Bidston and St James Children's Centre

Quality Report

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

Overall summary

Bidston and St James Children's Centre is operated by One to One (North West) Limited. The North West registered location is situated in the Bidston and St James Children's Centre, Birkenhead.

There are also three-satellite community Hubs or Patient Advisory Centre's (PAC), situated in Crewe, Warrington and Ellesmere Port.

The service provides maternity care.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 16 and 17 January 2017. We interviewed 25 members of staff and four service users.

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

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

Strategy for the service was underpinned by the service five core values: excellence, safety, women centred, integrity and professionalism. These also underpinned midwifery practice and organisational systems.

An established leadership team, were both visible and accessible in the North West service. Staff, we interviewed as part of the inspection, were positive about the visibility and support from senior team. In addition, there were regular opportunities for midwives to meet with their line managers to discuss cases related to risks and suitable plans of care.

For long-term sustainability of the service, One to One envisaged the ongoing provision of the midwifery caseloading continuity of carer model. Caseload midwifery offers continuity of care by a primary midwife during the antenatal, intrapartum and postpartum periods.

We regulate and inspected this service but we do not currently rate single service providers. We highlighted good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

Summary of findings

- There was risk assessment guidance in place and an escalation policy to ensure women received safe care. Risk assessments were reviewed regularly, and when there were any concerns about the health of the woman or her baby, referrals were made to other providers.
- The service had internal and one external supervisor of midwives (SoM) to support staff and women.
- Ninety eight percent of staff had completed safeguarding training in line with best practice guidance. Staff had an awareness of issues relating to domestic violence and female genital mutilation.
- Caseloads were planned based on midwife availability, staff experience and women's complex care needs. The service monitored the number of women on its caseload to ensure there was sufficient staff to provide the level of care required.
- Care and treatment was provided in line with One to One policies and Practice Points (similar to standard operating procedures), which reflected guidance from the National Institute of Health and Care Excellence (NICE) and Royal Colleges.
- Women received education about choices for feeding their babies and they were supported by staff to feed their baby by their chosen method.
- Some staff had completed the NHS New born and Infant Physical Examination Programme (NIPE).
- Twenty-one of the 47 midwives were trained in hypnobirthing.
- One to One (North West) Limited worked closely with a number of external agencies and third party providers and were working towards improvements in communication to increase shared working pathways with other providers in an effective way.
- Staff were kind, caring and sensitive in the way they communicated. They spent time speaking with women, addressing any worries or concerns. Care was individualised and women valued the close relationships they built with the midwives.
- Staff took time to discuss previous birth experiences, worries, and fears about the current pregnancy. Women spoke very positively about the high level of emotional support provided and told us they felt confident and reassured by the support they were given.
- Staff spoke with women about their mental and physical well-being. They had access to formal assessment tools to use where there were concerns about depression or anxiety.
- Appointments were tailored around the needs of the women. Midwives provided care in the PACs and women's homes.
- Staff had access to a telephone translation service if required.
- There was access to advice from a midwife 24 hours a day. Appointments could be arranged at mutually convenient times with women. Midwives were able to visit women on the same day if requested and considered necessary.
- Complaints were managed in a timely manner and communication with families were undertaken by telephone or a home visit and followed up with a letter addressing concerns with an action plan. We saw evidence of lessons learnt from complaints displayed.
- Quality of care, incidents, risks and lessons learnt were reviewed and discussed at regular meetings.
- There was a risk management policy in place that set out how risks should be monitored and mitigated and we saw examples of completed risk assessments.
- There was a positive, open and enthusiastic culture within the service. Staff were committed to provide the best service possible to their women.
- There was a vision and strategy for the service that had been developed by the registered manager.
- However, we also found the following issues that the service provider needs to improve:
- The service did not follow best practice guidance in relation to infection prevention and control.
- The environment was not always visibly clean.

Summary of findings

- Clinical risk assessments were completed for women. These were documented well on the electronic records system but not always clearly or concisely in women's handheld maternity notes.
- Electronic records were maintained to a high standard, however, these were not contemporaneous with the women's handheld notes, which were difficult to follow, information was not clearly or concisely recorded and copies of screening results and hospital discharge letters were not filed in a timely manner.
- Staff supported women to make decisions and choices about their care and treatment. However, this was not always fully and concisely documented in the women's handheld records.
- Seventy nine per cent of staff had received an annual appraisal. However, specific personal development objectives were set and discussed as part of the "consolidation" passport.
- Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with five requirement notices that affected maternity and midwifery services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals North Region

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity		We regulate this service but we do not currently rate it. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary. Clinical risk assessments were completed but documentation was not always accurate, complete or contemporaneous. There were policies and procedures in place to ensure staff escalated care to other providers if required. Electronic records were completed to a high standard; however, maternity handheld notes were not clear or concise. The majority of care was provided by staff that followed evidence-based guidelines and policies. However, some national guidelines were not adhered to fully. Ninety eight percent of midwives had completed safeguarding level three training. Not all staff had completed their mandatory training or received specific complex obstetric needs training, pool birth or suturing training. Not all had had received an annual appraisal review. Staff provided advice and support in feeding their babies. Staff provided care in an individualised way, supported women to make informed choices and respected their decisions. However, this was not always documented in full. Women told us staff provided a high level of emotional support and feedback was consistently positive. Women were able to access advice 24 hours a day. There were no restrictions to the number of appointments they could receive to ensure they were fully supported throughout their pregnancy and for up to six weeks following the birth. Staff understood that some women might have additional needs and there were facilities in place to support this for example, access to translation services. There had been 18 complaints about the service in 2016 and staff were able to give examples of learning from previous complaints.

Summary of findings

The vision for the service was to grow the service into a company that was seen as the preferred choice for women and their families for their maternity care and to deliver this care to the safest and highest standards. The culture in the service was positive and enthusiastic and staff were dedicated to providing the best care possible. Staff met monthly and discussed key information such as clinical quality, care outcomes and key incidents or risks. A risk management policy was in place and we saw this had been implemented appropriately.

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Maternity

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Background to Bidston and St James Children's Centre

One to One (North West) Ltd was set up in May 2010. One to One provides a community based caseloading midwifery led service with the main ethos based on the concept of continuity of carer. One to One is an independent provider of maternity services commissioned by the NHS, which specialises in large-scale community caseloading midwifery. This includes providing antenatal and postnatal care in the community setting as well as offering private scanning, homebirths and pool births at home.

Currently One to One employs 100 staff, of which 70 are clinical staff across all provider locations. The provider had a registered manager in the North West.

Previous CQC inspections were undertaken in April 2015 and November 2015

Our inspection team

The team that inspected the service in the North West comprised of a CQC lead inspector, who is a registered midwife and two CQC inspectors. One of these inspectors is based in Essex, which ensured continuity of staff across both provider sites during both inspections and who had a midwifery background. An inspection manager and CQC registration staff member were also present. Ann Ford, Head of Hospital Inspection, oversaw the inspection team.

Information about Bidston and St James Children's Centre

The One to One (North West) Ltd consists mainly of a caseloading model with a focus on maximising continuity of care. The service consists of a "hub" providing leadership and support, skills and expertise and a model comprising of teams of midwives, Maternity and Mother Assistants (MaMA), community hub midwives, communication assistants and volunteers .

The registered location in the North West is in Bidston and St James Children Centre, Birkenhead

In the North West, there are three satellite community hubs or Patient Advisory Centre's (PAC), situated in Crewe, Warrington and Ellesmere Port. There are six midwifery teams in the North West.

One to One operates mainly a community case loading maternity care model. A whole time equivalent midwife holds a caseload of 32 women and has freedom to work flexibly to meet the women's needs. A named midwife and "buddy" midwife are identified prior to booking, so that care is delivered by a professional that will become well known to the woman and her family, promoting continuity of care and carer. Ultrasound scans are performed at different sites between Monday and Saturday, 9 am to 7 pm.

The service also offered a team model which comprised of a midwife to woman ratio of 1:50 (maximum) and work to a structured on call rota. They also worked within a buddy system and were allocated annual leave of 35 days per annum. The service introduced the two different models after feedback from staff, to improve staff recruitment and retention and improve continuity of care rates. Each midwifery team was clear about what model they were following.

All staff were home based workers but had access to the registered locations and hub offices to work from, attend training and team meetings.

Midwives use a diary management system that is flexible to meet both the needs and preferences of women and midwives, working with the buddy system (in pairs) to support each other and ensure availability for

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non-routine or triage visits. The intention is for the (primary) named midwife to attend the majority of routine antenatal and postnatal appointments, to support women during labour with a home assessment and to be present at the birth for women who choose to birth at home.

One to One midwives routinely offer women an unlimited number of antenatal visits at home, scans in the community, flexibility of appointments, 8 am to 8 pm, seven days a week, and postnatal care up to six weeks.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- We observed a good incident reporting culture within the One to One service (North West). All the midwives we spoke to were clear about reporting an incident through their online incident reporting system. The online reporting system automatically flagged incidents to senior managers and staff.
- Incident reporting policies and procedures were in place for staff to follow. Senior staff informed us that they encouraged an open reporting culture and following review would often down grade some of the incidents.
- From January 2016 to December 2016, one serious incident occurred in the North West. An independent external review has been commissioned. This was under way at the time of our inspection.
- Governance and risk managers discussed, reviewed and monitored actions from incidents at monthly Quality Assurance (QA) meetings. Information was cascaded to different levels of staff through regular co-ordinators meetings, team leader meetings, teams and individual staff meetings. Lessons learnt were also shared through the One to One shared drive intranet pages. The service used root cause analysis (RCA) processes to investigate serious incidents.
- A Midwives Mitigating Risk (MMR) pathway was introduced as a guide, in conjunction with the One to One practice points and other relevant national guidance, to assist staff to create a detailed plan of care for women.
- A Fresh Eyes Review was undertaken monthly by staff to review and ensure that women were on the correct pathway as per the MMR guidance and that the correct assessments and documentation, including information sharing with the wider MDT were in place.
- Complex Care logs were available online. These were reviewed and updated on a monthly basis by the team leaders. The logs were used to assist in the escalation process to other staff, local trusts, relevant external agencies and risk midwife. The log was also discussed and reviewed at the QA meeting.
- An Intrapartum “Time Out” online checklist was implemented in December 2016 following lessons learnt and discussions of incidents. Staff at a homebirth completed the checklist. The checklist provided a summary of all staff attending the birth, review of care, assisted in a staff member clinically challenging another staff member andprovided a clear and concise

Summary of this inspection

summary if a woman was transferred into an acute trust. A separate checklist sheet was completed for every four hourly review. This was also a tool used to provide feedback to team leaders in order to monitor care and provide support in the management of care.

- One to One had introduced "variance" sheets and (SBAR) handover forms to ensure an
- A Modified Early Obstetric Warning Score (MEOWS) Prompt Chart for the immediate postnatal period following birth was available for all staff, to assist in their detection of a seriously ill and deteriorating woman.
- A safety thermometer was completed but senior staff informed us that the response was low as data was only recorded for their homebirth women, which consisted of 25% of their overall numbers.
- The Safeguarding Lead had regular meetings with the designated nurse for safeguarding at local CCGs to ensure the department met all legal and contractual requirements.
- A safeguarding adult and children's policy were in place. Information and guidance included working with sexually active less than 18 years old, looked after children, disabled children, missing children and children missing from education, female genital mutilation (FGM)forced marriages.
- Staff were to be allocated a new "Safeguarding Passport" document from February 2017. The safeguarding team designed this three-year "passport", to ensure all midwives met their statutory and mandatory requirements within safeguarding.
- Midwives had access to an extensive resource area on the internal internet system, which detailed internal policies and guidance and links to local services, forms and pathways to link into external services.
- Staffing numbers was adequate at the time of inspection. However, staff informed us that previous months had been difficult due to staffing levels and recruitment and retention of midwives. The service had introduced a new model of care to improve work life balance for staff and had employed new senior roles to support clinical staff.
- There was a service level agreement was in place for the disposal of placentas and removal of clinical waste with an external company.

However:

- Written documentation in the handheld notes, we reviewed, was poor. Information was not always clear and concise and documents were not always fully completed.

Summary of this inspection

- Poorly written documentation and lack of contemporaneous record keeping observed in the antenatal handheld notes and the lack of postnatal handheld notes informed us that documentation did not meet the needs of the service, therefore providing limited assurance in the management of and escalation of risk We were not provided with assurance that all information was easily available, especially for external agencies who could not access the One to One EHR for full online details.
- From our observations, a time lag of up to two weeks was evident between the management and filing of the paper blood results in the women's hand held notes.
- A One to One hand written birth observation record was used rather than a standardised NHS partogram (partogramis a record used to monitor the progress oflabour) to record labour details and observations. They informed us that from the summer 2017, they planned to electronically record all labour details on staff portable electronic devises and discontinue using the handheld birth observation records. This did not assure us that all essential information to manage safe care was easily available to external care providers, especially for women who are transferred in an emergency in labour to an acute hospital.
- One to One were running a pilot project for the “GROW” package. GROW provides standardised procedures, training and tools for assessment of baby growth and birthweight. This pilot was due for completion in June 2017. Only 60% of midwives had completed the GROW training and the service had still not implemented the full package since the last inspection in November 2015. The GROW package was to be implemented because of the outcome of a Root Cause Analysis (RCA) investigation by One to One in 2015.
- Not all staff had completed their annual mandatory training.
- Some medicine fridges were visibly dirty on inspection. Clinical procedures rooms contained carpets and cloth covered chairs. We observed one chair soiled with bloodstains. These were highlighted to staff at the time of inspection.
- There were no visible cleaning rotas.
- Staff did not consistently follow the cleaning and use of the pool guidance.
- Staff offered both syntoncinon and syntometrine for the delivery of the placenta. National guidance recommends syntoncinon as this has less side effects.
- Entonox cylinders were not secured in transport bags in community midwives cars.

Summary of this inspection

- There was no daily equipment maintenance checklist by staff and there no annual service maintenance sticker visible on the cardiotocography (CTG) machine we inspected.

Are services effective?

- There was a yearly audit plan in place to monitor care, to ensure healthcare was being provided in line with national standards and let care providers and women know where their service is doing well and where there could be improvements.
- All new staff received a six-week induction training programme and a preceptorship programme, including
- Staff attended “Keeping in Touch” (KIT) meetings with their team leaders to discuss
- Hypnobirthing and water was used as relaxation techniques during labour.
- Between July 2015 and June 2016, breastfeeding statistics for homebirths showed that between 81% and 86% of women were breastfeeding after delivery. This was within the national rates (Infant feeding Survey 2010).
  Staff monitored postnatal baby weight loss and jaundice.
- The One to One (North West) maternity dashboard recorded information that was divided under three main subheadings: Key Performance IndicatorsKPIs) and Activity, Morbidity and Risk and Patient care. The dashboard did not currently record any service or national targets.
- There was one midwife trained in the Frenulotomy procedure (to correct tongue-tie in babies.)
- Five midwives had completed the NIPE programme, therefore able to complete the examination of the newborn soon after delivery.
- One to One worked closely with a number of third party providers. Providers included nutritional experts, a private ultrasound scanning company and complementary therapists.
- Staff accessed policies, guidelines and other information through the services intranet and all staff had access to computers and individual electronic devices.
- Staff told us that they did not use a specific standardised mental health assessment tool but each individual midwives used a tool of her own preference, for example the Edinburgh Mental Well-being scale or
- Whooley assessment tool. Staff informed us they were aware how to make and who to contact to make a referral if required.
- The SoM to midwife ratio of 1:12, which was within the current NMC (2012) guidelines.

Summary of this inspection

However:

- Midwives did not offer Pethidine or any other form of opioid drugs as a form of pain relief at homebirths in the North West.
- Service level agreements (SLA) to provide shared pathways and shared care for high-risk pregnancies were not yet in place with commissioners of services. At the time of inspection, we were informed that there were eight shared pathways in draft.Staff informed us that multidisciplinary working with local acute trust maternity services could be problematic but some positive and productive meetings had recently taken place.
- Staff told us that clinical staff from some NHS trusts were supportive and welcoming; however, they reported that they also faced negativity in some areas towards their service, which led to difficult working relationships. Staff had taken steps to improve working relationships with other providers including formal and informal meetings and invitations to training or social events.
- External care providers had limited access to information, as they could not access the electronic information system used by One to One.
- One to One did not use any specific postnatal handheld notes to document observations and procedures. This was all documented electronically.
- Informed consent was not always clearly and concisely documented in the women's handheld notes.
- The reason why women refused or declined treatment was not clearly visibly documented in the women's handheld notes that we observed during the inspection.
- Midwives mandatory training covered some medical condition such as high blood pressure, infection, severely ill women and complex care planning.

However,

- Only 79% of staff had completed a yearly appraisal interview.
- Midwives mandatory training covered some medical condition such as high blood pressure, infection, severely ill women and complex care planning. However, staff informed us that they did not receive specific training in obstetric or medical complex conditions but supported each other and referred to national guidelines online.
- Suturing the perineum was part of an outline agenda for mandatory training. However, three programme timetables we reviewed did not have suturing listed. Not all staff were competent in suturing. This could affect the transfer of women into an acute hospital for perineal repair.

Summary of this inspection

- We observed that not all national guidance was strictly followed, for example the use of syntometrine drug, the safe transport of Entonox and a woman who had a home delivery after previously having a caesarean section delivery. The inclusion criteria checklist also stated that women with a history of previous stillbirth or neonatal death, hepatitis B or C, HIV positive and haematological disease were suitable for homebirths. However, this was not in line with the NICE Intrapartum Care guideline 190, which recommend births at an obstetric unit for these conditions.Staff informed us that homebirth inclusion and exclusion criteria were set by the local Clinical Commissioning Groups.

Are services caring?

- We observed sensitive interaction and discussions between staff and women.
- Staff allocated individual appointments in the women's home or PAC and ensured adequate time was allotted to discuss all the woman's needs.
- Women felt very supported and reported that midwives responded in a timely manner when they were contacted.

Are services responsive?

- The Warrington Patient Advisory Centre (PAC) was located in a central suite in a busy shopping precinct. This innovative service enabled and encouraged women to seek advice and access antenatal care as frequently as they wanted.
- Senior staff attended the Clinical Commissioning Group (CCG) maternity network meetings and contributed to discussions and planning for local maternity services.
- There was no waiting list for appointments with One to One.
- Women were able to access midwives and maternity care 24 hours a day, seven days a week.
- Complaints we reviewed were all managed in a timely manner and communication with families were undertaken by telephone or a home visit and followed up with a letter addressing concerns with an action plan. Complaints were discussed at the clinical meetings and the QA meetings on a monthly basis.
- Lessons learnt were used to share learning from complaints throughout the organisation. Monthly lessons learnt were disseminated via the shared drive, displayed on staff notice boards, discussed at locality team meetings, and were a standing agenda on the locality team meetings.

Summary of this inspection

- Parent education classes were offered in a group setting in various locations or on an individual basis if requested.
- The service had a service level agreement with a private scanning company to perform scans at Bidston and St James children centre, Crewe, Ellesmere Port and Warrington PAC's]. Women were also referred to their local trust scan departments if concerns or deviations from the normal were seen.
- Hypnobirthing classes were offered to women.

However:

- The service continued to promote and encourage continuity of carer, however, staff informed us that at times this was difficult to achieve. The service target was 80% for continuity of carer; however, data from the provider showed that across both locations, between April 2015 and March 2016, this target was only achieved six of the 12 months.
- Staff informed us that the service aimed to establish good working relationships with local CCG and local NHS trusts to ensure that women received the best care and birth experience possible. However, in some instances, this had been challenging and difficult.

Are services well-led?

- Risk was reviewed and managed through an online reporting system, executive board review, QA meeting reviews and shared lessons learnt.
- The QA panel met monthly to review and discuss the performance dashboard, risk register, RCAs and incidents, lessons learnt, complaints and claims and the complex care log.
- Team leaders meet monthly with the Operational lead and Head of Clinical Services to discuss complex cases and feedback board level information.
- Team meetings and Hub meetings were held monthly.
- Introduction of Variance sheets, SBAR, MMR, Complex Care Plans, Time Out sheets, MEOWS and the Fresh Eyes system were all elements of the One to One quality assurance framework.
- All staff informed us that they felt well supported from within their teams, team leaders and senior management staff. They told us that there was an open, honest and helpful culture within the service in the North West.

However:

Summary of this inspection

- An up to date risk register for the service was provided during the inspection, with nine risks recorded. This was reduced from 14 risks on the previous register provided. All risks were reviewed and action plans in place. However, the register did not state a named lead for each risk. Five of the nine risks remained static, with the same information carried over from the previous register review. The impact and control rating for the retention of midwives risk had increased from moderate to high. However, the action plan remained unchanged from the previous register review. Two of the three new risks identified did not have an action plan documented. However, one risk was rated as high.
- The service informed us that they did not refuse care for any women but referred to their inclusion and exclusion criteria to categorize “low” and “high” risk pregnancies and whether women were suitable for homebirths. However, we observed that this criteria list was not always strictly adhered to for all women. Staff informed us that if a woman declined to birth in a trust, the CCG were informed and a shared care plan was put in place with an obstetrician.

Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Maternity

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are maternity services safe?

Incidents

- We observed a good incident reporting culture within the One to One service (North West). All the midwives we spoke to were clear about reporting an incident through their online incident reporting system. The online reporting system automatically flagged incidents to senior managers and staff.
- Incident reporting policies and procedures were in place for staff to follow. Senior staff informed us that they encouraged an open reporting culture and following review would often down grade some of the incidents from high or medium hard to low hard.
- From January 2016 to December 2016, one serious incident occurred in the North West. Following a multidisciplinary investigation review meeting, the panel were unable to make a decision around determining the root cause and the incident required further review. Therefore, after discussion with NHS England, the Local Supervising Authority and local CCG, an independent external review had been commissioned. This was under way at the time of our inspection.
- An Incident Overview report from April 2016 to December 2016 was provided by the service. Incidents were rated according to cause, harm and severity. Types of incidents included communication with external provider and one to one staff, screening and shoulder dystocia.
- An Incident Overview Report from November 2016 and December 2016 was provided by the service. This report provided a monthly overview of the risk management activities across the company and was presented to the Quality Assurance board and discussed at senior management and locality team meetings. The report also gave an overview of current complaints that had potential to lead to claims. The report was cumulative over a period April 2016 to March 2017 to give the board an understanding of risk, trends, themes and action plans to mitigate risk, reduce reoccurrence and inform improvements.
- The overview report recorded that in November 2016, there were 117 births. There were 22 reported incidents, six clinical and 16 non-clinical. The report stated that all incidents were uploaded onto the online reporting system and reviewed within seven days. SIRI) was reviewed within 24 hours by a senior midwife and risk manager and when appropriate, the governance lead.
- The December 2016 overview report recorded that from 120 births there was a total 16-reported incidents, 10 clinical and 6 nonclinical incidents. There were no serious incidents reported in December 2016.
- Governance and risk managers discussed, reviewed and monitored actions from incidents at monthly Quality Assurance meetings. Information was cascaded to different levels of staff through weekly co-ordinators meetings, team leader meetings, teams and individual staff meetings. Lessons learnt were also shared through the One to One shared drive intranet pages. The service used root cause analysis (RCA) processes to investigate serious incidents. The RCA is a structured way of investigating and analysing the circumstances surrounding an incident.
- As a result of completed of a RCA investigation, prior to the inspection in April 2015, the service had taken steps to introduce the GROW fetal growth measurement package. This provides standardised procedures, training and tools for assessment of fetal growth and birthweight. However, it was found during the inspection in November 2015, that the service was slow

to implement changes and the GROW package was not fully implemented at the time of that inspection. During this inspection, we found that 60% of midwives in the North West had completed the GROW training but the service had still not implemented the GROW package. One to One had implemented customised growth charts in one specific CCG area only as a six-month trial since 1st December 2016. No decisions have been made to roll out to other areas until the trial was completed.

- We observed lessons learnt displayed and shared staff following the MBRRACE-UK confidential enquiry into maternal deaths publication in December 2016.Senior staff also informed us that three staff had completed RCA training and that One to One were soon to start staff "safety huddles" to look, discuss and learn from key themes and raise awareness for incidents. It would also discuss findings from audits.
- Duty of candour (DOC) responsibilities was highlighted in the incident reporting policy. Senior managers described how the responsibilities were carried out and we saw evidence that this involved face-to-face meetings and letters of explanation for women and their families. However, when we asked staff about duty of candour, some caseloading midwives told us it was about the duty to report openly and honestly but were not sure what it entailed in detail. Therefore, it did not assure us that all staff had a full understanding and process required around the DOC.
- Once a month One to One used the maternity safety thermometer, which is a nationally agreed tool to monitor care in maternity services. They used it to review how many women and babies experienced certain types of "harm" and to understand what improvements were needed. 'Harm' relates to complications of labour and birth and cannot necessarily be avoided. Senior staff informed us that the response was low as data was only recorded for their homebirth women, which consisted of 25% of their overall woman numbers.

Cleanliness, infection control and hygiene

- Following a homebirth, placentas were transported to a dedicated freezer at the Bidston and St James children's centre and Warrington PAC by midwives. Placentas were stored, packaged and transported in double bin bags in the midwives car boot. One midwife informed us that she kept her double bin bag with placenta in a box in her car boot to avoid any contamination or leakage.
- When we inspected the placenta freezer at Bidston and St James children's centre, it was situated in a clean equipment room, with the door held open. It was empty of placentas but it was soiled with old blood and appeared dirty. This was highlighted to senior staff at the time of our inspection. Senior staff informed us that staff did not routinely use secure boxes to transport the placentas to help avoid leakage and contamination. On the unannounced inspection, the freezer was clean. The placenta freezer at Warrington PAC was clean at the time of the unannounced inspection.
- The storeroom at the Bidston and St James children's centre contained two locked small fridges. One fridge contained ice packs (for transportation of Anti D injections) and the other fridge stored drugs such as syntometrine and syntocinon. Both fridges appeared dirty. This was highlighted to senior staff at the time of inspection who stated that the fridges were "unacceptable". Fridge temperature checks were completed but it was difficult to ascertain what temperature checklist were for what fridge as both fridges were unlabelled. This was also raised as a concern to senior management. At the unannounced visit, both fridges were labelled, clean and tidy.
- There were also two fridges at the Warrington PAC. One was currently used to store Flu vaccinations, syntoncinon and syntometrine drugs. This fridge was soon to be decommissioned, as a newer fridge was already bought, in situ and ready for use. A fridge temperature checklist was maintained daily.
- The small clinical room at Bidston and St James children's centre consisted of a sink, chairs and a trolley with equipment for taking women's blood. The room had a carpet and cloth covered chairs with bloodstains on one of the chairs. This was highlighted to staff at the time of inspection. The DOH (Infection control in the built environment, 2013) states that there should be no carpets in any area where clinical procedures are performed or where there is a risk of body fluid spillage

and all surfaces and furniture including chairs should be smooth and easy to clean. There was also no universal laboratory poster or list of correct blood sample bottles to use, displayed in the clinical room.

- We did not observe any cleaning rotas or schedules displayed in the clinical areas. However, clinics must have a cleaning schedule in place to keep them clean and dust controlled (National Standards of Cleanliness in the NHS 2007).
- Staff informed us that a service level agreement was in place for the disposal of placentas and removal of clinical waste with an external company.
- No reports of Meticillin resistant staphylococcal aureus (MRSA), Clostridium difficile (C. Diff) or puerperal infections were made within the last 12 months.
- Small hand hygiene gel bottles were available to staff to use or attach to their uniforms.
- A Practice Point (guidance document) for Use of Water for Birth, issued following each birth the midwife MUST mark the side of the pool (with an indelible marker) to indicate number of times it has been used – a pool must be discarded once it has been used 40 times". The practice point also stated, "for audit standards, 100% of pools are discarded after being used 40 times". This does not follow manufactures guidance.
- There was some discrepancy between some midwives we spoke to about how many times a pool could be used. Some staff said they followed the 20 use only guidance, however, one staff member told us she was not sure and thought it was between 10 and 20 occasions.
- There was some discrepancy between some midwives we spoke to about what products they used to clean the pools after use. Some midwives informed us they only used sterile wipes to clean the pool while other midwives informed us that they used both sterile wipes and sterilizing tablets to clean the pools after use.
- Staff informed us that pools were cleaned after use with sterilizing fluid or tablets and/or alcohol based wipes and dried well. However, one senior midwife informed us that there was no official cleaning record kept, it was the expectation that midwives cleaned the pool well after use. This did not assure us that hygiene and infection control measures were robust.
- An external courier collected urine and blood sample on pre-arranged collection days at each PAC. Staff used appropriate, secure transport bags for the samples. Staff informed us that if samples were urgent, they would take the samples to the laboratory at the local trust themselves.

Environment and equipment

- One to One (North West) operated from a suite of offices and clinic rooms at Bidston and St James children's centre and satellite community hubs such as Warrington's main shopping precinct and Crewe.
- The Bidston and St James children's centre base consisted of a large reception area on the first floor with seating, a dedicated scan room, and a small clinical room. Through a secure door, staff worked in a large open spaced shared room, with a storeroom, meeting room, kitchen area and toilets. There was lift access from the ground floor.
- The Warrington Hub was centrally located in Warrington town. Downstairs consisted of a large open plan area. This was used as the reception area, a seating area for midwives and woman discussions and parent education sessions. There was also a dedicated scan room, small clinical room and baby changing facilities. Upstairs, through a key coded door, were a large meeting room, computer facilities for staff, kitchen area, a storeroom, which contained a filing cabinet with sensitive information and toilet facilities. This storeroom had a key coded lock, which only staff could access.
- Women and family members used these toilet facilities, so they had to be accompanied to the locked door by staff to enable access. However, we observed that once access was gained, the public were unaccompanied until they returned downstairs. We also observed that the storeroom was not always kept locked by staff going in and out of it. We also observed that the filing cabinet within the storeroom, which contained sensitive and personnel information had the key continuously in the cabinet lock. Therefore, this did not assure us that securely of data and equipment was maintained at all times.
- Midwives made up home birth kits from stock at the Bidston and St James children's centre and Warrington hub. During our inspection, we checked a home birth kit. It was complete and ready for use.

- Midwives did have immediate access to a resuscitation "Ambu" bag (a manual, hand-held device commonly used to provide positive pressure ventilation to women who are not breathing or not breathing adequately) for babies born in poor condition.
- Midwives did not carry any adult emergency airway equipment (Resuscitation Council UK, 2011) for maternal collapse at homebirths; therefore, there was no basic resuscitation equipment readily available for women until a paramedic ambulance arrived.
- Equipment included a sonicaid fetal listening devices and transportable CTG machine that were used to monitor a baby's heart rate. Staff informed us that they only used the CTG machine when concerns were raised about reduced fetal movements, as per their guideline. Any other concerns that required CTG monitoring were transferred into the local trust or trust the woman was booked at. These were visibly clean and in good condition. However, when we observed the CTG machine at the Warrington hub, there was no daily maintenance checklist by staff and no annual service maintenance sticker visible. Staff at the time were unable to tell us if the machine had annual compliance and safety services completed (DOH, Electrical Services, 2007)
- Staff at the Warrington Hub took part in monthly fire safety procedures that was part of the wider building requirements within the shopping centre. One member of staff informed us that every week she completed a fire check.

Medicines

- Medication fridges, at the Bidston and St James children's centre and Warrington hub were checked and maintained within the required temperature ranges however, fridges and temperature checklistswere not labelled or numbered, thereforeit was difficult to ascertain what temperature checklist were for which fridge. This was highlighted at the time of inspection to senior midwives. On the unannounced, all fridges and checklists were numbered and identifiable. Fridges contained drugs such as syntoncinon, syntometrine, flu vaccinations for women and blood sugar glucose test strips. All drugs were in date.
- Medications, such as lignocaine injections and voltoral suppositories were stored in a locked "safe" at Warrington hub. However, the key for the safe was stored in the key lock on the safe and the key for the drugs fridge were stored on top of the safe. This was also highlighted to staff at the time.
- There was a robust process in place for ordering Anti-D for women at the Bidston and St James children's centre. However, the guideline for "use of prophylactic anti- D immunoglobulin" that was displayed in the storeroom for staff, was out of date since 2008. We asked senior staff for a more recent version but we were informed this was the current version available.
- Portable medication gas cylinders (Entonox) were stored lying horizontal, on shelves off the ground, in secure cabinets in an outside designated secure storage areas. Access to these storage areas were to authorised individuals only, by a security key fob. When transported by midwives, cylinders were not secured in transport bags. Staff informed us they lay the cylinders flat but not secured from movement in the boots of their cars. This was not in keeping with best practice guidance. British Compressed Gases Association (BCGA) guidance for the carriage of gas cylinders (2015) state that cylinders are to be secured so that they cannot move during transport.
- We observed a staff signing in and out record box at Warrington Hub, to record what staff had used Entonox. Staff informed us that they contacted BOC directly for replacement Entonox cylinders and removal of empty cylinders.
- The service used both syntoncinon and syntometrine intramuscular injection drugs to manage the delivery of the placenta.Syntoncinon by intramuscular injection is recommended for routine use in active management in accordance with NICE guidance (2007 syntoncinon should be given, according to national guidance. However, it also stated that ifsyntometrine should be given. There was no explanation in the guidance why this was advised.
- Midwives did not offer and did not store or carry Pethidine or any other form of opioids drugs as a form of pain relief at homebirths in the North West.

- One to One informed us that they did not have a pharmacy SLA. They purchased medicines through an accredited supplier who also supplied to the NHS and GP. One to One only purchased drugs from the midwife exemption list.

Records

- One to One Ltd used their own designed handheld maternity case notes, which documented a summary of care only. Staff informed us that these were given to women at booking within a plastic folder, however, some of the notes we reviewed were soiled and dirty as they were not in folders.
- Electronic records and hand written maternity notes were used. We reviewed eight electronic records with staff and 10 sets of handheld notes.
- Written documentation in the handheld notes, we reviewed, was poor. Information was not always clear and concise and documents were not always fully completed. Examples included midwives name not always printed on each page, vitamin k recorded as given but evidence of discussion page not completed, no documentation of a uterus being palpated following delivery or consent gained to check the woman's perineum. Some antenatal pages contained minimal information and written text was often written over the text box (which was very small) which was difficult to read. We saw evidence that fundal height measurements, vaginal examinations and number of contractions were not always documented. If some aspects of care was declined by the women, it was not always clearly documented by the staff the reasons why or if the midwife had discussed the risk and benefits in detail. These were often in high risk cases. Therefore, we were not assured that staff followed the NMC record keeping (2015) guidance.
- Within the maternity handheld notes, there was a dedicated section for multidisciplinary team communication. This was to enable correspondence to be visibly shared teams to ensure seamless care provision. However, in notes we reviewed, these pages were not always completed for high-risk women.
- One to One also used an electronic health records system, which indicated in more deal that best practice guidance was discussed and documented in the care plans and risk assessments. It was also easy to navigate on the screen tabs to see if women had been referred to specialist services.
- Although electronic records were clear, it was not always clear from the handheld notes whether midwives had discussed best practice guidance with expectant women. We observed that the handheld notes did not provide enough information to help determine whether the service considered a pregnancy as low or high risk. Staff we spoke to agreed that it was unclear. Neither was it always possible to confirm in the handheld notes, if all the risks had been fully explored when women with a high-risk pregnancy opted for a home birth. This was also highlighted at the last CQC inspection in November 2015.
- Staff informed us that if women were admitted to a local trust, staff in the trust would only have access to the summary case notes. However, staff informed us that they accompanied the majority of their women into the trust and could give a verbal handover.
- It was not clearly documented on the handheld notes who was the lead carer or if care and treatment was "shared care" with a local trust. Again, when we discussed this with staff, they agreed it was not clear.
- On the unannounced visit, we observed 18 paper copies of blood results that were reviewed and dated but were stored in a filing cabinet and required filing in the women's handheld notes. These were dated as far back as 10 January 2017. Two of the blood result forms stated that the results were abnormal and needed actioning. One of the midwives told us that all the midwives individually checked their own women's blood results on the IT system and actioned and recorded management immediately via the online records system. However, from our observations, a time lag of up to two weeks was evident between the management and filing of the paper blood results in the handheld notes. The impact of this may affect the ability to provide timely information on transfer of women to an acute care setting.

Maternity

- We also observed a woman discharge summary letter following delivery, dated December 2016, from a local trust stored in an envelope in the filing cabinet. Staff informed us that this was supposed to be attached to the woman's handheld notes.
- Women's handheld notes reviewed during the unannounced visit highlighted that newborn blood spot screening page was not fully completed and there were no discharge summaries or operative details from acute trusts attached to the notes. Staff used many abbreviations and patterns of care were difficult to read, as summary boxes were small to write in. During the unannounced visit, we asked midwives to review these women's notes on their portable electronic device. All documentation was completed, concise and clear. However, it did not assure us that information in the handheld notes was contemporaneous with the documentation on the portable electronic device and that a time lag or lack of information in the handheld notes would be fully informative if transferred to acute care setting in an emergency. Staff informed us that they always tried to accompany their women if transferred into hospital and they also complete an SBAR form to assist with an effective handover but this was always guaranteed.
- Staff told us that they used a paper hand written birth observation record rather than a standardised NHS partogram to recorded labour details and observations. They informed us that from the summer 2017, they planned to electronically record all labour details on staff portable electronic device and discontinue using the handheld birth observation records. This did not assure us that all essential information to manage safe care was easily available, especially for external agencies that could not access the One to One electronic system for full online details, especially women who are transferred in an emergency in labour to an acute hospital.
- Electronic postnatal care records we observed were completed to provide comprehensive information about the care of mother and baby for up to six weeks after labour. However, One to One did not use any specific written postnatal handheld notes.
- Therefore, poor documentation and lack of contemporaneous record keeping observed in the antenatal handheld notes and the lack of postnatal handheld notes informed us that documentation did not meet the needs of the service, therefore providing limited assurance in the management of and escalation of risk to external providers. This was highlighted as a concern to the senior team during the unannounced visit.
- The hand written notes were kept by the women and returned to One to One at the conclusion of post-natal care. Electronic records were stored on the 'cloud' and were subject to sufficient security checks and encryptions and data protection act compliant to reduce the risk of women's records been accessed by those without the correct authority.
- Lack of documented risk assessments and intrapartum records that did not support contemporaneous record keeping was recorded on the One to One risk register. However, the service had introduced "variance" sheets and SBAR handover forms.
- All midwives have access to electronic handheld devises with 3G access 24 hours access to guidelines and research to support practice.
- A Record Keeping and Handheld Records Policy was available to staff. The review date was February 2017.

Safeguarding

- Senior staff informed us that safeguarding level 3 training had been completed by 98% of staff. The service target was 95%.
- One to One safeguarding (SG) department consisted of a Head of Safeguarding, a safeguarding midwife, and one safeguarding supervisor.
- A safeguarding adult's policy, review date 2018, was available to all staff. This included advise and pathways on , Mental Capacity Act, PREVENT is part of the Governments counter terrorism strategy to prevent people becoming terrorist and supporting violent extremism. Staff were advised to read the policy in conjunction with the local multi agency safeguarding adult's policy and procedures documents, which are available on the Local Safeguarding Children Board (LSCB) websites, and other local guidance, which could be accessed on the shared drive under the relevant locality files.

Maternity

- Safeguarding adults performance data provided by the service for 2016/17, showed that above 90% of clinical and non-clinical staff had appropriate safeguarding adult training within the past 3 years. The performance data did not record information such as the number of Independent Mental Capacity Advocate (IMCA) requests made, numbers of Adult Safeguarding referrals to Local Authority, internal safeguarding incidents investigated and appropriate action taken by the organisation or number of cases of FGM identified
- A safeguarding children's policy, review date 2018, was also available to all staff. Information and guidance included working with sexually active under 18 years old, looked after children, disabled children, missing children and children missing from education, female genital mutilation (FGM)forced marriages involving young people and unborn babies and vulnerable women. The policy stated that One to One did not accept referrals from anyone aged 14 and under, but all staff needed to be aware that any child aged 13 or under needed to have involvement from the criminal justice system.
- Safeguarding children's performance data provided by the service for 2016/17 showed that formal safeguarding children clinical supervision compliance for midwives carrying safeguarding cases was between 90% and 100%.
- Safeguarding children performance measures such asMulti Agency Risk Assessment Conference
- Staff informed us that there was a longstanding relationship both with the safeguarding team at the Local Acute Trusts and neighbouring CCG areas. The Safeguarding Lead (Named Midwife for safeguarding) had regular meetings with the designated nurse for safeguarding at local CCGs to ensure the department meets all legal and contractual requirements.
- The midwives had access to an extensive resource area on the internal internet system, which detailed internal policies and guidance and links to local services, forms and pathways to link into external services. One to One were able to access MARAC and other relevant local services. For example, the Head of Safeguarding was part of a local working group for Female Genital Mutilation (FGM).
- Staff informed us that all safeguarding data was documented electronically which included the number of Independent Mental Capacity Advocate (IMCA) requests made, numbers of adult safeguarding referrals to local authority, number of cases of Female genital mutilation (FGM) identified, internal safeguarding incidents investigated and appropriate action taken by the provider. Each patient electronic record had the facility of a safeguarding tab, which enabled staff to record any concerns or actions. The tab would highlight blue if any concerns were noted. Handheld notes only had summaries of care.
- We observed a new draft safeguarding dashboard template to populate safeguarding performance data during our inspection, which was to be used by the staff from the middle of 2017.
- The safeguarding lead and governance lead reviewed all safeguarding incidents. Staff informed us that they had safeguarding supervision at a minimum of three monthly to guide and support practice, and monthly for ongoing/active cases.
- Staff were to be allocated a new "Safeguarding Passport" document from February 2017. The safeguarding team designed this three-year "passport", to ensure all midwives met their statutory and mandatory requirements within safeguarding. The passport included safeguarding requirements, a list of One to One safeguarding polices, links to national statutory guidance, local safeguarding children's and adult board details and guidance on assessing the NHS safeguarding App on their portable electronic device. The passport also recorded staff safeguarding training, safeguarding supervision and trigger list for safeguarding consideration and staff reflective tool.
- One staff member gave us an example of caring for a pregnant teenager. She had direct access to social services as well as attending MDT meetings with the police, social services and health visitor. She was involved in the "children in need" care plan and felt very well supported.
- We observed staff pathway posters displayed contained information about pregnancy guidance for sexual active under 18 year olds and a live online link to information

for less than 16 years old. The pathway included national consent and confidentiality guidance, prompts for child sexual exploitation, and Frazer compete net guidance.

Mandatory training

- Data provided by the service showed that for midwives, over the last 12 months, 78% were compliant in CTG and fetal heart interpretation. Adult basic life support training was completed by 67% of midwives and 73% had completed child basic life support. Breast-feeding training was completed by 71% of midwives and 82% had completed fire safety training. Sixty percent had completed the GROW training package and 89% had completed governance information training. Only 58% of midwives had completed mental health training and 82% were compliant in perineal care. Seventy six percent were trained to provide a physiological (no drugs used to deliver the placenta) birth, 86% had completed record keeping training and 91% were compliant in risk management.
- For the same period, skills drills such as antenatal bleeding, breech delivery, cord prolapse and should dystocia were completed by 84% of midwives. Training for postnatal bleeding was completed by 82% of midwives.
- Training for the unwell baby was completed by 78% of midwives.
- All midwives had completed their induction training.
- One to One informed us that they provided staff 10 days protected time per annum to attend training. All midwives had to provide evidence of continuing professional development (CPD) every 12 months to sign their Intention to Practice form.
- One to One informed us that they provided an induction programme, mentorship and preceptorship programme, a rolling mandatory training programme, multiple workshops, ad hoc training on request from staff and support with flexibility for midwives and employees to undertake external training programmes.
- The induction programme for all new starters was held over 6 days andincluded topics such as organisational culture and structure, health and safety, mandatory training obligations, conflict resolution, equipment, caseloading, UK national screening programme, supervision and revalidation, risk management, escalation policy, homebirth, risk assessment,hypertension, pre-eclampsia,severely ill woman, anaphylaxis, sepsis, collapse, emergency procedures, complex care planning , newborn behaviourand escalation and management reduced baby movements.
- All staff informed us they had received fire safety training.
- Of the 47 midwives, 21 midwives were trained in hypnobirthing.
- Some midwives informed us that they had not received Vaginal Birth after Caesarean (VBAC) training, although this was offered as a service. They also informed us that they had not received specific training or completed any competencies requirements for water births. They told us they followed the guidelines for water birth, available on their portable electronic device. Staff also informed us that they had not received any routine training for specific complex obstetric conditions. They informed us that they researched the conditions themselves and worked closely with the acute trusts these women would be also booked with (shared care). However, this did not assure us that all staff were adequately trained and skilled to manage and/or recognise deteriorating signs of women with complex conditions.
- As well as mandatory One to One specific training, MaMAs received training from a large local university. The training included newborn blood spot screening, capillary blood testing (adult), neonatal resuscitation, basic maternal life support, support at home birth (to include recognitionof some skills/drills, assistance with manoeuvres, calling for help, taking basic observations and documentation)and maternal observations.
- Information from One to One showed that from January to December 2016, 100% of MaMA staff had completed adult and neonatal basic life support training, baby friendly initiative (BFI)infant feeding training, infection prevention and control, mental health training, newborn blood spot and induction training. Fire safety training was completed by 77.78% and information governance was completed by 88.89% of MaMA staff.
- Following a birthing pool audit December 2016, it was recommended that all new midwives on their induction were trained on how to set up the birthing pool with the

pool liners. However, waterbirth and set up of pool equipment was not mentioned on the induction programme agenda for 9 January 2017. When we discussed this at the unannounced with senior midwives, they were unsure if this had been added to the training agenda yet.

Assessing and responding to patient risk

- The inclusion and exclusion criteria list was divided into "intermediate" and "intensive" pathways and sub divided into areas such as risk, suitable for inclusion into caseloading service, transfer into obstetric led service after booking assessment at One to One, suitable for shared obstetric led care and suitability for a homebirth.
- Examples from the inclusion and exclusion criteria list showed that a woman with a BMI less that 18kgs was suitable for caseloading but not for homebirth. Epilepsy, existing hypertension and respiratory disease requiring medications were suitable for transfer into obstetric led service after the booking assessment but not for homebirth. Patients who had five or more previous babies were suitable for caseloading but not suitable for homebirth. The same applied also to previous caesarean sections and shoulder dystocia. However, we observed records that showed there was one VBAC homebirth in the last 12 months.
- The criteria checklist also stated that women with a history of previous stillbirth or neonatal death, hepatitis B or C, HIV positive and haematological disease were suitable for homebirths. However, this was not in line with the NICE Intrapartum Care guideline 190, which recommend births at an obstetric unit for these conditions.
- We observed risk assessments, complex care plans and referrals for high-risk women to external providers.
- Staff could access internet links on their electronic devices to the most up to date and relevant best practice guidance.
- At the booking visit, the midwife undertook a risk assessment to confirm that the woman was placed on the appropriate pathway and when appropriate a robust plan of care was put in place. The pathways online were RAG rated in a colour system: green). Amber indicated potential risk factors identified (intermediate pathway). This was where potential medical, obstetric and/or social risk factors were identified and a referred to the One to One regional clinical lead obstetrician and the wider multi-disciplinary team (MDT) for further assessment and plan of care was indicated. . This indicated are referral to the One to One consultant obstetrician or to the local trust obstetrician and a decision then made to refer to the external MDT, e.g. anaesthetist, diabetologist, cardiologist, neonatologist, psychiatrist and allied health professionals.
- A Modified Early Obstetric Warning Score (MEOWS) Prompt Chart for the immediate postnatal period following birth was available for all staff, to assist in their detection of a seriously ill and deteriorating woman. Triggers were coloured coded. The chart stated, "the midwife cannot leave the woman unless all scores are green. This chart is to be used in conjunction with the 'Midwives Mitigating Risk' (MMR) pathways and where appropriate the escalation policy if a mother declines aspects of care or transfer to trust when clinically recommended". Staff informed us that completion of the MEOWS was part of the risk assessment and was considered part of normal clinical care.
- An escalation policy was available which included antenatal escalation and flowchart, women who decline escalation of transfer of care, intrapartum escalation of care and flowchart, neonatal escalation of care, postnatal escalation of care, escalation of concerns regarding a colleague and local contact details.

Midwifery staffing

- Midwifery staffing levels at One to One (North West) was 47 midwives. Six of these midwives were employed within the last six months. Ten midwives had come directly from qualifying to work at the service.
- Information received from One to One showed that between July and December 2016, staff turnover rates within the total company for midwives were 19% and MaMAs

  were 7%. Over this six-month period, the total attrition rates for all staff were 15%. Over the last 10 months, data showed that the overall attrition rate for all staff over the total company was 25%. Currently there were no concerns with sickness rates.

- Staff informed us that One to One took into account the following to ensure safe midwifery staffing levels were maintained and reviewed within the organisation: caseload sizes, women's needs, midwives additional responsibilities, homebirth numbers and additional duties such as parent education classes or attending events. This was calculated using approximate timeframes and compliance with NICE guidance on minimum number of visits. The hours were calculated monthly to give a monthly booking/birth rate which was taken into account when setting caseload sizes.
- The MaMA role required the assistants to help and support midwives to provide a high standard of care to women, their families and babies before, during and after birth.
- Following appropriate training, the MaMA role includes the by assisting in the teaching and demonstration of basic parenting skills on an individual basis and in group sessions. They provided smoking cessation advice, re-enforced key health messages delivered by the midwifery staff, reporting any significant changes in women's progress to the midwife. They also assisted, where appropriate, in the running and preparation of drop in sessions, parent education and breastfeeding support groups and assist a family in accessing appropriate services.
- The MaMA job description stated that NVQ level three was an essential requirement at interview. However, data provided by the service showed that only two MaMA staff had this requirement at interview. Five other MaMA staff had received their training from a large local university once they had been employed.
- One to One (North West) employed a Communication Co-ordinate and Marketing member of staff. The role involved opening and closing a specific hub, recording fridge temperatures, accessing theIT system for community midwives who phoned in for blood results, communication via telephone to women and liaison with external agencies who facilitated classes within the hub building. The marketing role involved attending events in the community such as the weekly NCT coffee mornings at a local large shop, communication and promotion with GP, children's centres and play groups about the One to One service. This role was based at the Warrington hub Monday to Friday. The midwife specifically allocated to the hub worked Tuesday to Saturdays. We were informed that the communication and engagement manager for the North West directly managed the communication co-ordinator role. Senior communication management support was accessed remotely through a long distance arrangement.
- One to One had developed a volunteer programme to provide opportunities for women who wished to gain work experience or who wanted to give back something to their community. Volunteers used the hubs to gain insight into how a caseloading midwifery model works especially if they were looking to access midwifery courses in the future.
- There were six Volunteers in the North West and five more to start soon. All had Disclosure and Barring Service (DBS) checks completed and were supported with additional training opportunities, which included health and safety, hypnobirthing and first aid. Senior staff informed us that the aim of the volunteers was to sit on the QA group, be an advisory to the service and obtain user satisfaction.
- We were unable to review staff personnel and development files as there were no paper files kept on site by the service. One to One used a remote, external online Human Resources (HR) system.
- We were informed that six new midwives, four new MaMA, one administration staff member and one PAC midwife were on the induction programme currently.

Medical staffing

- There was one obstetric consultant employed by One to One. This role included review and development documents, review template of plans of care, attend Quality Assurance meetings, provide supervision and support to staff. The consultant also ran one monthly obstetric clinic in the North West.
- Staff informed us that their working relationships with some acute trusts was improving and that if a One to One woman was transferred into hospital, the midwife would always try to complete a SBAR or transfer of care sheet and accompany the woman into hospital to discuss thecare and needs directly with medical and midwifery staff.

Emergency awareness and training

- Staff reported that they received emergency awareness training as part of their induction and mandatory training.

- A Business Continuity Plan was available that set outplans for One to One (North West) Ltd to take to survive a any situation or incident that may lead to interruption of One to One's key services for more than half a day. This included denial of access to business premises, failure of the information system or network, or inability for all users to access information, loss of a significant number of staff, loss of travel capability, inability to reach clients' homes or other relevant locations.

Are maternity services effective?

Evidence-based care and treatment

- There were local policies and guidance in place that were in line with evidence-based care from the National Institute for Health and Care Excellence (NICE) and guidance from the Royal Colleges of Midwifery (RCM) and. We reviewed 13 policesincluding the escalation (referral to other services) policy, management of third stage labour, informed consent ,inclusion and exclusion criteria for booking clients and medicines management and management of women with complex needs.
- Staff informed us that they also development their own "Practice Point" guidance which were based on relevant national guidelines, recommendation from RCOG and evidence based practice. They included general information and comprehensive overviews of complex obstetric conditions.
- We reviewed six One to One Practice Points, including birth after VBAC, antenatal and intrapartum baby heart monitoring and reduced fetal movement. All were in date and version controlled.
- Most policies and procedures had been reviewed and updated although we found that one policy, the guideline for the prophylactic use of Anti D, required a review in 2008 and this had not been completed.
- Staff had access to online up to date national guidelines and One to One guidelines on the portable electronic devices.
- One to One had an annual audit table which listed necessary audits that needed completion over a 12-month period. Between April 2016 and December 2016, there were 12 items requiring auditing. For the same period, eight audits had been completed which included perineal trauma, documentation and screening, which were completed twice, incident reporting, safeguarding process and intrapartum transfer. One audit for continuity of care was completed but was waiting for ratification.
- A Public Health England Quality Assurance Report for Antenatal and Newborn (ANNB) Screening Programmes was published July 2016. Key recommendations included one immediate action relating to the NIPE referral pathways needing to meet national standards. Nine other recommendations were identified which included SLAs oversight and monitoring, communication channels and procedures, developmentofmicrobiology laboratory failsafe, SOPs update to include failsafe mechanisms and commissioning performance monitoring. All actions were to be completed by October 2016 and a re-audit was suggested by July 2017.
- Carbon monoxide (breath) test and brief smoking cessation advice was currently only being offered to women who smoked. However, staff told us that there were plans to extend this to all women in the future and that the local smoking cessation service they worked with, was planning to provide a smoking cessation service at a local PACs. NICE (2010) advise that all women should be provided with information about the risks of smoking to her and her unborn child including smoking by partners and family members. Therefore, all women should be offered a carbon monoxide (CO) at booking.
- A birthing pool audit was undertaken December 2016. Forty-two midwives took part in the review through telephone interview. Birthing pool usage was dependent on the home births midwives had in the previous six months. The pool was used between one and 26 times over the six-month period. The main actions were that midwives should be aware of the tick usage on the sides of the pools and should use this to monitor the maintenance of the pool. The pools must be cleaned between usage with the products listed in the One to One practice points and manufacturers guidelines, ensure that all new midwives on their induction are trained on how to set up the birthing pool with the pool liners. However, we observed that water birth was not mentioned on the induction programme

agenda for 9 January 2017 and from speaking to midwives there was some different in the cleaning products used to clean the pools. Some informed us they only used sterile wipes to clean the pool while other midwives informed us that they used both sterile wipes and Milton tablets to clean the pools after use.

- An audit of documentation took place over three months in 2016. Twenty-two sets of handheld notes and electronic records were randomly audited from across the organisation (North West and Essex).100% of the booking details and pregnancy details were documented on the electronic record system and handheld notes, booking risk assessments were made on all women,the majority of women who required an onward referral, the midwives evidenced a management plan, a proforma was used to alert GP/Health Visitors if a woman miscarried, women with complex pregnancies who opted for a homebirth had an individualised plan of care devised that was signed and dated and filed in the handheld notes. One hundred percent of risk assessments were completed following a homebirth. Risks were identified and documented, plans of care were devised, and when onward referrals were required during the intrapartum period, they were documented appropriately and completed within a timely manner. All NIPE examinations were completed within 72 hours. At the time of our inspection, these good practice areas were not evident in all the notes we reviewed.
- Staff informed us that babies received their newborn hearing screening test before either they were discharged from hospital, or a letter was sent to parents to attend an appointment at the trust.

Pain relief

- Midwives did not offer Pethidine or any other form of opioid drugs as a form of pain relief at homebirths in the North West.
- Hypnobirthing and water were used as relaxation techniques during labour.

Nutrition and hydration

- The service offered support to women who choose to breast feed or bottle-feed their babies. MaMAs received training in how to support new mothers with feeding their babies.
- Breast-feeding was promoted in keeping with the Unicef UK Baby Friendly Initiative programme however, there were no immediate plans for the service to apply for BFI accreditation. Accreditation is based on evidence-basedstandards for maternity and are designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.
- Staff offered skin-to-skin contact at birth to promote bonding and initiate breast-feeding.
- Data provided by the service showed that between July 2015 and June 2016, breastfeeding statistics for homebirths only showed that between 81% and 86% of women were breastfeeding after delivery. For the same period, between 70% and 77% of women were breastfeeding at discharge from hospital and between 57% and 70% of women breastfeeding at discharge from maternity care.
- Staff informed us that if they had concerns about baby weight loss postnatally, they would discuss feeding with the parents, review any possible risk factors, develop a strict care plan including re-weighting baby. If baby had lost more than 12 % of its birth weight, staff would always transfer to the local trust for further review Midwives carried equipment to test for jaundice (a yellowish or greenish pigmentation of the skin and whites of the eyes due to high bilirubin levels) in babies. These samples were transported to the local laboratory for analysis.

Patient outcomes

- The One to One (North West) maternity dashboard recorded information that were divided under three main subheadings: Key Performance IndicatorsKPIs) and Activity, Morbidity and Risk and Patient care.
- The One to One North West dashboards did not contain information such as postpartum haemorrhage (PPH) rates below and above 2000mls, born before arrival (BBA) rates, maternal collapse, maternal sepsis, Stillbirth rates, booked VBAC and successful VBAC rates. This information was requested separately.
- The North West dashboard did not record any service or national targets. Senior staff informed us that submitting targets were “not truly meaningful “as it was

difficult to obtain comparable data as their model of care was so different. However, senior staff also informed us that this has been discussed and agreed at the QA meetings that targets would be reintroduced in the future as well as colour ratings and actions for declining rates.

- Data recorded from April 2016 to December 2016, on the North West dashboard showed that 1699 women booked with the service in the North West region.
- For the same reporting period, between 91% and 100 % of women were booked on or before 12+6 weeks gestation. Between 84% and 95% of women offered booking within 2 weeks of referral if over 12+6 weeks gestation at referral.
- One hundred percent of women were referred to the Health Visitors (antenatal) at 28 weeks gestation.
- Planned home births from April 2016 to December 2016, was between 30-45%. Home births achieved ranged from 18% to 30%.
- From April 2016 to December 2016, the normal vaginal delivery rate ranged between 65% and 79% for women of all risk pathways that gave birth at the local trust.
- Planned caesarean section deliveries ranged from 3% to 17%. Unplanned Caesarean deliveries were between 7% and 14%.
- Instrumental vaginal deliveries for women under the care of One to One North West ranged from 4% in June 2016 and 12% in September 2016, which was within the national standards.
- The number of homebirths from April 2016 to December 2016 was 954. The number of homebirths where the named midwife was the same as the midwife through the antenatal, intrapartum and postnatal care period was 232.
- There was no recorded third or fourth degree tears recorded from April 2016 to December 2016.
- From April 2016 to December 2016, there were 49 low birthweight babies, whose mothers were booked with One to One, that were born, in a hospital setting.
- The dashboard stated that urgent call outs achieved within one hour and the number of occurrences of pre-eclampsia at home delivery were not currently being recorded.
- The dashboard states that discharges where 'Discharge Summary of Care' is provided within 24 hours to the woman's GP and Health Visitor was difficult to obtain as they did nothave a time frame on the recipient receiving the data form.
- From April 2016 to December 2016, there were 255 women identified with mental health problems, some women with pre-existing conditions, some women newly diagnosed. One hundred percent of care for these women with mental health problems followed the perinatal mental health pathway.
- There were 219 women with Body Mass Index (BMI) over 30kgs at booking and 91 women with a BMI over 35kgs at booking. Again, the dashboard did not specifically state if these women delivered at home or in a hospital setting. However, the Intrapartum Care Guideline 90 (NICE 2014) states that women with a BMI at booking of greater then 35kgshould have a planned birth in an obstetric unit.
- For the same reporting period, 100% of women were advised and provided with contraception of choice at discharge.
- Supervisor to midwife ratio was recorded as 1:12 from April 2016 to December 2016, which was within the national recommendations.
- There were 34 teenage mothers aged below 20 years old recorded for the same reporting period. However, this data was not broken down into the number of teenagers below 18, 16 and 14 years old. There were also no referrals to Family Nurse Partnership (FNP) recorded even though staff told us that they had a good working relationship with this external agency. FNP is a voluntary home visiting programme for first time young mums, aged 19 years or under. A specially trained family nurse visits the young mum regularly, from the early stages of pregnancy until their child is two years old. Some staff were unable to tell us what the age cut off was, for booking with One to One. However, they informed us

that they would complete a consultant referral to the local trust, liaise with the trust teenage pregnancy midwife and liaise with the One to One safeguarding lead to consider opening a safeguarding case.

- Information provided by email from the provider, stated that from January 2016 to December 2016, PPH rates were between 500ml and 1000mls was 11.6%. National average was 13% of all maternities in England (MBRRACE-UK, 2014). PPH above 1000mls were recorded as one and above 2000mls were recorded as zero, however, it was not clear if this was percentage or actual numbers.
- < >, described asborn before arrival(BBA), are rapidbirths that take place without the presence of a midwife. Data provided by the service showed that BBA rates were 1.4% of all births. It was not clear if this was for all births in the North West or all births in the whole company. The North West service reported one maternal collapse and one maternal sepsis over the previous 12 months.
- One to One reported no stillbirths in the North West from January 2016 to December 2016.
- Data provided by the service showed that from January 2016 to December 2016, there were five VBAC deliveries. One had a homebirth and the remaining four had vaginal births at their booked trust. However, the Intrapartum Care Guideline 90 (NICE 2014) states that women who have had a previous caesarean section should have a planned birth in an obstetric unit.
- Between January and March 2016, 45 women booked for antenatal care. All women were offered Hepatitis B, HIV, syphilis and rubella screening. Two women declined Hepatitis screening, two women declined HIV screening, two women declined syphilis screening and five women declined rubella screening. There were no newly diagnosed or positive results for Hepatitis B, HIV or syphilis. One woman was not immune to Rubella.

Competent staff

- Staff attended monthly Fresh Eyes meetings and attended hospital appointments with their women to improve communication and ensure a complete understanding of the condition and care plan set out. However, staff informed us that they did not routinely receive complex care training on such conditions as epilepsy, neurological disorders, diabetes, asthma, renal disease, congenital or known acquired cardiac disease, autoimmune disorders, haematological disorders, obesity and informed us that they were often were reliant on the women knowing and managing her condition herself or advice from the trust. Some staff who came directly from qualifying to work at One to One reported that they had little experience with some complex conditions but never felt unsupported or worked outside their NMC professional code of Practice.
- All MaMA staff received a development programme document, which should be completed within six weeks of the enhanced MaMA training. This document was agreed within a local network group and was in the process of being updated. We observed a completed document for the training and competency of the newborn blood spot training.
- Some MaMA staff we spoke to informed us as well as providing non-clinical antenatal care, they provided non-clinical advice and support postnatal care from 10 days to discharge. This included postnatal baby checks, baby weights and observation of a well baby. All deviations from normal or any concerns were always escalated to the midwives. However, we were also informed that MaMA staff were trained to undertake newborn blood spot screening and Glucose Tolerance tests.
- There was one midwife trained in the Frenulotomy procedure to correct tongue-tie. Tongue-tie is a congenital anomaly where the tongue movement is restricted and can interfere with breastfeeding. The One to One Frenulotomy clinic was not current up and running at the time of our inspection. However, there were clinics running across the Northwest area, for staff to refer babies.
- There were five trained midwives to provide examination of the newborn programme.
- There were no sonographer-trained midwives in the service.
- Staff informed us that One to One did not provide specific perineal suture training therefore not all midwives had the skills or training to suture. Staff told us that the team leaders, if required provided suturing peer training within teams. However, this could affect the transfer rate of women into hospital for perineal (area

between the pubic symphysis and the coccyx) repair. Suturing the perineum was part of an outline agenda for mandatory training. However, three programme timetables we reviewed did not have suturing listed.

- Practice Point (guidance document) for Use of Water for Birth stated that all new midwives should be shown how to use a pool as part of the induction period within the first three months of commencement. This training will include how to clean and maintain the pool and the pump. Water birth was not mentioned on the induction programme agenda for 9 January 2017 however, it was documented in a blank, undated copy of the Training Review and Mapping of Education document supplied by One to One, stating that water birth should be completed annually on the three-day skills and drills programme.
  The service employed five SoM. Three worked directly within the organisation, one was contracted to provide support and advice and one was on maternity leave. Therefore, the ratio of SoM to midwives was 1:12, which was within the recommended guidance.
- From January 2016 to December 2016, 79% of midwives had completed an annual appraisal review in the North West. This was down from 80% from April 2015 to April 2016. The Nursing andMidwiferyCouncil (NMC 2014) supports the benefitsof appraisals, as it helps access and address personal development planning and performance review. It also states that for the new revalidation process "appraisals must be high quality, robust, fairly carried out, objective and not purely focused on employer/employee contract". This did not assure us that a robust appraisal system was embedded in the service.
- However, One to One has been chosen as one of six pilot sites to test a new national model for midwifery supervision. The intention is for the pilot sites to run for a period of four months, with on-going evaluation designed to facilitate rapid learning to enable a national launch of the final model by April 2017. The new model includes the new A-EQUIP (advocating for education and quality improvement) approach, which is a continuous improvement process that builds personal and professional resilience, enhances quality of care for women and babies and supports preparedness for appraisal and professional revalidation. The A-EQUIP approach aims to ensure that through staff development, action to improve quality of care becomes an intrinsic part of everyone's job, every day, in all parts of the system.
- All new midwives were given a "consolidation passport" document to record training and development and highlight any needs when they commenced working for the service.
- A Coach midwife was employed by the service. She also cared for a small caseload of women and was a SoM. Her role included providing staff support, developing an individualised tailored approach for new midwives professional needs and facilitate "keeping in touch" meetings. The role also aimed to identify gaps in staff training needs and facilitate training sessions, observe and support midwives in the clinical areas and assist in practical processes such as taking bloods to a local large hospital laboratory. This role was also to assist with staff retention.

Multidisciplinary working

- One to One worked closely with a number of third party providers. Providers included nutritional experts, a private ultrasound scanning company and complementary therapists. The midwives told us there were good working relationships with these providers.
- Staff offered basic smoking cessation advice. Staff informed us that they worked closely with a local stop smoking service and referred women to this service for more advice and support.
- Staff often accompanied women to appointments at NHS hospitals and liaised directly with hospital staff. When women were referred to other services, the midwife completed a formal referral form detailing the reasons for the referral. Staff told us that they would screen shot women's records for trust staff to assist with management of care.
- Staff told us that clinical staff from some NHS trusts was supportive and welcoming; however they reported that they also faced negativity in some areas towards their service, which led to difficult working relationships. Staff had taken steps to improve working relationships with other providers including formal and informal meetings and invitations to training or social events.

- Service level agreements (SLA) to provide shared pathways and shared care for high-risk pregnancies were not developed between One to One and local providers. At the time of inspection, we were informed that there were eight shared pathways in draft.Staff informed us that multidisciplinary working with local acute trust maternity services could be problematic but some positive and productive meetings had recently taken place.
- We observed meeting minutes from January 2017, between One to One and a local large trust, which discussed the continuingneed to identify the most effective way to refer women into the trust maternity services when an obstetric opinion was required or when new risks developed during pregnancy and an obstetric review was required. Other items discussed included the development of routine, urgent and abnormal screening pathways between the two services, documentation and communication improvements.
- Staff at the Warrington PAC informed us that they were made aware of postnatal discharges by phone from the local trust. These were not recorded in an official discharge record book. A member of staff sent an email to the wider team daily to inform them what women had been discharged. However, we were informed that many of the staff already knew their women had been discharged as the women rang their One to One midwives directly to inform them. Staff could not recall any delays or incidents regarding to delayed awareness of discharges.

Access to information

- Staff had access to all maternity records, including antenatal and postnatal records, electronically via their electronic devices. However, women were only provided with an antenatal handheld paper record summary, which they were expected to carry with them for all appointments, including trust appointments, transfers and deliveries at the local trusts. The trusts did not have access to the full care record as they did not have access to One to One shared electronic records system. This provided limited assurance in the management of and escalation of risk. We were not provided with assurance that all relevant information was easily available, especially for external agencies that could not access the One to One electronic system for full online details.
- The service did not provide the women with any specific postnatal handheld notes. All postnatal care was documented online via the midwives electronic device. Again, this information was unavailable to share or dissemination to other external agencies. Therefore, this also provided limited assurance in the management of and escalation of risk especially for external agencies that could not access the One to One electronic system for full online details.
- We observed a time lag of approximately two weeks between filing of paper copies of antenatal screening reports and results in the women's handheld notes and documentation by staff of screening results on the electronic devices. Again, this did not assure us that care and obstetric history was communicated fully and effectively with external colleagues. Therefore, we were not assured that all the information needed, especially in an emergency, was available and provided immediately.
- Staff accessed policies, guidelines and other information through the services intranet and all staff had access to computers and individual electronic devices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The One to One Informed Consent policy stated that when obtaining consent, women should be told about proposed treatment, and care and that the information is given in a sensitive and understandable way. The NMC code (2015) states that women should be given enough time to consider the information and the opportunity to ask questions if they wish to. This was not always clearly and concisely documented in the women's handheld notes.
- The NMC code also states that midwives should not assume that the person in their care has sufficient knowledge, even about basic treatment, for them to make a choice. It also supports involving people in the care giving processes. It clearly states: "You must uphold people's rights to be fully involved in decisions about their care." It is essential that they be given sufficient information to enable them to determine whether or not to accept or decline treatment and care. This right is supported in the code where it states:

- The consent policy contained guidance for when consent was refused by a woman, refusal of treatment, children under 16 years old and mental health capacity.
- The policy also states that if a woman refused treatment, the midwife must document the offer and the refusal and if possible the reason why the woman has refused the treatment. The midwife may need to consider contacting her line manager or Supervisor of Midwives for advice dependent on individual circumstances. This evidence was not plainly or clearly visibly documented in the women's handheld notes that we observed during the inspection.
- A safeguarding adult's policy, review date 2018, was available to all staff. This included advice and guidance Mental Capacity Act and
- We reviewed the handheld notes of some women with high-risk pregnancies. It was not clearly documented in full the risks, benefits and consequences of obstetric decisions. Staff we spoke to assured us that full informed consent was always obtained and documented in the electronic records; however, it was clear that this was not always completed in the handheld notes. Therefore, we were not assured that women were given sufficient information to make a fully informed decision. This was also highlighted at the last inspection.
- Some staff informed us that they routinely assessed women's mental health wellbeing at 28 weeks of pregnancy and postnatally. They informed us that they did not us a specific standardised assessment tool but each individual midwives used a tool of her own preference, for example the Edinburgh MentalWell-being scale or Whooley assessment tool. Staff informed us they were aware how to make and who to contact to make a referral if required.

Are maternity services caring?

Compassionate care

- We observed an antenatal appointment, where topics such as the flu vaccination, whooping cough vaccine were discussed thoroughly and sensitively.
- We also observed a midwife discussing the options for hypnobirthing and active birth workshops and the availability of classes within the service.
- We were informed from one woman, that even though she delivered in hospital, she was well supported postnatally, especially with breastfeeding.
- Friends and Family data were provided by the service showed an overall response rate of 41.5% for 2016/17. However, it was difficult to ascertain if the data was for the whole service or just for the North West. Between 89% and 97% responses said, they were likely to recommend the service to family and friend if they needed similar care and treatment. Eighty seven percent reported convenience of scan appointments, 100% reported being involved in the decision-making during their pregnancy. Ninety three percent said they had received informed choice about place of birth. Ninety two percent said they were informed with decision making during labour. Ninety nine percent reported they had made the choice about place of birth. Eighty percent said they had a home assessment in labour. Seventy percent reported having the named One to One midwife present at birth.

Understanding and involvement of women and those close to them

- Staff involved women's partners, children and the wider family unit within the care model.
- Women told us staff considered their needs throughout the pregnancy and postnatally and their views and opinions on birth choices and plans were sought and respected. They felt that the midwives' presence during the birth of their child had relieved their anxieties and reduced the pressure they felt when supporting their partner.
- Staff encouraged and supported skin-to-skin contact at birth.

Emotional support

- During an antenatal appointment, we observed a midwife discussing, sensitively, the woman's mental health wellbeing and discussing appropriate referrals that had been made. The midwife also discussed the outcome following a recent scan and blood pressure findings.

Maternity

- All women had the option and plan of care developed on an individual basis. Midwives told us that they were able to respond to the emotional needs of their women because they had time to talk and listen to their women's needs.
- One woman informed us that she felt supportive by the staff, through a pregnancy loss.
- Women told us support from midwives was readily available and provided through different forums including individual planned visits, referrals to specialist support groups, face to face appointments, phone calls, text messages and walk in hub facilities.
- One to One did not employ a specific bereavement midwife and no specific bereavement support or training was provided by the service. Staff told us that they would liaise with the named bereavement midwife at local trusts.

Are maternity services responsive?

Service planning and delivery to meet the needs of local people

- Staff informed us that the service aimed to establish good working relationships with local NHS trusts to ensure that the women received the best pregnancy and birth experience possible. However, staff said in some instances this had been challenging due to historic poor communication and lack of mutual understanding of services.
- The service was continuing to work and build working relationships with commissioners and acute trust in different geographical areas across the North West, to develop shared pathways and enable access for all eligible women across all services.
- The Warrington parents' advice centre (PAC) was located in a central suite in a busy shopping precinct. This innovative service enabled and encouraged women to seek advice and access antenatal care as frequently as they wanted.
- Senior staff attended the Clinical Commissioning Group (CCG) maternity network meetings and contributed to discussions and planning for local maternity services. We saw communication with commissioners and other stakeholders was ongoing. Staff also gave us examples of relationship building and meeting held with some local trusts.
- The service continued to promote and encourage continuity of carer, however, staff informed us that at times this was difficult to achieve. The service target was 80% for continuity of carer; however, data from the provider showed that across both locations, between April 2015 and March 2016, this target was only achieved six of the 12 months.

Access and flow

- There was no waiting list for appointments for One to One. Appointments were arranged at a mutually convenient time with flexibility offered by the service to fit around the woman's lifestyle and other commitments. Midwives were able to visit women on the same day if requested and considered necessary.
- Patients were able to access midwives and maternity care 24 hours a day, seven days a week. The service had a criteria pathway for including or excluding women into different care pathways. Expectant mothers were excluded if they lived outside the area of a commissioning CCG and if they were under 14 years old.
- Parent education classes were offered in a group setting in various locations or on an individual basis if requested.
- The service had a service level agreement with a private scanning company to perform scans at Bidston and St James children centre and the Warrington PAC. Patients were also referred into their local trust scan departments if concerns or deviations from the normal were seen.
- Information leaflets and booklets about all aspects of pregnancy including healthy eating, fetal movements and smoking cessation were available at the Bidston and St James children centre and the Warrington PAC.
- The service provided postnatal care to women who delivered their babies in an acute trust.

Meeting people's individual needs

- The service accepted low and high-risk women for maternity care. Midwives manged the care of women with pre-existing medical or obstetric conditions by

following One to One pathways and national guidelines and sharing care with acute trusts the women were also booked at. When we asked staff who led the care if women were under shared care and staff informed us that the trust were the lead care provider.

- Midwives told us they always researched the required best practice guidance for managing the care of women with complex medical and obstetric conditions. The midwives developed complex plans of care based on individual needs and appropriate communications with external agenises and health providers.
- Hypnobirthing classes were offered to women antenatally. This encouraged deep relaxation and considered to reduce the need for pain control during birth. The service provided specialist new born baby clinics including 'tongue tie' and breast-feeding clinics.
- Some staff had completed the This enable staff to offer the first (new born) examination to new born babies within 72 hours of birth; and subsequently, the second examination at the six to eight week check, in the primary care setting.
- A maternal mental health risk assessment form was completed and the midwives received training to provide initial support. Midwives referred women to external perinatal mental health services, which include antenatal and postnatal mental health.
- One to One staff and external agencies also provided services such as pregnancy and baby yoga, baby massage, smoking cessation, weight management, baby music sessions, crochet classes, breast-feeding support groups.
- It was announced at the team leader meeting, we attended, that One to One midwives were now able to facilitate delivery unit tours for their One to One women at a local trust. This was a positive example of how communications and relationships were being developed.
- One woman told us that the midwives offered a personal service, with extended appointments in the woman's own home.

Learning from complaints and concerns

- There were 18 complaints received in 2016. These included complaints about lack of contact from allocated midwife, lack of continuity of midwife at birth and poor communication.
- Complaints we reviewed were all managed in a timely manner and communication with families were undertaken by telephone or a home visit and followed up with a letter addressing concerns with an action plan.
- We saw evidence of lessons learnt displayed in a staff room, following a complaint from a service user in October 2016.
- The Chief Executive had overall responsibility for complaints and ensured that the necessary action had been taken to address the complaint. The Quality and Governance Team were responsible for overseeing the management of complaints within the organisation.
- Complaints were a standing agenda item for the following monthly meetings: board, clinical senior management team and QA group. The QA reviewed complaints and compliments and would identify any themes. Themes would then be escalated to the Board and to the clinical teams for recommendations and development of an action plan.
- The One to One complaints policy was uploaded on the intranet for all staff to access. How to make a complaint was also printed in the handheld notes for women to access.
- Patients and their families had several routes whereby concerns or formal complaints could be made. These included social media (there was a comments link for women to fill and submit on the One to One webpage). These were reviewed daily by the marketing and communications lead. All feedback was submitted via email to the Risk lead midwife to action.
- Complaints were risk assessed for severity and dependent on risk determined who lead the investigation. The majority of less serious complaints were addressed through local resolution; each member of staff had the responsibility to try to resolve the complaint locally. If the complainant was unhappy with the response then the complaint was then escalated to the Quality and Governance team for review. On receipt of a complaint or a concern through social media, the

risk manager would call the complainant to discuss her concerns and expectations for resolution, and try to resolve the concerns. If the woman indicated that she wanted to make a formal complaint then the complaint would be logged on the database (Ulysses) and the complaints process followed.

- If the complaint was not resolved at a local level then the complainant would contact the Parliamentary and Health Service Ombudsman (PHSO). The contact details for the Ombudsman were printed in the handheld notes in the section, "How to contact with concerns?
- Lessons learnt were used to share learning from complaints throughout the organisation. The monthly lessons learnt were disseminated via the shared drive, displayed on staff notice boards and discussed at locality team meetings and are a standing agenda on the locality team meetings. Some lessons learnt were anonymised and then forwarded to the training manager to incorporate in aspects of training to ensure they became embedded within the organisation and reduce the risk of reoccurrence.

Are maternity services well-led?

Vision and strategy for this this core service

- Senior staff informed us that the vision for One to One Ltd was to grow the service into a company that was seen as the preferred choice for women and their families for their maternity care and to deliver this care to the safest and highest standards.
- Senior management informed us that One to One aimed to provide midwives with the ability to practice midwifery and not only improve the outcomes and reduce inequalities for women and their babies, but save lives.
- Over the next three years in line with the National Maternity Review (2016), One to One aims to grow the service provision in their existing geographical area, maintain, and improve safe, quality care and outcomes.
- During this period, senior staff informed us that they aim to continue to develop their caseloading continuity of carer model, with a focus on research opportunities to provide evidence and measure the impact of this model in community settings. One of the main priorities of One to One is to seek opportunities to promote and facilitate women's choices, including choice of provider for their maternity care.
- In order to achieve their vision, we were informed that the service would continue to value and develop their workforce in order that they can contribute to delivering safe, excellent care that women and their babies want and need.

Governance, risk management and quality measurement

- The service informed us that they did not refuse any women but referred to their inclusion and exclusion criteria to categorize "low" and "high" risk pregnancies. 'Low risk' referred to a pregnancy that was anticipated to be problem free, with no underlining obstetric or medical conditions. A 'high risk' pregnancy referred to a pregnancy, which is thought from the onset to be more at risk of complications before, during or after the delivery. This assessment of risk was based on a woman's past medical, gynaecological and/or obstetric history, pre-existing conditions and any other relevant issues as the pregnancy continues.
- The service informed us that the risk management process was underpinned by the organisational core values: excellence, safety, woman centred, integrity and professionalism.
- One to One participated in the RCOG (2015) "Each Baby Counts" programme. This national quality improvement programme aims to reduce the number of babies who die or are left severely disabled because of incidents occurring during term labour.
- Monthly QA meetings were scheduled. Meeting minutes from September 2016 to December 2016 showed that only the consultant obstetrician and SoM attended the September meeting. Attendees were not recorded for the October meeting. The November meeting all the senior team attended. The December meeting was cancelled due to annual leave and the January 2017 meeting was rescheduled to the end of the month due to the CQC inspection. The agenda include discussions about the risk register, incidents, high-risk homebirths and safety thermometer. Meeting minutes had an action

plan, which was derived directly from the information received during the meeting and sets out a clear action. A responsible lead and timeframes for completion were also identified.

- To support midwives through the clinical booking risk assessment and referral or transfer of care to a local acute trust, One to One had developed maternity pathways including the Midwives Mitigating Risk (MMR) document. This included antenatal, intrapartum and postpartum pathways, risk assessment, alerts and , which assisted staff to create a detailed plan of care for women. Staff used this detailed document in relation to NICE and RCOG guidance, internal policies and the NMC midwives rules and standards.
- A Fresh Eyes Review was undertaken monthly between the team leader and One to One midwives. The midwife was given the opportunity to discuss each woman on her caseload and the review would assist in ensuring that the women were on the correct pathway as per the MMR guidance. It also ensured that the correct assessments and documentation, including information sharing with the wider MDT were in place. This process was a supportive process and record keeping, shared information requirements, support an escalation process and ensure additional support for the care delivery, including internal and external MDT was provided. It helped identify any additional learning and development needs for the midwife in ensuring that they were competent confident practitioner who were acting within their scope of practice. It also ensured sharing of lessons learnt. It also provided an audit trail (evidence of discussion and overview). Staff told us that it helped with communication between the team if the midwife is unavailable or if a midwife is absent unexpectedly.
- Women with complex issues with recorded on Complex Care logs online. These were reviewed and updated on a monthly basis by the team leaders. These logs were used to assist in the escalation process to other staff, local trusts, relevant external agencies and risk midwife. The log was discussed and reviewed at the QA meeting.
- An Intrapartum “Time Out” online checklist was implemented in December 2016 following lessons learnt and discussions of incidents at the QA meeting. Staff at a homebirth completed the checklist, for women who were in active labour longer than four hours or a new member of staff attending the birth or any care deviations from normal. The checklist provided a summary of all staff attending the birth, review of care, assisted in a staff member clinically challenging another staff member andprovided a clear and concise summary if the woman was transferred into an acute trust. A separate checklist sheet was complete for every four hourly review. This tool used to provide feedback to team leaders in order to monitor care and provide support in order to continue and manage care provided. We observed four completed checklist sheets for two different women. All documentation was clear and concise. We did note that one midwife had been at the same homebirth for over 12 hours.
- Deviations from the normal during a labour at home were recorded on a variance sheet and a plan of care discussed with the woman was documented in the handheld birth record. A new variance sheet was completed for every new episode of concern. The midwives used the MMR as a reference to support clinical decision-making.
- If a decision was taken by staff to transfer a woman into hospital, an SBAR handover form was completed.
- A Safety Thermometer (a tool that allows teams to measure harm and review systems in progress in providing a care environment free of harm for women, NHS 2013) was available to staff to input relevant data monthly. A monthly email reminder was sent to all staff to upload their data however, senior staff informed us that the response was low as data was only recorded for their homebirth women, which consisted of 25% of their overall numbers. Data was included in the NHS England Open and Honest report.
- An up to date risk register for the service was provided during the inspection, with nine risks recorded. This was reduced from 14 risks on the previous register provided. Safeguarding training, documentation, screening failsafe, newborn infant examination, capacity constraints, and update of training database were all completed and closed.
- New current risks included SoM statute, inappropriate management of women with complex care needs, unable to meet GROW timescale, retention of midwives and caring for women with high risk pregnancies.

- All risks were reviewed. However, the register did not state a named lead for each risk. Five of the nine risks remained static, with the same information carried over from the previous register review. Two of the three new risks identified did not have an action plan documented.
- From January 2016 to December 2016, there were five VBAC deliveries. One had a homebirth and the remaining four had vaginal births at their booked trust. However, RCOG (2015) states that women should be advised to have continuous electronic fetal monitoring for the duration of a planned VBAC, in an obstetric unit. Therefore, the service was not following national guidelines at all times.
- Senior staff informed us that they held "risk reflection" sessions with staff to raise awareness of risks and discuss mock incidents and RCA s. These sessions were held every three months and enabled discussions around documentation and role-play.

Leadership and culture of service

- The organisational structure consisted of an executive team comprising of a chairperson, chief executive officer, clinical director, governance lead, head of clinical services and operational lead.
- The clinical director had direct communication and lines of responsibility to specialist and locality coordinators, clinical midwives and operational staff.
- We observed strong, knowledgeable leadership from the team leaders, who themselves felt well supported and engaged within the service. However all four team leaders had been promoted to their current leadership role between July and November 2016.
- During our inspection, we attended a team leader monthly meeting with the Head of Operations and Head of Clinical Services. Items on the agenda included health and safety, lone worker, infection control, occupational health, lessons learnt, feedback from the head of clinical services, summary of fresh eyes reviews, and audits.
- Team leaders informed us that senior managers were visible, approachable and were willing to listen and implement changes when necessary.
- All staff informed us that they felt well supported from within their teams, team leaders and senior management staff. They told us that there was an open, honest and helpful culture within the service in the North West.
- Staff that were employed by the service directly after qualifying felt they received a good induction programme, preceptorship package and were given adequate time to read the services Practice Points.
- All new staff we spoke to informed us that they were allocated their caseloading women gradually in order to avoid them being overwhelmed at the beginning. They also told us that it was a similar situation for the on call rota.
- Staff informed us about the buddy system in place for staff to support each other within their own and wider teams. It enabled staff to provide cross cover while they were away, on annual leave or on protected time. The buddy system also helped with the on call rota systems and flexibility with caseloading demands.
- Staff informed us that they held Keeping in Touch (KIT) meetings with their team leaders to discuss
- Staff informed us that management were supportive if they requested to attend specific training days.

Public and staff engagement

- A monthly staff survey was issued to obtain staff feedback.
- Patients we spoke to felt very positive and happy about the care they had received from the service. They told us their concerns were answered quickly and midwives responded to their text messages in a timely manner.
- The annual staff survey was conducted in January 2016 and included all full and part time clinical and non-clinical staff as well as administrative and information technology employees across the service. At the time, One to One (Ltd) employed 91 staff with 69 staff completing the survey, giving a response rate of over 75%. Of those respondents, 58% are clinical and 7.69%, support and allied staff.
- Summary from the findings showed that over 86% of employees looked forward to going to work and over 94% were enthusiastic about their job. Ninety two percent of employees have never experienced

harassment of bullying and 98.5% have not experienced discrimination. Eighty two percent of employees said that their manager takes a positive interest in their health and wellbeing. Eighty four percent of staff felt there were opportunities within their role to show initiative. An area for improvement was staff appraisals, 57.58% of staff reported having had their annual appraisal completed. One to One had identified this as a key goal for 2016 with team restructure and the additional training offered to locality coordinators and relevant managers. The aim was to achieve 100% of staff receiving timely and meaningful annual appraisal. Current figures showed that 79% of staff had received an annual appraisal.

- The staff survey also showed that 88.60% knew how to report unsafe clinical practice and over 80% would feel secure raising concerns. This is moderate decrease from the previous survey with 91% and 91% respectively. Over 97% of employees saw the care of service users as the organisations top priority. Over 95% of employees were happy with the standard of care for their friends or relatives and over 90% of employees were satisfied with the quality of care they gave to women. Ninety seven percent of staff believed in the One to One core values. These figures are all comparative to the previous survey.

Innovation, improvement and sustainability

- The regional clinical and operational leads informed us that they were working with partner organisations to establish shared pathways in all locations where One to One offered services. SLA agreements were being developed in some areas and One to One senior team were working with local trusts and CCG to ensure these were agreed and signed. However, One to One informed us that this was proving challenging with some partner organisations.
- One to One aim to continue to develop collaborative working relationships and agree and sign service level agreements with local trusts and CCGs.
- One to One aim to continue their development of shared pathways and governance with local trusts.
- Senior staff informed us that they would like to develop consistency across organizations especially proportionate responses to incidents.

Outstanding practice and areas for improvement

Outstanding practice

Start here...

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that all records include completed risk assessments, informed consent and decline of care and treatment by women are recorded fully and clearly and are easily assessable to other care providers.
- The provider must ensure that all national guidelines and inclusion and exclusion criteria pathways are strictly adhered to by staff.
- The provider must ensure NICE guidelines are followed for the administration of syntoncinon for the delivery of the placenta.
- The provider must ensure all staff complete all annual mandatory training.
- The provider must ensure all staff receives an annual appraisal review.
- The provider must undertake formal risk assessments for carrying medical gases in midwives cars and ensure that cylinders are transported in secure bags.
- The provider must complete formal risk assessments for the use of pools at homebirths.
- The provider must kept their risk register fully up to date, including review of static risks and include a named lead for each risk.
- The provider must ensure all staff complete the GROW training package and fully implementation the GROW package.

Action the provider SHOULD take to improve

- The provider should ensure that paper handheld notes are accurate, complete and contemporaneous records are kept in relation to care and treatment.
- The provider should ensure that all electronic records are printed and made available when women end the pregnancy.
- The provider should ensure all postnatal records are accurately documented in women's handheld notes and are easily assessable to other care providers.
- The provider should ensure all staff follow the correct cleaning process following the use of a pool.
- The provider should ensure all clinical areas are clean and well maintained in order to minimise the risk of infection.
- The provider should ensure that the "Lead" carer (especially if shared care) and a "High risk" pregnancy are clearly documented in the front of the handheld notes.
- The provider should continue to develop collaborative working relationships, agree, and sign service level agreements with local trusts and CCGs.
- The provider should continue to develop shared pathways and governance with local trusts.
- The provider should ensure all policies are up to date.
- The provider should continue to develop consistency across organizations especially proportionate responses to incidents.
- The provider should ensure better attendance from senior management at the monthly QA meetings.
- The provider should ensure that all staff are trained in providing care for women with complex obstetrics and medical conditions.
- The provider should ensure that all postnatal discharges that are received by telephone from the local trust are recorded in an official discharge record book.

Outstanding practice and areas for improvement

- The provider should monitor the competencies of staff such as caring for women using a pool and suturing and provide adequate training and regular updates to ensure staff skills are maintained.
- The provider should monitor and review the working hours of midwives attending homebirths.
- The provider should ensure all staff receive appropriate training and understand their individual responsibilities in relation to the duty of candour.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (b) Safe Care and Treatment. The provide must ensure all risk assessments are completed to mitigate any such risks. Regulation 12 (2) (c) Safe care and Treatment The provide must ensure that all staff have the qualification, competence, skills and experience to provide safe care.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (b) Good Governance The provider must ensure that all national guidelines and inclusion and exclusion criteria pathways are strictly followed in order to assess monitor and mitigate risks.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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