.

Cleanliness, infection control and hygiene

In February 2017 there was no effective mechanism to monitor infection prevention and control across MSUK locations.

- **The service had a clear infection prevention and control (IPC) structure in place. A process for monitoring across the organisation to improve standards and consistency had been implemented.** The IPC structure had been revised in 2018 with clear lines of accountability and line management. The medical director was the director for infection prevention and control (DIPC), with an advisor microbiologist and clinical director providing clinical advice below them. There was an IPC lead for the organisation that reported into the medical director. Link IPC nurses had been introduced to all locations.
- Oversight of IPC occurred through quarterly IPC committee meetings. Assurance and exception reports were prepared by the IPC lead and presented to the quality subcommittee. Quarterly IPC environmental and clinical audits were undertaken and trends were included in the IPC assurance and exception report. In addition, an annual IPC report was undertaken to provide a summary update to the divisional board in relation to the infection control plan.
- Infection control was included as part of the compliance monitoring programme (CMP). The CMP comprised of several surveys being undertaken across all locations. There were five surveys that related to IPC. We reviewed the CMP for 2018 and found the frequency of surveys differed depending on topic. For example, hand hygiene surveys were scheduled every two months, personal protective equipment (PPE) and IPC practice

were scheduled twice a year (May and November). Peripheral venous cannulation (a thin, flexible tube that is inserted into a vein) was scheduled quarterly in March, June, September and December. The sharps and waste survey was scheduled in January and July. Facilities and cleaning were scheduled in May and September. This meant that overall IPC scores achieved were subject dependent and therefore provided limited assurance of any overall improvement. We were informed post inspection by the provider that these results were not used in isolation to provide assurance.

- We reviewed the 2017 annual IPC report which was presented to the MSUK board in September 2017, alongside the IPC Strategy 2017-2010. The report included areas of progress, areas of concern, governance arrangements, surveillance, audit, IPC training, policies and guidelines, cleanliness, estates, ICT resources and provider core objectives. We noted that not all MSUK locations were included in the report. Training compliance and cleaning scores for Manchester, Telford, Sandwell and Coventry were missing. The provider stated that these were not included as the locations had been suspended as surgical sites.
- The 2018 annual report was not available at the time of our inspection. We were informed this would be completed in December 2018. This meant that analysis of progression against core objectives could not be determined.
- The three most recent location inspections, MSI Maidstone, MSI Manchester and MSI Essex, between August and September 2018, indicated that IPC processes were in place and infection risks were controlled well. IPC training and hand hygiene audits were improving and were rated as green, above 90%, but were slightly under the provider target of 95%.

Environment and equipment

In February 2017 there was no effective mechanism to monitor the safety of equipment across the organisation. Locations maintained their own systems which were inconsistent.

- **Policy and procedures relating to management of equipment had been reviewed, updated and implemented**. The Managing Medical Devices Policy v2 had been reviewed and updated in October 2017, with the next review scheduled for October 2020. This had been approved by the director of finance and ratified at the quality subcommittee

(QSC). This policy outlined the responsibilities of registered managers, acting as medical device safety officers (MDSO) at location level and the governance responsibilities of the medical devices management group (MDMG).

- The MDMG were responsible for improving communication, ensuring involvement of the correct people in relation to potential changes in devices. Defining those responsible for management, training and device operation, reviewing incidents related to medical devices and approving new medical devices models. The MDSOs were responsible for maintaining equipment registers, ensuring completion of a training matrix, purchasing approved devices, ensuring access to manufacturers instruction, local oversight of corporate contracts and decommissioning and disposing of devices. The policy also outlined individual staff responsibilities.
- A number of standard operating procedures (SOPs) had been implemented in January 2018. These included, but were not limited to; regular checks of commercial boilers, external lighting, emergency lighting, treatment room ventilation and the recording and upkeep of maintenance records, which also outlined the requirement for all third-party maintenance activity to be logged.
- The three most recent location inspections, MSI Maidstone, MSI Manchester and MSI Essex, between August and September 2018 indicated that local management of equipment had improved. Equipment checked on site during these inspections were in date for servicing and records were itemised, organised and maintained, with daily checks in place where appropriate.
- A monthly biomedical equipment survey, undertaken across all locations, had been introduced in September 2018 as part of the compliance monitoring programme (CMP). In October 2018 average compliance across the nine locations was 90% with six locations scoring 100%. MSI Maidstone and MSI West London were both rated as amber with compliance at 88%. However, MSI Bristol was rated as red with compliance at 38%. The CMP calendar document contained no additional narrative with regard to any identified actions for improvement. We were informed post inspection that the CMP calendar document was a planner tool and record of scores only. All actions related to noncompliance with CMP would be documented on the individual locations service improvement plan. We reviewed MSI Bristol's service improvement plan and found that no action had been documented in relation to the October survey findings and score of 38%. The last recorded action on this plan from a CMP audit was 16 March 2018, with a due date of 30 April 2018, and this remained "in progress".

- A monthly update report was provided to the senior leadership team outlining the end of month performance for facilities, management and health and safety. We reviewed reports for July and September 2018 and saw that the privacy and dignity screens, that had been raised as ongoing concerns in the location inspections at MSI Manchester and MSI Maidstone, were featured and a paper was to be put together for the clinical effectiveness group meeting on 25 October 2018. This meant that concerns identified were sighted.
- We reviewed the Facilities / Health and Safety/ Statutory Compliance assurance and exception report for QSC dated 7 June 2018. This report identified that external parties had reported concerns related to the maintenance of equipment in location centres and early medical units, specifically relating to items 'not presented' for servicing. In MSI South London, the maintenance report, dated November 2017, identified that one item was at repair and therefore not serviceable and six items were not presented. In the EMU at Enfield, the maintenance report, dated March 2018 eight items were not presented.
- It was recorded in the QSC minutes that there should be a nominated member of staff responsible for the monitoring, maintenance and service log upkeep of biomedical equipment at each location. The agreed action documented was "Operations registered manager should be accountable for equipment status in each centre" with due date of 6 September 2018. This meant that the issue of equipment not being presented for servicing would be addressed.

Assessing and responding to patient risk

In February 2017 processes for the review of safety concerns were in their infancy. Subcommittees, such as resuscitation, medicines management, safeguarding and quality, safety and risk, had limited traction and monitoring and effectiveness could not be measured. The termination of pregnancy early warning score (TEWS), had not been rolled out across all locations. There was a lack of assurance that accurate and appropriate completion of World Health Organisation (WHO) and five steps to safer surgery checklist was embedded into practice.

- **The service had processes in place to monitor risk and patient safety. However, numerous changes had impacted on the effectiveness of how these were managed**. Structures had been revised and monitoring improved through the implemented internal inspections, surveys and use of dashboards to collect data.

- The sub committees had developed and evolved and some no longer existed in their original format. For example, the previous quality, safety and risk committee had been replaced by the quality subcommittee (QSC).The clinical effectiveness group included within it the resuscitation committee and infection prevention and control committee. The safeguarding group and medicines management group remained, and were chaired by the director of nursing and the clinical director respectively.
- The director of nursing (DoN) had been in post approximately 12 weeks at the time of our inspection. They told us there was a revised focus on clinical effectiveness, clinical standards and clinical leadership. For example, it had been recognised that quarterly clinical effectiveness groups did not provide the ability to respond to safety and risk related concerns in a timely manner as oversight was delayed. The decision had been made to move these meetings to monthly from September 2018.
- The DoN had recently introduced weekly telephone calls with the location clinical service managers as an 'informal clinical huddle'. Clinical team leaders were encouraged to join the telephone calls as a development opportunity. Clinical team leaders also had the nominated responsibility to dial in if the clinical team leader was absent.
- A compliance monitoring programme had been designed and implemented from October 2017. This consisted of surveys undertaken in relation to a variety of safety and quality assurance measures. These included, but were not limited to, topics such as; informed consent, safeguarding, the World Health Organisation (WHO) and five steps to safer surgery checklist, infection prevention and control, medicine management, health and safety and risk management.
- There had been a review of the safeguarding structure, training and supervision requirements since our previous inspection. The revised structure included a named nurse and named doctor for safeguarding as well as safeguarding leads for individual locations and remote doctors. The current named doctor for safeguarding took up post in October 2018.
- The providers improvement action plan stated that safeguarding assurance frameworks were in place for children and adults, safeguarding dashboards had been in place since March 2018 and compliance monitoring surveys had been designed and implemented in October 2017. In addition, a safeguarding hub had been developed for staff to access key policies, procedures and guidelines.
- The safeguarding dashboard included data for training, competencies, supervision and compliance. The dashboard

detailed a percentage for each score as well as an overall total score per location, region and MSUK overall average. Training related to the percentage of staff up to date with mandatory safeguarding training for their role. Competencies related to the percentage of staff who had their safeguarding competencies assessed and signed off by a safeguarding lead. Supervision related to locations that had safeguarding supervision with an appropriately trained safeguarding lead within the previous three months and compliance was the most recent safeguarding compliance monitoring programme (CMP) scores.

- We reviewed the safeguarding dashboard for the first three quarters of 2018 and improvement could be seen in the majority of locations across the North and South regions. For example, supervision had been 0% in quarter one but this had improved to an overall score of 78% in the South and 57% in the North demonstrating that seven out of nine centre locations were now receiving supervision. The two exceptions to this were Central London and Bristol locations where supervision was still 0% and both showed a decline in overall compliance score of 59% and 48% respectively.
- We reviewed the safeguarding quality subcommittee assurance and exception report for quarter two, dated 5 September 2018. We found that the exact compliance figures did not match those provided on the dashboard. It was noted that a significant improvement in compliance had been seen in comparison to the previous quarter. There was improvement needed in regard to supervision although no centre location was individually identified.
- We reviewed the safeguarding children and adult assurance framework and found these had not regularly been updated. The children's framework had been devised on 29 December 2017 and was set out in line with the Department of Health statutory guidance 'Working together to safeguard children 2015'. This guidance was updated by the Department of Health on 1 August 2018 however, the assurance framework had not been reviewed in line with this latest guidance as the last update was 23 April 2018.The framework had been rated to indicate action complete (green), action ongoing (amber) and action not started (red). Out of the 15 objectives, six had been rated as green and nine rated as amber. Out of six standards on the adult framework, two had been rated as green, three as amber and one, relating to addressing issues of diversity, was red.
- The termination of pregnancy early warning score (TEWS) had been fully implemented across all locations in the organisation. This had been included in the reviewed resuscitation policy and

the TEWS chart had been redesigned. An audit of patient records was undertaken across eight locations, where surgical termination of pregnancy was undertaken. The audit looked at overall completion, correct calculation of the score and record of clinical decision making, escalation and action taken. It also identified staff that had correctly, or incorrectly, completed the TEWS to enable individual training where required.

- The compliance monitoring programme (CMP) included surveys for the World Health Organisation (WHO) and five steps to safer surgery checklist and TEWS. Both surveys were scheduled to be completed every other month. This meant that there was regular ongoing compliance monitoring undertaken across every location.
- Data provided for October 2018 identified that average compliance in regard to completion of the World Health Organisation (WHO) and five steps to safer surgery checklist was 94%. Seven of the nine locations were rag rated as green, with six achieving 100%. The two locations rated as amber were MSI Essex at 86% and MSI West London at 71%.Results for TEWS were similar. Overall compliance for October 2018 was 96%, with seven of the nine locations RAG rated as green, six of which scored 100%. The two locations rated as amber were MSI Maidstone at 88% and MSI Bristol at 82%.
- The three most recent location inspections, MSI Maidstone, MSI Manchester and MSI Essex, had taken place between August and September 2018. Findings indicated there had been significant improvement in staff knowledge, accurate monitoring and recording of the safety surgery checklist and TEWS chart.
- Resuscitation scenario drills had been introduced and were being delivered by a third-party provider. We reviewed reports, provided by the third-party provider, following five scenario sessions undertaken across MSI Coventry, MSI Birmingham, MSI Leeds, MSI Bristol and MSI West London. We saw that the simulation session registers detailed staff present, scenario details and a summary of performance. The majority of scenarios were undertaken well, with clear leadership and appropriate systemic ABCDE (airway, breathing, circulation, disability, exposure) approach. Key learning points were discussed with a debrief and reflection discussion taking place. Where concerns were identified, for example at Birmingham, feedback was given and reassessment undertaken. The provider improvement action plan identified that TEWS and sepsis would be included in the scenario training from January 2019.

Incidents

Summary of findings

In February 2017 the provider had been in a transition phase between a paper based and electronic incident reporting system. Effectiveness and impact of learning from incident investigations could not therefore be measured. Nurses had not received training in duty of candour. It could not be assured that duty of candour was undertaken in a timely manner. Submission of statutory notifications of serious incidents was inconsistent. In eight of the 13 CQC location inspections, undertaken between June and October 2017, concerns had been raised with incident reporting, analysing data and sharing lessons learnt.

- **The service had an established process for reporting patient safety incidents and the electronic reporting system was now fully embedded. However, we found oversight and timely management of reported incidents, serious incidents and duty of candour needed to improve.** The electronic incident reporting system had been embedded throughout the organisation and provided improved recording and monitoring of safety performance. The electronic reporting system had improved staff awareness to report safety concerns, incidents and near misses.
- Three MSUK location inspections, MSI Maidstone, MSI Manchester and MSI Essex, had taken place between August and September 2018. These inspections affirmed that staff had confidence in the reporting system and that incidents were reviewed and signed off by local managers. Improvement had been seen at these locations with evidence of learnings from investigations and incidents being shared at team meetings.
- There was an established process in place for the investigation of serious incidents (SI). All potential serious incidents were escalated to the executive team and assessed through a serious incident panel that was convened as necessary.All investigations were undertaken by a member of staff that had received appropriate root cause analysis (RCA) training. All final SI reports were signed off through the quality subcommittee (QSC). This was confirmed in the improvement action plan submitted by the provider.
- We saw evidence that RCA training had taken place on several dates in 2017 and 2018. Attendance sheets were used to monitor and record reasons for nonattendance and compliance was recorded and monitored on iLearn. At the time of our inspection overall compliance was 73%.
- Weekly complaints, litigation, incidents and patient feedback (CLIP) meetings had been established to review any relevant issues arising from the week before. The improvement action plan indicated that CLIP meetings provided the opportunity to

highlight significant issues and themes and ensure communication across multiple locations. However, our findings on site demonstrated that the systems in place were not fully effective and we raised our concerns with the senior leadership team during our inspection.

- CLIP meetings were chaired by the director of quality and governance. Representatives from each location dialled into these calls to discuss incident reports, highlight emerging themes, concerns, actions undertaken and provide an opportunity for shared learning. The head of quality and governance told us the meeting provided assurance that all incidents were appropriately reported and regularly reviewed. They stated that at the last meeting an incident at MSI Bristol was identified as a never event. 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. It had not been previously reported as such but was subsequently actioned and the appropriate statutory notifications made. We were concerned that staff locally had not identified this incident as a never event prior to the meeting. We raised the never event with the CQC team for MSI Bristol following our inspection and found the information had not been provided to us as indicated until a further request was made.
- We reviewed the electronic incident reporting system on site and found that 380 incidents were being reviewed, of which 207 were overdue. The number of incidents awaiting review was 170, of which 144 were overdue. This meant a potential risk that serious incidents may have occurred but the provider was unaware as these were yet to be reviewed. We requested sight of the 144 overdue incidents pending review. We found there were three incidents that had occurred in March and April 2018, the other 141 had occurred from September 2018 onwards. Two incidents, that had occurred in November 2018, were identified as moderate harm. The oldest incident was dated 1 March 2018 and related to a concern with the interpreting service, the last entry in this record was on 6 March 2018 and no handler had been assigned, therefore no one was managing this incident on the system.
- There were eight serious incidents (SI) open on the electronic system. The oldest of these was dated the 16 August 2017. When we reviewed this record, we found the incident had been

investigated and actions taken, with supporting documentation saved yet the SI record had not been closed. The handler assigned had left the organisation and the record had not been reassigned.

- The head of quality and governance was newly appointed, having been in post eight weeks at the time of our inspection. They had created a spreadsheet as a way of monitoring SIs. This had been emailed to all clinical leads on 30 October 2018 with a request to complete, however when we viewed the spreadsheet we found this to be blank. When questioned further the quality and safety lead told us that a similar report could be generated from the electronic incident system itself.
- We reviewed the last four QSC meeting minutes. We saw that at the 6 September 2018 meeting it had been identified within the North and South assurance and exception report summaries that additional support with incidents was required. In response at the executive team meeting the decision had been made that each member of the executive team would "sponsor" a centre and base themselves at that designated centre more often, which would create more executive visibility for location staff.
- We reviewed three 'Serious Incidents and Other Investigations QSC reports' (quarter four 2017, quarter one and two 2018). There were 38 serious incidents recorded between 11 February 2017 and 9 August 2018. We saw that these spreadsheets covered the complete incident process. Headings included incident number, incident summary, status of investigation, due date, owner, 72-hour report, SI panel, duty of candour call, letter and follow up, incident record, lessons learned and actions recorded. Drop down responses of 'yes' 'no', 'N/A', 'complete' or 'in progress' were formatted using a red / amber / green (RAG) system and embedded into the spreadsheet. Whilst these reports provided a certain level of oversight we noted that the formatted responses did not identify the timeliness of actions. All three reports had an additional actions sheet that was completely blank.
- We were concerned that the action required did not always correlate with the severity of the incident and was not consistent. For example, there were seven incidents of missed ectopic pregnancies, three of which had ruptured. Two had the documented action 'timeline / low level' (including one rupture) whilst four documented the action required as either 'investigation' or 'root cause analysis'. We also saw that 'timeline / low level' was recorded against one incident where consent was not signed, two incidents of suspected perforation, two incidents of HSA1 forms (the legal document to allow an

abortion to be carried out) not being signed and two incidents relating to patients scanned over the legal limit. In all of these incidents 'not applicable' had been selected in the SI panel and duty of candour columns and 'no' selected for lessons learned and actions taken. Therefore, we were not assured that the process was effective for ensuring all appropriate incidents were identified, categorised correctly or escalated to the SI panel.

- We reviewed the last four quarterly meeting minutes from the QSC and found there had been a standing item on the agenda, since November 2017, for the quality assurance report, quality dashboard, serious incidents and duty of candour. However, the detail discussed and recorded was not consistent. In some minutes the top themes for incidents and the number requiring duty of candour was recorded. In others general statements such as "overall there has been a reduction in Serious Incidents" was recorded. There was no detail recorded to demonstrate any analysis of the SIs to provide assurance that the incidents were being categorised and investigated appropriately or that duty of candour had taken place when required and within stipulated timeframes.
- In the QSC meeting minutes of 14 June 2018 it was documented there had been 'no improvement on monitoring serious incidents and following up from the duty of candour. There are a lot of missed lessons learned. There are no trends but questions have been raised around ultrasound scanning and the management of complex cases. The management of serious incidents now lies within the regions.' Despite this being documented there were no agreed actions recorded. At the following QSC meeting on 6 September 2018 the minutes indicated that there had been a discussion that all serious incidents needed to have lessons learned disseminated across the organisation and general improvement in SI management with locally lead accountability. The documented agreed action was not measurable. It was recorded as 'Improvement needs to be made to the management of serious incidents', with a completion deadline of 3 December 2018.
- The duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014 that relates to openness and transparency. Where, as soon as reasonably practicable. after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident had occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

Summary of findings

- Duty of candour training had been implemented with an established system for monitoring compliance. A duty of candour course had been launched as part of the electronic training system iLearn in October 2018. We were informed that staff had until the 1 December 2018 to complete this training. Evidence seen during our inspection demonstrated that action had been taken to address the previous lack of training and that compliance had improved but remained below target, with only nine days remaining for compliance to be achieved. Medical staff compliance was 66%, nursing staff compliance was 82% with overall compliance at 72% against a target of 85%.
- Feedback from the three most recent location inspections, MSI Maidstone, MSI Manchester and MSI Essex, between August and September 2018 indicated an improvement and that processes were established. Staff understood the principles of duty of candour as being open and transparent, where duty of candour had been applicable this had been undertaken.
- At our previous inspection in February 2017, we reported that MSI had reviewed and updated their policy on duty of candour, originally ratified in April 2016, and that the updated policy was due to be approved at the next clinical policy and guidelines group on 30 March 2017. However, we found that the original policy, version 1.0, dated April 2016 remained in place. There was no notification to indicate that this had been revised or updated as planned and the review date remained April 2019. The timeframe for response to a patient was set within the policy at 10 days of the incident occurring.
- The duty of candour policy outlined the duties and responsibilities of staff, the categorisation of harm and which fall within the scope of duty of candour, five stages of actions to be taken and the monitoring process. The monitoring process, according to local policy, was by analysis of incident data and quarterly at the central governance committee (CGC).However, according to the revised governance structure the CGC was no longer in place.
- Information provided, as part of the providers improvement action plan, indicated that the balance score card, trialled as a way of tracking if duty of candour had been applied within local policy time frames, had been of limited value. Instead a separate indicator on the quality dashboard was included in the quality report presented to the quality subcommittee on a quarterly basis. This was confirmed by the HR deputy director during interview. They told us that duty of candour was managed as part of the electronic incident reporting system from which a status report was reviewed at clinical

effectiveness meetings and monitored through the quality subcommittee (QSC). However, the actual time taken to apply duty of candour was not captured in the data or minutes. Therefore, we were not assured that the senior executive team had full oversight of the timeliness of the process.

Are services at this provider well-led?

- Work had been undertaken to strengthen leadership at location level with the appointment of a clinical and operational registered manager.
- There was a clear structure of clinical leadership and support for all medical staff across the organisation with the appointment of two clinical directors to work alongside the medical director.
- The human resources (HR) structure and team had been strengthened and positive results were being seen in staff recruitment.
- Regional governance meetings were now fully embedded. Assurance and exception reports and a required reporting proforma had been introduced to improve consistency.
- Regular teleconference call meetings had been introduced to monitor performance with all locations represented.
- A nursing annual work programme had been introduced and safer staffing guidance had been issued on 1 June 2018.
- The ultrasound scanning strategy had been reviewed and strengthened. Recruitment for sonographers was ongoing to improve the provision of support provided to staff and the assessment of staff competencies.
- Implementation of several digital systems had improved the data collection and analysis capability of the service with the aim to strengthen quality assurance and improve services.
- There had been several initiatives undertaken to improve staff engagement.

However, we also found the following areas that the provider needed to improve:

- The continued changes in leadership, at an executive and location level, had impacted on the pace of change. A period of sustained stability at location level had not yet been achieved.
- Regional matrons had been removed from the structure on 1 November 2018 which meant a potential risk to the amount of support provided to local leaders.
- The governance and assurance framework had been redesigned. Not all policies had been amended to reflect changes made to structures and committees.

Summary of findings

- We found weak assurance systems in place with a lack of appropriate levels of check and challenge from the leadership team.
- Meeting minutes were of poor quality. Recording of outcomes was not always accurate or specific.
- An internal compliance monitoring programme had been introduced. The sporadic frequency and changes in survey topics meant assurance was limited to specific subjects only.
- Internal visits, known as supportive quality assurance visits, had been introduced but were not robust. Not all actions were added to the individual service improvement plan.
- The pace of progress remained slow. Many of the actions stated in the improvement action plan were not yet fully operational, and some were not due to commence until mid-2019.
- There remained a gap in the oversight and assurance of staff induction.
- A new central records system was not due to be implemented until the end of 2019.

Are termination of pregnancy services well-led?

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Leadership

In February 2017 there had been significant changes within the senior executive team and some senior clinical posts remained vacant. There were inconsistencies in leadership and reporting from the Marie Stopes UK (MSUK) locations. This meant that the stability of the core leadership remained in a period of high flux and we were not assured an effective system of leadership and governance was in place to monitor the service and reduce the risk of harm.

- **Continued changes in executive team members, and location registered managers had impacted on the pace of change.** During our inspection in November 2018 we found there had continued to be several changes of leadership at executive level and there remained a lack of clarity in the structure of the senior management team and some roles had been subject to change.
- An element of stability had been created by the UK managing director (UKMD), director of quality and governance and the medical director. They were the longest serving members of the executive team. The UKMD had been in post since September 2017.

Summary of findings

- The UK management structure, outlined within Marie Stopes UK statement of purpose (SoP), dated October 2018, demonstrated that the UK managing director reported directly into the chief executive officer (CEO) of Marie Stopes International. Under the UK managing director were five executive positions: the director of quality and governance, chief operating officer (COO), medical director (MD), director of nursing (DoN) and human resources (HR) director.
- Prior to our inspection we were provided with an outline of the executive team and an updated organisational structure, dated November 2018. Neither of these documents matched each other or the management structure outlined within the SoP. In the organisational structure the chief operating officer role had been replaced with the director of finance and operations. In addition, the executive team pictogram outlined a commercial operations director that was not identified in either the SoP management structure or the MSUK organisational structure.
- We sought clarity about the senior management structure whilst on site during our inspection. The UKMD informed us there had been a chief operating officer in place during 2018 but they had now left the organisation and a commercial operations director had been appointed. Their role, alongside that of the director of operations and finance, would encompass the responsibilities of the previous chief operating officer. It was confirmed that the current executive team consisted of the UK managing director, director of nursing, director of quality and governance, director of operations and finance, human resources (HR) director, medical director and commercial operations director. This composition of the executive management team matched the terms of reference provided for the UK executive management meetings, as this included "(vii)such other Members as are appointed by the Chair and ratified by Members".
- There was a recognition by the senior team that the documented organisational structures failed to provide this clarity. Following our inspection, we were provided with an updated statement of purpose, dated December 2018, that reflected and addressed the changes identified and queried on site. Whilst the provider had been responsive in addressing these changes, there remained a requirement to submit a statutory notification when the statement of purpose was amended and this was not undertaken and had to be requested, at which point the notification was received.
- We had previously reported in 2017 that certain key clinical roles remained vacant, including the medical director and director of nursing roles. These roles had been substantively

filled, however some had seen several appointments (both interim and substantive). For example, there had been four changes in the director of nursing (DoN) position within the last 18 months, with the current substantive DoN having been in post for 12 weeks prior to our inspection.

- The executive medical director was supported by two clinical directors, one for surgery and one for anaesthesia and an associate clinical director with the responsibility for overseeing early medical abortion and Right Care (patient pre-assessment team). None of the appointments were whole time based, however collectively this provided a clear structure for clinical leadership and support for all medical staff across the organisation.
- The UK managing director acknowledged that since the February 2017 inspection, there had continued to be a number of changes within the senior executive team. They stated that there had been a focus not to just appoint to vacancies but to ensure the most appropriate and competent individuals were recruited. They were aware of the strengths of the executive team alongside areas where support and direction may be required. They felt the senior executive team was now in a much stronger stable position to move forward. There had been forward planning undertaken in preparation for an upcoming change in June 2019, when the fixed term contract was due to end for one of the team.
- We found that there had been a review of the human resources (HR) structure and the team had been strengthened by appointments from a variety of corporate and healthcare backgrounds. This meant a fresh approach to policy, process and procedures. Leaders within the HR team had focused on recruitment and retention with successful results, and the number of staff vacancies had reduced from 40 to 10, with 50 staff on induction at the time of our inspection.
- Leadership at location level throughout the organisation had undergone review. MSUK had revised the centre management structure to include a clinical registered manager and an operational registered manager. This was to address the ongoing concerns highlighted during the 2017 location level inspections where gaps in registered managers had been identified at several MSUK centres. CQC had considered enforcement action directly at location level where applicable.
- We remained concerned that a period of sustained stability was yet to be achieved as there had continued to be multiple changes in personnel and registered managers. Information provided as part of the improvement action plan was that the change programme for management in all centres was nearly

complete. At the time of inspection all 12 centres (five locations in the South region, five in the North region, vasectomy centre and One Call) had at least one of the two registered managers in place. Nine centres had individuals where applications for registered manager status remained in progress. Many of these were due to either structure reconfiguration or staff changes, through promotion or staff leaving the organisation.

- We saw that management, leadership and registered manager training was discussed as part of the learning and development assurance and exception report to the quality subcommittee (QSC) in February 2018. It was documented that team members were promoted into managerial roles with no people management knowledge or experience and that there was a lack of understanding of what was meant to be a registered manager. The minutes stated that a plan was in place to develop and implement a leadership development programme from April 2018 and provide a training programme to guide registered managers through their accountabilities and key responsibilities. At the time of our inspection bespoke training was being developed such as the "iCan manage" module for iLearn.
- Monitoring of the status of registered managers was undertaken by the executive team through the registered managers status report. The improvement action plan indicated that leaders at location level would be supported by a regional structure and the executive team, with each executive being nominated a centre to "buddy" with. We were informed that from 1 November 2018, it had been decided that the two-regional matron positions were no longer required. This was due to the revised structure of two registered managers, one clinical and one operational, at each location. The aim of which was to enable an increased clinical focus and provision of support locally.

Governance

In February 2017 a new governance structure had been put in place. Whilst clinical and corporate processes had been developed and strengthened they were in their infancy which meant the effectiveness and impact of these could not be determined. There were variations across locations with regard to completion of statutory notifications. A policy ratification process had been implemented however this was not fully effective. Not all policies referenced latest guidance.

- **Structures, processes and systems of accountability to support governance and management of the service were**

in place. **However, there had continued to be multiple changes as these had evolved which had impacted on the pace of progress. We found weak assurance systems and a lack of appropriate levels of check and challenge. Minutes were of poor quality**. We found that as the governance structure had developed several of the committees were reformed, integrated or discontinued. The integrated governance and assurance committee (IGC) remained in place and reported directly into the Marie Stopes UK divisional board.

- The structure and number of subcommittees below the IGC had been revised and changed several times. We were informed by the senior executive team that the whole approach to the governance and assurance framework had progressed as it was felt the previous 2017 structure had been too operational and had not provided the oversight and assurance required.
- The latest structure, version 11, outlined a quality subcommittee (QSC) and executive team / senior leadership team meeting that reported into the IGC. Reporting into the quality subcommittee were the regional integrated governance meetings, the policy approval group and the following four sub groups: safeguarding group, clinical effectiveness group, medicines management group and information governance steering group. These meetings were held quarterly except for the executive team meeting which was monthly and the policy approval group which was bi-monthly.
- The senior team had very recently reviewed the schedule and working arrangements of these meetings to ensure that reporting of information was timely and where appropriate they had made amendments to improve. For example, it had been recognised that holding the clinical effectiveness group quarterly meant there was a potential for delay in escalation and oversight of clinical concerns and the decision was made to change these meetings to monthly from September 2018. It was mandated that all minutes would be available on the human resources HR digital platform “sharepoint” once launched in January 2019.
- At the time of our inspection, we were not assured that the revised governance process had progressed significantly. We found weak assurance systems and a lack of appropriate check and challenge from the senior executive team. Several documents for risk and quality metrics had multiple titles which was confusing. For example, the corporate integrated scorecard was named as the clinical key performance indicator (KPI) dashboard. The integrated dashboard that looked at

operational, financial, quality and people metrics was also known as the balanced scorecard. We raised this on site as a concern and information provided post inspection was that action had been taken to provide clarity.

- We reviewed the minutes from the last four quarterly integrated governance meetings (January, March, June and September 2018). We found that there were set agenda items that enabled both strategic and tactical discussions. Financial and operational updates and clinical dashboard data was used to map services and opportunities and influence strategic thinking. Actions were identified, with owners and timeframes for completion and any ongoing agenda items were documented on an action log.
- When we followed through some actions from each quarter we found that the recording of outcomes was not always accurate or specific. For example, it had been noted from Q1 minutes, dated 15 January 2018, that referral of complex cases not undertaken by the provider, referred to as avoidable do not proceed (DNP), could be improved. The subsequent action identified was to add a column on the integrated dashboard to enable monitoring of this. The action was marked as closed at the next meeting, but on review of the scorecard we found there was no DNP column. When we questioned this on site we were informed that the original scorecard did not enable an additional column. Therefore the 'closed' action did not necessarily indicate a completed action. There was no additional documented text in the subsequent IGC meeting minutes to state this had been discussed further or to provide detail of how this was to be alternatively addressed.
- The IGC meeting for Q2 (April to June 2018) took place on 28 March 2018.The minutes of this meeting reflected that the uptake of long acting reversible contraception (LARC) was discussed as an area for improvement. Action 41 in the action log was for an integrated dashboard report on the number of patients taking up LARC compared to the total number of patients and the action was documented as closed. The minutes of Q3 highlighted that this had not been included. In the minutes of Q4 there was no specific data documented, however it was recorded that LARC had been included in an exception report and that a task and finish group had been set up to gather data and review. Therefore, from March to September 2018 nothing other than initial data sourcing had taken place.
- We reviewed the meeting minutes from the QSC and found the minutes were poorly completed with a limited level of detail documented. This meant the level of immediate assurance was

limited and questionable. We reviewed minutes from November 2017, March, June and September 2018. It had been noted in the March 2018 meeting that the management of pregnancy remains was an area of concern, with issues surrounding consent and information given to clients. The agreed action was to review the Fetal remains policy by 30 April 2018. There was no follow up regarding this action documented at the next QSC meeting in June. We found that the policy issued in May 2016 was still in use when CQC inspected MSI Essex in September 2018, although it was stated as under review. Therefore, this action remained outstanding six months after initiation.

- Assurance and exception reports were prepared for QSC meetings and provided an opportunity for more in-depth information. We reviewed four assurance and exception reports presented to QSC between February and August 2018. There was a set agenda for these reports, split into the following four sections; assurance, exceptions, horizon scanning and issues of risk that required support by the QSC. This meant that there was a level of oversight in relation to achievements, based on business intelligence data if appropriate, areas of concern, identification of risks and any issues that may impact the organisation in the forthcoming months.
- MSUK had reviewed and altered their policy ratification process and introduced separate routes of sign off dependent on the type of policy being introduced or renewed. The clinical policy group had been replaced by a policy approval group. This was chaired by the director of quality and governance and the director of nursing. Information provided as part of the improvement action plan indicated that all policies were presented to the approval group. Following which clinical policies went to the quality subcommittee (QSC) and operational policies went to the senior leadership team meeting.All policies had an executive director owner that held accountability for oversight of the content and quality of the policy written by the policy owner. A process for automatic renewal email reminders had been implemented and all policies were available for staff to access on the electronic system.
- Information provided as part of the improvement action plan stated that the serious incident panel terms of reference had been included with the incident reporting policy that had been ratified by the QSC in June 2018. However, when we reviewed the June 2018 minutes we found the documented text was vague and failed to clearly stipulate which policies and terms of reference had been reviewed and approved. For example, it was

documented "All ToR's reviewed and ratified." Concerns with the policy ratification process were raised at this meeting with the suggestion made for a clinical review ahead of a policy being submitted to the approval group and agreed actions were identified. In the next QSC meeting minutes, dated 6 September 2018, there was no follow up of these actions documented.

- We saw that a number of human resource (HR) policy reviews and updates were included as part of the HR assurance and exception report to QSC in August 2018. Whilst summary information was recorded that 12 policies had been reviewed and refreshed and five new policies would be ready for ratification at Octobers policy group, again the exact policies were not stipulated.

Managing risks, issues and performance

In 2017 there was no effective system to ensure safety measures and new ways of working across all locations were in place. Newly formed systems and processes for monitoring patient safety had been implemented but there was limited evidence of the impact these measures were having on ensuring patients were protected from avoidable harm.

- **The service had revised the processes in place to monitor risk and patient safety. However, the oversight and monitoring of results was not effective to enable prompt action to be taken. We were not assured that information being fed through to QSC and IGC was robust.** Several electronic systems had been introduced to enable monitoring and oversight of risk since our last inspection in 2017. These included the electronic incident reporting system, a live performance platform, quality scorecards and dashboards. Regular performance meetings such as complaints, litigation, incidents and patient feedback (CLIP), weekly safety huddles, supportive quality assurance visits and Right Care.
- The Risk Management Policy v4.2 had been reviewed and updated in November 2018. This had been approved by the clinical policy group and ratified at the IGC. The policy outlined the risk management governance. Overall responsibility for risk management sat with the board of directors (MSI). The senior executive team (MSUK) was responsible for all aspects of operational management within the organisation (UK) including the oversight of development and delivery of the risk management activities. The responsibilities for all aspects of the risk management agenda (except financial risk) were

delegated to the MSI Integrated Governance Committee (IGC). The key function of the quality sub-committee (QSC) was to assure the IGC and therefore the executive team of the quality of clinical services across the organisation.

- Regional governance meetings were now fully embedded. We reviewed three sets of minutes from meetings in the North and South, between March and August 2018. Set agenda items had been introduced to address any inconsistencies regarding how these were managed and held regionally. Assurance and exception reports and a required reporting proforma had been introduced to improve consistency in relaying information to the QSC.
- Communication between provider and location leaders took place regularly through a variety of remote teleconference meetings. Weekly CLIP meetings provided the opportunity for location managers to discuss themes, concerns and actions and ensure that shared learning across the locations was taking place. The aim of the CLIP meeting was to provide a contemporaneous organisational overview of all complaints, litigation, incidents and to ensure correct investigation, remedial action and patient feedback took place. It was expected that each location was represented at these meetings.
- We reviewed CLIP meeting minutes between 17 September 2018 and the 12 November 2018. Minutes included a list of attendees, a review of all aspects of CLIP and actions arising from the discussion. We saw that these meetings were well attended, with between 13 and 21 members of staff joining the call. The action log was managed through a separate digital platform. There was no documentation in the CLIP minutes to indicate what specific actions were in place and no follow up to demonstrate if actions had been addressed. The minutes simply referred staff to the digital platform. We saw an example of the action log on site and noted the system was very responsive and easy to use. It enabled individuals to update each action, mark as complete, message between assignees and receive email reminders to complete. However, we could not see evidence in the CLIP minutes that oversight of progress was undertaken.
- Several teleconference meetings had been introduced, in addition to the CLIP meetings, to improve communication and provide team support. Two weeks prior to our inspection, the director of nursing had introduced Friday morning clinical huddles. They told us this offered all location clinical managers the opportunity to engage. Representatives from each centre location were expected to attend. Clinical team leaders were

also invited to join as an opportunity for development. The quality and governance lead informed us that they also undertook bi-weekly calls with link staff at each location to look at outstanding actions. This call was joined monthly by the director of quality and governance.

- Executive team meetings took place fortnightly, with an informal meeting each week to discuss any pressing matters outside of business as usual (not formally recorded). The director of nursing confirmed that the digital performance platform was utilised during board meetings to facilitate discussion and challenge. They provided an example of a discussion at the previous weeks executive meeting that had prompted a deep dive into patients that did not proceed (DNP), and we saw this reflected in the executive team meeting minutes dated 19 November 2018. We were also told that a recent thematic review around retained products of conception had taken place and that a quantitative comparison report was prepared for the clinical effectiveness group (CEG) on 15 October 2018. We requested sight of the comparison report but this was not provided. Nor was the topic reflected in the October CEG minutes.
- A nursing annual work programme 2018/20 had been introduced along with a nursing plan on a page document. The objectives outlined in the programme were; improved and efficient clinical standards, becoming the clinical employer of choice, creating a caring and compassionate culture and leading by example. The work programme was divided into 23 work streams, with 118 actions, split across the four following domains: safety, effectiveness, caring and well led. We reviewed the progress overview document that was red, amber, green (RAG) rated to indicate if work streams were on track or had slipped. Only three of the 118 had been fully completed. 75 were green (on track to achieve), 27 were red (not progressed at all). Three were rated as amber (timescale slipped) and ten had not progressed in the last week. The document was not dated and therefore we could not ascertain when this had started.
- A safer staffing guidance had been issued on 1 June 2018. This outlined the principles of safe staffing, the regulatory requirement, internal MSUK requirement and escalation pathway and safe staffing assurance. The guidance stated that monitoring and assurance would be achieved through local integrated dashboards, local and regional IGC, the clinical effectiveness committee, patient and staff surveys and the

internal supportive quality review process. We reviewed the clinical effectiveness meeting minutes from 9 August 2018 and 25 October 2018. There was no mention of safer staffing in August however this was included by the October meeting.

- A specialist team 'Right Care' had been introduced at MSI One Call in September 2018 to strengthen the initial patient assessment and individualise plans of care to meet the needs of patients right from the beginning of the patient pathway. At the time of booking, the Right Care team would clinically triage any patients with specific needs, such as those with learning difficulties, to the most appropriate centre. This team also had a role in contacting other organisations should there be a specific medical or safeguarding concern identified.
- The director of nursing (DoN) stated that they were currently reviewing patient pathways to reduce inconsistencies across locations. They were engaging and encouraging staff across locations to be involved and drive a standardised approach. They had found staff to be driven and receptive in the aim to unify pathways, and there was a plan for three staff to produce a video outlining what worked well.
- The scanning strategy had been reviewed and strengthened. An associate director of ultrasound had been recruited and recruitment was ongoing for additional sonographers to work alongside the director, to support staff and assess ongoing competencies. The plan was for a team of six sonographers in total, with three each allocated across the North and South regions. The policy had been updated for clarity and was due to be ratified on 22 November 2018.
- The electronic incident reporting system had become embedded in practice across locations and was used not only to record incidents but also to record risk registers, complaints and safeguarding concerns. Each MSI location was responsible for maintaining risk registers. The previous quality, safety and risk committee had been replaced by the quality subcommittee (QSC). Assurance on risk management performance was provided to IGC by way of a risk management performance report.
- At the time of our inspection there were 83 open corporate risks. To reduce inconsistencies and variation in clinical practice across the locations and improve quality of care, several initiatives had been developed or redesigned. Information provided in the improvement action plan highlighted a variety of monitoring dashboards were in place.
- The live performance platform had been in situ for approximately six months. We viewed the performance platform on site and saw that operational, finance, quality and

people metrics were collated to allow analysis. We were informed by members of the senior executive team that this was still being developed and had been introduced using a phased approach. At the time of our inspection, it was available at executive level although many of the senior team, including the director of quality and governance, told us they had not yet received training on this system and that it was mainly utilised by the UK managing director.

- Each member of the executive team had individual areas of expertise, however as board members we would expect each member to be able to comment and provide information when asked about governance, risk and quality improvement. We found that some of the executive team were reluctant to comment on questions they perceived did not fall under their specific remit. This meant we were not fully assured that all members of the senior executive team had appropriate oversight of some governance issues.
- A compliance monitoring programme (CMP) had been introduced in October 2017. This programme consisted of 22 surveys that were undertaken across the nine locations where surgical termination of pregnancy was undertaken. We reviewed the CMP for 2018 and found that the timing of these surveys differed depending on the topic. Some were undertaken every two months, some were quarterly, some twice a year and some annually. The surveys had to be undertaken by one nominated member of staff in every location. The system was updated on the first of the month and results amalgamated.
- We were concerned that the level of frequency and limited number of individuals required to complete the survey diluted the level of assurance being taken from the data. Only the nine locations undertaking surgical termination of pregnancy were included and therefore each survey only reflected the knowledge of nine individuals. There was a risk that specific individuals with competencies in specific areas would be undertaking the most relevant survey according to their knowledge and skills. The changing audit topics, individuals taking part and the frequency of completion meant analysis was not robust and assurance gained was subjective and debatable. There was also the potential for delay in recognising areas of deterioration and taking action to improve.
- For example, legionella was an annual survey on the CMP and was last undertaken in January 2018.The CMP audit indicated that the legionella average compliance overall was 81%. Four of the nine locations, three in the South and one in the North, had red scores (under 70%). MSI Essex, MSI Maidstone and MSI

Bristol had all scored 63% and MSI West London had scored 68%.We reviewed the Facilities / Health and Safety / Statutory Compliance assurance and exception report for QSC dated 7 June 2018. This report identified and raised a concern that the CMP audit results did not reflect recent equipment site visits and inspection. It was noted that, despite easy to follow guidance, legionella controls had been poor and this had been reflected in the internal IPC inspections. No actions had been identified and despite this concern being raised the survey had not been brought forward or undertaken again.

- It had been recorded in the IGC meeting minutes of January 2018 that action plans were reviewed at both QSC and regional meetings every six months to provide a quality review and compare findings. We reviewed the regional integrated governance meetings from March, May and August 2018, for both the South and North. Minutes were vague and reference related to survey completion compliance rather than results or areas for improvement. None of the minutes reviewed documented any discussion around the legionella scores. Therefore, we were not assured that accurate reporting was undertaken to enable robust challenge at every level from ward to board.
- Scheduled internal location visits, known as peer reviews, had previously been undertaken focusing on the 15-step challenge approach to quality assurance to monitor clinical practice and highlight any issues. These had been reviewed, the format redesigned and renamed as supportive quality assurance visits.
- The inspection framework, dated 1 February 2018, was extensive and consisted of 53 pages of prompts. Visits had been undertaken in MSI Leeds and Batley and Wakefield early medical units (EMU's) in January 2018 and MSI Birmingham and MSI Manchester in July 2018. Results provided an overall score of 63% in Leeds, 69% for the EMU's, 69% in Birmingham and 76% in Manchester. Each centre location had a service improvement plan that should include actions from the quality assurance visits. We reviewed the local service plans for Birmingham, Leeds and Manchester and found that some actions had been added but not all. For example, in Birmingham one of the greatest risks included on the summary scoring sheet referred to emergency medication checklists but this had not been included in the local service plan. It was not clear what monitoring took place to ensure progression with service improvement plans.
- We were informed that the visits had been redesigned again. We reviewed the schedule and could see that these were planned at each location throughout 2019. The head of quality

and governance explained that the supportive visits were unannounced and were undertaken by a group of eight specialist experts for consistency. The specialists were the infection prevention and control (IPC) lead, director of quality and governance, the head of facilities, head of health and safety, named nurse for safeguarding, the clinical transformation lead, the head of quality and governance and another nurse from a different centre location providing peer review. Once feedback was received from all parties the lead for quality and governance would collate and produce a report. The report was due to be set out in line with CQCs five key questions and the planned format was to be similar to the CQC report itself. We were concerned that the large number of attendees would put staff under high pressure with the potential risk of impacting on patient care during the visit. The nature of the evidence gathering and multiple individuals involved may also delay feedback to the centres, although we were informed that initial verbal feedback would be provided on the day.MSI Birmingham was the only location that had a quality supportive visit using the new format. This had occurred the day before our inspection, on 20 November 2018 and therefore the results were not yet available.

- The quarterly assurance report, submitted to the QSC, included the clinical quality scorecard. Indicators included, but were not limited to, number of medical and surgical termination of pregnancies (ToPs), percentage of early medical abortion, incidents and safeguarding reported, externally reportable incidents, clinical audits, complaints and mandatory training compliance.
- Implementation of several digital systems had improved the data collection and analysis capability of the service with the aim to strengthen quality assurance and improve services. However, our findings demonstrated that whilst there was some level of scrutiny of clinical quality this was not fully effective. The scrutiny of the questions asked, data source and oversight of outcome actions needed to improve.
- For example, on review of iLearn on site, overall compliance with mandatory training for permanent doctors was positive at 98.8%.The filters enabled deeper analysis and we identified four doctors where basic life support (BLS), immediate life support (ILS) and infection, prevention and control had expired, with the days out of date ranging between seven and 37 days. BLS for one of the four expired on 22 November 2018 and they were not booked to attend until 12 March 2019 which meant they would be out of date for four months. The medical director was

responsible for doctors' supervision and ensuring mandatory training and appraisals were up to date. At the time of our inspection, the medical director informed us that MSI were exploring medical appointments under practicing privileges.

- We found that management of incidents and serious incidents needed to improve. There were 144 risks still pending review and eight serious incidents open. This was despite numerous CLIP and quality and governance weekly telephone calls. We found inconsistent categorisation of incident severity and no evidence that the timeliness of duty of candour was captured. Whilst many policies had been updated and ratified we found that the process was delayed for others, such as the policy relating to pregnancy remains. In addition, the safeguarding children assurance framework did not reference the most updated guidance.
- The pace of progress remained slow. Many of the actions stated in the improvement action plan were not yet fully operational, and some were not due to commence until mid-2019. We were informed that the third-party provider responsible for resuscitation scenario training had changed in August 2018. We requested dates of all resuscitation scenario training that had been completed and were only provided with five dates in total between 17 September 2018 and 25 October 2018. Scenario drills for sepsis and the deteriorating patient were not planned to start until January 2019.
- The ageing IT system, first reported as a concern in 2016, was still in place. We were informed that this would not be updated until the end of 2019 and that there was a project board in place with a clinical and operational steering group to undertake mapping of the project. The new digital technology being introduced would need to feed into the new central records system (CRS) when it happened. Senior staff told us that there was a feeling of frustration that advancements could only be undertaken in stages as it remained unknown how the current systems would interact with the CRS.
- In two of the three most recent location inspections, MSI Manchester and MSI Essex in August and September 2018 respectively, well led was rated as requires improvement. The findings were reflective of those at provider level. Whilst governance frameworks were in place these were not yet fully embedded and local oversight of risk was not fully effective. In both centres there had been changes in local leaders and registered managers.

Engagement

Summary of findings

In February 2017 there was no formal staff survey to establish staff well being

- **There had been several initiatives undertaken to improve staff engagement however, communication remained a priority and pace of change remained a challenge with several initiatives still in development.** A staff survey was completed in July 2017 and summary points were identified in October 2017. The response rate was 65% with 377 out of 581 staff taking part. Areas of focus relating to engagement included relationships and communication, leadership and accountability, recognition and motivation, training and development and advocacy and pride for Marie Stopes.
- Twenty percent of staff believed that regional and departmental senior managers tried to involve staff in important decisions. Thirty nine percent of staff knew who the executive management team were. Thirty five percent of staff felt they received recognition for the work they did. Seventeen percent of staff believed MSUK would take positive action on staff health and wellbeing. Staff expressed a desire to have autonomy in their workplace and have more training and development. Sixty two percent of staff would recommend care at Marie Stopes and forty four percent would recommend as a place to work.
- There was an aim to bring together a unified action plan arising from staff survey. We saw evidence that the 2017 staff survey summary had been shared across the organisation and benchmarking had been undertaken at a regional, location and individual level. Following this, action plans had been developed at executive team level and regional level.
- We were provided with the 2018 engagement survey information pack that detailed 15 results. This meant that a survey had occurred in 2018 however, we were not provided with detail as to when this had been undertaken, the full survey or details of response rate. From the 15 results provided there were no direct comparators to enable direct analysis against the 2017 results. Five of the 15 results provided scored positively (above 90%). The highest scoring result was 94% in response to the importance of data security and protection. Understanding the mission of MSUK, would recommend the services of MSUK and would be interested to hear how MSUK is performing all scored 91%. Understanding how individual roles contribute to the success of MSUK scored 90% and discussions around performance in the previous six months scored 82%.

The question "I am encouraged to focus on client needs and safety" scored 77%. The two lowest scores were related to recommending MSUK as a great place to work (57%) and MSUK has effective communication (49%).

- There was an aim to make the staff survey digital with the development of an 'Insight' platform in March 2019 to be launched in April 2019.
- The UK managing director informed us there was a desire for the executive team to be more visible and that an executive buddy system had been introduced. They stated that communication would continue to be a top priority and the senior executive team had introduced several initiatives to continue to improve staff engagement. These included the introduction of a thank you scheme, with 270 "thank you's" undertaken since August 2018, a blog from the UKMD, and a plan to introduce a feedback scheme "Tell Richard" (UKMD) in December 2018.
- When the director of nursing took up post they visited every MSUK location and met with staff. They told us that initial feedback was positive, in that staff stated they had listened to staff and not inspected them. The DoN recognised that there was an understandable nervousness amongst staff as to how long they may stay in post and only time would build trust.
- There was a new human resources (HR) structure in place that included a HR director, UK learning and development manager, UK HR manager and recruitment lead. The HR manager told us the team had full support from board. They felt there were great relationships within the organisation and a real commitment from senior executive staff to continue to drive improvement.We spoke with another member of staff that had been supported and encouraged to develop and progress in their career. Over two years they had worked in several roles from administrator at clinic level up to a lead co-ordinator at provider level.
- There was an operational plan for 2018 and 2019. Goals for 2018 were to improve the capability of managers and leaders. To engage, motivate and train staff, simplify and clarify people processes and make MSUK a great place to work. Projects undertaken to achieve these included the launch of iLearn and the design and review of HR policies, as well as the development of HR sharepoint pages to enable staff to easily access policies and procedures. At the time of our inspection, projects that were in progress included design of "iCan manage" modules; a suite of line manager guides to support the upskilling of local leaders, a review of employee benefits platform and design and launch of "iMatter".

- Goals identified for 2019 included a full review of the HR toolkit and processes. To create a suite of HR key performance indicators, continue to evolve HR reporting and to support the induction process.
- We were provided with a timeline that aimed for HR sharepoint to be launched in January 2019, iCan manage to be launched in March 2019, apprenticeships and succession planning document to be launched in April 2019 and iMatter to be launched with workshops in June 2019. IMatter was a benefits platform that would provide individual support and advice. Including a counselling service for staff 365 days a year, that could be arranged at any MSUK location within 24 to 72 hours. Counselling could also be organised for a team where appropriate, for example, in response to a trauma or critical incident.
- It was recognised within the HR senior team that the induction process required improvement. There was a local package in place with reviews at one, three and six-monthly intervals. However there remained a gap in the oversight and assurance of this, as induction was location based. As a result, training, induction and supervision had been included as an indicator in the supportive quality review process.
- We were informed on site that a health care assistant (HCA) forum had been developed with HCA representatives from each location, monthly catch up and quarterly face to face meetings. We viewed the terms of reference and saw the purpose of the forum was to support, promote and develop the role of HCAs working within MSUK, including the provision of a safe space for discussion and facilitation of problem solving. Therefore, there were no plans to minute these meetings. However, we were provided with a "You said, We did" document that depicted how the provider responded to concerns raised.
- It was apparent that this was a newly initiated forum, the terms of reference remained in draft with no date / review date stipulated. Whilst the "You said, We did" document identified concerns raised and what action was happening or had been taken, the actions themselves were vague. There was no clarity of timeline or route for follow up of items discussed. The document itself was not dated so we were unable to determine when the forum had taken place. The terms of reference indicated that an agenda would be set by the director of nursing with HCA representatives informing the agenda items, but we were not provided with a draft agenda. We were informed post inspection that the first meeting of the HCA forum had taken place in October 2018. During which, the

purpose and terms of reference for the forum were drafted. Any actions identified within the “You said, We did” would be outlined within the nursing workplan. A follow up meeting was held in December 2018.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that governance, risk and quality assurance processes continue to improve and embed at provider and location levels.
- The provider should ensure that there are effective processes in place to ensure policies and procedures reflect national guidance updates in a timely manner.
- The provider should ensure changes to governance, such as committee structures, are reflected in appropriate local policies.
- The provider should review the mechanisms used to monitor clinical standards and outcomes to ensure data analysis and check and challenge is robust.
- The provider should improve the level of scrutiny undertaken at senior executive team level to provide appropriate assurance that quality care is provided and the level of risk is minimised.
- The provider should ensure effective processes are in place for completion of statutory notifications.